ELECTRIC INSURANCE COMPANY
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Decision Point Review Plan Requirements

IMPORTANT INFORMATION ABOUT YOUR NO-FAULT MEDICAL COVERAGE AND REIMBURSEMENT

Please read this information carefully and share it with your treating health care providers.

In 1998 New Jersey enacted the Automobile Insurance Cost Reduction Act and as a result there are established obligations which you must satisfy for coverage of medically necessary treatment, diagnostic testing and durable medical equipment arising from injuries sustained in an automobile accident. During the course of your claim, you may be contacted by our PIP vendor, Consolidated Services Group, Inc. (hereinafter referred to as **"CSG"**), as it relates to obligations you have while receiving medical treatment for your injuries and any subsequent bills. This communication from CSG may include, but is not limited to, information pertaining to your obligation to attend an independent medical examination (hereinafter referred to as **"IME"**). Please be on notice that the failure to abide by the following obligations defined herein and as defined in your Policy of Insurance, may affect the authorization for medical treatment, diagnostic testing and durable medical equipment.

This document serves as Electric Insurance Company®'s Decision Point Review and Pre-Certification Plan in accordance with N.J.A.C. 11:3-4.7 and N.J.A.C. 11:3-4.8.

CSG is a PIP vendor as defined in N.J.A.C. 11:3-4.2. CSG's contact information is as follows:

Phone: 877.258.2378 **Fax:** 856.910.2501

Website: www.csg-inc.net **Address:** CSG, Inc. | 300 American Metro Blvd., Suite 170 | Hamilton, NJ 08619 Attn: Pre-Certification Department

DISTRIBUTION OF INFORMATION TO POLICY HOLDERS, INJURED PERSONS AND PROVIDERS.

Informational materials will be issued to policyholders and injured parties by Electric Insurance and/or CSG at policy issuance, renewal and upon notification of a claim. Providers will be issued a copy upon notification of treatment.

Additionally, in accordance with N.J.A.C. 11:3-4.7 (c)3, a copy of the informational materials for policy holders, injured persons, and treating providers approved by the New Jersey Department of Banking and Insurance, is available at CSG's website, www.csg-inc.net.

The information provided herein as well as in the copies available at CSG's website, www.csg-inc.net, includes, but is not limited to:

- How to contact Electric Insurance through CSG to submit Decision Point Review/Pre-certification requests including telephone, fax numbers, and addresses.
- An explanation of the Decision Point Review process/Pre-certification Process including a list of the identified injuries and the diagnostic tests (N.J.A.C. 11:3-4.5). The materials shall also include copies of the Care Paths or indicate how copies can be obtained. Additionally, the web site will include the list of voluntary networks with their telephone, fax and email addresses.
- A list of the medical services that require pre-certification.
- An explanation of when treatment, diagnostic testing, and durable medical equipment may be classified as "medically necessary"
- An explanation of "Business hours" and "Calendar days" as well as "Business days" as it relates to this Decision Point Review Plan
- An explanation of how Electric Insurance or CSG will respond to Decision Point Review/Pre-certification requests, including time frames. The materials will indicate that telephonic responses will be followed with a written authorization, denial or request for more information within three business days.
- An explanation of the penalty co-payments imposed for the failure to submit Decision Point Review/Pre-certification requests where required or failure to provide clinically supported findings that support the treatment, diagnostic tests or durable medical goods in accordance with N.J.A.C. 11:3-4.4.

- An explanation of the Electric Insurance's voluntary network for certain types of testing and durable medical equipment by N.J.A.C. 11:3-4.4.
- An explanation of the alternatives available to the provider if reimbursement for a proposed treatment or test is denied or modified, including the internal appeals process and how to use it.
- An explanation of the Electric Insurance's restriction on assignment of benefits.

