DECISION POINT REVIEW PLAN

The New Jersey Automobile Insurance Cost Reduction Act (NJ AICRA) which became effective March 22, 1999, established certain obligations that **you** must satisfy so that **we** may provide coverage for medically necessary treatment, **diagnostic testing** and durable medical equipment arising from injuries sustained in an automobile **accident**. This document details those requirements and provides additional information.

DECISION POINT REVIEW AND PRE-CERTIFICATION REQUIREMENTS UNDER YOUR AUTO POLICY
The following provisions apply in the event that **you** (or anyone else claiming benefits under **your** policy) are involved in a covered **loss** that results in personal injury. This notice is a part of **your** policy and **you** are encouraged to keep it with **your** other insurance documents. Bolded terms are defined in **your** policy.

When any co-payments or co-payment penalties apply, please refer to the section titled "Deductibles, Co-Payments and Co-Payment Penalties" to determine the Financially Responsible Party.

When documentation is required to be provided within a specified number of "business days", please note that **our** close of business is 5:00 pm. Information regarding holidays and emergency closings is available on **our** website at: plymouthrocknj.com.

WHAT SHOULD YOU DO IF YOU'RE INJURED IN AN AUTOMOBILE ACCIDENT?

REQUIREMENTS AFTER AN ACCIDENT OR LOSS
Report your **accident** as soon as possible to our First Report Unit. They can be reached toll-free at (800) 437-3535, 24 hours a day, seven days a week. If any persons insured under your policy have an automobile **accident** or loss, they or someone acting for them must promptly contact us. This notification shall include information regarding the facts of the **accident**, the nature and cause of the injury, the diagnosis and the anticipated course of treatment. You also may be required to provide previous medical history; including any and all records, diagnoses, and treatment information.

Failure to comply with prompt notice may result in a reduction of reimbursement (co-payment penalty) of eligible charges for **medically necessary** expenses that are incurred after notification to **us** is required and until notification is received. This additional co-payment will be based on the timeframe in which the **loss** is reported:

Reporting Timeframe	Co-Payment Penalty	Financially Responsible Party
Loss reported 31-60 days after **accident**	25% penalty	**Eligible Injured Person**
Loss reported 61 or more days after **accident**	50% penalty	**Eligible Injured Person**

A Personal Injury Protection (PIP) claim representative will contact **you** within 48 hours of reporting **your** claim to discuss **your** injuries and also to obtain the names of any **health care providers you** may be seeing. It is important that **we** have this information so that **we** can maintain contact with **your** providers regarding **your** treatment.

In order for **us** to process **your** claim, **you** must fully complete all sections of all forms sent to you. **We** will provide the Application for Benefits - Personal Injury Protection form, the HIPAA Compliant Medical Authorization form and a copy of this notice, when **you** report a claim involving personal injury. During the course of **your** claim, **we** may require **you** to provide additional information or forms.

Failure to promptly provide this information within the time frames set forth below may result in a reduction of reimbursement (co-payment penalty) of eligible charges for **medically necessary** expenses that are incurred after the information has been requested and until a complete response is received.

Information Production Timeframe	Co-Payment Penalty	Financially Responsible Party
Information provided 31-60 days after request	25% penalty	**Eligible Injured Person**
Information provided 61 or more days after request	50% penalty	**Eligible Injured Person**

You should share this information with all of **your health care providers** as they also will be responsible for adhering to the Decision Point Review and Pre-certification requirements and regulations. Each provider also is responsible for submitting the Notification of the Commencement of Treatment form.

SPECIAL REQUIREMENTS FOR MEDICAL EXPENSES

All providers with whom **you** consult or treat must follow the same Decision Point Review or Pre-certification procedures. These requirements apply at all times, except when the **medically necessary** treatments or care, diagnostic tests, medical services and medical transportation are provided within the first 10 days following the covered **accident** or when administered during **emergency care**.

Emergency care means any **medically necessary** treatment of a traumatic **bodily injury** or traumatic medical condition caused by the automobile **accident** that manifests itself by acute symptoms of sufficient severity, such that absence of immediate attention could result in death, serious impairment of bodily functions, or serious dysfunction of a bodily organ or part. **Emergency care** ends when the **eligible injured person** is discharged from acute care by the attending **health care provider. Emergency care** shall be presumed when medical care is initiated at a hospital within 120 hours following the **accident**.

