IMPORTANT INFORMATION ABOUT YOUR PERSONAL INJURY PROTECTION COVERAGE

(ALSO KNOWN AS NO-FAULT MEDICAL COVERAGE)

The New Jersey Automobile Insurance Cost Reduction Act (AICRA) introduced changes to how auto insurance carriers, medical providers and injured parties manage medical treatment for injuries related to automobile accidents. There are certain obligations and requirements that must be satisfied to obtain the maximum amount reimbursable under your policy. This document summarizes the steps that must be taken to maximize reimbursement. You should read your policy and review your Declarations for information on the coverage provided to you. **THE PROVISIONS OF THE POLICY, DECISION POINT REVIEW PLAN OR NEW JERSEY REGULATION CONTROL IF THERE IS ANY CONFLICT WITH THIS SUMMARY.**

INTRODUCTION BROCHURE

At Liberty Mutual Insurance Group, “Liberty Mutual”, we understand that when you purchase an automobile insurance policy, you are buying protection and peace of mind in the event you are injured in an accident. It is, therefore, important to you that Liberty Mutual Insurance provide you first rate claims service. Our goal is to process claims for medically necessary treatment and testing quickly and fairly.

This brochure explains how your medical claims will be handled, including the Decision Point Review/Precertification requirements which you and your medical provider must follow in order to receive the maximum benefits provided by your policy. Liberty Mutual Insurance has selected Medlogix, LLC (Medlogix) to handle Decision Point Review/Precertification requirements and medical review services. Please read this brochure carefully.

DECISION POINT REVIEW AND PRECERTIFICATION REQUIREMENTS

Please note: Under the provisions of your policy and applicable New Jersey regulations, Decision Point Reviews and/or Precertification of specified medical treatment and testing is required in order for medically necessary expenses to be fully reimbursable under the terms of your policy. The following questions and answers only provide an overview of Decision Point Reviews and Precertification requirements. In accordance with N.J.A.C. 11:3-4.7(c) 3, a copy of the informational materials for policy holders, injured persons and providers approved by the New Jersey Department of Banking and Insurance, is available through our website at www.libertymutual.com and Medlogix, LLC website at www.Medlogix.com. You should read your policy for the actual Precertification requirements as well as other policy terms and conditions.

Treatment in the first 10 days after an accident and emergency care does not require Decision Point Review or Precertification. However, for benefits to be paid in full, the treatment must be medically necessary. This is true in all events.

Question: What is a Decision Point Review?

Answer: The New Jersey Department of Banking and Insurance (the "Department") has published standard courses of treatment, **Care Paths**, for soft tissue injuries of the neck and back, collectively referred to as the "Identified Injuries". These Care Paths provide your health care provider with general guidelines for treatment and diagnostic testing as to these injuries. In addition the Care Paths require that treatment be evaluated at certain intervals called **Decision Points**. At Decision Points, your health care provider must provide us information about any further treatment or test required. This is called **Decision Point Review.** During the Decision Point Review process, all services requested are evaluated by medical professionals to insure the level of care you are receiving is medically necessary for your injuries. This does not mean that you are required to obtain our approval before consulting your medical provider for your injuries. However, it does mean that your medical provider is required to follow the Decision Point Review requirements in order for you to receive maximum reimbursement under the policy. In addition, the administration of any test listed in N.J.A.C. 11:3-4.5(b) 1-10 also requires Decision Point Review, regardless of the diagnosis. The **Care Paths** and accompanying rules are available on the Internet at the Department's website at www.nj.gov/dobi/aicrapg.htm or can be obtained by contacting Medlogix @ 1 (877) 258-CERT (2378).

Question: What is Precertification?

Answer: Precertification is a medical review process for the specific services, tests, prescription drugs or equipment listed below in (a)-(p). During this process all specific services, tests, prescription drugs or equipment requested are evaluated by medical professionals to insure the level of specific services, tests prescription drugs or equipment you are receiving is medically necessary for your injuries. This does not mean that you are required to obtain our approval before consulting your medical provider for your injuries. However, it does mean that your medical provider is required to follow the Precertification requirements in order for you to receive maximum reimbursement under the policy.