MEDICALLY NECESSARY TREATMENT AND TESTING

Electric Insurance's personal injury protection coverage shall provide reimbursement for all medically necessary expenses for the diagnosis and treatment of injuries sustained from a covered automobile accident, up to the limits set forth in the policy and in accordance with New Jersey personal injury regulations. "*Medically necessary*" or "*medical necessity*" means:

- That the medical treatment or diagnostic test is consistent with the clinically supported symptoms, diagnosis or indications of the injured person, and;
- The treatment is the most appropriate level of service that is in accordance with the standards of good practice and standard professional treatment protocols consisting of evidence-based clinical guidelines/practice/treatment published in peer-reviewed journals;
- The medical treatment or diagnostic testing is consistent with the Care Paths in the Appendix, as applicable;
- The treatment of the injury is not primarily for the convenience of the injured person or provider; and
- Does not include unnecessary testing or treatment.

BUSINESS HOURS

As it relates to this Decision Point Review Plan, "Business hours" are defined as Monday through Friday, between the hours of 7:00 a.m. and 7:00 p.m. EST, except for federally and/or state declared holidays and New Jersey declared state of emergencies where travel is prohibited.

***CALENDAR* AND *BUSINESS* DAYS**

As it relates to this Decision Point Review Plan, the following applies when "days" are referenced:

- "Days" means calendar days unless specifically designated as business days.
- A calendar and business day both end at the time of the close of business hours (7:00 p.m. EST Monday through Friday, except for federally and/or state declared holidays and New Jersey declared state of emergencies where travel is prohibited).
- In computing any period of time designated as either "calendar" or "business days", the day from which the designated period of time begins to run shall not be included.
- The last day of a period of time designated as "calendar days" or "business day" is to be included unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day which is neither a Saturday, Sunday or legal holiday.

Example: Response to a properly submitted Decision Point Review and Precertification request must be communicated to the requesting provider no later than three (3) "Business days" from the date CSG receives the submission. CSG receives an Attending Provider Treatment Plan Form by facsimile transmission dated 1:00 p.m. EST on Wednesday February 3, 2016. Day one of the 3-business day period is Thursday February 4, 2016. Since the 3rd day would be Saturday, February 6, 2016, CSG's decision is due no later than close of business Monday, February 8, 2016.

Example: Decisions on treatment appeals shall be communicated to the provider no later than fourteen (14) "Business days" from the date the insurer or CSG receives the appeal. The insurer or CSG receives the appeal by facsimile, transmission stamped 3:00 p.m. on Tuesday, January 8. Day one of the 14 business day period is Wednesday, January 9 and the 14th business day would be Monday, January 28. However, there is a state of emergency declared in New Jersey on Monday January 28 due to inclement weather. The insurer's decision would be due no later than Tuesday, January 29, providing the State of Emergency has been lifted.

FIRST TEN DAYS AFTER LOSS

No decision point or precertification requirements shall apply within ten days of the motor vehicle accident necessitating the treatment in question, or to treatment administered in emergency care as stated in N.J.A.C. 11:3-4.7. Such treatment

shall be subject to retrospective review as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary.

CARE PATHS, DECISION POINTS & PRE-CERTIFICATION Pursuant to N.J.A.C. 11:3-4, 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 "Identified Injuries". These Care Paths provide health care providers with general guidelines for treatment and diagnostic testing as to these injures. In addition the Care Paths require that treatment be evaluated at certain intervals called Decision Points

At Decision Points, the health care provider must provide Electric Insurance and/or CSG information about any further treatment or tests 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 is medically necessary for the injuries. This does not mean that an insured and/or injured party is required to obtain approval from Electric Insurance before consulting a medical provider for injuries. However, it does mean that the medical provider is required to follow the Decision Point Review requirements in order 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 http://www.state.nj.us/dobi/pipinfo/aicrapg.htm or can be obtained by contacting CSG at 877.258.2378.

The Decision Point Review process requires any and all health care providers supplying treatment, diagnostic testing, and/or durable medical equipment to submit all requests for treatment on the "Attending Providers Treatment Plan" form. A copy of this form can be found on the DOBI website http://www.state.nj.us/dobi/pipinfo/aicrapg.htm, CSG's website www.csg-inc.net or by contacting CSG @ 877.258.2378.

