

**State Farm Mutual Automobile Insurance Company,
For the benefit of itself, its subsidiaries and affiliates
Personal Injury Protection Benefits
New Jersey Decision Point Review Plan**

Pursuant to N.J.A.C. 11:3-4.7, State Farm submits the following Decision Point Review Plan (Plan), including Medical Services Review, Precertification and Decision Point Review procedures, to the New Jersey Department of Banking and Insurance. This Plan includes a description of the primary procedures for Decision Point Review and Precertification. Samples of the principal claimant and provider communications described in N.J.A.C. 11:3-4.7 (d) will also be submitted to the Department including State Farm's Conditional Assignment of Benefits form. Pursuant to N.J.A.C. 11:3-4.7(c), this Plan contains the following elements.

1. Essential Procedures: This Plan includes the following essential procedures:

Medical Services Review: A Medical Services Review (MSR) is required for all claims to collect essential claim information, the facts of the accident, the nature and cause of the injury, the diagnosis and the anticipated course of treatment. An MSR will be conducted upon initial notification of the claim to State Farm and, if needed, periodically thereafter while the claim remains open.

Decision Point Review: Upon determination an injury is subject to Care Path Treatment Protocols, the matter will be monitored for appropriate follow up at relevant decision points, as defined by the Care Path Treatment Protocols. In the event a diagnostic test identified in N.J.A.C. 11:3-4.5 (b) is requested, State Farm or its designee will obtain the information necessary to evaluate the request according to the procedures outlined herein.

Precertification: Upon determination a claim involves medical procedures, treatment, or other services, non-medical expenses, or durable medical goods as specified herein; the Precertification process will review the proposed treatment plan, with the goal of developing a comprehensive treatment plan for the insured.

2. Scope: The MSR will apply to all claims in order to collect essential claim information, facts of the accident, the nature and cause of the injury, diagnosis, and the anticipated course of treatment. Decision Point Review and Precertification apply only to the medical procedures, treatment, diagnostic tests, services, non-medical products, devices, services and activities, or durable medical goods specified below.

Decision Point Review will be conducted in accordance with the Care Path Treatment Protocols set forth in the Appendix of N.J.A.C. 11:3-4.1, et seq., and with the standards set forth in N.J.A.C. 11:3-4.5 for diagnostic tests. Decision Point means those junctures in the treatment of identified injuries indicated by hexagonal boxes on the Care Paths where a decision must be made about the continuation or choice of further treatment. At each Decision Point, the medical provider is required to consult with State Farm's vendor for Decision Point Review.

Decision Point Review applies to the following:

- a) All treatment of accidental injury to the spine and back for ICD-9 Codes specified in the Care Paths in the Appendix of N.J.A.C. 11:3-4.1, et seq,
- b) All diagnostic tests identified in N.J.A.C. 11:3-4.5 (b) for both identified and all other injuries.

For diagnostic tests, treatments, surgery, services, durable medical goods and non-medical products, devices, services and activities identified below, the patient's medical provider is required to submit prior notification, written or verbal, to State Farm's vendor. Alternatively, the insured or the medical provider can voluntarily agree to submit all proposed treatment to Precertification. For written notification, it must be submitted on the Attending Provider Treatment Plan form approved by the NJ Department of Banking and Insurance. Copies of this form can be requested from State Farm by calling 1-888-326-0152 or can be accessed at www.statefarm.com/claims/njpip.htm, www.nj.gov/dobi/aicrapg.htm and www.medlogix.com.

Precertification applies to the following:

- a) Non-emergency inpatient and outpatient hospital care;
- b) Non-emergency surgical procedures;
- c) Outpatient care, including follow-up evaluations, 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;
- d) Temporomandibular disorders; any oral facial syndrome
- e) Carpal tunnel syndrome;
- f) Outpatient psychological/psychiatric testing and/or services;
- g) Home health care;
- h) Durable medical goods with an aggregate cost or monthly rental in excess of \$75.00, including durable medical equipment and associated supplies, prosthetics and orthotics,
- i) Non-medical products, devices, services and activities and associated supplies, not exclusively used for medical purposes or as durable medical goods, with an aggregate cost or monthly rental in excess of \$75.00, including but not limited to the following:
 - 1) vehicles
 - 2) modifications to vehicles
 - 3) durable goods
 - 4) furnishings
 - 5) improvements or modifications to real or personal property
 - 6) fixtures
 - 7) spa/gym memberships
 - 8) recreational activities and trips
 - 9) leisure activities and trips
- j) Non-emergency medical transportation with a round trip transportation expense in excess of \$75.00;
- k) Non-emergency dental restoration;
- l) Physical, occupational, speech, cognitive or other restorative therapy, or body part manipulation, including follow up evaluations by the referring physician, except that provided for identified injuries in accordance with Decision Point Review; and
- m) Pain management treatment except that provided for identified injuries in accordance with Decision Point Review, including but not limited to the following:
 - 1) Acupuncture
 - 2) nerve blocks
 - 3) manipulation under anesthesia
 - 4) anesthesia when performed in conjunction with invasive techniques
 - 5) epidural steroid injections
 - 6) radio frequency/rhyzotomy
 - 7) 7) narcotics, when prescribed for more than three months
 - 8) 8) biofeedback
 - 9) 9)implantation of spinal stimulators or spinal pumps, and
 - 10) 10) trigger point injections

