This insurance policy document details the procedures and requirements for managing medical claims under Personal Injury Protection (PIP) coverage following an automobile accident. Insured individuals are required to promptly notify GEICO of their injury and claim, providing essential details about the accident, injury, diagnosis, and treatment plan. Late submissions may incur a penalty co-payment of up to 50%. GEICO has designated Auto Injury Solutions (AIS) to oversee various claims processes, including treatment plan reviews and medical bill audits. Certain treatments for soft tissue injuries, termed Identified Injuries, are subject to Decision Point Review, necessitating healthcare providers to submit information at specified intervals to evaluate the necessity of ongoing treatment. Emergency treatments within the first ten days post-accident are exempt from this review, but only medically necessary services will be reimbursed. A list of diagnostic tests requiring prior authorization is included, and failure to obtain necessary approvals may also lead to a 50% co-payment penalty, even if the services are later deemed necessary.

Mandatory precertification is required for various non-emergency medical services, including inpatient care, surgical procedures, and certain therapies, while voluntary precertification is encouraged to streamline the approval process for reimbursement. Requests for Decision Point Review and precertification must include appropriate clinical documentation, which AIS will review within three business days. All treatments must be medically necessary to qualify for full reimbursement, and healthcare providers are obligated to support all requests with thorough clinical findings. The policy outlines the procedures for obtaining treatment, diagnostic testing, and durable medical equipment through a Decision Point Review/Precertification process, with approval based solely on medical necessity. An Authorization for Precertification Treatment Plan (APTP) must accompany every request; incomplete submissions cannot be processed. The insurer will inform providers of any additional documentation needed, and failure to provide required information will result in an administrative denial. The insurer will determine requests within three business days of receiving complete documentation, and if no response is given, treatment may proceed, but only medically necessary services related to the accident will be reimbursed.

Approved treatments are valid only for the specified dates in the determination letter, and services rendered after this period without following proper procedures will incur a 50% penalty co-payment, regardless of medical necessity. Independent Medical Examinations (IMEs) may be requested, and the insured must attend these examinations, providing necessary medical records and identification; failure to attend without proper notice may affect future reimbursements. The policy encourages using pre-approved vendors for services to ensure full reimbursement for medically necessary goods, while reimbursement for non-network vendors is limited to 70% of the lesser of the vendor's charge or the usual and customary fee. Penalty co-payments apply for failure to pre-certify treatment or for using non-network providers, which will be applied before any deductible or co-payment.

Assignment of benefits to healthcare providers is restricted and requires compliance with the insurer's review plan and other conditions. Providers must initiate an internal appeals process for disputes regarding payment or treatment decisions within 14 days of an adverse decision, including the basis for the appeal and supporting medical criteria; failure to comply may nullify the assignment of benefits. The policy outlines procedures for appealing adverse medical determinations related to PIP benefits, requiring written appeals within fourteen calendar days of the adverse determination, with late submissions not considered. An Expedited Appeal can be processed within three business days, with the Nurse Case Manager determining the necessary level of appeal. Additional documentation may be requested, and resubmission of identical information from the initial request is not accepted. Appeals must be sent to AIS via certified mail or fax, with proof of receipt required upon GEICO's request. A final decision will be communicated within fourteen calendar days after receiving a properly submitted appeal or within three business days after an IME, if applicable.

For a Second Level Appeal, healthcare providers have fourteen calendar days from notification of the first-level decision to submit their appeal, which must include supporting documentation and reasons for the appeal. Similar submission rules apply as in the first level, and no more than two

appeal requests will be considered. If the insured or healthcare provider retains legal counsel during the appeal process, they do so at their own expense, with no compensation for counsel fees. In disputes regarding the Decision Point Review/Precertification Plan or claims for benefits, requests for resolution can be made by the insured, GEICO, or a treating healthcare provider with a valid Assignment of Benefits. Disputes must be resolved through a dispute resolution organization as per New Jersey law, and healthcare providers must comply with the internal appeal process before filing any claims. The policy includes a Conditional Assignment of Benefits, allowing GEICO to pay medical providers directly for services rendered, contingent upon compliance with the plan's requirements. Providers must submit all necessary documentation and comply with requests from GEICO, agreeing to hold patients harmless for any co-payment penalties resulting from non-compliance. The assignment of benefits may require GEICO's written consent and can be revoked at their discretion.