New Jersey Skylands Insurance
Auto and Home

Personal Injury Protection Benefits And Pre-Certification

When you are injured in an auto accident, you need to concentrate on getting better, and not worry about getting your medical bills paid. At New Jersey Skylands, our goal is to deliver on our promise of protection by processing your medical claim quickly and fairly. We realize the claims process can some-times be confusing and we have provided this brochure to answer the most commonly asked questions concerning Personal Injury Protection claims. Please read it carefully and retain it for reference throughout the life of your claim. It explains how your claim will be handled including the Decision Point Review / Pre-Certification Requirements which you and your medical provider must follow to obtain the maxi-mum benefit available under the policy. Most importantly, remember that New Jersey Skylands is here for you every step of the way. You can contact your New Jersey Skylands Claim Representative at any time for professional guidance and answers to your questions.

DECISION POINT REVIEW AND PRE-CERTIFICATION REQUIREMENTS

Important Notice

The New Jersey Department of Banking and Insurance has approved a Decision Point Review Plan for New Jersey Skylands. Under the Plan, Decision Point Review and/or Pre-Certification of specified medical treatment and testing are required for medically necessary expenses to be fully reimbursable under the policy. A copy of the Plan can be accessed at www.njsi.com in the Claims page under the Services tab or requested directly from your Claim Representative. The following questions and answers only provide an overview of the Decision Point Review / Pre-Certification requirements. *You should refer to our approved Decision Point Review Plan and your policy for the actual Decision Point Review / Pre- Certification requirements as well as other important policy terms and conditions.*

MKT 09-366-NJ (11/15/17)

Can I Assign My Benefits So You Can Pay My Provider Directly?

Yes, your benefits are assignable to any Health Care Provider that is supplying you with covered medical supplies or services. However, any Health Care Provider that accepts an assignment of benefits must agree, in writing, to be bound by all the requirements, duties and conditions of the policy and our approved Decision Point Review Plan. An assignment that does not explicitly contain such an agreement is not valid. For the purposes of this summary, we will assume that your provider has accepted an assignment of benefits according to our Plan. If your provider has not accepted an assignment of benefits, please contact your Claim Representative for further information.

What Is A Decision Point Review (DPR)?

The New Jersey Department of Banking and Insurance has published standard courses of treatment for soft tissue injuries of the neck and back, known as "identified injuries". These are called **Care Paths** and provide your medical provider with general guidelines for treatment and diagnostic testing. The **Care Paths** include requirements that your medical provider consult with us at certain stages in your treatment. These are called Decision Point Reviews.

What Is Pre-Certification?

Pre-Certification is required for injuries not included in the "identified injuries" described above. **Pre-Certification** means that a medical professional will review the treatment plan submitted by your medical provider to make sure that you are receiving the appropriate level of medical care for your injuries. This does not mean that you need to obtain our approval before consulting your medical provider when you are injured. **Your medical provider, however, is required to submit a treatment plan and/or request approval for specific treatment and diagnostic testing outlined in this policy.**

What Do I Need To Do To Comply With The Decision Point Review And Pre-Certification Requirements When I Have Assigned My Benefits To My Provider?

All you need to do is give us the names, addresses and telephone numbers of your medical providers. We will contact them by phone and in writing to explain the entire process. You should also give your medical providers a copy of the Injury Notification Information on the back of your insurance card.

How Does The Decision Point Review/ Pre-Certification Process Work?

Your medical provider will be responsible for supplying the treatment / **Decision Point** information and requesting Pre-Certification of treatment and diagnostic testing in accordance with the requirements of the policy. We will encourage your medical provider to submit a detailed treatment plan, whenever possible, so that your treatment will not be interrupted.

When we receive a **Decision Point Review** or **Pre-Certification** request from your medical provider, along with the appropriate medical documentation, your provider will be notified within three (3) business days in accordance with our Decision Point Review / Pre-Certification plan whether or not our medical professional agrees with the treatment plan submitted. If we fail to respond within three (3) business days, you may continue with the testing or treatment until a final determination is communicated to your provider. If we do not agree, your provider has the right to appeal our decision using the appeal process described below.

