

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PERSONAL INJURY PROTECTION COVERAGE
(STANDARD PERSONAL AUTO POLICY) - NEW JERSEY

With respect to coverage provided by this endorsement, the provisions of the policy apply unless modified by the endorsement.

SCHEDULE

I. Principal Personal Injury Protection Coverage Benefits

A. Medical Expenses

1. **“Named Insured”** and **“Family Members”** the Limit Of Liability is indicated in the Declarations.
2. However, regardless of the limit indicated in the Declarations, a limit of \$250,000 per person per accident is available for a **“named insured”** or **“family member”** for **“catastrophic injury treatment”**.
3. **“Insureds”** Other Than **“Named Insured”** and **“Family Members”** the limit of liability is \$250,000.

B. **Income Continuation** unless otherwise indicated in the Declarations and endorsed to this policy the limit of liability is \$100 per week to a maximum of \$5,200.

C. **Essential Services** unless otherwise indicated in the Declarations and endorsed to this policy the limit of liability is \$12 per day to a maximum of \$4,380.

D. Death Benefits

1. **Income Producer** unless otherwise indicated in the Declarations and endorsed to this policy the limit of liability is \$5,200 less any Income Continuation Benefits paid.
2. **Essential Services Provider** unless otherwise indicated in the Declarations and endorsed to this policy the limit of liability is \$4,380 less any Essential Services Benefits paid.

E. **Funeral Expenses** unless otherwise indicated in the Declarations and endorsed to this policy the limit of liability is \$1,000.

II. **Extended Medical Expense Benefits Coverage** Benefits is \$10,000 per person per accident.

III. Medical Expense Benefits Deductible

- A. Unless otherwise indicated in the Declarations, medical expense benefits applicable to the **“named insured”** and **“family members”** are subject to a deductible of \$250 per accident.
- B. **“Insureds”** other than the **“named insured”** and **“family members”** shall be subject to a separate deductible of \$250 per accident.

IV. Medical Expense Benefits Co-Payment

Medical expense benefits are subject to a co-payment of 20% per accident for amounts payable between the applicable deductible and \$5,000.

V. **Deletion Of Benefits Other Than Medical Expense Benefits** If indicated in the Declarations, no principal personal injury protection benefits, other than medical expense benefits, apply to the **“named insured”** or **“family members”**.

VI. **Medical Expense Benefits As Secondary Coverage** If indicated in the Declarations, medical expense benefits applicable to the **“named insured”** and **“family members”** shall be secondary coverage to health benefits plans under which the **“named insured”** and **“family members”** are insured.

VII. **Pedestrian Personal Injury Protection Coverage** If Pedestrian Personal Injury Protection Coverage is specified for a vehicle in the Declarations, Pedestrian Personal Injury Protection Coverage is the only personal injury protection coverage provided for that vehicle.

I. Definitions

The Definitions Section is amended as follows:

A. The following definitions are replaced:

1. “**Bodily injury**” means bodily harm, sickness or disease, including an “**Identified injury**” or death that results.
2. “**Your covered auto**” means an “**auto**”:
 - a. For which the “**named insured**” is required to maintain automobile liability insurance coverage under the New Jersey Automobile Reparation Reform Act;
 - b. To which the bodily injury liability coverage under this policy applies; and
 - c. For which a specific premium is charged.

B. The following definitions are added:

1. “**Actual benefits**” means those benefits determined to be payable for “**allowable expenses**”.
2. “**Allowable expense**” means a “**medically necessary**”, reasonable and customary item of expense covered as benefits by the “**named insured’s**” or a “**family member’s**” health benefits plan or personal injury protection benefits as an “**eligible expense**”, at least in part. When benefits provided are in the form of services, the reasonable monetary value of each such service shall be considered as both an “**allowable expense**” and a paid benefit.
3. “**Auto**” means a self-propelled vehicle of one of the following types, which is designed for use principally on public roads:
 - a. A private passenger or station wagon type automobile;
 - b. A pickup, delivery sedan or van; or
 - c. A utility automobile designed for personal use as a camper, motor home, or for family recreational purposes.

However, “**auto**” does not include:

- a. A motorcycle;
- b. An automobile used as a public or livery conveyance;
- c. A pickup, delivery sedan, van, or utility automobile customarily used in the occupation, profession or business of an “**insured**” other than farming or ranching; or

d. A utility automobile customarily used for the transportation of passengers other than members of the user’s family or their guests.

4. “**Catastrophic injury treatment**” means medical expenses incurred for treatment of:

- a. Permanent or significant brain injury, spinal cord injury or disfigurement; or
- b. Other permanent or significant injuries rendered at a trauma center or acute care hospital immediately following the accident and until the “**insured**”:

(1) Is stable;

(2) No longer requires critical care; and

(3) Can be safely discharged or transferred to another facility in the judgment of the attending “**health care provider**”.

5. “**Clinically supported**” means that a “**health care provider**”, prior to selecting, performing or ordering the administration of a treatment or “**diagnostic test**”, has:

a. Physically examined the “**insured**” to ensure that the proper medical indications exists to justify ordering the treatment or test;

b. Made an assessment of any current and/or historical subjective complaints, observations, objective findings, neuralgic indications, and physical tests;

c. Considered any and all previously performed tests that:

(1) Relate to the injury and the results and

(2) Are relevant to the proposed treatment or test and

d. Recorded and documented these observations, positive and negative findings and conclusions on the “**insured’s**” medical records.

6. “**Diagnostic test(s)**” means a medical service or procedure utilizing any means, other than bioanalysis, intended to assist in establishing a :

a. Medical;

b. Dental;

c. Physical therapy;

d. Chiropractic; or

e. Psychological diagnosis;

for the purpose of recommending or developing a course of treatment for the tested patient to be implemented by the treating practitioner or by the consultant.

