[Sent on Auto Injury Solutions Letter Head]

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, durable medical equipment and prescription drugs that a Named Insured or Eligible Injured Person may incur as a result of an auto accident. The Decision Point Review Plan is accessible by accessing: www.mapfreusa.com.

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 are being relied upon to support that the anticipated treatment or test is medically necessary. The Decision Point Review requirements do not apply to treatment or diagnostic tests administered during emergency care or during the first ten (10) days after the accident causing the injury. The Care Paths and accompanying rules, are available on the Internet on the Department's website at http://www.nj.gov/dobi/aicrapg.htm (Scroll down to PIP Reforms) or by calling Auto Injury Solutions at the number designated per American Commerce Insurance Company and on the Internet at www.mapfreusa.com.
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);
- Somatosensory evoked potential (SSEP), visual evoked potential (VEP), brain audio evoked potential (BAEP), brain evoked potential (BEP), nerve condition velocity(NCV), and H-reflex study;
- Electroencephalogram (EEG);
- Videofluroscopy;
- Magnetic resonance imaging (MRI);
- Computer assisted tomographic studies (CT, scan);
- Dynatron/cyber station/cybex;
- Sonograms/ultrasound;
- Thermography / Thermograms;
- Brain Mapping;
- Any other diagnostic test that is subject to the requirements of the Decision Point Review Plan by New Jersey law or regulation.

These diagnostic tests 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 the evaluation of injuries sustained in an auto accident.

MANDATORY PRE-CERTIFICATION

New Jersey regulation provides that insurers may require Pre-certification of certain treatments or diagnostic tests for other types of injuries or tests not included in the Care Paths. Pre-certification means providing us with notification of intended medical procedures, treatments, diagnostic tests, prescription supplies, durable medical equipment or other potentially covered medical expenses. Pre-certification 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 Pre-certification is required:

- Non-emergency inpatient and outpatient hospital care; including the facility where the services will be rendered and any provider services associated with these services and/or care;
- Non-emergency surgical procedures; performed in a hospital, freestanding surgical center, hospital outpatient surgical facility, office, etc., and any provider services associated with the surgical procedure;
- Extended care rehabilitation facilities;
- Outpatient care for soft-tissue/disc injuries of the person's neck, back and related structures not included within the diagnoses covered by the Care Paths;
- Physical, occupational, speech, cognitive, rehabilitation or other restorative therapy or other therapeutic or body- part manipulation including manipulation under anesthesia except that provided for identified injuries in accordance with decision point review;
- Non-Emergency Inpatient and Outpatient psychological / psychiatric services and testing including biofeedback;
- All pain management services except as provided for identified injuries in accordance with Decision Point Review;
- Home health care;
- Non-emergency dental restoration;
- Temporomandibular disorder; any oral facial syndrome;
- Acupuncture;
- Infusion therapy;
- Bone scans;
- Vax-D/DRX type devices
- Transportation Services costing more than $50.00;
- Brain Mapping other than provided under Decision Point Review;
- Durable Medical Equipment including orthotics and prosthetics with a cost or monthly rental more than $50.00;
- Prescriptions costing more than $50.00;
- Any procedure that uses an unspecified CPT; CDT; /DSM IV; HCPCS code
- CT Scan with Myelogram and discogram;
- Current Perceptual Testing;
- Temperature gradient studies ;
- Work hardening;
- Carpal tunnel syndrome;
- Podiatry services;
- Audiology services;
- Non-medical products, devices, services and activities and associated supplies not exclusively used for medical purposes or as durable medical goods with a monthly rental or rental in excess of thirty (30) days.

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 or dentist as appropriate for the injury and treatment contemplated.

VOLUNTARY PRE-CERTIFICATION

Health care providers are encouraged to participate in a voluntary precertification process by providing Auto Injury Solutions with a comprehensive treatment plan for both identified and other injuries.

Auto Injury Solutions, Inc. 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 Pre-certified 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. In addition, having an approved treatment plan means that as long as treatment is consistent with the plan, additional notification to Auto Injury Solutions, Inc. at Decision Points is not required.

DPR/PRE-CERTIFICATION PROCESS

In order to submit a Decision Point Review and Pre-certification request, your medical provider must submit a legible completed attending provider treatment form via fax to 732-734-2546, or via the internet at www.autoinjurysolutions.com along with legible clinically supported findings that support the treatment, diagnostic test or durable medical equipment requested. A copy of the attending provider treatment form can be found on the internet on the New Jersey Department of Banking and Insurance website at http://www.state.nj.us/dobi/pipinfo/aicrapg.htm or at www.mapfreusa.com.

