PROPRIETARY AND CONFIDENTIAL

Liberty Mutual Agency Corporation (LMAC) on behalf of the Business Lines Business Unit Operating Collectively as:

American Fire and Casualty Company
American States Insurance Company
Excelsior Insurance Company
General Insurance Company of America
Indiana Insurance Company
The Netherlands Insurance Company
The Ohio Casualty Insurance Company
Ohio Security Insurance Company
Peerless Indemnity Insurance Company (formerly Atlas Assurance Company of America)
Safeco Insurance Company of America
West American Insurance Company

Decision Point Review Plan
And
Pre-certification Requirements

Plan Administrator:
Insight Services Group ("ISG")
55 Ferncroft Road, Ste #300
Danvers, MA 01923

DECISION POINT REVIEW

Pursuant to N.J.A.C. 11:3-4, 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 the Identified Injuries. The Care Paths provide that treatment be evaluated at certain intervals called Decision Points. On the Care Paths, Decision Points are represented by hexagonal boxes. At Decision Points the Named Insured, Eligible Injured Person or treating health care provider must provide us information about further treatment that is intended to be provided (Decision Point Review). In addition, the administration of any diagnostic tests set forth in N.J.A.C 11:3-4.5(b) is subject to Decision Point Review regardless of the diagnosis. 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 ISG at 1-800-818-7610. The Decision Point Review Plan is accessible by accessing URL: http://isgvalue.com.

We will advise the Named Insured and/or Eligible Injured Person of the Care Path requirements upon notification to us of a claim filed under Personal Injury Protection. The Decision Point Review requirements do not apply to treatment or diagnostic tests administered during emergency care or during the first (10) days after the accident causing the injury, however only medically necessary treatment related to the motor vehicle accident will be reimbursed.

We will review the course of treatment at various intervals (Decision Points) unless a comprehensive treatment plan has been pre-certified by us. In order for us to determine if additional treatment or the administration of a test is medically necessary, the treating provider or the Named Insured and/or Eligible Injured Person must provide us with reasonable prior notice together with appropriate, legible, clinically supported findings that the anticipated treatment or test is medically necessary. In order to submit a Decision Point Review and/or pre-certification request, your treating provider must submit a completed attending provider treatment form via fax to 1-855-450-2676 along with 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 www.nj.gov/dobi/aicrapg.htm and at http://isgvalue.com. We will review this notice and supporting materials within three business days. Business days is defined as Monday through Friday 9 AM to 5:30 PM eastern time excluding Federal, New Jersey State Holidays or Safeco Insurance / Liberty Mutual Company Holidays, ISG Company Holidays and any time when our

offices are closed due to a declared state of emergency.

Following our review, we have the option to:

a. Recommend authorization of reimbursement for the treatment, test, durable medical equipment, prescriptions drug; or
b. Recommend denial of reimbursement for the treatment, test, durable medical equipment, prescription drugs where the information submitted is incomplete and/or fails to provide clinically supported findings to establish medical necessity; or
c. Recommend modification/partial certification of reimbursement for the treatment, test, durable medical equipment, prescription drugs where the information submitted is incomplete and/or fails to provide clinically supported findings to establish medical necessity for the treatment plan requested; or
d. Request additional documentation from the attending providers documentation when the submitted documentation is illegible; or
e. Schedule a physical examination of the Named Insured and/or Eligible Injured Person where the notice and supporting materials are insufficient to authorize, deny, or modify reimbursement or further treatment, test, durable medical equipment or prescription drugs; or
f. Advise you that the DPR/Pre-certification request cannot be processed as the request is incomplete due to the lack of, or an incomplete Attending Provider Treatment Plan which is mandated to be submitted with every DPR/Pre-certification request as per New Jersey Department of Banking and Insurance Order AO4-143. A submitted Attending Provider Treatment Plan is considered to be incomplete if it lacks information that is vital to determining medical necessity. A submitted Attending Provider's Specialty must be signed by the Attending Provider and dated.

If we request a physical examination:

a. The appointment for the examination will be scheduled within seven (7) calendar days of our receipt of the notice of additional treatment or tests unless the Named Insured and/or Eligible Injured Person agrees to extend the time period.

b. The medical examination will be conducted by a provider in the same discipline as the treating provider.

c. The examination will be conducted at a location reasonably convenient for the Named Insured and/or Eligible Injured Person. If unable to attend the examination, the Named Insured and/or Eligible Injured Person must notify ISG at (800) 278-0550 at least three (3) business days before the examination date. Failure to comply with this requirement will result in an unexcused absence.

d. The Named Insured and/or Eligible Injured Person must, if requested, provide medical records and other pertinent information to the examining provider conducting the examination. In addition, the Named Insured and/or Eligible Injured Person may be requested to bring prescribed electro-stimulation devices and/or

supports/braces to the examination. The requested records must be provided no later than the time of the examination. Failure to provide the requested records will be considered an unexcused absence.

e. The Named Insured and/or Eligible Injured Person must supply proper identification at the examination. A photo ID would be preferred but any form of identification will be accepted. Failure to supply proper identification will result in an unexcused absence.

f. Examinations will be scheduled to occur within thirty (30) calendar days of the receipt of the request for additional treatment/test or service in question. Examinations scheduled to occur beyond thirty (30) calendar days of the receipt of the request of additional treatment/test or service in question, must be attended. Failure to attend an examination scheduled to occur more than thirty (30) calendar days after receipt of the request will be considered an unexcused absence.

g. When a medical examination is scheduled the Named Insured and/or Eligible Injured Person and the provider and attorney if noted, will be given notice of the examination date, time and location. The examination notice details the consequences for more than one unexcused failure to attend. If the Named Insured and/or Eligible Injured Person has two or more 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.

We will notify the Named Insured and/or Eligible Injured Person of our decision to recommend authorization or denial of reimbursement for the treatment or test as promptly as possible, but no later than three (3) business days following the examination. Any recommendation of denial for reimbursement of further treatment or tests will be based on the determination of a physician or dentist. The Named Insured and/or Eligible Injured Person or his designee may request a copy of any written report prepared in conjunction with any physical examination we request. If we fail to take any action or fail to respond to the Named Insured and/or Eligible Injured Person within three business days after receiving the required notification and supporting medical documentation at a Decision Point, then the provider is permitted to continue the course of treatment until we provide the required notice.

MANDATORY PRE-CERTIFICATION

If the Named Insured and/or Eligible Injured Person does not have an Identified Injury, we will require that the Named Insured and/or Eligible Injured Person or their health care provider request

pre-certification for services, treatments and procedures outlined in Exhibit B which includes: diagnostic tests, durable medical equipment, prescription supplies, or otherwise potentially covered medical expense benefits. In the event that a Named Insured and/or Eligible Injured Person is injured in an automobile accident, the Named Insured and/or Eligible Injured Person or their health care provider should contact ISG at 1-800-818-7610 in order to request pre-certification. In order to submit a Decision Point Review and/or a pre-certification request, your treating provider must submit a completed attending provider treatment form via fax 855-450-2676. Along with 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 www.nj.gov/dobi/aicrapg.htm and at http://isgvalue.com.

Pre-certification will not apply to treatment or diagnostic tests administered during emergency care or during the first ten (10) days after the accident causing the injury; however, only medically necessary treatment related to the motor vehicle accident will be reimbursed.

Our approval of requests for pre-certification 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, the medical protocols adopted in N.J.A.C. 11:3-4 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. The Named Insured and/or Eligible Injured Person or their health care provider must provide us with reasonable prior notice of the anticipated services, treatments and procedures as outlined above, as well as, the appropriate clinically supported findings to facilitate timely approval. When appropriate, the health care provider may submit a comprehensive treatment plan for pre-certification.

The IME and DPR requirements and response options outlined in Decision Point Review above apply to Pre-Certification.

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 (50) per cent 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 (50) percent 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.

This additional co-payment will not apply if we have received the required notice, supporting medical documentation, and have failed to act within three (3) business days to authorize or deny

reimbursement of further treatment or tests. Our failure to respond within three business days will allow a provider to continue treatment until we provide the required notice.

For the purposes of the penalty/copayments 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 Pre-Certification 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 11:3-4.4(g) (failure to use an approved diagnostic/electrodiagnostic, 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).

INITIAL AND PERIODIC NOTIFICATION REQUIREMENT

Liberty Mutual Agency Corporation (LMAC) 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, Liberty Mutual Agency Corporation (LMAC) may impose an additional co-payment 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.

VOLUNTARY PRE-CERTIFICATION

Health care providers are encouraged to participate in a voluntary pre-certification process by providing ISG with a comprehensive treatment plan for both identified and other injuries.

ISG will utilize nationally accepted criteria and the medical protocols adopted in NJAC 11:3-4 to work with the health care provider with the intent 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 comprehensive treatment plan means that as long as treatment is consistent with the agreed upon comprehensive treatment plan, additional notification to ISG is not required.

VOLUNTARY NETWORKS

ISG has established networks of pre-approved vendors that can be recommended for the provision of certain services, diagnostic tests, durable medical equipment and/or prescription supplies. Named Insured and/or Eligible Injured Persons are encouraged, but not required, to obtain certain services, diagnostic tests, durable medical equipment and/or prescription supplies from one of the

pre-approved vendors. If they use a pre-approved vendor from one of these networks for medically necessary goods or services, they will be fully reimbursed for those goods and services consistent with the policy. If they use a vendor that is not part of these pre-approved networks, reimbursement will be provided for medically necessary goods or services but only up to seventy (70) 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.

For the purposes of the penalty/copayments 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 Pre-Certification 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 11:3-4.4(g) (failure to use an approved diagnostic/electrodiagnostic, 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).

PPO NETWORKS – These networks include providers in all specialties, hospitals, outpatient facilities, and urgent care centers throughout the entire State of New Jersey. The Nurse Case Manager can provide the Named Insured and/or Eligible Injured Person with 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 Named Insured and/or Eligible Injured Person. The PPO networks are provided as a service to those persons who do not have a preferred health care provider by giving a list of recommended providers from which they may select that they may select.

DECISION POINT REVIEW PLAN PROCESS

The requirements for precertification only apply after the tenth (10) day following the automobile accident causing the injury. For every claim that is reported by the Named Insured and/or Eligible Injured Person, a loss report is created and transmitted electronically to Liberty Mutual Agency Corporation's (LMAC) claim office. A claim representative contacts the Named Insured and/or Eligible Injured Person, confirms coverage and reviews policy requirements. During this conversation, the claim representative explains that precertification is required for the services, treatments and procedures outlined in Exhibit B. ISG will provide assistance as the Named Insured and /or Eligible Injured Person proceeds through their course of treatment. The Named Insured and/or Eligible Injured Person is advised that they, and their provider (if known) will be contacted by ISG within forty-eight (48) hours of referral to ISG to discuss their treatment plan. The Named Insured and/or Eligible Injured Person is provided with the toll-free number to call with any questions they may have regarding the precertification process. Carrier then transfers the loss information to ISG within one (1) business day so that they can begin the precertification process.

Within forty-eight (48) hours, initial contact is made by the Nurse Case Manager at ISG with the Named Insured and/or Eligible Injured Person or their attorney, if represented, and the provider if known. A toll-free number, designated per Liberty Mutual Agency Corporation (LMAC) is available. Nurse Case Managers are available between 9:00 a.m. and 5:30 p.m. Eastern Time every business day, excepting Holidays.

The Customer Service Call Center Staff is available twenty-four (24) hours a day for the Named Insured and/or Eligible Injured Person or attorney if represented, and their provider to call with any questions pertaining to the medical expense payment portion of the claim, during telephone consultations with a Nurse Case Manager an attempt is made by ISG to:

- Establish a detailed account of the injury without duplicating the information electronically transferred by the Carrier
- Identify medical providers currently active on the case
- Provide educational assistance in regard to the Decision Point Review Plan / Precertification

Each person will have a Nurse Case Manager assigned to his/her case who can answer medical or billing questions pertaining to the claim. For all other questions concerning their claim, the Named Insured and/or Eligible Injured Person should contact their claim representative. After this initial consultation, if the Named Insured and/or Eligible Injured Person or treating provider calls with a question about an existing New Jersey PIP claim as it pertains to medical expense benefits, a telephone prompt within the toll free number voicemail system [800-818-7610 offers them the option to be connected directly with the Nurse Case Manager at ISG.

During the initial telephone consultation, the Named Insured and/or Eligible Injured Person is also advised of the Liberty Mutual Agency Corporation (LMAC) designated providers for diagnostic tests; MRI, CT, CAT Scan, 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), 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 N.J.A.C. 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.

Carisk Imaging Group - Diagnostic testing
Optum – Durable Medical Equipment and Prescriptions

DIAGNOSTIC TESTING – Carisk Imaging Group (Atlantic) is a provider based organization that arranges for the provisions of Diagnostic Radiology Services through access to a panel of preferred providers. Atlantic is a full-service management services organization that provides network access, credentialing, compliance, utilization review and quality assurance. Currently there are 149 participants in the State of New Jersey.

DURABLE MEDICAL EQUIPMENT – Optum. offers a full-service program including arrangements for fittings, delivery, set-up and training. Its national network has over 4,500 providers of which 51 are in New Jersey. The Nurse Case Manager assists in this process by obtaining a prescription from the treating provider who notes specific items needed to aid the Named Insured and/or Eligible Injured Person in recovery. The Nurse Case Manager can make referrals to the DME vendor either over the telephone or electronically via their web site. If equipment is rented, the Nurse Case Manager follows the treatment plan to determine when the

Named Insured and/or Eligible Injured Person will no longer medically require the equipment. When no longer medically required, the supplying vendor will be notified to pick up the equipment.

PRESCRIPTIONS

Optum. offers multiple paths for prescription drug needs. There is access to a network of over 55,000 pharmacies nationwide of which 1,989 are in New Jersey. Their website offers a pharmacy locator service utilizing a city, state and zip code search or can also be reached via telephone. The Nurse Case Manager can make referrals to the prescription vendor either over the telephone or electronically via its web site. The Named Insured and/or Eligible Injured Person may also call a toll-free customer service help desk to find participating pharmacies in their geographic area. Mail order is also available.

PPO NETWORKS – These networks include providers in all specialties, hospitals, outpatient facilities, and urgent care centers throughout the entire State of New Jersey. The Nurse Case Manager can provide the Named Insured and/or Eligible Injured Person with 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 Named Insured and/or Eligible Injured Person. The PPO networks are provided as a service to those persons who do not have a preferred health care provider by giving a list of recommended providers from which they may select that they may select. Named Insured and/or Eligible Injured Person may contact ISG, Inc. to identify the providers in the network at 800-818-7610.

Upon request, the ISG nurse case manager, will provide the Named Insured and/or Eligible Injured Person with a current PPO Network list.

All bills for medical services will be received at the ISG office. For any questions regarding billing, you should call ISG at 800-818-7610 and the follow the prompts accordingly The bills will be scanned into the document management system and entered into the Bill Review system. They will then be matched against the information entered into the system by the Nurse Case Manager and any medical necessity reviews entered by a Physician Advisor. The bills will be processed for payment if they match treatment authorized as indicated in the system. If any information differs, including diagnosis, CPT coding and services rendered, the bills will be referred to the Nurse Case Manager for utilization review.

Any bills for services recommended as medically necessary by utilization review will be processed for payment and sent to Liberty Mutual Agency Corporation (LMAC) for any applicable deductible and/or co-payments. A denial by a Nurse Case Manager would warrant referral to a Physician Advisor for medical necessity review. The results of the Physician Advisor's decision will be noted on the Explanation of Benefits. In addition, any issue related to bill payment, bill processing, Decision Point Review Request or Pre-certification request may be submitted to the Internal Appeal Process, prior to filing a formal dispute.

Under Liberty Mutual Agency Corporation's (LMAC) Assignment of Benefits conditions, a provider who has accepted an assignment of benefits is required to utilize the Internal Appeals Process for these issues, prior to filing a demand for alternative dispute resolution.

ASSIGNMENT OF BENEFITS

Medical expense benefits may be paid at our option to the person or organization furnishing the products or services for which such benefits are due. These benefits shall not be assignable except to providers of service benefits. Any such assignment is not enforceable unless the provider of service benefits agrees to be subject to the requirements of our Decision Point Review Plan.

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 Liberty Mutual Agency Corporation's (LMAC) Decision Point Review Plan, including pre-certification requirements,
(b) Comply with the terms and conditions of the Liberty Mutual Agency Corporation's (LMAC) policy
(c) Provide complete and legible medical records or other pertinent information when requested by us,
(d) Utilize 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 Pre-certification request,
(e) Submit disputes to alternative dispute resolution pursuant to N.J.A.C. 11:3
(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 Liberty Mutual Agency Corporation's (LMAC) 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 Liberty Mutual Agency Corporation (LMAC) for any reduction of payment for services caused by the provider's failure to comply with the terms of the insured's policy.

3 Level Review Process

1 . First Level/The Clinical Review - The title of the person performing first level clinical reviews is the Nurse Case Manager. The State of New Jersey Board of Nursing licenses all persons in the Nurse Case Manager position as either a Registered Nurse or Licensed Practical Nurse.

In the first level of review, the Nurse Case Manager will review all diagnosis codes, Current Procedural Terminology (CPT), Current Dental Terminology (CDT), DSM IV codes, or HCPCS codes against the treatment and testing recommendations.

Medical documentation will be reviewed on an ongoing basis. Required medical documentation from the treating provider must include documented results of the initial and subsequent evaluations to include an assessment of any current and/or historical subjective complaints, observations, objective findings, neurologic indications, and physical tests. All previously performed tests that relate to the injury and their subsequent

results must be submitted in writing.

Anticipated discharge will be reviewed to verify the established treatment date. If discharge has been extended and/or an additional request for services has been made, any additional medical information needed to complete the review will be requested within two (2) business days. If the Nurse Case Manager approves the requests, the system will be documented. Precertification authorization letters will be sent to Eligible Injured Person/Provider and attorney if noted on file the next business day. The Nurse Case Manager may request additional documentation when the attending provider's submitted documentation is illegible. If the Nurse Case Manager cannot render a decision that results in certification of the services requested, based on the documentation requested and submitted by the attending provider, the file will be routed to a Physician Advisor to review for medical necessity. The Physician Advisor will perform a Healthcare Provider Review/ Second Level Clinical Review

2. Healthcare Provider Review/ Second Level Clinical Review - Healthcare Provider Review/ Second Level Clinical Review are conducted only by healthcare providers (As defined in N.J.A.C. 11:3-4.2) who hold a current non-restricted license to practice medicine or other healthcare professions in the state of New Jersey and are currently in active practice in New Jersey.

The Nurse Case Managers who review cases where documentation is considered to be complete, are required to refer any case that does not meet the clinical criteria to certify a treatment request to a Physician Advisor for review. The attending provider is notified of this at the time of intake. The Nurse Case Manager electronically submits a case information sheet to the Physician Advisor for assessment and medical determination. If additional documentation including: initial and subsequent evaluations to include an assessment of any current and/or historical subjective complaints, observations, objective findings, neurological indications, and physical tests are available, this is also submitted for review.
The Physician Advisor may:

a. Recommend that the clinical documentation submitted by the attending provider support the treatment request as medically necessary.
b. Recommend that the clinical documentation submitted by the attending provider does not support the treatment request as medically necessary and render an adverse determination.
c. Recommend that the clinical documentation submitted by the attending provider supports a modified treatment/partial certification request as medically necessary.

The Physician Advisor may make an attempt to contact the attending physician prior to making his/her recommendation.

Should the Physician Advisor render an adverse decision, the appropriate adverse decision notifications are processed and directed to the provider, injured party and attorney if applicable.

The Physician Advisor will complete the Healthcare Provider Review/ Second Level Clinical Review. If services are recommended as medically necessary, the Utilization Review/Bill Review System will be documented and letters to the injured party, provider and attorney if applicable, and will be sent the next business day. If services are recommended as not medically necessary, the provider will be notified of the right to appeal the decision. A letter confirming the decision will be sent to the provider the next business day with an attachment describing the appeal process.

If a Decision Point Review request or a request to pre-certify any medical treatment, tests, durable medical equipment or prescriptions drugs is recommended as not medically necessary or modified/partial certification, you are entitled to seek an appeal of such decision. To access the Internal Appeals Process you must comply with the following.

INTERNAL APPEALS PROCESS

Pre-Service Appeal:

Each issue shall be required to receive an internal appeal review by the insurer prior to making a request for Alternative Dispute Resolution.

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. ISG 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 on the State Mandated Pre-Service Appeal Form 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 ISG via fax to 1-855-450-2676.

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. ISG must be notified of a post service appeal at least 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 (*) 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 inclusive on the State Mandated Post-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 ISG via fax 1-855-450-2676 or Liberty Mutual Agency Corporation (LMAC) at PO Box 5014 Scranton, PA 18505-5014.
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.

A Standard Healthcare Provider Clinical Review Appeal (Third Level Review) will be conducted within fourteen (14) calendar days.

The Physician Advisor is available through ISG via the Nurse Case Manager by telephone at 800-818-7610 between 9:00 a.m. and 5:30 p.m. Eastern Time every business day.

3. Healthcare Provider Clinical Review Appeal (Third Level Review): Healthcare Provider Clinical Review Appeal (Third Level Review) clinical reviews are conducted only by healthcare providers (as defined in N.J.A.C. 11:3-4.2) who hold a current non-restricted licenses to practice medicine or other healthcare professions in the state of New Jersey and are currently in active practice in New Jersey. The physicians who perform the medical reviews at this level will also be credentialed and certified in accordance with the requirements of the State of New Jersey A provider filing an appeal has thirty (30) calendar days from the date he/she is notified of the adverse decision. If an appeal is received after thirty (30) calendar days, it will not be considered. If an appeal is not submitted as required in the Pre-Service Appeal and Post-Service Appeal sections of this Plan, it will not be considered. A Pre-Service appeal must be communicated by facsimile as designated by the carrier 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. A Post- Service appeal must be communicated by facsimile as designated by the carrier in writing with supporting documentation and reasons for the appeal.

Should a physician review be necessary, a specialist will be selected to perform this appeal who is medically qualified by certification, practice and training to deal specifically with the clinical issue under review.

Either party can appeal to an Alternate Dispute Resolution Organization as provided for in N.J.A.C. 11:3-5 if the issue cannot be resolved through the Internal Appeals Process. Under Liberty Mutual Agency Corporation (LMAC) Assignment of Benefits conditions, a provider who has accepted an assignment of benefits is required to utilize the Internal Appeals Process for these issues, prior to filing a demand for alternative dispute resolution.

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.

EXHIBIT B

Services and Procedures rendered for injuries not included in the Care Paths which are subject to pre-certification:

- 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 prosthestics with a costing 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;
- Cat 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;