Introduction

The primary objective of NJSI's Decision Point Review/Pre-Certification Plan is to provide for the timely payment of medically necessary treatment and testing whenever an eligible insured is injured in a covered automobile accident. We encourage open communication with Insureds and medical providers to ensure that the medical review process does not delay the planned course of treatment designed to return a patient to his/her pre-accident status.

Another important objective of our DPR plan, which protects all of our Insureds, is to mitigate payments for treatment and testing which is not medically necessary.

> "Medically necessary" as defined in our policy means that the medical treatment or diagnostic test is consistent with the clinically supported symptoms, diagnosis or indications of the injured person, and:
>
> 1. The treatment is the most appropriate level of service that is in accordance with the standards of good practice and standard professional treatment protocols including the Care Paths and other protocols recognized or designated by the Commissioner of Banking and Insurance of New Jersey, as applicable;
> 2. The treatment of the injury is not primarily for the convenience of the injured person or provider; and
> 3. Does not include unnecessary testing or treatment.

Effective Date

The effective date of the plan is the date approved by the Department of Banking and Insurance.

Plan Outline

The following Plan Outline provides a detailed description of the NJSI Decision Point Review/Pre-Certification Plan. The outline is designed to correspond with the numbering used in 11:3-4.7(c) with the number of each section of the Outline corresponding to each section of the regulation for easy reference. Supporting documents are included in the Plan Binder and are referenced accordingly in each section of the Outline.

1. **Identification of Vendor**
   NJSI's Decision Point Review / Pre-Certification Plan Administrator is:

   Horizon Casualty Services, Inc.
   33 Washington Street, 11th Floor

Newark, NJ 07102-3194
www.horizon-bcbsnj.com
(866) 866-1427 – phone
(973) 622-7265 – fax

Details concerning Horizon's Medical Director Program, Pre-certification/Decision Point Review procedures, and workflows are all provided in the Horizon vendor filing, which has been submitted under separate cover.

2. Identification of Specific Medical Procedures, Treatments, Diagnoses, Diagnostic Tests, Durable Medical Equipment, and Other Services Subject to Decision Point Review / Pre-Certification

The following is a comprehensive list of all services and supplies requiring pre-certification under the NJSI Plan. This list is unchanged from our previously approved DPR plan.

1. Non-emergency in-patient and outpatient hospital care.
2. All non-emergency surgical procedures.
3. Durable medical equipment (including orthotics and prosthetics) costing greater than *$50,* or rental greater than 30 days
4. Extended care rehabilitation facilities
5. Home health services.
6. Infusion therapy
7. Outpatient psychological/psychiatric services and testing.
8. All physical, occupational, speech, cognitive or other restorative therapy, or body part manipulation including Manipulation Under Anesthesia, 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. All non-emergency diagnostic testing services, except those provided for Identified Injuries in accordance with Decision Point Review
11. Non-emergency dental restoration

3. Informational Materials for Policyholders, Eligible Injured Persons (EIP), and Providers

NJSI believes that adequate and appropriate communication with our Policyholders, EIPs, and Providers is not only good customer service, but it is essential for the smooth and effective functioning of the Decision Point Review/Pre-Certification and claims investigation process. The more we can do to eliminate ambiguity for claimants and providers by carefully explaining the process to them, the less we will experience disputes and unsatisfied customers.

To that end, NJSI utilizes several avenues to distribute important information concerning the Decision Point Review / Pre-Certification process to Policyholders, EIPs, and Providers. The requirement column in the following table is numbered to correspond with the requirements outlined in 11:3-4.7(d) 1-9 of the revised regulations for easy reference.

Copies of all relevant informational materials are attached in Section II for review.

NJSI Notice Materials	Requirements of 11:3-4.7(d) 1-9 Covered by Materials	Recipient of Notice	Method/Time of Delivery
S13392 "Claim Satisfaction" Policy Addendum & Policy ID Card	1, 5, 6, 7, 8, 9	Policyholders	Attached to policy at inception and renewal.
Claim Acknowledgement Letter and "Personal Injury Protection and Decision Point Review/Pre-Certification" brochure	1, 5, 6, 7, 8, 9	All Claimants	Letter sent by NJSI Claim Representative to each Claimant or their designated representative upon receipt of the claim.
Point of Contact Letter	1, 2, 3, 4, 6, 7, 8, 9	Providers, Claimants	Letter sent by Horizon to each provider upon receipt of notice of treatment. Copy also sent to claimant.

