CURE'S DPRP AND PRE-CERTIFICATION REQUIREMENTS DISCLOSURE NOTICE

How To Comply with the DPRP and Pre-Certification Requirements Of Your CURE Policy

The '**Automobile Insurance Cost Reduction Act'** was signed into law on May 19, 1998, and it has led to changes in your no-fault (Personal Injury Protection or PIP) medical coverage. In enacting these reforms, the Legislature found that the substantial increase in the cost of medical expense benefits over the years had to be addressed by providing controls to eliminate medically unnecessary treatments, diagnostic testing and use of durable medical equipment.

As a result, in accordance with the provisions of your CURE auto policy including its **Decision Point Review Plan (DPRP) and Pre-Certification** requirements, you have certain obligations that you must satisfy so that we may provide coverage for medically necessary treatment, diagnostic testing and use of durable medical equipment arising from an automobile accident in which you are injured. **See EXHIBIT I** for a copy of the DPRP section of your PIP coverage provisions.

Failure to comply with the policy requirements as summarized below may affect the **reimbursement** for **medical treatment, diagnostic tests** and **durable medical equipment.** No decision point or pre-certification requirements shall apply within 10 days of the insured event or to treatment administered in emergency care. However, such items may be reviewed retrospectively and must be medically necessary and as a result of a covered automobile accident in order to be reimbursable.

For all deadlines relating to CURE's DPRP **and Pre-Certification Requirements, a calendar and business day** both end at the time of CURE's close of business, which is 4:45 P.M. **Additionally, please note that** "business day" does not include Saturdays, Sundays, legal holidays, or days that the office i**s closed due to severe weather, mandatory evacuation, or a State of Emergency.**

YOUR OBLIGATIONS

1. **<u>Your Notice Requirements After an Accident or Loss:</u>** After an accident, you must report your accident as soon as possible to CURE. They can be reached toll-free at (800) 229-9151, 24 hours a day, 7 days a week. If anybody insured under the policy has an automobile accident or loss, they, or someone acting for them, must promptly contact us. This notification shall include information regarding the facts of the accident, the nature and cause of any injury, the diagnosis and the anticipated course of treatment.

Failure to comply with prompt notice may result in a reduction of reimbursement (co-payment) of eligible charges for medically necessary expenses that are incurred after notification to us is required and until notification is received. This additional co-payment will be based on the timeframe in which the loss is reported:

Reporting Timeframe Co-Payment:

- Loss reported 31-60 days after the accident will result in a 25% co-payment
- Loss reported 61 or more days after the accident will result in a 50% co-payment

A Personal Injury Protection (PIP) claim representative will contact you within 48 hours of reporting your claim to discuss your injuries, and also to get the names of any health care providers you may be seeing. It is important that we have this information so that we can maintain contact with your providers regarding your treatment. In order for us to process your claim, you must complete the Application for Benefits - Personal Injury Protection form, which we will send to you, along with a copy of this notice, when you report a claim involving personal injury. It is also a good idea for you to share this information with all of your health care

providers; they will be responsible for adhering to the Decision Point Review and Pre-certification requirements and the related New Jersey laws and regulations.

2. **Treatment of "Identified Injuries":** Pursuant to N.J.A.C. 11:3-4, the New Jersey Department of Banking and Insurance has published standard courses of treatment, called ***care paths,*** for injuries of the neck and back, collectively referred to as the ***identified injuries.*** A more specific list of identified injuries is provided in **EXHIBIT II** attached.

   The care paths provide that treatment of identified injuries must be evaluated at certain intervals called ***decision points.*** At ***decision points,*** *you* or your medical provider must provide **prior notice and supporting medical information** to CURE about further treatment and/or the use of durable medical equipment that is proposed.

   If requests for decision point review are not submitted where required or clinically supported findings that support a request for treatment and/or durable medical equipment are not submitted, payment of your bills will be subject to a **penalty co-payment of 50%,** even if services are determined to be medically necessary.

   The care paths and accompanying rules are available on the Internet at the website of the New Jersey Department of Banking and Insurance; http://www.nj.gov/dobi/aicrapg.htm.

