The Personal Injury Protection (PIP) component of the auto policy provides coverage for medical expenses arising from motor vehicle accidents, adhering to specified policy limits, deductibles, co-payments, and medical fee schedules. To qualify for payment, medical expenses must be reasonable, medically necessary, and directly related to the accident. GEICO General Insurance Company has appointed Prizm, LLC to manage claims under the Automobile Cost Reduction Act of 1998, which includes treatment plan reviews, medical bill audits, and case management services. Medical services performed without prior notification to GEICO or Prizm may incur penalties, although care provided within the first 10 days post-accident or during emergencies is exempt from pre-certification, provided it meets payment criteria. Providers must submit a Conditional Assignment of Benefits to receive direct payment for their services.

All documentation related to Decision Point Review and pre-certification should be directed to Prizm, LLC, while other correspondence is to be sent to GEICO. Treatment plan requests must include a completed "Attending Provider Treatment Plan" form along with supporting medical documentation, which can be submitted via fax, mail, or email. The Decision Point Review process assesses treatment plans based on established Care Paths for soft tissue injuries, and certain diagnostic tests require pre-certification to avoid penalties. Prizm, LLC will make decisions on treatment requests within three business days, with the timeframe extending if additional information is required. Failure to provide necessary information may lead to administrative denial, and voluntary pre-certification is encouraged for smoother processing. Independent Medical Examinations may be requested by Prizm or GEICO, and non-attendance may result in non-reimbursement for future treatments.

Prizm maintains a network of approved vendors for various medical services, and utilizing these providers can waive certain co-payments. Non-compliance with pre-certification requirements may lead to additional co-payments. The Assignment of Benefits section stipulates that providers must comply with the Decision Point Review Plan, and any penalties incurred due to non-compliance will not be charged to the patient. Providers are also required to submit disputes through established

resolution processes and comply with GEICO's information requests. The Conditional Assignment of Benefits is the only valid assignment recognized by GEICO, which retains the right to reject, terminate, or revoke the assignment, potentially requiring GEICO's written consent.

The internal appeal process consists of Pre-Service and Post-Service Appeals. For a Pre-Service Appeal, addressing denials or modifications before services are performed, the policyholder must notify Prizm, LLC within thirty days of receiving a denial. The appeal must be submitted in writing using the New Jersey PIP Pre-Service Appeal Form, including all required fields and supporting documentation, and sent via fax or mail. Only providers with a valid Assignment of Benefits can file an appeal, and a decision will be issued within fourteen days of receipt. Post-Service Appeals, which occur after services have been rendered, must be submitted within ninety days of the decision being appealed and at least forty-five days before initiating alternative dispute resolution. Similar to Pre-Service Appeals, the New Jersey PIP Post-Service Appeal Form must be completed with supporting documents included, and a decision will be issued within thirty days of receipt. It is important to note that any dispute not submitted through the appeal process cannot be part of arbitration or litigation, and proof of a timely-filed appeal is required for alternative dispute resolution requests.

The policy also delineates obligations for providers, including adherence to pre-certification requirements and submission of complete medical records. Providers must hold patients harmless for any co-payment penalties resulting from non-compliance with the outlined requirements. The assignment of benefits is contingent upon GEICO's consent, and the insurer retains the right to reject or revoke the assignment.