IMPORTANT NOTICE

INTRODUCTION

At GEICO, we understand that when you purchase an automobile insurance policy, you are buying protection and peace of mind in the event you are injured in an accident. It is, therefore, important to you that GEICO provide you first rate claims service. Our goal is to process claims for medically necessary treatment and testing quickly and fairly.

This document explains how your medical claims will be handled, including the Decision Point Review/Pre-certification requirements which you and your medical provider must follow in order to receive the maximum benefits provided by your policy. Please read this document carefully.

If you (or anyone else making a claim under your policy) are injured in an automobile accident, please contact us immediately to report the loss. You can reach us 24 hours a day, seven days a week at 1-800-841-3000.

Your Personal Injury Protection (PIP) examiner will contact you to discuss your injuries and obtain the names of any medical providers you may be treating with. Your PIP examiner will also send you a No Fault application for you to complete.

Pursuant to N.J.A.C. 11:3-4.4, the insured and the injured party or their medical provider must provide us with information regarding the facts of the accident, nature and cause of the injury, the diagnosis and the anticipated course of treatment. This must be provided to us as promptly as possible after the accident and periodically thereafter. Failure to provide this required information can result in a penalty co-payment of up to 25% if received after 30 calendar days from the accident or up to 50% if received 60 calendar days or more after the accident.

DECISION POINT REVIEW AND PRE-CERTIFICATION REQUIREMENTS

Please note: Under the provisions of your policy and applicable New Jersey regulations, Decision Point Reviews and/or Pre-certification of specified medical treatment and testing is required in order for medically necessary expenses to be fully reimbursable under the terms of your policy. The following questions and answers only provide an overview of Decision Point Reviews and Pre-certification requirements. You should read your policy for the actual Pre-certification requirements as well as other policy terms and conditions.

Treatment in the first 10 calendar days after an accident and emergency care does not require Decision Point Review or Pre-certification. However, for benefits to be paid, the treatment must be reasonable, medically necessary, and related to the subject motor vehicle accident. In addition, in order for a provider to receive direct payment for rendering services to you, regardless of whether it is within or beyond the first 10 calendar days, the provider must submit to GEICO a fully executed Conditional Assignment of Benefits. This is true in all events.

Question: What is a Decision Point Review?

Answer: The New Jersey Department of Banking and Insurance (the "Department") has published standard courses of treatment, **Care Paths**, for soft tissue injuries of the neck and back, collectively referred to as the "Identified Injuries". These Care Paths provide your health care provider with general guidelines for treatment and diagnostic testing as to these injuries. In addition, the Care Paths require that treatment be evaluated at certain intervals called **Decision Points**. At Decision Points, your health care provider must provide us information about any further treatment or test required. This is called **Decision Point Review**. During the Decision Point Review process, all services requested are evaluated by medical professionals to ensure the level of care you are receiving is medically necessary for your injuries. This does not mean that you are required to obtain our approval before consulting your medical provider for your injuries. However, it does mean that your medical provider is required to follow the Decision Point Review requirements in order for you to receive maximum reimbursement under the policy. 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 http://www.state.nj.us/dobi/pipinfo/aicrapg.htm or can be obtained by contacting Prizm, LLC at 1-856-596-5600.

Question: What is Pre-certification?

Answer: Pre-certification is a medical review process for the specific services, tests or equipment listed below in (1)-(13). During this process all services, tests or equipment requested are evaluated by medical professionals to ensure the level of services, tests or equipment you are receiving are medically necessary for your injuries. This does not mean that you are required to obtain our approval before consulting your medical provider for your injuries. However, it does mean that your medical provider is required to follow the Pre-certification requirements in order for you to receive maximum reimbursement under the policy.

1. Non-emergency inpatient and outpatient hospital care

2. Non-emergency surgical procedures
3. Extended Care Rehabilitation Facilities
4. 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
5. Physical, Occupational, Speech, Cognitive, Rehabilitation or other restorative therapy or therapeutic or body part manipulation except as provided for identified injuries in accordance with Decision Point Review
6. Outpatient psychological/psychiatric treatment/testing or services
7. All pain management services except as provided for identified injuries in accordance with Decision Point Review
8. Home Health Care
9. Acupuncture
10. Durable Medical Equipment (including orthotics or prosthetics) with a cost or monthly rental in excess of $100.00, or rental in excess of 30 calendar days
11. Non-Emergency Dental Restorations
12. Temporomandibular disorder, any oral facial syndrome
13. Non-medical products, devices, services and activities, and associated supplies, not exclusively used for medical purposes or as durable medical goods, with an aggregate cost or monthly rental in excess of $100.00 or rental in excess of 30 calendar days, including but not limited to:
    (a) Vehicles;
    (b) Modification to vehicles;
    (c) Durable goods;
    (d) Furnishings;
    (e) Improvements or modifications to real or personal property;
    (f) Fixtures;
    (g) Spa/gym memberships;
    (h) Recreational activities and trips;
    (i) Leisure activities and trips.