(a) non-emergency inpatient and outpatient hospital care
(b) non-emergency surgical procedures
(c) extended care rehabilitation facilities
(d) outpatient care 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
(e) physical, occupational, speech, cognitive or other restorative therapy or other body part manipulation, including massage therapy, except that provided for Identified Injuries in accordance with Decision Point Review
(f) outpatient psychological/psychiatric testing and/or services
(g) all pain management services except as provided for identified injuries in accordance with decision point review
(h) home health care
(i) non-emergency dental restoration
(j) temporomandibular disorders; any oral facial syndrome
(k) infusion therapy
(l) Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of $100.00.

(m) Acupuncture
(n) All treatment and testing related to balance disorders
(o) Compound drugs and compounded prescriptions
(p) Schedule II, III and IV Controlled Substances, as defined by the Drug Enforcement Administration (DEA), when prescribed in combination or succession for more than three (3) months

Question: What do I need to do to comply with the Decision Point Review and Precertification requirements in my policy?

Answer: Just provide us with the name(s) of your medical providers. We will then contact them to explain the entire process.

Question: What are the Vendors hours of operation?

Answer: Medlogix Hours of Operation – 8:00 AM to 5:00 PM EST Monday through Friday (excluding legal

holidays)

Question: How does the Decision Point Review/Precertification Process Work?

Answer: In order for Medlogix to complete the review, your health care provider is required to submit all requests

on the "Attending Physicians Treatment Plan" form. A copy of this form can be found on the DOBI web site www.nj.gov/dobi/aicrapg.htm, Medlogix's web site www.Medlogix.com or by contacting Medlogix at (877) 258-CERT (2378).

The health care provider should submit the completed form, along with a copy of your their most recent/appropriate progress notes and the results of any tests relative to the requested services to Medlogix via fax at (856) 910-2501 or mail to the following address: Medlogix, LLC, 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619, ATTN.: Precertification Department. Medlogix's phone number is (877) 258-CERT (2378).

The review will be completed within three (3) business days of receipt of the necessary information and notice of the decision will be communicated to both you and your health care provider by telephone, fax and/or confirmed in writing. If your health care provider is not notified within 3 business days, they may continue your test or course of treatment until such time as the final determination is communicated to them. Similarly, if an independent medical examination should be required, they may continue your tests or course of treatment until the results of the examination become available. Keep in mind that treatment which is not medically necessary is not reimbursable under the terms of the policy.

Denials of decision point review and precertification requests on the basis of medical necessity shall be the determination of a physician. In the case of treatment prescribed by a dentist, the denial shall be by a dentist.

Question: What is the definition of days?

Answer: The definition of days is as follows: “Days” means calendar days unless specifically designated as business days.

1. A calendar and business day both end at the time of the close of business hours 5:00 PM EST Monday through Friday (excluding legal holidays).

2. In computing any period of time designated as either calendar or business days, the day from which the designated period of time begins to run shall not be included. The last day of a period of time designated as calendar or business day is to be included unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day which is neither a Saturday, Sunday or legal holiday.

3. Example: Response to a properly submitted provider request is due back no later than 3 business days from the date Medlogix receives the submission. Medlogix receives an Attending Provider Treatment Plan Form by facsimile transmission dated 1:00 PM EST on Wednesday February 19, 2014. Day one of the 3-business day period is Thursday, February 20, 2014. Since the 3rd day would be Saturday, February 22, 2014, Medlogix’s decision is due no later than close of business Monday, February 24, 2014.

INDEPENDENT MEDICAL EXAMS

Question: What are the requirements and consequences if I am requested to attend an Independent Medical Exam?

Answer: If the need arises for Medlogix to utilize an independent medical exam during the decision point review/precertification process, the guidelines in accordance to 11:3-4.7(e) 1-7 will be followed. This includes but is not limited to: prior notification to the injured person or his or her designee, scheduling the exam within seven calendar days of the receipt of the attending physicians treatment plan form (unless the injured person agrees to extend the time period), having the exam conducted by a provider in the same discipline, scheduling the exam at a location reasonably convenient to the injured person, and providing notification of the decision within three business days after attendance of the exam. If the examining provider prepares a written report concerning the examination, you or your designee shall be entitled to a copy upon written request.

