IFA Insurance Company
New Jersey Automobile Personal Injury Protection
Decision Point/Pre-Certification Benefit Plan

This Benefit Plan ("Plan") will cover medically necessary expenses incurred as a result of a covered loss to eligible persons, subject to the terms and conditions of this "Plan". This "Plan" applies to your Personal Injury Protection Coverage for both Basic and Standard Policy coverage. Please refer to your policy Declaration Sheet to confirm whether you have selected Basic or Standard Coverage. IFA insurance Company ("us" or "we") will assist you in answering any questions regarding this "Plan". This Plan shall describe our Decision Point Review procedure as well as our Pre-Certification Plan.

Medial Expense Deductible and Co-payment:
The medical expense deductible and co-payment specified in your Declaration Sheet will apply to eligible medial expenses, on a per accident basis. The deductible and co-payment will apply to the first $5000 in eligible medical expenses, unless otherwise specified in this "Plan". You are responsible to pay the health care provider directly for any deductible and co-payment you are responsible for.

Plan Limit of Liability:
We will pay benefits up to the Limit of Liability stated in your Declaration Sheet. In case of an injury requiring treatment meeting the definition of "Catastrophic Injury", the limit of liability will be $250,000, subject to the terms and conditions of your policy and this plan.

Other than applicable deductible and co-payments, no health care provider may balance bill you for any service covered under this policy within the limits of this policy Limits of Liability.

Notice:
- We request that you, your "health care provider" or someone on your behalf report an injury to us within 24 hours of treatment by providing notice of said injury. If you receive emergency care and are admitted to a hospital, we request that you, your health care provider or someone on your behalf report the injury by providing notice of said injury to us within three days of the admission.

- **"Notice" shall be defined as sufficient information to identify who is injured, when the injury occurred, what injuries were sustained, and the names and location of any heath care provider involved in the treatment of those injuries.**

Throughout this document, **Decision Point Review** shall mean the timely review of treatment of certain identified injuries at the junctures in the treatment of those identified injuries where a decision must be made about the continuation or choice of further treatment. Decision Point also refers to a determination to administer one or more diagnostic test authorized by the Department of Banking and Insurance. Our Decision Point Review Plan is more specifically described below.

Throughout this document, **Care Path** shall mean a recommended extensive course of care based on professionally recognized standards.

Throughout this document, **Pre-Certification** shall mean pre-approval of medical procedures, treatments, diagnostic tests or other services, non-medical expenses and durable medical equipment associated with injuries for which Decision Point Review shall not apply. Our Pre-Certification plan is more specifically described below.

Decision Point Review Plan:

Pursuant to the changes made as a result of the Automobile Cost Reduction Act of 1998, the New Jersey Department of Banking and Insurance has published standard courses of treatment, or **Care Paths**, for soft-tissue injuries to the neck and back – known as **Identified Injuries.** We shall utilize these care paths to monitor the treatment rendered to you whenever you have been diagnosed with one or more of the identified injuries. The **Care Paths** provide that the treatment be evaluated again at **Decision Points**. These decision points are represented by hexagonal boxes on the Care Paths. In addition, the determination to administer certain diagnostic tests also involves a Decision Point regardless of the diagnosis. At these Decision Points before the treatment in question is rendered, we will require your health care provider to submit documentation regarding your injuries, treatment, results of diagnostic testing, and we may request you be examined by a health care provider of our choice. **Failure to request Decision Point Review when required will result in a penalty co-payment.** All services must be medically necessary, clinically supported by information provided by your health care provider, and related to the injuries sustained in the accident in order to be reimbursed.

For a complete copy of the Care Paths and a list of identified injuries, please visit the web site of the Department of Banking and Insurance at http://states.naic.org/nj/attpip.htm. You may also find the Care Paths and identified injuries in the New Jersey Administrative Code at N.J.S.A. 11:3-4 Appendix.

The following Diagnostic Testing always requires Decision Point Review as well:

- **Needle Electromyography (EMG);**
- **Somasensory Evoked Potential (SSEP), Visual Evoked Potential (VEP), Brain Audio Evoked Potential (BAEP), Brain Evoked Potential (BEP), Nerve Conduction Velocity (NCV), or H-reflex study;**
- **Electroencephalogram (EEG);**
- **Videofluroscopy;**

- **Magnetic Resonance Imaging (MRI);**
- **Computer Assisted Tomagraphic Studies (CT, CAT scans);**
- **Dynatron/ Cyber Station/ Cybex; and**
- **Sonograms/ Ultrasounds.**

<u>We will not pay</u> for diagnostic testing that has no clinical value or is ineligible under the rules, regulations or laws of New Jersey, or as determined by the NJ Department of Banking and Insurance as not being reimbursable.

