AAA Insurance
underwritten by CSAA General Insurance Company
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AMENDATORY AUTOMOBILE COVERAGE ENDORSEMENT – NEW JERSEY

PERSONAL AUTO

Your policy is amended only as described below. All other terms, conditions, and exclusions remain unchanged.

PART II – PERSONAL INJURY PROTECTION COVERAGE

SPECIAL REQUIREMENTS FOR MEDICAL EXPENSES, PAYMENT OF BENEFITS, RECONSIDERATION AND APPEALS and **DISPUTE RESOLUTION** provisions are DELETED and REPLACED by the following**:**

SPECIAL REQUIREMENTS FOR MEDICAL EXPENSES

A. Care Paths For "Identified Injuries" (Medical Protocols)

1. The New Jersey Department of Banking and Insurance has established by regulation the standard courses of diagnosis and treatment for medical expenses resulting from "identified injuries". These courses of diagnosis and treatment are known as care paths.

The care paths do not apply to treatment administered during "emergency care".

2. Upon notification to us of a "bodily injury" covered under this policy, we will advise the "insured" of the care path requirements established by the New Jersey Department of Banking and Insurance.

3. Where the care paths indicate a decision point, further treatment or the administration of a "diagnostic test" is subject to our **Decision Point Review** Plan.

A decision point means the juncture in treatment where a determination must be made about the continuation or choice of further treatment of an "identified injury".

B. Coverage For "Diagnostic Tests"

1. In addition to the care path requirements for an "identified injury", the administration of any of the following "diagnostic tests" is also subject to the requirements of our **Decision Point Review Plan**:

a. Brain audio evoked potential (BAEP);

b. Brain evoked potential (BEP);

c. Computer assisted tomographic studies (CT, CAT Scan);

d. Dynatron/cyber station/cybex;

e. H-reflex Study;

f. Magnetic resonance imaging (MRI);

g. Nerve conduction velocity (NCV);

h. Soma sensory evoked potential (SSEP);

i. Sonogram/ultrasound;

j. Visual evoked potential (VEP);

k. Any of the following "diagnostic tests" when not otherwise excluded under Exclusion **C.**:

(1) Brain mapping;

(2) Doppler Ultrasound;

(3) Electroencephalogram (EEG);

(4) Needle electromyography (Needle EMG);

(5) Sonography;

(6) Thermography/thermograms;

(7) Video fluoroscopy; or

l. Any other diagnostic test that is subject to the requirements of our **Decision Point Review Plan** by New Jersey law or regulation.

2. The "diagnostic tests" listed under Paragraph **B.1.** must be administered in accordance with New Jersey Department of Banking and Insurance regulations, which set forth the requirements for the use of "diagnostic tests" in evaluating injuries sustained in an auto accident.

However, those requirements do not apply to "diagnostic tests" administered during "emergency care".

3. We will pay for other "diagnostic tests" which are:

a. Not subject to our Decision Point Review Plan; and

b. Not specifically excluded under Exclusion **C.**;

only if administered in accordance with the criteria for medical expenses as provided in Part II.

C. Decision Point Review Plan

1. Coverage for certain medical expenses under this endorsement is subject to our **Decision Point Review Plan**, which provides appropriate notice and procedural requirements that must be adhered to in accordance with New Jersey law or regulation. We will provide a copy of this plan upon request, or in the event of any claim for medical expenses under this coverage.

2. Our Dec**ision Point Review Plan** includes the following minimum requirements as prescribed by New Jersey law or regulation:

a. The requirements of the **Decision Point Review Plan** only apply after the tenth day following the accident.

b. We must be provided prior notice as indicated in our plan, with appropriate "clinically supported" findings, that:

(1) Additional treatment for an "identified injury";

(2) The administration of a "diagnostic test" listed under Paragraph **B.1.**; or

(3) The use of durable medical equipment;

is required.

The notice and "clinically supported" findings may include a comprehensive treatment plan for additional treatment.

3. Once we receive such notice with the appropriate "clinically supported" findings, we will in accordance with our plan:

a. Promptly review the notice and supporting materials; and

b. If required as part of our review:

(1) Request any additional medical records; or

(2) Schedule a physical examination.

4. We will then determine, and notify the insured, whether we will provide coverage for the additional treatment, "diagnostic test" or the use of durable medical equipment as indicated in our plan and within the applicable three business day requirements specified in the New Jersey Department of Banking and Insurance regulations. Any determination we make will be based on the determination of a physician or dentist.

5. Any physical examination of an "insured" scheduled by us will be conducted in accordance with our plan. If a written report concerning the physical examination is prepared by the "health care provider", we will make such report available to the "insured" upon request.

We may deny reimbursement of further treatment, "diagnostic tests" or the use of durable medical equipment for repeated unexcused failure of any "insured" to appear for a physical examination required by us, in accordance with our plan.

