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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	**Limit of Liability**
Medical Expenses	
"Named Insured" and "Family Members"	$_____ per person per accident however, regardless of the limit shown above, a limit of $250,000 per person per accident is available for a "named insured" or "family member" for "catastrophe injury treatment".
"Insureds" Other Than "Named Insured" and "Family Members"	$250,000 per person per accident.
Income Continuation	$100 per week to a maximum of $5,200
Essential Services	$12 per day to a maximum of $4,380
Death Benefits	
Income Producer	$5,200 less any Income Continuation benefits paid
Essential Services Provider	$4,380 less any Essential Services Benefits paid.
Funeral Expenses	$1,000

II. Extended Medical Expense Benefits Coverage Benefits	**Limit of Liability**
Medical Expenses	$_____ per person per accident.

III. Medical Expense Benefits Deductible

Unless otherwise indicated below or in the Declarations, medical expense benefits are subject to a deductible of $250 per accident.

☐ If indicated to the left or in the Declarations, medical expense benefits applicable to:

A. The "named insured" and "family members" shall be subject to a deductible of $_____per accident instead of the $250 deductible; and

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-Payments

Medical expense benefits are subject to a co-payment of 20% per accident for amounts payable between the applicable deductible and $5,000. In addition, the application of the following co-payments apply to the corresponding services when an insured does not voluntarily utilize a network facility:

1. Diagnostic lmaging and Electrodiagnostic Testing 30% per person/per service.
2. Durable Medical Equipment costing greater than $50.00, or rental greater than 30 days - 30% per person/per item.
3. Prescription Drugs - $10.00 per prescription.

V. Deletion of Benefits Other Than Medical Expense Benefits

☐ If indicated to the left or 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 to the left or 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 described below or in the Declarations, Pedestrian Personal Injury Coverage is the only personal injury protection coverage provided for that vehicle.

Description of Vehicle	**Premium**
1. _____	**$** _____
2. _____	**$**_____
3. _____	**$** _____

Benefits	**Limit of Liability**
Medical Expenses	$250,000 per person per accident
Income Continuation	$100 per week to a maximum of 5,200
Essential Services	12 per day to a maximum of $4,380
Death Benefits	
Income Producer	$5,200 less any Income Continuation Benefits paid
Essential Services Provider	$4,380 less any Essential Services Benefits paid
Funeral Expenses	$1,000

The policy also has Decision Point Review / Pre-Certification and Voluntary Network Features. Failure of an insured to comply with these features will result in the insured's having to pay an additional payment as more fully described in Section **IV - General Provisions, Part D – Special Requirements for Medical Expenses.**

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 or All Terrain Vehicle (ATV);
      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.
      e. An unregistered and/or uninsured vehicle.
   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 exist to justify ordering the treatment or test;
      b. Made an assessment of any current and/or historical subjective complaints, observations, objective findings, neurological 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. "Decision Point" means those junctures in the treatment of identified injuries where a decision must be made about the continuation or choice of further treatment. Decision point also refers to a determination to administer one of the tests listed in N.J.A.C. 11:3-4.5(b).
   7. "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.
   8. "Durable Medical Equipment" is equipment which is:
      a. designed and able to withstand repeated use;
      b. primarily and customarily used to serve a medical purpose;
      c. generally not useful to an insured in the absence of an illness or injury; and
      d. suitable for use in the home.

      Some examples are walkers, wheelchairs, hospital-type beds, breathing equipment and transcutaneous electrical nerve stimulator units. Among other things, durable medical goods does not include adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, emergency alert

equipment, handrails, heat appliances, improvements made to the home or place of business, waterbeds, whirlpool baths and exercise and massage equipment. We cover charges for the rental of "durable medical equipment" needed for therapeutic use. At our option, and with our pre-certification, we may cover the purchase of such items when it is less costly and more practical than rental. But, we do not pay for:

a. any purchase without our advance written approval;
b. replacement or repairs; or
c. the rental or purchase of items such as air conditioners, exercise equipment, saunas and air humidifiers which do not fully meet the definition of durable medical goods.

9. "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 items and conditions of the plan, without application of the deductible 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, when an incurred medical expense is not included on the medical fee schedules.
10. "Emergency care" means all treatment of a "bodily injury" which manifests itself by acute symptoms or 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.
11. "Health care provider" or "provider" means those persons licensed or certified in the state where services are rendered 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;
       2. Licensed by the Department of Health and Senior Services of New Jersey;
    b. other hospitals or health care facilities designated by the Department of Health and Senior Services of New Jersey to provide health care services or other facilities, including facilities for radiology and diagnostic testing, freestanding 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) Chiropodists (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.

    "Health Care Provider" does not include practitioners of:
    a. Massage therapy;
    b. Aromatherapy;
    c. Folk medicine;
    d. Music/Sound Therapy;
    e. Herbal therapy;
    f. Homeopathy;
    g. New Age healing;
    h. Naturopathy;
    i. Magnetic Field Therapy; and
    j. Other non-medical services

    unless specifically recognized as compensable by the New Jersey Department of Banking and Insurance under New Jersey law or regulation.
12. "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.

13. "Hospital" means a facility which mainly provides impatient care for ill or injured people. We will recognize a facility as a hospital if it carries out its' stated purpose under all relevant state and local laws and it is either:
    a. accredited as a hospital by the Accreditation of Health Care Organizations; or
    b. approved as a hospital by Medicare, i.e., Part A and B of the health care program for the aged and disabled provider by Title XVII of the United States Social Security Act as amended from time to time.
14. "Hospital admission" means admission of an insured to a hospital or health care facility as an inpatient for medically necessary and appropriate care and treatment of an illness or injury.
15. "Identified injury" means the following "bodily injuries" for which the New Jersey Department of Banking and Insurance has established standard courses of appropriate diagnosis and treatment:
    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 Injuries
    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 such injuries.
16. "Income" means salary, wages, tips, commissions, fees and other earnings derived from work or employment.
17. "Income producer" means a person who, at the time of the accident, was in an occupational status earning or producing "income".
18. "Insured motor vehicle" means a motor vehicle:
    a. That is insured for both Bodily Injury Liability Coverage and Personal Injury Protection Coverage under this policy; and
    b. For which specific premiums have been charged.
19. "Medically necessary" or "medical necessity" means that the medical treatment or diagnostic test is consistent with the clinically supported symptoms, diagnosis or indications of the injured person, and:
    1. The treatment is the most appropriate level of service that is in accordance with the standards of good practice and standard professional treatment protocols including the Care Paths and other protocols recognized or designated by the Commissioner of Banking and Insurance of New Jersey, as applicable;
    2. The treatment of the injury is not primarily for the convenience of the injured person or provider; and
    3. Does not include unnecessary testing or treatment.
20. "Named insured" means:
    a. The person named in the Declarations; and
    b. That person's spouse if a resident of the same household.

    However, if
    a. The spouse ceases to be a resident of the same household during the policy period, the spouse 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.
21. "Non-medical expenses" 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.

    prescribed by a treating "health care provider" for permanent or significant brain, spinal cord or disfiguring injury.

22. "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/or tracks.
23. "Pre-certification" or "pre-certified" means a program by which the medical necessity of diagnostic tests, medical treatments and procedures are subject to prior authorization, utilization review and/or case management.
24. "Prescription drugs" are drugs, biologicals and compound prescriptions which are required to show on the manufacturer's label the words, "Caution-Federal Law Prohibits Dispensing without a Prescription" or other drugs and devices as determined, such as insulin. In addition, we only cover drugs which are:
    a. approved for treatment of the insured's illness or
       injury by the Food and Drug Administration;
    b. approved by the Food and Drug Administration for the treatment of a particular diagnosis of condition other than the insured's and recognized as appropriate medical treatment for the insured's diagnosis or condition in one or more of the following established reference compendia:

(1) The American Medical Association Drug Evaluations;
(2) The American Hospital Formulary Service Drug Information;
(3) The United States Pharmacopoeia Drug Information: or

c. Recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal. Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

"Prescription drugs" does not include:

a. drugs labeled, "Caution — Limited by Federal Law to Investigational Use"; or
b. any drug which the food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed;
c. drugs that can be bought without a prescription even if a health care provider orders them.

25. "Regular working day" means Monday through Friday from 8:00 a.m. to 5:00 p.m. Eastern Time, not including legal holidays.
26. "Surgery" means:
    a. The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations and other invasive procedures;
    b. The correction of fractures and dislocations;
    c. Reasonable and customary preoperative and post-operative care; or
    d. Any of the procedures designated by the Current Procedures Terminology (C.P.T.) codes, i.e., the codes listed in the most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care as surgery.

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 Schedule or 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"

All medical expenses must:

1. Be rendered by a "health care provider";
2. Be "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 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 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".
      (3) No coverage is afforded where the "insured" or "family member" is the operator of a:
         i. public or livery conveyance.
         ii. motorcycle or All Terrain Vehicle (ATV)
         iii. Other "highway vehicle" while being used for business purposes.
   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) All Terrain Vehicle (ATV); or
         (c) Vehicle being used as a public or livery conveyance;
3. Subject to the limit shown in the Schedule or in the Declarations, extended medical expense benefits consist of medical expenses.

C. Pedestrian Personal Injury Protection Coverage
INSURING AGREEMENT

1. If the Schedule or 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, and
   e. Funeral Expenses.

EXCLUSIONS

A. We do not provide Personal Injury Protection coverage for "bodily injury":
   1. To any "insured":
      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 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 automobile registered or principally garaged in New Jersey that was being operated without personal injury protection coverage.

      We have the right to inspect any vehicle that is claimed to be inoperable prior to providing any coverage under this policy.

   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) Workers' compensation policy; or
            (c) In (a) and (b) above, where coverage is available under workers compensation for an injured party's claim, we do not afford additional coverage for specific treatments or testing not covered by the workers compensation policy including, but not limited to, Chiropractic.
            (d) 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. Who is not "occupying" "your covered auto" 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 diagnostic tests:
   1. Which have been determined to yield no data of any significant value in the development evaluation and implementation of an appropriate plan of treatment for injuries sustained in motor vehicle accidents as specified in N.J.A.C. 11:3-4.5(a); or
   2. Any other diagnostic test that is determined to be ineligible for coverage under personal Injury Protection Coverage by New Jersey law or regulation.

LIMIT OF LIABILITY

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:
      a. Workers' compensation law, disability benefits law, or similar law;
      b. Medicare provided under federal law; or
      c. 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.

D. Any amounts payable for medical expense benefits as a result of any one accident shall be:
   1. Reduced by any 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. In addition, the application of the following co-payments apply to the corresponding services when an insured does not voluntarily utilize a network facility:
      1. Diagnostic Imaging and Electrodiagnostic Testing – 30% per person/per service.
      2. Durable Medical Equipment costing greater than $50.00, or rental greater than 30 days – 30% per person/per item.
      3. Prescription Drugs – $10.00 per prescription.

   Proof that any such deductibles and co-payments have been satisfied must be furnished, if we request it.

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.
      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 "name 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 Schedule or 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" 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, expect 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 Schedule or 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. In addition, the application of the following co-payments apply to the corresponding services when an insured does not voluntarily utilize a network facility:
            1. Diagnostic Imaging and electrodiagnostic Testing – 30% per person/per service.
            2. Durable Medical Equipment costing greater than $50.00, or rental greater than 30 days – 30% per person/per service.
            3. Prescription Drugs – $10.00 per prescription.
         (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 Schedule or 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. Duties After An Accident Or Loss

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

A. In the event of an accident, the "insured" must provide us with prompt notice of the loss. Such notice shall include:
   1. Sufficient details to identify the "insured";
   2. Reasonably obtainable information as to how, when and where the accident happened;
   3. A detailed description of the injuries sustained by the "insured"; and
   4. The names of any physicians and/or medical facilities consulted by the "insured" with respect to the injuries along with their contact information including address and telephone number.

B. A person seeking Personal Injury Protection Coverage must:
   1. Cooperate fully with our investigation of the claim;
   2. Provide us with a detailed statement concerning the nature and circumstances of the loss and any other facts relevant to our investigation;
   3. Submit to examination under oath (EUO), by persons we designate, more than once if necessary;
      a. We may sequester parties during the EUO.
      b. Our Attorney, Claim Representative, SIU Investigator, and/or any other persons as appropriate may attend and participate in the EUO.
      c. Neither an "insured" nor an assignee of the "insured's" benefits shall be entitled to compensation for their attendance at an EUO.
   4. Authorize us to obtain:
      a. Medical reports; and
      b. Other documents or records we deem relevant to our investigation of the claim.
   5. At our request, promptly supply us with a written proof of claim, on our form, 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
   6. 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 that is or may be legally liable.
   7. Submit, as often as we require, to physical or mental examinations by physicians we select. We will provide the "insured" or their designee with a copy of the medical report, if requested.
      a. The "insured" is expected to attend each examination appointment as scheduled by us or our Plan Administrator.
         1. Failure of an "insured" to attend a scheduled examination without a minimum of 3 business days notice to the examining physician or the Plan Administrator shall constitute an "unexcused" failure to attend. The burden is on the "insured" to prove that proper notice was provided.
         2. Failure of an "insured" to attend a scheduled examination will be considered "excused" if the "insured" notifies the examining physician or Plan Administrator at least 3 business days prior to the examination date and re-schedules the appointment for a date, not to exceed 35 calendar days from the date of the original appointment.
            a. If an "insured" has an otherwise "excused" failure to attend a scheduled examination and does not re-schedule the

appointment to occur within 35 calendar days of the original appointment date, the failure to attend the original examination shall be deemed "unexcused".

b. If an "insured" re-schedules an examination for a date more than 35 calendar days from the date of the original appointment, any failure to attend the re-scheduled appointment will be "unexcused".

3. If an "insured" attends a scheduled examination, but fails to supply
   a. all requested medical records, test results, diagnostic imaging films and other pertinent materials; and
   b. proper photo identification

   it shall be deemed an "unexcused" failure to attend the examination and the examination will not take place.

Consequences of "Unexcused" Failures to Attend Scheduled Independent Medical Examinations.

If an "insured" has more than one "unexcused" failure to attend a scheduled examination, any treatment, diagnostic testing, prescription drugs or durable medical equipment provided on or after the date of the second "unexcused" failure to attend the examination shall not be reimbursable under this policy.

C. The following provisions are added:
   a. 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; and
      2. Any penalty imposed in accordance with our decision point review plan.

IV. 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

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 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 Decision Point Review:
      (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) Needle EMG (EMG)
      (8) Nerve Conduction Velocity (NCV)
      (9) Somatosensory Evoked Potential (SSEP)
      (10) Sonogram / Ultrasound
      (11) Visual Evoked Potential / Visual Evoked Response (VEP/VER)
      (12) Any of the following "diagnostic tests" when not otherwise excluded from coverage under Exclusion C.
         (a) Brain Mapping;
         (b) Doppler Ultrasound;
         (c) Electroencephalogram (EEG);
         (d) Needle Electromyography (Needle EMG)
         (e) Surface Electromyography (Surface EMG)
         (f) Sonography;
         (g) Thermography / thermograms;
         (h) Videofluoroscopy
      (13) Any other "diagnostic test" that is subject to the requirements of our Decision Point Review / Pre-Certification 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 for 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 / Pre-Certification 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 / Pre-Certification Plan
   a. Coverage for certain medical expenses under this endorsement is subject to our Decision Point Review / Pre-Certification Plan, which provides specific notice and procedural requirements that must be adhered to in accordance with New Jersey law or regulation. We will make a copy of the Plan available to an "insured" upon request.

   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 / Pre-Certification Plan only apply after the tenth day following an accident and do not apply to "emergency care".
      (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 2a;
         (c) The use of "durable medical equipment" or "prescription drugs"; or
         (d) Any of the procedures requiring pre-certification under the Plan;

      is required.

      The notice and "clinically supported" findings may include a comprehensive 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; and/or
         (b) Schedule a physical examination.

d. We will then determine, and notify the "insured" within 3 business days whether we will certify the additional treatment, "diagnostic test", "prescription drugs" or "durable medical equipment" as indicated in our plan.

Any determination we make regarding certification of treatment, "diagnostic testing", "prescription drugs" or "durable medical equipment" will be based on the opinion 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 examining physician, we will make such report available to the "insured" upon request.

We may deny reimbursement of treatment, "diagnostic testing", "prescription drugs", and/or "durable medical equipment" for the "unexcused" failure of an "insured" to attend physical examinations scheduled by us in accordance with our plan.

f. Consequences of Non-Compliance:

If there is non-compliance with the policy's Decision Point Review / Pre-Certification provisions, the "insured" shall be subject to an additional co-payment of 50% in addition to the standard co-payment and any other co-payments which may apply. Any amounts for which the insured becomes responsible as a result of non-compliance with the policy's utilization review features cannot be used to meet the policy's:

a. Deductibles, if any
b. Co-payments, if any.

However, we will not impose a penalty where we received proper notice and were provided with necessary "clinically supported findings" and we failed to render a determination or respond with a request for additional information within the timeframes provided for in our plan or applicable regulations.

Compliance with the policy's Decision Point Review / Pre-Certification features does not guarantee the amount we will pay for medically necessary expenses. The amount we will pay is based on:

a. The medically necessary expenses actually incurred;
b. The insured being eligible for coverage under the policy at the time the medically necessary expenses are incurred;
c. The insured's deductible(s) and co-payment(s), if any (proof that any such deductibles and co-payments have been satisfied must be furnished, if we request it);
d. The insured's having incurred the expenses because of an automobile related injury, i.e., bodily injury sustained by the insured as a result of an accident;
   (1) While occupying, entering, leaving or using an "auto"; or
   (2) As a pedestrian;
   And the injury was caused by an automobile or by an object propelled by or from an automobile.
e. And all other policy provisions, including duties of cooperation, Limit of Liability and Other Insurance.

VOLUNTARY NETWORK PROVISIONS

1. The policy encourages an "insured" to obtain certain services and/or supplies from a network of providers of services and/or supplies located in the "insured's" geographical area. The services and/or supplies that are currently subject to the Voluntary Network provisions of the policy are:
   a. "Durable medical equipment";
   b. Magnetic Resonance Imaging (MRI);
   c. Computer Assisted Tomography (CT/CAT Scan);
   d. "Electrodiagnostic Testing"; and
   e. "Prescription drugs".

   Use of the network is voluntary; however, if the insured complies with the Voluntary Network provisions of the policy, the co-payments listed under "Medical Expense Benefits Co-Payments" (Schedule Section IV) will be waived.
2. To utilize the voluntary network, an "insured" or assignee must contact the Decision Point Review / Pre-Certification Plan Administrator and request a list of participating Network Providers for the "insured's" geographic area. We will provide a toll free telephone number for this purpose. We may also, at our option, make this information available via the internet.
3. A single written notification sent via regular mail to an "insured" and/or assignee either by us or our designated representative (including our Plan Administrator) shall constitute sufficient notice of the voluntary network provisions of this policy.
   a. Receipt of this policy constitutes sufficient notice of the voluntary network provisions to the "Named Insured" and any "family members".
4. It is the obligation of the "insured" to inform all treating providers of the voluntary network provisions of the policy and to verify that any relevant "diagnostic testing", "durable medical equipment", or "prescription drugs" are obtained

through a Network Provider in order to have the corresponding co-payment waived.

PAYMENT OF BENEFITS

1. We may, at our option, pay any medical expense benefits to the:
   a. "Insured"; or
   b. "Health Care Provider" that afforded the services and/or supplies to the "insured".

Our decision to make payment directly to a "Health Care Provider" does not constitute our acceptance of an assignment of benefits from that "Health Care Provider".

ASSIGNMENT OF BENEFITS

Benefits under this policy are not assignable except to a "health care provider" that provides covered services and/or supplies to the "insured".

In order for any assignment of benefits to be considered valid, the "health care provider" must agree, in writing, as part of the assignment, to comply fully with our Decision Point Review / Pre-Certification Plan and all the terms and conditions of our policy. An assignment that does not explicitly contain such an agreement is invalid.

The provider must also agree, in writing as part of their assignment, to hold harmless the Insured, the Company, and the Company's Vendor(s) for any reduction in benefits caused by the provider's failure to comply with the terms of the Decision Point Review / Pre-Certification Plan or our Policy.

Any and all assignments of benefits by an "insured" to a "health care provider" become void and unenforceable under the following conditions:

a. Coverage is not afforded under the policy;
b. A "provider" of services and/or supplies does not submit to an Examination Under Oath;
c. A "provider" of services and/or supplies does not comply with all requests for medical records, test results, or other records including, but not limited to corporate documents necessary to verify the "provider's" compliance with NJ law and regulation; or
d. A "provider" does not comply with all requirements, duties and conditions of the Policy, including but not limited to all duties of cooperation listed in Part E of the policy.
e. A "provider" does not comply with the Dispute Resolution provisions of the policy including utilization of the Internal Appeals Process.

2. In the event of the death of an "insured", we will pay any amounts payable, but unpaid prior to death, for medical expense benefits to the "insured's" estate.

DISPUTE RESOLUTION

If we and any assignee seeking Personal Injury Protection benefits disagree as to the provision of said benefits, either party shall have the right to submit the matter to litigation either through the Dispute Resolution Organization (DRO) appointed by the New Jersey Commissioner of Banking and Insurance or via the Courts.

However, prior to entering into any form of litigation, the assignee must utilize our Internal Appeals process as outlined in this policy and our Decision Point Review / Pre-Certification plan approved by the Department of Banking and Insurance.

Internal Appeal Process Requirements

All appeals concerning Decision Point Review, Pre-certification, or payment of medical bills must be submitted to our Plan Administrator for reconsideration. Any other disputes or any disputes not resolved through reconsideration by the Plan Administrator must be submitted to us as follows:

1. Written notice of the dispute and request for Appeal shall be submitted to the Company by the assignee via certified mail/return receipt requested or via another courier that provides proof of delivery such as Federal Express. Proof of receipt by us must be provided to the Company, upon request.

2. The assignee shall set forth in the notice to the Company the facts underlying the dispute. The assignee shall also include copies of all relevant supporting documents with the notice, including, but not limited to, any unpaid medical bills that may be in dispute.

3. The Company shall have 30 days from receipt of the notice and supporting documents to resolve the dispute. During this time, the assignee shall cooperate with the investigation of the matter in question and negotiate in good faith with the Company in an effort to resolve the dispute amicably.

4. If, after 30 days, the good faith efforts of both parties fail to bring resolution to the dispute, the assignee may proceed to litigate the matter. Any request for dispute resolution through the DRO may include a request for review by a Medical Review Organization.

If the assignee retains counsel to represent them during the Appeal Process, they do so strictly at their own expense. No counsel fees or costs incurred during the Appeal Process shall be compensable irrespective of whether the dispute is resolved on appeal or is eventually litigated.

The assignee agrees to hold harmless and indemnify the Company for any legal fees and/or costs awarded should the assignee litigate any matter prior to fulfilling the Dispute Resolution requirements of the policy including utilization of the Internal Appeals process.

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" and any "family members" are insured by health insurance coverage and 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 Declaration indicates that the Deletion of Benefits Other Than Medical Expense Benefits option applies, we will pay Principal Personal Injury Protection Benefits for the "named insured" and any "family member".

EMPLOYEE BENEFITS REIMBURSEMENT

If an "insured" fails to apply for workers' compensation 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.