DECISION POINT REVIEW PLAN

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: www.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 (877) 894-6467, 24 hours a day, 7 days a week. If any persons insured under the 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.

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
Loss reported 31-60 days after accident	25% penalty
Loss reported 61 or more days after accident	50% penalty

A Personal Injury Protection (PIP) claim representative will contact **you** within 48 hours of reporting **your** claim to discuss **your** injuries, and also to get 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 complete the Application for Benefits - Personal Injury Protection form, which **we** will send to **you**, along with a copy of this notice, when **you** report a claim involving personal injury.

It is also a good idea for **you** to share this information with all of **your health care providers**; they will be responsible for adhering to the Decision Point Review and Pre-certification requirements and regulations. Each provider will be responsible for submitting the Notification of the Commencement of Treatment form, which is also sent to **you** when **you** report a claim involving personal injury.

SPECIAL REQUIREMENTS FOR MEDICAL EXPENSES

All providers **you** consult or treat with 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 which 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 of the accident.

DECISION POINT REVIEW

Pursuant to the Automobile Insurance Cost Reduction Act and N.J.A.C. 11:3-4, 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 and accompanying rules are
available upon request or by accessing the NJDOBI web site at http://www.nj.gov/dobi/aicrapg.htm. For a list of **Identified injuries** by ICD-9 codes, 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 the Decision Points, 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 Exhibit B [as set forth in N.J.A.C. 11:3-4.5(b)] is subject to Decision Point Review regardless of the diagnosis.

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

WHY IS PRE-CERTIFICATION NECESSARY?

The regulations were designed to be certain 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 any medications prescribed. This comprehensive treatment plan may also include treatment for injuries with recommended Care Paths. If pre-certification is required but not obtained, **we** will impose a co-payment penalty on services that are **medically necessary**, but not pre-certified. The 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, 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
- Skilled Nursing Care
- Non-emergency inpatient and out patient hospital care
- Infusion Therapy
- Non-emergency medical transportation over $50.00
- Outpatient psychological/psychiatric testing and/or services
- Non-emergency dental treatment and/or restoration
- Durable Medical Goods including orthotics and prosthetics costing in excess of $100
- 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 that provided for **Identified Injuries** in accordance with Decision Point Review.

Below is a list of some of the types of durable medical goods which may cost in excess of $100, 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

VOLUNTARY NETWORK REQUIREMENTS
(Diagnostic Testing, Durable Medical Equipment, and Outpatient Facility Services)

Eligible injured persons will be referred to our approved Voluntary Networks.

DIAGNOSTIC TESTING
This requirement 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:

- Magnetic Resonance Imagery (MRI);
- Computer Assisted Tomography (CAT);
- Needle Electromyography (EMG) except when performed by the treating physician;*
- Somasensory 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; or
- Electroencephalogram (EEG)

* **Your** treating **health care provider** may perform this electrodiagnostic testing and other electrodiagnostic testing in conjunction with a Needle Electromyography (Needle EMG) which is medically necessary and clinically supported. An out of network penalty will not apply in this situation.

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 his or her 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 his or her 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 the durable medical equipment. Failure to obtain durable medical equipment over $100 from one of the approved third party suppliers 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
This requirement applies at all times except when outpatient facility services needed for any **medically necessary** treatment or procedures 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. These procedures are normally performed in ambulatory surgical centers. This does not include any charges incurred in the emergency room on the date of loss 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 his or her 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 Voluntary Network will result in an additional 30% patient co-payment of the eligible charges that are incurred for outpatient facility services.

HOW TO SUBMIT REQUESTS FOR DECISION POINT REVIEW/PRE-CERTIFICATION
In order to obtain a Decision Point Review or pre-certification (when necessary), **you** or **your health care provider** are required to contact us by fax at (732) 978-7100 or by mail at: P.O. 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 appeals and any supporting documentation for these items will be accepted at this 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. A04-143. A copy of the Attending Provider Treatment Plan form can be found on the New Jersey Department of Banking and Insurance website at www.nj.gov/dobi/aicrapg.htm. This form must be signed and dated by your treating provider.