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

Answer: Just provide us with the name(s) of your medical providers. We will then contact them to explain the entire process. You should also give your medical provider a copy of the *"Dear Doctor Letter"* (starting on page 8).

Question: How does the Decision Point Review/Pre-certification process work?

Answer: In order for Prizm, LLC to complete the review, your health care provider is required to submit all requests on the "Attending Physician's Treatment Plan" form in accordance with the state mandated form. A copy of this form can be found on the DOBI web site http://www.state.nj.us/dobi/pipinfo/aicrapg.htm. Prizm, LLC web site is www.Prizmllc.com or by contacting Prizm, LLC at 856-596-5600.

The health care provider should submit the completed form, along with a copy of their most recent/appropriate progress notes and the results of any tests relative to the requested services to Prizm, LLC via fax at 856-596-6300 or mail to the following address: Prizm,LLC, 10 East Stow Road, Suite 100, Marlton, NJ 08053, ATTN.: Pre-Certification Department. The phone number is 856-596-5600. 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. Business days is defined as Monday through Friday 8:00 AM to 5:00 PM EST excluding Federally Declared holidays or any time when our offices are closed due to a declared state of emergency. 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.

Prizm, LLC, may do one or more of the following as a result of the review:

a. Recommend authorization of reimbursement for the treatment, test, durable medical equipment, prescription medication; or
b. 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
c. Request additional documentation from the attending providers documentation when the submitted documentation is illegible; or
d. 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/Precertification request as per New Jersey Department of Banking and Insurance on the State mandated form. 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 Treatment Plan must be signed by the attending health care provider and dated; or
e. Recommend denial of reimbursement for the treatment, test, durable medical equipment, prescription medication where the information submitted is incomplete and/or fails to provide clinically supported findings to establish medical necessity. 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; or
f. Schedule a physical examination of the 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 medication.

INDEPENDENT MEDICAL EXAMS

Question: What are the requirements and consequences if I am requested to attend an Independent Medical Exam?
Answer: If the need arises for Prizm, LLC to utilize an independent medical exam during the decision point review/pre-certification process or internal appeals process described below, then the guidelines in accordance with New Jersey Regulations will be followed. This includes but is not limited to: prior notification to the injured person or his or her designee, scheduling the exam within seven calendar days of the receipt of the Attending Physician's Treatment Plan form (unless the injured person agrees to extend the time period), having the exam conducted by a provider in the same discipline, scheduling the exam at a location reasonably convenient to the injured person, and providing notification of the decision within three business days after attendance of the exam.

If the examining provider prepares a written report concerning the examination, you or your designee shall be entitled to a copy upon written request.

If you have two 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 Physician's 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 Physician's Treatment Plan form will not be reimbursable as a consequence for failure to comply with the plan.

If Prizm, LLC fails to respond to the Insured and/or Eligible Injured Person within three (3) business days after receiving the required notification and supporting medical documentation at a decision point, then the health care provider is permitted to continue the course of treatment until the required notice is provided.

INTERNAL APPEAL PROCESS Pre-Service Appeal

Question: Can my health care provider appeal the Decision Point Review or Pre-certification decision?

Answer: Yes, 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. Prizm, LLC 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 an Prizm, LLC 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 New Jersey PIP Pre-Service Appeal Form and all applicable fields 1-34 must be completed in order to be considered. If either the New Jersey PIP Pre-Service Appeal Form is not submitted or any applicable fields on the New Jersey PIP Pre-Service Appeal Form are not completed then the Appeal may be administratively denied. In addition, the original APTP form, APTP decision/response document, and appeal rationale narrative document must be included with the submission of the New Jersey PIP Pre-Service Appeal form or the Pre-Service appeal may be administratively denied.

