PIP Claim Information – Basic Policy

We understand this may be a difficult and confusing experience and we wish to assist you in any way we can. We hope the following information will help explain the claims process and answers some frequently asked questions.

Personal Injury Protection, otherwise known as "PIP", is medical coverage included as part of your automobile insurance policy. PIP provides reimbursement for medically necessary expenses related to injuries caused by a covered automobile accident.

- ***How much medical coverage do I have under my policy?***

  Your policy provides for reimbursement of medical expenses up to $15,000. However, this limit will automatically increase to $250,000 in the case of a permanent or significant brain injury, spinal cord injury or disfigurement. The $250,000 limit would cover medically necessary treatment for permanent or significant injuries provided at a trauma center or acute care hospital immediately after the accident until you are stable and can be safely discharged or transferred to another facility. The limits applicable to your policy are stated on the Declaration Page of your policy. If you have any questions about your limits, please call your State Farm Agent or ask your claim handler.

- ***Are there benefits available if I can't work due to my injuries?***

  Your basic auto policy does not include Income Continuation benefits. However, if you were employed at the time of loss, you may qualify for New Jersey Temporary Disability Benefits (TDB). Be sure to discuss with your employer whether you are eligible for benefits and, if so, apply within 30 days from the date of the accident.

- ***Do I have a deductible?***

  Yes; unless you selected a different deductible option, medical expense benefits are subject to a mandatory $250 deductible per accident. Please refer to the Declaration Page of your policy to confirm your selected deductible.

- ***Am I responsible for any out of pocket co-payments?***

  Yes; there is a 20% co-payment on medical expenses in excess of your deductible, up to $5,000.

The New Jersey Department of Banking and Insurance has approved a Decision Point Review Plan (Plan) for State Farm. The Plan includes a number of procedures related to your claim including **Medical Services Review, Decision Point Review and Pre-certification.** Cooperation with these procedures is required for medically necessary expenses to be reimbursed to the full extent available under the policy. A full copy of

the Plan can be accessed at www.statefarm.com/claims/njpip.htm or can be requested from State Farm by calling 1-888-326-0152.

- ***What is a medical services review?***

Medical services review is the process by which we collect essential claim information, the facts of the accident, the nature and cause of your injury, your diagnosis and anticipated course of treatment. A medical services review is required for all claims and must be completed as promptly as possible after the accident. The medical services review will help us determine whether your injury and treatment are subject to Decision Point Review or Pre-certification. A medical services review may also be repeated every 60 days while your claim remains open to obtain updated information concerning your medical condition.

- ***How do I meet the medical services review requirement?***

You must provide essential claim information to State Farm (including the facts of the accident, the nature and cause of your injury, the diagnosis and anticipated course of treatment) as promptly as possible after the accident. If not provided promptly, a **25% co-payment** may apply when information is received more than 30 days after the accident or **50% co-payment** when received more than 60 days after the accident or not received at all.

- ***What is Decision Point Review?***

The New Jersey Department of Banking and Insurance has published a set of medical treatment guidelines, known as Care Paths, as the standard course of care for soft tissue injuries of the neck and back. They also published general guidelines for the administration of certain types of diagnostic testing.

The Care Paths include stages or points during your treatment where a decision must be made about the continuation or choice of further treatment. At these "decision points", your medical provider is required to notify and consult with State Farm regarding proposed treatment or testing. This process of consultation and decision-making between State Farm and your medical provider is known as ***Decision Point Review***. The use of diagnostic tests specified in Department regulations are also subject to Decision Point Review.

A copy of the Care Paths is available at the NJ Dept of Banking and Insurance website,
http://www.nj.gov/dobi/aicrapg.htm.

- ***What is Pre-certification?***

Pre-certification is a process by which your medical provider submits prior notification to State Farm for certain types of treatment, testing and durable medical

goods not subject to Decision Point Review. ***Pre-certification*** 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. narcotics, when prescribed for more than three months,
8. biofeedback,
9. implantation of spinal stimulators or spinal pumps, and
10. trigger point injections

- ***Do the Decision Point Review/Pre-certification requirements apply to emergency care?***

No; the requirements do not apply to treatment administered during emergency care or to treatment within the first 10 days after the auto accident. Treatment within the first 10 days, however, may be reviewed retrospectively and must be medically necessary and as a result of the accident in order to be reimbursable.

- ***Should my doctor submit Decision Point Review and Pre-certification notifications directly to State Farm?***

No; State Farm has selected Consolidated Services Group (CSG) to be our independent contractor for Decision Point Review and Pre-certification medical evaluations. Decision Point Review and Pre-certification notifications or requests must be submitted directly to CSG. For written notification, it must be submitted on the Attending Provider Treatment Plan form approved by the NJ Department of Banking and Insurance. The form will be supplied by State Farm or is available at www.statefarm.com/claims/njpip.htm, http://www.nj.gov/dobi/aicrapg.htm and www.medlogix.com. The form can also be requested from State Farm by calling 1-888-326-0152. CSG can be reached by phone (877) 258-2378 or by fax (856) 910-2501

Any medical bills associated with your claim should be submitted directly to State Farm.

- ***What should be included with the request?***

Your doctor should provide clinically supported findings to support the request for treatment, testing or durable medical goods. Failure to do so could result in a **50% co-payment penalty**. For a comprehensive list of information needed to process the request without application of penalty, please refer to State Farm's Plan. A copy is available at www.statefarm.com/claims/njpip.htm or can be requested from State Farm by calling 1-888-326-0152.

- ***What will CSG do with the request?***

CSG's medical staff will review the information supplied by your doctor in accordance with the standards of good practice, standard professional treatment protocol and established practice parameters utilized by CSG. Once their review is

completed, you and your doctor will be notified whether the treatment, testing or durable medical good was evaluated as medically necessary.

The Decision Point Review/Pre-certification evaluation is strictly a review of medical necessity by CSG 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.

- ***Once my doctor submits a Decision Point Review/Pre-certification request, how long does the review take?***

Within three (3) business days of receipt of the request, CSG will advise you and your provider in writing of the evaluation result. If CSG fails to respond to the request within three (3) business days, you may proceed with your treatment or test until such time an evaluation result is communicated.

- ***What if my doctor doesn't agree with the Decision Point Review or Pre-certification evaluation?***

If your doctor has additional or clarifying information to support his or her position, he or she can utilize an internal appeal process. This process encourages your doctor to speak directly with a CSG Medical Director in hopes of reaching an agreement on your treatment plan.
In addition to an internal appeal, your doctor may also submit disputes to State Farm's Internal Dispute Resolution process. This process allows for your doctor to select another physician to review your case. Again, your doctor can submit any supporting documentation to the reviewing physician for consideration in the resolution of the dispute.

You also have the right to arbitrate the denial pursuant to New Jersey law and your policy contract, or utilize any other dispute resolution remedies applicable under New Jersey law.

For a complete list of appeal and dispute resolution options, you can request a copy of the Plan from State Farm by calling 1-888-326-0152 or access a copy at www.statefarm.com/claims/njpip.htm

- ***What happens if my doctor does not submit a request for Decision Point Review or Pre-certification?***

If your doctor fails to submit requests in accordance with the Plan, payment of bills may be subject to a **50% penalty** co-payment even if the services provided are determined to be medically necessary.

- ***Can I go to any medical provider for services, testing and durable medical goods?***

Yes, however, while we do not select your provider(s) of medical services, testing, or durable medical goods, CSG has established relationships with pre-approved vendors who can provide **Durable Medical Goods**, **MRIs and CAT Scans.**

If you obtain durable medical goods or diagnostic testing from the networks provided by CSG, you can **avoid a 30% co-payment penalty** that would otherwise apply.

You or your medical provider can arrange for delivery of durable medical goods, or find out the names and locations of the available MRI/CAT Scan imaging facilities by contacting CSG at 1-877-258-2378 or accessing their website at www.medlogix.com.

- ***What is an Independent Medical Opinion?***

In response to a request for Decision Point Review/Pre-certification, we may ask you to attend a second opinion medical examination with a doctor of our choosing. State Farm, or CSG, will notify you of the time, date, and place of examination. This exam will be scheduled within 7 days of CSG's receipt of the request or Attending Provider Treatment Plan form unless you agree to extend the time period. The exam will be at a location reasonably convenient to you and will be at our expense. The exam will be conducted by a practitioner in the same discipline as the medical provider who submitted the request. State Farm, or CSG, will promptly notify you and your treating provider whether the request was evaluated as medically necessary, but no later than three (3) business days after the examination. If the examining physician prepares a written report concerning the examination, you will be entitled to a copy.

- ***What happens if I don't attend the Independent Medical Examination?***

If the exam was scheduled as part of the Decision Point Review/Pre-certification process, State Farm will deny further reimbursement for treatment, diagnostic testing or durable medical goods if you have more than one unexcused failure to attend. State Farm's denial will apply to all treatment, diagnostic testing and durable medical goods relating to the diagnosis code(s), and corresponding family of codes, contained in the request or Attending Provider Treatment Plan form that necessitated the scheduling of the examination.

- ***What is considered an unexcused failure to attend the exam?***

Failure to attend a physical/mental examination scheduled to occur within thirty-five (35) calendar days from CSG's receipt of the Decision Point Review/Pre-certification

request will be **unexcused** if you do not notify State Farm or CSG at least three (3) business days before the examination date of your inability to attend the exam.

Also, failure to attend a physical/mental examination rescheduled to occur more than thirty-five (35) calendar days from CSG's receipt of the Decision Point Review/Pre-certification request will be **unexcused.**

- ***What is a Conditional Assignment of Benefits?***

A Conditional Assignment of Benefits allows you to "assign" certain benefits under the policy to your treating physician or other medical provider. By signing State Farm's Conditional Assignment of Benefits, you allow State Farm to issue payments directly to your physician instead of issuing payments to you.

If your treating physician or other medical provider signs State Farm's Conditional Assignment of Benefits, he or she agrees to comply with the Decision Point Review/Pre-certification requirements. If a penalty is applied based on your physician's failure to follow the requirements, he or she also agrees not to seek payment from you for the unpaid penalty amount. In addition, your State Farm auto policy conditions your ability to assign benefits upon your medical provider's agreement to submit certain types of disputes to State Farm's Internal Dispute Resolution process and the Personal Injury Protection Dispute Resolution Process.

For a complete list of appeal and dispute resolution options, you can request a copy of the Plan from State Farm by calling 1-888-326-0152 or access a copy at www.statefarm.com/claims/njpip.htm

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In order for medical treatment, services and diagnostic testing to be reimbursed to the fullest extent available under your policy, certain requirements may apply.

If you have any questions about the bills you receive, the treatment provided by your doctor, or the handling of your claim, please contact us. We will attempt to answer any questions you may have.

Please complete all forms entirely. Be sure to sign where indicated (both front and back). NOTE: We need a signed Application for Benefits to assist us in processing your claim. Also, a signed "Conditional Assignment of Benefits" form from your provider is required before we will pay the provider directly for your care. We are anxious to help you with your claim. With your cooperation, we will be able to handle your claim promptly and efficiently.

Thank you.