INTRODUCTION BROCHURE

At Foremost Insurance Company Grand Rapids, Michigan and/or Bristol West Insurance Group, we understand that when you purchase an automobile insurance policy, you are buying protection and peace of mind in the event you are injured in an accident. It is, therefore, important to you that carrier provide you first rate claims service. Our goal is to process claims for medically necessary treatment and testing quickly and fairly.

This brochure explains how your medical claims will be handled, including the Decision Point Review/Precertification requirements which you and your medical provider must follow in order to receive the maximum benefits provided by your policy. Please read this brochure carefully. If you have any questions, please call your Claim Representative at

DECISION POINT REVIEW AND PRE-CERTIFICATION REQUIREMENTS

Please note: Under the provisions of your policy and applicable New Jersey regulations, Decision Point Reviews 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. The following questions and answers only provide an overview of Decision Point Reviews and Pre-certification requirements. You should read your policy for the actual Pre-certification requirements as well as other policy terms and conditions.

Treatment in the first 10 days after an accident and emergency care does not require Decision Point Review or Pre-certification. However, for benefits to be paid in full, the treatment must be medically necessary. This is true in all events.

Question: What is a Decision Point Review?

Answer: 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 the "Identified Injuries". These Care Paths provide your health care provider with general guidelines for treatment 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 health care provider must provide us information about any further treatment or test 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 you are receiving is medically necessary for your injuries. This does not mean that you are required to obtain our approval before consulting your medical provider for your injuries. However, it does mean that your medical provider is required to follow the Decision Point Review requirements in order for you 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 www.nj.gov/dobi/aicrapg.htm or can be obtained by contacting CSG @ 1 (877) 258-CERT (2378).

Question: What is Pre-certification?

Answer: Pre-certification is a medical review process for the specific services, test or equipment listed below in (a)-(l). During this process all services, test or equipment requested are evaluated by medical professionals to insure the level of services, tests or equipment you are receiving is medically necessary for your injuries. This does not mean that you are required to obtain our approval before consulting your medical provider for your injuries. However, it does mean that your medical provider is required to follow the Pre-certification requirements in order for you to receive maximum reimbursement under the policy.

(a) non-emergency inpatient and outpatient hospital care
(b) non-emergency surgical procedures
(c) extended care rehabilitation facilities
(d) outpatient care for soft tissue/disc injuries of the insured person's neck, back and related structures not included within the diagnoses covered by the Care Paths
(e) 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
(f) outpatient psychological/psychiatric testing and/or services
(g) all pain management services except as provided for identified injuries in accordance with decision point review
(h) home health care
(i) non-emergency dental restoration
(j) temporomandibular disorders; any oral facial syndrome
(k) infusion therapy
(l) Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of $75.00.

Question: What do I need to do to comply with the Decision Point Review and Pre-certification requirements in my policy?

Answer: Just provide us with the name(s) of your medical providers. We will then contact them to explain the entire process. You should also give your medical provider a copy of the "Dear Provider Letter" included with this brochure.

Question: What are the Vendors hours of operation?

Answer: CSG Hours of Operation – 7:00 AM to 7:00 PM EST Monday through Friday (excluding legal holidays)

Question: How does the Decision Point Review/Pre-certification Process Work?

Answer: In order for CSG to complete the review, your health care provider is required to submit all requests on the "Attending Physicians Treatment Plan" form as adopted by the DOBI. A copy of this form can be found on the DOBI web site www.nj.gov/dobi/aicrapg.htm, CSG's web site www.csginc.net or by contacting CSG @ (877) 258-CERT (2378).

The health care provider should submit the completed form, along with a copy of your 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. Its phone number is (877) 258-CERT (2378).

The review will be completed within three (3) business days of receipt of the necessary information and notice of the decision will be communicated to both you and your health care provider by telephone, fax and/or confirmed in writing. If your health care provider is not notified within 3 business days, they may continue your test or course of treatment until such time as the final determination is communicated to them. Similarly, if an independent medical examination should be required, they may continue your tests or course of treatment until the results of the examination become available.

Denials of decision point review and 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.

Question: What is the definition of days?

Answer: The definition of days is as follows: "Days" means calendar days unless specifically designated as business days.

1. A calendar and business day both end at the time of the close of business hours (7:00 PM EST Monday through Friday (excluding legal holidays).

2. 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 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.

3. Example: Response to a properly submitted provider request is due back no later than 3 business days from the date CSG receives the submission. CSG receives an Attending Provider Treatment Plan Form by facsimile transmission dated 1:00 PM EST on Wednesday February 6, 2013. Day one of the 3-buisness day period is Thursday, February 7, 2013. Since the 3rd day would be Saturday, February 9, 2013, CSG's decision is due no later than close of business Monday, February 11, 2013.