DECISION POINT REVIEW

Pursuant to N.J. AICRA and N.J.A.C. 11:3-4.1 et seq., the New Jersey Department of Banking and Insurance (NJDOBI) has published standard courses of treatment, known as Care Paths, for soft tissue injuries of the neck and back, collectively referred to as the **Identified Injuries**. A copy of the Care Paths, accompanying rules, and list of identified injuries are available by accessing the NJDOBI web site at http://www.nj.gov/dobi/aicrapg.htm. For a list of **Identified Injuries,** see Exhibit A.

The Care Paths provide that treatment be evaluated at certain intervals called decision points. On the Care Paths, decision points are represented by hexagonal boxes. At each decision point, the **named insured**, **eligible injured person**, or treating **health care provider** must provide **us** with information about proposed further treatment. In addition, the administration of any diagnostic test referenced in paragraph (b) of N.J.A.C. 11:3-4.5 is subject to Decision Point Review, subject to the provisions of the remainder of that section.

Failure to comply with the Decision Point Review Plan will result in an additional 50% provider co-payment penalty of the eligible charges that are incurred for **medically necessary** services after notification is required, but before authorization is granted.

WHY IS PRE-CERTIFICATION NECESSARY?

The regulations were designed to ensure that **you** receive the appropriate level of quality care for **your** injuries. For this reason, **we** encourage **your health care provider** to contact **us** and agree to a comprehensive treatment plan, including prescription medications. This comprehensive treatment plan also may include treatment for injuries with recommended Care Paths. If pre-certification is required but not obtained, **we** will impose a provider co-payment penalty on services that are **medically necessary**, but not pre-certified. The provider co-payment penalty will be 50% of the lesser of:

1. the treating **health care provider's** usual, customary and reasonable charges; or,
2. the upper limit of the Medical Fee Schedule developed by the NJDOBI.

Keep in mind that in order to be considered medically necessary, all medical expenses must:

1. be rendered by a "**health care provider**";
2. be **“clinically supported**" and consistent with the symptoms, diagnosis, or indications of the "**insured**";
3. be consistent with the most appropriate level of service that is in accordance with the standards of good practice and standard professional treatment protocols, including Care Paths for an "**Identified Injury**";
4. not be rendered primarily for the convenience of the "**insured"** or the "**health care provider**"; and,
5. not involve unnecessary testing or treatment.

PRE-CERTIFICATION REQUIREMENTS

All of the following are subject to Pre-certification:

- Non-emergency surgical procedures

- Home health care
- In-patient rehabilitative services beyond 21 days
- Skilled nursing care
- Non-emergency inpatient and outpatient hospital care
- Infusion therapy
- Non-emergency medical transportation in excess of $50.00
- Outpatient psychological/psychiatric testing and/or services
- Non-emergency dental treatment and/or restoration
- Durable medical equipment, including orthotics and prosthetics costing in excess of $50
- All outpatient care, including follow-up evaluations, for soft tissue/disc injuries of the claimant's neck, back and related structures not included within the diagnoses covered by the Care Paths.
- All pain management services, except those provided for **Identified Injuries** in accordance with Decision Point Review.
- Any physical, occupational, speech, cognitive, or other restorative therapy, except those provided for **Identified Injuries** in accordance with Decision Point Review.
- Non-emergency drug screening and/or drug testing, including but not limited to any technical analysis of urine, hair, blood, breath, sweat, saliva or other biological specimen used to detect the presence or absence of specified drugs or their metabolites, controlled substances, alcohol or drugs prohibited by law.

Below is a list of some of the types of durable medical equipment that may cost in excess of $50, and would require pre-certification. Please note that the requirement includes, but is not limited to:

- Beds/mattresses
- Prosthetic devices
- TENS units
- Neuromuscular stimulators
- OBUS forms (back belt)
- Car seats
- Whirlpools/saunas/hot tubs
- Crutches/braces

While reimbursement for prescription medications does not require pre-certification, **we** do reserve the right to review all prescribed medications for medical necessity and/or causal relationship to the covered **accident**.

VOLUNTARY NETWORK REQUIREMENTS

(Diagnostic Testing, Durable Medical Equipment, Outpatient Facility Services, Prescription Drug Services)

Eligible injured persons will be referred to **our** approved Voluntary Networks as outlined below.