7. “**Eligible expense**” means:

a. With respect to health benefits plans, that portion of the medical expenses incurred for the treatment of “**bodily injury**” which is covered under the terms and conditions of the plan, without application of the deductible(s) and co-payment(s), if any.

b. With respect to personal injury protection benefits, that portion of the medical expenses incurred for the treatment of “**bodily injury**” which, without considering any deductible and co-payment, shall not exceed:

(1) The percent or dollar amounts specified on the medical fee schedules, or the actual billed expense, whichever is less; or

(2) The reasonable amount, as determined by us, considering the medical fee schedules for similar services or equipment in the region where the service or equipment was provided, when an incurred medical expense is not included on the medical fee schedules.

8. “**Emergency care**” means all treatment of a “**bodily injury**” which manifests itself by acute symptoms of sufficient severity such that absence of immediate attention could reasonably be expected to result in:

a. Death;

b. Serious impairment to bodily functions; or

c. Serious dysfunction of a bodily organ or part.

“**Emergency care**” ends when the “**insured**” is discharged from acute care by the attending “**health care provider**”.

“**Emergency care**” shall be presumed when medical care is initiated at a hospital within 120 hours of the accident.

9. “**Health care provider**” means those persons licensed or certified to perform health care treatment or services

compensable as medical expenses and shall include, but not be limited to:

a. Hospital or health care facilities that are:

(1) Maintained by a State or any of its political sub-divisions; or

(2) Licensed by the Department of Health and Senior Services;

b. Other hospitals or health care facilities designated by the Department of Health and Senior Services to provide health care services, or other facilities, including facilities for radiology and diagnostic testing, free-standing emergency clinics or offices, and private treatment centers;

c. A non-profit voluntary visiting nurse organization providing health care services other than in a hospital;

d. Hospitals or other health care facilities or treatment centers located in other States or nations;

e. Physicians licensed to practice medicine and surgery;

f. Licensed:

(1) Audiologists;

(2) Chiropractors (podiatrists);

(3) Chiropractors;

(4) Dentists;

(5) Health Maintenance Organizations;

(6) Occupational Therapists;

(7) Occupational Therapy Assistants;

(8) Optometrists;

(9) Orthotists and Prosthetists;

(10) Pharmacists;

(11) Physical Therapists;

(12) Physical Therapists Assistants;

(13) Physician Assistants;

(14) Professional Nurses;

(15) Psychologists; and

(16) Speech-Language Pathologists;

- g. Registered bio-analytical laboratories;
 - h. Certified nurse-midwives and nurse practitioners/clinical nurse-specialists; or
 - i. Providers of other health care services or supplies including durable medical goods.
10. **“Highway vehicle”** means a land motor vehicle or trailer other than:
- a. An **“auto”**;
 - b. A farm type tractor or other equipment designed for use principally off public roads, while not on public roads;
 - c. A vehicle operated on rails or crawler treads or
 - d. A vehicle while located for use as a residence or premises.
11. **“Identified injury”** means the following **“bodily injuries”** for which the New Jersey Department of Banking and Insurance has established standard courses of diagnosis and treatment for medical expenses resulting from such injuries:
- a. Cervical Spine: Soft Tissue Injury;
 - b. Cervical Spine: Herniated Disc/Radiculopathy;
 - c. Thoracic Spine: Soft Tissue Injury;
 - d. Thoracic Spine: Herniated Disc/Radiculopathy;
 - e. Lumbar-Sacral Spine: Soft Tissue Injury;
 - f. Lumbar-Sacral Spine: Herniated Disc/Radiculopathy; and
 - g. Any other **“bodily injury”** for which the New Jersey Department of Banking and Insurance has established standard courses of diagnosis and treatment for medical expenses resulting from such injuries.
12. **“Income”** means salary, wages, tips, commissions, fees and other earnings derived from work or employment.
13. **“Income producer”** means a person who, at the time of the accident, was in an occupational status earning or producing **“income”**.
14. **“Insured motor vehicle”** means a motor

vehicle:

- a. That is insured for both bodily injury liability coverage and Pedestrian Personal Injury Protection Coverage under this policy; and
- b. For which specific premiums have been charged.

15. **“Named insured”** means:

- a. The person named in the Declarations; and
- b. That person’s spouse; or
- c. A party who has entered into a civil union with the **“named insured”** legally recognized under New Jersey law;

if a resident of the same household.

However, if:

- a. The spouse or party who has entered into a civil union with the **“named insured”** ceases to be a **“resident”** of the same household during the policy period, the spouse or such party shall be a **“named insured”** for the full term of that policy period.
- b. **“Your covered auto”** is owned by a farm family co-partnership or corporation, **“named insured”** includes the head of the household of each family designated in the policy as having a working interest in the farm.

16. **“Pedestrian”** means any person who is not **“occupying”** a vehicle:

- a. Propelled by other than muscular power; and
- b. Designed primarily for use on highways, rails and tracks.

17. **“Medically Necessary”** or **“Medical Necessity”** means those services or supplies which are provided by a **“health care provider”** that are required to identify or treat a condition or injury, and which, as determined by us, are:

- a. Consistent with **“clinically supported”** symptoms, diagnoses or indications of the condition or injury;
- b. The most appropriate level of service that is in accordance with the standards of good practice and professional treatment protocols

(including Care Path protocols as established by the New Jersey Department of Banking and Insurance). When applied to an inpatient, it further means that the symptoms or condition require that the services or supplies cannot be safely provided as an outpatient;

- c. Not primarily for any **“insureds”** convenience or any **“health care providers”** convenience; and
- d. Not unnecessary tests or treatments.

The fact that a **“health care provider”** prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services or supplies **“medically necessary”**.

- 18. **“Resident”** means a person who physically resides in the same household with the intention to continue residence there and who has been identified to us as a resident of the household, whether as an operator or non-operator, within 30 days of taking up residence.
- 19. **“Permission”** means express permission to operate, occupy, use, enter into or alight from the **“insureds”** vehicle on the date of accident. Any person operating the vehicle without a valid license or any person who is not old enough to apply for a New Jersey license shall be conclusively presumed to be operating the insured vehicle without permission.