We will notify the Named Insured or Eligible Injured Party or 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 (3) business days after a request has been made. Business days is defined as Monday through Friday 9 AM to 5:30 PM Eastern Standard Time excluding Federal or New Jersey State Holidays and any time when our offices are closed due to a declared state of emergency. A request for treatment, testing, durable medical equipment or prescription drugs is to be submitted together with legible, conspicuously presented, clinically supported findings that the proposed treatment, testing, durable medical equipment or prescription drugs is in accordance with the standards of medical necessity established under the American Commerce Insurance Company policy and New Jersey law. Any denial of reimbursement for further medical treatment or tests will be based on the determination of a physician or dentist.

If we fail to take any action or fail to respond within three (3) business days after receiving the required notification and supporting medical documentation at a decision point, or for precertification, 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 and Pre-certification requirements do not apply to treatment or diagnostic tests administered during emergency care.

PENALTY/CO-PAYMENTS

If requests for decision point reviews are not submitted as required or if clinically supported findings that support the request are not supplied, payment of your bills will be subject to a penalty co-payment of fifty percent (50%) even if the services are determined to be medically necessary. This co-payment is in addition to any deductible or co-payment under the Personal Injury Protection coverage

If requests for Pre-certification are not submitted as required or if clinically supported findings that support the request are not supplied, payment of your bills will be subject to a penalty co-payment of fifty percent (50%) even if the services are determined to be medically necessary. This co-payment is in addition to any deductible or co-payment required under the Personal Injury Protection coverage.

FOR THE PURPOSES OF THE PENALTY/CO-PAYMENTS NOTED ABOVE AND ALL DEDUCTIBLES, THE ORDER OF APPLICATION WILL BE CONSISTENTLY APPLIED IN THE FOLLOWING MANNER: CO-PAYMENTS PURSUANT TO N.J.A.C. 11:3-4.4(e) (FAILURE TO REQUEST DECISION POINT REVIEW OR PRECERTIFICATION REVIEW), N.J.A.C. 11:3-4.4(f) (FAILURE TO PROVIDE TIMELY INFORMATION ABOUT INJURY AND/OR CLAIM), AND N.J.A.C. 11:3-4(g) (FAILURE TO USE AN APPROVED DIAGNOSTIC/ELETRODIAGNOSTIC, DURABLE MEDICAL OR PRESCRIPTION DRUG NETWORK), SHALL BE APPLIED BEFORE THE APPLICATION OF OTHER CO-PAYMENTS OR DEDUCTIBLES, INCLUDING THOSE IDENTIFIED IN N.J.A.C. 11:3-4.4(a) AND (b) (STANDARD AND OPTIONAL DEDUCTIBLE AND COPAYMENTS).

VOLUNTARY NETWORKS

American Commerce Insurance Company's vendor, Auto Injury Solutions, Inc. has established networks of pre-approved vendors that can be recommended designated providers for diagnostic tests and electrodiagnostic tests; MRI, CT, CAT Scan, Somatosensory evoked potential (SSEP), visual evoked potential (VEP), brain audio evoked potential (BAEP), brain evoked potential (BEP), nerve conduction velocity (NCV) and H-reflex study, Electroencephalogram (EEG), needle electromyography (needle EMG) and durable medical equipment and prescriptions costing more than fifty dollars ($50.00). An exception from the network requirement applies for any of the electrodiagnostic tests performed in 11:3-4.5b1-3 when done in conjunction with a needle EMG performed by the treating provider. The designated providers are approved through a Workers Compensation Managed Care Organization.

You are encouraged, but not required, to obtain the noted service 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 seventy percent of the lesser of the following: (1) the charge or fee provided for in N.J.A.C. 11:3-29, or (2) the non-network vendor's usual, customary and reasonable charge or fee. The Networks can be accessed either through a referral from the Nurse Case Manager or by contacting:

The Atlantic Imaging Group - Diagnostic testing 888-340-5850

Optum– Durable Medical Equipment and Prescriptions 800-777-3574

FOR THE PURPOSES OF THE PENALTY/CO-PAYMENTS NOTED ABOVE AND ALL DEDUCTIBLES, THE ORDER OF APPLICATION WILL BE CONSISTENTLY APPLIED IN THE FOLLOWING MANNER: CO-PAYMENTS PURSUANT TO N.J.A.C. 11:3-4.4(e) (FAILURE TO REQUEST DECISION POINT REVIEW OR PRECERTIFICATION REVIEW), N.J.A.C. 11:3-4.4(f) (FAILURE TO PROVIDE TIMELY INFORMATION ABOUT INJURY AND/OR CLAIM), AND N.J.A.C. 11:3-4(g) (FAILURE TO USE AN APPROVED DIAGNOSTIC/ELETRODIAGNOSTIC, DURABLE MEDICAL OR PRESCRIPTION DRUG NETWORK), SHALL BE APPLIED BEFORE THE APPLICATION OF OTHER CO-PAYMENTS OR DEDUCTIBLES, INCLUDING THOSE IDENTIFIED IN N.J.A.C. 11:3-4.4(a) AND (b) (STANDARD AND OPTIONAL DEDUCTIBLE AND CO-PAYMENTS).

Auto Injury Solutions, Inc. has PPO Networks available that include providers in all specialties, hospitals, outpatient facilities, and urgent care centers throughout the entire State. The Nurse Case Manager can provide a current PPO network list. The use of these networks is strictly voluntary and the choice of health care provider is always made by the injured party. The PPO networks are provided as a service to those persons who do not have a preferred health care provider by giving them recommendations of providers that they may select from.

INITIAL AND PERIODIC NOTIFICATION REQUIREMENT

American Commerce Insurance Company may require that the insured advise and inform them about the injury and the claim as soon as possible after the accident and periodically thereafter. This may include the production of information regarding the facts of the accident, the nature and cause of the injury, the diagnosis and the anticipated course of treatment. If this information is not supplied as required, American Commerce Insurance Company may impose an additional copayment as a penalty which shall be no greater than:

a. Twenty - five percent (25%) when received 30 or more days after the accident; or

b. Fifty percent (50%) when received 60 or more days after the accident.

INTERNAL APPEALS PROCESS

Pre-Service Appeal:

A pre-service appeal is an appeal of decision point review and/or precertification denials or modification prior to performance or issuance of the requested medical procedure, treatment, diagnostic test, other service, and/or durable medical equipment and prescriptions. In order to be considered a valid pre-service appeal all the requirements listed below must be met:

1. AIS must be notified within thirty (30) calendar days after receipt of the written denial or modification of requested services.
2. An appeal must be communicated to the Nurse Case Manager in writing with supporting documentation and reasons for the appeal. Submission of information identical to the initial documentation submitted in support of the initial request shall not be accepted as an appeal request.
3 The appeal must be submitted on the State Mandated Pre-Service Appeal Form and all the required fields as designated by an asterisk (*) must be completed in order to be considered. If either the State Mandated Pre-Service Appeal Form is not submitted or required fields are not completed the appeal will be administratively denied. In addition, applicable fields 29-34 on the State Mandated Pre-Service Appeal Form must be completed and if any of these fields is not completed, the appeal may be administratively denied.
4. Appeals must be submitted to Auto Injury Solutions, Inc. either via fax to (732) 734-2546 or via the Internet at www.autoinjurysolutions.com.
5. Only those providers who have a valid Assignment of Benefits are permitted to file an appeal. Providers who are assigned benefits or who have a valid Proof of Assignment from the insured/eligible injured person, must make and complete an internal appeal prior to making a request for dispute resolution.
6. Filing an appeal as stated in numbers 1-5 is a condition precedent to filing through Alternative Dispute Resolution.

7. Available required information about a dispute should be submitted as part of the internal appeals process. Only with a showing of substantial good cause should additional required information not submitted as part of the internal appeal process be submitted in arbitration for the first time.

Medical necessity appeals of denial of Decision Point Review or Precertification requests must be made as a Pre-Service Appeal.

A decision shall be issued by the insurer to the provider who submitted the Pre-Service Appeal no later than fourteen (14) days after receipt of the State Mandated Pre-Service Appeal Form and any supporting documentation.

Post-Service Appeal:

A Post-Service Appeal is an appeal made subsequent to the performance or issuance of the services.