DIAGNOSTIC TESTING

The requirement to use **our** voluntary network for **diagnostic testing** applies at all times except when **medically necessary** diagnostic tests are provided within the first 10 days following the covered **accident** and when administered during **emergency care**. This applies to:

1. Magnetic resonance imagery (MRI)
2. Computer assisted tomography (CAT)
3. Needle electromyography (EMG), H-reflex and nerve conduction velocity (NCV) tests except when performed together by the treating physician;*
4. Soma sensory evoked potential (SSEP), visual evoked potential (VEP), brain audio evoked potential (BAEP), or brain evoked potential (BEP), nerve conduction velocity (NCV) and H-reflex study**
5. Electroencephalogram (EEG)

Pursuant to N.J.A.C 11:3-4.5, **we** will provide reimbursement for the tests outlined in numbers 3 and 4 above ONLY when the test results are provided and reports (including wave forms) meet the standard professional treatment protocols of the American Association of Neuromuscular and Electro-diagnostic Medicine (AANEM), even if the tests were authorized through the Decision Point Review or Pre-certification process.

***Your** treating **health care provider** may perform this electrodiagnostic testing and other electrodiagnostic testing in conjunction with a needle electromyography that is **medically necessary** and **clinically supported**. An out-of-network

penalty will not apply in this situation.

**These diagnostic tests are reimbursable when used to evaluate neuropathies and/or signs of atrophy, but not within 21 days following a traumatic injury.

We will provide an **eligible injured person** with a toll-free telephone number and/or Internet site information for **our** approved networks. It is the responsibility of the **eligible injured person** and/or their treating physician to obtain a current directory of providers within the individual network. The **eligible injured person,** their designee, or their treating physician must contact one of these networks directly in order to schedule an appointment with one of the providers within the network.

Failure to schedule the appointment through the voluntary diagnostic network or to utilize the voluntary diagnostic network will result in an additional 30% patient co-payment of the eligible charges that are incurred for **medically necessary** tests listed above.

DURABLE MEDICAL EQUIPMENT

We will provide an **eligible injured person** and/or their treating physician with a toll free telephone number and/or Internet site information for **our** approved durable medical equipment network. It is the responsibility of the **eligible injured person** and/or the treating physician to obtain a current directory of providers within the network. The **eligible injured person**, their designee, or their treating physician must contact one of these suppliers in order to obtain durable medical equipment.

Failure to obtain durable medical equipment in excess of $50 from a supplier in the approved network will result in an additional 30% patient co-payment of the eligible charges that are incurred for **medically necessary** durable medical equipment.

OUTPATIENT FACILITY SERVICES

The requirement to use **our** voluntary network for outpatient facility services applies at all times except when outpatient facility services are needed for any **medically necessary** treatment or procedures that are provided within the first 10 days following the covered **accident** and when administered during **emergency care**.

Outpatient facility services are facility charges for an outpatient medical procedure not requiring an overnight stay. This does not include any charges incurred in the emergency room on the date of **accident** or care rendered during the first 10 days following the **accident** date.

We will provide an **eligible injured person** with a toll free number and/or Internet site information for **our** approved outpatient facility network. It is the responsibility of the **eligible injured person** and/or the treating physician to obtain a current directory of providers within the individual network. The **eligible injured person,** their designee, or their treating physician must contact one of these networks directly in order to schedule an appointment with one of the providers within the network.

Failure to utilize the outpatient facility services network will result in an additional 30% patient co-payment of the eligible charges that are incurred for outpatient facility services.

PRESCRIPTION DRUG SERVICES

The requirement to use our voluntary network for prescription drug services applies at all times except when prescription medications are provided within the first 10 days following the covered **accident** and when administered during **emergency care**.

Prescription medications shall include any and all medications manufactured, compounded, dispensed or otherwise provided pursuant to a valid prescription from a licensed physician. Prescription medication shall also cover any form of medication, including pill, tablet, cream, spray or any other possible form in which medication can be distributed that is prescribed pursuant to a valid prescription from a licensed physician.

We will provide an **eligible injured person** and/or their treating physician with a toll free telephone number and/or Internet site information for **our** approved networks. It is the responsibility of the **eligible injured person** and/or his or her treating physician to identify pharmacies within the approved networks. The **eligible injured person**, their designee, or their treating physician must contact one of these pharmacies in order to obtain the prescription medications.

Failure to obtain the prescription medications from one of the approved third party pharmacies will result in an additional 30% patient co-payment of the eligible charges that are incurred for medically necessary prescription medications.

This does not include any prescription medications provided during **emergency care** or care rendered within the first 10 days following the date of the **accident.**

We reserve the right to review all prescription medications for medical necessity and/or causal relationship to the covered **accident**.

HOW TO SUBMIT REQUESTS FOR DECISION POINT REVIEW/PRE-CERTIFICATION

In order to obtain a Decision Point Review or Pre-certification (when necessary), **your health care provider** is required to contact **us** by fax at (732) 978-7100 or by mail at: PO Box 907, Lincroft, N.J. 07738-0907.