II. Personal Injury Protection Coverage

A. Principal Personal Injury Protection Coverage

INSURING AGREEMENT

- 1. We will pay principal personal injury protection benefits to or for an **“insured”** who sustains **“bodily injury”**. The **“bodily injury”** must be caused by an accident arising out of the ownership, maintenance or use, including loading or unloading, of an **“auto”** as an automobile.
- 2. With respect to Principal Personal Injury Protection Coverage, **“insured”** means:
 - a. The **“named insured”** or any **“family**

member” who sustains **“bodily injury”** while:

- (1) **“Occupying”** or using an **“auto”**; or
- (2) A **“pedestrian”**, when caused by:
 - (a) An **“auto”**; or
 - (b) An object propelled by or from an **“auto”**.

b. Any other person who sustains **“bodily injury”** while **“occupying”** or using **“your covered auto”** with the **“permission”** of the **“named insured”**.

- 3. Subject to the limits shown in the Declarations, principal personal injury protection benefits consist of the following:

a. Medical Expenses

Reasonable and necessary expenses incurred for:

- (1) Medical, surgical, rehabilitative and diagnostic treatments and services;
- (2) Hospital expenses;
- (3) Ambulance or transportation services;
- (4) Medication; and
- (5) Non-medical expenses that are prescribed by a treating **“health care provider”** for a permanent or significant brain, spinal cord or disfiguring injury.

Non-medical expense means charges for:

- (a) Products and devices, not exclusively used for medical purposes or as durable medical equipment, such as vehicles, durable goods, equipment, appurtenances, improvements to real or personal property, fixtures; and
- (b) Services and activities such as recreational activities, trips and leisure activities.

All medical expenses must:

- (1) Be rendered by a **“health care provider”**;
- (2) **“clinically supported”** and consistent with the symptoms, diagnosis or indications of the

“insured”;

- (3) Be consistent with the most appropriate level of service that is in accordance with the standards of good practice and standard professional treatment protocols, including care paths for an “**Identified injury**”;
- (4) Not be rendered primarily for the convenience of the “insured” or the “**health care provider**”; and
- (5) **Not** include unnecessary testing or treatment.

However, medical expenses include any non-medical remedial treatment rendered in accordance with recognized religious methods of healing.

b. **Income Continuation**

Loss of “**income**” of an “**income producer**” payable during his lifetime as a result of “**bodily injury**” disability.

Income continuation shall not exceed net income normally earned during the period in which benefits are payable.

c. **Essential Services**

Reimbursement to an “insured”, for payments made to others, for necessary and reasonable expenses incurred in obtaining substitute essential services ordinarily performed by such “insured” during his lifetime, not for income but for the benefit of himself and any “**family members**”.

d. **Death Benefits**

An amount payable in the event of the death of an “insured” calculated as follows:

- (1) If the “insured” was an “income producer” at the time of the accident, the amount of any unpaid income continuation benefits available to such “insured” at the time of the “insured’s” death.
- (2) If the “insured” ordinarily performed essential services for the care and maintenance of himself and any “**family member**”, the amount of any unpaid essential services benefits available to such “insured” at the time of the “insured’s” death.

e. **Funeral Expenses**

Reasonable expenses incurred for funeral, burial, and cremation.

B. Extended Medical Expense Benefits Coverage

INSURING AGREEMENT

1. We will pay extended medical expense benefits to or for an “insured” who sustains “**bodily injury**”. The “**bodily injury**” must be caused by an accident arising out of the ownership, maintenance or use, including loading and unloading, of a “**highway vehicle**” not owned by or furnished or available for the regular use of the “**named insured**” or any “**family member**”.

2. With respect to Extended Medical Expense Benefits Coverage, “insured” means:

a. The “**named insured**” or any “**family member**” who sustains “**bodily injury**” while:

(1) “**Occupying**” or using a “**highway vehicle**”; or

(2) A “**pedestrian**”, caused by a “**highway vehicle**”.

b. Any other person:

(1) Who sustains “**bodily injury**” while “**occupying**” a “**highway vehicle**” being operated by the “**named insured**” or any “**family member**”, other than a:

(a) Motorcycle; or

(b) Vehicle being used as a public or livery conveyance; or

(2) Using such “**highway vehicle**” with the “**permission**” of the “**named insured**”.

3. Subject to the limits shown in the Declarations, extended medical expense benefits consist of medical expenses.

C. Pedestrian Personal Injury Protection Coverage

INSURING AGREEMENT

1. If the Declarations indicates that Pedestrian Personal Injury Protection Coverage applies to a vehicle, we will pay pedestrian personal injury protection benefits to or for an “insured” who sustains “**bodily injury**”.

2. With respect to Pedestrian Personal Injury Protection Coverage, “**insured**” means a person who sustains “**bodily injury**” while a “**pedestrian**”:
 - a. Caused by an “**insured motor vehicle**”; or
 - b. As a result of being struck by an object propelled by or from an “**insured motor vehicle**”.
3. Subject to the limits shown in the Schedule or in the Declarations, pedestrian personal injury protection benefits consist of the following:
 - a. Medical expenses
 - b. Income continuation
 - c. Essential services
 - d. Death benefits
 - e. Funeral expenses

EXCLUSIONS

A. We do not provide Personal Injury Protection Coverage for “**bodily injury**”:

1. To any person:
 - a. Whose conduct contributed to the “**bodily injury**” in any of the following ways:
 - (1) While committing a high misdemeanor or felony, or seeking to avoid lawful apprehension or arrest by a police officer; or
 - (2) While acting with specific intent to cause injury or damage to himself or others.
 - b. Operating or “**occupying**” an “**auto**” without the “**permission**” of the:
 - (1) Owner of the “**auto**”; or
 - (2) “**Named insured**” under the policy insuring that “**auto**”.
 - c. Other than the “**named insured**” or any “**family member**” if that “**insured**” is entitled to New Jersey personal injury protection coverage as a “**named insured**” or “**family member**” under the terms of another policy.
2. To any “**family member**” if that “**family member**” is entitled to New Jersey personal injury protection coverage as a named insured under the terms of another policy.
3. Arising out of the ownership,

maintenance or use, including loading or unloading, of any vehicle while located for use as a residence or premises, other than for transitory recreational purposes.