4. Appeals must be submitted to Prizm, LLC by fax at 856-596-6300, or in writing at 10 East Stow Road, Suite 100, Marlton, NJ 08053.

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. All 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 appeals 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) calendar days after receipt of the New Jersey PIP 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 of the requirements listed below must be met:

1. A post-service appeal shall be submitted to the Prizm, LLC in writing within ninety (90) calendar days of the issuance of the decision that is being appealed and at least forty five (45) calendar days prior to initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5 or any other litigation against us. If a New Jersey PIP Post-Service appeal form is submitted outside of this period of time then it will be administratively denied.

2 The post-service appeal must be submitted on a New Jersey PIP Post-Service Appeal Form and all applicable

fields 1-38 shall be completed. If either the New Jersey PIP Post-Service Appeal Form is not submitted or the applicable fields on said form are not completed then the appeal may be administratively denied. In addition, the original bill (HCFA or UB), explanation of benefit/payment (EOB), and appeal rationale narrative document must be included with the submission of the New Jersey PIP Post-Service Appeal Form or the Post-Service Appeal may be administratively denied.

3. 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.

4. Appeals must be submitted to .Prizm, LLC, via fax at 856-596-6300 or in writing at 10 East Stow Road, Suite 100, Marlton, NJ 08053.

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 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. All 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 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) calendar days after receipt of the New Jersey PIP Post Service Appeal Form and any supporting documentation.

Any dispute which has not been submitted to the appeal process shall not be a valid part of any arbitration or litigation. Proof of a timely-filed appeal is required documentation when an Alternate Dispute Resolution demand is made.

VOLUNTARY UTILIZATION PROGRAM

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

Answer: In accordance with the regulations, the plan includes a voluntary utilization program for:

1. Magnetic Resonance Imagery;
2. Computer Assisted Tomography;
3. Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of $100.00, or rental in excess of 30 days;
4. Prescription Drugs;
5. The electrodiagnostic tests listed in N.J.A.C. (11:3-4.5(b) 1 through 3, unless performed in conjunction with a needle EMG by the treating provider.

Question: How do I gain access to one of these networks?

Answer: Prizm, LLC has established a network of approved vendors for diagnostic imaging studies for all MRI's and CAT Scans, durable medical equipment with a cost or monthly rental over $100.00, prescription drugs and all electrodiagnostic testing, listed in N.J.A.C. 11:3-4.5(b) 1-3, (unless performed in conjunction with a needle EMG by the treating provider). If the injured party utilizes one of the pre-approved networks, the 30% co-payment will be waived. If any of the electrodiagnostic tests listed in N.J.A.C. 11:3-4.5(b) are performed by the treating provider in conjunction with a needle EMG, the 30% co-payment will not apply. In cases of prescriptions, the $10.00 co-pay of GEICO will be waived if obtained from one of the pre-approved networks.

To secure a list of preferred provider networks for Diagnostic tests (MRI's and CAT Scans), Durable Medical Equipment, Prescription Drugs, and Electrodiagnostic Testing, please visit Prizm, LLC website @ www.Prizmllc.com, contact Prizm, LLC by phone at 856-596-5600, via fax at 856-596-6300, or in writing at 10 East Stow Road, Suite 100, Marlton, NJ 08053.

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PENALTY CO-PAYMENTS

Question: Why would payment of my bills for health care services, tests and durable medical equipment be subject to additional co-pay, and how much is it?

Answer: Failure of your health care provider to comply with the Decision Point Review/Pre-certification provisions of the plan, including failure to submit a request for Decision Point Review/Pre-certification or failure to provide clinically supported findings that corroborate a request, will result in a co-payment of 50% (in addition to any deductible or co-payment that applies under the policy) for medically necessary treatment and tests and equipment. Keep in mind that treatment which is not medically necessary is not reimbursable under the terms of the policy.

If you do not utilize a network provider/facility to obtain those services, tests or equipment listed in the voluntary utilization review program section, payment for those services rendered will result in a co-payment of 30% (in addition to any deductible or co-payment that applies under the policy) for medically necessary treatment, tests and equipment. Keep in mind that treatment which is not medically necessary is not reimbursable under the terms of the policy.

Any reduction shall be applied prior to any other deductible or co-payment requirement.

ASSIGNMENT OF BENEFITS

Question: Can I assign my benefits?