In addition with the completed Attending Providers Treatment Plan form, health care providers must submit a copy of 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., 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619, Attn: Pre-Certification Department.

You or your health care provider must obtain pre-certification for specific services and/or conditions for treatment, diagnostic testing or durable medical equipment not included in the Care Paths or subject to Decision Point Review. Pre-certification is a medical review process for specific services, tests, or equipment during which medical professionals evaluate whether the level of services, tests, or equipment you are receiving is medically necessary and reasonable for your injuries.

OBLIGATIONS OF INJURED PARTY AND PROVIDERS DURING THE DECISION POINT REVIEW AND PRE-CERTIFICATION PROCESS

- An insured or injured party is obliged to notify Electric Insurance at the time of injury resulting from a motor vehicle accident. Electric Insurance can be reached at 800.227.2757. Once Electric Insurance is notified of injuries, the claims handler will contact the injured party to explain the Decision Point Review/Pre-certification process and obtain necessary facts surrounding the injury. The claims handler forwards via mail, a notification packet to the injured party or designee and any named medical providers. The insured or injured party must notify Electric Insurance and/or CSG of any and all health care providers supplying treatment, diagnostic tests, or durable medical equipment.
- Any and all medical providers who supply treatment, diagnostic tests, or durable medical equipment to the insured or injured party must notify Electric Insurance or its designated vendor, CSG that treatment has begun within twenty-one (21) days of the commencement of treatment pursuant to N.J.A.C. 11:3-25.5. **The provider shall contact CSG at via telephone at 877.258.2378 or by fax at 856.910.2501.** When submitting treatment plans and supporting medical documentation for Decision Point Review/Pre-certification, providers must complete the "Attending Provider Treatment Plan" form and forward with any applicable medical documentation to CSG by fax (856.910.2501), or mail (300 American Metro Blvd., Suite 170, Hamilton, NJ 08619 Attn: Pre-Certification Department) This form can be accessed on CSG's web site at www.csg-inc.net.

  Any questions regarding treatment requests can be directed to CSG at 877.258.2378 during regular business hours of Monday through Friday 7:00 a.m. to 7:00 p.m., EST except for federally and/or state declared holidays and/or New Jersey declared states of emergencies related to inclement weather where travel is prohibited.

- Failure to submit a completed Decision Point Review and Pre-certification treatment request, including but not limited to a completed "Attending Provider Treatment Plan" and legible, clinically supported records, will result in

the submitting provider being notified of an administrative denial. This notification will take place within three business days after receipt of the incomplete request for Decision Point Review and Pre-certification request. A copy of the "Attending Provider Treatment Plan" can be found on the New Jersey Department of Business and Insurance web site http://www.state.nj.us/dobi/pipinfo/aicrapg.htm or at CSG's web site www.csg-inc.net.