6. Penalty

A penalty will be imposed in accordance with our approved plan if:

a. We do not receive proper notice for treatment, "diagnostic tests" or the use of durable medical equipment in accordance with the requirements of our **Decision Point Review Plan**;

b. We are not provided "clinically supported" findings; or

c. If any "insured" fails to use a network in accordance with N.J.A.C. 11:3-4.8, and our approved **Decision Point Review Plan**.

However, we will not impose a penalty where we received proper notice or are provided "clinically supported" findings and we failed to request further information, modify or deny reimbursement of further treatment, "diagnostic tests" or the use of durable medical equipment with respect to that notice or those findings in accordance with our plan.

D. "Pre-certification" of Medical Care

1. "Pre-certification" means those programs established by us where the "medical necessity" of certain medical procedures, treatments, "diagnostic tests", or other services, non-medical expenses and durable medical equipment are subject to prior authorization by us or our designated representative, and are also subject to utilization review and/or case management by us.

a. Prior authorization generally means obtaining the approval of a proposed medical procedure, treatment, "diagnostic test", service or supply in accordance with our "Pre-certification" procedures before the receipt or administration of such medical care.

b. Utilization review generally means that part of a quality assurance program that supports and assures a comprehensive effort to monitor effective, efficient and timely utilization of medical care, and serves as a process to review and determine whether medical care is "medically necessary".

c. Case management generally means those methods of coordinating the provision of health-care to persons injured in automobile accidents, with the goal of ensuring continuity and quality of care and cost effective outcomes.

2. Our "Pre-certification" programs do not apply during the first ten (10) days following an accident.

3. This policy is not responsible for any medical or other results arising directly or indirectly from an "insured's" participation in either the "Pre-certification" programs, or the care path medical protocols, or the decision point review plan processes.

4. Procedures, Service and Supplies subject to "Pre-certification":

a. The following treatments, procedures, services, are subject to "Pre-certification" for an injury that is not an "Identified injury":

(1) Non-emergency inpatient and outpatient hospital care

(2) Non-emergency surgical procedures

(3) Extended care rehabilitation facilities

(4) 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

(5) 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

(6) Outpatient psychological/psychiatric testing and/or services

(7) All pain management services, except as provided for identified injuries in accordance with Decision Point Review.

(8) All qualitative and quantitative drug testing and/or screenings

(9) Home health care

(10) Non-emergency dental restoration

(11) Temporomandibular disorders; any oral facial syndrome

(12) Infusion therapy

(13) Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of $75.00

(14) Acupuncture

(15) Schedule II Ill and IV Controlled Substances, as defined by the Drug Enforcement Administration (DEA), when prescribed for more than three months

(16) Prescriptions, including but not limited to, Schedule II, III, and IV Controlled Substances

(17) Any and all procedures that use an unspecified CPT, CDT, DSM IV and/or HCPC

code

(18) Non-emergency transportation services

(19) Computerized muscle testing

b. "Pre-certification" requirements do not apply within the first ten (10) days of the motor vehicle accident, nor does it apply to "emergency care". All services and treatments are subject to retrospective review for "medical necessity" and causation.

5. Our "Pre-certification" includes the following minimum requirements as prescribed by New Jersey law or regulation:

a. The requirements of the "Pre-certification" only apply after the tenth day following the accident.

b. We must be provided prior notice as indicated in our plan, with appropriate "clinically supported" findings, that:

(1) Additional treatment;

(2) Testing;

(3) The use of durable medical equipment; is required.

6. Once we receive such notice with the appropriate "clinically supported" findings, we will in accordance with our plan:

a. Promptly review the notice and supporting materials; and

b. If required as part of our review:

(1) Request any additional medical records; or

(2) Schedule a physical examination.

We will then determine, and notify the "insured", whether we will provide coverage for the additional treatment, testing or the use of durable medical equipment as indicated in our plan and within the applicable three business day requirements specified in the New Jersey Department of Banking and Insurance regulations. Any determination we make will be based on the determination of a physician or dentist.

7. Any physical examination of an "insured" scheduled by us will be conducted in accordance with our plan. If a written report concerning the physical examination is prepared by the "health care provider", we will make such report available to the "insured", upon request.

8. We may deny reimbursement of further treatment, testing, or the use of durable medical equipment for repeated unexcused failure of any "insured" to appear for a physical examination required by us, in accordance with our plan.

9. Notice Requirements

a. For non-emergency admissions, procedures, services or supplies listed above, you or your "health care provider" must contact us at least three (3) days prior to admission, treatment or purchase to obtain authorization.

b. We will provide you or your "health care provider" with our determination within those three (3) days.

c. For continued confinement as an inpatient beyond the time authorized, you or your "health care provider" must contact us at least 24 hours prior to the discharge date for additional authorization.

d. We will provide you or your "health care provider" with our determination within those 24 hours.

e. In the event we do not provide an "insured" or his or her "health care provider" with a determination within the time frames stated above, we will tell the "insured" or his or her "health care provider" what specific information is needed to make our determination.

