MERCHANTS INSURANCE GROUP

Policy Number

Policy Period

DECISION POINT REVIEW/PRE-CERTIFICATION PLAN FOR PERSONAL INJURY PROTECTION BENEFITS

IMPORTANT NOTICE

Under the provisions of your policy, Decision Point Review and Pre-Certification of specified non-emergency medical treatment and diagnostic tests are required in order for the expenses related to such services to be reimbursable in full. Pursuant to N.J.A.C. 11:3-4, you or your health care provider are required to provide notification for such services that may be rendered during the course of your treatment. If you do not follow the Decision Point Review and Pre-Certification requirements for these treatments and tests, you will be responsible for part of their costs consistent with the co-payment requirements of your policy. We have selected **Consolidated Services Group, Inc. (CSG)** to be the Utilization Review Organization involved with the decision point review/pre-certification process/extended treatment notification. A listing of those treatments and tests which are subject to Pre-Certification are on page two of this notice.

WHAT IS DECISION POINT REVIEW?

The New Jersey Department of Banking and Insurance has established standard courses of treatment (Care Paths) for soft tissue injuries of the neck and back (identified injuries). At designated points on the Care Paths, you and your provider must provide us with notice about further treatment that is necessary (Decision Point Review). Also Decision Point Review is required prior to the administration of specified diagnostic tests. Decision Point Review does not apply until the 11th day following the motor vehicle accident.

WHAT IS PRE-CERTIFICATION?

Pre-Certification means that certain treatments, tests, procedures and other services and expenses (listed on page 2 of this notice) must be reviewed by a medical professional to make sure that the medical care for the injuries you received in your accident is medically necessary. This does not mean that you need to obtain our approval before consulting your health care provider. However, your health care provider is required to request Pre-Certification before you get the services in order for them to be fully reimbursable under the policy. The Pre-Certification requirements included in your policy will commence on the 11th day after the accident. However, the Pre-Certification requirements do not apply to emergency care as defined in the policy.

YOUR RESPONSIBILITY TO COMPLY WITH THE DECISION POINT REVIEW/ PRE-CERTIFICATION PLAN

Once you report an injury to us, we will contact you and your health care provider to explain the Decision Point Review/Pre-Certification requirements of the policy. We will also send a letter to your health care provider requesting specific information regarding your injury. Your health care provider will be responsible for supplying treatment information to us and for requesting Decision Point Review or Pre-Certification of certain medical treatments and diagnostic tests in accordance with the provisions of your policy. We will encourage your health care provider to submit a detailed treatment plan to us, whenever possible, so that your treatment will not be interrupted. If you fail to comply with any of the Decision Point Review/Pre-Certification requirements, additional co-payments will be applied. These co-payments are listed in your policy as well as on pages three and four of this notice. You may assign your medical benefits to your health care provider. If you do so, the health care provider will assume the responsibility of complying with the policy's Decision Point Review/ Pre-Certification requirements.

WHAT IS THE DECISION POINT REVIEW/PRE-CERTIFICATION PROCESS?

The request for Decision Point Review or Pre-Certification of treatments, tests, procedures, other services or expenses and the duration of therapy should be directed to our Utilization Review Organization:

Consolidated Services Group, Inc. 1-877-258-2378
Fax (856) 910-2501 Website: www.csg-inc.net

When we receive a Decision Point Review or Pre-Certification request and appropriate medical documentation from your health care provider, you and your provider will be notified by phone and in writing whether or not our medical professional agrees that the proposed treatment is medically necessary. Your health care provider will be informed by CSG what medical documentation is required. Upon receipt of the appropriate medical documentation, CSG will, within three regular working days, provide its determination. If a determination is not provided within 3 regular working days, the treatment may continue. If we do not agree that the proposed treatment plan is medically necessary, you have the right to appeal our decision. The appeal process is described below. If we do not agree that the proposed treatment plan is medically necessary under the provisions of the policy, you still have the right to continue that course of treatment - but the expenses you incur will not be fully reimbursable under the policy.

If we do not agree that your health care provider's treatment is medically necessary, we may also request you get an independent medical examination. If such an examination is requested, the exam will be scheduled within 7 days of the Decision Point Review or Pre-Certification request (unless you agree with us to extend the time period); conducted by a health care provider similar to your treating health care provider, and conducted at a location reasonably convenient to you.

APPEALING A DECISION POINT REVIEW/PRE-CERTIFICATION DECISION

There are two types of appeals (with specific workflows) that can be considered:

(1) Pre-service: an appeal of the denial or modification of a decision point review or precertification request prior to the performance or issuance of the requested medical procedure, treatment, diagnostic test, other service, and/or durable medical equipment on the grounds of medical necessity.

The Pre-service appeal form and any supporting documentation shall be submitted by the provider to CSG via fax at (856) 910-2501 or in writing at 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619.

A pre-service appeal shall be submitted no later than 30 days after receipt of a written denial or modification of requested services.

Decisions on pre-service appeals shall be issued by the insurer or its designated vendor to the provider who submitted the appeal no later than 14 days after receipt of the pre-service appeal form and any supporting documentation. If it's determined that the new information submitted with the appeal requires the need of an expert report or addendum to an expert report (i.e.: Peer Review, Independent Medical Exam, Medical Director Review, etc...) to properly respond to the appeal, an additional 10 days will be added to the response time requirement.

(2) Post-service: an appeal subsequent to the performance or issuance of the services and/or what should be reimbursed.

The Post-service appeal form and any supporting documentation shall be submitted by the provider to CSG via fax at (856) 552-1999 or in writing at 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619.

A post-service appeal shall be submitted at least 45 days prior to initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5 or filing an action in Superior Court.