4. Due to:
 - a. War (declared or undeclared);
 - b. Civil war;
 - c. Insurrection;
 - d. Rebellion or revolution; or
 - e. Any act or condition incident to any of the above.
5. Resulting from the:
 - a. Radioactive;
 - b. Toxic;
 - c. Explosive; or
 - d. Other hazardous; properties of nuclear material.

B. We do not provide:

1. Principal Personal Injury Protection Coverage for “**bodily injury**” to any “**insured**” who is not “**occupying**” “**your covered auto**” if the accident occurs outside of New Jersey. However, this Exclusion (B.1.) does not apply to:
 - a. The “**named insured**”;
 - b. Any “**family member**”; or
 - c. Any “**resident**” of New Jersey.
2. Principal Personal Injury Protection Coverage or Extended Medical Expense Benefits Coverage for “**bodily injury**” to any “**insured**” who, at the time of the accident, was the owner or registrant of an “**auto**” registered or principally garaged in New Jersey that was being operated without personal injury protection coverage.
3. Extended Medical Expense Benefits Coverage for “**bodily injury**” to any “**insured**”:
 - a. Who is entitled to benefits for the “**bodily injury**” under:
 - (1) Principal Personal Injury Protection Coverage; or
 - (2) Any:
 - (a) Workers Compensation law; or
 - (b) Medicare provided under

federal law.

- b. Who would be entitled to benefits for the “**bodily injury**” under Principal Personal Injury Protection Coverage, except for the application of a:
 - (1) Deductible;
 - (2) Co-payment; or
 - (3) Medical fee schedule promulgated by the New Jersey Department of Banking and Insurance.
- c. If the accident occurs outside of New Jersey. However, this Exclusion (B.3.c.) does not apply to:
 - (1) The “**named insured**”;
 - (2) Any “**family member**”; or
 - (3) Any “**resident**” of New Jersey.
- C. We do not provide Personal Injury Protection Coverage with respect to the following “**diagnostic tests**”:
 - 1. Brain mapping, when not done in conjunction with appropriate neurodiagnostic testing;
 - 2. Iridology;
 - 3. Mandibular tracking and simulation;
 - 4. Reflexology;
 - 5. Spinal diagnostic ultrasound;
 - 6. Surface electromyography (surface EMG);
 - 7. Surrogate arm mentoring; or
 - 8. Any other diagnostic test that is determined to be ineligible for coverage under Personal Injury Protection Coverage by New Jersey law or regulation.
- D. We do not provide Personal Injury Protection Coverage with respect to the following “**diagnostic tests**” when used to treat temporomandibular joint disorder (TMJ/D):
 - 1. Doppler ultrasound;
 - 2. Electroencephalogram (EEG);
 - 3. Needle electromyography (needle EMG);
 - 4. Sonography;
 - 5. Thermograms/thermographs; or
 - 6. Videofluoroscopy.
- A. **The limits of liability shown** in the Schedule or in the Declarations for the personal injury protection coverage benefits that apply are the most we will pay to or for each “**insured**” injured in any one accident, regardless of the number of:
 - 1. “**Insureds**”;
 - 2. Policies applicable; or
 - 3. Vehicles insured.
- B. Any amounts payable under Personal Injury Protection Coverage shall be reduced by any amounts:
 - 1. Paid;
 - 2. Payable; or
 - 3. Required to be provided; under any of the following:
 - 1. Workers compensation law, disability benefits law, or similar law;
 - 2. Medicare provided under federal law; or
 - 3. Benefits actually collected that are provided under federal law to active and retired military personnel.
- C. Any amounts payable for medical expense benefits shall be limited by the medical fee schedules promulgated by the New Jersey Department of Banking and Insurance for specific injuries or services or the usual, customary, and reasonable fee, whichever is less.
- D. Any amounts payable for medical expense benefits as a result of any one accident shall be:
 - 1. Reduced by the applicable deductible indicated in the Schedule or in the Declarations; and
 - 2. Subject to a co-payment of 20% for the amount between the applicable deductible and \$5,000.
- E. If the Schedule or Declarations indicates that the “**named insured**” has elected the Medical Expense Benefits as Secondary Coverage option, the following provisions apply to medical expenses benefits:
 - 1. **Priority Of Benefits**
 - a. The health benefits plans under which the “**named insured**” and any “**family member**” are insured shall provide primary coverage for “**allowable expenses**” incurred by the “**named insured**” or any “**family member**” before any medical expense benefits are paid by us.

LIMIT OF LIABILITY

- b. This insurance shall provide secondary coverage for medical expense benefits for “**allowable expenses**” which remain uncovered after the health benefits plans, under which the “**named insured**” and any “**family member**” are insured, have paid benefits towards those “**allowable expenses**”.
- c. The total benefits paid by the health benefits plans and this insurance shall not exceed the total amount of “**allowable expenses**”.