Decision Point Review/Precertification requirements will not apply to diagnostic tests, treatments or durable medical goods administered or obtained within 10 days of the insured event. However, such items may be reviewed retrospectively and must be medically necessary and as a result of a covered automobile accident in order to be reimbursable

- 3. Emergency Care:** Emergency care as defined by N.J.A.C. 11:3-4.2 will not be subject to Decision Point Review or Precertification. However, such care may be reviewed retrospectively and must be medically necessary and as a result of a covered automobile accident in order to be reimbursable.
- 4. Notification:** A written summary of this Plan will be mailed to policyholders at policy issuance and renewal.

Upon notification of an injury claim, a claim handler will promptly contact the insured/injured person or designee to explain this Plan, obtain the facts of the accident, description of the injury, site of initial medical care, name of the provider the injured party has selected for further care, and any other information necessary to the complete

the MSR and refer the matter to Decision Point Review or Precertification processes for covered conditions. The insured/injured person will be verbally advised of the potential for a co-payment penalty. The claim handler will mail the insured/injured person a packet of informational materials which includes a letter summarizing the Plan, including the MSR, Decision Point Review and Precertification procedures, the necessary no-fault forms, an introductory letter to the treating physician advising him/her about the Plan requirements, and an authorization for release of medical information. The material will include information on how to contact State Farm's vendor to submit Decision Point Review/Precertification requests including telephone number, facsimile number and e-mail address and will also explain the circumstances under which a co-payment penalty may apply. Periodic communication with the insured and the provider will occur as is appropriate for the specific course of treatment.

For purposes of communicating with insureds and providers concerning the administration of this Plan, State Farm may also mean State Farm's vendor.

5. **PIP Vendor:** Means a company we use for utilization management. State Farm has selected Medlogix, LLC (Medlogix) to be its independent contractor for the medical evaluations concerning this Plan. Medlogix has provided medical claims service for over 20 years. Its corporate office is located in Lansdale, PA.

A team of specialty specific, board certified, and NJ licensed physicians will function as the Medical Directors for State Farm's Plan. This team consists of physicians with specialty expertise in Cardiology, Chiropractic, Dental, Dermatology, ENT, Gastroenterology, General Surgery, Neurology, Neuropsychology, Neurosurgery, Optometry, Orthopedics, Pain Management, Physiatry, Plastic Surgery, Podiatry, Psychology, Psychiatry, and Urology. Medlogix will provide a dedicated team of registered nurses and support staff to work with State Farm claims staff to provide Decision Point Review, Precertification and other medical management services as permitted under New Jersey law.

Medlogix Medical Reviewers will be available from 7:00 am to 7:00 pm Monday-Friday to respond to provider inquiries by phone at 1-877-258-2378. Voice mail and pager contact with Medlogix on-call personnel will be activated for messages received on Saturdays.

6. Review Procedure

- A. **Medical Services Review (MSR)** is required for all claims to collect essential claim information, the facts of the accident, the nature and cause of the injury, the diagnosis and the anticipated course of treatment. An MSR will be conducted upon initial notification of the claim to State Farm. The insured must provide this information as promptly as possible. Failure to provide this information within 30 days after the accident shall result in the application of a co-payment penalty. Each claim will be initially evaluated through the MSR process to determine whether Decision Point Review or Precertification apply.