Answer: 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. As a condition of the assignment of benefits, a provider must agree to comply with all procedures of the Decision Point Review Plan. The provider must agree to all Pre-certification and Decision Point Review requests as required by the Plan. In the event the provider fails to comply with the conditions of the Plan, and such failure results in the imposition of a copayment penalty, the provider will hold you harmless for such co-payment penalty insofar as the provider will not seek payment from you for any unpaid portion of the medical services arising from such co-payment penalty. Additional conditions that also apply to the provider include:

a. Submission of disputes as defined in the Plan to the Internal Appeals Process set forth therein. After final determination, submission of disputes not resolved by the Internal Appeals Process to the Personal Injury Protection Dispute Resolution Process set forth in N.J.A.C. 11:3-5.

b. Submission of all disputes not subject to the Internal Appeals Process to the Personal Injury Protection Dispute Resolution Process set forth in N.J.A.C 11:3-5.

c. Submission of complete and legible medical records with clinically supported findings to support the diagnosis, the causal relationship to the motor vehicle accident and the care plan.

d. Compliance with a request by GEICO to (i.) Submit to an examination under oath, and (ii.) Provide GEICO with any other pertinent information/documentation requested.

e. Agreement not to pursue payment directly from the patient and to hold the patient harmless for any denial of coverage arising from the failure to comply with the conditions established by the Plan and under the Conditional Assignment of benefits. The conditional Assignment of benefits may be revoked by the assigned and the assigned shall be entitled to pursue payment from the patient, when benefits are not payable due to lack of coverage/or violation of a policy condition by the patient.

NO COVERAGE IS PROVIDED BY THIS DOCUMENT OR THE QUESTIONS AND ANSWERS CONTAINED IN IT. THIS DOCUMENT DOES NOT REPLACE ANY OF THE PROVISIONS OF YOUR POLICY. YOU SHOULD READ YOUR POLICY CAREFULLY FOR COMPLETE INFORMATION AS TO THE TERMS OF YOUR COVERAGE. IF THERE IS ANY CONFLICT BETWEEN THE POLICY AND THIS SUMMARY, THE PROVISIONS OF THE POLICY SHALL PREVAIL.

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

GEICO Indemnity Company
P. O. Box 986
Marlton, NJ 08053-0986

1-800-841-3000

GEICO
P.O. Box 9515
Fredericksburg, VA 22403-9515

Company Name:
Claim Number:
Loss Date:
Policyholder:
Prizm, LLC
Acct No.:
Injured
Party:

Dear Doctor:
Personal Injury Protection (PIP) is the portion of the auto policy that provides coverage for medical expenses. These medical expenses are subject to policy limits, deductibles, co-payments and any applicable medical fee schedules. Additionally, these medical expenses must be for services that are deemed reasonable, medically necessary and causally related to the motor vehicle accident. With the adoption of the Automobile Cost Reduction Act of 1998, several important changes have been made in the way a claim is processed. Additional information regarding Decision Point Review/Pre-Certification can be accessed on the Internet at the New Jersey Department of Banking and Insurance's website at http://www.state.nj.us/dobi/pipinfo/aicrapg.htm

Prizm, LLC has been selected by GEICO to implement their plan as required by the Automobile Cost Reduction Act. Prizm, LLC will review treatment plan requests for Decision Point Review/Pre-Certification, perform Medical Bill Repricing and Audits of provider bills, coordinate Independent Medical Exams and Peer Reviews, and provide Case Management Services.

If certain medically necessary services are performed without notifying GEICO or Prizm, LLC a penalty/co-payment may be applied. Medical care rendered in the first 10 days following the covered loss or any care received during an emergency situation is not subject to Decision Point Review/Pre-Certification. However, for benefits to be paid, the treatment must be reasonable, medically necessary, and related to the subject motor vehicle accident. In addition, in order for a provider to receive direct payment for rendering services to you, regardless of whether it is within or beyond the first 10 days, the provider must submit to GEICO a fully executed Conditional Assignment of Benefits. This is true in all events.

The Plan Administrator is Prizm LLC.

