INTRODUCTION BROCHURE

At Personal Service Insurance Company (PSI), we understand that when you purchase an automobile insurance policy, you are buying protection and peace of mind in the event you are injured in an accident. It is, therefore, important to you that Personal Service Insurance Company provides you with first rate claims service. Our goal is to process claims for medically necessary treatment and testing quickly and fairly.

This brochure explains how your medical claims will be handled, including the Decision Point Review/Pre-certification requirements which you and your medical provider must follow in order to receive the maximum benefits provided by your policy. Please read this brochure carefully. If you have any questions, please call your Claim Representative at 610-832-4940.

DECISION POINT REVIEW AND PRE-CERTIFICATION REQUIREMENTS

Please note: Under the provisions of your policy and applicable New Jersey regulations, Decision Point Reviews and/or Pre-certification of specified medical treatment and testing is required in order for medically necessary expenses to be fully reimbursable under the terms of your policy. The following questions and answers only provide an overview of Decision Point Reviews and Pre-certification requirements. You should read your policy for the actual Pre-certification requirements as well as other policy terms and conditions.

Treatment in the first 10 days after an accident and emergency care does not require Decision Point Review or Pre-certification. However, for benefits to be paid in full, the treatment must be medically necessary. This is true in all events.

Question: What is a Decision Point Review?

Answer: The New Jersey Department of Banking and Insurance (the "Department") has published standard courses of treatment, **Care Paths**, for soft tissue injuries of the neck and back, collectively referred to as the "Identified Injuries". These Care Paths provide your health care provider with general guidelines for treatment and diagnostic testing as to these injuries. In addition the Care Paths require that treatment be evaluated at certain intervals called **Decision Points**. At Decision Points, your health care provider must provide us information about any further treatment or test required. This is called **Decision Point Review.** During the Decision Point Review process, all services requested are evaluated by medical professionals to insure the level of care you are receiving is medically necessary for your injuries. This does not mean that you are required to obtain our approval before consulting your medical provider for your injuries. However, it does mean that your medical provider is required to follow the Decision Point Review requirements in order for you to receive maximum reimbursement under the policy. In addition, the administration of any test listed in N.J.A.C. 11:3-4.5(b) 1-10 also requires Decision Point Review, regardless of the diagnosis. The **Care Paths** and accompanying rules are available on the Internet at the Department's website at www.nj.gov/dobi/aicrapg.htm or can be obtained by contacting CSG @ 1 (877) 258-CERT (2378).

Question: What is Pre-certification?

Answer: Pre-certification is a medical review process for the specific services, test or equipment listed below in (a)-(l). During this process all services, test or equipment requested are evaluated by medical professionals to insure the level of services, tests or equipment you are receiving is medically necessary for your injuries. This does not mean that you are required to obtain our approval before consulting your medical provider for your injuries. However, it does mean that your medical provider is required to follow the Pre-certification requirements in order for you to receive maximum reimbursement under the policy.

(a) non-emergency inpatient and outpatient hospital care
(b) non-emergency surgical procedures
(c) extended care rehabilitation facilities
(d) outpatient care for soft tissue/disc injuries of the insured person's neck, back and related structures not included within the diagnoses covered by the Care Paths
(e) physical, occupational, speech, cognitive or other restorative therapy or other body part manipulation except that provided for Identified Injuries in accordance with Decision Point Review
(f) outpatient psychological/psychiatric testing and/or services
(g) all pain management services except as provided for identified injuries in accordance with decision point review
(h) home health care
(i) non-emergency dental restoration
(j) temporomandibular disorders; any oral facial syndrome
(k) infusion therapy
(l) Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of $75.00.

Question: What do I need to do to comply with the Decision Point Review and Pre-certification requirements in my policy?

Answer: Just provide us with the name(s) of your medical providers. We will then contact them to explain the entire process. You should also give your medical provider a copy of the "*Dear Provider Letter*" included with this brochure.

Question: How does the Decision Point Review/Pre-certification Process Work?

Answer: In order for CSG to complete the review, your heath care provider is required to submit all requests on the "Attending Physicians Treatment Plan" form in accordance with order number A04-143. A copy of this form can be found on the DOBI web site www.nj.gov/dobi/aicrapg.htm, CSG's web site www.medlogix.com or by contacting CSG @ (877) 258-CERT (2378).