2. Determination Of Medical Expense Benefits Payable

- a. To calculate the amount of “**actual benefits**” to be paid by us, we will first determine the amount of “**eligible expenses**” which would have been paid by us, after application of the deductible and co-payment indicated in the Declarations, had the “**named insured**” not elected the Medical Expense Benefits As Secondary Coverage option.
- b. If the remaining “**allowable expenses**” are:
 - (1) Less than the benefits calculated in Paragraph a. above, we will pay “**actual benefits**” equal to the remaining “**allowable expenses**”, without reducing the remaining “**allowable expenses**” by the deductible or co-payment.
 - (2) Greater than the benefits calculated in Paragraph a. above, we will pay “**actual benefits**” equal to the benefits calculated in Paragraph a. above, without reducing the remaining “**allowable expenses**” by the deductible or co-payment.
- c. We will not reduce the “**actual benefits**” determined in Paragraph b.:
 - (1) By any deductibles or co-payments of the health benefits plans which have provided primary coverage for medical expense benefits; or
 - (2) For any “**allowable expense**” remaining uncovered which otherwise would not be an “**eligible expense**” under personal injury protection coverage, except as set forth in Paragraph (d.) below.

- d. In determining remaining uncovered “**allowable expenses**”, we shall not consider any amount for items of expense which exceed the dollar or percent amounts recognized by the medical fee schedules promulgated by the New Jersey Department of Banking and Insurance.
- e. The total amount of medical expense benefits for the “**named insured**” or any “**family member**” per accident shall not exceed the maximum amount payable for medical expense benefits under this policy.

3. Health Benefits Plan Ineligibility

- a. If, after the “**named insured**” has elected the Medical Expense Benefits as Secondary Coverage option, it is determined that the “**named insured**” or any “**family member**” did not have a health benefits plan in effect at the time an accident occurred which resulted in “**bodily injury**” to the “**named insured**” or any “**family member**”, medical expense benefits shall be provided to the “**named insured**” or any “**family member**”, subject to the following:
 - (1) Only Paragraphs **A.** and **B.** of the Limit of Liability provision will apply with respect to medical expense benefits.
 - (2) Any amount payable for medical expense benefits for the “**named insured**” and any “**family member**” as a result of any one accident shall:
 - (a) Be reduced by a deductible equal to the sum of \$750 plus the applicable deductible indicated in the Declarations; and
 - (b) Be subject to a co-payment of 20% for amounts less than \$5,000 after the deductible has been applied.
 - (c) Be determined:
 - (i) By the medical fee schedules promulgated by the New Jersey Department of Banking and Insurance; or
 - (ii) By us, on a reasonable basis, considering the medical fee schedules for similar services or

equipment in the region where the service or equipment was provided, if an item of expense is not included on the medical fee schedules.

(d) Not exceed the maximum amount payable for medical expense benefits under this policy.

b. All items of medical expense incurred by the “**named insured**” or any “**family member**” for the treatment of “**bodily injury**” shall be “**eligible expenses**” to the extent the treatment or procedure from which the expenses arose:

(1) Is recognized on the medical fee schedules promulgated by the New Jersey Department of Banking and Insurance; or

(2) Are reasonable expenses in accordance with Section 4. of the New Jersey Automobile Reparation Reform Act.

c. We shall be entitled to recover the difference between:

(1) The reduced premium paid under this policy for the Medical Expense Benefits As Secondary Coverage option; and

(2) The premium which would have been paid under this policy had the “**named insured**” not elected such option.

We will not provide any premium reduction for the Medical Expense Benefits As Secondary Coverage Option for the remainder of the policy period.

F. The limit of liability shown in the Declarations for weekly income continuation benefits shall be prorated for any period of “**bodily injury**” disability less than one week.

OTHER INSURANCE

A. No one will be entitled to duplicate payments for the same elements of loss under this or any similar insurance, including approved plans of self-insurance. If an “**insured**” receives benefits from another insurer, that insurer shall be entitled to recover from us its pro rata share of the benefits paid. An insurer’s pro rata share is the proportion that the insurer’s liability bears to the total of all

applicable limits

B. With respect to:

1. Principal personal injury protection coverage; or

2. “**Pedestrian**” personal injury protection coverage;

if there is other applicable insurance, including approved self-insurance plans, the maximum recovery under all such insurance shall not exceed the amount which would have been payable under the insurance with the highest limit of liability.

C. With respect to extended medical expense benefits coverage, any insurance we provide under this policy shall be excess over any amounts:

1. Payable; or

2. Required to be provided;

under any other automobile no-fault law or medical payments coverage.

III. Part E — Duties After An Accident Or Loss

Part E amended as follows:

A. Duties A. and B. are replaced by the following:

A. In the event of an accident, prompt written notice must be given to us or our authorized representative. Such notice shall include:

1. Sufficient details to identify the “**insured**”; and

2. Reasonably obtainable information as to how, when and where the accident happened.

B. A person seeking Personal Injury Protection Coverage must:

1. Promptly give us written proof of claim, including;

a. Full particulars of the nature and extent of the “**bodily injury**”; and

b. Any other information which may assist us in determining the amount due and payable.

2. Promptly send us copies of:

a. The summons and complaint; or

b. Other process; served in connection with any legal action taken, to recover damages for “**bodily injury**”, against a person or organization who is or may be legally liable.

3. Submit, as often as we reasonably require:
 - a. To physical exams by physicians we select. We will provide the “insured” with a copy of the medical report if requested.
 - b. To examination under oath, separately and apart from others and subscribe the same.
4. Authorize us to obtain:
 - a. Medical reports; and
 - b. Other pertinent records.
5. Submit a proof of loss when required by us.
6. Submit proof of payment of co-payments and deductibles due pursuant to this policy.

B. The following provision is added:

If the notice, proof of claim or other reasonably obtainable information regarding the accident is received by us 30 or more days after the accident, we may impose an additional medical expense benefits co-payment in accordance with New Jersey law or regulation. This co-payment shall be in addition to:

1. Any medical expense benefits deductible or co-payment; or
2. Any penalty imposed in accordance with our **Decision Point Review Plan**.