If we do not agree with the treatment plan submitted by your provider, you still have the right to continue treatment. The expense for this treatment will be reimbursable if the treatment is found to be medically necessary and related to the accident.

If we do not agree with your medical provider's

treatment plan, we may also request that you attend an Independent Medical Examination. If an independent medical exam is requested, the exam will be:

- scheduled within seven business days of the Decision Point Review / Pre-Certification request unless you agree with us to extend the time period;
- conducted by a "health care provider" similar to your treating "health care provider" and;
- conducted at a location reasonably convenient to you.

If an Independent Medical Examination is requested, treatment may proceed while the exam is being scheduled and until the results are available. A copy of the written examination report, if prepared, will be provided to you upon request. You are expected to attend each examination as scheduled by us or our Plan Administrator.

Your failure to attend a scheduled examination without a minimum of three (3) business days notice to the examining physician or the Plan Administrator shall constitute an **unexcused** failure to attend.

Your failure to attend a scheduled examination will be considered **excused** if you notify the examining physician or Plan Administrator at least three (3) business days prior to the examination date and re-schedule the appointment for a date, not to exceed 30 calendar days from the date of the original appointment.

If you have an otherwise **excused** failure to attend a scheduled examination and do not re-schedule the appointment to occur within 30 calendar days of the original appointment date, the failure to attend shall be deemed **unexcused**.

If you re-schedule an examination for a date more than 30 calendar days from the date of the original appointment, any failure to attend the re-scheduled appointment will be **unexcused**.

If you attend a scheduled examination, but fail to supply all requested medical records, test results, diagnostic imaging films and other pertinent materials along with proper photo identification, it shall be deemed an **unexcused** failure to attend the examination and the examination will not take place.

If you have more than one **unexcused** failure to attend a scheduled examination, notification will be sent to you or your representative and all known treating providers advising that payment for all treatment, diagnostic testing, prescription drugs, and durable medical equipment provided on or after the date of notification and relating to the diagnosis code(s) and / or corresponding family of codes associated with the DPR / Pre-Certification request that necessitated scheduling of the examination will be denied. In such cases, no future treatment, diagnostic testing, prescription drugs, or durable medical equipment associated with the relevant diagnosis code(s) will be reimbursable under our policy.

What Type Of Treatment Needs A Decision Point Review Or Pre-Certification?

When we contact your medical provider, we will furnish complete information regarding the type of treatment or services that require Decision Point Review or Pre-Certification. If you would like more information, please contact your New Jersey Skylands Claim Representative or you may reference our complete Plan, which is available at www.njsi.com in the Claims page under the Services tab.

Emergency care and other treatment obtained within the first 10 days after an accident does not require Decision Point Review or Pre-Certification. For benefits to be paid in full, however, all treatment must be medically necessary and causally related to the accident.

How Does My Medical Provider Request A Decision Point Review Or Pre-Certification?

Requests for Decision Point Reviews and Pre-Certification of medical treatment should be directed to Optum Managed Care Services which performs these services for New Jersey Skylands and can be reached at:

Optum Managed Care Services
2500 Monroe Boulevard, Suite 100
Norristown, PA 19403
Phone: 800-275-9485
Fax: 610-631-7011

What Happens If My Medical Provider Does Not Request A Decision Point Review Or Pre-Certification Of Medical Treatment As Required In My Policy?

If your medical provider does not submit requests for Decision Point Review or Pre-Certification as required, or fails to submit clinically supported findings to support the request, an additional 50% co-payment penalty may be applied to the provider's bill even if the services are medically necessary.

Treatment, which is not both medically necessary and causally related to the accident, is not reimbursable. However, if we fail to render a determination or respond with a request for additional information within three (3) business days from our receipt of proper notice, we will not impose a penalty.

Can My Medical Provider Appeal The Decision Point Review Or Pre-Certification Decision?

Yes. When Optum Managed Care Services is unable to certify an admission, hospital stay, treatment plan, diagnostic test, or other service, your medical provider may request reconsideration by a Physician Advisor. The reconsidera-tion process will occur within three (3) business days of the receipt of the request and all supporting documentation. When reconsideration does not resolve a difference of opinion, your medical provider may submit the case for appeal through New Jersey Skylands Insurance's (NJSI) Internal Appeals process. If you have any questions regarding medical services, which have been denied, you can contact the Optum Managed Care Services customer service line at 800-275-9485. You can also contact your local New Jersey Skylands Claim Representative for more information.

