Countryway Insurance Company
P.O. Box 4851, Syracuse, New York 13221-4851

Dear Insured:

Please read this letter carefully because it provides specific information concerning how a medical claim under personal injury protection coverage will be handled, including specific requirements which you must follow in order to ensure payment for medically necessary treatment, tests and durable medical equipment that a named insured or eligible insured person may incur as a result of an auto accident.

Decision Point Review

The New Jersey Department of Banking and Insurance has published standard courses of treatment, **Care Paths**, for soft tissue injuries of the neck and back, collectively referred to as **Identified Injuries**. The **Care Paths** provide that treatment be evaluated at certain intervals called **Decision Points**. At decision points, either you or the treating health care provider must provide us with information about further treatment that is intended to be provided (this is referred to as **Decision Point Review**). Such information includes reasonable prior notice and the appropriate clinically supported findings that the anticipated treatment or test is medically necessary. The **Care Paths** and accompanying rules are available on the Internet on the Department's website at http://www.premierprizm.com/clients/ or by calling National Healthcare Resources at 1-800-818-7610.

In addition, the administration of certain diagnostic tests is subject to **Decision Point Review** regardless of the diagnosis. The following tests are subject to decision point review:

- Needle electromyography (needle EMG)
- Somasensory evoked potential, visual evoked potential, brain audio evoked potential, brain evoked potential, nerve condition velocity, and H-reflex study
- Electroencephalogram (EEG)
- Videofluroscopy
- Magnetic resonance imaging
- Computer assisted tomographic studies (CT, CAT scan)
- Dynatron/cyber station/cybex
- Sonograms/ultrasound
- Thermography/Thermograms
- Brain Mapping

We will notify you or your treating health care provider of our decision to authorize or deny reimbursement of the treatment or test as promptly as possible, but no later than three business days. Any denial of reimbursement for further medical treatment or tests will be based on the determination of a physician. If we fail to take any action or fail to respond within three business days after receiving the required notification and supporting medical documentation at a decision point, then the treating health care

provider is permitted to continue the course of treatment until we provide the required notice. Please note that the decision point review requirements do not apply to treatment or diagnostic tests administered during emergency care.
If requests for decision point reviews are not submitted, payment of your bills will be subject to a penalty co-payment of 50 percent even if the services are determined to be medically necessary. This co-payment is in addition to any deductible required under the Personal Injury Protection coverage.

Mandatory Precertification

New Jersey Regulation provides that insurers may require precertification of certain treatments or diagnostic tests for other types of injuries or tests not included in the Care Paths. Precertification means providing us with notification of intended medical procedures, treatments, diagnostic tests, prescription supplies, durable medical equipment or other potentially covered medical expenses. Precertification does not apply to treatment or diagnostic tests administered during emergency care or during the first ten days after the accident causing the injury.
The following are procedures, treatments, diagnostic tests, prescription supplies, durable medical equipment or other potentially covered medical expenses for which precertification is required.

- All non-emergency acute care in-patient hospital services, rehabilitation hospital services, ambulatory surgical facilities services and services provided by other licensed facilities
- Non-emergency Field Nursing Services
- All non-emergency surgical procedures
- Therapeutic Manipulation conducted by a Registered Physical Therapist, Chiropractor, Osteopath or any other Practitioner
- Home Care
- Physical Therapy
- Occupational Therapy
- Podiatry
- Durable Medical Equipment costing more than $50.00
- Non-emergency services provided by a psychologist or psychiatrist or other health care provider for services related to mental or nervous conditions
- Pain Management Services
- Prescription Drugs
- Non-emergency dental restoration
- Restorative therapy
- Speech therapy
- Infusion therapy
- Prosthetic devices
- Audiology
- Bone scans
- Vax-D

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Our approval of requests for precertification will be based exclusively on medical necessity, as determined by using standards of good practice and standard professional treatment protocols, including, but not limited to, **Care Paths** recognized by the Commissioner of Banking and Insurance. Our final determination of the medical necessity of any disputed issues shall be made by a physician, dentist, chiropractor or other health care provider as appropriate for the injury and treatment contemplated.
If requests for precertification are not submitted, payment of your bills will be subject to a penalty co-payment of 50 percent even if the services are determined to be medically necessary. This co-payment is in addition to any deductible required under the Personal Injury Protection coverage.