IV. Part F — General Provisions

A. The Our Right To Recover Payment Provision is replaced by the following:

OUR RIGHT TO RECOVER PAYMENT

If we make a payment under this coverage and the person to or for whom payment was made recovers damages from another:

1. That person shall:
 - a. Hold in trust for us the proceeds of the recovery;
 - b. Reimburse us to the extent of our payment;
 - c. Execute and deliver such instruments and papers as may be appropriate to secure the rights and obligations of that person and us; and
 - d. Do nothing after loss to prejudice these rights.

2. We shall have a lien to the extent of such payment. We may give notice of lien to:
 - a. The person or organization causing the “**bodily injury**”;
 - b. His agent;
 - c. His insurer; or
 - d. A court having jurisdiction.

B. Paragraph B. of the Policy Period And Territory Provision is replaced by the following:

POLICY PERIOD AND TERRITORY

B. The policy territory is, with respect to:

1. Principal Personal Injury Protection Coverage or Extended Medical Expense Benefits Coverage, anywhere in the world.
2. Pedestrian Personal Injury Protection Coverage, New Jersey.

C. The following is added to the **Two Or More Auto Policies** Provision:

TWO OR MORE AUTO POLICIES

1. This provision does not apply to Extended Medical Expense Benefits Coverage.
2. No one will be entitled to receive duplicate payments for the same elements of loss under Extended Medical Expenses Benefits Coverage.

D. The following provisions are added:

SPECIAL REQUIREMENTS FOR MEDICAL EXPENSES

1. Care Paths For “Identified Injuries” (Medical Protocols)

- a. The New Jersey Department of Banking and Insurance has established by regulation the standard courses of diagnosis and treatment for medical expenses resulting from “**Identified injuries**”. These courses of diagnosis and treatment are known as care paths.

The care paths do not apply to treatment administered during “**emergency care**”.

- b. Upon notification to us of a “**bodily injury**” covered under this policy, we will advise the “insured” of the care path requirements established by the New Jersey Department of Banking and Insurance.
- c. Where the care paths indicate a

decision point, further treatment or the administration of a **“diagnostic test”** is subject to our **Decision Point Review**.

A decision point means the juncture in treatment where a determination must be made about the continuation or choice of further treatment of an **“Identified injury”**.

2. Coverage For **“Diagnostic Tests”**

- a. In addition to the care path requirements for an **“Identified injury”**, the administration of any of the following **“diagnostic tests”** is also subject to the requirements of our **Decision Point Review Plan**:
- (1) Brain audio evoked potential (BAEP);
 - (2) Brain evoked potential (BEP);
 - (3) Computer assisted tomographic studies (CT, CAT Scan);
 - (4) Dynatron/cyber station/cybex;
 - (5) H-reflex Study;
 - (6) Magnetic resonance imaging (MRI);
 - (7) Nerve conduction velocity (NCV);
 - (8) Somasensory evoked potential (SSEP);
 - (9) Sonogram/ultrasound;
 - (10) Visual evoked potential (VEP);
 - (11) Any of the following **“diagnostic tests”** when not otherwise excluded under Exclusion C.:
 - (a). Brain Mapping;
 - (b). Doppler Ultrasound;
 - (c). Electroencephalogram (EEG);
 - (d). Needle electromyography (Needle EMG);
 - (e). Sonography;
 - (f). Thermography/thermograms;
 - (g). Videofluoroscopy; or
 - (12) Any other **“diagnostic test”** that is subject to the requirements of our **Decision Point Review Plan** by New Jersey law or regulation.
- b. The **“diagnostic tests”** listed under Paragraph 2.a. must be administered

in accordance with New Jersey Department of Banking and Insurance regulations which set forth the requirements for the use of **“diagnostic tests”** in evaluating injuries sustained in an auto accident.

However, those requirements do not apply to **“diagnostic tests”** administered during **“emergency care”**.

- c. We will pay for other **“diagnostic tests”** which are:

- (1) Not subject to our **Decision Point Review Plan**; and
- (2) Not specifically excluded under Exclusion C.;

only if administered in accordance with the criteria for medical expenses as provided in this endorsement.

3. Decision Point Review Plan

- a. Coverage for certain medical expenses under this endorsement is subject to our **Decision Point Review Plan**, which provides appropriate notice and procedural requirements that must be adhered to in accordance with New Jersey law or regulation. We will provide a copy of this plan upon request, or in the event of any claim for medical expenses under this coverage.
- b. Our **Decision Point Review Plan** includes the following minimum requirements as prescribed by New Jersey law or regulation:
- (1) The requirements of the **Decision Point Review Plan** only apply after the tenth day following the accident.
 - (2) We must be provided prior notice as indicated in our plan, with appropriate **“clinically supported”** findings, that:
 - (a) Additional treatment for an **“Identified injury”**;
 - (b) The administration of a **“diagnostic test”** listed under Paragraph 2.a.; or
 - (c) The use of durable medical equipment;is required.
- The notice and **“clinically supported”** findings may include a comprehensive treatment plan

for additional treatment.

- c. Once we receive such notice with the appropriate “**clinically supported**” findings, we will in accordance with our plan:

- (1) Promptly review the notice and supporting materials; and
- (2) If required as part of our review:
 - (a) Request any additional medical records; or
 - (b) Schedule a physical examination.

- d. We will then determine, and notify the “**insured**”, whether we will provide coverage for the additional treatment, “**diagnostic test**” or the use of durable medical equipment as indicated in our plan and within the applicable three business day requirements specified in the New Jersey Department of Banking and Insurance regulations. Any determination we make will be based on the determination of a physician or dentist.

- e. Any physical examination of an “**insured**” scheduled by us will be conducted in accordance with our plan. If a written report concerning the physical examination is prepared by the “**health care provider**”, we will make such report available to the “**insured**” upon request.

We may deny reimbursement of further treatment, “**diagnostic tests**” or the use of durable medical equipment for repeated unexcused failure of any “**insured**” to appear for a physical examination required by us, in accordance with our plan.

f. Penalty

A penalty will be imposed in accordance with our approved plan if:

- (1) We do not receive proper notice for treatment, “**diagnostic tests**” or the use of durable medical equipment in accordance with the requirements of our **Decision Point Review Plan**;
- (2) We are not provided “clinically supported” findings; or
- (3) If any “**insured**” fails to use a network in accordance with

N.J.A.C. 11:3-4.8, and our approved Decision Point Review Plan.