After making initial contact with the injured person and obtaining information about the injury, the State Farm claim handler will notify Medlogix of the essential claim information. Contact with the insured and the medical provider will be coordinated between State Farm and Medlogix. Based on a completed MSR, a determination will be made as to whether the injury and treatment are subject to Decision Point Review or Precertification. The information required during the initial MSR will include:

- Patient's Name, address and phone number
- Patient's social security number, gender, occupation
- Facts of the accident
- Provider(s) name, address, phone number, contact person, specialty
- History of the injury, prior injuries, previous medical history; current clinical findings
- Diagnosis related to this accident
- Anticipated course of treatment, including diagnostic testing

State Farm shall impose an additional co-payment penalty for not providing the information promptly. Such penalties shall result in a reduction in the amount of reimbursement of the eligible charge for medically

necessary expenses that are incurred after notification is required and until notification is received. The additional co-payment shall be:

- a) 25% when received 30 or more days after the accident; or
- b) 50% until notification is received if 60 or more days after the accident.

At the request of State Farm or its vendor, an MSR may also occur every 60 days thereafter while the claim remains open to obtain updated information concerning the patient's medical condition.

- B. Decision Point Review/Precertification**, the treating physician has the opportunity to explain any complicating factors which might require additional treatment or provide medical justification for diagnostic testing.

Decision Point Review/Precertification is performed by Medlogix Medical Reviewers who receive the necessary medical information from the treating provider either by phone, mail, or by electronic transmission, to the extent such information has not already been obtained through the MSR.

In order to consider a request for Decision Point Review/Precertification, the following information is required and must be submitted to Medlogix:

- Provider's name, address, phone number, contact person and specialty
- History of the injury, prior injuries, previous medical history; current clinical findings
- ICD-9 diagnosis codes related to this accident
- Current patient evaluation including objective clinical findings
- Results of performed diagnostic testing
- Amount and type of treatment received to date with documented response
- Proposed diagnostic tests, for comparison to criteria contained in N.J.A.C. 11:34.5
- Proposed course of treatment consistent with subjective and objective findings
- Proposed CPT-4, HCPC's and procedural codes related to the diagnoses, including frequency and duration
- Date of re-evaluation for discharge or anticipated discharge date (Decision Point Review)
- Legible notes (written requests)

For written requests, notification must be submitted on the Attending Provider Treatment Plan form approved by the NJ Department of Banking and Insurance.

This information will be compared to standards of good practice, standard professional treatment protocol and established practice parameters utilized by Medlogix. The medical necessity of proposed diagnostic tests will be evaluated based on the criteria contained in N.J.A.C. 11:3-4.5.

Attempts will be made to resolve verbal requests for medical services at the time of a provider's contact with Medlogix. If the request is not resolved at the time of contact, however, a written response will be sent within three (3) business days after receipt of the request.

All responses to requests for services, written or verbal, will be communicated in writing. A Decision Point Review/Precertification Evaluation letter confirming Medlogix's evaluation of the treatment or test will be sent to the patient, the treating provider, and State Farm within three (3) business days after receipt of the request for Decision Point Review/Precertification. In some cases, if additional information is required to process the request, it will be specifically identified in the evaluation letter.

The provider and patient will be advised:

1. The request was evaluated as medically necessary, or
2. There was insufficient information provided to process the request, or if the Medlogix Medical Reviewer and the treating provider cannot agree on treatment, services, tests, goods, or non-medical expenses, a Medical Director will review all appropriate documents and make an evaluation. The provider and patient will then be advised:
3. The request was evaluated as medically necessary, or
4. The request was evaluated as not medically necessary, or

5. The request was evaluated as not medically necessary and modified, or
6. There was insufficient information provided to process the request.

If a treatment plan, medical procedure, non-medical product, device, service and activity, durable medical goods, or diagnostic test other than those listed in 11:3-4.5 (a) is evaluated as not medically necessary or is modified, that evaluation is always made by a physician. In the case of treatment prescribed by a dentist, the evaluation is made by a dentist.

Written notification of the Medical Directors evaluation will be made within three (3) business days after receipt of the initial request or after receipt of a subsequent submission of information.

If State Farm or Medlogix fails to respond to a request for Decision Point Review/Precertification within three (3) business days, the treatment or test may proceed (without application of a co-payment penalty) until State Farm or Medlogix notifies the provider of the evaluation results.

If the Medical Director determines the supporting medical information is insufficient to render an opinion as to the medical necessity of the request, the scheduling of an independent medical examination may be requested (see Section 10).