Voluntary Precertification

Health care providers are encouraged to participate in a voluntary precertification process by providing National Healthcare Resources with a comprehensive treatment plan for both identified and other injuries.
National Healthcare Resources will utilize nationally accepted criteria and the Care Paths to work with the health care provider to certify a mutually agreeable course of treatment to include itemized services and a defined treatment period.
In consideration for the health care provider's participation in the voluntary certification process, the bills that are submitted, when consistent with the precertified services, will be paid so long as they are in accordance with the PIP medical fee schedule set forth in N.J.A.C. 11:3-29.6 and the review requirements of the Unsatisfied Claim and Judgment Fund. In addition, having an approved treatment plan means that as long as treatment is consistent with the plan, additional notification to National Healthcare Resources at decision points is not required.

Voluntary Networks

Countryway Insurance's vendor, National Healthcare Resources, has established networks of pre-approved vendors which can be recommended for the provision of certain services, diagnostic tests, prescription supplies, and/or durable medical equipment. These pre-approved vendors are tested and monitored to ensure that the highest of quality in goods and services are provided. You are encouraged, but not required, to obtain certain services, diagnostic tests, prescription supplies, and/or durable medical equipment from one of the pre-approved vendors. If you use a pre-approved vendor from one of these networks for medically necessary goods or services, you will be fully reimbursed for those goods and services consistent with the terms of your auto insurance policy. If you choose to use a vendor that is not part of these pre-approved networks, we will provide reimbursement for medically necessary goods or services but only up to fifty percent of the lesser of the following: (1) the charge or fee provided for the N.J.A.C. 11:3-29, or (2) the vendor's usual, customary and reasonable charge or fee.

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Decision Point Review and Precertification Compliance Requirements

In the event that a named insured or eligible injured person is injured in an auto accident, such person or their health care provider should call 1-800-818-7610 in order to obtain precertification or decision point review prior to incurring the medical expense.

Appeals

Any questions or concerns regarding the precertification/decision point review process should be submitted in writing to National Healthcare Resources, P.O. Box 5038, Woodbridge, NJ 07095 or faxed to (732) 734-2587. If the Quality Assurance Department is unable to resolve the issue, it will be forwarded to the Medical Director for review. This review process will be completed within seven days. Any dissatisfaction with the results of this intervention may be reported to a Certified State Dispute Resolution Organization by either the eligible injured person or the provider.

Assignment of Benefits

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 plan and decision point review and agrees that any disputed issues involving treatment or services provided to the eligible injured person must be resolved through the dispute resolution process. Failure on the part of a provider to comply with all the precertification and decision point review requirements or the dispute resolution process will render any prior assignment of benefits under the policy null and void. If the provider accepts direct payment of benefits, the provider is required to hold harmless the insured and us for any reduction of payment for services caused by the provider’s failure to comply with the terms of the insured’s policy.

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EXHIBIT B

Services and Procedures rendered for injuries not included in the Care Paths which are subject to precertification:

- All non-emergency acute care in-patient hospital services, rehabilitation hospital services, ambulatory surgical facilities services and services provided by other licensed facilities
- Non-emergency Field Nursing Services
- All non-emergency surgical procedures
- Therapeutic Manipulation conducted by a Registered Physical Therapist, Chiropractor, Osteopath or any other Practitioner
- Home Care
- Physical Therapy
- Occupational Therapy
- Podiatry
- Durable Medical Equipment costing more than $50.00
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