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.

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 requirement applies at all times unless the **eligible injured person** submits written proof providing clear and reasonable justification for the failure to comply with such time limitations. This additional co-payment will be based on the timeframe in which the loss is reported:

Reporting Timeframe	Co-Payment Penalty
Loss reported 30-59 days after accident	25% penalty
Loss reported 60 or more days after accident	50% penalty

A Personal Injury Protection (PIP) case worker 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 treatment of a **bodily injury** 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.**

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

Eligible injured persons will be referred to our approved Voluntary Network. 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**.

- Magnetic Resonance Imagery;
- Computer Assisted Tomography;
- 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 list of approved networks, including a toll free 1-800 number and internet site information, to access the current directory of providers in the network, including addresses and telephone numbers.

Failure to utilize the Voluntary Network will result in an additional 30% co-payment of the eligible charges that are incurred for medically necessary tests listed above.

We can provide an **eligible injured person** with durable medical goods through a third party supplier. Should **you** wish to obtain these goods from any other source, they will be subject to an additional 30% co-payment.

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 in any other format. 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.

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. The proposed CPT codes for care
2. **Clinically supported** findings to justify the requested treatment
3. The name of the **insured** and eligible person, date of loss and claim number (if known)
4. The ICD-9 Diagnosis Code
5. Any diagnostic testing that has been rendered or is being considered, and
6. Any prescriptions or durable medical goods that are being recommended
7. 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. If **we** respond by telephone, a written notification will follow. If **we** do not respond within 3 business days of **our** receipt of the request, **your** treatment can proceed with no co-payment penalty imposed, as long as the treatment is medically necessary. 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(b)1iii and N.J.A.C. 11:3-4.8(e)1 require 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 specialty, to verify that **you** are being treated appropriately. Repeated unexcused failure to attend a scheduled physical examination will result in treatment 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 **your** treating **health care provider(s).**

N.J.A.C. 11:3-4.7(b)2 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 notice to **us** of further treatment 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 days after the exam. 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.

OUR INTERNAL APPEAL PROCESS

If **your** provider disagrees with Twin Lights regarding a comprehensive treatment plan, authorization for treatment, or reimbursement for treatment, testing, services, or goods, they must contact our Medical Doctor within 30 days of **our** denial at (800) 258-1476, from 8:00 a.m. until 5:00 p.m., to discuss **our** decision. **Your** provider may also submit additional supporting documentation as part of their internal appeal. This additional documentation may be sent via fax to (732) 978-7100 or mailed to **us** at: P.O. Box 907, Lincroft, N.J. 07738-0907. 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.

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; 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; and
- Videofluoroscopy
- Mandibular tracking
- Surface electromyography (surface EMG)
- 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 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 NJAC 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.

DEDUCTIBLES, CO-PAYMENTS AND CO-PAYMENT PENALTIES

Statutory Deductibles and Co-Payments:

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

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 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**
30-59 days after the loss	25%*	Patient
60 or more days after the loss	50%*	Patient

***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%*	Patient
Obtaining Durable Medical Goods (in excess of $100) from another source other than our third party supplier.	30%*	Patient
Failure to attend Second Independent Medical Examination	100%*	Patient

*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

Needle electromyography (Needle EMG) #
Somasensory evoked potential (SSEP) #
Magnetic resonance imaging (MRI) #
H-reflex study #
Electroencephalogram (EEG) #
Videofluroscopy

Visual evoked potential (VEP) #	Dynatron/cyber station/cybex
Brain audio evoked potential (BAEP) #	Sonograms/ultrasound
Brain evoked potential (BEP) #	Thermogram/Thermography
Nerve conduction velocity (NCV) #	Brain mapping
Computer assisted tomographic studies (CT, CAT Scan) #	

Voluntary Network applies