4. Procedures for Prompt Review of Pre-Certification and Decision Point Review Requests

The procedures for review of Pre-Cert and DPR requests under the NJSI DPR Plan are outlined in the Horizon Casualty Services filing, which has been submitted under separate cover.

5. Procedures for Scheduling Independent Medical Examinations (IMEs)

The procedures for scheduling IMEs are outlined in the Horizon Casualty Services filing, which has been submitted under separate cover.

The purpose of an IME scheduled pursuant to this Plan is to provide a timely review of proposed medical care in order to determine the medical necessity of further treatment or testing and/or to verify the causal relationship of the claimed injuries to the accident. If a physical/mental examination of the Eligible Injured Person (EIP) is requested pursuant to this Plan, we or our Plan Administrator will notify the EIP of the date, time and location of the examination. The appointment for the IME will be scheduled within seven business days of the Plan Administrator's receipt of the request for DPR/Pre-Certification unless the injured person agrees to extend the time period. The IME will be conducted by a practitioner in the same discipline as the treating provider at a location that is reasonably convenient to the EIP.

If requested by us or the Plan Administrator, the EIP may be required to provide medical records, test results, diagnostic films, and other pertinent information to the IME physician in order to facilitate a proper review of the EIP's case. This information must be provided

no later than at the time of the examination. The EIP is also required to present proper photo identification to the IME physician at the time of the examination.

When an IME is scheduled, a notice will be sent to all known treating providers advising them of the examination and the consequences of the EIP's unexcused failure to attend more than one scheduled appointment.

Treatment may proceed while the IME is being scheduled and until the results are available. A copy of the written IME report, if prepared, will be provided to the EIP or his/her representative upon request.

Consequences of Failure to Attend Scheduled IMEs.

The EIP is expected to attend each examination as scheduled by us or our Plan Administrator.

Failure of an EIP to attend a scheduled examination without a minimum of 3 business days notice to the examining physician or the Plan Administrator shall constitute an **unexcused** failure to attend.

Failure of an EIP to attend a scheduled examination will be considered **excused** if the EIP notifies the examining physician or Plan Administrator at least 3 business days prior to the examination date and re-schedules the appointment for a date, not to exceed 35 calendar days from the date of the original appointment.

If an EIP has an otherwise **excused** failure to attend a scheduled examination and does not re-schedule the appointment to occur within 35 calendar days of the original appointment date, the failure to attend shall be deemed **unexcused**.

If an EIP re-schedules an examination for a date more than 35 calendar days from the date of the original appointment, any failure to attend the re-scheduled appointment will be **unexcused**.

If an EIP attends a scheduled examination, but fails to supply all requested medical records, test results, diagnostic imaging films and other pertinent materials; and proper photo identification it shall be deemed an **unexcused** failure to attend the examination and the examination will not take place.

If an EIP has more than one **unexcused** failure to attend a scheduled examination, notification will be sent to the EIP or his/her representative and all known treating providers advising that payment for all treatment, diagnostic testing, prescription drugs, and durable medical equipment provided on or after the date of notification and relating to the diagnosis code(s) and/or corresponding family of codes associated with the DPR/Pre-Certification request that necessitated scheduling of the examination will be denied.

In such cases, no future treatment, diagnostic testing, prescription drugs, or durable medical equipment associated with the relevant diagnosis code(s) will be reimbursable under our policy.

6. Reconsideration Procedure – 1st Level Appeal.

The procedure for internal appeal of a decision by the vendor to modify or deny reimbursement for treatment or testing is outlined in the Horizon Casualty Services filing, which has been submitted under separate cover.

A complete description of our entire Internal Appeals process is provided under Section 7.

7. Restrictions on Assignment of Benefits and Dispute Resolution

NJSI has included restrictions on the Assignment of Benefits under our policy. A copy of the revised endorsement is included in Section IV of the plan binder for easy reference.

The revised policy allows any EIP to assign his or her benefits to any "health care provider" that is providing the EIP with covered services or supplies in conjunction with their Personal Injury Protection claim. In order for any assignment to be valid, the "health care provider" must agree, in writing as part of the assignment, to fully comply with our Decision Point Review/Pre-Certification plan and all of the terms and conditions of our policy including pre-certification, decision point reviews, deductibles, co-payments, exclusions, duties of cooperation, and conditions for dispute resolution.