Mailing Instructions:

All Decision Point Review, pre-certification and internal appeals related documents are to be submitted to:

Prizm, LLC
10 East Stow Road
Suite 100
Marlton, New Jersey 08053
Phone Number: 856-596-5600
Fax Number: 856-596-6300
Email Address: Documents@Prizmllc.com

All other mail is to be submitted to:

GEICO P.O. Box 9515
Fredericksburg, VA 22403
Fax Number: 516-213-1484

Submission of Treatment Plan Requests for Decision Point Review/PreCertification

Please complete the "Attending Provider Treatment Plan" form and forward with any applicable medical documentation to Prizm, LLC by fax (856-596-6300), or mail (10 East Stow Road, Suite 100, Marlton, NJ 08053) or email to TreatmentRequests@Prizmllc.com. This form can be accessed on Prizm, LLC's web site at www.Prizmllc.com. Any questions regarding your treatment request can be directed to Prizm, LLC at 856-596-5600 during regular business hours of Monday through Friday 8:00 A.M. to 5:00 P.M., EST except for Federally and/or State Declared Holidays and/or New Jersey declared “State of Emergencies” related to inclement weather where travel is prohibited.

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, known as **Care Paths,** for soft tissue injuries, collectively referred to as **identified injuries** . Additionally, guidelines for certain diagnostic tests have been established by the New Jersey Department of Banking and Insurance according to N.J.A.C. 11:3-4. Decision Points are intervals within the Care Paths where treatment is evaluated for a decision about the continuation or choice of further treatment the attending physician provides. At Decision Points, the eligible injured person or the health care provider must provide Prizm, LLC with information regarding further treatment the health care provider intends to provide.

In accordance with N.J.A.C. 11:3-4.5 the administration of any of the following diagnostic tests is subject to Decision Point Review, regardless of diagnosis:

Diagnostic Tests which are subject to Decision Point Review according to N.J.A.C. 11:3-4.5

1. Needle Electromyography (EMG)
2. Somatosensory Evoked Potential (SSEP)
3. Visual Evoked Potential (VEP)
4. Brain Audio Evoked Potential (BAEP)
5. Brain Evoked Potentials (BEP)
6. Nerve Conduction Velocity (NCV)
7. H-Reflex Studies
8. Electroencephalogram (EEG)
9. Videofluoroscopy
10. Magnetic Resonance Imaging (MRI)
11. Computer Assisted Tomograms (CT, CAT Scan)
12. Dynatorn/Cybex Station/Cybex Studies and any range of muscle motion testing
13. Sonogram/Ultrasound
14. Brain Mapping
15. Thermography/Thermograms

Pre-Certification

Pursuant to N.J.A.C. 11:3-4.7, the New Jersey Department of Banking and Insurance, Prizm, LLC's Pre-Certification Plan requires pre-authorization of certain treatment/diagnostic tests or services. Failure to pre-certify these services may result in penalties/co-payments even if services are deemed medically necessary. If the eligible injured person does not have an Identified Injury, you as the treating provider are required to obtain Pre-Certification of treatment, diagnostic tests, services, prescriptions, durable medical equipment or other potentially covered expenses as noted below:

1. Non-emergency inpatient and outpatient hospital care
2. Non-emergency surgical procedures
3. Extended Care Rehabilitation Facilities
4. 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.
5. Physical, Occupational, Speech, Cognitive, Rehabilitation or other restorative therapy or therapeutic or body part manipulation except as provided for identified injuries in accordance with Decision Point Review.
6. Outpatient psychological/psychiatric treatment/testing or other services
7. All pain management services except as provided for identified injuries in accordance with Decision Point Review.
8. Home Health Care
9. Acupuncture
10. Durable Medical Equipment (including orthotics or prosthetics) with a cost or monthly rental in excess of $100.00 or rental in excess of 30 days
11. Non-Emergency Dental Restorations

12. Temporomandibular disorder; any oral facial syndrome
13. Non-medical products, devices, services, and activities, and associated supplies, not exclusively used for medical purposes or as durable medical goods, with an aggregate cost or monthly rental in excess of $100.00 or rental in excess of 30 days, including but not limited to:
    (a) Vehicles
    (b) Modifications to vehicles
    (c) Durable goods
    (d) Furnishings
    (e) Improvements or modifications to real or personal property
    (f) Fixtures
    (g) Spa/gym memberships
    (h) Recreational activities and trips
    (i) Leisure activities and trips

Decision Point Review/Pre-Certification Process

On behalf of GEICO, Prizm, LLC will review all treatment plan requests and medical documentation submitted. A decision will be rendered within three business days of receipt of a completed "Attending Provider Treatment Plan" form request with supporting medical documentation. If additional information is requested, the decision will be rendered within three business days of our receipt of the additional information. In the event that GEICO Insurance Company or Prizm, LLC does not receive sufficient medical information accompanying the request for treatment, diagnostic tests or services to make a decision, an administrative denial will be rendered, until such information is received.

