CHAPTER 3

AUTOMOBILE INSURANCE

Authority

N.J.S.A. 17:1C–6(e) and 17:1–8.1.

Source and Effective Date

R.2001 d.44, effective January 4, 2001.
See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

Executive Order No. 66(1978) Expiration Date

Chapter 3, Automobile Insurance, expires on January 4, 2006.

Chapter Historical Note

Chapter 3, New Jersey Automobile Insurance Plan, was adopted as R.1972 d.20, effective January 31, 1972. See: 3 N.J.R. 223(d), 4 N.J.R. 49(d).

Subchapter 7, Automobile Reparation Reform Act, was adopted as R.1972 d.244, effective December 4, 1972. See: 4 N.J.R. 270(a), 5 N.J.R. 13(c).

Subchapter 10, Auto Physical Damage Claims, was adopted as R.1976 d.46 and R.1976 d.47, effective May 1, 1976. See: 8 N.J.R. 38(b), 8 N.J.R. 136(b).

Pursuant to Executive Order No. 66(1978), Subchapter 8, Nonrenewal of Automobile Insurance Policies, was readopted as R.1983 d.190, effective June 6, 1983. See: 15 N.J.R. 231(a), 15 N.J.R. 927(a).

Subchapter 12, Automobile Rate Filers: Flattening of Premium Taxes and Assessments Made for the Unsatisfied Claim and Judgment Fund, was adopted as R.1983 d.424, effective October 3, 1983. See: 15 N.J.R. 1170(a), 15 N.J.R. 1666(a).

Subchapter 13, Automobile Rate Filers: Deductibles for Private Passenger Automobile Collision and Comprehensive Coverage, was adopted as R.1983 d.467, effective October 17, 1983. See: 15 N.J.R. 1342(a), 15 N.J.R. 1769(b).

Pursuant to Executive Order No. 66(1978), Subchapter 6, Insurance Identification Card, was readopted as R.1983 d.648, effective December 29, 1983. See: 15 N.J.R. 1919(a), 16 N.J.R. 145(c).

Public Notice: Automobile Insurance Written Notice/Buyer's Guide Coverage Selection Form. See: 16 N.J.R. 254(d).

Subchapter 15, Standards for Written Notice: Buyer's Guide and Coverage Selection Form, was adopted as R.1984 d.114, effective April 2, 1984. See: 15 N.J.R. 2142(a), 16 N.J.R. 733(a).

Subchapter 14, Personal Injury Protection Options, was adopted as R.1984 d.116, effective April 2, 1984. See: 15 N.J.R. 2139(a), 16 N.J.R. 730(b).

The Executive Order No. 66(1978) expiration date of Subchapter 7, Automobile Reparation Reform Act, was extended by gubernatorial directive from August 17, 1984 to November 15, 1984, and was further extended by gubernatorial directive from November 15, 1984 to February 13, 1985. See: 17 N.J.R. 43(a).

Pursuant to Executive Order No. 66(1978), Subchapter 7, Automobile Reparation Reform Act, was readopted as R.1985 d., effective February 13, 1985. See: 17 N.J.R. 43(a), 17 N.J.R. 707(b).

Subchapter 17, Rating Organizations, was adopted as R.1985 d.609, effective October 6, 1985. See: 16 N.J.R. 2936(a), 17 N.J.R. 2905(a).

Pursuant to Executive Order No. 66(1978), Chapter 3, Automobile Insurance, was readopted as R.1985 d.654, effective January 6, 1986, operative May 6, 1986. See: 16 N.J.R. 3286(a), 17 N.J.R. 89(b).

Subchapter 20, Reporting Financial Disclosure and Excess Profit Reports, was adopted as R.1986 d.111, effective April 7, 1986. See: 17 N.J.R. 2597(a), 18 N.J.R. 692(a).

Subchapter 17, Rating Organizations, was repealed and Subchapter 17, Rating Organizations, was adopted as new rules by R.1986 d.419, effective October 6, 1986. See: 18 N.J.R. 1171(b), 18 N.J.R. 2045(a).

Subchapter 22, Coverage Option Survey: Personal Injury Protection and Tort Threshold Options, was adopted as R.1986 d.463, effective November 17, 1986. See: 18 N.J.R. 1344(b), 18 N.J.R. 2329(a).

Subchapter 23, Dangerous Drivers or Drivers with Excessive Claims, was adopted as R.1987 d.527, effective December 21, 1987. See: 19 N.J.R. 1880(a), 19 N.J.R. 2403(b).

Public Notice: Rescission of Circular Letter #75. See: 19 N.J.R. 570(e).

Subchapter 26, Accident Claims, Subchapter 27, Unsatisfied Claim and Judgment Fund Board, and Subchapter 28, Unsatisfied Claim and Judgment Fund's Reimbursement of Excess Medical Expense Benefits Paid by Insurers, were adopted as R.1989 d.268, effective May 15, 1989. See: 21 N.J.R. 688(a), 21 N.J.R. 1363(a).

Subchapter 20, Reporting Financial Disclosure and Excess Profit Reports, was repealed and Subchapter 20, Reporting Financial Disclosure and Excess Profit Reports, was adopted as new rules by R.1989 d.277, effective May 15, 1989. See: 21 N.J.R. 667(b), 21 N.J.R. 1335(a), 21 N.J.R. 1517(b).

Subchapter 24, Policy Constants, and Subchapter 25, Residual Market Equalization Charges (RMECs), were adopted as R.1989 d.278, effective May 15, 1989. See: 20 N.J.R. 3104(a), 21 N.J.R. 1358(b).

Subchapter 20A, Standard Limiting Effect of Negative Excess Investment Income in the Computation of Excess Profits, was adopted as R.1989 d.306, effective June 5, 1989. See: 21 N.J.R. 842(a), 21 N.J.R. 1517(c).

Subchapter 17, Rating Organizations, was repealed by R.1989 d.328, effective June 19, 1989. See: 21 N.J.R. 973(a), 21 N.J.R. 1708(a).

Subchapter 30, Motor Vehicle Self–Insurance, was adopted as R.1989 d.584, effective November 20, 1989. See: 21 N.J.R. 2876(a), 21 N.J.R. 3666(b).

Subchapter 31, Examination of the Financial Experience of Private Passenger Automobile Insurers, was adopted as R.1990 d.108, effective February 5, 1990. See: 21 N.J.R. 3726(a), 22 N.J.R. 425(a).

Subchapter 18, Private Passenger Automobile Insurance: Rate Filing Review Procedures, was adopted as R.1990 d.109, effective February 5, 1990. See: 21 N.J.R. 3422(b), 22 N.J.R. 421(a).

Subchapter 16, Rate Filing Requirements: Voluntary Market Private Passenger Automobile Insurance, was adopted as R.1990 d.116, effective February 5, 1990. See: 21 N.J.R. 2182(a), 22 N.J.R. 399(a).

Subchapter 1, Provisions and Operations, was repealed and Subchapter 1, Commercial Automobile Insurance Plan, was adopted as new rules by R.1990 d.118, effective February 5, 1990. See: 21 N.J.R. 3613(a), 22 N.J.R. 392(b).

Subchapter 16A, Flex Rate Percentage Calculations for Private Passenger Automobile Insurance, was adopted as R.1990 d.161, effective March 19, 1990. See: 21 N.J.R. 3719(a), 22 N.J.R. 963(a).

Subchapter 34, Eligible Persons Qualifications and Automobile Insurance Eligibility Points Schedule, was adopted as emergency new rules by R.1990 d.620, effective November 26, 1990, operative April 1, 1991, to expire January 25, 1991. See: 22 N.J.R. 3847(a). The provisions of R.1990 d.620 were readopted as R.1991 d.93, effective January 25,

1991, operative April 1, 1991, with changes effective February 19, 1991. See: 22 N.J.R. 3847(a), 23 N.J.R. 572(a)

Subchapter 36, Automobile Physical Damage Insurance Inspection Procedures, was adopted as emergency new rules by R.1990 d.622, effective November 26, 1990, operative March 1, 1991, to expire January 25, 1991. See: 22 N.J.R. 3861(a). The provisions of R.1990 d.622 were readopted as R.1991 d.95, effective January 25, 1991, operative October 1, 1992, with changes effective February 19, 1991. See: 22 N.J.R. 3861(a), 23 N.J.R. 579(a), 23 N.J.R. 1132(c).

Subchapter 38, Towing and Storage Fee Schedule, was adopted as emergency new rules by R.1990 d.623, effective November 26, 1990, operative January 1, 1991, to expire January 25, 1991. See: 22 N.J.R. 3874(a). The provisions of R.1990 d.623 were readopted as R.1991 d.97, effective January 25, 1991, with changes effective February 19, 1991. See: 22 N.J.R. 3874(a), 23 N.J.R. 592(a).

Subchapter 29, Medical Fee Schedules: Automobile Insurance Personal Injury Protection Coverage, was adopted as emergency new rules by R.1990 d.624, effective November 26, 1990, operative January 1, 1991, to expire January 25, 1991. See: 22 N.J.R. 3809(a). The provisions of R.1990 d.624 were readopted as R.1991 d.96, effective January 25, 1991, with changes effective February 19, 1991. See: 22 N.J.R. 3809(a), 23 N.J.R. 536(a).

Subchapter 37, Order of Benefit Determination Between Automobile Personal Injury Protection and Health Insurance, was adopted as emergency new rules by R.1990 d.625, effective November 26, 1990, to expire January 25, 1991. See: 22 N.J.R. 3777(a). The provisions of R.1990 d.625 were readopted as R.1991 d.90, effective January 25, 1991, with changes effective February 19, 1991. See: 22 N.J.R. 3777(a), 23 N.J.R. 597(a).

Subchapter 35, Private Passenger Automobile Insurance Underwriting Rules, was adopted as emergency new rules by R.1990 d.627, effective November 26, 1990, to expire January 25, 1991. See: 22 N.J.R. 3856(a). The provisions of R.1990 d.627 were readopted as R.1991 d.94, effective January 25, 1991, with changes effective February 19, 1991. See: 22 N.J.R. 3856(a), 23 N.J.R. 577(a).

Subchapter 19, Standard/Non–Standard Rating Plans, was adopted as emergency new rules by R.1990 d.628, effective November 26, 1990, to expire January 25, 1991. See: 22 N.J.R. 3804(a). The provisions of R.1990 d.628 were readopted as R.1991 d.92, effective January 25, 1991, with changes effective February 19, 1991. See: 22 N.J.R. 3804(a), 23 N.J.R. 532(a).

Pursuant to Executive Order No. 66(1978), Chapter 3, Automobile Insurance, was readopted as R.1991 d.45, effective January 4, 1991, and Subchapters 2 through 5, concerning the Automobile Insurance Plan (AIP), were repealed by R.1991 d.45, effective February 4, 1991. See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).

Subchapter 24, Policy Constants, was repealed by R.1991 d.216, effective April 15, 1991. See: 22 N.J.R. 3441(a), 23 N.J.R. 1132(a).

Subchapter 25, Residual Market Equalization Charges (RMECs), was repealed by R.1991 d.217, effective April 15, 1991. See: 22 N.J.R. 3442(a), 23 N.J.R. 1132(b).

Subchapter 39, Reductions in Premium Charges for Private Passenger Automobiles Equipped with Anti–Theft, Vehicle Recovery and Safety Features, was adopted as R.1991 d.363, effective July 15, 1991, operative September 1, 1991. See: 23 N.J.R. 384(a), 23 N.J.R. 2144(a).

Subchapter 33, Appeals from Denial of Automobile Insurance, was adopted as R.1992 d.192, effective April 30, 1992. See: 24 N.J.R. 546(a), 24 N.J.R. 1510(a).

Subchapter 40, Insurers Required to Provide Automobile Insurance Coverage to Eligible Persons, was adopted as R.1992 d.207, effective May 4, 1992. See: 23 N.J.R. 3736(a), 24 N.J.R. 336(a), 24 N.J.R. 1796(b).

Subchapter 2, New Jersey Personal Automobile Insurance Plan, was adopted as new rules by R.1992 d.370, effective September 21, 1992. See: 24 N.J.R. 331(a), 24 N.J.R. 3400(a).

Subchapter 3, Limited Assignment Distribution Servicing Carriers, was adopted as new rules by R.1992 d.371, effective September 21, 1992. See: 24 N.J.R. 519(a), 24 N.J.R. 3414(a).

Subchapter 42, Producer Assignment Program, was adopted as emergency new rules by R.1992 d.381, effective September 4, 1992, to expire November 3, 1992. See: 24 N.J.R. 3421(a). The provisions of R.1992 d.381 were readopted as R.1992 d.482, effective November 2, 1992, with changes effective December 7, 1992. See: 24 N.J.R. 3421(a), 24 N.J.R. 4397(a).

Subchapter 44, Special Rules for Effecting Coverage for Private Passenger Automobile Insurance, was adopted as emergency new rules by R.1993 d.135, effective March 1, 1993, operative March 8, 1993, to expire April 30, 1993. See: 25 N.J.R. 1290(a). The provisions of R.1993 d.135 were readopted as R.1993 d.238, effective April 30, 1993. See: 25 N.J.R. 1290(a), 25 N.J.R. 2479(a).

Subchapter 2B, Market Transition Facility of New Jersey Suspension of Claims, was adopted as emergency new rules by R.1994 d.164, effective March 1, 1994, to expire April 30, 1994. See: 26 N.J.R. 1393(a). The provisions of R.1994 d.164 were readopted as R.1994 d.261, effective April 29, 1994. See: 26 N.J.R. 1393(a), 26 N.J.R. 2288(a).

Subchapter 32, Certification of Compliance: Mandatory Liability Coverages, was adopted as R.1994 d.477, effective September 19, 1994. See: 26 N.J.R. 1939(a), 26 N.J.R. 3866(a).

Subchapter 31, Examination of the Financial Experience of Private Passenger Automobile Insurers, was repealed by R.1995 d.171, effective March 20, 1995. See: 27 N.J.R. 41(a), 27 N.J.R. 1190(b).

Subchapter 45, Insurers Required to Provide Survey Information, was adopted as R.1995 d.235, effective May 1, 1995. See: 27 N.J.R. 289(a), 27 N.J.R. 1803(a).

Pursuant to Executive Order No. 66(1978), Chapter 3, Automobile Insurance, was readopted as R.1996 d.58, effective January 4, 1996, and Subchapter 2A, New Jersey Automobile Full Insurance Underwriting Association Claims Payment Deferral, Subchapter 3, Limited Assignment Distribution Servicing Carriers, and Subchapter 23, Dangerous Drivers or Drivers with Excessive Claims, were repealed by R.1996 d.58, effective February 5, 1996. See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).

Subchapter 20A, Standard Limited Effect of Negative Excess Investment Income in the Computation of Excess Profits, was repealed by R.1996 d.312, effective July 15, 1996. See: 28 N.J.R. 1616(a), 28 N.J.R. 3627(b).

Subchapter 25, Private Passenger Automobile Insurance: Notification by Treating Health Care Providers, was adopted as new rules by R.1997 d.14, effective January 6, 1997. See: 28 N.J.R. 3876(a), 29 N.J.R. 132(a).

Subchapter 24, Defensive Driving Rate Reductions, was adopted as new rules by R.1997 d.522, effective December 15, 1997. See: 28 N.J.R. 4854(a), 29 N.J.R. 5305(a).

Subchapter 28A, Unsatisfied Claim and Judgment Fund Assessments, was adopted as R.1997 d.535, effective December 15, 1997. See: 29 N.J.R. 4246(a), 29 N.J.R. 5309(a).

Subchapter 19A, Tier Rating Plans and Underwriting Rules, was adopted as R.1998 d.129, effective March 2, 1998. See: 29 N.J.R. 5253(a), 30 N.J.R. 839(a).

Subchapter 46, Automobile Insurance Urban Enterprise Zone Program, was adopted as R.1998 d.290, effective June 1, 1998. See: 30 N.J.R. 773(a), 30 N.J.R. 2010(a).

Subchapter 3, Basic Automobile Insurance Policy, was adopted as new rules by R.1998 d.592, effective December 21, 1998, operative March 22, 1999. See: 30 N.J.R. 3209(a), 30 N.J.R. 4398(a).

Subchapter 5, Personal Injury Protection Dispute Resolution, was adopted as new rules by R.1998 d.593, effective December 21, 1998. See: 30 N.J.R. 3359(a), 30 N.J.R. 4437(a).

Subchapter 4, Personal Injury Protection Benefits; Medical Protocols; Diagnostic Tests, was adopted as new rules by R.1998 d.597, effective December 21, 1998, operative March 22, 1999. See: 30 N.J.R. 3211(a), 30 N.J.R. 3748(a), 30 N.J.R. 4401(a).

Subchapter 38, Towing and Storage Fee Schedule, was repealed by R.1999 d.1, effective January 4, 1999. See: 30 N.J.R. 2813(a), 31 N.J.R. 54(c).

Pursuant to Executive Order No. 66(1978), Chapter 3, Automobile Insurance, was readopted as R.2001 d.44, effective January 4, 2001, and Subchapter 2B, Market Transition Facility of New Jersey Payment Prioritization and Claims Payment Deferral, Subchapter 16A, Flex Rate Percentage Calculations for Private Passenger Automobile Insurance, Subchapter 19, Standard/Nonstandard Rating Plans, and Subchapter 42, Producer Assignment Program, were repealed by R.2001 d.44, effective February 5, 2001. See: Source and Effective Date. See, also, section annotations.

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SUBCHAPTER 1. COMMERCIAL AUTOMOBILE INSURANCE PLAN

11:3–1.1 Purpose and scope

(a) The purpose of this subchapter is to establish a plan pursuant to N.J.S.A. 17:29D–1:

1. To provide the coverages described herein, subject to the conditions stated, for motor vehicles other than those vehicles subject to the New Jersey Personal Automobile Insurance Plan and any other private passenger vehicle that is owned by or driven by a person who meets the definition of an eligible person pursuant to N.J.S.A. 17:33B–13 and N.J.A.C. 11:3–34;

2. To provide for the apportionment of insurance coverage for qualified applicants who are in good faith entitled to but are unable to procure the same, through the voluntary market; and

3. To establish a procedure for the sharing of premiums, losses, and expenses among all insurers who are participants in New Jersey as defined within this subchapter for all risks qualified for coverage under the provisions of this subchapter.

Amended by R.1996 d.58, effective February 5, 1996.
See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).
Amended by R.1996 d.502, effective October 21, 1996.
See: 27 N.J.R. 4489(a), 28 N.J.R. 4586(a).
Amended by R.2003 d.415, effective October 20, 2003.
See: 35 N.J.R. 2391(a), 35 N.J.R. 4900(a).
In (a), inserted "other" preceding "private passenger vehicle" in 1, substituted "qualified" for "eligible" preceding "applicants" in 2 and substituted "qualified" for "eligible" preceding "for coverage" in 3.

11:3–1.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"CAIP" or "Plan" means the Commercial Automobile Insurance Plan pursuant to this subchapter.

"CAIP manager" means the entity employed by the Governing Committee to manage and conduct the administrative affairs of the CAIP on a daily basis.

"Commissioner" means the Commissioner of the New Jersey Department of Banking and Insurance.

"Emergency type vehicle" means any land vehicle, used to respond to distress calls, fires, or rescue, propelled by other than muscular power and not run upon rails or tracks. This term includes, but is not limited to, fire trucks, rescue trucks, police cars and ambulances.

"Gross participation" means a participant's Voluntary All Other Automobile Direct Written Premiums derived from information contained in the annual statement times a fraction, the numerator of which is the sum of the plan's total written premiums for that year and the Statewide total Voluntary All Other Automobile Direct Written Premiums which are eligible for depopulation credit for that policy year, and the denominator of which is the Statewide total Voluntary All Other Automobile Net Direct Written Premiums of all participants for that second prior year.

"Light truck" means a vehicle with a gross vehicle weight (G.V.W.) of 10,000 pounds or less.

"Motor vehicle" means any land vehicle propelled otherwise than by muscular power including trailers and semitrailers, except such vehicles that run only upon rails or tracks.

"Net participation" means a participant's gross participation for that policy year less its business eligible for depopulation credit for that policy year.

"Net participation percentage" means a participant's net participation for that policy year in proportion to the comparable Statewide total net participation for all participants.

"Operating headquarters" means the chief place of business where the principal officers generally transact business, and the place to which reports are made and from which orders emanate. It is the location where the executive offices are, corporate decisions are made and corporate functions are performed.

"Participant" means an insurer licensed and authorized to write motor vehicle liability or physical damage insurance and specifically includes any insurer who writes all other automobile liability and all other automobile physical damage insurance.

"Personal injury protection" means those benefits as set forth at N.J.S.A. 39:6A–4.

"Policy year" means the exposure and premiums for all policies written during a calendar year and all losses attributable to policies written during the same calendar year.

"Private passenger automobile" means a vehicle that meets the definition in N.J.S.A. 39:6A–2a, that is not eligible for coverage through any voluntary or residual market mechanism created by statute, and is owned by an individual or husband and wife; or owned jointly by two or more relatives other than husband and wife; or owned jointly by two or more resident individuals; or owned by a corporation, partnership or unincorporated association, governmental agency, or registered to a professional designation (that is, T/A, PA or P.C.) where such automobiles are furnished to individuals and are not used for business purposes.

"Private passenger type automobile" means a vehicle that meets the definition in N.J.S.A. 39:6A–2a and is owned by a corporation, partnership or any other entity except an individual or husband and wife and used for business purposes.

"Qualified applicant" means the owner or registrant of a motor vehicle registered in New Jersey or to be registered within 60 days who is unable to obtain automobile insurance in New Jersey in the voluntary market and is not in good faith qualified for automobile insurance coverage in any residual market mechanism created by statute other than the CAIP. For multi-state operations, the applicant must have its operating headquarters in New Jersey but vehicles may be registered in other states. No applicant shall be deemed qualified if the principal operator of the vehicle to be insured does not hold a driver's license which is valid in New Jersey, or if a regular operator of the vehicle other than the principal operator does not hold such a license.

"Voluntary All Other Automobile Direct Written Premiums" means automobile liability, personal injury protection, and physical damage premiums written by a participant on New Jersey risks, minus:

1. CAIP direct written premiums included in the figures which the participant wrote as a service carrier for CAIP;

2. Any direct written premiums included in the figures from insureds who are qualified applicants for any residual market mechanism created by statute other than the CAIP;

3. Any reinsurance premiums assumed from other insurers included in the figures;

4. Any premiums for Death and Disability coverage included in the figures;

5. Private passenger nonfleet automobile bodily injury and property damage liability, medical payments, basic and additional personal injury protection, and uninsured and underinsured motorists voluntary premium;

6. Miscellaneous nonfleet specialty personal automobile bodily injury and property damage liability voluntary premiums for any class approved by the Department as specified in the plan of operation; and

7. Taxi bodily injury, property damage liability, uninsured and underinsured motorists and physical damage premiums.

Amended by R.1991 d.45, effective February 4, 1991.
See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).
Deleted definition of NJAFIUA and references to it; added text to definitions for "Private passenger automobile" and "Voluntary All Other Automobile Direct Written Premiums."
Amended by R.1996 d.502, effective October 21, 1996.
See: 27 N.J.R. 4489(a), 28 N.J.R. 4586(a).
Amended by R.1998 d.591, effective December 21, 1998 (operative March 22, 1999).
See: 30 N.J.R. 3202(a), 30 N.J.R. 4390(b).
Inserted "Personal injury protection".
Amended by R.2003 d.415, effective October 20, 2003.
See: 35 N.J.R. 2391(a), 35 N.J.R. 4900(a).

(e) The PIP Medical Expense Limits Report shall be filed in accordance with the template found at http://www.state.nj.us/dobi, listing the total number of standard and basic combined in-force exposures for the six standard medical expense limits ($15,000; $50,000; $75,000; $150,000; $250,000; and excess of $250,000) and total by territory.

(f) Reports with an evaluation date of December 31 shall be due by January 31.

(g) Reports with an evaluation date of June 30 shall be due by July 31.

(h) Reports shall be submitted using the Excel templates, available on the Department's website at http://www.state.nj.us/ dobi, on one of the following media:

1. E-mail (preferred media);
2. CD-ROM; or
3. Floppy Diskette.

(i) The Excel templates shall not be modified by the user in any way except as stated above in (b)2iv above.

(j) Reports shall be submitted to:

New Jersey Department of Banking and Insurance
Office of Property and Casualty
PO Box 325
Trenton, NJ 08625–0325
E-mail: reports@dobi.state.nj.us

11:3–3A.4 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of penalties pursuant to N.J.S.A. 17:33–2 and as otherwise authorized by law.

SUBCHAPTER 4. PERSONAL INJURY PROTECTION BENEFITS; MEDICAL PROTOCOLS; DIAGNOSTIC TESTS

11:3–4.1 Scope and purpose

(a) This subchapter implements the provisions of N.J.S.A. 39:6A–3.1, 39:6A–4 and 39:6A–4.3 by identifying the personal injury protection medical expense benefits for which reimbursement of eligible charges will be made by automobile insurers under basic and standard policies and by motor bus insurers under medical expense benefits coverage.

(b) This subchapter applies to all insurers that issue policies of automobile insurance containing PIP coverage and policies of motor bus insurance containing medical expense benefits coverage.

(c) This subchapter shall apply to those policies that are issued or renewed on or after March 22, 1999.

Case Notes

Statute and the regulations promulgated by the Commissioner represented a complex legislative and regulatory package designed to reform automobile insurance law in New Jersey, and the courts of New Jersey were in the best position to consider the validity of the applicable regulations under state law. Chiropractic America v. Lavachchia, 180 F.3d 99 (3rd Cir. N.J. 1999).

Associations representing personal injury attorneys and health-care providers for automobile accident victims had standing to challenge approval of automobile policies by the commissioner of Banking and Insurance. Quality Health Care v. DOBI, 348 N.J.Super. 272, 791 A.2d 1085.

11:3–4.2 Definitions

The following words, phrases and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise.

"Basic automobile insurance policy" or "basic policy" means those private passenger automobile insurance policies issued in accordance with N.J.S.A. 39:6A–3.1 and N.J.A.C. 11:3–3.

"Clinically supported" means that a health care provider prior to selecting, performing or ordering the administration of a treatment or diagnostic test has:

1. Personally examined the patient to ensure that the proper medical indications exist to justify ordering the treatment or test;

2. Physically examined the patient including making an assessment of any current and/or historical subjective complaints, observations, objective findings, neurologic indications, and physical tests;

3. Considered any and all previously performed tests that relate to the injury and the results and which are relevant to the proposed treatment or test; and

4. Recorded and documented these observations, positive and negative findings and conclusions on the patient's medical records.

"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).

"Diagnostic test" means a medical service or procedure utilizing biomechanical, neurological, neurodiagnostic, radiological, vascular or any means, other than bioanalysis, intended to assist in establishing a medical, dental, physical therapy, chiropractic or 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.

"Eligible charge" means the treating health care provider's usual, customary and reasonable charge or the upper limit of the medical fee schedule as found in N.J.A.C. 11:3–29.6, whichever is lower.

"Emergency care" means all medically necessary treatment of a traumatic injury or a medical condition manifesting itself by acute symptoms of sufficient severity such that absence of immediate attention could reasonably be expected to result in: death; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. Such emergency care shall include all medically necessary care immediately following an automobile accident, including, but not limited to, immediate pre-hospitalization care, transportation to a hospital or trauma center, emergency room care, surgery, critical and acute care. Emergency care extends during the period of initial hospitalization until the patient is discharged from acute care by the attending physician. Emergency care shall be presumed when medical care is initiated at a hospital within 120 hours of the accident.

"Health care provider" or "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:

1. A hospital or health care facility that is maintained by State or any political subdivision;

2. A hospital or health care facility licensed by the Department of Health and Senior Services;

3. 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 radiological and diagnostic testing, free-standing emergency clinics or offices, and private treatment centers;

4. A nonprofit voluntary visiting nurse organization providing health care services other than a hospital;

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

6. Physicians licensed to practice medicine and surgery;

7. Licensed chiropractors;

8. Licensed dentists;

9. Licensed optometrists;

10. Licensed pharmacists;

11. Licensed chiropodists (podiatrists);

12. Registered bioanalytical laboratories;

13. Licensed psychologists;

14. Licensed physical therapists;

15. Certified nurse mid-wives;

16. Certified nurse practitioners/clinical nurse-specialist;

17. Licensed health maintenance organizations;

18. Licensed orthotists and prosthetists;

19. Licensed professional nurses;

20. Licensed occupational therapists;

21. Licensed speech-language pathologists;

22. Licensed audiologists;

23. Licensed physicians assistants;

24. Licensed physical therapy assistants;

25. Licensed occupational therapy assistants; and

26. Providers of other health care services or supplies, including durable medical goods.

"Identified injury" means those injuries identified by the Department in the subchapter Appendix as being suitable for medical treatment protocols in accordance with N.J.S.A. 39:6A–3.1a and 39:6A–4a.

"Medical expense" means the reasonable and necessary expenses for treatment or services rendered by a provider, including medical, surgical, rehabilitative and diagnostic services and hospital expenses and reasonable and necessary

expenses for ambulance services or other transportation, medication and other services, subject to limitations as provided for in the policy forms that are filed and approved by the Commissioner.

"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 in the Appendix, 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.

"Non-medical expense" means charges for those:

1. Products and devices, not exclusively used for medical purposes or as durable medical equipment, such as any vehicles, durable goods, equipment, appurtenances, improvements to real or personal property, fixtures; and

2. Services and activities such as recreational activities, trips and leisure activities.

"Pre-certification" means a program, described in policy forms in compliance with these rules, by which the medical necessity of certain diagnostic tests, medical treatments and procedures are subject to prior authorization, utilization review and/or case management.

"Standard automobile insurance policy" or "standard policy" means a private passenger automobile insurance policy issued in accordance with N.J.S.A. 39:6A–4.

Amended by R. 2000 d.454, effective November 6, 2000.
See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c).
Inserted "Diagnostic test".

Case Notes

Associations representing personal injury attorneys and health-care providers for automobile accident victims had standing to challenge approval of automobile policies by the commissioner of Banking and Insurance. Quality Health Care v. DOBI, 348 N.J.Super. 272, 791 A.2d 1085.

11:3–4.3 Personal injury protection benefits applicable to basic and standard policies

(a) Personal injury protection coverage shall provide reimbursement for all medically necessary expenses for the diagnosis and treatment of injuries sustained from a covered automobile accident up to the limits set forth in the policy and in accordance with this subchapter.

(b) Personal injury protection coverage shall only provide reimbursement for clinically supported necessary non-medical expenses that are prescribed by a treating medical provider for a permanent or significant brain, spinal cord or disfiguring injuries.

11:3–4.4 Deductibles and co-pays

(a) Each insurer shall offer a standard $250.00 deductible and 20 percent copayment on medical expense benefits payable between $250.00 and $5,000.

(b) Each insurer shall also offer, at appropriately reduced premiums, the option to select medical expense benefit deductibles of $500.00, $1,000, $2,000 and $2,500 in accordance with the following provisions:

1. Any medical expense deductible elected by the named insured shall apply only to the named insured and any resident relative in the named insured's household, who is not a named insured under another automobile policy and not to any other person eligible for personal injury protection benefits required to be provided in accordance with N.J.S.A. 39:6A–3.1 and 39:6A–4;

2. Premium credits calculated and represented as a percentage of the applicable premium shall be provided for each deductible. The premium percentage shall be uniform by filer on a statewide basis; and

3. The deductible option elected by the named insured shall continue in force as to subsequent renewal or replacement policies until the insurer or its authorized representative receives a properly executed coverage selection form to eliminate or change the deductible.

(c) All deductibles and co-pays in (a) and (b) above shall apply on a per accident basis.

(d) Notwithstanding (a) and (b) above, an insurer may offer alternative deductible and co-pay options as part of an approved pre-certification program pursuant to N.J.A.C. 11:3–4.8.

(e) An insurer may require that the insured advise and inform the insurer about the injury and the claim. This requirement may include the production of information from the insured regarding the facts of the accident, the nature and cause of the injury, the diagnosis and the anticipated course of treatment.

1. This information may be required to be provided as promptly as possible after the accident, and periodically thereafter.

2. An insurer may impose an additional co-payment as a penalty for failure to supply the required information. Such penalties shall result in a reduction in the amount of reimbursement of the eligible charge for medically necessary expenses that are incurred after notification to the insurer is required and until notification is received. The additional co-payment shall be an amount no greater than:

i. Twenty-five percent when received 30 or more days after the accident; or

ii. Fifty percent when received 60 or more days after the accident.

3. Any reduction in the amount of reimbursement for PIP claims shall be in addition to any other deductible or co-payment requirement.

4. Information about this requirement and how to comply with it shall be included in the informational materials required by N.J.A.C. 11:3–4.7(d).

(f) For private passenger automobiles insured under a commercial automobile insurance policy where no natural person is a named insured, insurers shall only provide personal injury protection with medical expense benefits coverage in an amount not to exceed $250,000 per person, per accident, with the deductible and copayment amount set forth in (a) above.

Amended by R. 2000 d.454, effective November 6, 2000.
See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c).
Inserted a new (e); and recodified former (e) as (f).

11:3–4.5 Diagnostic tests

(a) The personal injury protection medical expense benefits coverage shall not provide reimbursement for the following diagnostic tests, 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:

1. (Reserved)

2. Spinal diagnostic ultrasound;

3. Iridology;

4. Reflexology;

5. Surrogate arm mentoring;

6. Surface electromyography (surface EMG);

7. (Reserved); and

8. Mandibular tracking and stimulation.

(b) The personal injury protection medical expense benefits coverage shall provide for reimbursement of the following diagnostic tests, which have been determined to have value in the evaluation of injuries, the diagnosis and development of a treatment plan for persons injured in a covered accident, when medically necessary and consistent with clinically supported findings:

1. Needle electromyography (needle EMG) when used in the evaluation and diagnosis of neuropathies and radicular syndrome where clinically supported findings reveal a loss of sensation, numbness or tingling. A needle EMG is not indicated in the evaluation of TMJ/D and is contraindicated in the presence of infection on the skin or cellulitis. This test should not normally be performed within 14 days of the traumatic event and should not be repeated where initial results are negative. Only one follow up exam is appropriate.

2. Somasensory evoked potential (SSEP), visual evoked potential (VEP), brain audio evoked potential (BAEP), or brain evoked potential (BEP), nerve conduction velocity (NCV) and H-reflex Study are reimbursable when used to evaluate neuropathies and/or signs of atrophy, but not within 21 days following the traumatic injury.

3. Electroencephalogram (EEG) when used to evaluate head injuries, where there are clinically supported findings of an altered level of sensorium and/or a suspicion of seizure disorder. This test, if indicated by clinically supported findings, can be administered immediately following the insured event. When medically necessary, repeat testing is not normally conducted more than four times per year.

4. Videofluroscopy only when used in the evaluation of hypomobility syndrome and wrist/carpal hypomobility, where there are clinically supported findings of no range or aberrant range of motion or dysmmetry of facets exist. This test should not be performed within three months following the insured event and follow up tests are not normally appropriate.

5. Magnetic resonance imaging (MRI) when used in accordance with the guidelines contained in the American College of Radiology, Appropriateness Criteria to evaluate injuries in numerous parts of the body, particularly the assessment of nerve root compression and/or motor loss. MRI is not normally performed within five days of the insured event. However, clinically supported indication of neurological gross motor deficits, incontinence or acute nerve root compression with neurologic symptoms may justify MRI testing during the acute phase immediately post injury. In the case of TMJ/D where there are clinical signs of internal derangement such as nonself-induced clicking, deviation, limited opening, and pain with a history of trauma to the lower jaw, an MRI is allowable to show displacement of the condylar disc, such procedure following a panographic or transcranial x-ray and six or eight weeks of conservative treatment. This TMJ/D diagnostic test may be repeated post surgery and/or post appliance therapy.

6. Computer assisted tomographic studies (CT, CAT Scan) when used to evaluate injuries in numerous aspects of the body. With the exception of suspected brain injuries, CAT Scan is not normally administered immediately post injury, but may become appropriate within five days of the insured event. Repeat CAT Scans should not be undertaken unless there is clinically supported indication of an adverse change in the patient's condition. In the case of TMJ/D where there are clinical signs of degenerative joint disease as a result of traumatic injury of the temporomandibular joint, tomograms may not be performed sooner than 12 months following traumatic injury.

7. Dynatron/cyber station/cybex when used to evaluate muscle deterioration or atrophy. These tests should not be performed within 21 days of the insured event and should not be repeated if results are negative. Repeat tests are not appropriate at less than six months intervals.

8. Sonograms/ultrasound when used in the acute phase to evaluate the abdomen and pelvis for intra-abdominal bleeding. These tests are not normally used to assess joints (knee and elbow) because other tests are more appropriate. Where MRI is performed, sonograms/ultrasound are not necessary. However, echocardiogram is appropriate in the evaluation of possible cardiac injuries when clinically supported.

9. Thermography/thermograms only when used to evaluate pain associated with reflex sympathetic dystrophy ("RSD"), in a controlled setting by a physician experienced in such use and properly trained.

10. Brain mapping, when done in conjunction with appropriate neurodiagnostic testing.

(c) The terms "normal," "normally," "appropriate" and "indicated" as used in (b) above, are intended to recognize that no single rule can replace the good faith educated judgment of a health care provider. Thus, "normal," "normally," "appropriate" and "indicated" pertain to the usual, routine, customary or common experience and conclusion, which may in unusual circumstances differ from the actual judgment of course of treatment. The unusual circumstances shall be based on clinically supported findings of a health care provider. The use of these terms is intended to indicate some flexibility and avoid rigidity in the application of these rules in the decision point review required in (d) below.

(d) Except as provided in (e) below, a determination to administer any of the tests in (b) above shall be subject to decision point review pursuant to N.J.A.C. 11:3–4.7.

(e) The requirements of (b) and (d) above shall not apply to diagnostic tests administered during emergency care.

(f) Pursuant to N.J.A.C. 13:30–8.22(b), the personal injury protection medical expense coverage shall not provide reimbursement for the following diagnostic tests which have been identified by the New Jersey State Board of Dentistry as failing to yield data of sufficient volume to alter or influence the diagnosis or treatment plan employed to treat TMJ/D:

1. Mandibular tracking;
2. Surface EMG;
3. Sonography;
4. Doppler ultrasound;
5. Needle EMG;
6. Electroencephalogram (EEG);
7. Thermograms/thermographs;
8. Video fluoroscopy; and
9. Reflexology.

Amended by R.2000 d.454, effective November 6, 2000.
See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c).
In (a), deleted a former 6, and recodified former 7 through 9 as 6 through 8; in (b), substituted a reference to infections for a reference to staph infections in 1, added fourth and fifth sentences in 5, rewrote 6, deleted a former fourth sentence in 8, and added 9 and 10; in (c), substituted references to health care providers for references to trained medical professionals throughout; and added new (f).

11:3–4.6 Medical protocols

(a) Pursuant to N.J.S.A. 39:6A–3.1 and 39:6A–4, the Commissioner designates the care paths, set forth in the subchapter Appendix incorporated herein by reference, as the standard course of medically necessary treatment, including diagnostic tests, for the identified injuries.

(b) Where the care path indicates a decision point either by a hexagon in the care path itself or by reference in the text to a second opinion, referral for a second independent consultative medical opinion, development of a treatment plan or mandatory case management, the policy shall provide for a decision point review in accordance with N.J.A.C. 11:3–4.7.

(c) Treatments that vary from the care paths shall be reimbursable only when warranted by reason of medical necessity.

(d) The care paths do not apply to treatment administered during emergency care.

Law Review and Journal Commentaries

What's Next for No Fault? Gerald H. Baker, 159 N.J.L.J. 267 (2000).

11:3–4.7 Decision point review

(a) Insurers shall file for approval policy forms that provide a plan for the timely review of treatment of identified injuries at decision points and for the approval of the administration of the diagnostic tests in N.J.A.C. 11:3–4.5(b).

(b) The decision point review plan shall meet the following requirements:

1. The plan shall include procedures for the injured person or his or her designee to provide prior notice to the insurer or its designee together with the appropriate clinically supported findings that additional treatment or the administration of a test in accordance with N.J.A.C. 11:3–4.5(b) is medically necessary, as follows:

i. The prompt review of the notice and supporting materials submitted by the provider and authorization or denial of reimbursement for further treatment or tests;

ii. The scheduling of a physical examination of the injured person in accordance with (b)2 below where the notice and supporting materials and other medical records if requested, are not sufficient to authorize or deny reimbursement of further treatment or tests; and

iii. Any denial of reimbursement for further treatment or tests shall be based on the determination of a physician.

2. A physical examination of the injured party as part of a decision point review shall be conducted as follows:

i. The insurer shall notify the injured person or his or her designee that a physical examination is required;

ii. The physical examination shall be scheduled within seven calendar days of receipt of the notice in (b)1 above unless the injured person agrees to extend the time period;

iii. The medical examination shall be conducted by a provider in the same discipline as the treating provider;

iv. The medical examination shall be conducted at a location reasonably convenient to the injured person;

v. The treating provider or injured person, upon the request of the insurer, shall provide medical records and other pertinent information to the provider conducting the medical examination. The requested records shall be provided no later than the time of the examination; and

vi. The insurer shall notify the injured person or his or her designee whether reimbursement for further treatment or tests is authorized as promptly as possible but in no case later than three days after the examination. If the examining provider prepares a written report concerning the examination, the injured person or his or her designee shall be entitled to a copy upon request.

3. The plan may provide that failure to notify the insurer as required in the plan; failure to provide medical records; or failure to appear for the physical examination scheduled in accordance with b(2) above shall result in an additional co-payment not to exceed 50 percent of the eligible charge for medically necessary diagnostic tests, treatments, surgery, durable medical goods and non-medical expenses that are incurred after notification to the insurer is required but before authorization for continued treatment or the administration of a test is made by the insurer. No insurer may impose the additional co-payment where the insurer received the required notice but failed to act in accordance with its approved decision point plan to authorize or deny reimbursement of further treatment or tests.

4. The plan shall avoid undue interruptions in a course of treatment.

5. Insurers are encouraged to provide decision point review plans that permit the treating provider to submit for review a comprehensive treatment plan so as to minimize the need for piecemeal review.

(c) All decision point review plans, including a pre-certification program filed and approved pursuant to N.J.A.C. 11:3–4.8 shall contain provisions for the disclosure of the procedures in the decision point review plan to injured persons and providers.

1. The information required to be disclosed pursuant to this subsection shall include a description of:

i. The financial responsibility of the injured person including co-payments and deductibles;

ii. The financial responsibility of the provider for providing treatment or administering tests without authorization from the insurer; and

iii. How authorization for treatment and the administration of tests may be obtained.

2. In addition to the description of the plan set forth in the policy form, the insurer shall provide any information necessary to comply with decision point review in accordance with this rule to the injured person, the provider, or both, promptly upon receiving notice of the claim.

(d) No decision point requirements shall apply within 10 days of the insured event. This provision should not be construed so as to require reimbursement of tests and treatment that are not medically necessary.

Amended by R.2000 d.454, effective November 6, 2000.
See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c).
Deleted a former (c); and recodified former (d) and (e) as (c) and (d).

11:3–4.8 Precertification

(a) Insurers may require precertification of certain specific medical procedures, treatments, diagnostic tests, other services and durable medical equipment that are not subject to decision point review and that may be subject to overutilization.

(b) Precertification requirements shall be included with a decision point review plan submission but the medical procedures, treatments, diagnostic tests, durable medical equip-

ment or other services that require precertification shall be identified separately from decision point review.

(c) No precertification requirements shall apply within 10 days of the insured event.

(d) Precertification shall be based exclusively on medical necessity and shall not encourage over or under utilization of the treatment or test.

(e) An insurer that wishes to use precertification shall designate a licensed physician to serve as medical director for services provided to covered persons in New Jersey. The medical director shall ensure that:

1. Any utilization decision to deny reimbursement for further testing or treatment because the treatment or diagnostic tests are not medically necessary, shall be made by a physician. In the case of treatment prescribed or provided by a dentist, the decision shall be by a dentist;

2. A utilization management decision shall not retrospectively deny payment for treatment provided when prior approval has been obtained, unless the approval was based upon fraudulent information submitted by the person receiving treatment or the provider; and

3. The utilization management program shall be available, at a minimum, during normal working hours to respond to authorization requests.

(f) The insurer shall include precertification requirements in the information about its decision point review plan that will be given to consumers with new and renewal policies and upon notice of a claim. The consumer information shall include at a minimum the items in N.J.A.C. 11:3–4.7(d).

(g) A precertification plan may include provisions that require injured persons to obtain durable medical equipment directly from the insurer or its designee.

(h) Policy forms may include an additional co-payment not to exceed 50 percent of the eligible charge for medically necessary diagnostic tests, treatments, surgery, durable medical equipment and non-medical expenses that are incurred without first complying with precertification requirements.

(i) Precertification shall avoid undue interruptions in a course of treatment.

(j) Insurers are encouraged to permit a treating provider to submit a comprehensive treatment plan for precertification so as to minimize the need for piecemeal review.

Amended by R.2000 d.454, effective November 6, 2000.
See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c).
Rewrote the section.

11:3–4.9 Assignment of benefits; public information

(a) Insurers may file for approval policy forms that include reasonable procedures for restrictions on the assignment of personal injury protection benefits, consistent with the efficient administration of the coverage.

(b) An insurer shall identify documents containing proprietary information in its decision point review plan submission. Documents containing proprietary information shall be confidential and shall not be subject to public inspection and copying pursuant to the "Right-to-Know" law, N.J.S.A. 47:1A–1 et seq. The Department shall notify the insurer prior to responding to any public record request for proprietary information.

Amended by R.2000 d.454, effective November 6, 2000.
See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c).
Designated existing section as (a) and added (b).

11:3–4.10 (Reserved)

New Rule, R.2000 d.454, effective November 6, 2000.
See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c).
Amended by R.2003 d.3, effective January 6, 2003.
See: 34 N.J.R. 2518(a), 35 N.J.R. 249(b).
Rewrote (a) and (b).
Repealed by R.2004 d.218, effective June 7, 2004.
See: 35 N.J.R. 3072(a), 36 N.J.R. 2890(a).
Section was "Reporting requirements".

APPENDIX

TREATMENT OF ACCIDENTAL INJURY TO THE SPINE AND BACK CARE PATHS

Exhibit 1

Glossary of Terms

Acute Disease—a disease with rapid onset and short course to recovery. Not chronic.

Care Path—a recommended extensive course of care based on professionally recognized standards.

Case Management—a method of coordinating the provision of healthcare to persons injured in automobile accidents, with the goal of ensuring continuity and quality of care and cost effective outcomes. The Case Manager may be a nurse, social worker, or physician, preferably with certification in case management.

Cauda Equina—a collection of spinal roots that descend from the lower part of the spinal cord. They exist in the lower part of the vertebral canal.

Chronis Disease—a disease with long duration that changes little and progresses slowly. The apposite of acute.

Clinical Evaluation—the evaluation of the symptoms and signs of an injured person by a treating practitioner.

Conservative Therapy—treatment which is not considered aggressive; avoiding the administration of medicine or utilization of invasive procedures until such procedures are clearly indicated.

Contusion—an injury to underlying soft tissues when the skin is not broken. A bruise.

Diagnostic Evaluation—the process of differentiating between two or more diseases with similar signs and symptoms through the use of evaluative procedures such as imaging, laboratory, and physical tests.

Herniation—the protrusion or projection of an organ or other body structure through a defect or natural opening in a covering membrane, muscle, or bone.

Independent Consultative Opinion—physical examination by a physician of similar specialty to the injured person's treating practitioner to provide a second medical opinion. The independent physician may support, refute, or provide alternatives to the current diagnosis and treatment plans.

Non-Compliant—a patient who wilfully chooses not to participate in the treatment plan agreed upon by the patient and his/her healthcare provider and does not have secondary issues such as lack of transportation, pre-existing conditions or comorbidities.

PT—Physical Therapy—the therapeutic use of heat, light, water, electricity, massage, exercise, and non-ionizing radiation in treatment of injuries to the soft tissue and muscles/skeleton. PT rendered to persons injured in automobile accidents must be provided by a person whose scope of licensure includes physical therapy.

Radicular—pertaining to a root (such as a nerve root) disorder.

Radiculopathy—a disorder of a nerve root.

Sign—an objective manifestation, usually indicative of a disease or disorder. Signs can be observed by the clinician, as opposed to symptoms, which are perceived only by the affected individual.

Soft Tissue Injury—injuries sustained to the muscle, skin, connective tissue.

Spine—the vertebral column.

Spinal Shock—an acute condition resulting from spinal cord severance. Characterized by a total sensory loss and loss of reflexes below the level of injury and flaccid paralysis.

Sprain—an injury at a joint where a ligament is stretched or torn.

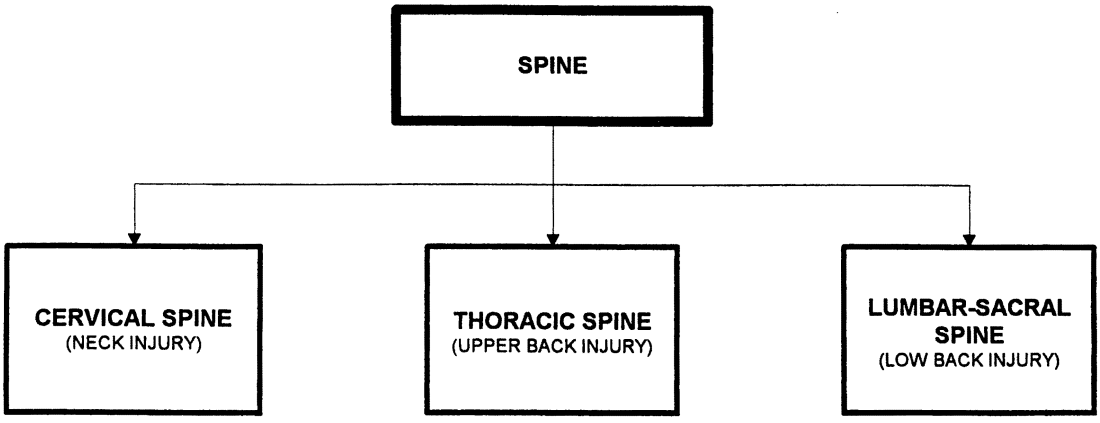
Strain—an injury caused by the over-stretching or tearing of a muscle or tendon. In its most severe form, the muscle ruptures.

Symptom—a subjective manifestation, usually indicative of a disease or disorder. Symptoms are experienced only by the affected individual, as opposed to signs, which can be observed by others.

Treatment Plan—specific medical, surgical, chiropractic, acupuncture, or psychiatric procedures used to improve the signs or symptoms associated with injures sustained in automobile accidents, e.g., physical therapy, surgery, administration of medications, etc.

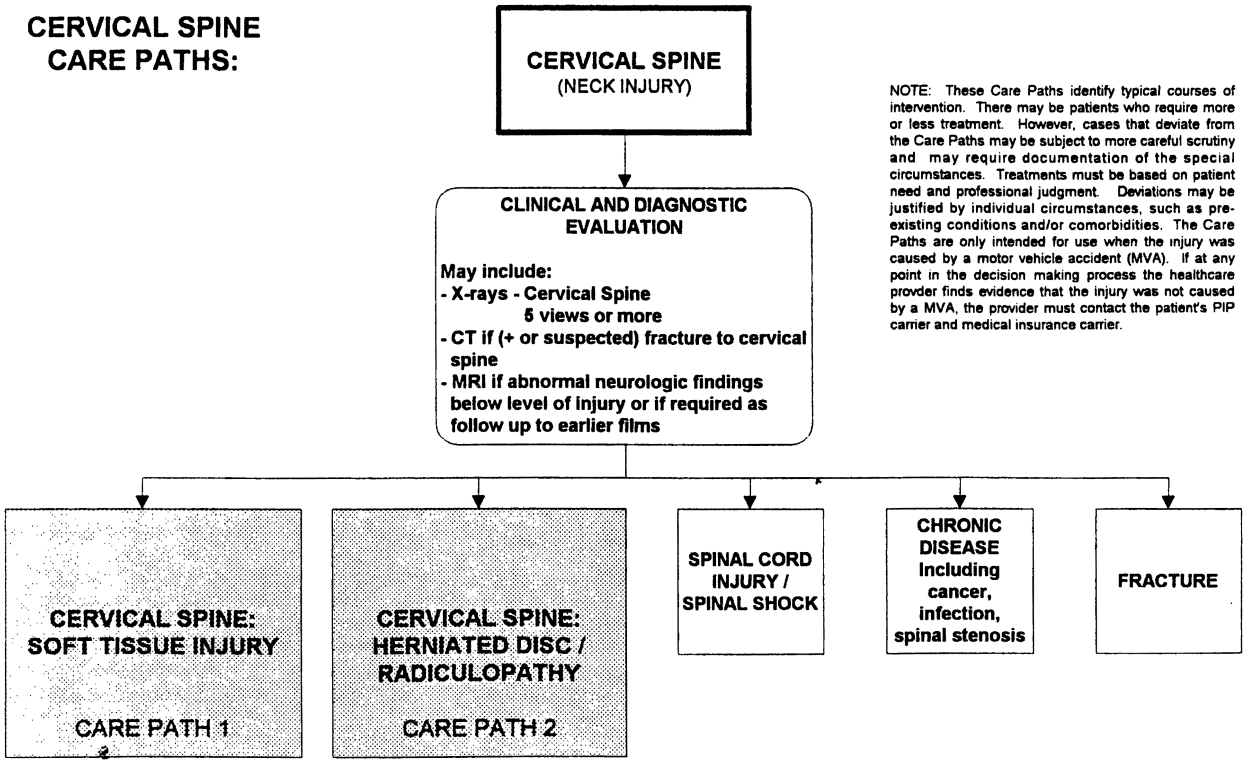
EXHIBIT 2

TREATMENT OF ACCIDENTAL INJURY TO THE SPINE AND BACK CARE PATH OVERVIEW



The following flow charts address the three anatomical areas of spinal injuries; Care Paths 1 through 6 have been developed for the conditions noted in the shaded boxes.

CERVICAL SPINE CARE PATHS:



NOTE: These Care Paths identify typical courses of intervention. There may be patients who require more or less treatment. However, cases that deviate from the Care Paths may be subject to more careful scrutiny and may require documentation of the special circumstances. Treatments must be based on patient need and professional judgment. Deviations may be justified by individual circumstances, such as pre-existing conditions and/or comorbidities. The Care Paths are only intended for use when the injury was caused by a motor vehicle accident (MVA). If at any point in the decision making process the healthcare provder finds evidence that the injury was not caused by a MVA, the provider must contact the patient's PIP carrier and medical insurance carrier.

Amended by R.2000 d.454, effective November 6, 2000.
See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c).
Rewrote Exhibits 3 and 10; inserted new Exhibit 11.
Amended by R.2003 d.2, effective January 6, 2003.
See: 34 N.J.R. 1784(a), 35 N.J.R. 249(a).
Amended Appendix Exhibit 11.

SUBCHAPTER 5. PERSONAL INJURY PROTECTION DISPUTE RESOLUTION

11:3–5.1 Purpose and scope

(a) The purpose of this subchapter is to establish procedures for the resolution of disputes concerning the payment of medical expense and other benefits provided by the personal injury protection coverage in policies of automobile insurance. This subchapter implements N.J.S.A. 39:6A–5.1 and 5.2, which provide that PIP disputes shall be resolved by binding alternate dispute resolution as provided in the policy form approved by the Commissioner. This subchapter also implements provisions of N.J.S.A. 2A:23A–1 et seq., as applicable to PIP dispute resolution.

(b) This subchapter shall apply to disputes arising under policies of private passenger automobile insurance, on either a personal lines or commercial lines policy form, that provide medical expense benefits and other benefits under personal injury protection coverage, as follows:

1. PIP benefits under a standard automobile insurance policy pursuant to N.J.S.A. 39:6A–4;

2. PIP benefits under a basic automobile insurance policy pursuant to N.J.S.A. 39:6A–3.1;

3. PIP benefits provided by the UCJF pursuant to N.J.S.A. 39:6–86.1; and

4. Additional PIP benefits provided pursuant to N.J.S.A. 39:6A–10.

(c) This subchapter shall apply to policies issued or renewed on or after March 22, 1999 in accordance with the approved policy terms.

Case Notes

Associations representing personal injury attorneys and health-care providers for automobile accident victims had standing to challenge approval of automobile policies by the commissioner of Banking and Insurance. Quality Health Care v. DOBI, 348 N.J.Super. 272, 791 A.2d 1085.

11:3–5.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise:

"Administrator" means the dispute resolution organization designated by the Commissioner pursuant to N.J.S.A. 39:6A–5.1 and N.J.A.C. 11:3–5.3.

"Basic policy" means an automobile insurance policy issued pursuant to N.J.S.A. 39:6A–3.1 and N.J.A.C. 11:3–3.

"Commissioner" means the Commissioner of the New Jersey Department of Banking and Insurance.

"Control" or "controlled" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds the power to vote, or holds proxies representing, 10 percent or more of the voting securities of any other person, provided that no such presumption of control shall of itself relieve any person so presumed to have control from any requirement of P.L. 1970, c.22 (N.J.S.A. 17:27A–1 et seq.). This presumption may be rebutted by a showing made in the manner provided by N.J.S.A. 17:27A–3j that control does not exist in fact. The Commissioner may determine, after furnishing all persons in interest notice and an opportunity to be heard, and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

"Department" means the New Jersey Department of Banking and Insurance.

"Dispute resolution organization" or "DRO" means an organization that meets the standards set forth in N.J.S.A. 39:6A–5.1 and N.J.A.C. 11:3–5.4.

"Dispute resolution professional" or "DRP" means a natural person who meets the standards set forth in N.J.A.C. 11:3–5.5

"Medical review organization" or "MRO" means an organization of health care professionals who are licensed in New Jersey, which is certified by the Commissioner to engage in unbiased medical review of the medical care provided to persons injured in automobile accidents in accordance with N.J.S.A. 39:6A–5.2 and this subchapter. The term includes either ;

1. Any peer review organization with which the Federal Health Care Financing Administration or the State contracts for medical review of Medicare or medical assistance services; or

2. Any independent health care review company.

"Personal Automobile Insurance Plan" or "PAIP" means the personal lines automobile insurance residual market mechanism established pursuant to N.J.S.A. 17:29D–1 by N.J.A.C. 11:3–2.

"Personal injury protection" or "PIP" means the coverage provided by a policy of automobile insurance pursuant to N.J.S.A. 39:6A–3.1 or 39:6A–4.

"PIP dispute" includes, but is not limited to, matters concerning:

1. Interpretation of the insurance contract's PIP provisions;

2. Whether the medical treatment or diagnostic tests are in accordance with the provisions of applicable statutes and rules for the basic and standard policies and in compliance with the terms of the policy;

3. Eligibility of the treatment or service for compensation or reimbursement, including whether the injury is causally related to the accident and the application of deductible and copayment provisions;

4. Eligibility of the provider performing the service to be compensated or reimbursed under the terms of the policy and the provisions of N.J.A.C. 11:3–4, and including whether the provider is licensed or certified to perform the treatment or service;

5. Whether the treatment was actually performed;

6. Whether the diagnostic tests performed are recognized by the Professional Boards in the Division of Consumer Affairs, Department of Law and Public Safety, administered in accordance with their standards, and approved by the Commissioner at N.J.A.C. 11:3–4;

7. The necessity and appropriateness of consultation with other health care providers;

8. Disputes involving the application of, or adherence to, the automobile insurance medical fee schedule at N.J.A.C. 11:3–29;

9. Whether the treatment or service is reasonable, necessary and in accordance with medical protocols adopted by the Commissioner at N.J.A.C. 11:3–4; or

10. Amounts claimed for PIP income continuation benefits, essential services benefits, death benefits and funeral expense benefits.

"Provider" or "health care provider" is as defined at N.J.A.C. 11:3–4.2.

"Standard policy" means an automobile insurance policy including PIP coverage as provided in N.J.S.A. 39:6A–4.

"UCJF" means the Unsatisfied Claim and Judgement Fund created pursuant to N.J.S.A. 39:6–61 et seq.

11:3–5.3 Designation of the administrator

(a) The Commissioner shall designate a dispute resolution organization as the administrator of the PIP alternate dispute resolution system by entering into a contract with a dispute resolution organization.

(b) The contract designating the administrator shall be for a term not to exceed five years, but may be extended according to its terms until a new administrator is designated and substituted. Nothing in this subsection shall prohibit an administrator from succeeding itself, if so designated in accordance with N.J.S.A. 39:6A–5.1 and this subchapter.

The contract may provide for adjustments in the price paid for services performed over the life of the contract.

(c) The Commissioner shall request competitive proposals from among qualified dispute resolution organizations interested in serving as administrator.

(d) Dispute resolution organizations shall submit the following documents and information in connection with their proposal to serve as administrator:

1. A dispute resolution plan that describes how the organization shall meet the requirements of the Act and these rules, which shall include procedures and rules governing the dispute resolution process to ensure adherence to the standards of performance set forth in N.J.S.A. 39:6A–5.1 and 5.2 and this subchapter;

2. A description of the organization and biographical information about the key personnel that shall be responsible for executing the duties of the administrator;

3. A description of the management information systems that shall be utilized by the organization;

4. A draft budget for at least the first two years;

5. A cost proposal, which shall provide for the payment of the administrator's expenses, including the cost of dispute resolution professionals, from fees generated from the users of the system;

6. Such other information as may be provided by law, and that the Commissioner or the Treasurer may request in order to understand and evaluate the applicant's proposal.

11:3–5.4 Dispute resolution organizations

(a) In order to be eligible for designation as administrator, a dispute resolution organization shall meet the following criteria:

1. The dispute resolution organization shall not be owned or controlled by an insurer or affiliate of an insurer;

2. The dispute resolution organization shall utilize full-time dispute resolution professionals that meet the standards set forth in N.J.A.C. 11:3–5.5. For the purpose of this paragraph, "full-time" shall be construed to include persons who work fewer than five days per week, but who do not engage in other, conflicting employment;

3. The dispute resolution organization shall utilize an advisory council composed of parties who are users of the dispute resolution mechanism in connection with the selection of dispute resolution professionals and the periodic review of the organization's rules and processes;

4. The dispute resolution organization shall utilize procedures to avoid conflicts of interests as prohibited at N.J.A.C. 11:3–5.12;

5. The dispute resolution organization shall arrange for proceedings in locations reasonably convenient to the parties;

6. The dispute resolution organization shall maintain published rules for the conduct of the proceedings, and shall make them available to the parties and the public upon request;

7. The dispute resolution organization shall perform its functions in a prompt and efficient manner, giving due regard to the nature of the proceeding and the need for special attention when required by the exigencies of a particular matter; and

8. The dispute resolution organization shall provide sufficient oversight and training of its dispute resolution professionals so as to promote fair, efficient and consistent determinations consistent with substantive law and with rules adopted by the Commissioner.

(b) The dispute resolution organization shall develop and maintain a dispute resolution plan approved by the Commissioner that sets forth its procedures and rules. The dispute resolution plan shall be reviewed at least annually and revisions made upon approval by the Commissioner. The plan shall include the following elements:

1. The plan shall provide that PIP dispute resolution be initiated by written notice to the administrator and to all other parties of the party's demand for dispute resolution, which notice shall set forth concisely the claims, and where appropriate the defenses, in dispute and the relief sought. The notice shall include such other information as may be required for administrative purposes;

2. The plan shall provide for consolidation of claims into a single proceeding where appropriate in order to promote prompt, efficient resolution of PIP disputes consistent with fairness and due process of law;

3. The plan shall provide the assigned dispute resolution professional with sufficient authority to provide all relief and to determine all claims arising under PIP coverage, but may provide for limited, procedural or emergent matters to be determined by one or more specially designated dispute resolution professionals;

4. The plan shall provide for the assignment of a medical review organization to review the case and report its determination when requested pursuant to N.J.S.A. 39:6A–5.2 and this subchapter;

5. The plan shall provide for the prompt, fair and efficient resolution of PIP disputes, after a hearing by the assigned dispute resolution professional, but shall also provide that alternate procedures may be utilized when appropriate, which may include mediation, conferences to promote consensual resolution and expedited hearings upon receipt of a medical review organization report, consistent with principles of substantive law and rules adopted by the Commissioner; and

1. Any determination filed with the Department shall be indexed and coded so as to facilitate retrieval.

2. The name of any injured party, except when appearing in the caption of the matter or used as identification of the particular case, shall be redacted in the copy filed with the Department so as to protect the privacy of the injured person.

(c) The administrator shall keep such other records as may be required by the Commissioner and as set forth in the contract designating the administrator.

11:3–5.8 Medical review organizations

(a) Medical review organizations shall be authorized to determine in connection with the PIP dispute resolution process set forth in this subchapter:

1. Whether the medical treatment or diagnostic test is medically necessary;

2. Whether the treatment is in accordance with medically recognized standard protocols including those protocols approved by the Commissioner and set forth in N.J.A.C. 11:3–4;

3. Whether the treatment is consistent with symptoms or diagnosis of the injury;

4. Whether the injury is causally related to the accident ;

5. Whether the treatment is of a palliative rather than a restorative nature; and

6. Whether medical procedures and tests that have been repeated are medically necessary.

(b) The findings of a medical review organization shall be presumed to be correct, but may be rebutted by a preponderance of the evidence submitted to the dispute resolution professional.

11:3–5.9 Standards for medical review organizations

(a) Medical review organizations shall be capable of performing medical reviews for all primary specialties and disciplines.

(b) Medical review organizations shall employ a medical director to actively participate in the review of cases to assure quality and consistency.

(c) Medical review organizations shall utilize health care providers in the same discipline as the treating provider to perform the reviews who meet the following standards:

1. Reviewing health care providers shall be active practitioners who obtain a minimum of one-half of their income from practice in their area of specialty;

2. Reviewing health care providers shall be licensed in New Jersey and board certified in their specialty;

3. Reviewing health care providers shall have at least two years' experience in medical review, or be certified as a medical review physician; and

4. Reviewing health care providers shall have completed an orientation with the MRO, including medical review instruction and report writing.

(d) A medical review organization shall have adequate procedures in place to assure confidentiality of patient records.

1. All MRO files shall be indexed and referred to by reference number rather than patient name.

2. Medical files shall be maintained in a secure area of the MRO's offices.

3. Only the MRO shall request additional documents relating to the injured person's medical condition, or direct that the injured person be physically examined.

(e) A medical review organization shall utilize procedures to provide for the fair and open exchange of information and records related to the review between the treating health care provider, any provider that has reviewed the case on behalf of the insurer, and the MRO's reviewing health care provider.

(f) A medical review organization shall complete its review and submit its report to the dispute resolution professional in accordance with the medical exigencies of the case, but in no event in excess of 20 business days from receipt of medical records from the treating health care provider.

(g) A medical review organization shall have a procedure for obtaining mental or physical examinations of injured persons that may be required in the course of its review.

(h) A medical review organization shall utilize written review procedures. In reaching its determinations, the MRO shall consider all information submitted by the parties and information deemed appropriate by the MRO, including: pertinent medical records, consulting physician reports and other documents submitted by the parties; applicable commonly accepted protocols, professional standards and practices by national standard setting organizations, and protocols and diagnostic tests approved by the Commissioner and set forth in N.J.A.C. 11:3–4.

(i) A medical review organization shall utilize audit procedures to ensure compliance with statutory and regulatory requirements.

(j) A medical review organization shall retain records of its determinations for five years.

11:3–5.10 Medical review organization certification process

(a) The Commissioner shall certify a medical review organization to provide medical review services in connection with the resolutions of PIP disputes if the Commissioner determines that the MRO complies with the standards set forth in N.J.A.C. 11:3–5.9 to provide an impartial review of the medical necessity or appropriateness of treatments, health care services or items of durable medical equipment for which medical expense benefits may be provided under personal injury protection coverage.

(b) For the purpose of obtaining certification by the Commissioner to act as a medical review organization to perform medical review in connection with the resolution of

PIP disputes, an MRO shall submit two copies of a written application that sets forth the information in (b) below to:

Medical Review Organization Certification
New Jersey Department of Banking and Insurance
PO Box 325
Trenton, NJ 08625–0325

(c) The MRO application shall include the following:

1. A list of the names, addresses and specialties of the individuals health care providers, that will provide the medical review services. If the MRO will be limited in its service area, the application shall provide a map of the service area, including the providers by specialty;

2. A copy of the MRO's certificate of incorporation and by-laws;

3. A diagram of the MRO's organizational structure;

4. The location of the MRO's place of business where it administers its services and maintains its records;

5. A listing and biography of the MRO's officers and directors, or the individuals in the organization responsible for administration of medical reviews, including the medical director;

6. A detailed description of the MRO's experience in the review of medical care;

7. A description of its procedures for review of medical treatments, diagnostic tests and items of durable medical equipment in conjunction with PIP medical expense benefits;

8. A current list identifying all property/casualty insurers, health insurers, health maintenance organizations and health care providers with whom the MRO maintains any health related business arrangement. The list shall include a brief description of the nature of the arrangement, so as to permit the administrator to avoid assignments that may create a conflict of interest;

9. Such other information as the Commissioner may specifically request in connection with the certification of a particular applicant; and

10. A fee in the amount of $1,000 payable to the Department of Banking and Insurance.

(d) The materials specified in (c) above shall be retained by the Department and may be referred to the Department of Health and Senior Services for consultation as necessary. Any significant changes in the materials filed with the Department shall be reported as an amendment to the materials filed within 30 days of the change.

(e) The Department, in consultation with the Department of Health and Senior Services, shall review the materials and grant or deny certification within 45 days of receipt of a complete filing. The Commissioner may extend the time an additional 30 days for good cause shown, and shall notify the applicant of any extension. A decision to deny certification shall be in writing and include an explanation of the reason for the denial.

(f) Initial certification shall be effective for a period of two years. Certified MROs shall reapply for certification 90 days prior to expiration by submitting the items set forth in (b)1, 6, 7, 8, 9 and 10 above and any changes to items previously submitted in (b)2, 3, 4 and 5 above. Renewal certification may be effective for a period of up to five years.

(g) All data or information in the MRO's application for certification shall be confidential and shall not be disclosed to the public, except as follows:

1. The MRO's certificate of incorporation;

2. The MRO's address;

3. The names of the MRO's officers and directors, or the individuals in the organization responsible for the administration of medical reviews including the medical director; and

4. The date of certification of the MRO and date that certification expires.

(h) Upon certification, the Department shall advise the administrator of the name and address of the MRO, any limitations on its geographical service area and information about persons with whom it maintains health related business arrangements.

(i) The Commissioner may suspend or revoke the certification of an MRO upon finding that the MRO no longer meets the standards set forth in N.J.A.C. 11:3–5.9; that medical review services are not being provided in accordance with the requirements of this subchapter; or that the certification was granted based on false or misleading information.

1. Proceedings to revoke or suspend the certification shall be conducted pursuant to N.J.A.C. 11:17D.

2. Upon request of the MRO for a hearing, the matter shall be transferred to the Office of Administrative Law for a hearing conducted pursuant to the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

11:3–5.11 Fees

(a) (Reserved)

(b) When a mental or physical examination is performed in connection with the medical review organization's services, the health care provider performing the examination shall be paid the fee provided for that service set forth on the Department's medical fee schedule, N.J.A.C. 11:3–29.

11:3–5.12 Prohibition of conflicts of interest

(a) No administrator or employee thereof, dispute resolution professional, medical review organization or reviewing health care provider shall have any personal or financial interest, direct or indirect, or engage in any business or transaction which is in conflict with the proper conduct of his or her duties under this subchapter.

(b) No administrator or employee thereof, dispute resolution professional, medical review organization or reviewing health care provider shall act in such capacity in any matter wherein he or she has a direct or indirect personal or financial interest that might reasonably be expected to impair his or her objectivity or independence of judgment.

(c) No administrator or employee thereof, dispute resolution professional, medical review organization or reviewing health care provider shall accept any gift, favor, service or other thing of value under circumstances from which it might be reasonably inferred that such gift, service or other thing of value was given or offered for the purpose of influencing him or her in the conduct of duties under this subchapter.

(d) No dispute resolution professional shall accept from any person, whether directly or indirectly and whether by him or herself or through a spouse or any family member or through any partner or associate or controlled business, any gift, favor, service, employment or offer of employment or any other thing of value which he or she knows or has reason to believe is offered with the intent to influence the performance of his or her duties as a dispute resolution professional.

(e) No dispute resolution professional shall make any determination in any PIP dispute in which he or she directly or indirectly or through a spouse, family member or by partner or associate or controlled business has any personal or financial interest.

SUBCHAPTER 6. INSURANCE IDENTIFICATION CARDS

11:3–6.1 Scope

In accordance with N.J.S.A. 39:3–29.1, this subchapter concerns the issuance, design and content of auto insurance identification cards issued by insurance companies in this State. This subchapter shall not apply to policies covering commercial motor vehicles regulated by the U.S. Department of Transportation or the New Jersey Board of Public Utilities.

As amended, R.1983 d.648, effective January 17, 1984.
See: 15 N.J.R. 1919(a), 16 N.J.R. 145(c).
Reference to dates deleted.
Amended by R.2004 d.166, effective April 19, 2004.
See: 35 N.J.R. 3521(a), 36 N.J.R. 1939(a).
Rewrote the section.

Case Notes

Policy provision defining an eligible person as a spouse only if resident in the same household as insured held void; named insured's deletion of estranged wife; reformation of policy ordered. Matland v. United Services Automobile Ass'n, 174 N.J.Super. 499, 417 A.2d 46 (Law Div.1980).