If you cannot attend a scheduled examination, Medlogix must be contacted at least three (3) business days prior to the scheduled examination by phone at (877) 258-CERT (2378), fax at (856) 9102501, or in writing at 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619, ATTN.: Precertification Department. When attending your scheduled examination, you are required to supply proper photo identification to the examining provider and if non-English speaking, be accompanied by an English speaking interpreter (Interpreter fees and costs are not compensable or reimbursable.). You, or your designee, must provide all pertinent medical records and diagnostic studies/tests available before, or at the time, of the examination. In addition, you must cooperate fully with the examining physician and may be asked to bring specific prescribed durable medical equipment items to the examination. Failure to comply with any of the provisions as stated in this paragraph will be considered an unexcused absence to attend the scheduled exam.

If you have more than one unexcused failure to attend the scheduled exam, notification will be immediately sent to you, and all health care providers treating you for the diagnosis (and related diagnosis) contained in the attending physicians treatment plan form. The notification will place you on notice that all treatment, diagnostic testing or durable medical equipment required for the diagnosis (and related diagnosis) contained in the attending physicians treatment plan form will not be reimbursable as a consequence for failure to comply with the plan.

INTERNAL APPEAL PROCESS

Question: Can my provider appeal a decision made by Medlogix or my insurer?

Answer:

Yes, please note all appeals must be initiated using the forms established by the New Jersey Department of Banking and Insurance. A copy of these forms can be found on the New Jersey Department of Banking and Insurance website**,** Medlogix's website (www.Medlogix.com), or by contacting Medlogix at (877) 258-CERT (2378).

There are two types of appeals, each with a separate and specific workflow, which will be considered:

Pre-Service Appeals: This is an appeal of the denial or modification of a decision point review or precertification request prior to the performance or issuance of the requested medical procedure, treatment, diagnostic test, durable medical equipment, and/or other service on the basis of medical necessity.

For the NEW JERSEY PIP PRE-SERVICE APPEAL FORM, the minimum required information (identified by form section number) is as follows: The key dates (sections 1-2), CLAIM INFORMATION (sections 3-5), PATIENT INFORMATION (sections 6-7 and 9-13), PROVIDER/FACILITY INFORMATION (sections 14-25), DOCUMENTS INCLUDED (section 29 indicated with asterisk), PRE-SERVICE APPEAL ISSUES (sections 30-31, and 32, 33, or 34), and the signature information (sections 35-36).

The New Jersey PIP Pre-Service Appeal Form and any supporting documentation shall be submitted by the provider to Medlogix via fax @ (856) 910-2501 or in writing @ 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619.

A pre-service appeal must be submitted no later than 30 days after receipt of a written denial or modification of requested services. Decisions on pre-service appeals shall be issued by Medlogix or the insurer to the provider who submitted the appeal no later than 14 days after receipt of the pre-service appeal form and any supporting documentation. If it is determined that new information submitted with the appeal requires the need of an expert report or addendum to an expert report (i.e.: Peer Review, Independent Medical Exam, Medical Director Review, etc.) to properly respond to the appeal, an additional 10 days will be added to the response time requirement.

Post-Service Appeals: This is an appeal subsequent to the performance or issuance of the services rendered and can include, but is not limited to, bill review issues, payment or non-payment.

For the NEW JERSEY PIP POST-SERVICE APPEAL FORM the minimum required information (identified by form section number) is as follows: The key dates (sections 1-2), CLAIM INFORMATION (sections 3-5), PATIENT INFORMATION (sections 6-7 and 9-13), PROVIDER/FACILITY INFORMATION (sections 14-

25) , DOCUMENTS INCLUDED (section 29 indicated with asterisk), POST-SERVICE APPEAL ISSUES (sections 30-31, 33 and/or 38 and 34-36 if completing section 38), and the signature information (sections 3940).

The New Jersey PIP Post-Service Appeal Form and supporting documentation must be submitted to Safeco or Liberty Mutual Claims in writing at P.O. Box 5014, Scranton, PA 18505-5014.

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. Decisions on post-service appeals shall be issued by the insurer or Medlogix to the party who submitted the appeal no later than 30 days after receipt of the appeal form and any supporting documentation. If it is determined that new information submitted with the appeal requires the need of an expert report or addendum to an expert report (i.e.: Professional Code Review, Medical Bill Audit Report, UCR Analytical Analysis, etc.) to properly respond to the appeal, an additional 10 days will be added to the response time requirement.