The provider must also agree, in writing as part of their assignment, to hold harmless the Insured, the Company, and the Company's Vendor(s) for any reduction in benefits caused by the provider's failure to comply with the terms of the Decision Point Review / Pre-Certification plan or our Policy.

An assignment that does not specifically agree to these conditions will not be considered valid. In addition, any and all assignments become void and unenforceable under certain conditions including:

- Coverage is not afforded under the policy.
- An "Insured" or "Provider" does not submit to Examination Under Oath.
- A "provider" does not comply with the Dispute Resolution provisions of the policy including utilization of the Internal Appeals Process.
- A "provider" does not comply with requests for medical records, test results, or other relevant medical documentation.
- An "insured" or "provider" does not comply with all requirements, duties, and conditions of the policy and the Decision Point Review / Pre-Certification plan.

While we make every effort to provide fair and timely payment of benefits on all valid claims, there are situations where a dispute will arise between us and an assignee over payment of PIP benefits. Often, such disputes are simple matters that, when brought to our

attention, can be resolved quickly and amicably without the need for costly and time consuming litigation.

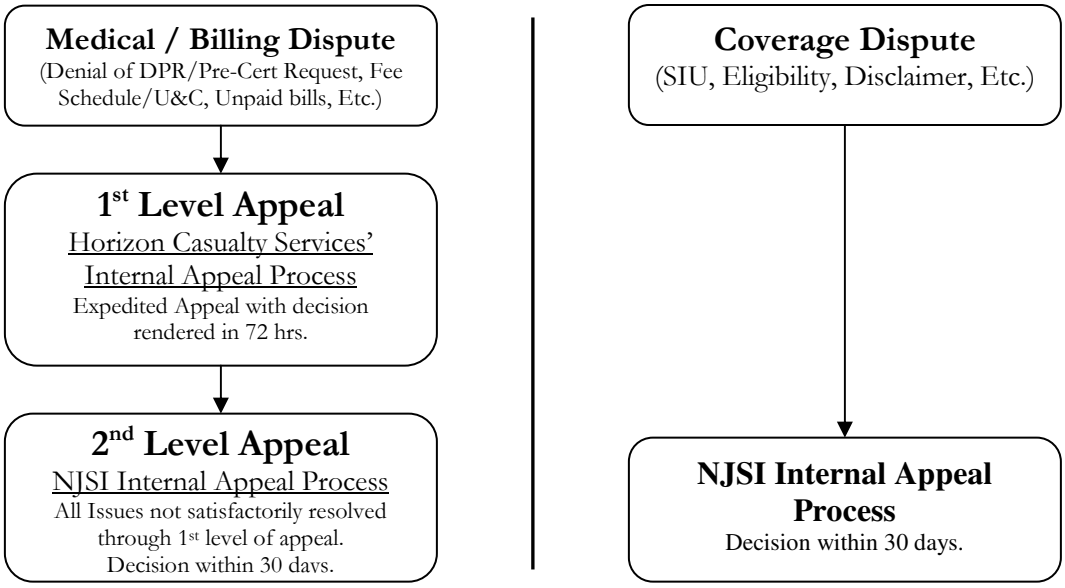
In an effort to avoid such unnecessary litigation, which is ultimately very costly to our policyholders, we have included a requirement in our policy that any assignee who has a dispute must utilize our Internal Appeals process prior to filing any form of litigation.

When a dispute arises, it will either involve Medical/Billing issues or Coverage Issues. For Medical/Billing issues such as denial of a Decision Point Review or Pre-Certification request; a fee schedule or Usual & Customary dispute; or alleged failure to make timely payment of medical bills, there are two levels of appeal.

At the first level of appeal, the matter is submitted to Horizon Casualty Services via their internal appeals process, which is outlined in their plan filing. This process results in a decision being rendered within 72 hours of Horizon's receipt of the request and all supporting documentation. If the matter is not satisfactorily resolved through the Horizon Appeal process, it is then escalated to the second level of appeal.

At the second level, the appeal is submitted to NJSI for review under the Internal Appeals Process outlined in our policy. In addition to second level Medical and Billing issues, all coverage issues are submitted directly to NJSI since they are outside of Horizon's purview as the Plan Administrator. NJSI will investigate the matter under appeal and render a decision within 30 days of our receipt of the appeal.