We will not accept or respond to submissions sent to any other address or fax number.

Please note that only Decision Point Review, Pre-certification requests, internal pre-service appeals and any supporting documentation for these items will be accepted at the foregoing fax and mailing address. All Decision Point Review and Pre-certification requests must include a completed Attending Provider Treatment Plan pursuant to Department of Banking and Insurance Order No. A16-101. A copy of the Attending Provider Treatment Plan form can be found on the NJDOBI website at www.nj.gov/dobi/aicrapg.htm. This form must be signed and dated by **your** treating provider.

Please note: An Attending Provider Treatment Plan form will not be accepted from a provider of service benefits (including, but not limited to, durable medical equipment suppliers, imaging facilities, ambulatory surgery centers, and pharmacies) who did not personally examine the patient. An Attending Provider Treatment Plan form must be submitted by the attending **health care provider** ordering the requested treatment, **diagnostic testing**, prescription medication or durable medical equipment.

So that **we** may consider and approve treatment or services rendered, or to establish a comprehensive treatment plan, each of **your** treating **health care providers** will be required to provide the following information:

1. A completed Attending Provider Treatment Plan which must include:
    a. the name of the insured and **eligible injured person**, date of **accident,** and claim number (if known)
    b. the proposed CPT codes for care
    c. the ICD diagnosis code
    d. specialty of the treating provider
    e. when seen by a nurse practitioner or physician assistant, the specialty of the supervising physician
2. **Clinically supported** findings to justify the requested treatment
3. All **diagnostic testing** results
4. All prescriptions or durable medical equipment that are being recommended
5. The patient's subjective complaints and legible medical records, including the **health care provider's** findings and plan (subjective complaints, objective findings, medical assessment, and plan; (SOAP) notes)
6. For surgical procedures, a completed Supplemental Surgical Pre-Certification Request Form (see below)

Once **we** receive **your** request, **we** will review **your** information and documentation and respond within three business days. The three business day period will not begin until **your** treating **health care provider** submits all of the information described in items 1 through 6**.**

If **we** make a request for additional information, the request for treatment is not deemed complete until the additional information is submitted and reviewed. **We** will respond to your request for treatment within three business days of our receipt of all of the additional information necessary to evaluate **your** request.

If **we** do not respond within three business days following **our** receipt of the complete request, then **your medically necessary** treatment can proceed with no provider co-payment penalty imposed, until a determination is communicated to **your health care provider**.

If **we** respond by telephone, a written notification will follow.

Approved services must be completed within the dates specified in our letter responding to the Decision Point Review/Pre-certification treatment request. Extensions of the time within which the approved services are to be performed must be

obtained by **your health care provider** via submission by fax at (732) 978-7100 or by mail at: PO Box 907, Lincroft, N.J. 07738-0907. Failure to obtain an extension of time will result in a 50% provider co-payment penalty even if the services are determined to be medically necessary.

N.J.A.C. 11:3-4.7(c) 4 requires that denials for reimbursement of treatment or administration of a test be based on medically necessity as determined by a physician or dentist.

We reserve the right to review all proposed treatment *after* the initial 10-day period if it differs from a Care Path or treatment plan already agreed to by your **health care provider** and **us**. **We** will perform this review to determine if the proposed treatment is "**medically necessary**" and "**clinically supported.**" **We** also reserve the right to review all treatment that was given *during* the initial 10-day period, in order to determine if that treatment was "**medically necessary**" and **"clinically supported."**

Supplemental Surgical Pre-Certification Request Form

In addition, **we** require supplemental information for pre-certification requests for all surgical procedures, including the name of the facility where services will be performed, the proposed surgery date, the need for and names of co-surgeons, assistant surgeons, physician assistants and/or Registered Nurse First Assistant as supported by CMS guidelines, anticipated post-operative services and care not included in the global fee, such as therapy, **diagnostic testing**, and/or durable medical equipment. This information must be submitted on the Surgery Precertification Request Form which is available for **your** convenience on http://www.Plymouthrocknj.com or by contacting the assigned PIP Claim Representative. Requests for surgeries that do not include the necessary information will be denied as deficient until the additional information required is supplied.

