CHUBB GROUP OF INSURANCE COMPANIES

Dear Insured,

Attached please find an informational letter which is being sent to your treating provider outlining the processes and procedures for Precertification and Decision Point Review in accordance with N.J.A.C. 11:3-4. All of the information contained in this packet will assist you in understanding the protocols which need to be followed in order to handle the medical portion of your PIP claim. Chubb has enlisted the services of Active Care to assist you with the medical management process. An Active Care Nurse Case Manager will be contacting you to assist you with your medical care.

If at any time you have questions, please do not hesitate to contact your claim representative who will assist you.

Sincerely,

Chubb and Son, a division of Federal Insurance Company

CHUBB GROUP OF INSURANCE COMPANIES

Date:

RE: **(Patient Name)**
(Address)

Claim Number:
Date of Accident:

Dear Dr. _____:

The patient noted above was involved in a motor vehicle accident (MVA). We have been informed that he/she will receive treatment with you. Pursuant to N.J.A.C. 11:3-4, you are required to provide us with notification for certain tests you may order, or services you may perform on the patient. As described more fully below, this notification is provided in connection with Decision Point Review and Precertification. Chubb & Son, a division of Federal Insurance Company, as manager of your patient's automobile insurer, Chubb Insurance Company of New Jersey ("Chubb") has contracted with Active Care Corporation ("Active Care") to be the utilization review organization involved with the decision point review/precertification process. Decision Point Review/Precertification does not apply until the 10th day following the MVA and does not apply to emergency care. As part of the process you are required to utilize the treating providers form (ExhibitA) attached to this document.

Please be advised that pursuant to N.J.A.C. 11:3-4.4, the insured and the injured party or their medical provider must provide Chubb with information regarding the facts of the accident, nature and cause of the injury, diagnosis and anticipated course of treatment. Failure to provide this required information can result in a penalty co-payment of up to 25% if received after 30 days from the date of accident or up to 50% if received 60 days or more after the date of the accident.

PRE-CERTIFICATION & DECISION POINT REVIEW PROCESS

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 continuation or choice of further treatment. Decision Point also refers to a determination to administer one or more diagnostic tests 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 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 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 Insurance Cost Reduction Act of 1998, the New Jersey Department of Banking and Insurance has published standard courses of treatment, or Care Paths, to monitor the treatment rendered when an EIP is diagnosed with one or more of the Identified Injuries. The Care Paths provide that treatments be evaluated at certain intervals called Decision Points.

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 the health care provider to submit documentation regarding the injuries, treatments and results of diagnostic testing. Also, we may request that a health care provider of our choice examine the EIP. 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 the 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 the identified injuries, please visit the web site of the Department of Banking and Insurance. www.nj.gov/dobi/aicrapg.htm.

The following diagnostic testing always requires a 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 Tomographic Studies (CT, CT Scans);
Dynatron/Cyber Station/Cybex; and
Sonograms/Ultrasounds.
Thermography/Thermograms
Brain mapping, when done in conjunction with appropriate neurodiagnostics.

Chubb will not pay 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 being not reimbursable.

Mandatory Pre-Certification Plan

If the EIP has been diagnosed with an injury that is not included as an Identified Injury, the health care provider must contact us for prior authorization of the treatments listed below. No pre-certification requirements shall apply for the first ten (10) days of the insured event. Pre-Certification shall be based exclusively on medical necessity and shall not encourage under or over utilization of the treatment and test. Any medically necessary diagnostic tests, treatments, surgery, durable medical equipment and non-medical expenses that are incurred without first complying with our Pre-Certifications requirements shall be subject to a 50% co-payment.

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

1) Physical, occupational, speech, cognitive or other restorative therapy, or other body part manipulation, except that provided for identified injuries in accordance with a Decision Point Review.
2) Non-emergency transportation services by ambulance or ambulette.
3) Non-emergency surgical procedures.
4) Non-emergency inpatient and outpatient hospital care.
5) Extended care rehabilitation facilities.
6) Outpatient psychological, psychiatric testing and/or services.
7) Durable medical equipment including orthotics and prosthetics with a cost or monthly rental in excess of $50.00.
8) Home health care.
9) All pain management services except as provided for identified injuries in accordance with Decision Point Review.
10) Non emergency dental restoration.
11) Skilled nursing care.