<u>Mandatory Pre-Certification Plan:</u>
If you have been diagnosed with an injury that is not included as an Identified Injury, your health care provider must contact us for prior authorization of the treatments listed below. No pre-certification requirements shall apply during the first ten (10) days of the insured event. Pre-certification shall be based exclusively on medical necessity and shall not encourage over or under utilization of the treatment or a test.

Any medically necessary diagnostic tests, treatments, surgery, durable medical equipment and non-medical expenses that are incurred without first complying with our Pre-Certification requirements shall be subject to a 50% copayment.

The following require pre-certification if not authorized as a part of a Comprehensive Treatment Plan approved by us:

- **Referral to a health care provider of different specialty** for examination, consultation, or opinion.
- **Physical therapy, occupational therapy, speech or other restorative therapy, or therapeutic manipulation** as ordered by a licensed health care provider **except those services provided for identified injuries in accordance with Decision Point Review.**
- **Transportation services** by ambulance, ambulette, or other medical transportation.
- **Surgery, other <u>than emergency surgery</u>, either at an in-patient or at an out-patient facility. All surgery and surgical admissions MUST be authorized and are subject to second opinion examinations by a health care provider of our choice.**
- **Inpatient hospitalizations** for observation, treatment, diagnostic testing, or care other than emergency care.
- **Inpatient or outpatient rehabilitative care, skilled nursing facilities, or inpatient convalescent care settings.**
- **Non-emergency psychological, psychiatric, or mental health services.**
- **Durable medical equipment** in excess of $100 in value. Durable medical equipment below this dollar value will be subject to utilization review by us.
- **Home health aid, and/or attendant services in a hospital, health care facility, or at home.** Such services must be prescribed by a licensed physician.

General Provisions applicable to both Decision Point Review and Pre-Certification:

- **Any treatment in which Decision Point Review/Pre-Certification has been applied shall also be subject to all terms and conditions contained within your policy of insurance.**
- **Neither Decision Point Review nor Pre-Certification will apply to the first 10 days of care immediately after an accident.** Treatment received during these first 10 days will be subject to utilization review. This means that treatment, testing of services received in this first 10 days are not appropriate or do not meet nationally recognized guidelines or protocols for such services, we may not be responsible for them.
- This plan will not limit access to medically necessary care you require.
- This plan will not allow for the under-utilization or over-utilization of care, nor will it allow for care that is solely for the convenience of you or your health care provider.
- **You and your health care provider are strongly urged to formulate and submit a Comprehensive Treatment Plan at the beginning of the treatment, regardless of whether your injury requires Decision Point Review or Pre-Certification.** Once a Comprehensive Treatment Plan is approved by the medical director, there is no need to seek any further approval for those services specifically described in the Comprehensive Treatment Plan during the time covered by the Comprehensive Treatment Plan. Of course, any additional testing or treatment beyond the Comprehensive Treatment Plan may need to be subject to Decision Point Review or pre-certified.

Notification under Decision Point Review/ Pre-Certification:

After an accident where you have been injured, we strongly urge you to contact us within 24 hours to ensure prompt handling of your claim.

You or your health care provider will contact us with any request for pre-certification by contacting:

IFA Insurance Company
Address: 14 Walnut Avenue
Clark, NJ 07066

Phone #: **(732) 815-2103**
Fax #: **(732) 815-1779**

We have retained the services of third party medical claims administrators to assist us in this process. You may contact us directly for information on how to contact them or our medical director.

Required Information under Decision Point Review/ Pre-Certification:

We will require your health care provider to provide documentation of the nature and extent of your injuries, type and duration of treatment and diagnostic test to be

performed, and/ or durable goods requested in order to approve treatment. In most cases, we will be able to arrive at a decision quickly, and in any event not more than three business days; however, we may need to request specific documentation to render a decision. If we do not authorize or deny treatment within 3 business days, you may proceed with the treatment or test until you receive a denial.

If we make a request for additional information, the requested information needs to be submitted by your health care provider within 10 days and must clinically support the request for services. Failure to provide any requested medically necessary information will result in an additional penalty co-payment of 50% of eligible charges. This clinically supported information must include information such as:

- Date of accident
- Based upon actual examination of you, a complete history of all complaints, clinical symptoms, dates and types of previous treatments and observations.
- Report of objective findings, diagnoses (ICD-code(s)) and results of physical examination and tests preformed.
- Your health care provider must consider any previous tests and examinations performed, and consider any and all other conditions you may have had prior to the accident, and render a diagnosis.

Bills cannot be processed for payment without qualifying documents.

It is the responsibility of your health care provider to advise us of any change in your condition or need for services.