3. **CURE will not provide reimbursement for the following:**

   - Laboratory testing services from any entity that is not certified by the Department of Health and Human Services ("HHS").
   - Prescription medications, drugs and biologicals that are not approved by the USFDA.
   - Compound prescription medications, drugs and/or biologicals that, as compounded, are not approved by the USFDA, including but not limited to, compounds that may have in their formulary one or more medications, drugs and/or biologicals individually approved by the USFDA.

   CURE has no obligation to reimburse for specific CPT/HCPC codes, even if those codes are pre-certified through a Decision Point Review or Precertification request as being medically necessary and causally related to the accident, if the DOBI has adopted payment adjudication methodologies in the NJ PIP regulations that consider those charges not to be reimbursable. These payment adjudication methodologies include, but are not limited to, the NCCI edits and other Medicare guidelines. The DOBI's interpretation of the auto medical fee schedule can be viewed at www.state.nj.us/dobi/pipinfo/medfeequa.htm. The current NCCI edits can be obtained from the Center for Medicare and Medicaid Services website: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html

4. **Mandatory Pre-Certification:** The pre-certification requirements apply to your claim if your treatment relates to an accident that occurred under polices with an effective date that is on or after May 1, 2014. If you do not have an Identified Injury, you or your provider is required to obtain pre-certification of all the services listed below. If you or your provider fails to submit requests for the pre-certification of all the services listed below or fails to provide clinically supported findings that support the request, payment of your bills will result in a co-payment of 50% (in addition to any deductible or co-payment that applies under the policy) of the eligible charge for medically necessary services. You are encouraged to maintain communication with CURE on a regular basis as pre-certification requirements may change.

   Pre-certification is mandatory as to any of the following medical services, treatments, and procedures once 10 days have elapsed since the accident:

   a) non-emergency inpatient and outpatient hospital care;
   b) non-emergency surgical procedures;
   c) outpatient care, including follow-up evaluations, 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;

d) temporomandibular disorders; any oral facial syndrome
e) carpal tunnel syndrome;
f) outpatient psychological/psychiatric testing and/or services;
g) home health care;
h) durable medical goods with an aggregate cost or monthly rental in excess of $75.00, including durable medical equipment and associated supplies, prosthetics and orthotics,
i) non-medical products, devices, services and activities and associated supplies, not exclusively used for medical purposes or as durable medical goods, with an aggregate cost or monthly rental in excess of $75.00, including but not limited to the following:
    1) vehicles,
    2) modifications to vehicles,
    3) durable goods,
    4) furnishings,
    5) improvements or modifications to real or personal property,
    6) fixtures,
    7) spa/gym memberships,
    8) recreational activities and trips,
    9) leisure activities and trips;
j) non-emergency medical transportation with a round trip transportation expense in excess of $75.00;
k) non-emergency dental restoration;
l) physical, occupational, speech, cognitive or other restorative therapy, or body part manipulation, including follow up evaluations by the referring physician, except that provided for identified injuries in accordance with Decision Point Review;
m) pain management treatment except that provided for identified injuries in accordance with Decision Point Review, including but not limited to the following:
    1) acupuncture,
    2) nerve blocks,
    3) manipulation under anesthesia,
    4) anesthesia when performed in conjunction with invasive techniques,
    5) epidural steroid injections,
    6) radio frequency/rhyzotomy,
    7) narcotics, when prescribed for more than three months,
    8) biofeedback,
    9) implantation of spinal stimulators or spinal pumps,
    10) trigger point injections;
n) Schedule II, III and IV Controlled Substances, as defined by the Drug Enforcement Administration (DEA), when prescribed for more than three months;
o) Prescriptions, including but not limited to Schedule II, III and IV Controlled Substances; and
p) Any and all procedures that use an unspecified CPT, CDT, DSM IV and/or HCPC code.

5. **Diagnostic Tests**: If your medical provider considers certain diagnostic tests to be medically necessary, this also requires decision point review as provided by N.J.A.C. 11:3-4, regardless of diagnosis, and you or your medical provider must notify us by providing written support and medical records required to establish the need for the test before we can consider it for coverage.

EXHIBIT III attached provides a list of diagnostic tests requiring our **prior authorization. EXHIBIT IV** is a list of diagnostic tests that the law **prohibits** us from covering depending on circumstances. If requests for decision point review are not submitted where required or clinically supported findings that support requests for diagnostic tests are not submitted, payment of your bills will be subject to **a penalty co-payment of 50%,** even if the services are determined to be medically necessary.