The health care provider should submit the completed form, along with a copy of your their most recent/appropriate progress notes and the results of any tests relative to the requested services to CSG via fax at (856) 910-2501 or mail to the following address: CSG, Inc., 3 Executive Campus,

Suite 100, Cherry Hill, NJ 08002, ATTN.: Pre-Certification Department. Its phone number is (877) 258-CERT (2378).

The review will be completed within three (3) business days of receipt of the necessary information and notice of the decision will be communicated to both you and your health care provider by telephone, fax and/or confirmed in writing. If your health care provider is not notified within 3 business days, they may continue your test or course of treatment until such time as the final determination is communicated to them. Similarly, if an independent medical examination should be required, they may continue your tests or course of treatment until the results of the examination become available.

Denials of decision point review and pre-certification requests on the basis of medical necessity shall be the determination of a physician. In the case of treatment prescribed by a dentist, the denial shall be by a dentist.

INDEPENDENT MEDICAL EXAMS

Question: What are the requirements and consequences if I am requested to attend an Independent Medical Exam?

Answer: If the need arises for CSG to utilize an independent medical exam during the decision point review/pre-certification process, the guidelines in accordance to 11:3-4.7(e) 1-7 will be followed. This includes but is not limited to: prior notification to the injured person or his or her designee, scheduling the exam within seven calendar days of the receipt of the attending physicians treatment plan form (unless the injured person agrees to extend the time period), having the exam conducted by a provider in the same discipline, scheduling the exam at a location reasonably convenient to the injured person, and providing notification of the decision within three business days after attendance of the exam. If the examining provider prepares a written report concerning the examination, you or your designee shall be entitled to a copy upon written request.

If you have two or more unexcused failures to attend the scheduled exam, notification will be immediately sent to you, and all health care providers treating you for the diagnosis (and related diagnosis) contained in the attending physicians treatment plan form. The notification will place you on notice that all future treatment, diagnostic testing or durable medical equipment required for the diagnosis (and related diagnosis) contained in the attending physicians treatment plan form will not be reimbursable as a consequence for failure to comply with the plan.

INTERNAL DISPUTE RESOLUTION PROCESS / PERSONAL INJURY PROTECTION DISPUTE RESOLUTION

Question: Can my health care provider appeal the Decision Point Review or Pre-certification decision?

Answer: Under Personal Service Insurance Company's Conditional Assignment of Benefits, the provider shall be required to submit disputes to the Internal Dispute Resolution process before submitting the disputes to Personal Injury Protection Dispute Resolution under N.J.A.C. 11:3-5, et seq.

To submit an issue to the Internal Dispute Resolution process, the provider must complete an Internal Dispute Resolution request form and select a physician to review the dispute from a list maintained by CSG. If the provider does not select a reviewing physician, one will be selected on the provider's behalf. The request form and any supporting documentation must be submitted to PSI. The reviewing physician's Internal Dispute Resolution decision will be communicated to the provider no more than 30 days after receipt of the request form and all pertinent medical information required to review the dispute. The decision by the reviewing physician is non-binding to all parties.

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

The Internal Dispute Resolution request form is available at PSI's website at www.personalserviceinsurance.com or at CSG's website at www.medlogix.com,. The list of physician reviewers is available at CSG's website at www.medlogix.com.

A PIP dispute, as defined by N.J.A.C. 11:3-5, may be submitted to Personal Injury Protection (PIP) Dispute Resolution in accordance with the Personal Service Insurance Company policy. PIP Dispute Resolution shall be conducted in accordance with the procedures set forth in N.J.A.C. 11:3-5, including any amendments. The final determination made by the dispute resolution professional shall be binding on the parties, but subject to vacation, modification or correction by the Superior Court in an action filed pursuant to N.J.S.A 2A:23A-13 for review of the award.

Under PSI's Conditional Assignment of Benefits, after exhausting the Internal Dispute Resolution process, a provider must submit any PIP dispute, as defined by N.J.A.C. 11:3-5, to PIP Dispute Resolution in accordance with this Plan.

VOLUNTARY UTILIZATION PROGRAM

Question: Does the plan provide voluntary networks for certain services, tests or equipment?