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

1) Any treatment to which Decision Point Review/Pre-Certification has been applied shall also be subject to all terms and conditions contained within the insurance policy.
2) Neither Decision Point Review nor Pre-Certification will apply to the first 10 days of care immediately after an accident or during emergency care. Treatment received during those first 10 days will be subject to utilization review. This means that if treatment, testing or services received during the first 10 days are not appropriate and do not meet nationally recognized guidelines or protocols for such services, we may not be responsible to pay for them.
3) This Plan will not limit access to medically necessary care required.
4) This Plan will not allow for under-utilization or over-utilization of care, nor will it allow for care that is solely for the convenience of the EIP or the health care provider.
5) The EIP and the health care provider are strongly urged to formulate and submit a Comprehensive Treatment Plan at the beginning of treatment, regardless of whether the injury requires Decision Point Review or Pre-Certification. Once the Medical Director approves a Comprehensive Treatment Plan, there is no need to seek further approval for those services specifically described in the treatment plan.

Notification under Decision Point Review / Pre-Certification

After an accident, which results in injuries, we recommend that Chubb be contacted within 24 hours to ensure prompt handling of the claim. Chubb will in turn notify Active Care to begin the Precertification and Decision Point Review Process.

Required Information under Decision Point Review / Pre-Certification:

We will require the health care provider to submit documentation of the nature and extent of the EIP's injuries, type and duration of treatment and diagnostic tests to be performed, and/or durable medical equipment requested in order to approve treatment. In most cases, we will be able to arrive at a decision quickly, no more than three (3) business days. However, we may need to request specific documentation to render a decision. If we do not respond to the requested treatment within three (3) business days, the EIP may proceed with treatments or tests until he/she receives notification from us that it is no longer approved.

If we make a request for additional information, the requested information needs to be submitted by the health care provider within (10) days and must clinically support the requested 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:

1) Include the date of accident
2) Be based on actual examination of you, a complete history of all complaints, clinical symptoms, dates and types of previous treatments and observations.
3) Report objective findings, diagnoses (ICD-9 codes) and results if physical examinations and tests performed
4) Indicate that the health care provider has considered any previous tests and examinations performed, and consider any and all other conditions the EIP may have had prior to the accident, and render a diagnosis

Bills cannot be processed for payment without supporting documentation.

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

Comprehensive Treatment Plans under Decision Point Review or Pre-Certification

The health care provider may establish, along with us, a Comprehensive Treatment Plan. This plan will be reviewed and adjusted based on information the health care provider submits and discusses with us. This Comprehensive Treatment Plan will allow the EIP to seek needed treatment for a specific time period, which will be agreed upon by the health care provider and us. As the EIP's needs change, we will, along with the health care provider, change the treatment plan. Our Medical Director will review this plan. This plan should outline treatments, diagnostic testing, special services and durable medical equipment required to recover from the injuries.

Any treatment, diagnostic tests, services or durable medical equipment that are included in an approved Comprehensive Treatment Plan are not required to be individually pre-certified. This is because the Medical Director has already reviewed the Comprehensive Treatment Plan, and the services described in the Comprehensive Treatment Plan will have been pre-approved.

If there is no Comprehensive Treatment Plan submitted, then pre-certification is required to avoid co-payment penalties.

Should there be a need, based upon the EIP's progress, to change the treatment plan, we must be advised. If the EIP is being treated pursuant to a Comprehensive Treatment Plan that has been approved by us, we will not be required to pay for any treatment that is not described in that Comprehensive Treatment Plan unless warranted by reasons of medical necessity. A penalty of 50% of charges for unauthorized treatment may apply.

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

We may request that the EIP submit to an examination by a health care provider of our choosing. This examination will be with a health care provider of a similar specialty as the treating health care provider, and will take place at a location reasonably convenient to the EIP. We shall schedule this examination within seven (7) days of our request, unless the injured person agrees to extend the time period. Medically necessary treatment during this time will not be interrupted; however, it will be subject to utilization review. The EIP will be notified of decision within three (3) days of examination. A copy of examining physician report is available upon request.

The EIP must cooperate with us in scheduling and attending the examination, and must provide us with all medical records and diagnostic testing results at the time of the examination. More than one unexcused failure to attend a scheduled physical examination will result in denial of reimbursement for further treatment, diagnostic testing or durable medical equipment required for the diagnosis (and related diagnosis) contained in the attending physician's treatment plan form.

Denial of any treatment, service, diagnostic testing or durable medical 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). In the case of treatment prescribed by a dentist, the denial shall be by a dentist.

Penalty under Decision Point Review or Pre-Certification:

Failure to request decision point review or pre-certification, where required or failure to provide clinically supported findings that support the treatment, diagnostic test or durable medical equipment requested, will result in an additional co-payment of 50% of eligible charges for medically necessary diagnostic tests, treatments or durable medical goods that were provided between the time notification to the insurer was required and the time that proper notification **is** made and the insurer has an opportunity to respond in accordance with its approved decision point review plan. This is in addition to any deductible or co-payment applicable to the loss.