PHYSICAL EXAMINATIONS / INDEPENDENT MEDICAL EXAMS (IMES)

If we are concerned that you are not receiving the level of care you need for your injuries, New Jersey law specifically calls for us to request a physical examination. A physical examination will ensure that you receive a “second opinion” from an independent doctor of the same discipline, to verify that you are being treated appropriately. N.J.A.C. 11:3-4.7(e) requires that:

- **You** or **your** designee is notified that a physical exam is required before reimbursement of further treatment, tests, or durable medical equipment is authorized.
- The appointment will be scheduled within seven calendar days of **your** receipt of notice of the need for a physical examination or tests unless **you** agree to extend the time period.
- The exam will be conducted by a provider of the same discipline as **your** treating **health care provider**.
- The exam shall be conducted at a location reasonably convenient to **you**.
- **Your** treating **health care provider** or **you** shall, upon request, provide medical records and other pertinent information to the provider conducting the exam no later than at the time of the exam.
- The results of the exam will be provided within three business days after the exam. If **we** fail to notify **your** treating provider within three business days, then the provider is permitted to continue the course of treatment until **we** provide the required notice. If a written report concerning the exam was prepared, then **you** or **your** designee shall be entitled to a copy upon request. All **medically necessary** treatment or tests may proceed while a physical or mental examination is being scheduled and until the results are available; however, only **medically necessary** treatment related to the motor vehicle **accident** will be reimbursed.

You must provide all requested medical records, including but not limited to, diagnostic imaging films and test results to the provider who conducts the examination. **You** must bring all prescribed durable medical equipment including but not limited to electro-stimulation devices, supports and braces to the examination. All requested information must be provided no later than the date and time of the examination. Failure to comply with the request and submission of information will be considered an unexcused failure to attend the examination.

You or your legal guardian must provide proper identification, in the form of a photo ID, at the time of the examination. Failure to produce such identification at the time of the examination may constitute an incomplete examination. If you are non-English speaking, then an English speaking interpreter must accompany you to the examination. Should the need arise for the use of an interpreter service, notification to **us** must be received at least ten (10) business days prior to the scheduled examination date. Failure to comply with the conditions set forth with in this section will be considered an unexcused failure to attend the examination.

Your failure to attend the scheduled physical examination will be considered excused if **you or your** legal representative

notifies Plymouth Rock at least three (3) business days prior to the examination date and reschedules the date not to exceed thirty (30) days from the original physical examination date. Failure to comply with these conditions will result in an unexcused failure to attend the examination.

Your repeated unexcused failure to attend a scheduled physical examination will result in all treatment, **diagnostic testing**, approved prescription medication and/or durable medical equipment becoming non-reimbursable. If **you** have had two (2) unexcused failures to attend the scheduled physical examination, notification will be sent to **you** or **your** designee, and **your health care provider**(s). The notification will place **you** or **your** designee, and all of **your health care provider**s on notice that all future treatment, **diagnostic testing**, prescription medication and/or durable medical equipment for **your** injuries will not be reimbursable as a consequence of **your** failure to comply with the Decision Point Review Plan.

OUR INTERNAL APPEAL PROCESS

If **your provider** disagrees with **us** regarding a comprehensive treatment plan or authorization for treatment, or the amount of reimbursement for medically necessary treatment, diagnostic tests, laboratory tests, prescription medications, or durable medical equipment, then he or she must submit a written appeal in accordance with the procedures set forth below.

Pursuant to N.J.A.C. 11:3-4.7B, there shall be two types of internal appeals:

1. **Pre-service**: Appeals of Decision Point Review and/or precertification denials or modifications prior to the performance or issuance of the requested medical procedure, treatment, diagnostic test, other service and/or durable medical equipment (collectively known as "services"); and
2. **Post-service**: Appeals subsequent to the performance or issuance of the services.

An appeal of a decision regarding a Decision Point Review/Pre-certification request must be made as a **pre-service** appeal.

Pre-service appeals must be submitted prior to the performance or issuance of the requested medical procedure, treatment, diagnostic test, other service and/or durable medical equipment (collectively known as "services"); and must be made within 30 days after we issue our denial or modification of your requested services.

We will issue our decision on a **pre-service** appeal within 14 days after receipt of a properly completed **pre-service** appeal form that includes all required supporting documentation.

A **post-service** appeal is not permitted with respect to a decision as to the medical necessity or causal relationship to the **accident** of a medical procedure, treatment, diagnostic test, pharmaceutical prescriptions, other service and/or durable medical equipment that is provided more than 10 days after the **accident** or after **emergency care**. Appeals regarding the medical necessity or causal relationship to the **accident** of treatments or care, diagnostic tests, medical services and medical transportation provided within the first 10 days following the covered **accident** or administered during **emergency care** may be submitted as **post-service** appeals.

Post-service appeals must be submitted within ninety (90) days following our decision and at least 45 days prior to initiating PIP Dispute Resolution.