- Failure to request Decision Point Review or Pre-certification where required, or failure to provide clinically supported findings that support the treatment, test or durable medical equipment requested, shall result in an additional copayment of 50% of the eligible charge for medically necessary: (1) diagnostic tests; (2) treatments; or (3) durable medical goods that were rendered/provided between the time notification to Electric Insurance or CSG was required, and when CSG communicates the decision three business days after the receipt of the treatment request. Such treatment shall be subject to retrospective review as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary.
- Providers who submit Decision Point Review/Pre-certification requests are those providers who, in part, physically and personally perform evaluations of the injured person's condition, and must provide the specific treatment requested and set treatment goals. Electric Insurance and/or CSG will not accept Decision Point Review/Pre-certification requests from the following providers:
    - Hospitals
    - Radiologic Facilities
    - Durable Medical Equipment Companies
    - Ambulatory Surgery Centers
    - Registered bio-analytical laboratories
    - Licensed health maintenance organizations
    - Transportation Companies
    - Suppliers of prescription drugs/pharmacies
- If any of the above restricted providers submits a Decision Point Review/Pre-certification request, CSG will respond to that submitting provider no later than three business days after the receipt of the request, informing that they are a restricted provider and will instruct that the submission must be made by the referring/treating provider. These providers will be informed that the request will not be reviewed until and unless same is made by the referring/treating provider.
- A decision in response to the provider's complete request for treatment/test/durable medical equipment will be communicated within three business days of receipt of the treatment by the Electric Insurance or CSG. This decision is communicated to the requesting provider by mail or fax during business hours. Denials of Decision Point Review/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.
- If CSG on behalf of Electric Insurance fails to respond to a request for Decision Point Review/Pre-certification within three business days after the time the complete request is received by Electric Insurance or CSG, the treatment, testing or durable medical equipment may proceed until Electric Insurance or CSG notifies the requesting provider that reimbursement for the treatment or testing is not authorized. Payment of such treatment though is not guaranteed and will be made only upon a determination that the treatment is medically necessary, reasonable, and arising from the motor vehicle accident.

CSG or ELECTRIC INSURANCE COMPANY'S DECISIONS IN RESPONSE TO COMPLETE REQUESTS FOR DECISION POINT REVIEW/PRE-CERTIFICATION

CSG or Electric Insurance will respond to complete requests for Decision Point Review/Pre-certification with responses which include but are not limited to the following:

Approved– A request for treatment/testing/durable medical equipment is approved by either the Nurse or a Medical Director (if forwarded to a Medical Director Reviewer) or as a result of an Independent Medical Examination.

Denied– A request for treatment/testing/durable medical equipment is denied either by a Medical Director Review or an Independent Medical Examiner.

Modified – A request for treatment/testing/durable medical equipment is modified either by a Medical Director Review or an Independent Medical Examiner.

Administrative Denial – Failure to submit a completed Attending Provider Treatment Plan or Decision Point Review/Pre-certification treatment request, including but not limited to a restricted provider as outlined above, the failure to submit legible, clinically supported records, will result in the submitting provider being notified within three business days after

transmittal of the incomplete submission, of what is needed to complete the Pre-certification submission. Upon receipt of the required additional information, the completed request will be reviewed and a decision will be rendered within three business days.

Retrospective Date of Service – If the request for treatment/testing/durable medical equipment is for a date of service which has already occurred, a retrospective decision on necessity will be rendered with regard to that/those date(s) of service.

Pended to IME – If, based upon the Medical Director's opinion, a physical or mental examination is needed to render a decision, an appointment for an IME (of the same discipline and the most appropriate specialty related to the treating diagnoses) at a location reasonably convenient location to the examinee, is scheduled within seven (7) calendar days of the date of the request. It is noted that medically necessary treatment can continue while the IME is being scheduled. Such treatment shall be subject to retrospective review as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary.

DECISION POINT REVIEW/PRECERTIFICATION REQUESTS

In accordance with N.J.A.C. 11:3-4.5, the administration of any of the following **diagnostic tests** is subject to Decision Point Review, regardless of diagnosis:

1. Needle Electromyography (EMG)
2. Somatosensory Evoked Potential (SSEP)
3. Visual Evoked Potential (VEP)
4. Brain Audio Evoked Potential (BAEP)
5. Brain Evoked Potentials (BEP)
6. Nerve Conduction Velocity (NCV)
7. H-Reflex Studies
8. Electroencephalogram (EEG)
9. Videofluoroscopy
10. Magnetic Resonance Imaging (MRI)
11. Computer Assisted Tomograms (CT, CAT Scan)
12. Dynatron/Cybex Station/Cybex Studies
13. Sonogram/Ultrasound
14. Brain Mapping
15. Thermography/Thermograms

The following list identifies **treatment, tests and medical services** that are subject to Pre-Certification according to the Plan:

1. Non-emergency inpatient and outpatient hospital care
2. Non-emergency surgical procedures
3. Infusion Therapy
4. Extended Care Rehabilitation Facilities
5. All Outpatient care for soft-tissue/disc injuries of the person's neck, back and related structures not included within the diagnoses covered by the Care Paths
6. All Physical, Occupational, Speech, Cognitive, Rehabilitation or other restorative therapy or therapeutic or body part manipulation except that provided for identified injuries in accordance with decision point review
7. All Outpatient psychological/psychiatric treatment/testing and/or services
8. All pain management/pain medicine services except as provided for identified injuries in accordance with decision point review
9. Home Health Care
10. Acupuncture
11. Durable Medical Equipment (including orthotics and prosthetics), with a cost or monthly rental, in excess of $75.00
12. Non-Emergency Dental Restorations
13. Temporo-mandibular disorders; any oral facial syndrome
14. Current Perception Testing
15. Nutritional Supplements
16. All treatment and testing related to balance disorders
17. Bone Scans

18. Podiatry
19. Any and all procedures that use an unspecified CPT/CDT, DSM IV, and/or HCPC code

Treating providers are encouraged to submit their requests in an effort to establish an agreed upon voluntary comprehensive treatment plan for all of a covered person's injuries, to minimize the need for piecemeal review. Reimbursement for treatment, testing or durable medical equipment consistent with the consensual treatment plan will be made without review or audit.

Electric Insurance shall not retrospectively deny payment for treatment, diagnostic testing or durable medical equipment on the basis of medical necessity, where a decision point review or precertification request for that treatment or testing was properly submitted to the insurer, unless the request involved fraud or misrepresentation by the provider or the person receiving the treatment, diagnostic testing or durable medical equipment.

New Jersey Personal Injury Protection Law prohibits coverage for the following tests:

1. Spinal diagnostic ultrasound;
2. Iridology;
3. Reflexology;
4. Surrogate arm mentoring;
5. Surface electromyography (surface EMG);
6. Mandibular tracking and stimulation
7. Any other diagnostic tests that is determined by New Jersey Law or regulation to be ineligible for Personal Injury Protection Coverage

New Jersey Personal Injury Protection Law prohibits reimbursement for the following treatment:

1. Kinesio Tape;
2. X-ray Digitization; and
3. Any other treatment/test that is determined by New Jersey law or regulation to be ineligible for Personal Injury Protection reimbursement

Pursuant to N.J.A.C. 13:30-8.22(b), personal injury protection medical expense coverage shall not provide reimbursement for the following diagnostic tests which have been identified by the New Jersey State Board of Dentistry as failing to yield data of sufficient volume to alter or influence the diagnosis or treatment plan employed to treat TMJ/D:

1. Mandibular tracking;
2. Surface EMG;
3. Sonography;
4. Doppler ultrasound;
5. Needle EMG;
6. Electroencephalogram (EEG);
7. Thermograms/thermographs;
8. Video fluoroscopy;
9. Reflexology; and
10. Any other treatment/test that is determined by New Jersey law or regulation to ineligible for Personal Injury Protection reimbursement shall be deemed to be included in this list.

REQUEST FOR PHYSICAL OR MENTAL EXAMINATION

CSG shall notify the injured person or designee if a physical or mental examination is required to determine the medical necessity of further treatment, test, or durable medical equipment.

- If a physical or mental examination is required, the appointment will be scheduled within seven (7) calendar days of the date of the request for the treatment, test or durable medical equipment unless the injured person/designee agrees to extend the time period.

- If based upon the reviewing physician's opinion, a physical or mental examination is needed to render a decision, an appointment for an IME (of the same discipline and within a location reasonably convenient to the patient) will

be scheduled within seven (7) calendar days of the date of the request. It is noted that medically necessary treatment can continue while the IME is being scheduled.

- CSG on behalf of Electric Insurance shall notify the injured person or their designee by mail or fax, and shall notify the requesting provider by fax, whether reimbursement for further treatment or testing is authorized as promptly as possible but, not later than three (3) business days after the examination.