Comprehensive Treatment Plans under Decision Point Review or Pre-Certification:

Your health care provider may establish along with us, a **Comprehensive Treatment Plan**. This plan will be reviewed and adjusted based upon information your health care provider provides and discusses with us. This **Comprehensive Treatment Plan** will allow you to seek needed treatment for a specific time period agreed to by your health care provider and us. As your needs change, we will, along with your doctor, change your treatment plan. Our medical director will review this plan. This plan should outline treatments, diagnostic testing, special services, and durable medical equipment you need to effect a recovery from your injuries.

Any treatment, diagnostic tests, services, goods or supplies that are rendered pursuant to a Comprehensive Treatment Plan are not required to be individually pre-certified. This is because the Comprehensive Treatment Plan has already been reviewed by the medical director, and every service or treatment described in the Comprehensive Treatment Plan will have been pre-approved.

If there is no **Comprehensive Treatment Plan** submitted, then each service or treatment does require pre-certification to avoid co-payment penalties.

Should there be a need, based upon your progress, to change your treatment plan, we must be advised. If you are being treated pursuant to a Comprehensive Treatment Plan, we will not pay for treatment that is not noted as a part of that Comprehensive Treatment Plan approved by us unless warranted by reasons of medical necessity. A penalty co-payment of 50% of charges for unauthorized treatment may apply.

Independent Consultative Opinion Examination under Decision Point Review or Pre-Certification:

We may request you attend an examination by a health care provider of our choosing. This examination will be with a health care provider of a similar specialty as your health care provider, and will take place at a location reasonably convenient to you. We shall schedule this examination within 7 days of our request, unless we agree otherwise. Treatment during this time will continue and will not be compromised; however, it will be subject to utilization review. You may request a copy of the examiner's report, which will be made available within 3 days of the examination.

You must attend the Independent Consultative Examination and cooperate with us in scheduling this examination. Failure to do so may jeopardize your future benefits, and may be subject to a 50% co-payment of costs incurred during this time until you comply with this request.

You and your health care provider must provide us with all medical records and diagnostic testing results at the time of the examination. Failure to do so may jeopardize your benefits, as may failure to attend the appointment.

Denial of any treatment, service, diagnostic testing or durable goods, whether under Decision Point Review or Pre-Certification, will be by a medical director, and will be subject to appeal. (See Internal Appeal Process)

Penalty under Decision Point Review or Pre-Certification:

- **Failure to follow these procedures for Decision Point Review or the Pre-Certification of treatment, services, diagnostic tests, durable medical goods, will result in an additional co-payment of 50% of eligible charges in addition to any deductible or co-payment applicable to the loss.**
- **Failure to provide requested information within 10 days of request or failure to appear for physical examination requested by us will result in an additional penalty co-payment of 50% of eligible charges. This penalty co-payment will not be applied to any co-payment noted in the declaration page of the policy.**

Preferred Provider Network:

We, through our Plan Administrator, have made special arrangements with preferred providers for the following:

- Diagnostic Testing
- Durable Medical Goods
- Transportation
- Nursing, home health aid and attended services
- Inpatient and outpatient rehabilitation services
- Prescriptions

Failure to utilize the Preferred Provider Network will result in an additional 30% deductible for each service or test. Please discuss any questions regarding this with us or with the Plan Administrator.

Initial Notification of Claim

As promptly as possible after an accident, you, the insured person and/or the treating health care provider must notify us and advise and inform us about the injury and the claim. This information shall include: the facts of the accident, the nature and cause of the injury, the diagnosis and anticipated course of treatment.

In the event that this notification is received 30 days or more after the accident, you shall be responsible for an additional co-payment of 25% of the eligible charges for medically necessary expenses that are incurred after notification to us is required and until notification is received. If this notification is received 60 days or more after the accident, the co-payment penalty shall be 50% of the eligible charges for medical expenses that are incurred after notification to us is required and until notification is received. Any reduction in the amount of reimbursement for PIP claims shall be in addition to any other deductible or co-payment requirement.

Internal Appeals Process:
You, your health care provider or someone on your behalf may request us and the Plan Administrator to review any decision we make regarding your treatment plan, or denial of any service, treatment, diagnostic test, or durable medical good. The **Request for Appeal** must be in writing and submitted to us within 14 days of out decision to you. Attached to the request, please provide any additional documentation you wish us to consider.

We will respond to your request, request additional information, or request examination with another health care provider within 5 business days of receipt of your request. The decision of our internal appeals committee will be forwarded to you in writing within 3 business days of receipt of all documentation required.

In the event that we do not solve the dispute, you may apply to the appropriate Dispute Resolution Organization as specified under the Laws and Regulations promulgated by the New Jersey Department of Banking and Insurance.

On all claims the following law applies: "Any person who knowingly and with intent to defraud any insurance company or other persons, files a statement of claim containing materially false information, or conceals for the purpose of misleading,

information concerning any fact, material thereto, commits a fraudulent insurance act, which is a crime, subject to criminal prosecution and civil penalties."

Please share this document with your health care providers to avoid any confusion.