6. **How Your Provider Will Notify CURE**: The **Attending Provider Treatment Plan** form ("Treatment Plan") must be completed by your health care provider when required to notify CURE of a proposed diagnostic test or treatment or use of durable medical equipment. Copies of this form can be requested from CURE by calling 800-535-2873 or can be accessed at http://www.cure.com/claims.aspx, www.nj.gov/dobi/aicrapg.htm and

CURE'S DPRP AND PRE-CERTIFICATION REQUIREMENTS DISCLOSURE NOTICE https://www.Medlogix.com.

With the form, CURE's Decision Point Review Plan and Pre-Certification Requirements may require the submission of additional **clinical supporting** materials and medical records, including the supporting materials and medical records specified below.

SUPPORTING MATERIALS AND MEDICAL RECORDS

1. Initial Examination Report
2. Patient Questionnaire
3. Re-examination Reports
4. Operative/Discharge Reports
5. Attending Physician's Report (PIP-2)
6. Pertinent Medical Records and Medical Reports, Including Reports of Referrals and Consultations, Obtained from Other Health Care Providers

Please attach all other *supporting materials and medical records* pertinent to this injury.

You or your provider may call CURE at 1-800-535-2873 for help and further information regarding these requirements and the use of the **Treatment Plan** form. The completed form can be mailed or faxed to CURE by your health care provider. **The fax number is:** 1-856-910-2501.

CURE Response to Test or Treatment Notifications

Upon receipt of a completed Attending Provider Treatment Plan form as described in paragraph 3 above, we will (a) authorize the treatment, diagnostic test, or durable medical equipment; (b) deny the treatment, diagnostic test, or durable medical equipment; (c) request additional medical records and materials; or (d) advise that an independent medical examination *("IME")* will be scheduled. Any decision we make to deny additional diagnostic tests, durable medical equipment or treatment will be based on the determination of a physician.

If we fail to do any of these four things within three business days after our receipt of the proper notice with all the required supporting materials and medical records as described in paragraph 3, then medically necessary treatment, use of durable medical equipment or diagnostic testing may continue without penalty until a final determination is communicated to you or your provider.

If requests for decision point review or clinically supported findings that support a request for treatment, diagnostic tests and/or durable medical equipment are not submitted where required, payment of your bills will be subject to a **penalty co-payment of 50% after application of the provisions of N.J.A.C. 11:3- 29,** even if the services are determined to be medically necessary.

Should an IME be required, we will schedule the examination within 7 calendar days of our receipt of the notice from the treating provider, unless we have authorization from the injured person to extend this time period. The examination will be made with a provider in the same discipline as the treating provider and at a location reasonably convenient to the patient. The resulting decision will be communicated to the treating provider and the injured person within 3 business days after the examination. If the examining provider prepares a written report, a copy of the report shall be available upon request.

We may deny reimbursement of further treatment, request for the use of durable medical equipment and/or diagnostic testing for repeated unexcused failure of any "insured" to appear for a physical examination required by us. Repeated unexcused failure shall mean the failure to attend more than one scheduled appointment for an

IME. If it is necessary for a patient to miss a scheduled IME, the patient must provide at least 72 hours notice by contacting CURE's IME Coordinator at 800-293-9795. Failure to attend the initial IME scheduled will be excused if timely notice is given to us.

Another examination will be scheduled for the patient to occur within the forty-five (45) calendar day period that will begin with our receipt of the patient's Decision Point Review/Pre-Certification request. Failure to appear at any rescheduled appointment that is scheduled for a date within the initial forty-five (45) calendar day period will be excused if the patient provides at least 72 hours notice of unavailability.

Failure to attend an examination rescheduled to occur more than forty-five (45) calendar days from our receipt of the Decision Point Review/Pre-Certification request will be considered unexcused.

The patient shall, if requested by us, provide medical records and other pertinent information to the health care provider conducting the physical examination. The requested records must be provided no later than the time of the examination. If the patient fails to supply the requested records at or before the scheduled examination, the examination may not take place and may be considered an unexcused failure to attend the examination.