- The IME shall be scheduled with a provider of the same discipline and the most appropriate specialty related to the treating diagnoses as the treating provider and within a location reasonably convenient to the patient pursuant to N.J.A.C. 11:3-4.7(e). The injured person, upon the request of Electric Insurance and/or CSG, shall provide medical records and other pertinent information to the provider conducting the medical examination. The requested records shall be provided at the time of the examination or before.

- If the injured party being examined does not speak English, they must contact Electric Insurance and/or CSG who may be able to arrange an appropriate interpreter be provided for the purpose of translating at the IME appointment. The injured party can also provide their own interpreter at their own cost.

- Treatment may continue with the treating provider until the results of the IME are available, however only medically necessary care will be reimbursed. Such treatment shall be subject to retrospective review as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary.

- CSG shall notify the treating provider whether reimbursement for further treatment or testing is authorized as promptly as possible, but no later than three (3) business days after the examination.

- The injured party or their designee, and the treating provider, shall be entitled to a copy of the IME report upon request.

- The notification may also require the injured party to bring medical records and/or CT/MRI or x-ray films to the examination appointment.

UNEXCUSED FAILURE TO ATTEND A SCHEDULED PHYSICAL AND/OR MENTAL EXAM

IT IS IMPORTANT THAT THE INSURED ATTEND ALL SCHEDULED IMES. YOU SHOULD BE AWARE THAT THE UNEXCUSED FAILURE OF AN INSURED AND/OR INJURED PARTY TO ATTEND TWO OR MORE SCHEDULED EXAMINATIONS MAY RESULT IN NOTIFICATION TO THE INSURED AND/OR INJURED PARTY OR DESIGNEE AND THE PROVIDER THAT NO REIMBURSEMENT WILL BE MADE FOR ANY AND ALL 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 will constitute an unexcused failure to attend a requested examination:

- **Failure of the injured party to attend a scheduled IME without proper notice to CSG;**
- **Failure of the injured party to notify CSG at least two days prior to the IME date of the need to reschedule;**
- **Any rescheduling of an unattended IME that exceeds thirty-five (35) calendar days from the date of the original IME, without permission from Electric Insurance;**
- **Failure to provide requested medical records, including radiology films, at the time of the IME;**
- **Failure to provide adequate proof of identification at the time of the IME;**
- **If the injured party being examined does not speak English and they fail to request or provide an appropriate interpreter for the exam.**

Electric Insurance will notify the treating provider by fax or mail if the injured party has a second unexcused failure to attend the IME. This notification will state no further reimbursement will be made.

INTERNAL APPEALS PROCESS (EFFECTIVE APRIL 17, 2017)

Prior to making a request for alternate dispute resolution, all appeals must be initiated using the forms established by the NJ Department of Banking and Insurance. The minimum required information (identified by form section number) is as follows: KEY DATES (sections 1-2) CLAIM INFO (sections 3-5) PATIENT INFO (sections 6-7 and 9-13) PROVIDER/FACILITY INFO (sections 14-25) DOCUMENTS INCLUDED INFO (section 29 indicated with asterisk) PRE-SERVICE APPEALS ISSUES INFO (sections 30-31, and 32, 33, or 34) POST-SERVICE APPEALS ISSUES INFO (sections 30-31, 33 and/or 38 and 34-36 if completing section 38) PRE-SERVICE SIGNATURE INFO (sections 35-36) POST-SERVICE SIGNATURE INFO (sections 39-40). Failure to follow these requirements will be considered an incomplete submission and will result in an administrative denial. This incomplete submission does not constitute acceptance within the required timeframes for Pre-service and Post-service appeals.

Failure to utilize the Internal Appeals procedures as outlined in 11:3-4.7B on the forms established by the Department prior to filing arbitration or litigation will invalidate any assignment of benefits.

There are two types of appeals (with specific workflows) that can be considered:

Pre-service: an appeal of the denial or modification of a decision point review or precertification request prior to the performance or issuance of the requested medical procedure, treatment, diagnostic test, other service, and/or durable medical equipment on the grounds of medical necessity.