Answer: In accordance with the regulations, the plan includes a voluntary utilization program for:

1. Magnetic Resonance Imagery
2. Computer Assisted Tomography
3. The electro diagnostic tests listed in N.J.A.C. 11:3-4.5(b)1 through 3, except when performed by the treating physician
4. Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of $75.00
5. Services, equipment or accommodations provided by an ambulatory surgery facility

Question: How do I gain access to one of these networks?

Answer: When one of the above listed services, tests or equipment is requested through the decision point review/pre-certification process, a detailed care plan evaluation letter containing the outcome of the review is sent to you, and the requesting health care provider. The notice will include how to acquire a list of available preferred provider networks, with phone numbers and addresses, to obtain the medically necessary services, tests or equipment requested. In accordance with N.J.A.C.11:3-4.4(g), failure to use an approved network will result in an additional co-payment not to exceed 30 percent of the eligible charge.

In addition to securing a list of preferred provider networks through the process outlined in the paragraph above, visit CSG's website @ www.medlogix.com, contact CSG by phone @ (877) 258-CERT (2378), via fax @ (856) 910-2501, or in writing @ 3 Executive Campus, Suite 100, Cherry Hill, NJ 08002.

PENALTY CO-PAYMENTS

Question: Why would payment of my bills for health care services, tests and durable medical equipment be subject to additional co-pay, and how much is it?

Answer: If you're health care provider does not comply with the decision point review/pre-certification previsions of the plan, including failure to submit a request for decision point review/pre-certification or failure to provide clinically supported findings that support the request, payment of those services rendered will result in a co-payment of 50% (in addition to any deductible or co-payment that applies under the policy) for medically necessary treatment and tests and equipment. Keep in mind that treatment which is not medically necessary is not reimbursable under the terms of the policy.

If you do not utilize a network provider/facility to obtain those services, tests or equipment listed in the voluntary utilization review program section, payment for those services rendered will result in a co-payment of 30% (in addition to any deductible or co-payment that applies under the policy) for medically necessary treatment, tests and equipment. Keep in mind that treatment which is not medically necessary is not reimbursable under the terms of the policy.

ASSIGNMENT OF BENEFITS

Question: Can I assign my benefits?

Answer: Yes, but only to a provider of service benefits. As a condition of the assignment of benefits, the treating medical provider or provider of service benefits agrees to comply with all the procedures of the Plan. The provider also agrees to initiate all Pre-certification and Decision Point Review requests as required by the Plan. In the event the provider fails to comply with the conditions of the Plan, and such failure results in the imposition of a co-payment penalty, the provider will hold the patient harmless for such co-payment penalty insofar as the provider will not seek payment from the patient for any unpaid portion of the medical services arising from such co-payment penalty. Additional conditions that also apply to the provider include:

a) Submission of disputes as defined in the Plan to the Internal Dispute Resolution Process set forth therein. After final determination, submission of disputes not resolved by the Internal Dispute

Resolution process may be submitted to the Personal Injury Protection Dispute Resolution process set forth in N.J.A.C. 11:3-5.

b) Submission of medical records with clinically supported findings to support the diagnosis, causal relationship to the accident and care plan.

PSI's Conditional Assignment of Benefits is the only valid assignment of benefits. The assignee agrees that PSI has the right to reject, terminate or revoke the PSI Conditional Assignment of Benefits. An assignment of benefits may require PSI's written consent.

NO COVERAGE IS PROVIDED BY THIS BROCHURE OR THE QUESTIONS AND ANSWERS CONTAINED IN IT. THIS BROCHURE DOES NOT REPLACE ANY OF THE PROVISIONS OF YOUR POLICY. YOU SHOULD READ YOUR POLICY CAREFULLY FOR COMPLETE INFORMATION AS TO THE TERMS OF YOUR COVERAGE. IF THERE IS ANY CONFLICT BETWEEN THE POLICY AND THIS SUMMARY, THE PROVISIONS OF THE POLICY SHALL PREVAIL.

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

Personal Service Insurance Company
PO Box 3001
Plymouth Meeting, PA 19462
Ph: 610.832.4940 Fax: 610.832.2138
Toll Free: 800.954.2442