A provider cannot submit a Pre-Service Appeal and then a Post-Service Appeal on the same issue. The preapproval of treatment and reimbursement for that treatment are separate issues.

This Internal Appeal Process provides only one-level of appeal prior to submitting the dispute to alternate dispute resolution or litigation.

Failure to follow the Pre-Service and Post-Service appeal requirements will be considered an incomplete submission and will result in an administrative denial. This incomplete submission and administrative denial does not constitute acceptance of the appeal within the required timeframes for Pre-Service and Post-Service appeals.

Any provider who has accepted an assignment of benefits is required to follow the Internal Appeal Process as described and agrees to exhaust such appeals process prior to submitting any dispute through alternate dispute resolution or litigation. Failure to utilize the Internal Appeal Process as outlined will invalidate any assignment of benefits.

If a claimant, provider, or assignee retains counsel to represent them during the Internal Appeal Process, 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.

VOLUNTARY UTILIZATION PROGRAM

Question: Does the plan provide voluntary networks for certain services, tests, prescription drugs or equipment?

Answer: In accordance with the regulations, the plan includes a voluntary utilization program for:

1. Magnetic Resonance Imagery
2. Computer Assisted Tomography
3. The electro diagnostic 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 (NVC) tests performed together by the treating physician

4. Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of $100.00
5. Services, equipment or accommodations provided by an ambulatory surgery facility
6. Prescription Drugs

Question: How do I gain access to one of these networks?

Answer: When one of the above listed services, tests, prescription drugs or equipment is requested through the decision point review/precertification process, a detailed care plan evaluation letter containing the outcome of the review is sent to the injured person or his or her designee, and the requesting provider. In addition the notice will include how to acquire a list of available preferred provider networks to obtain the medically necessary services, tests, prescription drugs or equipment requested. In the case of Prescription Drugs, a pharmacy card will be issued that can be presented at numerous participating pharmacies. A list of these participating pharmacies will be made available at time of card issuance. In accordance with N.J.A.C.11:3-4.4(g), failure to use an approved network will result in an additional co-payment not to exceed 30% of the eligible charge.

In addition to securing a list of preferred provider networks through the process outlined in the paragraph above, visit Medlogix's website at www.Medlogix.com, contact Medlogix by phone at (877) 258-CERT (2378), via fax at (856) 910-2501, or in writing @ 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619.

PENALTY CO-PAYMENTS

Question: Why would payment of my bills for health care services, tests, prescription drugs, and durable medical equipment be subject to additional co-pay, and how much is it?

Answer: If your health care provider does not comply with the decision point review/precertification previsions of the plan, including failure to submit a request for decision point review/precertification or failure to provide clinically supported findings that support the request, payment of those services rendered will result in a co-payment of 50% (in addition to any deductible or co-payment that applies under the policy) for medically necessary treatment and tests and equipment. Keep in mind that treatment which is not medically necessary is not reimbursable under the terms of the policy.

If you do not utilize a network provider/facility to obtain those services, tests, prescription drugs or equipment listed in the voluntary utilization review program section, payment for those services rendered will result in a co-payment of 30% (in addition to any deductible or co-payment that applies under the policy) for medically necessary treatment, tests, prescription drugs and equipment. Keep in mind that treatment which is not medically necessary is not reimbursable under the terms of the policy.

ASSIGNMENT OF BENEFITS

Question: Can I assign my benefits?

Answer:

Yes pursuant to the terms of its insurance policies, Liberty Mutual Insurance will only accept its own form of Assignment of Benefits (Attached to this Brochure). This form of assignment must be signed by the insured and the Provider or an agent authorized to act on behalf of the Provider. By executing the Assignment of Benefits form or having it executed, the Provider agrees to be bound by terms of the assignment and other applicable terms, conditions and duties as set forth in the policy of insurance.

If the provider accepts assignment for payment of benefits, please note that the provider is required to hold harmless the insured and the insurer for any reduction of benefits caused by the provider's failure to comply with the terms of this Decision Point Review/Precertification Plan and the Policy's terms and conditions.

