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Information Sheet: Overview of the Provisions of the NJ Automobile Insurance Cost Reduction Act

Privilege Underwriters Reciprocal Exchange has requested that CorVel Corporation work with you and your physician to assure that you receive all medically necessary treatment as a result of your auto accident. These services are provided under the provisions of the NJ Auto Insurance Cost Reduction Act.

Decision Point Review/Pre-Certification and Medical Necessity.

If you are injured in an automobile accident, Privilege Underwriters Reciprocal Exchange will pay, subject to your PIP benefits limits and all of the applicable Privilege Underwriters Reciprocal Exchange policy terms and conditions, all medically necessary treatment in accordance with the standards of good practice and standard professional treatment practices.

The New Jersey Department of Banking and Insurance has published standard courses of treatment called "Care Paths", for soft tissue injuries of the neck and back, collectively referred to as "Identified Injuries". These Care paths provide your healthcare provider with general guidelines for treatments 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 healthcare provider must provide us information about any further treatment or test required. This is called "Decision Point Review". In addition, the administration of any test listed in NJAC 11:3-4.5(b) 1-10 also requires Decision Point Review, regardless of diagnosis. A list of the tests requiring Decision Point Review is shown below. Care Paths and accompanying rules are available at the N.J. Department of Banking and Insurance website (<http://www.nj.gov/dobi/aicrapg.htm>) or by calling CorVel at 1-800-491-8350. You may also access our website at www.corvel.com.

Pre-Certification is a medical review process for specific services, tests or equipment for other than "Identified Injuries". Your medical provider must provide us information about any further treatment or testing required. The list of those items requiring pre-certification is shown below.

Under the provisions of your policy and applicable New Jersey regulations, Decision Point Review 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. This means your medical provider is required to provide advance notice to us of proposed tests, treatments or services along with clinically supported findings to support the request, as provided under the Decision Point Review and/or pre-certification plan, for you to be eligible for maximum reimbursement under the policy. This information can be sent to CorVel by mail. We will respond to Decision Point Review/Pre-Certification requests within 3 business days following the receipt of the request. If CorVel fails to respond within 3 business days, medically necessary treatment may continue until a decision has been communicated to you or your treating provider. No co-payment penalty will be applied during that time. Any decision to deny a request based on medical necessity will be made by a physician or dentist. Our address is 51 Haddonfield Road, Suite 200, Cherry Hill, NJ 08002 or by fax at 1-856-450-9337.

Diagnostic Tests that are subject to Decision Point Review regardless of diagnosis.

1. Brain audio evoked potentials
2. Brain evoked potentials
3. Computer assisted tomograms (CT, CAT scans)
4. Dynatron/cybex station/cybex studies,
5. EEG
6. H-reflex studies
7. MRI
8. EMG
9. NCV
10. SSEP

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11. Sonogram/ultrasound
12. Videofluoroscopy
13. Visual Evoked potential
14. Brain-mapping
15. Thermogram/Thermography

Services that require Pre-Certification

1. Non-emergency inpatient and outpatient hospital care
2. Non-emergency surgical procedures
3. Outpatient care for soft tissue/disc injuries of the insured person's neck, back and related structures not included within the diagnoses covered by care paths.
4. Temporomandibular, any oral facial disorders
5. Non-emergency dental restoration
6. Carpal tunnel syndrome
7. Outpatient psychological/psychiatric test and/or services.
8. Home health care
9. Skilled nursing care
10. Infusion therapy
11. Durable medical equipment, (including orthotics and prosthetics), leased or purchased for more than \$75. (or the rental of which exceeds 30 days).
12. Extended care and rehabilitation facilities
13. Physical, occupational, speech, cognitive or other restorative therapy or other body part manipulation except that provided for "Identified Injuries" in accordance with Decision Point Review.
14. All Pain Management services except as provided for in "Identified Injuries" and in accordance with Decision Point Review

Emergency Care and Care in the First 10 Days After An Accident.

Please note that treatment in the first ten (10) days after an accident and emergency care does not require Decision Point Review and/or Pre-certification. However, for benefits to be paid in full in accordance with the terms of your policy, the treatment must be medically necessary.

Right of Provider Choice.

You are entitled to seek medical treatment from any licensed provider you choose. If you should need assistance in locating a medical professional in your area, you may call 1-800-491-8350 and a Case Manager will be happy to provide names and contact information or access our provider lookup online at www.corvel.com. CorVel Corporation (CorVel) will perform the Decision Point Review and/or Pre-certification review of your medical care. Your doctor and any other treatment providers must contact CorVel at 1-800-491-8350 to discuss the treatment of your injuries related to this accident, in accordance with our decision point review/pre-certification plan. It is important that your provider assist in this process by providing all the medical information necessary for CorVel to make a timely decision about your care. Within three business days of receipt of the request and clinically supported documentation, we will either approve the request, modify the request, ask for additional documentation, seek an Independent Medical Examination (IME) or deny treatment. Our findings will be confirmed in writing to you and your provider.

Independent Medical Examinations (IME).

If the treatment or testing is not approved or we are unable to determine medical necessity, CorVel may request additional information from your physician or a physical examination may be required to determine the medical necessity of further treatment, diagnostic testing or durable medical equipment. CorVel may send you to another physician in the same specialty as your physician for an independent medical examination (IME). The appointment for the physical examination shall be scheduled within seven calendar days of receipt of the notice unless the injured

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person agrees to extend the time period. Medically necessary treatment may continue while the examination is being scheduled and results become available. You will receive a letter providing this information and the information as to where to go for the scheduled examination. This examination will be scheduled at a location convenient to the injured person. You would be required to bring a copy of your medical records and x-rays or MRI films to the appointment for the IME physician to review. Once the review of medical records and/or independent medical examination has been completed, you and your physician will be notified of the results within 3 business days after the examination. A copy of the examining provider's report, if completed, is available upon request.