We will issue our decision on a **post-service** appeal within 30 days after receipt of a properly completed **post-service** appeal form that includes all required supporting documentation.

We only permit a one level appeal procedure for each appealed issue before PIP Dispute Resolution. That is each issue shall only be permitted to receive one internal appeal review by **us** prior to PIP Dispute Resolution. An appeal of the denial of a medical procedure, treatment, diagnostic test, pharmaceutical prescriptions, other service, and/or durable medical equipment on the grounds of medical necessity is a different issue than an appeal of what **we** reimbursed **you** or **your** provider for that same service.

All post-service appeals involving a dispute over usual, customary or reasonable allowances (UCR) must include UCR proofs from the **health care provider** by way of explanations of reimbursement (EOBs/EORs) from other payers including both PIP and health care carriers.

All post-service appeals involving a dispute over Health Care Primary/PIP Secondary payments must include copies of the health carrier's EOB for each date of service in dispute and documentation from the health carrier as to why the treatment was not reimbursed.

All post service appeals involving a Preferred Provider Organization (PPO) dispute must include any document or other information that the **health care provider** is relying upon to rebut the application of the PPO agreement and/or the PPO payment amount.

All appeals must be submitted using the **Pre-service** Appeal Form and/or **Post-service** Appeal Form posted on the NJDOBI website.

Pre-service appeals must be sent via fax to (732) 978-7100 or mailed to **us** at: P.O. Box 907, Lincroft, N.J. 07738-0907.

Post-service appeals must be sent via fax to (732) 978-6320 or mailed to **us** at: P.O. Box 907, Lincroft, N.J. 07738-0907. Only post service appeal forms and supporting documentation will be accepted at this post service appeal fax line.

Only pre-certification requests, pre-service appeals, and post-service appeals with their supporting documents will be accepted at P.O. Box 907.**We** will not accept or respond to submissions in any other format or faxed to any other fax number.

Only **your health care provider** may file an internal appeal. **Your** provider must include the specific reason(s) explaining why he or she disagrees with our decision and must supply any additional documentation or cite to the exact portion of previously submitted documentation on which the provider bases his or her disagreement with our decision. Submission of information identical to the documentation submitted in support of the initial request shall not be accepted as an appeal request. Failure to provide supporting documents with the appeal shall deem the appeal invalid. Pursuant to N.J.A.C. 11:3-4.7B(h) and (i), a written response will be submitted to the provider who filed the appeal.

Please note that only Decision Point Review, pre-certification requests, internal appeals and any supporting documentation for these items will be accepted at the above referenced mailing address and fax number. Should **your** provider disagree with **our** internal appeal decision, he or she may proceed to PIP Dispute Resolution in accordance with New Jersey law.

Your provider must comply with and exhaust **our** internal appeal process as a condition precedent to the filing of PIP Dispute Resolution.

Your provider may contact **our** Medical Management Department with questions regarding Decision Point Review, pre-certification and internal appeals by calling 1-888-814-6397, Monday through Friday 8 a.m. to 5 p.m.

The internal appeals process is an attempt to resolve disputes directly between **us** and the **provider**. Providers who retain counsel to assist them in the internal appeals process do so strictly at their own expense. **We** will not reimburse providers for their attorney fees or any other costs regardless of the outcome of the appeals process.

PIP DISPUTE RESOLUTION

A Dispute Resolution Organization ("DRO"), appointed by the NJDOBI, administers the PIP Dispute Resolution Plan ("DRP"). As to any dispute that arises from issues within the scope of PIP coverage, the DRP is the sole and exclusive method or remedy for resolving disputes not subject to or resolved by the internal appeals process. Please be aware that unless both parties agree to resolve this dispute in a court of law or equity, this Dispute Resolution Plan shall be the sole initial forum to resolve this dispute, and that **you** and **we** have waived any right **you** or **we** have to select a court of law or equity as the first forum for resolution of this dispute.

DIAGNOSTIC TESTING NOT COVERED

Reimbursement will not be provided under the PIP portion of **your** automobile policy for the following tests:

- Iridology
- Mandibular tracking and simulation
- Reflexology
- Spinal diagnostic ultrasound
- Surface electromyography (surface EMG)
- Surrogate arm mentoring
- X-ray digitization
- Computer-aided radiographic mensuration; and
- Any other diagnostic test that is determined to be ineligible for PIP coverage under New Jersey law or regulation.

Under NJDOBI regulations, these tests have been determined to yield no data of significant value in the development,

evaluation, or implementation of a plan for treatment.