However, we will not impose a penalty where we received proper notice or are provided “clinically supported” findings and we failed to request further information, modify or deny reimbursement of further treatment, “**diagnostic tests**” or the use of durable medical equipment with respect to that notice or those findings in accordance with our plan.

4. “Precertification” of Medical Care

- a. “**Precertification**” means those programs established by us where the “**medical necessity**” of certain medical procedures, treatments, “**diagnostic tests**”, or other services, non-medical expenses and durable medical equipment are subject to prior authorization by us or our designated representative, and are also subject to utilization review and/or case management by us.

- (1) Prior authorization generally means obtaining the approval of a proposed medical procedure, treatment, “**diagnostic test**”, service or supply in accordance with our “**Precertification**” procedures before the receipt or administration of such medical care.

- (2) Utilization review generally means that part of a quality assurance program that supports and assures a comprehensive effort to monitor effective, efficient and timely utilization of medical care, and serves as a process to review and determine whether medical care is “**medically necessary**”.

- (3) Case management generally means those methods of coordinating the provision of health-care to persons injured in automobile accidents, with the goal of ensuring continuity and quality of care and cost effective outcomes.

- b. Our “**Precertification**” programs do not apply during the first ten (10) days following an accident.
 - c. This policy is not responsible for any medical or other results arising directly or indirectly from an “**insured’s**” participation in either the “**Precertification**” programs, or the care path medical protocols, or the decision point review plan processes.
 - d. Procedures, Service and Supplies subject to “**Precertification**”:
 - (1) The following treatments, procedures, services, are subject to “**Precertification**” for an injury that is not an “**Identified injury**”:
 - (a) Non-emergency inpatient and out patient hospital care;
 - (b) Non-emergency surgical procedures;
 - (c) Home health care;
 - (d) Physical, occupational, speech, cognitive or other restorative therapy or other body part manipulation (except that provided for an “**Identified injury**” in accordance with **Decision Point Review**);
 - (e) Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of \$75.00;
 - (f) Infusion therapy;
 - (g) Outpatient psychological/psychiatric testing and/or services;
 - (h) Extended care rehabilitation facilities;
 - (i) All pain management services (except that provided for an “**Identified injury**” in accordance with **Decision Point Review**);
 - (j) Non-emergency dental restoration;
 - (k) Outpatient care for soft tissue/disc injuries of the patient’s neck, back and related structures not included within the diagnoses covered by the Care Paths;
 - (l) Temporomandibular disorder; any oral facial disorder;
- “**Precertification**” requirements do not apply within ten (10) days of the insured motor vehicle accident, nor does it apply to “**emergency care**”. All services and treatments are subject to retrospective review for “**medical necessity**” and causation.
- e. Our “**Precertification**” includes the following minimum requirements as prescribed by New Jersey law or regulation:
 - (1) The requirements of the “**Precertification**” only apply after the tenth day following the accident.
 - (2) We must be provided prior notice as indicated in our plan, with appropriate “**clinically supported**” findings, that:
 - (a) Additional treatment;
 - (b) Testing;
 - (c) The use of durable medical equipment;
 is required.
 - f. Once we receive such notice with the appropriate “**clinically supported**” findings, we will in accordance with our plan:
 - (1) Promptly review the notice and supporting materials; and

- (2) If required as part of our review:
 - (a) Request any additional medical records; or
 - (b) Schedule a physical examination.

We will then determine, and notify the “insured”, whether we will provide coverage for the additional treatment, testing or the use of durable medical equipment as indicated in our plan and within the applicable three business day requirements specified in the New Jersey Department of Banking and Insurance regulations. Any determination we make will be based on the determination of a physician or dentist.

- g. Any physical examination of an “insured” scheduled by us will be conducted in accordance with our plan. If a written report concerning the physical examination is prepared by the “health care provider”, we will make such report available to the “insured”, upon request.
- h. We may deny reimbursement of further treatment, testing, or the use of durable medical equipment for repeated unexcused failure of any “insured” to appear for a physical examination required by us, in accordance with our plan.

i. Notice Requirements

- (1) For non-emergency admissions, procedures, services or supplies listed above, you or your “health care provider” must contact us at least three (3) days prior to admission, treatment or purchase to obtain authorization.
- (2) We will provide you or your “health care provider” with our determination within those three (3) days.

- (3) For continued confinement as an inpatient beyond the time authorized, you or your “health care provider” must contact us at least 24 hours prior to the discharge date for additional authorization.
- (4) We will provide you or your “health care provider” with our determination within those 24 hours.
- (5) In the event we do not provide an “insured” or his or her “health care provider” with a determination within the time frames stated above, we will tell the “insured” or his or her “health care provider” what specific information is needed to make our determination.

In such circumstances, an “insured” may proceed with the treatment or procedure suggested by his or her “health care provider”, subject to the requirement that all medical services be “medically necessary”. Such courses of treatment or procedures may continue until such time we communicate with you or your “health care provider” that the treatment or procedure is not authorized.

- (6) In the event we do not respond to an “insured” or his or her “health care provider” within the time frames, we will not apply any additional co-payment requirements on the “insured” for “medically necessary” services incurred between the time the “insured” or his or her “health care provider” gives us notification and we respond.
- (7) In the event we do not authorize the admission, procedure, services or supplies, we will send a written explanation to the “health care provider”, stating

the reasons for the denial of the authorization.