Preferred Provider Network:

Chubb, through our plan administrator, Active Care, has contracted with Preferred Providers for the following**:**

1) Magnetic Resonance Imagery – The Active Care Network
2) Computer Assisted Tomography – The Active Care Network
3) The electrodiagnostic tests listed in N.J.A.C. 11:3-4.5(b) 1 through 3 except when performed by the treating physician in conjunction with a needle EMG – The Active Care Network
4) Durable medical equipment with a cost or monthly rental in excess of $50.00 – The Active Care Network
5) Prescription drugs – The Active Care Network

Use of a preferred Provider is strictly voluntary. However, if you do not utilize the Preferred Provider Network for the items listed above, an additional 30% co-payment will apply for each service or test. Please discuss any questions regarding this with us or the Plan Administrator.

The Active Care Network, as a wholly owned subsidiary of First Managed Care Option, Inc. is approved as part of a Workers' Compensation managed care pursuant to NJAC 11:6.

Per NJAC 11:3-4.8 d) 1-2 Active Care is a proprietary health care network specializing in auto injury claims in the State of New Jersey. The Active Care Network is an Auto-specific medical provider network. Participation in the network is directly related to contracts exclusively with the medical professionals, who understand the unique nature and treatment of auto related injuries.

In addition, we have a PPO network available for the following services:

Medical Specialists, Chiropractors, Hospitals, and Physical and Occupational Therapy Centers.

Use of Healthcare Provider from the PPO network is strictly voluntary and there is no co-pay associated with not using a PPO provider in the network. It is provided as a service to the EIP. A list can be obtained of PPO providers in your area by contacting your case manager at Active Care directly.

Providers who participate in the Active Care PPO Network have the following five major credentialing requirements:

1) Active License.
2) Active Malpractice Insurance in the amount of 1 million liability/3 million aggregate. Malpractice cases are taken into consideration as per URAC guidelines.
3) Board Certification per medical specialty.
4) DEA certificate (Drug Enforcement Administration).
5) CDS certificate (Controlled Dangerous Substance).

Credentials are updated and verified every three years, as per URAC standards.

An EIP may be notified, as per their insurance policy that a Network of Medical providers exists. Where this situation exists, Active Care telephonic nurse case managers will assist the EIP in identifying our Network providers in their area for treatment or testing purposes, as related to

MVA injuries. Network participation will ensure that care is being rendered by medical professionals, who treat auto-related injuries.

Upon receipt of the first report of injury and referral from the carrier, Active Care will send out an Introduction letter to the EIP along with a copy of their carriers plan. The plan identifies that the Network program is in place and the introduction letter furnishes the EIP with contact information to obtain provider information. Our telephonic nurse case manager will assist the EIP in locating a provider in their geographic area, if they choose to treat In-Network**.**

Internal Appeals Process:

The EIP and his/her health care provider, or someone on their behalf, may request us and the Plan Administrator to review any decision we make regarding the treatment plan, or denial of any service, treatment, diagnostic testing or durable medical goods. The Request for Appeal must be in writing and submitted to us within fourteen (14) days of our decision notification to the EIP. Attached to the request, please provide any additional documentation you wish us to consider.

We will respond to the appeal, request additional information, or request an examination with another health care provider within five (5) five business days of receipt of the appeal. If an ICE is requested it will be scheduled within (7) seven days. The decision of our Internal Appeals Committee will be forwarded to the EIP, in writing and verbally, within (5) five business days of receipt of all documentation requested.

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

ASSIGNMENT OF BENEFITS

In New Jersey, PIP coverage is considered to be a first party benefit. This means that we can reimburse the patient directly for covered expenses. However, in some cases, the doctor or other provider may ask that benefits be "assigned" to them, so that we pay them directly. At our option, medical expense benefits under the policy may be assigned to a health care provider who complies with the requirements of the precertification and decision point review, and agrees that any disputed issues involving treatment or services provided to the patient must be resolved through the dispute resolution process. If benefits are paid directly to the provider, the provider is subject to the requirements of this decision point review/pre-certification plan, and agrees that they will seek resolution of all issues defined as "PIP Disputes" under N.J.A.C. 11:3-5.2 through alternative dispute resolution. The provider must agree to hold harmless the patient and Chubb for any reduction of benefits caused by their failure to comply with the terms of the patient's policy.

We are available to you and your patient to answer questions pertaining to the contents of this letter.

Thank you for your anticipated cooperation.

Sincerely,
Claims Adjuster, Chubb and Son and/or Precertification Department/Active Care