If a decision is not rendered within three business days of receipt of an "Attending Provider Treatment Plan" form, you, as the treating health care provider, may render medically necessary treatment until a decision is rendered.
Please note that the denial 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.

Voluntary Pre-Certification

We encourage you, as the treating health care provider, to participate in a voluntary pre-certification process by submitting a comprehensive treatment plan to Prizm, LLC for all services provided. Prizm, LLC will utilize nationally accepted criteria to authorize a mutually agreeable course of treatment. In consideration for your participation in this voluntary pre-certification process, the bills you submit consistent with the agreed plan will not be subject to review or audit as long as they are in accordance with the policy limits, deductibles, and any applicable PIP fee schedule. This process increases the communication between the patient, provider and Prizm, LLC to develop a comprehensive treatment plan.

Independent Medical Examination

Prizm, LLC or GEICO may request an Independent Medical Examination. At times, this examination may be necessary to reach a decision in response to the treatment plan request or internal appeal request by the treating provider. This examination will be scheduled with a provider in the same discipline and at a location reasonably convenient to the injured person.
Prizm, LLC will schedule the appointment for the examination within 7 calendar days of the day of the receipt of the request unless the insured/designee otherwise agrees to extend the time frame. Medically necessary treatment may proceed while the examination is being scheduled and until the Independent Medical Examination results become available. Upon completion of the Independent Medical Examination, you, as the treating provider, will be notified of the results by fax or mail within three business days after the examination. If the examining provider prepares a written report concerning the examination, the insured or their designee shall be entitled to a copy upon written request.

Prizm, LLC will notify the injured party or designee and the treating provider of the scheduled physical or mental examination and of the consequences for unexcused failure to appear at two or more appointments. If the injured party has two or more unexcused failures to attend the scheduled exam, notification will be immediately sent to the injured person or his or her designee, and all the providers treating the injured person for the diagnosis (and related diagnosis) contained in the attending physicians treatment plan form. This notification will place the injured person on notice that all future treatment diagnostic testing or durable medical equipment required for the diagnosis and (related diagnosis) contained in the attending physician's treatment plan will not be reimbursable as a consequence for failure to comply with the plan.

Voluntary Network Services

Prizm, LLC has established a network of approved vendors for diagnostic imaging studies for all MRI's and CAT Scans, durable medical equipment with a cost or monthly rental over $100.00, prescription drugs and all

electrodiagnostic testing listed in N.J.A.C. 11:3-4.5(b) 1-3, (unless performed in conjunction with a needle EMG by the treating provider). If the injured party utilizes one of the pre-approved networks the 30% co-payment will be waived. If any of the electrodiagnostic tests listed in N.J.A.C. 11:3-4.5(b) are performed by the treating provider in conjunction with the needle EMG, the 30% co-payment will not apply. In cases of prescriptions, the $10.00 co-pay of GEICO will be waived if obtained from one of the pre-approved networks.

To secure a list of preferred provider networks for Diagnostic tests (MRI's and CAT Scans), Durable Medical Equipment, Prescription Drugs, and Electrodiagnostic Testing, please visit Prizm, LLC website @ www.Prizmllc.com , contact Prizm, LLC by phone at 856-596-5600, via fax at 856-596-6300, or in writing at 10 East Stow Road, Suite 100, Marlton, NJ 08053..

Penalty Notification

Failure to submit requests for Decision Point Review or Pre-Certification where required, or failure to submit clinically supported findings that support the treatment, diagnostic testing, or durable medical goods requested will result in a co-payment penalty of 50%. This co-payment is in addition to any deductible or co-payment stated in the insured's policy.
If you do utilize a network provider/facility to obtain those services, tests or equipment listed in the voluntary utilization review program section, payment for those services rendered will result in a co-payment of 30% (in addition to any deductible or co-payment that applies under the policy) for medically necessary treatment, tests and equipment. Keep in mind that treatment which is not medically necessary is not reimbursable under the terms of the policy.

Any reduction shall be applied prior to any other deductible or co-payment requirement.