All requests for durable medical equipment must be submitted by the ordering physician and include items 1 through 5 below.

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 loss and claim number (if known)
    b. the proposed CPT codes for care
    c. the ICD-9 Diagnosis Code
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 (SOAP notes)

Once **we** receive **your** request, **we** will review **your** information and documentation and respond within 3 business days. The 3 business day period will not begin until **your** treating **health care provider** submits all of the information described in items 1 through 5**.**

If **we** do not respond within 3 business days of **our** receipt of the request, **your** medically necessary treatment can proceed with no co-payment penalty imposed, unless you receive notification from us that it is no longer approved.

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

If **we** make a request for additional information, the request for treatment is not deemed complete until the additional information is submitted and reviewed.

Approved services must be completed within 60 days of authorization, unless a longer timeframe has been requested and authorized. 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 the determination of 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 the provider and Twin Lights. **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".**

PHYSICAL EXAMINATIONS

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. Repeated unexcused failure to attend a scheduled physical examination will result in all treatment, diagnostic testing or durable medical equipment for the diagnosis and any related diagnosis becoming non-reimbursable. After **your** second unexcused failure to attend **your** scheduled physical examination, a denial of treatment, diagnostic testing or services letter will be sent to **you**, with a copy to all **your** treating **health care provider(s)** who are providing treatment for the diagnosis or any related diagnosis, regardless of medical specialty or medical necessity.

N.J.A.C. 11:3-4.7(e) requires:

- The injured person or designee is notified that a physical exam is required before reimbursement of further treatment or tests is authorized.

- The appointment will be scheduled within seven calendar days of the injured person's receipt of notice of the need for a physical examination or tests unless the injured person agrees to extend the time period.

- The exam will be conducted by a provider of the same discipline as the treating provider.
- The exam shall be conducted at a location reasonably convenient to the injured person.
- The treating provider or injured person 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, the injured person or 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.

OUR INTERNAL APPEAL PROCESS

If **your** provider disagrees with Twin Lights regarding a comprehensive treatment plan or authorization for treatment, they must submit a written appeal within 30 days of **our** denial. **Your** provider must acknowledge that they are appealing **our** decision and include their reasons for the appeal. **Your** provider must include any additional documentation that they wish to have considered.

Submission of information identical to the initial documentation submitted in support of the initial request shall not be accepted as an appeal request.

Appeals may be sent via fax to (732) 978-7100 or mailed to us at: P.O. Box 907, Lincroft, N.J. 07738-0907. We will not accept or respond to submissions in any other format or faxed to any other fax number.

Once **we** receive the appeal request, **we** will review the information and documentation and respond within 10 business days. Please note that only decision point review, pre-certification requests, internal appeals and any supporting documentation for these items will be accepted at this mailing address.

Should **your** provider disagree with **our** Internal Appeal decision, they may proceed to PIP Dispute Resolution in accordance with New Jersey law. **Your** provider must exhaust **our** Internal Appeal process as a condition precedent to the filing of PIP Dispute Resolution.

Your treating provider may contact **our** Medical Management Department with questions regarding **our** Decision Point Review, Pre-Certification and/or Internal Appeal Process by calling 1-888-814-6397, Monday through Friday 8 A.M. to 5 P.M.

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 coverage under Personal Injury Protection Coverage by New Jersey law or regulation.

Under NJDOBI regulations, these tests have been determined to yield no data of any significant value in the development, evaluation, or implementation of a plan for treatment.

In addition, 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:

N.J.A.C. 11:3-4.5 (f)
- Sonography
- Doppler Ultrasound
- Needle EMG
- EEG
- Thermograms/Thermographs
- Videofluoroscopy
- Mandibular tracking
- Surface electromyography (surface EMG); and
- Reflexology

ASSIGNMENT OF BENEFITS

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 instead. If **you** choose to assign your benefits to **your** doctor or other **health care provider, you** no longer have the 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.