CONSEQUENCES OF THE UNEXCUSED FAILURE TO ATTEND AN INDEPENDENT MEDICAL EXAMINATION

It is important that you attend all scheduled IMES. You should be aware that your unexcused failure to attend two or more scheduled IMES may result in notification to you and your treating providers that no reimbursement will be made for any further treatment, diagnostic testing or durable medical equipment relating to the diagnosis code(s), and corresponding family of codes, contained in the request or attending provider treatment plan form that necessitated the scheduling of the examination, regardless of medical necessity.

The following actions constitute an unexcused failure to attend an independent examination:

- **Failure to appear at a scheduled examination without providing at least 3 business days notification of inability to attend**
- **Failure to attend a rescheduled examination when you have notified the scheduling IME office of inability to attend the initial examination**
- **Failure to provide requested medical records, and/or imaging reports**
- **Failure to bring and provide photo identification to the examination if this results in the examination being canceled**

Use of Voluntary Networks.

You should also be aware that your policy includes a voluntary utilization program for durable medical equipment over **\$75**, (or if rental of such equipment exceeds 30 days) and diagnostic imaging (Magnetic Resonance Imaging and Computer Assisted Tomography). If you elect to use a network provider for these services or tests, the additional 30% co-payment described in the policy will be waived. CareIQ, our network service, offers timely appointments and preferred pricing. CareIQ services include imaging services and durable medical equipment. Our imaging service offers a full range diagnostic imaging through a contracted network of independent diagnostic imaging facilities. Imaging services may be contacted at (888) 922-7347. Durable medical equipment can be obtained via use of the CareIQ network by calling (888) 922-7347 or email to careiq@corvel.com.

Penalty Co-Payment.

Any of the medical treatment or services that require Decision Point Review or Pre-certification that is deemed medically necessary but for which we were not provided advance notice will be subject to up to a 50% co-payment. Failure to submit clinically supported findings that support the treatment or services will also result in a 50% co-payment. This penalty co-payment is in addition to any other deductible or co-payment applicable to your policy. Of course, any treatment deemed not medically necessary would not be reimbursed under this policy.

Internal Appeal Process

Appeals Regarding a Decision Related to a Treatment Request

Your treating provider may request an internal appeal on any modified or denied services or other matters related to the treatment or care being provided by that physician for you, the injured person. For appeals regarding a decision related to a treatment request, notification to CorVel Corporation need to occur, in writing, within 10 business days of the physician's receipt of the denial or modification. This appeal must be made in writing by fax or mail and must be accompanied by any additional documentation in support of the appeal. Submission of information identical to the

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initial records submitted in support of the request shall not be accepted as a request for reconsideration. This appeal must contain the treating provider's signature, the specific treatment request being appealed, and the reason for the appeal. CorVel Corporation is unable to address appeals for any and all denials. Provided that additional necessary medical information has been submitted, CorVel's response to the appeal will be communicated to the requesting provider, in writing, by fax within ten(10) business days of the receipt.

Appeals Regarding any Issue other than a Decision Related to Requested Treatment

Your treating provider may request an internal appeal for any and all issues. These issues may include, but are not limited to, payment of services or bill review. This appeal must be signed by the treating provider and submitted in writing stating the issues being disputed along with supporting documentation within thirty (30) business days of receipt of the original determination. CorVel Corporation's written response to this appeal will be communicated to the requesting provider by fax or mail within 10 business days of the receipt of the request. If additional documentation is needed a decision will be provided within 10 business days of receipt of the requested information.

If the treating provider has a valid assignment of benefits, this appeal must be submitted to CorVel Corporation 30 days prior to the initiation of any arbitration or litigation.

Submission of an appeal through the Internal Appeals Process as stated above is required for any treating provider who has accepted an assignment of benefits. Should the assignee choose to retain an attorney to handle the Appeals Process, they do so that their own expense.

Should the treating provider disagree with the final appeal outcome the provider must contact Privilege Underwriters Reciprocal Exchange to discuss the proposed treatment and outcomes and obtain a final decision regarding approval for the proposed treatment prior to pursuing any arbitration or litigation.

Dispute Resolution Process

If there is any dispute that is not able to be resolved through the Internal Appeals Process, it may be resolved through the Personal Injury Protection Dispute Process(N.J.A.C. 11:3-5.1 et seq.). This process can be initiated by contacting the National Arbitration Forum at 1-800-747-2371.

Failure to utilize the Internal Appeal Process prior to filing arbitration or litigation will invalidate an Assignment of Benefits.

Assignment of Benefits

If a provider accepts assignment of benefits from an insured, the provider is required to hold the insured harmless from any reduction in benefits caused by a failure on provider's part to follow the decision point review/pre-certification process. All assignments are subject to all requirements, duties and conditions of the patient's/insured's policy including but not limited to, pre-certification, decision point reviews, exclusions, deductibles and co-payments.

For disputes on issues other than requests for decision point review and pre-certification, any treating provider who has accepted an assignment of benefits must submit a written request for Reconsideration and Appeals specifying the issues in dispute accompanied by supporting documentation at least 30 days prior to initiating arbitration or litigation.