This document details the Decision Point Review and Pre-Certification requirements for medical claims under the GEICO automobile insurance policy, specifically regarding Personal Injury Protection (PIP) coverage. In the event of an automobile accident, it is essential to report the incident immediately by contacting GEICO at 1-800-841-3000, available 24/7. The Decision Point Review assesses the necessity of medical treatments and tests, while Pre-Certification ensures that specific services, tests, or equipment are medically necessary. Both processes are critical for maximizing benefits under PIP coverage. The insured and their medical provider must promptly provide detailed information about the accident, injuries, and treatment plans; delays can result in penalty co-payments of up to 25% if information is submitted after 30 days, or 50% after 60 days. Treatments within the first 10 days post-accident and emergency care are exempt from these reviews but must still be medically necessary. For providers to receive direct payment, they must submit a Conditional Assignment of Benefits.

Certain treatments, including outpatient psychological services, home health care, and durable medical equipment over $100, require Pre-Certification, with requests submitted using the "Attending Physician’s Treatment Plan" form, and reviews completed within three business days. If a Pre-Certification request is denied, the healthcare provider can appeal through a reconsideration process. The policy includes a voluntary utilization program for specific services that can waive co-payments if pre-approved networks are utilized. Non-compliance with Decision Point Review or Pre-Certification requirements can lead to significant co-payments, including a 50% penalty for non-compliance.

The policy outlines coverage for medical expenses under PIP, subject to limits, deductibles, co-payments, and medical fee schedules, covering only services deemed medically necessary and related to a motor vehicle accident. A 30% co-payment applies for services from non-network providers, in addition to any deductible or co-payment. Providers must comply with the Decision Point Review Plan and pre-certification requirements; failure to do so prevents them from seeking

payment from the insured for any incurred co-payment penalties. Disputes must be submitted to the Internal Dispute Resolution Process, and complete medical records must support claims. Compliance with requests for examinations under oath and other documentation from GEICO is also mandated.

The Decision Point Review and Pre-Certification process requires pre-authorization for certain treatments and diagnostic tests, with penalties for non-compliance. Medical care rendered within the first 10 days post-accident or during emergencies is exempt from pre-certification. Premier Prizm Solutions, LLC manages treatment plan requests and medical bill audits. If a treatment plan is not approved within three business days, providers may proceed with necessary treatment. The policy specifies that certain diagnostic tests and non-emergency services require pre-certification, and failure to obtain this may result in penalties.

The policy emphasizes the importance of utilizing approved networks for diagnostic imaging and durable medical equipment to avoid co-payments. If a provider does not receive sufficient medical information for a treatment request, an administrative denial will occur until the information is provided. The Internal Appeal Process must be followed before arbitration for any decisions made regarding claims. The document warns against filing false claims, which may lead to criminal and civil penalties.

The policy outlines the requirements and penalties associated with treatment requests, specifically regarding Decision Point Review and Pre-Certification processes. Failure to submit these requests or clinically supported findings incurs a 50% co-payment penalty, in addition to any applicable deductible or co-payment. If services are obtained from a network provider, a 30% co-payment applies for medically necessary treatments, tests, and equipment, while non-medically necessary treatments are not reimbursable. Policyholders must comply with all procedures of the Decision Point Review Plan and initiate required requests; non-compliance may void prior assignments of

benefits and result in the provider seeking payment from the patient. Disputes must be submitted to the Internal Dispute Resolution Process, and if unresolved, can escalate to the Personal Injury Protection Dispute Resolution Process. Providers must submit complete medical records and comply with requests from GEICO, including examinations under oath. The Conditional Assignment of Benefits is the only valid assignment, and GEICO reserves the right to revoke it. Appeals regarding treatment requests must be submitted to Premier Prizm within 10 business days of the decision, including the treating provider's signature and supporting documentation. If necessary, an Independent Medical Examination will be scheduled within seven days of the appeal request. For appeals unrelated to treatment requests, providers must submit a written request to Premier Prizm, which will respond within 10 business days. All disputes not resolved through the Internal Appeals process must be submitted to GEICO via certified mail. The policy emphasizes that providers retain counsel at their own expense and must hold GEICO harmless for any legal fees incurred during disputes.