In such circumstances, an "insured" may proceed with the treatment or procedure suggested by his or her "health care provider", subject to the requirement that all medical services be "medically necessary". Such courses of treatment or procedures may continue until such time we communicate with you or your "health care provider" that the treatment or procedure is not authorized.

f. In the event we do not respond to an "insured" or his or her "health care provider" within the time frames, we will not apply any additional co-payment requirements on the "insured" for "medically necessary" services incurred between the time the "insured" or his or her

"health care provider" gives us notification and we respond.

g. In the event we do not authorize the admission, procedure, services or supplies, we will send a written explanation to the "health care provider", stating the reasons for the denial of the authorization.

E. Non-compliance

For the care path medical protocols, the listed "diagnostic test" the applicable decision point provisions and "Pre-certification", if an "insured" fails to:

1. Submit requests for **Decision Point Review**, or "Pre-certification" where required;

2. We are not provided "clinically supported" findings;

then we will impose a co-payment penalty. The co-payment penalty will be 50% (in addition to any deductible or co-payment that applies under the policy) of the eligible charge for medically necessary services.

F. Voluntary Networks

1. Upon receiving notification of "bodily Injury" covered under this Policy, we will make available to the "named insured" and the treating "health care provider" information about our approved Voluntary Networks providers for certain types of testing, durable medical equipment, prescription drugs, services or ambulatory surgery facilities.

2. If an "insured" does not use a Voluntary Networks provider, we will impose a co- payment not to exceed 30% of the eligible charges for "medically necessary diagnostic tests" durable medical equipment, prescriptions, services or ambulatory surgery facilities.

PAYMENT OF BENEFITS

A. We may, at our option, pay any medical expense benefits or essential services benefits to the:

1. "Insured"; or

2. Person or organization providing products or services for such benefits.

These benefits shall not be assignable except to providers of service benefits. Any such assignment is not enforceable unless the provider of service benefits agrees to:

1. Be subject to the requirements of our **Decision Point Review Plan**, "Pre-certification";

2. Hold an "insured" harmless for a penalty copayments imposed by us for the failure of the provider of service benefits to adhere to the requirements of our **Decision Point Review Plan**, including but not limited to failure to submit a request for **Decision Point Review** or "Pre-certification";

3. Submit disputes to the "Internal Appeal Process" prior to submitting any disputes through the Dispute Resolution Process (N.J.A.C.11:3-5); and

4. Furnish a copy of the signed assignment agreement upon request.

B. Failure of the provider to comply with:

1. Our **Decision Point Review Plan**, "Pre-certification" or

2. The requirement to follow the "Internal Appeal Process" prior to initiating arbitration or litigation;

will render any prior assignment of benefits under the policy null and void.

C. In the event of the death of an "insured", we will pay:

1. Any amounts payable, but unpaid prior to death, for medical expense benefits to the "insured's" estate.

2. Death benefits for an "insured" who was:

a. An "income producer", to:

(1) The surviving spouse, "domestic partner" or partner in a "civil union"; or

(2) If there is no surviving spouse or such surviving party, the surviving children; or

(3) If there are no surviving children, the "insured's" estate.

b. A provider of essential services, to the person who has incurred the expense of providing essential services.

3. Funeral expense benefits to the "insured's" estate.

INTERNAL APPEAL PROCESS

When a dispute arises related to **Decision Point Review** and/or "Pre-certification", you must refer to the **Decision Point Review Plan** for how to proceed with an appeal in this situation.

When a dispute arises, other than under the Decision Point Review/"Pre-certification", any treating "health care provider" who has accepted an assignment of benefits or a power of attorney from an "insured" must submit a written request for the "Internal Appeal Process," specifying the issues in dispute, accompanied by supporting documentation, at least 30 days prior to initiating arbitration or litigation.

Written notice of the dispute and request for the "Internal Appeal Process" shall be submitted to "us" via certified mail/return receipt requested or via delivery mail service providing proof of delivery. Proof of receipt by "us" must be provided to "us" upon request.

DISPUTE RESOLUTION

Any disputes not resolved under the **Decision Point Review**/"Pre-certification" or in the Internal Appeal Process shall be submitted through the Dispute Resolution Process which is governed by regulations promulgated by the New Jersey Department of Banking and Insurance (N.J.A.C.11:3- 5.6).

However, prior to submitting such matter to dispute resolution, providers who are assigned service benefits by an "insured" or have a power of attorney from an "insured", shall be subject to our internal appeals process in accordance with New Jersey law or regulation. Unless emergent relief is sought, failure to utilize the "Internal Appeal Process" prior to filing arbitration or litigation will render any prior assignment of benefits null and void.