The Decision Point Review/Precertification evaluation shall be based exclusively on medical necessity and shall not encourage over or under-utilization of the treatment or test. The treating provider shall provide information on the diagnosis and proposed plan of treatment, including the clinically supported findings that are the basis for the treating provider's determination that the treatment, diagnostic test, services, goods, or further treatment is necessary and that the injury is causally related to the motor vehicle accident. Providers will be encouraged to provide a comprehensive treatment plan of care for patients to minimize the need for piecemeal review.

State Farm will not retrospectively deny payment for treatment, services, diagnostic testing, durable medical goods or non-medical expenses on the basis of medical necessity where a Decision Point Review or Precertification request for that treatment or testing was properly submitted to Medlogix unless the request involved fraud or misrepresentation, as defined in N.J.A.C. 11:16-6.2, by the provider or the person receiving the treatment, diagnostic testing or durable medical goods. All billing, however, will be subject to billing and coding guidelines established by the American Medical Association, outlined in the Current Procedural Terminology (CPT) guide, and the provisions of N.J.A.C. 11:3-29.

The Decision Point Review/Precertification evaluation is strictly a review of medical necessity by Medlogix on State Farm's behalf. Reimbursement for the expenses of medically necessary care is subject to the provisions of the auto insurance policy and New Jersey law including deductibles, co-payments, policy limits and the medical fee schedule. Reimbursement is also subject to a determination apart from medical necessity that the care is for injuries caused by a covered accident.

C. State Farm Close of Business for Submission

State Farm's close of business is 7:00 PM EST Monday through Friday (excluding legal holidays). Requests must be submitted by close of business to be considered received on that business day. Requests received after close of business will be considered received on the next business day. See definition of "Days" in N.J.A.C. 11:3-4.2.

7. Internal Appeals Procedures

Under State Farm's Conditional Assignment of Benefits, the provider shall be required to utilize the Internal Appeals process before submitting the disputes to Personal Injury Protection Dispute Resolution under N.J.A.C. 11:3-5, et seq.

To file a Pre-Service Appeal, the provider must complete and submit the Pre-Service Appeal form and any supporting documentation to Medlogix via fax at **(856) 910-2501** or mail at 300 American Metro Blvd, Suite 220, Hamilton, NJ 08619.

For Post Service Appeals, the provider must complete the Post Service Appeal form and select a physician to review the dispute from a list maintained by Medlogix. If the provider does not select a reviewing physician, one will be selected on the provider's behalf. The appeal form and any supporting documentation must be submitted to State Farm Claims, P.O. Box 106170, Atlanta, GA 30348-6170 or by fax at (844) 218-1140. The decision by the reviewing physician is non-binding to all parties.

As per 11:3- 4.7B - Requirements for insurer internal appeals procedures:

- State Farm only requires a one-level appeal procedure for each appealed issue before making a request for alternate dispute resolution in accordance with N.J.A.C. 11:3-15. That is, each issue shall only be required to receive one internal appeal review by the insurer prior to making a request for alternate dispute resolution. An appeal of the denial of a medical procedure, treatment, diagnostic test, other service, and/or durable medical equipment on the grounds of medical necessity is a different issue than an appeal of what the insurer should reimburse the provider for that same service.
- There are two types of internal appeals and a separate and distinct form is available for each type of appeal:
 1. Pre-service: Appeals of decision point review and/or precertification denials or modifications prior to the performance or issuance of the requested medical procedure, treatment, diagnostic test, other service and/or durable medical equipment (collectively known as "services"); and
 2. Post-service: Appeals subsequent to the performance or issuance of the services.
- Both the New Jersey PIP Pre-Service Appeal Form and the New Jersey PIP Post Service Appeal Form can be found on the NJ Department of Banking and Insurance website or at State Farm's website, www.statefarm.com/claims/njpip.htm, or upon request from State Farm by calling 1-888-326-0152. The list of physician reviewers is available at Medlogix's website, www.medlogix.com, or upon request from State Farm or Medlogix
- A pre-service appeal shall be submitted no later than 30 days after receipt of a written denial or modification of requested services.
- 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 pre-service appeals shall be issued by 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.
- Decisions on post-service appeals shall be issued by the insurer to the provider who submitted the appeal no later than 30 days after receipt of the appeal form and any supporting documentation.
- Nothing in this section shall be construed so as to require reimbursement of services that are not medically necessary or to prevent the application of the penalty co-payments in N.J.A.C. 11:3-4.4(e), (f) and (g).

The Internal Appeals process is an attempt to resolve disputes directly between State Farm and the provider. Providers who retain counsel to assist them in the Internal Appeals process do so strictly at their own expense. State Farm will not reimburse providers for their counsel fees or any other costs regardless of the outcome of the process.