After more than one unexcused failure to attend the scheduled IME, CURE will deny payment for treatment, diagnostic testing and durable medical goods provided on or after the date of the second unexcused failure to attend. This denial will apply to treatment, diagnostic testing, durable medical equipment and pre-certification requests relating to the diagnosis code(s) and corresponding family of codes associated with the Decision Point Review/ Pre-Certification request that necessitated the scheduling of the IME.

Written notification will be sent to the patient (or his/her designee) and the treating provider for the diagnosis code(s) and corresponding family of codes contained in the Attending Provider Treatment Plan form. This notification will advise that as of the notification date, no future treatment, diagnostic testing and/ or durable medical equipment associated with the diagnosis code(s) and corresponding family of codes contained in the Attending Provider Treatment Plan form will be eligible for payment.

Voluntary Network

In accordance with N.J.A.C. 11:3-4.8, the plan includes a voluntary network for certain tests, durable medical equipment, and certain non-emergency benefits specified in **EXHIBIT V**. When one of the specified tests or durable medical equipment is requested through the decision point review process, information about our voluntary network will be supplied to the claimant and requesting provider. A list of network providers will be available at www.Medlogix.com or by contacting Medlogix at 877-258-CERT (2378). **Those individuals who choose not to utilize the network will be assessed an additional co-payment not to exceed 30% of the eligible charge**. That co-payment will be the responsibility of the claimant.

Emergency Care

Medically necessary treatment in the first ten days after the accident, and "emergency care" treatment or testing, do not require our prior authorization before coverage may be provided.

Internal Appeals Process and Dispute Resolution

Prior to making a request for alternate dispute resolution, all appeals must be initiated using the forms established by the New Jersey Department of Banking and Insurance ("Department") and posted on the Department's website. 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. **Pre-Service Appeals**: For appeals of decision point review and/or precertification denials or modifications prior to the performance or issuance of the requested medical procedure, treatment, diagnostic test, other service and/or durable medical equipment (collectively known as "services"), any treating provider who has accepted an assignment of benefits must submit a pre-service appeal using the forms established by the Department and posted on the Department's website, specifying the issues in dispute accompanied by supporting documentation. A pre-service appeal shall be submitted no later than 30 days after receipt of a written denial or modification of requested services. Submission of information identical to the original material submitted in support of the request shall not be accepted as a valid pre-service appeal. Provided that the pre-service appeal form and additional necessary medical information has been submitted, a response to the pre-service appeal will be made within 14 days after receipt of the pre-service appeal form and any supporting documentation. If it is determined that a peer review or an Independent Medical Examination is appropriate, this information will also be communicated within 14 days. 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 to properly respond to the appeal, an additional 10 days will be added to the response time requirement.

All pre-service appeals should be mailed to Medlogix, LLC, 300 American Metro Blvd., Suite 220 Hamilton, or faxed to 1-856-910-2501.

Post-Service Appeals: For appeals subsequent to the performance or issuance of the services, any treating provider who has accepted an assignment of benefits must submit a post-service appeal using the forms established by the Department and posted on the Department's website, specifying the issues in dispute accompanied by supporting documentation. 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. Provided the post-service appeal form and additional necessary medical information has been submitted, a response to the post-service appeal will be made within 30 days after receipt of the post-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 (e.g., Professional Code Review, Medical Bill Audit Report, UCR Analytical Analysis) to properly respond to the appeal, an additional 10 days will be added to the response time requirement.

All post-service appeals, including those identified on the New Jersey PIP Post-Service Appeal Code Key which is included with the Department's Post-Service Appeals Form, should be mailed to Medlogix, LLC, 300 American Metro Blvd., Suite 220 Hamilton, or faxed to 1-856-5521999.

If there is any dispute that was properly submitted but that was not resolved by the Internal Appeals Process, it must be submitted through the Personal Injury Protection Dispute Resolution Process (N.J.A.C. 11:3-5) and can

be initiated by contacting Forthright at 732-271-6100 or toll-free 1-888-881-6231. Information is also available on Forthright's Web site, http://www.nj-no-fault.com.. We retain the right to file a Motion to remove any Superior Court action to the Personal Injury Protection Dispute Resolution Process pursuant to N.J.S.A. 39:6A-5.1. As a condition of this Internal Appeals Process, an issue must be raised by the treating provider through either a pre-service or a post-service appeal before that provider can raise that issue in arbitration.