Assignment of Benefits

As a condition of the assignment of benefits, you agree to comply with all procedures of the Decision Point Review Plan, Decision Point Review and precertification requirements (collectively, " **Plan**").You also agree to initiate all Pre-certification and Decision Point Review requests as required by the Plan. In the event you fail to comply with the conditions of the Plan, and such failure results in the imposition of a copayment penalty, you will hold the patient harmless for such co-payment penalty insofar as you will not seek payment from the patient for any unpaid portion of the medical services arising from such co-payment penalty. Failure to comply with the Decision Point Review Pre-certification Plan or the requirements to follow the Internal Appeals Process prior to filing litigation including arbitrations will void any and all prior assignment of benefits under this policy. Should you choose to retain an attorney to handle the Internal Appeals Process, you do so at your own expense. Additional conditions that also apply to you include:

a. Submission of disputes as defined in the Plan to the Internal Dispute Resolution Process set forth therein. After final determination, submission of disputes not resolved by the Internal Dispute Resolution Process to the Personal Injury Protection Dispute Resolution Process set forth in N.J.A.C. 11:3-5.
b. Submission of all disputes not subject to the Internal Dispute Resolution Process to the Personal Injury Protection Dispute Resolution Process set forth in N.J.A.C 11:3-5.
c. Submission of complete and legible medical records with clinically supported findings to support the diagnosis, the causal relationship to the motor vehicle accident and the care plan
d. Compliance with a request by GEICO to (i.) Submit to an examination under oath, and (ii.) Provide GEICO with any other pertinent information/documentation requested.
e. Agreement not to pursue payment directly from the patient and to hold the patient harmless for any denial of coverage arising from the failure to comply with the conditions established by the Plan and under the Conditional Assignment of benefits. The Conditional Assignment of benefits may be revoked by the assignee, and the assignee shall be entitled to pursue payment from the patient, when benefits are not payable due to lack of coverage and/or violation of a policy condition by the patient.

GEICO's Conditional Assignment of Benefits is the only valid assignment of benefits. The assignee agrees that GEICO has the right to reject, terminate or revoke the GEICO conditional Assignment of Benefits. An assignment of benefits may require GEICO's written consent.

INTERNAL APPEAL 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. Prizm, LLC 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 a Prizm, LLC 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 New Jersey PIP Pre-Service Appeal Form and all applicable fields 1-34 must be completed in order to be considered. If either the New Jersey PIP Pre-Service Appeal Form is not submitted or if any applicable fields of the New Jersey PIP Pre-Service Appeal Form are not completed then the Appeal may be administratively denied. In addition, the original APTP form, APTP decision/response document, and appeal rationale narrative document must be included with the submission of the New Jersey PIP Pre-Service Appeal Form or the Pre-Service Appeal may be administratively denied.

4. Appeals must be submitted to Prizm, LLC via fax at 856-596-6300, or in writing at 10 East Stow Road, Suite 100, Marlton, NJ 08053.

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. All 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 appeals 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) calendar days after receipt of the New Jersey PIP 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 of the requirements listed below must be met:

1. A post-service appeal shall be submitted to the Prizm, LLC in writing within ninety (90) calendar days of the issuance of the decision that is being appealed and at least forty five (45) calendar days prior to initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5 or any other litigation against us. If a post-service appeal form is submitted outside of this period of time then it will be administratively denied.

2. The Appeal must be submitted on the New Jersey PIP Post-Service Appeal Form and all applicable fields 1-38 shall be completed. If either the New Jersey PIP Post-Service Appeal Form is not submitted or the applicable fields are not completed then the Appeal may be administratively denied. In addition, the original bill (HCFA or UB), explanation of benefit/payment (EOB), and appeal rationale narrative document must be included with the submission of the New Jersey PIP Post-Service Appeal Form or the Post-Service Appeal may be administratively denied.

3. 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.

4. Appeals must be submitted to Prizm, LLC, via fax at 856-596-6300, or in writing at 10 East Stow Road, Suite 100, Marlton, NJ 08053.

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 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. All 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 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) calendar days after receipt of the New Jersey PIP Post Service Appeal Form and any supporting documentation.

Any dispute which has not been submitted to the appeal process shall not be a valid part of any arbitration or litigation. Proof of a timely-filed appeal is required documentation when an Alternate Dispute Resolution demand is made.

Any request for dispute resolution may include a request for review by a medical review organization. The staff at Prizm, LLC remains available to you and your patient in order to assist with Decision Point Review/ Pre-Certification Process.

Sincerely,

GEICO Indemnity Company
P. O. Box 9515
Fredericksburg, VA 22403-9515
1-800-841-3000