The Appeals Process is illustrated as follows:



To utilize the NJSI Appeal Process for second level appeals or coverage appeals, the assignee simply needs to send notification of their dispute, in writing, including any supporting documents such as copies of unpaid bills or medical records to us at:

New Jersey Skylands Insurance
P.O. Box 623
Basking Ridge, NJ 07920

Attn: PIP Appeals Coordinator

To ensure proper receipt of the dispute by us, it should be submitted via certified mail/return receipt requested through the US Postal Service or via another courier that provides proof of delivery such as Federal Express. Proof of receipt by us must be provided at our request.

Should the assignee choose to retain an attorney to handle the Appeal Process, they do so strictly at their own expense.

If we are unable to resolve the matter within 30 days after having received proper notice, the assignee is free to litigate the matter through the approved Dispute Resolution Organization or the courts.

8. Network Information

NJSI offers Voluntary Utilization Networks for Diagnostic Imaging and Electro-diagnostic testing, Durable Medical Equipment, and Prescription Drugs. Each of these Networks is offered through our Plan Administrator as outlined below.

A. Prescription Drugs – Horizon Casualty Services through their Advanced PCS Network.
B. Diagnostic Imaging/Electrodiagnostic Testing – Horizon Casualty Services
C. Durable Medical Equipment – Horizon Casualty Services.

Benefits may be obtained through each of these networks via a single point of contact – Horizon Casualty Services. Horizon provides an explanation of the Voluntary Utilization process to each treating doctor in their "Provider Letter" and they include a list of Diagnostic & DME Network providers as an attachment to each letter. (A copy of Horizon's Provider Letter specific to NJSI's account is included in Section II of the binder for reference.) In addition, they provide a toll free number and a web address for access to the Advanced PCS pharmacy network for prescription drugs. Information on all Voluntary Utilization Networks is also available to any party to the claim through Horizon's toll free number.

Each of the listed networks meets the requirements outlined in 11:3-4.8 (a) as follows:

- Horizon Casualty Services is an approved Workers Compensation Managed Care Organization.

Copies of the vendor contracts are located in Section III.

Notice Requirements

The terms and conditions of both our existing PIP Endorsement and our revised PIP Endorsement require any "insured" to promptly notify us of any claim and provide us with information including:

- How, when and where the accident happened.
- A detailed description of the injuries sustained in the accident.
- A detailed description of all pre-existing injuries and/or conditions the "insured" may have.
- The names of any physicians and/or medical facilities consulted by the "insured" with respect to the injuries along with their contact information.

Pursuant to 11:3-4.4(e) 1-3, NJSI requires any "insured" to adhere to the reporting requirements outlined above. Failure to supply the required information shall result in a reduction in the amount of reimbursement of the eligible charge for medically necessary expenses that are incurred by the "insured" after he/she should have notified us of the loss according to the following schedule:

- Notice received 30-59 days after the date of the accident – 25%
- Notice received 60 or more days after the date of the accident – 50%

These penalties apply in addition to any other deductibles, co-payments, and penalties that may otherwise apply to the claim.

This provision does not relieve any treating medical provider from their obligation to promptly provide notification of treatment under NJAC 11:3-25 also known as the '21 Day Rule'.

Transition Plan

The existing NJSI PIP Endorsement and Decision Point Review plan already provide for a 30% out of network co-payment penalty. Therefore, there will be no change to existing claimants with respect to out of network penalties.

Similarly, NJSI does not have a provision in its existing plan for applying a 50% penalty for missed IMEs. We view attendance at an IME by an "insured" as a condition of coverage under the terms and conditions of our policy and it is our practice to address missed appointments in that context. Since we already do not apply the 50% penalty there will be no change for existing claimants.

Other changes that have been made to our PIP Endorsement including changes to our Assignment of Benefits and Dispute Resolution provisions will take effect upon approval of our policy filing.

These changes will be phased in for policyholders at their 6 month renewal or at policy inception for new business. There will be no impact to existing claims being handled under our current policy. NJSI policyholders, eligible injured persons, and providers will be notified of the changes with respect to decision point review and pre-certification penalties via our revised point of contact letter and point of contact cover letter that will be sent to each party in the event of a claim. Copies of the letters and attachments are found in section II of the plan.