Unless emergent relief is sought, failure to complete the Internal Appeals Process prior to filing arbitration or litigation will invalidate an assignment of benefits. Completion of the Internal Appeals Process means timely submission of an appeal and receipt of the response prior to filing for alternate dispute resolution. Performing any treatment or service that is the subject of the Internal Appeals Process prior to the receipt of the response to that appeal will also invalidate an assignment of benefits.

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

If you would like us to pay your treating medical provider directly, you must sign an Assignment of Benefits Agreement. As a condition of assignment, your provider must follow the requirements of this Decision Point Review Plan and Pre-Certification Requirements and shall hold you harmless for penalty co-payments imposed based on your provider's failure to follow the requirements of our Decision Point Review Plan and Pre-Certification Requirements. As a condition of assignment, your provider must also agree to submit disputes to alternate dispute resolution pursuant to N.J.A.C. 11:3-5. Providers who are assigned benefits by the insured or have a power of attorney from the insured must make a valid internal appeal pursuant to N.J.A.C. 11:3-4.7B, and in accordance with this DPRP and Pre-Certification Disclosure Notice, prior to making a request for dispute resolution in accordance with N.J.A.C. 11:3-5. Failure to comply with (1) our Decision Point Review Plan Requirements; (2) the Pre-Certification Requirements; or (3) the requirement to follow the Internal Appeals Process prior to initiating arbitration or litigation will render any prior assignment of benefits under the policy null and void.

Medical Necessity

This summary of CURE's Decision Point Review Plan and Pre-Certification requirements has been prepared for the convenience of our subscribers and their health care providers. However, please keep in mind that your policy contains additional provisions affecting whether there is coverage and how much you will be reimbursed.

All covered services and equipment, whenever provided and even if not subject to prior notification and review, must be medically necessary. For full details, please consult your policy. If you have any questions, please contact us at 1-800-535-2873.

Excerpted from:
RS 05 77 09 17
RB 05 76 09 17

SPECIAL REQUIREMENTS FOR MEDICAL EXPENSES

1. Care Paths and Decision Points For "Identified Injuries" (Medical Protocols)

a. 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".

b. 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.

c. Where the care paths indicate a decision point, further treatment, the utilization of durable medical equipment, or the administration of a "diagnostic test", it 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".

2. **Coverage For "Diagnostic tests"**

a. 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:

(1) Brain audio evoked potential (BAEP);
(2) Brain evoked potential (BEP);
(3) Computer assisted tomographic studies (CT, CAT Scan);
(4) Dynatron/cyber station/cybex;
(5) H-reflex Study;
(6) Magnetic resonanceimaging (MRI);
(7) Nerve conduction velocity (NVC);
(8) Somasensory evoked potential (SSEP);
(9) Sonogram/ultrasound;
(10) Visual evoked potential (VEP);
(11) Any of the following ""diagnostic tests" when not excluded under Exclusion **C.**
(a) Brain mapping;
(b) Doppler ultrasound;
(c) Electroencephalogram (EEG);
(d) Needle electromyography (Needle EMG);
(e) Sonography;
(f) Thermography/thermograms;
(g) Videoflouroscopy; or
(12) Any other "diagnostic test" that is subject to the requirements of our **Decision Point Review Plan** by New Jersey law or regulation.

b. The "diagnostic tests" listed under Paragraph **2.a.** 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".

c. We will pay for other "diagnostic tests" which are:
(1) Not subject to our **Decision Point Review Plan;** and
(2) Not specifically excluded under Exclusion **C;**

only if administered in accordance with the criteria for medical expenses as provided in this endorsement.

3. Pre-Certification Requirements

a. In addition to the care path requirements for an "identified injury", you or your provider is required to obtain pre-certification of all the services listed in our Decision Point Review Plan and Pre-Certification Requirements Disclosure Notice. If you or your provider fails to submit requests for the pre-certification of any of listed services, or fails to provide clinically supported findings that support the request, payment of your bills will result in a co-payment of 50% (in addition to any deductible or co-payment that

applies under the policy) of the eligible charge for medically necessary services. You are encouraged to maintain communication with CURE on a regular basis as pre-certification requirements may change. Pre-certification is mandatory as to any of the services listed in our Decision Point Review Plan and Pre-Certification Requirements Disclosure Notice once 10 days have elapsed since the accident.