In order to be considered a valid post-service appeal, all the requirements listed below must be met:

1. AIS must be notified of a post service appeal at least forty-five (45) days prior to initiating Alternative Dispute Resolution or filing an action in Superior Court.
2. An appeal must be communicated in writing with supporting documentation and reasons for the appeal. Submission of information identical to the initial documentation submitted in support of the billed services shall not be accepted as an appeal request.
3 The appeal must be submitted on the State Mandated Post-Service Appeal Form and the required fields as designated by an asterisk (*) must be completed. If either the State Mandated Post-Service Appeal Form is not submitted or required fields not completed the appeal will be administratively denied. In addition, applicable fields (29-38) on the State Mandated Post-Service Appeal Form must be completed and if any of these fields are not completed, the appeal may be administratively denied.
4. Appeals must be submitted to Auto Injury Solutions, Inc. either via fax to (732) 734-2546 or via the Internet at www.autoinjurysolutions.com.
5. Only those providers who have a valid Assignment of Benefits are permitted to file an appeal. Providers who are assigned benefits or who have a valid Proof of Assignment from the insured/eligible injured party must make and complete an internal appeal prior to make a request for dispute resolution.
6. Filing an appeal as stated in numbers 1-5 is a condition precedent to filing through Alternative Dispute Resolution.
7. Available required information about a dispute should be submitted as part of the internal appeal process. Only with a showing of substantial good cause should additional required information not submitted as part of the internal appeals process be submitted in arbitration for the first time.

Medical necessity appeals of denial of Decision Point Review or Precertification requests cannot be made as a Post-Service Appeal.

A decision shall be issued by the insurer to the provider who submitted the Post-Service appeal no later than thirty (30) days after receipt of the State Mandated Post Service Appeal Form and any supporting documentation.

Any new issue raised post-service shall be submitted to the internal appeals process before initiating alternative dispute resolution. Proof of a timely-filed appeal is required documentation when an Alternate Dispute Resolution demand is made.

ASSIGNMENT OF BENEFITS

Assignment of a named insured's or eligible injured person's rights to receive benefits for medically necessary treatment, durable medical equipment tests or other services is prohibited except to a licensed health care provider who agrees to:

a. Fully comply with American Commerce Insurance Company Decision Point Review Plan, including pre-certification requirements,
b. Comply with the terms and conditions of the American Commerce Insurance Company policy;
c. Provide complete and legible medical records or other pertinent information when requested by us;
d. Complete the "internal appeals process" which shall be a condition precedent to the filing of a demand for alternative dispute resolution for any issue related to bill payment, bill processing, Decision Point Review Request or Precertification request. Completion of the internal appeals process means timely submission of an appeal and receipt of the response prior to filing for alternate dispute resolution. Except for emergency care as defined in N.J.A.C. 11:3-4.2, any treatment that is the subject of the appeal that is performed prior to the receipt by the provider of the appeal decision shall invalidate the assignment of benefits.
e. Submit disputes to alternative dispute resolution pursuant to N.J.A.C. 11:3-5.
f. Submit to statements or examinations under oath as often as deemed reasonable and necessary.

Failure by the health care provider to comply with all the foregoing requirements will render any prior assignment of benefits under American Commerce Insurance Company New Jersey's policy null and void. Should the provider accept direct payment of benefits, the provider is required to hold harmless the insured and American Commerce Insurance Company for any reduction of payment for services caused by the provider's failure to comply with the terms of the insured's policy.

MEDICAL EXAMINATIONS

At our request, we may require an Independent Medical Examination (IME) to determine medical necessity of further treatment or testing. The appointment will be made within seven (7) calendar days of receipt of the notice that an IME is required unless the injured person agrees to extend the time period. The IME will be completed by a provider in the same discipline as the treating provider and upon request the injured person must provide medical records and other pertinent information to the provider conducting the IME. The IME will be conducted at a location reasonably convenient to the Insured and/or Eligible Injured Party. Within three (3) business days following the examination the injured party and provider will be notified as to whether they will be reimbursed for further treatment. The injured party or his designee may request a copy of any written report prepared in conjunction with any physical examination we request. If there is more than one unexcused failures to attend the scheduled exam, notification will be immediately sent to the Named Insured and/or Eligible Injured Person, Attorney if noted and all health care providers providing treatment for the diagnosis (and related diagnosis) contained in the attending physician's treatment plan form. The notification will place the parties on notice that all future treatment, diagnostic testing, durable medical equipment or prescription drugs required for the diagnosis (and related diagnosis) contained in the attending physician's treatment plan form will not be reimbursable as a consequence for failure to comply with the plan. Except for surgery, procedures performed in ambulatory surgical centers

and invasive dental procedures, treatment may proceed while the IME is being scheduled and until the results become available. However only medically necessary treatment related to the motor vehicle accident will be reimbursed.

Sincerely,

Nurse Case Managers Name
Nurse Case Managers Telephone number with extension