The Pre-service appeal form and any supporting documentation shall be submitted by the provider to CSG via fax @ (856) 910-2501 or in writing @ 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619.

A pre-service appeal shall be submitted no later than 30 days after receipt of a written denial or modification of requested services.

Decisions on pre-service appeals shall be issued by the insurer or its designated vendor to the provider who submitted the appeal no later than 14 days after receipt of the pre-service appeal form and any supporting documentation. If it's determined that the new information submitted with the appeal requires the need of an expert report or addendum to an expert report (ie: Peer Review, Independent Medical Exam, Medical Director Review, etc…) to properly respond to the appeal, an additional 10 days will be added to the response time requirement.

Post-service: an appeal subsequent to the performance or issuance of the services and/or what should be reimbursed.

The Post-service appeal form and any supporting documentation shall be submitted by the provider to CSG via fax @ (856) 552-1999 or in writing @ 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619.

A post-service appeal shall be submitted at least 45 days prior to initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5 or filing an action in Superior Court.

Decisions on post-service appeals shall be issued by the insurer or its designated vendor to the provider who submitted the appeal no later than 30 days after receipt of the appeal form and any supporting documentation. If it's determined that the new information submitted with the appeal requires the need of an expert report or addendum to an expert report (ie: Professional Code Review, Medical Bill Audit Report, UCR Analytical Analysis, etc…) to properly respond to the appeal, an additional 10 days will be added to the response time requirement.

The appeal process described above provides only one-level of appeal prior to submitting the dispute to alternate dispute resolution. A provider cannot submit a pre-service appeal and then a post-service appeal on the same issue. The preapproval of the treatment and the reimbursement for that treatment are separate issues. A provider can submit a pre-service appeal for the treatment and then a post-service appeal for the reimbursement for that treatment.

If a claimant or provider retains counsel to represent them during the Internal Appeal Procedures, they do so strictly at their own expense. No reimbursement will be issued for counsel fees or any other costs, regardless of the outcome of the appeal.

ASSIGNMENT OF BENEFITS

Assignment of Benefits – If the insured/injured party would like Electric Insurance to pay a provider of service benefits directly, the insured/injured party must sign an Assignment of Benefits agreement. As a condition of assignment, the treating provider must follow the requirements of the Decision Point Review Plan and shall hold harmless the insured/injured party for penalty co-payments imposed based on the provider's failure to follow the requirements of Electric Insurance's Decision Point Review Plan. **Failure to comply with Electric Insurance's Plan Requirements, the duties under the automobile insurance policy or the requirement to comply with the Appeals will render any prior Assignment of Benefits under the policy null and void. Please note that any provider that has accepted an assignment of benefits, must comply with and complete the Appeals Process as noted above prior to initiating arbitration or litigation. Completing the appeals process means timely submission of an appeal and receipt of the response prior to filing for alternate dispute resolution. Except for emergency care as defined in N.J.A.C. 11:3-4.2, any treatment that is the subject of the appeal that is performed prior to the receipt by the provider of the appeal decision shall invalidate the assignment of benefits.**

VOLUNTARY NETWORK SERVICES

CSG has established a network of approved vendors for diagnostic imaging studies for all MRI and CT scans, durable medical equipment with a cost or monthly rental over $75.00, prescription drugs and all electro diagnostic testing, listed in N.J.A.C 11:3-4.5(b) 1-3 except for needle EMGs, H-reflex and nerve conduction velocity (NVC) tests performed together by the treating physician and services, equipment or accommodations provided by an ambulatory surgery facility. **Failure to use an approved vendor will result in an additional copayment not to exceed 30% of the eligible charge**

A list of preferred provider networks is available at CSG's website at www.csg-inc.net. An insured and/or injured person or designee, and the requesting provider can also obtain a list of preferred provider networks by contacting CSG by phone at 877.258.2378, by facsimile at 856.910.2501, or in writing at 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619.