4. Decision Point Review Plan and Pre-Certification Requirements

a. Coverage for certain medical expenses under this endorsement are subject to the Decision Point Review Plan and Pre-Certification Requirements, 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.

b. Our Decision Point Review Plan and Pre-Certification Requirements include the following minimum requirements as prescribed by New Jersey law or regulation:

(1) The requirements of the Decision Point Review Plan and Pre-Certification Requirements only apply after the tenth day following the accident and do not apply to **Emergency Care.**

(2) We must be provided prior notice, with appropriate "clinically supported" findings, that**:**

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

(b) The administration of a “diagnostic test” listed under Paragraph 2.a; or

(c) The use of durable medical equipment; is required. The notice and “clinically supported” findings may include a comprehensive treatment plan for additional treatment.

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

(1) Promptly review the notice and supporting materials; and

(2) If required as part of our review:

(a) Request anyadditional medical records; or

(b) Schedule a physical examination.

d. We will then determine, and notify the "insured", whether we will provide coverage for the additional treatment, use of durable medical equipment or “diagnostic test” within 3 business days of the receipt of the request or the receipt of additional medical records.

Any decision we make to deny authorization for additional treatment, use of durable medical equipment or diagnostic tests subject to our Decision Point Review Plan or Pre-Certification Requirements will be based on the determination of a physician.

e. Any physical examination of an "insured" scheduled as part of this plan, will be conducted as follows:

We will notify the "insured" that a physical examination is required as part of our review. Should an Independent Medical Examination be required, we will schedule the examination within 7 calendar days of our receipt of the notice from the treating provider, unless we have authorization from the injured person to extend this time period. The examination will be made with a provider in the same discipline as the treating provider and at a location reasonably convenient to the patient. The resulting decision will be communicated to the treating provider and the injured person within 3 business days after the examination. If the examining provider prepares a written report, a copy of the report shall be available upon request.

We may deny reimbursement of further treatment, request for the use of durable medical equipment and/or diagnostic testing for repeated unexcused failure of any “insured” to appear for a physical examination required by us. Repeated unexcused failure shall mean the failure to attend more than one scheduled appointment for an IME. If it is necessary for a patient to miss a scheduled IME, the patient must provide at least 72 hours notice by contacting CURE’s IME Coordinator at 800-293-9795. Failure to attend the initial IME scheduled will be excused if timely notice is given to us.

Another examination will be scheduled for the patient to occur within the forty-five (45) calendar day period that will begin with our receipt of the patient’s Decision Point

Review or Pre-Certification Request. Failure to appear at any rescheduled appointment that is scheduled for a date within the initial forty-five (45) calendar day period will be excused if the patient provides at least 72 hour notice of unavailability.

Failure to attend an examination rescheduled to occur more than forty-five (45) calendar days from our receipt of the Decision Point Review Plan or Pre-Certification request will be considered unexcused.

The patient shall, if requested by us, provide medical records and other pertinent information to the health care provider conducting the physical examination. The requested records must be provided no later than the time of the examination. If the patient fails to supply the requested records at or before the scheduled examination, the examination may not take place and may be considered an unexcused failure to attend the examination.

After more than one unexcused failure to attend the scheduled IME, CURE will deny payment for treatment, diagnostic testing and durable medical goods provided on or after the date of the second unexcused failure to attend. This denial will apply to treatment, diagnostic testing and durable medical equipment relating to the diagnosis code(s) and corresponding family of codes associated with the Decision Point Review or Pre-Certification request that necessitated the scheduling of the IME.

Written notification will be sent to the patient (or his/her designee) and the treating provider for the diagnosis code(s) and corresponding family of codes contained in the Attending Provider Treatment Plan form. This notification will advise that as of the notification date, no future treatment, diagnostic testing and/or durable medical equipment associated with the diagnosis code(s) and corresponding family of codes contained in the Attending Provider Treatment Plan form will be eligible for payment.

f. Voluntary Network

Upon receiving notification of “bodily injury” covered under this policy, we may make available to the “named insured” and the treating “health care provider” information about our approved voluntary network providers for certain types of testing, durable medical equipment and certain non-emergency benefits.