- 8. Personal Injury Protection Dispute Resolution:** A PIP dispute, as defined by N.J.A.C. 11:3-5, may be submitted to Personal Injury Protection (PIP) Dispute Resolution in accordance with the State Farm Auto policy. PIP Dispute Resolution shall be conducted in accordance with the procedures set forth in N.J.A.C. 11:3-5, including any amendments. The final determination made by the dispute resolution professional shall be binding upon the parties, but subject to clarification / modification and / or appeal as provided by the rules of the dispute resolution organization, and / or vacation, modification or correction by the Superior Court in an action filed pursuant to N.J.S.A 2A:23A-13 for review of the award.

Under State Farm's Conditional Assignment of Benefits, after exhausting the Internal Appeals process, a provider must submit any PIP dispute, as defined by N.J.A.C. 11:3-5, to PIP Dispute Resolution in accordance with this Plan.

- 9. Independent Medical Examinations:** An exam scheduled pursuant to this Plan is intended to provide a timely review of proposed medical care. If a physical/mental examination of the injured person is requested pursuant to this Plan, State Farm, or its designated vendor, will notify the injured person or his or her designee of the time, date, and place of examination. A notice will also be sent to all known providers treating the injured person

advising of the examination and consequences for repeated unexcused failures to attend on the part of the patient. The appointment for the physical examination will be scheduled within seven (7) calendar days of receipt of the request for Decision Point Review/Precertification unless the injured person agrees to extend the time period. The medical examination will be conducted by a practitioner in the same discipline as the treating provider and at a location reasonably convenient to the injured person. Upon request of State Farm, or its designated vendor, the injured person will provide medical records and other pertinent information to the practitioner conducting the medical examination no later than at the time of the examination.

State Farm will schedule the physical/mental examination to occur during the first thirty-five (35) calendar days after Medlogix's receipt of the Decision Point Review/Precertification request.

Once the exam is attended, State Farm, or its designated vendor, will promptly notify the injured person or his or her designee and the treating provider whether the request was evaluated as medically necessary, but no later than three (3) business days after the examination. If the examining provider prepares a written report concerning the examination, the injured person or his or her designee shall be entitled to a copy and may request one from State Farm.

Failure to attend the physical/mental examination scheduled to occur within thirty-five (35) calendar days from Medlogix's receipt of the Decision Point Review/Precertification request will be **excused** if the injured person notifies State Farm or Medlogix at least three (3) business days before the examination date of his or her inability to attend the exam. Another exam will then be scheduled to occur within the thirty-five (35) calendar days.

Failure to attend a physical/mental examination scheduled to occur within thirty-five (35) calendar days from Medlogix's receipt of the Decision Point Review/Precertification request will be **unexcused** if the injured person does not notify State Farm or Medlogix at least three (3) business days before the examination date of his or her inability to attend the exam.

Failure to attend a physical/mental examination rescheduled to occur more than thirty-five (35) calendar days from Medlogix's receipt of the Decision Point Review/Precertification request will be **unexcused**.

If the injured person has two or more unexcused failures to attend a scheduled examination, State Farm will deny payment for treatment, diagnostic testing and durable medical goods provided on or after the date of the second unexcused failure to attend. State Farm's denial will apply to treatment, diagnostic testing and durable medical goods relating to the diagnosis code(s) and corresponding family of codes associated with the Decision Point Review/Precertification request that necessitated the scheduling of the physical/mental examination.

In such cases, notification will be sent to the injured person or his or her designee and all known providers treating the injured person. The notification will advise that all future treatment, diagnostic testing and durable medical equipment associated with the diagnosis code(s), and corresponding family of codes, contained in the request or Attending Provider Treatment Plan form will be ineligible for payment.

10. Voluntary Networks:

For non-emergency benefits, certain goods and services may be secured through State Farm or its designated voluntary network. These goods and services include:

- a) Durable Medical Goods with an aggregate cost or monthly rental in excess of \$75, including durable medical equipment and supplies, prosthetics and orthotics
- b) Magnetic Resonance Imagery
- c) Computer Assisted Tomography
- d) Ambulatory Surgical Center

The availability of voluntary networks does not waive the requirement for Decision Point Review and Precertification of goods or services as provided under this Plan. (See Section 12 for applicable penalty for non-compliance.)

A 30% penalty shall apply if goods or services, available through State Farm or its voluntary network, are not procured through our designated vendor's network. This penalty is in addition to any other policy or statutory deductible, co-payment and penalty applicable under this Plan and State Farm Auto policy.

The injured person or his or her designee will receive a written summary of State Farm's Decision Point Review Plan including the availability of Networks and the penalty assessed for failure to utilize the Networks upon the notification of an injury claim.

In addition, when Medlogix receives a request for goods and/or services, the patient and provider will receive a Decision Point Review/Precertification Evaluation letter advising if the request was evaluated as medically necessary. The Evaluation letter will also advise the patient of options available to receive in-network services, and an explanation of the 30% co-payment penalty that may apply for failure to obtain these goods or services from an in-network facility.

For information regarding available network facilities, the injured party or his or designee and the treating medical provider may contact State Farm, access Medlogix's website at www.medlogix.com or call Medlogix at 1-877-258-2378.

- 11. Penalties:** The co-payment penalties described under this section are in addition to any other policy or statutory co-payment/penalty applicable under your policy.
- a) State Farm shall assess an additional co-payment penalty for not providing the required MSR information within 30 days of the loss. Penalties will be assessed as follows:
 - 1. For failure to provide information timely, such penalties shall result in a reduction in the amount of reimbursement of the eligible charge for medically necessary expenses incurred more than 30 days after the accident and until notification is received. The additional co-payment shall be:
 - i. 25% when received more than 30 after the accident; or
 - ii. 50% until notification is received if 60 or more days after the accident;
 - b) State Farm shall assess an additional co-payment penalty for medically necessary diagnostic tests, treatments, surgery, services, durable medical goods and non-medical products, devices, services and activities that are incurred without first complying with the provisions of this Plan. The treating provider's non-compliance with the provisions of this Plan may trigger this additional co-payment penalty. No penalty under this provision will be applied within the first 10 days after the accident.

Noncompliance, which shall result in the imposition of a 50% co-payment penalty, includes any of the following:

- 1. Failure to follow the Precertification requirements of this Plan.
- 2. Failure to follow the Decision Point Review requirements of this Plan.
- 3. Failure to provide clinically supported findings that support the medical procedures, treatment, diagnostic tests, services, non-medical products, devices, services and activities, or durable medical goods at the time of the request for Decision Point Review/Precertification.

The 50% co-payment shall apply to the eligible charge for medically necessary diagnostic tests, treatments or durable medical goods that were provided between the time notification to Medlogix was required and the time that proper notification is made and State Farm or Medlogix has an opportunity to respond in accordance with this Plan.

Non-compliance, which shall result in the imposition of a 30% co-payment penalty, includes any of the following:

- 1. Failure to secure durable medical goods from State Farm or its designated vendor(s).
- 2. Failure to secure specified diagnostic imaging/testing from State Farm or its designated vendor(s).

12. Assignments: As a condition of the assignment of benefits, the treating medical provider or provider of service benefits agrees to comply with all the procedures of the Plan. The provider also agrees to initiate all Precertification and Decision Point Review requests as required by the Plan. In the event the provider fails to comply with the conditions of the Plan, and such failure results in the imposition of a copayment penalty, the provider will hold the patient harmless for such co-payment penalty insofar as the provider will not seek payment from the patient for any unpaid portion of the medical services arising from such co-payment penalty. Additional conditions that also apply to the provider include:

- a) Submission of disputes as defined in the Plan to the Internal Appeals Process set forth therein. After final determination, submission of disputes not resolved by the Internal Appeals process to the Personal Injury Protection Dispute Resolution process set forth in N.J.A.C. 11:3-5.
- b) Submission of all disputes not subject to the Internal Appeals process to the Personal Injury Protection Dispute Resolution process set forth in N.J.A.C. 11:3-5.
- c) Submission of medical records with clinically supported findings to support the diagnosis, causal relationship to the accident and care plan.
- d) Compliance with a request to (i.) submit to an examination under oath, and (ii.) provide the Company with any other pertinent information/documentation that it requests.
- e) Agreement not to pursue payment directly from the patient, with the exception of deductibles and copayments. The assignment may be revoked by the assignee, and the assignee shall be entitled to pursue payment from the patient, when benefits are not payable due to lack of coverage and/or violation of a policy condition by the patient.

State Farm's Conditional Assignment of Benefits is the only valid assignment of benefits. The assignee agrees that State Farm has the right to reject, terminate or revoke the State Farm Conditional Assignment of Benefits. An assignment of benefits may require State Farm's written consent.