Pursuant to N.J.A.C. 11:3-4.5(f), reimbursement will not be provided under the PIP portion of **your** automobile policy for the following tests for the diagnosis or treatment of TMJ/D:

- Sonography
- Doppler ultrasound
- Needle EMG
- EEG
- Thermograms/thermographs
- Videofluoroscopy
- Mandibular tracking
- Surface electromyography (surface EMG)
- Reflexology

OTHER SERVICES NOT COVERED

We also will not provide reimbursement for the following:

- Laboratory testing services from any entity that has not obtained the appropriate state and/or federal accreditations and/or certifications to perform testing on human specimens.
- Prescription medications, drugs and biologicals that are not approved by the United States Food and Drug Administration ("USFDA").
- Compound prescription medications, drugs and/or biologicals that, as compounded, are not approved by the USFDA, including but not limited to, compounds that may have in their formulary one or more medications, drugs and/or biologicals individually approved by the USFDA.
- Any CPT/HCPC codes that NJDOBI has determined as non-reimbursable pursuant to N.J.A.C. 11:3-4.5(a)
- **We** have no obligation to reimburse for unlisted procedure or unlisted service codes unless your provider submits documentation describing the procedure or service, demonstrating its medical appropriateness and indicating why it is not duplicative of a code for a listed procedure or service. This applies even if the unlisted procedure or unlisted service codes were approved through a Decision Point Review or Pre-certification request as being medically necessary and causally related to the **accident**.

ASSIGNMENT OF BENEFITS, CONDITIONS OF ASSIGNMENT

Under **your** PIP coverage, **we** can reimburse **you** directly for covered expenses. However, in some cases, **your** doctor or other **health care provider** may ask that **your** benefits be "assigned" to them, so that **we** pay *them* directly. If **you** choose to assign **your** benefits to **your** doctor or other **health care provider, you** have waived **your** right to file any claim, lawsuit or arbitration against **us** seeking reimbursement for those benefits. The doctor or other **health care provider** to whom **you** have assigned **your** benefits shall be required to file any disputes through PIP Dispute Resolution and must provide a dated, signed, and fully completed copy of the assignment with the filing.

If benefits are paid directly to the **health care provider**, then the provider is subject to the requirements of this Decision Point Review Plan and the **provider** agrees to resolve all issues defined as "PIP Disputes" under N.J.A.C. 11:3-5 through PIP Dispute Resolution. In order to invoke PIP Dispute Resolution, providers must comply with all procedures set forth in the internal appeals portion of this Decision Point Review plan. **Your provider** also agrees they must file any disputes through PIP Dispute Resolution. Any costs and attorney fees associated with filing a lawsuit involving a matter required to be filed with PIP Dispute Resolution will be the sole responsibility of the filing party.

As an additional condition of assignment, the **provider** must agree to be bound by the duties of cooperation as outlined in **your** automobile insurance policy and is required to hold harmless the **eligible person** and **us** for any reduction of benefits caused by his or her failure to comply with the terms of this Decision Point/Pre-certification Plan and/or policy condition.

As an additional condition of assignment, the **provider** must agree to cooperate with **us** and to supply **us** with all documents that **we** request in order to establish that the **provider** is properly licensed, incorporated, authorized and/or certified to perform and bill for the treatment, testing or services at issue. This includes but is not limited to providing copies of professional licenses, corporate charters, operating agreements and employee contracts. **Your provider** also must agree to be interviewed by **us** and/or appear for an examination under oath within 30 days of **our** request.

Failure by the **health care provider** to comply with all of the foregoing requirements will render any prior assignment of benefits under **your** policy null and void.

DEDUCTIBLES, CO-PAYMENTS AND CO-PAYMENT PENALTIES

Statutory Deductibles and Co-Payments:

Deductible Choice	Co-Pay	Total	Financially Responsible Party
$250	$950	$1,200	**Eligible Injured Person**
$500	$900	$1,400	**Eligible Injured Person**
$1,000	$800	$1,800	**Eligible Injured Person**
$2,000	$600	$2,600	**Eligible Injured Person**
$2,500	$500	$3,000	**Eligible Injured Person**

Co-payments listed above are the maximum statutory co-payments if **your** medical expense benefits exceed $5,000. The co-payment may be less depending on the medical expense benefits presented.

All Co-payments or Penalties listed below are in addition to the statutorily mandated deductible and co-payment.

Late reporting Co-Payment Penalties:

Reporting Loss Timeframe:	Co-Payment Penalty	Financially Responsible Party
31-60 days after the loss	25%*	**Eligible Injured Person**
61 or more days after the loss	50%*	**Eligible Injured Person**

Information Production Timeframe	Co-Payment Penalty	Financially Responsible Party
Information provided 31-60 days after request	25%*	**Eligible Injured Person**
Information provided 61 or more days after request	50%*	**Eligible Injured Person**

*Co-payment Penalties apply to eligible charges that are incurred for medically necessary services.

Decision Point Review Plan Co-Payments or Penalties:

Provisions that will trigger a Penalty:	Co-Payment or Penalty	Financially Responsible Party
Failure to comply with Decision Point Review	50% *	**Provider**
Failure to comply with Pre-certification	50% *	**Provider**
Failure to use voluntary diagnostic network	30% *	**Eligible Injured Person**
Failure to use our approved durable medical equipment supplier for equipment in excess of $50	30% *	**Eligible Injured Person**
Failure to use voluntary outpatient facility network	30% *	**Eligible Injured Person**
Failure to use prescription drug network	30% *	**Eligible Injured Person**
Failure to attend second independent medical examination	100%*	**Eligible Injured Person**

*Co-payment or Penalties apply to eligible charges that are incurred for **medically necessary** services.

EXHIBIT A –

ICD CODES FOR TREATMENT OF CARE PATH INJURIES

The following ICD diagnostic codes are associated with Care Path 1 through Care Path 6 for treatment of Accidental Injury to the Spine and Back and are included on each appropriate Care Path. The ICD codes referenced do not include codes for multiple diagnoses or co-morbidity.

Code	Description
722.0 / M50.20	Displacement of cervical intervertebral disc without myelopathy
722.1/ M51.26	Displacement of thoracic or lumbar intervertebral disc without myelopathy
722.2/ M51.9	Displacement of intervertebral disc, site unspecified, without myelopathy
722.11/ M51.24	Displacement of thoracic intervertebral disc without myelopathy
722.70/ M51.9	Intervertebral disc disorder with myelopathy, unspecified region
722.71/ M50.00	Intervertebral disc disorder with myelopathy, cervical region
722.72/ M51.04	Intervertebral disc disorder with myelopathy, thoracic region
722.73/ M51.06	Intervertebral disc disorder with myelopathy, lumbar region
728.0/ M60.09	Disorders of the muscle, ligament and fascia
728.85/ M62.40	Spasm of muscle
739.0/ M99.00	Non allopathic lesions-not elsewhere classified
739.1/ M99.01	Somatic dysfunction of cervical region
739.2/M99.02	Somatic dysfunction of thoracic region
739.3/M99.03	Somatic dysfunction of lumbar region
739.4/ M99.04	Somatic dysfunction of sacral region
739.8/ M99.08	Somatic dysfunction of rib cage
846/ S338.XXA	Strains and sprains of sacroiliac region
846.0/S338.XXA	Sprains and strains of lumbosacral (joint) (ligament)
846.1/S336.XXA	Sprains and strains of sacroiliac region
846.2/ S338.XXA	Sprains and strains of sacropinatus (ligament)
846.3/ S338.XXA	Sprains and strains of sacrotuberous (ligament)
846.8/ S338.XXA	Sprains and strains of other unspecified sites of sacroiliac region
846.9/S338.XXA	Sprains and strains, unspecified site of sacroiliac region
847.0/ S134.XXA	Sprains and strains of neck
847.1/ S233.XXA	Sprains and strains, thoracic
847.2/ S335.XXA	Sprains and strains, lumbar
847.3/ S338.XXA	Sprains and strains, sacrum
847.4/ S338.XXA	Sprains and strains, coccyx
847.9/ S239.XXA	Sprains and strains, unspecified site of back
922.3/ S300.XXA	Contusion of back
922.31/ S300.XXA	Contusion of back, excludes interscapular region
922.33/ S202.29A	Contusion of back, interscapular region
953.0/ S142.XXA	Injury to cervical root
953.2/ S342.1XA	Injury to lumbar root
953.3/ S342.2XA	Injury to sacral root

EXHIBIT B -

DIAGNOSTIC TESTS SUBJECT TO DECISION POINT REVIEW

Voluntary Network applies

Needle electromyography (Needle EMG) #
Somasensory evoked potential (SSEP) #
Magnetic resonance imaging (MRI) #
Visual evoked potential (VEP) #
Brain audio evoked potential (BAEP) #
Brain evoked potential (BEP) #
Nerve conduction velocity (NCV) #
Computer assisted tomographic studies (CT, CAT Scan) #

H-reflex study #
Electroencephalogram (EEG) #
Videofluroscopy
Dynatron/cyber station/cybex
Sonograms/ultrasound
Thermogram/Thermography
Brain mapping