INDEPENDENT MEDICAL EXAMS

Question: What are the requirements and consequences if I am requested to attend an Independent Medical Exam?

Answer: If the need arises for CSG to utilize an independent medical exam during the decision point review/pre-certification process, the guidelines in accordance to 11:3-4.7(e) 1-7 will be followed. This includes but is not limited to: prior notification to the injured person or his or her designee, scheduling the exam within seven calendar days of the receipt of the attending physicians treatment plan form (unless the injured person agrees to extend the time period), having the exam conducted by a provider in the same discipline, scheduling the exam at a location reasonably convenient to the injured person, and providing notification of the decision within three business days after attendance of the exam. If the examining provider prepares a written report concerning the examination, you or your designee shall be entitled to a copy upon written request.

If you have two or more unexcused failures to attend the scheduled exam, notification will be immediately sent to you, and all health care providers treating you for the diagnosis (and related diagnosis) contained in the attending physicians treatment plan form. The notification will place you on notice that all future treatment, diagnostic testing or durable medical equipment required for the diagnosis (and related diagnosis) contained in the attending physicians treatment plan form will not be reimbursable as a consequence for failure to comply with the plan.

PRE-SERVICE APPEALS

Question: Can my health care provider appeal the Decision Point Review or Pre-certification decision?

Answer: Yes. Per N.J.A.C. 11:3-4.7B, effective 4/17/17, a pre-service appeal of a decision point review and/or precertification denial or modification must be submitted no later than thirty (30) days after receipt of a written denial or modification of requested services.

In accordance with N.J.A.C. 11:3-4.7B (c), appeals must be submitted on the pre-service appeal form approved by the New Jersey Department of Banking and Insurance (DOBI), available on the DOBI website: (http://www.state.nj.us/dobi/pipinfo/aicrapg.htm). The properly completed pre-service appeal form and any supporting documentation must be submitted to CSG. In accordance with N.J.A.C.11:3-4.7B, a pre-service appeal decision will be provided to your health care provider within fourteen (14) calendar days from receipt of the properly completed pre-service appeal form and any supporting documents submitted by your health care provider or any documentation requested by us in order to complete our review. This process will afford your health care provider the opportunity to discuss the appeal with a “similar discipline” Medical Director or request an independent examination scheduled by CSG. Failure to submit a properly completed pre-service appeal form will result in an administrative denial. An incomplete submission and/or administrative denial shall not constitute acceptance within the required timeframe for pre-service appeals.

Disputes concerning medical necessity of a denial or modification of a treatment request, are to be made as pre-service appeals. The pre-service appeals process must be completed prior to the performance or issuance of the requested service.

Pre-service appeals must be submitted directly to CSG, via fax at (856) 910-2501, or in writing at 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619.

Pre-service appeals will only be considered valid if they are submitted to CSG at the address or fax number listed here. If your health care provider has accepted an assignment of benefits, or has a power of attorney, they are required to participate in this process. Failure to participate in this process shall void the assignment of benefits and/or power of attorney.

POST SERVICE APPEALS

Question: How can I or my health care provider appeal other disputes not related to a Decision Point Review or Pre-certification decision such as non-payment or reduced payment of a bill?

Answer: Effective 4/17/17, if any payment or non-payment is unacceptable to you or your health care provider, Bristol West Insurance provides an Internal Appeal Process which is available for review of the decision to which they object. A post-service appeal must be submitted at least 45 days prior to initiating alternative dispute resolution pursuant to N.J.A.C. 11:3-5 or filing action in Superior Court.

In accordance with N.J.A.C. 11:3-4.7B (c), appeals not related to pre-certification must be submitted on the post-service appeal form approved by the New Jersey Department of Banking and Insurance (DOBI), available on the DOBI website: (http://www.state.nj.us/dobi/pipinfo/aicrapg.htm).

In accordance with N.J.A.C.11:3-4.7B , a post-service appeal decision will be provided to your health care provider within thirty (30) calendar days from receipt of the properly completed post-service appeal form and any supporting documents submitted by your health care provider or any documentation requested by us in order to complete our review. Failure to submit a properly completed post-service appeal form will result in an administrative denial. An incomplete submission and/or administrative denial shall not constitute acceptance within the required timeframe for post-service appeals.

The properly completed post-service appeal form and any supporting documentation, must be submitted to Bristol West Insurance via fax to (844) 570-8231, or via certified mail to: New Jersey Appeals Administrator, Bristol West Insurance, 400 Colonial Center Parkway, Suite 200, Lake Mary, FL 32746. Post service appeals will only be considered valid if they are submitted to the fax number or address listed here.

