Please Read This Notice / Save for Future Reference

IMPORTANT INFORMATION

If you are injured in an Auto Accident

We hope that you'll never have to use this guide. But if misfortune strikes and you suffer an injury from an automobile accident, following the steps presented in this **Important Information** notice will help you on your way to recovery. We are presenting this information to help you get the most from the benefits available under your coverage. These guidelines apply to you and anyone covered under your policy.

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 we provide you 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/"Precertification"** 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.

This brochure also serves as notification that we have contracted with Consolidated Service Group, Inc. (CSG) to handle Decision Point Review, the Decision Point Review Plan, "Precertification," Voluntary Networks medical service review and medical fee schedules calculations of claims for us.

In accordance with N.J.A.C. 11:3-4.7(c)(3), a copy of the informational materials for policyholders, injured persons or providers approved by the New Jersey Department of Banking Insurance, are available through CSG's website at www.medlogix.com .

DECISION POINT REVIEW ,"PRECERTIFICATION "

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 the Decision Point Review Plan, "Pre-certification" and Voluntary Networks 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 a Decision Point Review or "Precertification". 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 "Precertification?"

Answer: "Precertification" 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 "Precertification" 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 the 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 the 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 "Precertification" 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 a "*Dear Provider Letter*" provided to you at the time of claim.

Question: How does the Decision Point Review/"Precertification" process work?

Answer: In order for CSG to complete the review, your heath care provider is required to submit all requests on the "Attending Provider 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 /"Precertification" 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.

RECONSIDERATION AND APPEALS PROCESS

Question: Can my health care provider appeal the **Decision Point Review** or **“Precertification”** decision?

Answer: Yes, if CSG fails to certify a request; the clinical rationale for this determination is available to you and/or your health care provider upon written request. If your health care provider would like to have the decision reconsidered, they can participate in CSG’s internal review process by notifying CSG of their intention to participate in the reconsideration process, by phone @ (877) 258-CERT (2378), via fax @ (856) 910-2501, or in writing @ 3 Executive Campus, Suite 100, Cherry Hill, NJ 08002. If your health care provider has taken on an assignment of benefits, they may be required to participate in this process. In accordance with the plan, the reconsideration decision will be provided to your health care provider within fourteen (14) days of the request. This process will afford your health care provider the opportunity to discuss the appeal with a “similar discipline” Medical Director or request an independent examination scheduled by CSG.

Question: How can I or my health care provider appeal disputes not related to the **Decision Point Review** or “**Precertification”**?

Answer: We provide an internal appeals process called the **Reconsideration and Appeals Process** that is available for review of the decision you or your “health care provider” find unacceptable. Any treating “health care provider” who has accepted an assignment of benefits must utilize the **Reconsideration and Appeals Process** prior to filing any form of litigation/arbitration. When a dispute arises, any treating “health care provider” must submit a written request for the **Reconsideration and Appeals Process**, specifying the issues in dispute, accompanied by supporting documentation, at least 30 days prior to initiating arbitration or litigation.

Written notice of the dispute and request for the **Reconsideration and Appeals Process** shall be submitted to “us” via certified mail/return receipt requested or via delivery mail service providing proof of delivery. Proof of receipt by “us” must be provided to “us” upon request.

Please note that any treating health care provider who has accepted an assignment of benefits must follow the **Reconsideration and Appeals Process** prior to initiating arbitration or litigation.

DISPUTE RESOLUTION PROCESS

Any disputes not resolved under the **Decision Point Review/Precertification** or in the “Reconsideration and Appeals Process” may be submitted through the Dispute Resolution Process which is governed by regulations promulgated by the New Jersey Department of Banking and Insurance (N.J.A.C.11:3-5) and can be initiated by contacting the National Arbitration Forum (NAF) at 1-732-271-6100 or toll-free 1-888-881-6231. Information is also available on the NAF’s Web site, http://www.nj.adrforum.com. Unless emergent relief is sought, failure to utilize the “Reconsideration and Appeals Process” prior to filing Arbitration or litigation will render any prior assignment of benefits null and void.

VOLUNTARY NETWORKS

Question: Does our program provide Voluntary Networks for certain services, tests or equipment?

Answer: In accordance with the regulations, our program includes voluntary utilization 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.

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/"Precertification"** 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 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(f), 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 your health care provider does not comply with the Decision Point Review Plan requirements, including failure to submit a request for Decision Point Review or"Precertification", 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 Voluntary Networks provider/facility to obtain those services, tests or equipment listed, 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.

PAYMENT OF BENEFITS

Question: Can I assign my benefits?

Answer: Yes, but only to a provider of service benefits. The provider of service benefits must agree to:

(a) Be subject to the requirements of our **Decision Point Review Plan, "Precertification"**; and,
(b) Hold you, the insured, harmless for any penalty imposed by us for the failure of the provider of service benefits to adhere to the requirements of our **Decision Point Review Plan**, **"Precertification"** ; and
(c) Submit disputes to the "**Reconsideration and Appeals Process**" prior to submitting any disputes through the Dispute Resolution Process, pursuant to N.J.A.C. 11:3-5.

Please read the Payment of Benefits section in your policy carefully. All assignments are subject to all requirements, duties and conditions of the policy, including, but not limited to, Decision Point Review/"Precertification." exclusions, deductibles and co-payments.

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.

AAA Mid-Atlantic Insurance Group

AAA Mid-Atlantic Insurance Company of New Jersey * Keystone Insurance Co.

New Jersey Regional Claims
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