Can I Choose My Own Doctor?

Yes. We do not provide a network of primary health-care providers. We will work directly with the medical provider of your choice.

What Is My Deductible?

Unless otherwise indicated on the declaration page of the policy under which you are seeking benefits, medical expense benefits are subject to a $250 deductible per accident.

What Is My Co-Payment?

The policy contains a 20% co-payment per accident for the first $5,000 of incurred expenses prior to application of the following co-payment features:

- Diagnostic Imaging and Electro-diagnostic Testing - 30% per person per service.
- Durable Medical Equipment over $50.00 - 30% per person per service.
- Prescription Drugs - $10.00 per prescription.

Are There Any Other Co-Payments?

As referenced earlier, if the Decision Point Review or Pre-Certification requirements in your policy are not met, your expenses for medically necessary treatment and test-ing will be subject to an additional co-payment of 50%. Treatment, which is not medically necessary, is not reim-bursable. However, if we fail to render a determination or respond with a request for additional information within three (3) business days from our receipt of proper notice, we will not impose a penalty.

Can I Reduce My Co-Payment By Using A Recommended Network Of Medical Providers?

Yes. We do not provide a network of primary health care providers. Your primary medical provider is selected by you. Your policy does, however, encourage you to obtain certain services and/or supplies from pre-approved medical service providers. The networks currently available include Prescription Drugs, Durable Medical Equipment, Diagnostic Imaging and Electro-diagnostic Testing. Use of these networks is strictly voluntary and would result in the waiver of the 30% copayment referenced above. For additional information, contact your Claim Representative.

Where Should My Medical Provider Send Their Bills?

All accident-related medical bills should be submitted to:

NGIC PIP
PO Box 2989
Clinton, IA 52733-2989
Fax: 859-497-7348

What If My Provider Has A Dispute?

While we make every effort to provide fair and timely payment of benefits, occasionally we may have a disagree-ment with your medical provider over payment of your Personal Insurance Protection (PIP) benefits. Often, such disputes are simple matters that, when brought to our attention, can be resolved amicably without the need for costly and time-consuming litigation. The policy and our approved Decision Point Review plan require that your providers utilize the NJSI Internal Appeal process prior to filing any form of litigation with respect to PIP disputes. For details concerning the Internal Appeals process and its requirements, please contact your Claim Representa-tive. You may also wish to review the Dispute Resolution section of your policy as well as our approved Decision Point Review / Pre-Certification plan, which is available at www.njsi.com in the Claims page under the Services tab for further information.

Will I Still Receive Superior Claim Service?

Our commitment to our policyholders to provide out-standing service at the ultimate moment of truth, when a claim occurs, remains unchanged. We understand the importance of being there when you need us most. Our goal is to satisfy all of your claim needs by delivering the type of service you expect and deserve.

Decision Point Review / Pre-Certification of medical treatment or testing does not guaran-tee payment, which is subject to the patient's eligibility for benefits as well as the terms, condi-tions and exclusions of the New Jersey Skylands policy. Coverage for a given claim is determined solely by New Jersey Skylands. No coverage is provided or implied by this summary of the Decision Point Review and Pre-Certification Requirements. If there is a conflict between the policy and this summary, the provisions of the policy shall prevail.

About New Jersey Skylands Insurance

New Jersey Skylands Insurance Association is a full-service property/casualty insurance company. The company is rated A (Exceptional) by Demotech, Inc., a long-time provider of Financial Stability Ratings® of property/casualty insurance companies.

New Jersey Skylands Insurance Association is managed by an Attorney-in-Fact, New Jersey Skylands Management, LLC (NJSM). NJSM is an indirectly wholly owned subsidiary of National General Holdings Corp., which is listed on the NASDAQ Global Market under the symbol NGHC.

New Jersey Skylands Insurance
P.O. Box 1623
Winston-Salem, NC 27102

Trusted Choice