If your health care provider has accepted an assignment of benefits, or has a power of attorney, they are required to participate in this process. Failure to participate in this process shall void the assignment of benefits and/or power of attorney.

Question: Am I or my health care provider required to submit a pre-service appeal and a post-service appeal for the same service?

Answer: The appeal process described above provides only one-level appeal prior to submitting the dispute to alternative dispute resolution or litigation. You or your health care 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. You or your health care provider can submit a pre-service appeal for the treatment and then a post-service appeal for the reimbursement of that treatment.

Question: Can I or my health care provider retain counsel for the Internal Appeal Process?

Answer: If you or your health care provider retain counsel for representation during the Internal Appeal Process, you or your health care provider do so strictly at your own expense. No reimbursement will be issued for counsel fees or any costs regardless of the outcome of the appeal.

VOLUNTARY UTILIZATION PROGRAM

Question: Does the plan provide voluntary networks for certain services, tests or equipment?

Answer: In accordance with the regulations, the plan includes a voluntary utilization program 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 EMGs, H-reflex and nerve conduction velocity (NVC) tests performed together by the treating physician
4. Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of $75.00
5. Services, equipment or accommodations provided by an ambulatory surgery facility

Question: How do I gain access to one of these networks?

Answer: When one of the above listed services, tests or equipment is requested through the decision point review/pre-certification process, a detailed care plan evaluation letter containing the outcome of the review is sent to you, and the requesting health care provider. The 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 accordance with N.J.A.C.11:3-4.4(g), failure to use an approved network will result in an additional co-payment not to exceed 30 percent of the eligible charge.

In addition to securing a list of preferred provider networks through the process outlined in the paragraph above, visit CSG's website @ www.csg-inc.net, contact CSG by phone @ (877) 258-CERT (2378), via fax @ (856) 910-2501, or in writing @ 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619.

PENALTY CO-PAYMENTS

Question: Why would payment of my bills for health care services, tests and durable medical equipment be subject to additional co-pay, and how much is it?

Answer: If you're health care provider does not comply with the decision point review/pre-certification previsions of the plan, including failure to submit a request for decision point review/precertification or failure to provide clinically supported findings that support the request, payment of those services rendered will result in a co-payment of 50% (in addition to any deductible or co-payment that applies under the policy) for medically necessary treatment and tests and equipment. Keep in mind that treatment which is not medically necessary is not reimbursable under the terms of the policy.

If you do not utilize a network provider/facility to obtain those services, tests or equipment listed in the voluntary utilization review program section, payment for those services rendered will result in a co-payment of 30% (in addition to any deductible or co-payment that applies under the policy) for medically necessary treatment, tests and equipment. Keep in mind that treatment which is not medically necessary is not reimbursable under the terms of the policy.

ASSIGNMENT OF BENEFITS

Question: Can I assign my benefits?

Answer: Yes, but only to a provider of service benefits. If a valid assignment is made by you and accepted by the provider of the assigned services benefits, the provider:

(a) agrees to follow the requirements of our decision point review plan for making decision point review and precertification requests;
(b) shall hold you harmless for penalty co-payments imposed by us based on the provider's failure to follow the requirements of our Decision Point Review Plan;
(c) agrees to follow the Internal Appeal Process for disputes arising out of a request for Decision Point Review or Precertification;
(d) agrees to follow the Internal Appeal Process for Other Disputes for any issues other than a decision related to a treatment request; and
(e) agrees to submit disputes to PIP Dispute Resolution pursuant to N.J.A.C. 11:3-5. However, prior to submitting to PIP Dispute Resolution, the provider must comply with the requirements of (c) and (d) above.

Failure on the part of your provider to comply with (a), (b), (c), (d) and (e) above, will render any assignment of benefits null and void.

NO COVERAGE IS PROVIDED BY THIS BROCHURE OR THE QUESTIONS AND ANSWERS CONTAINED IN IT. THIS BROCHURE DOES NOT REPLACE ANY OF THE PROVISIONS OF YOUR POLICY. YOU SHOULD READ YOUR POLICY CAREFULLY FOR COMPLETE INFORMATION AS

TO THE TERMS OF YOUR COVERAGE. IF THERE IS ANY CONFLICT BETWEEN THE POLICY AND THIS SUMMARY, THE PROVISIONS OF THE POLICY SHALL PREVAIL

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADINGINFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

Foremost Insurance Company Grand Rapids, Michigan
Bristol West Insurance Group