If an “insured” does not use a voluntary network provider, if requested by us, we may impose a co-payment not to exceed 30% of the eligible charges for “medically necessary” “diagnostic tests” or durable medical equipment.

This co-payment penalty will be in addition to any other applicable co-payment.

g. Penalty

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

(1) 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 and Pre-Certification Requirements; or**

(2) We are not provided with “clinically supported” findings.

The penalty will be 50% of the lesser of:

(1) The treating "health care provider's" usual, customary and reasonable charge; or

(2) The upper limit of the medical fee schedule promulgated by the New Jersey Department of Banking and Insurance;

for any medical expenses incurred after notification to us is required but before authorization for continued treatment, the use of durable medical equipment or the administration of a “diagnostic test” is made by us.

The penalty will be in addition to any other applicable co-payment.

However, we will not impose a penalty when 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.

A separate, additional co-payment of up to 30% of the eligible charges for “medically necessary” “diagnostic tests” or durable medical equipment may be imposed if an insured fails to use a network, if requested by us, in accordance with N.J.A.C. 11:34.8.

"IDENTIFIED INJURIES"

"Identified Injuries"
Requiring Prior Notification and Review
at Decision Points

1) Cervical Spine: Soft Tissue Injury;
2) Cervical Spine: Herniated Disc/Radiculopathy
3) Thoracic Spine: Soft Tissue Injury;
4) Thoracic Spine: Herniated Disc/Radiculopathy
5) Lumbar-Sacral Spine: Soft Tissue Injury;
6) Lumbar-Sacral Spine: Herniated Disc/Radiculopathy
7) Any other "bodily injury" for which the State of New Jersey Department of Banking and Insurance has established courses of diagnosis and treatment for medical expenses resulting from such injuries.

TESTS REQUIRING PRIOR NOTIFICATION AND REVIEW

Tests Requiring Prior Notification and Review to Establish Medical Necessity

1. Brain audio evoked potential (BAEP);
2. Brain evoked potential (BEP);
3. Computer assisted tomographic studies (CT, CAT Scan);
4. Dynatron/cyber station/cybex;
5. H-reflex Study;
6. Magnetic resonance imaging (MRI);
7. Verve conduction velocity (NCV);
8. Somasensory evoked potential (SSEP):
9. Sonogram/ultrasound;
10. Visual evoked potential (VEP);
11. Any of the following “diagnostic tests: when not excluded under Exclusion C.
    a. Brain mapping;
    b. Doppler ultrasound;
    c. Electroencephalogram (EEG);
    d. Needle electromyography (Needle EMG);
    e. Sonography;
    f. Thermography/thermograms; or
    g. Videoflouroscopy;
12. Any other diagnostic test that is subject to the requirements of our Decision Point Review Plan by New Jersey law or regulation.

PROHIBITED DIAGNOSTIC TESTS

Diagnostic Tests for Which the Law <u>Prohibits</u> Coverage

1. Brain mapping (when not done in conjunction with appropriate neurodiagnostic testing);
2. Iridology;
3. Mandibular tracking and stimulation;
4. Reflexology;
5. Spinal diagnostic ultrasound;
6. Surface electromyography (surface EMG);
7. Surrogate arm mentoring;
8. When used to treat temporomandibular joint disorder (TMJ/D):
    a. Doppler ultrasound;
    b. Electroencephalogram (EEG);
    c. Needle electromyography (needle EMG);
    d. Sonography;
    e. Thermograms/thermographs;
    f. Videoflouroscopy; or
9. Any other diagnostic test that is determined to be ineligible for coverage under Personal Injury Protection Coverage by New Jersey law or regulation.

VOLUNTARY NETWORK SERVICES

Services Subject to a 30% Co-Payment

If Not Provided by CURE's Voluntary Network

1. Magnetic Resonance Imagery (MRIs);

2. Computer Assisted Tomography (CAT Scans);

3. Electrodiagnostic 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 (NCV) tests performed together by the treating physician; and

4. Durable medical equipment with a cost or monthly rental in excess of $75.00.

5. Services, equipment and accommodations provided by an ambulatory surgery facility (the co-payment relating to this network only applies if your treatment relates to an accident that occurred under polices with an effective date that is on or after May 1, 2014).