Should Liberty Mutual file any action seeking relief under the New Jersey Insurance Fraud Prevention Act, N.J.S.A. 17:33A-1, et seq., N.J.S.A. 39:6A-13(G) or any cause of action alleging fraud or similar misconduct, the insured and/or the provider must agree to put any arbitration proceedings in abeyance until the legal action is resolved.

NO COVERAGE IS PROVIDED BY THIS BROCHURE OR THE QUESTIONS AND ANSWERS CONTAINED IN IT. THIS BROCHURE DOES NOT REPLACE ANY OF THE PROVISIONS OF YOUR POLICY. YOU SHOULD READ YOUR POLICY CAREFULLY FOR COMPLETE INFORMATION AS TO THE TERMS OF YOUR COVERAGE. IF THERE IS ANY CONFLICT BETWEEN THE POLICY AND THIS SUMMARY, THE PROVISIONS OF THE POLICY SHALL PREVAIL.

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

ASSIGNMENT OF BENEFITS AGREEMENT & DISCLOSURE REQUIREMENTS

PLEASE READ CAREFULLY AS THIS IMPOSES DUTIES AND OBLIGATIONS UPON THE PERSON AND THE ENTITY WHO SIGNS THIS AGREEMENT

I, (the patient) hereby assign my right to pursue a claim for reimbursement of Personal Injury Protection Benefits rendered by the medical provider who has signed this agreement (or designated an authorized representative to sign on his/her behalf) and his/her employees under the applicable insurance policy against Liberty Mutual Insurance Company. This assignment is expressly contingent upon the medical provider agreeing to the terms set forth in the Medical Provider Agreement below and I acknowledge that the medical provider's failure to honor the obligations set forth below render this assignment void. Nothing in this assignment authorizes the medical provider and/or its agents to pursue a claim for bodily injuries on my behalf. Furthermore, I authorize the release of medical records to the insurer and a photocopy of this document shall be considered as effective and valid as the original.

Signature of Patient: ______________________________________ Date:

Printed Name: ______________________________________ Date:

Medical Provider Agreement

I, (the medical provider or authorized agent for the medical provider), understand and agree to the terms of this Agreement on behalf of the Health Care Provider listed below and agree to abide by the following requirements and conditions:

1. I (individually and/or on behalf of my principal) agree to be personally bound by the terms and conditions of the Assignment of Benefits as contained in and made part of the applicable insurance policy, including the obligation to cooperate with investigations and limitations on arbitrations;
2. I agree to follow the Decision Point Review Plan and all requirements and conditions therein; and
3. I also agree to the following specific terms and conditions:

As a condition of this Assignment, upon commencement of treatment, I agree to cooperate with the insurer's investigation of this claim and any related claim, including, but not limited to, the following,

a. Submitting to an examination under oath regarding the treatment provided and issues reasonably relevant to our claims decisions within thirty (30) days of any such request and subscribe to the same;

b. Providing Liberty Mutual with copies of documents pertaining to the treatment provided and reasonably relevant to our claims decisions in your possession, in the possession of your agent(s) or which you can obtain using reasonable efforts which shall include but shall not be limited to those documents permitted by N.J.S.A. 39:6A-13;

c. Allowing us to inspect original documents, objects or locations under your control and/or provide us with the authority to inspect such items if determined by us to be relevant to your claim which shall include but shall not be limited to those documents permitted by N.J.S.A. 39:6A-13. Inspections will be made during mutually convenient times but within 30 days of any such request;

d. Allowing an inspection of the office(s) and location(s) where any professional services and or treatment or therapy were rendered at a mutually convenient time and date within thirty (30) days;

I HAVE READ, UNDERSTAND AND AGREE TO THE TERMS AND CONDITIONS OF THIS AGREEMENT. I ALSO UNDERSTAND THE REQUIREMENTS MAY BE IN ADDITION TO OTHER CONDITIONS CONTAINED IN THE POLICY. I ALSO UNDERSTAND THAT I AM BOUND BY THESE TERMS, AS IS THE PRACTICE OR FACILITY WHERE THE PROFESSIONAL SERVICES AND/OR TREATMENT IS/WAS PROVIDED. I ALSO AM BOUND IF I HAVE AUTHORIZED SOMEONE TO SIGN THIS AGREEMENT ON MY BEHALF.

Signature: ____ Date:

Printed Name:____Date:

Professional/
Practice: ____ Date: