HANOVER DECISION POINT REVIEW/PRE-CERTIFICATION PLAN BROCHURE

Introduction

We strive to process claims for medically necessary medical treatment and testing in a quick and fair manner.

Under the terms of the Hanover Insurance Company policy, when an accident causing injury occurs, the insured is required to notify Hanover Insurance Company and provide information regarding the facts of the accident, the nature and cause of the injury, the diagnosis and anticipated course of treatment. This information is required to be provided promptly after the accident and periodically thereafter.

Please read this brochure carefully as it explains how your medical claim will be processed, including Decision Point Review and Pre-certification requirements which you and your medical provider must follow. If you have any questions, please call your Claim Representative at 1-800-628-0250.

DECISION POINT REVIEW AND PRE-CERTIFICATION REQUIREMENTS

Under the provisions of your policy and New Jersey regulations, Decision Point Reviews and/or Pre-certification of specified medical treatment and testing is required, for medically necessary expenses to be fully reimbursable under the policy. The information in this brochure will provide an overview of Pre-certification and Decision Point requirements. Please read your policy, policy terms and conditions for the actual Pre-certification and Decision Point requirements.

What is a Decision Point Review?
The New Jersey Department of Banking and Insurance has published standard courses of treatment for soft tissue injuries of the neck and back. These are called Care Paths and provide your medical provider with general guidelines for treatment and diagnostic testing. The Care Paths include requirements that your medical provider consult with us at certain stages in your treatment. These are called Decision Point Reviews.

In addition, the administration of any test listed in N.J.A.C. 11:3-4.5(b)1-10 also requires Decision Point Review, regardless of the diagnosis. The *Care Paths* and accompanying rules are available on the internet at the Department's website at www.state.nj.us/dobi/pipinfo/aicrapg.htm, or by contacting Consolidated Services Group, Inc., (CSG) at 877-258-CERT (2378), a company contracted to provide Utilization Review on behalf of The Hanover Insurance Company.

What is Pre-certification?
Pre-certification is required for injuries not included in the Care Paths described above. Pre-certification means that a medical professional will review the treatment plan submitted by your medical provider to make sure that you are receiving the appropriate level of medical care for your injuries. This does not mean that you need to obtain our approval before consulting your medical provider when you are injured. Your medical provider, however, is required to submit a treatment plan and/or request approval for specified treatment and diagnostic testing outlined in your policy.

Services that require pre-certification are listed on Exhibit B.

Pursuant to N.J.A.C. 11:3-4.5, the following tests are prohibited under any circumstances:

- Spinal diagnostic ultrasound
- Iridology
- Reflexology
- Surrogate arm mentoring
- Surface electromyography (surface EMG)
- Mandibular tracking and stimulation
- X-ray digitization and/or computer assisted radiographic mensuration
- Any other diagnostic test that is determined by New Jersey law or regulation to be ineligible for personal injury protection coverage

Pursuant to N.J.A.C. 11:3-4.5(f) and 13:30-8.22(b), Hanover will not provide reimbursement for the following diagnostic tests which have been identified by the New Jersey State Board of Dentistry as failing to yield data of sufficient volume to alter or influence the diagnosis or treatment plan employed to treat temporomandibular joint disorder (TMJ/D):

- Mandibular tracking
- Surface EMG
- Sonography
- Doppler ultrasound
- Needle EMG
- Electroencephalogram ("EEG")
- Thermograms/thermographs
- Videofluoroscopy
- Reflexology

Hanover will also not provide reimbursement for the following:

- Laboratory testing services from any entity that is not certified by the Department of Health and Human Services ("HHS").

- Prescription medications, drugs and biologicals that are not approved by the USFDA.

- Compound prescription medications, drugs and/or biologicals that, as compounded, are not approved by the USFDA, including but not limited to, compounds that may have in their formulary one or more medications, drugs and/or biologicals individually approved by the USFDA.

What do I need to do to comply with the Decision Point Review and Pre-certification requirements in my policy?

Please provide the name, address and phone number of your medical providers. You should also give your medical provider a copy of the Injury Notification Information on the back of your insurance card.

How do I know what type of treatment needs a Decision Point Review or Pre-certification?

In accordance with N.J.A.C. 11:3-4.7(c) 3, a copy of the informational materials for policy holders, injured persons and providers approved by the New Jersey Department of Banking and Insurance, is available through our website at www.hanover.com, and CSGs website at www.csg-inc.net/njauto.
Treatment in the first 10 days after an accident and emergency care do not require Decision Point Review or Pre-certification. However, for benefits to be paid in full, all treatment must be medically necessary and causally related to the accident.

How does the Decision Point Review/Pre-certification process work?
Your medical provider is responsible to supply treatment/Decision Point information and request pre-certification of treatment and diagnostic testing in accordance with the requirements of your policy. It is encouraged that your medical provider provide a detailed treatment plan, whenever possible, so that your treatment will not be interrupted.

In order for CSG to complete the review, your health care provider is required to submit all requests on the "Attending Provider Treatment Plan" form. A copy of this form can be found at the Department's website www.state.nj.us/dobi/pipinfo/aicrapg.htm or through CSG's website www.csg-inc.net/njauto or by contacting CSG at (877) 258-CERT (2378).

When a Decision Point Review or Pre-certification request is received from your medical provider, along with the appropriate medical documentation, your provider will be notified within three (3) business days whether or not our medical professional agrees with the treatment plan submitted. If your medical provider is not notified within three business days, they may continue your test or course of treatment until a final determination is communicated to him. Any decision to deny a decision point review or pre-certification request based on medical necessity will be the determination of a physician or peer reviewer.

If you would like to have the decision reconsidered, you are encouraged to participate in CSG's internal review process. If you have taken on an assignment of benefits you may be required to participate in this process. To notify CSG of your intention to participate in the reconsideration process, you can contact them by phone at (877) 258-CERT (2378), via fax at (856) 910-2501, or in writing at 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619. Your reconsideration decision will be provided to you within fourteen (14) days of your request. This process will afford you the opportunity to discuss your appeal with a "similar discipline" Medical Director or request an independent examination scheduled by CSG.

If the request is denied, with your medical provider's treatment plan, you will be required to attend an Independent Medical Examination.

If an Independent Medical Examination is requested, treatment may proceed while the exam is being scheduled and until the results are available.

How does my Medical Provider request a Decision Point Review or Pre-certification?
In order for CSG to complete the review, your health care provider is required to submit all requests on the "Attending Physicians Treatment Plan" form. A copy of this form can be found on the DOBI web sitewww.state.nj.us/dobi/pipinfo/aicrapg.htm, CSG's web site www.csg-inc.net/NJAuto or by contacting CSG at (877) 258-CERT (2378).

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

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

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

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

1. A calendar and business day both end at the time of the close of business hours (7:00 PM EST Monday through Friday (excluding legal holidays).

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

3. Example: Response to a properly submitted provider request is due back no later than 3 business days from the date CSG receives the submission. CSG receives an Attending Provider Treatment Plan Form by facsimile transmission dated 1:00 PM EST on Wednesday February 6, 2013. Day one of the 3-buisness day period is Thursday, February 7, 2013. Since the 3rd day would be Saturday, February 9, 2013, CSG's decision is due no later than close of business Monday, February 11, 2013.

CSG Hours of Operation – 7:00 AM to 7:00 PM EST Monday through Friday (excluding legal holidays)

What happens if my medical provider does not request a Decision Point Review or Pre-certification of medical treatment, as required in my policy?

If your medical provider does not submit requests for decision point review or pre-certification as required by your policy, or your medical provider does not submit clinically supported findings that support the request, your expenses for medically necessary treatment, testing and durable medical equipment will be subject to an additional co-payment of 50%. Treatment which is not medically necessary is not reimbursable.

Can my medical provider appeal the Decision Point Review or Pre-certification decision?

If CSG fails to certify a request, the clinical rationale for this determination is available to you upon written request. If you would like to have the decision reconsidered, you are encouraged to participate in CSG's internal appeals process. If you have taken on an assignment of benefits you will be required to participate in this process.

Prior to making a request for alternate dispute resolution, all appeals must be initiated using the forms established by the NJ Department of Banking and Insurance. All forms must be fully completed and include the minimum associated documents required. Failure to follow these requirements will be considered an incomplete submission and will result in an administrative denial. This incomplete submission does not constitute acceptance within the required timeframes for Pre-service or Post-service appeals.

Failure to utilize the Internal Appeals procedures as outlined in 11:3-4.7B on the forms established by the

Department prior to filing arbitration or litigation will invalidate any assignment of benefits.

There are two types of appeals (with specific workflows) that can be considered:

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

The Pre-service appeal form and any supporting documentation shall be submitted by the provider to CSG via fax @ (856) 910-2501 or in writing @ 300 American Metro Blvd, Suite 170, Hamilton, NJ 08619.

A Pre-service appeal shall be submitted no later than 30 days after receipt of a written denial or modification of requested services.

Decisions on pre-service appeals shall be issued by the insured or its designated vendor to the provider who submitted the appeal no later than 14 days after receipt of the pre-service appeal form and any supporting documentation. If it's determined that the new information submitted with the appeal requires the need of an expert report or addendum to an expert report(i.e.: Peer Review, Independent Medical Exam, Medical Director Review, etc....) to properly respond to the appeal, an additional 10 days will be added to the response time requirement.

Post-service: an appeal subsequent to the performance or issuance of the services and/or what should be reimbursed.

The Post-service appeal form and any supporting documentation shall be submitted by the provider to CSG via fax @ (856) 910-2501 or in writing @ 300 American Metro Blvd, Suite 170, Hamilton, NJ 08619.

A Post-service appeal shall be submitted at least 45 days prior to initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5 or filing an action in Superior Court.

Decisions on post-service appeals shall be issued by the insured or its designated vendor to the provider who submitted the appeal no later than 30 days after receipt of the appeal form and any supporting documentation. If it's determined that the new information submitted with the appeal requires the need of an expert report or addendum to an expert report(i.e.: Peer Review, Independent Medical Exam, Medical Director Review, etc....) to properly respond to the appeal, an additional 10 days will be added to the response time requirement.

The appeal process described above provides only one-level of appeal prior to submitting the dispute to alternate dispute resolution. A provider cannot submit a pre-service appeal and then a post-service appeal on the same issue. The preapproval of the treatment and the reimbursement for that treatment are separate issues. A provider can submit a pre-service appeal for the treatment and then a post-service appeal for the reimbursement for that treatment.

If a claimant or provider retains counsel to represent them during the Internal Appeal Procedures, they do so strictly at their own expense. No reimbursement will be issued for counsel fees or any other costs, regardless of the outcome of the appeal.

If you have any questions regarding medical services which have been denied or certified, you can contact CSG via fax at (856) 910-2501, or in writing at 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619. You can also contact your Hanover Claim Representative at 1-800-628-0250.

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

If the need arises for you to attend an Independent Medical Exam during the decision point review/pre-certification process, you and your treating provider will receive prior notification. The exam will be:

- Scheduled within seven (7) days of receipt of the request unless you agree with us to extend the time period;
- Conducted by a provider in the same discipline as your treating provider;
- And conducted at a location reasonably convenient to you.

You may be requested to provide medical records and other pertinent information to the examining physician at or before the examination. The failure to provide requested medical records or other pertinent information at or before the exam will be considered an unexcused failure to attend the exam and the exam will not take place. You will be notified of the decision within three (3) business days after attendance at the exam. If the examining provider prepares a written report concerning the examination, you or your treating provider will be provided with a copy upon request. Treatment may proceed while the examination is being scheduled and until the results become available.

If you have two (2) or more unexcused failures to attend the scheduled exam, notification will be immediately sent to you, and all health care providers treating you for the diagnosis (and related diagnosis) contained in the attending physicians treatment plan form. The notification will place you on notice that all future treatment, diagnostic testing or durable medical equipment required for the diagnosis (and related diagnosis) contained in the attending provider treatment plan form will not be reimbursable as a consequence for failure to comply with the plan.

Voluntary Networks

Does the plan provide voluntary networks for certain services, tests or equipment?

Hanover Insurance Company does not provide a network of primary health care providers. Your primary medical provider is selected by you. Your policy does, however, encourage you to obtain certain services and/or supplies from networks of pre-approved vendors. The networks currently available include Ambulatory Surgical Care, Prescription Drugs, Durable Medical Equipment with a cost or monthly rental greater than $50, Diagnostic Imaging (MRI and CAT scans), and the Electro-diagnostic tests listed in N.J.A.C. 11:3-4.5(b)1 through 3, except when performed by the treating physician . If you obtain medically necessary services and/or supplies from a pre-approved vendor from one of these networks, you will be fully reimbursed for those services and/or supplies consistent with the terms of your policy and the N.J. Medical fee Schedule. If you choose to use a vendor that is not part of these pre-approved networks, a 30% co-payment ($10 for prescription drugs) will apply to the eligible charges. For additional information, contact The Hanover Insurance Company claim representative at 1-800-628-0250. **There is no co-payment penalty to the injured party when an eligible injured person voluntarily uses a provider from the following networks:**

Progressive Medical, LLC DBA Optum for prescription drugs and DME with a cost or monthly rental over $50 888-764-4844

Horizon Casualty Service for Ambulatory Surgical Care: 800-985-7777

Horizon Casualty Service, Inc provides access to the following in network diagnostic Centers. Appointments should be scheduled through:

Raytel: 800-453-0574 Monday- Friday 7:30AM to 7:30PM EST

One Call Medical: 800-872-2875 or 800-418-5058 Monday – Friday 8:00AM – 8:00PM EST

DEDUCTIBLES AND CO-PAYMENTS

What is my deductible?
Unless otherwise indicated on the declarations page of the policy, medical expense benefits are subject to a $250 deductible per accident.

What is my co-payment?
All other Medical Services - 20% per injured party up to $5,000

Are there any other co-payments?
If the Decision Point Review or Pre-certification **requirements** in your policy are **not met**, including failure to submit requests for decision point review or pre-certification or failure to provide clinically supported findings that support the request, your expenses for medically necessary treatment and testing will be subject to an **additional** co-payment of 50%. Treatment, which is not medically necessary, is **not** reimbursable.

If you do not promptly inform us about the facts of the accident, the nature and cause of injury, the diagnosis, and anticipated course of treatment, an additional co-payment penalty may apply as follows:

- A co-payment of 25% if the information is received 30 or more business days after the accident; or
- A co-payment of 50% if the information is received 60 or more business days after the accident.

ASSIGNMENT OF BENEFITS

Can I assign my benefits?
Yes, but only to a provider of service benefits. Please read the Assignment of PIP Benefits section in your policy carefully. All assignments are subject to all requirements, duties and conditions of the policy, including but not limited to Pre-certification, Decision Point Reviews, exclusions, deductibles, co-payments and duties of cooperation. In addition, if your provider takes an assignment of benefits, your provider is required to hold you harmless for any penalty imposed by us for your provider's failure to adhere to the requirements of our Decision Point Review Plan.