5. Non-compliance

- a. For the care path medical protocols, the listed **“diagnostic test”** the applicable decision point provisions and **“Precertification”**, if an **“insured”** fails to:
 - (1) Submit requests for **Decision Point Review**, or **Precertification** where required;
 - (2) We are not provided **“clinically supported”** findings;

Then we will impose a co-payment penalty. The co-payment penalty will be 50% (in addition to any deductible or co-payment that applies under the policy) of the eligible charge for medically necessary services.

6. **“Medically Necessary”** or **“Medical Necessity”** means those services or supplies which are provided by a **“health care provider”** that are required to identify or treat a condition or injury, and which, as determined by us, are:

- a. Consistent with **“clinically supported”** symptoms, diagnoses or indications of the condition or injury;
- b. The most appropriate level of service that is in accordance with the standards of good practice and professional treatment protocols (including Care Path protocols as established by the New Jersey Department of Banking and Insurance). When applied to an in-patient, it further means that the symptoms or condition require that the services or supplies cannot be safely provided as an outpatient;
- c. Not primarily for any **“insureds”** convenience or any **“health care providers”** convenience; and
- d. Not unnecessary tests or treatments.

The fact that a **“health care provider”** prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received,

does not make the services or supplies **“medically necessary”**.

7. Voluntary Networks

Voluntary Networks means:

- a. **Upon** receiving notification of **“bodily Injury”** covered under this Policy, we will make available to the **“named Insured”** and the treating **“health care provider”** information about our approved Voluntary Networks providers for certain types of testing, durable medical equipment, prescription drugs, services or ambulatory surgery facilities.
- b. If an **“insured”** does not use a Voluntary Networks provider, we will impose a co-payment not to exceed 30% of the eligible charges for **“medically necessary diagnostic tests”** durable medical equipment, prescriptions, services or ambulatory surgery facilities.

PAYMENT OF BENEFITS

1. We may, at our option, pay any medical expense benefits or essential services benefits to the:
 - a. **“Insured”**; or
 - b. Person or organization providing products or services for such benefits.
2. These benefits shall not be assignable except to providers of service benefits. Any such assignment is not enforceable unless the provider of service benefits agrees to:
 - a. Be subject to the requirements of our **Decision Point Review Plan, “Precertification”**; and
 - b. Hold an **“insured”** harmless for penalty co-payments imposed by us for the failure of the provider of service benefits to adhere to the requirements of our **Decision Point Review Plan**, including but not limited to, failure to submit a request for Decision Point Review or **“Precertification”**; and
 - c. Submit disputes to the **“Reconsideration and Appeals Process”** prior to submitting any disputes through the Dispute Resolution Process (N.J.A.C.11:3-5); and
 - d. Furnish a copy of the signed assignment

agreement upon request.

3. Failure of the provider to comply with :
 - a. Our **Decision Point Review Plan, "Precertification"** or
 - b. The requirement to follow the "Reconsideration and Appeals Process" prior to initiating arbitration or litigation,will render any prior assignment of benefits under the policy null and void.
4. In the event of the death of an "**insured**", we will pay:
 - a. Any amounts payable, but unpaid prior to death, for medical expense benefits to the "**insured's**" estate.
 - b. Death benefits for an "**insured**" who was:
 - (1) An "**income producer**", to:
 - (a) The surviving spouse; or
 - (b) Surviving party who has entered into a civil union with the "**named Insured**" legally recognized under New Jersey law; or
 - (c) If there is no surviving spouse, or such surviving party, the surviving children; or
 - (d) If there are no surviving children, the "**insured's**" estate.
 - (2) A provider of essential services, to the person who has incurred the expense of providing essential services.
 - c. Funeral expense benefits to the "**insured's**" estate.

RECONSIDERATION AND APPEALS PROCESS

When a dispute arises related to **Decision Point Review** and/or **Precertification**, you must refer to the Decision Point Review Plan for how to proceed with an appeal in this situation.

When a dispute arises, other than under the **Decision Point Review**/"**Pre-certification**," any treating "**health care provider**" who has accepted an assignment of benefits or a power of attorney from an "**insured**" must submit a written request for the "Reconsideration and Appeals Process,"

specifying the issues in dispute, accompanied by supporting documentation, at least 30 days prior to initiating arbitration or litigation.

Written notice of the dispute and request for the "Reconsideration and Appeals Process" shall be submitted to "us" via certified mail/return receipt requested or via delivery mail service providing proof of delivery. Proof of receipt by "us" must be provided to "us" upon request.

DISPUTE RESOLUTION PROCESS

Any disputes not resolved under the Decision Point Review/"Pre-certification" or in the "Reconsideration and Appeals Process" may be submitted through the Dispute Resolution Process which is governed by regulations promulgated by the New Jersey Department of Banking and Insurance (**N.J.A.C.11:3-5.6**). However, prior to submitting such matter to dispute resolution, providers who are assigned service benefits by an "**insured**" or have a power of attorney from an "**insured**", shall be subject to our internal appeals process in accordance with New Jersey law or regulation. Unless emergent relief is sought, failure to utilize the "Reconsideration and Appeals Process" prior to filing arbitration or litigation will render any prior assignment of benefits null and void.

PROOF OF HEALTH BENEFITS PLAN COVERAGE

If the Schedule or Declarations indicates that the Medical Expense Benefits As Secondary Coverage option applies, the "**named insured**" must provide proof that the "**named insured**" and any "**family members**" are insured by health insurance coverage or benefits in a manner and to an extent approved by the New Jersey Department of Banking and Insurance.

DELETION OF BENEFITS OTHER THAN MEDICAL EXPENSE BENEFITS

If the Schedule or Declarations indicates that the Deletion of Benefits Other Than Medical Expense Benefits option applies, we will pay principal personal injury protection benefits consisting of only medical expense benefits for the "**named insured**" or any "**family member**".

EMPLOYEE BENEFITS REIMBURSEMENT

If an "**insured**" fails to apply for workers' compensation benefits or disability benefits for which that "**insured**" is eligible, we may immediately apply to the provider of such benefits for reimbursement of any benefits we have paid under this coverage.