The voluntary utilization program is available in accordance with N.J.A.C. 11:3-4.8(b), 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 for needle EMG's, H-reflex and nerve conduction velocity (NCV) tests performed together by the same treating physician
4. Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of $75.00
5. Prescription Drugs
6. Services, equipment or accommodations provided by an ambulatory surgery facility

When one of the above listed services, tests or equipment is requested through the Decision Point Review plan/Pre-certification process, a detailed care plan evaluation letter containing the outcome of the review is sent to the insured and/or injured person or designee and the requesting health care provider as described in this document. This notice will include how to acquire a list of available preferred provider networks, with phone numbers and addresses, to obtain the medically necessary services, tests or equipment requested. In addition, that notice will include the following language "**FAILURE TO USE THE VOLUNTARY NETWORK WILL RESULT IN A COPAYMENT OF 30% (IN ADDITION TO ANY DEDUCTIBLE OR CO-PAYMENT THAT APPLIES UNDER THE POLICY) OF THE ELIGIBLE CHARGE"**

When you are in the need of *prescription* drugs, a pharmacy card will be issued that can be presented at numerous participating pharmacies. Instructions on how to find a list of participating pharmacies will be included with the pharmacy card.

Those individuals who choose not to utilize the networks discussed above, will be assessed an additional copayment not to exceed 30% of the eligible charge in accordance with N.J.A.C. 11:3-4.4(g). That co-payment will be the responsibility of the insured/patient.

PAYMENTS/REIMBURSEMENT

Electric Insurance will reimburse all eligible medically necessary services in accordance with the most current and applicable New Jersey PIP Regulations and Fee Schedule pertaining to the date of service.

When provider fees are not included in the applicable fee schedule, and there are likewise no similar services included in the applicable fee schedule, Electric Insurance will use the most current version of CSG's re-pricing software (Medlogix)

to adjudicate against submitted requests, and produce a detailed explanation of benefits outline of suggested reimbursement.

Electric Insurance is not obligated to reimburse for specific CPT/HCPC codes even if approved or pre-certified in a decision point review/precertification request. If the National Correct Coding Initiative Edits (hereinafter referred to as "NCCI Edits") prohibit reimbursement for any combination of codes that were billed, such codes will not be reimbursed. The New Jersey Department of Banking and Insurance has adopted the NCCI Edits to prevent duplication of services and unbundling of codes. The current NCCI Edits can be viewed at the following web site: **www.cms.gov/NationalCorrectCodInitEd/.**

When a provider bills CPT code(s) for medically necessary services that are not included in the applicable New Jersey Fee Schedule, Electric Insurance reserves the right to reimburse the appropriate fee schedule amount for similar services or equipment in the region where the service or equipment was provided, or Electric Insurance will determine the reasonableness of the provider's fee by comparison of its experience with that provider and with other providers in the region. National databases of fees, such as those published by FAIR Health (www.fairhealthus.org) or Wasserman (http://www.medfees.com/), for example, are evidence of the reasonableness of fees for the provider's geographic region or ZIP code. The use of national databases of fees is not limited to the above examples. Electric Insurance reserves the right to reimburse whichever amount is less.

DISPUTE RESOLUTION PROCESS

Any dispute not resolved in the Appeal and Reconsideration process may be submitted through the Personal Injury Protection Dispute Resolution process which is governed by the New Jersey Department of Banking and Insurance (N.J.A.C. 11:3-5) and can be initiated by contacting the current vendor approved by the New Jersey Department of Banking and Insurance to administer Dispute Resolution/arbitration. Electric Insurance Company reserves the right to require disputes to be submitted through this Personal Injury Protection Dispute Resolution process in lieu of litigation in the Superior Court, as permitted by NJSA 39:6A-5.1(a).

Unless emergent relief is sought, failure to utilize the Appeal and Reconsideration process prior to filing arbitration or litigation will invalidate any prior Assignments of Benefits.