If benefits are paid directly to the **health care provider**, the provider is subject to the requirements of this Decision Point Review Plan and agrees that they will seek resolution of all issues defined as "PIP Disputes" under N.J.A.C. 11:3-5 through Personal Injury Protection Dispute Resolution only after our Internal Appeals process has been exhausted. **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.

Additionally, the provider must agree to be bound by the duties of cooperation as outlined in this policy and is required to hold harmless the eligible person and Twin Lights for any reduction of benefits caused by their failure to comply with the terms of this Decision Point/Pre-certification Plan.

As an additional condition of assignment the provider must also agree to cooperate with **us** and to supply **us** with any and 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. This includes but is not limited to providing copies of professional licenses, corporate charters, operating agreements and employee contracts. **Your** provider must also agree to be interviewed by **us** and/or appear for an Examination Under Oath within 30 days of **our** request.

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**

If **you** have selected "Coordination Of Benefits" under **your** policy and **you** do not have health coverage or **your** health carrier will not cover **you** for this loss, there is an additional $750 deductible.

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-payment 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**

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

Decision Point Review Plan Co-Payment Penalties:

Provisions that will trigger a Penalty:	Co-Payment Penalty	Financially Responsible Party
Failure to comply with Decision Point Review	50%*	Provider
Failure to comply with Pre-Certification	50%*	Provider
Failure to utilize Voluntary Diagnostic Network	30%*	**Eligible Injured Person**

Failure to utilize our approved durable medical equipment supplier for equipment in excess of $100.	30%*	**Eligible Injured Person**
Failure to utilize Voluntary Outpatient Facility Network	30%*	**Eligible Injured Person**
Failure to attend Second Independent Medical Examination	100%*	**Eligible Injured Person**

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

Coverage provided by:
Twin Lights Insurance Company

EXHIBIT A

ICD-9 CODES FOR TREATMENT OF CARE PATH INJURIES

The following ICD-9 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-9 codes referenced do not include codes for multiple diagnoses or co-morbidity.

722.0	Displacement of cervical intervertebral disc without myleopathy
722.1	Displacement of thoracic or lumbar intervertebral disc without myleopathy
722.2	Displacement of intervertebral disc, site unspecified, without myleopathy
722.11	Displacement of thoracic intervertebral disc without myleopathy
722.70	Intervertebral disc disorder with myleopathy, unspecified region
722.71	Intervertebral disc disorder with myleopathy, cervical region
722.72	Intervertebral disc disorder with myleopathy, thoracic region
722.73	Intervertebral disc disorder with myleopathy, lumbar region
728.0	Disorders of the muscle, ligament and fascia
728.85	Spasm of muscle
739.0	Non allopathic lesions-not elsewhere classified
739.1	Somatic dysfunction of cervical region
739.2	Somatic dysfunction of thoracic region
739.3	Somatic dysfunction of lumbar region
739.4	Somatic dysfunction of sacral region
739.8	Somatic dysfunction of rib cage
846	Strains and sprains of sacroiliac region
846.0	Sprains and strains of lumbosacral (joint) (ligament)
846.1	Sprains and strains of sacroiliac region
846.2	Sprains and strains of sacropinatus (ligament)
846.3	Sprains and strains of sacrotuberous (ligament)
846.8	Sprains and strains of other unspecified sites of sacroiliac region
846.9	Sprains and strains, unspecified site of sacroiliac region
847.0	Sprains and strains of neck
847.1	Sprains and strains, thoracic
847.2	Sprains and strains, lumbar
847.3	Sprains and strains, sacrum
847.4	Sprains and strains, coccyx
847.9	Sprains and strains, unspecified site of back
922.3	Contusion of back
922.31	Contusion of back, excludes interscapular region
922.33	Contusion of back, interscapular region
953.0	Injury to cervical root
953.2	Injury to lumbar root
953.3	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