Decisions on post-service appeals shall be issued by the insurer or its designated vendor to the provider who submitted the appeal no later than 30 days after receipt of the appeal form and any supporting documentation. If it's determined that the new information submitted with the appeal requires the need of an expert report or addendum to an expert report (i.e.: Professional Code Review, Medical Bill Audit Report, UCR Analytical Analysis, etc...) to properly respond to the appeal, an additional 10 days will be added to the response time requirement.

The appeal process described above provides only one-level of appeal prior to submitting the dispute to

alternate dispute resolution. A provider cannot submit a pre-service appeal and then a post-service appeal on the same issue. The preapproval of the treatment and the reimbursement for that treatment are separate issues. A provider can submit a pre-service appeal for the treatment and then a post-service appeal for the reimbursement for that treatment.

If a claimant or provider retains counsel to represent them during the Internal Appeal Procedures, they do so strictly at their own expense. No reimbursement will be issued for counsel fees or any other costs, regardless of the outcome of the appeal.

Failure to comply with these Decision Point Review/Pre-Certification requirements will cause you to retain responsibility for a co-payment of 50% of the medically necessary expenses incurred.

Pre-Certification is required for non-identified injuries for charges incurred in connection with the items listed below. Decision Point Review is required along with tests listed below for identified injuries. Decision Point Review and Pre-Certification do not apply until day 11, all diagnosis.

1. Brain audio evoked potential (BAEP),
2. Brain evoked potential (BEP),
3. Computer assisted tomographic studies (CT, CAT, Scans),
4. Dynatron/cyber station/cybex,
5. H-reflex Study,
6. Magnetic resonance imaging (MRI),
7. Nerve conduction velocity (NCV),
8. Somatosensory evoked potential (SSEP),
9. Sonogram/ultrasound,
10. Visual evoked potential (VEP); or
11. Any of the following “diagnostic tests” when not otherwise excluded:
    a) Brain mapping,
    b) Doppler ultrasound,
    c) Electroencephalogram (EEG),
    d) Needle electromyography (needle EMG),
    e) Sonography,
    f) Thermography/thermograms,
    g) Videofluoroscopy; or
    h) Any other “diagnostic test” that is subject to the requirements of our Decision Point Review Plan by New Jersey law or regulation.

The following “diagnostic tests” are not covered:

1. Brain mapping, when not done in conjunction with appropriate neurodiagnostic testing,
2. Iridology,
3. Mandibular tracking and simulation,
4. Reflexology,
5. Spinal Diagnostic Ultrasound,
6. Surface electromyography (surface EMG),
7. Surrogate arm mentoring; or
8. Any other “diagnostic test” that is determined to be ineligible for coverage under Personal Injury Protection by New Jersey law or regulation.

Services that require pre-certification

1. Non-emergency inpatient and outpatient hospital care,
2. Non-emergency surgical procedures,
3. Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of $50.00,

4. Extended care rehabilitation facilities,
5. Home health care,
6. Infusion therapy,
7. Outpatient psychological/psychiatric testing and or services,
8. Physical, occupational, speech, cognitive or other restorative therapy, or body part manipulation except that provided for Identified Injuries in accordance with Decision Point Review,
9. All pain management services except that provided for Identified Injuries in accordance with Decision Point Review,
10. Non-emergency dental restoration,
11. 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,
12. Temporomandibular disorders; any oral facial syndrome,
13. Acupuncture
14. Compound drugs and compounded prescriptions, and
15. Schedule II, III and IV Controlled Substances, as defined by the Drug Enforcement Administration (DEA), when prescribed in combination or succession for more than three (3) months.

Your policy also includes a voluntary utilization program in which an insured is encouraged to obtain certain services and/or supplies provided by members of the CSG network of providers or services and/or suppliers located in your geographic area. In accordance with N.J.A.C. 11:3-4.8(b) the plan includes a voluntary utilization program for:

1. Magnetic Resonance Imagery,
2. Computer Assisted Topography,
3. The electro diagnostic tests listed in N.J.A.C. 11:3-4.5(b) 1 through 3 except for needle EMGs, H-reflex and nerve conduction velocity (NVC) tests performed together by the treating physician.
4. Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of $50.00,
5. Services, equipment or accommodations provided by an ambulatory surgery facility, and
6. Prescription drugs.

When one of the above listed services, tests, equipment, or prescription drugs 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 the injured person or his or her designee, and the requesting provider. In addition the notice will include how to acquire a list of available preferred provider networks to obtain the medically necessary services, tests, equipment, or prescription drugs requested. In the case of Prescription Drugs, a pharmacy card will be issued that can be presented at numerous participating pharmacies. A list of these participating pharmacies will be made available at the time of card issuance. In accordance with N.J.A.C.11:3-4.4(g), failure to use an approved network will result in a co-payment of 30 % (in addition to any deductible or co-payment that applies under the policy) of the eligible charge.

In addition to securing a list of preferred provider networks through the process outlined in the paragraph above, the injured person or his or her designee, and the requesting provider can visit CSG's website at www.csg-inc.net, contact CSG by phone at (877)258-CERT(2378),via fax at (856) 910-2501, or writing at 300 American Metro Blvd. Suite 170, Hamilton, NJ 08619.

OTHER POSSIBLE CO-PAYMENTS

Pursuant to your policy, medical expense benefits payable in any amount between the selected option deductible and $5,000 are subject to a co-payment of 20%. Merchants requires that the insured report the loss and injury as soon as possible after the accident. If the insured does not inform us about the facts of the accident, the nature and cause of injury, the diagnosis, and anticipated course of treatment timely an additional co-payment penalty may be imposed. A co-payment of 25% may be applied if the information is received 30 or more days after the accident and a co-payment penalty of 50% may be applied if the information is received 60 or more days after the accident.