11:3–6.2 Permanent identification cards

(a) A permanent insurance identification card shall conform to the following specifications:

1. The minimum size shall be three inches by five inches, and the maximum size shall be 5½ inches by 8½ inches.

2. The weight shall not be lighter than 20 pounds white bond.

3. The front of the card shall include the following:

i. The company name: Group name may be shown instead if it will identify the specific company involved. Insurance company logos are permitted;

ii. Named insured: The surname of the insured must agree with surname shown on the motor vehicle registration certificate. The Division of Motor Vehicles will conduct verification on surname basis;

iii. Address: The replacement of identification cards when there is a change of address will be optional with the insurance companies;

iv. Policy number: The complete policy number will be listed;

v. Effective date and expiration date: month, day, and year.

vi. Description of the vehicle: Year, make and vehicle identification number shall be noted on the insurance identification card. The model of the vehicle may be shown as the make. The make of the vehicle may be abbreviated, but the complete vehicle identification number (VIN) must be shown.

vii. In the case of fleets, dealership or leasing companies where the owner insures the vehicles, the make, year and VIN need not be recorded. In lieu of the make, year and VIN, the insurer may insert "ALL OWNED VEHICLES" or "FLEET". If the lessee insures the vehicles, the name of the owner as shown on the motor vehicle registration must be shown on the I.D. card in addition to the name of the insured if the designation "FLEET" is used without the VIN;

viii. Heading: The heading across the top shall read: State of New Jersey Insurance Identification Card;

ix. The insurance company code as established by the New Jersey Division of Motor Vehicles will be printed immediately preceding the insurance company name;

x. The name and address of the insurance company or the office or agency issuing the identification cards must be shown.

4. The reverse of card shall include the address, and may include a facsimile number and E-mail address, if any, established by the insurer for the filing of notification of the commencement of medical treatment by treating medical providers under N.J.A.C. 11:3–25. This information shall be provided under the following title: "ADDRESS FOR NOTIFICATION OF COMMENCEMENT OF MEDICAL TREATMENT"

5. This notice may be placed on the front or reverse of the identification card and may be printed on the card or affixed on the card by way of a label that contains the required information.

(b) Servicing carriers of any residual market mechanism authorized by statute shall issue an insurance identification card in accordance with (a) above. The card shall indicate that coverage is being issued by the servicing carrier on behalf of the residual market mechanism.

As amended, R.1973 d.140, eff. May 31, 1973.
See: 5 N.J.R. 150(a), 5 N.J.R. 229(b).
As amended, R.1973 d.247, eff. August 31, 1973.
See: 5 N.J.R. 350(b).
As amended, R.1983 d.648, eff. January 17, 1984.
See: 15 N.J.R. 1919(a), 16 N.J.R. 145(c).
Further specifications for ID cards added and alternative type of card introduced.
Amended by R.1991 d.45, effective February 4, 1991.
See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).
In (d): deleted NJAFIUA reference and added text referring to "residual market mechanism authorized by statute."
Amended by R.1996 d.58, effective February 5, 1996.
See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).
Amended by R.1997 d.14, effective January 6, 1997 (operative March 7, 1997).
See: 28 N.J.R. 3876(a), 29 N.J.R. 132(a).
Added (b)5 and (b)6.
Amended by R.2004 d.166, effective April 19, 2004.
See: 35 N.J.R. 3521(a), 36 N.J.R. 1939(a).
Deleted former (a) and (c); recodified former (b) as new (a); recodified former (d) as new (b); rewrote new (a).

Case Notes

Policy provision defining an eligible person as a spouse only if resident in the same household as insured held void; named insured's deletion of estranged wife from coverage held void; reformation of policy ordered. Matland v. United Services Automobile Ass'n, 174 N.J.Super. 499, 417 A.2d 46 (Law Div.1980).

11:3–6.3 Temporary identification card

(a) The format and content of the temporary card shall be the same as those for a permanent identification card except as noted below.

1. Title: "TEMPORARY" to precede heading on card;

2. Policy number: Indicate policy number if available; otherwise, the application or binder number is acceptable;

3. Effective date: Month, day and year that coverage becomes effective. Expiration date is not required;

4. Expiration: The card shall contain the following statement: "This card expires 60 days after the effective date shown above";

As amended, R.1973 d.35, eff. January 26, 1973.
See: 5 N.J.R. 20(b).
As amended, R.1974 d.208, eff. July 24, 1974.
See: 6 N.J.R. 322(b).
As amended, R.1983 d.648, eff. January 17, 1984.
See: 15 N.J.R. 1919(a), 16 N.J.R. 145(c).
Language changes and clarification.
Amended by R.1991 d.45, effective February 4, 1991.
See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).
Deleted subsection (b), describing components of the New Jersey Automobile Insurance Plan.
Amended by R.1996 d.58, effective February 5, 1996.
See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).
Amended by R.2004 d.166, effective April 19, 2004.
See: 35 N.J.R. 3521(a), 36 N.J.R. 1939(a).
Rewrote the section.

11:3–6.4 General provisions

(a) The order of the information to be contained on the identification cards may be rearranged in order to accommodate fixed printout systems already established by a company.

(b) Additional information may be printed on the reverse side of the identification cards, provided the additional information is appropriately captioned and is not at variance with the information required.

(c) One identification card shall be issued for each vehicle insured under the policy. Replacement identification card or cards will be issued at the request of the insured in the event of loss.

(d) Each identification card shall be effective for no more than 14 months from the effective date indicated on its face. A replacement identification card shall be issued to all insureds each year upon renewal of the policy. A replacement identification card must be issued upon either a change of vehicle or the acquisition of additional vehicles. Upon assignment of a new policy number, a new card must also be issued.

(e) Identification cards will not be required for trailers as the liability burden is on the towing or power unit.

(f) The insurer shall, prior to the expiration of a 60–day temporary identification card, issue to the insured a permanent identification card.

(g) The identification card shall contain at least one anti-counterfeiting measure approved in accordance with (h) below that makes it difficult to duplicate the card by photocopying, scanning or other means without detection.

(h) By June 18, 2004, each insurer or group of insurers shall file for approval with the Department a description of its anti-counterfeiting measures and the information necessary for law enforcement and other authorized persons to determine that the card has not been counterfeited.

1. The filing shall be deemed approved if not affirmatively approved or disapproved within 30 days of the date of its receipt by the Department.

(i) No later than April 19, 2004 and within 30 days of any change in the information, each insurer shall file with the Department:

1. An image of the front and back of each type of identification card used with sample policyholder information; and

2. An explanation of the policy number formats used by the insurer, for example, the number of characters, the position and meaning of alpha and numeric characters.

(j) By May 19, 2004, every insurer or group of insurers shall file with the Department an insurance verification phone number to which inquiries from law-enforcement personnel about the insurance status of a driver can be made.

1. The insurance verification phone number shall be staffed, at a minimum, during normal business hours.

2. The Department shall be notified within one business day at the address in (k) below of any change in the insurance verification phone number.

(k) The filings in (h) through (j) above shall be made to:

New Jersey Department of Banking and Insurance
Insurance Identification Card Unit
PO Box 329
Trenton, NJ 08625–0329
E-mail: autoidcards@dobi.state.nj.us

(*l*) The filings in (h) though (j) above contain proprietary commercial information and are not subject to public access pursuant to N.J.S.A. 47:1A–1 et seq., but may be provided to the Office of the Insurance Fraud Prosecutor and other law enforcement agencies to assist in the identification of fraudulent insurance identification cards.

As amended, R.1973 d.35, effective January 26, 1973.
See: 5 N.J.R. 20(b).
As amended, R.1983 d.648, effective January 17, 1984.
See: 15 N.J.R. 1919(a), 16 N.J.R. 145(c).
Dated material at (e) deleted.
Amended by R.1996 d.58, effective February 5, 1996.
See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).
Amended by R.2004 d.166, effective April 19, 2004.
See: 35 N.J.R. 3521(a), 36 N.J.R. 1939(a).
Deleted former (g); added new (g)-(*l*).

11:3–6.5 (Reserved)

R.1973 d.3, effective January 3, 1973.
See: 4 N.J.R. 307(a), 5 N.J.R. 47(d).
Repealed by R.2004 d.166, effective April 19, 2004.
See: 35 N.J.R. 3521(a), 36 N.J.R. 1939(a).
Section was "Commercial motor vehicles; exemption".

SUBCHAPTER 7. AUTOMOBILE REPARATION REFORM ACT

11:3–7.1 Purpose

This subchapter implements certain provisions of the Automobile Reparation Reform Act, N.J.S.A. 39:6A–1 et seq., including the Commissioner's authority to establish the amounts and terms of additional personal injury protection benefits that must be made available to insureds electing a standard automobile insurance policy pursuant to N.J.S.A. 39:6A–4.

Amended by R.1998 d.591, effective December 21, 1998 (operative March 22, 1999).
See: 30 N.J.R. 3202(a), 30 N.J.R. 4390(b).
Substituted "made available to insureds electing a standard automobile insurance policy pursuant to N.J.S.A. 39:6A–4" for "provided in policies covering automobiles as defined in N.J.S.A. 39:6A–2" at the end.

Case Notes

Additional personal injury protection coverage applied to all persons for whom basic coverage was provided. Clendaniel v. New Jersey Manufacturers Insurance Co., 190 N.J.Super. 286, 463 A.2d 369 (App. Div.1983), affirmed in part, reversed in part 96 N.J. 361, 476 A.2d 263 (1984).

Individual held to be "surviving spouse" until conclusive determination of divorce reached. Allstate Insurance Co. v. Skolny, 86 N.J. 112, 429 A.2d 1045 (1981).

11:3–7.2 General requirements applicable to additional personal injury protection benefits

(a) In addition to the personal injury protection benefits that insurers must provide pursuant to N.J.S.A. 39:6A–4 or 39:6A–3.1, insurers shall make available to the named insured, and, at his or her option, to any resident relatives in the name insured's household who are not named insureds on another standard or basic policy, additional income continuation benefits, essential services benefits, death benefits and funeral expense benefits pursuant to N.J.S.A. 39:6A–10 and this subchapter.

(b) The additional benefit indicated in each option that an insurer may offer for income continuation benefits and

essential services benefits represents the aggregate of the basic and additional personal injury protection benefits.

(c) Any additional income continuation benefits that an insurer may offer shall be limited to 75 percent of the insured's weekly income.

(d) The limits which are applicable to any additional personal injury protection benefits that an insurer may offer shall apply on a per person, per accident basis.

(e) Each insurer shall make available as an option additional income continuation benefits for as long as the disability persists.

1. Each insurer shall furnish rates for such benefits upon the request of the insured.

(f) Any additional death benefits which an insurer may offer shall be payable without regard to the period of time elapsing between the date of the accident and the date of death provided death occurs within two years of the accident and results from bodily injury from that accident.

1. The requirements of (f) above shall apply to any claim for additional death benefits where death occurs on or after April 21, 1986.

i. With respect to any claim presented on or after the effective date of this subchapter, each insurer shall disclose the availability of additional death benefits in conformance with the applicable provisions of N.J.A.C. 11:2–17.1 et seq.

ii. With respect to any claim initiated prior to the effective date of this subchapter, each insurer shall take appropriate steps to determine whether additional death benefits are payable, pursuant to (f) above. These steps shall include, but need not be limited to, review of claims closed on or after April 21, 1986 for the purpose of ascertaining the applicability of additional death benefits. Upon determining that such benefits are payable, each insurer shall provide written notice to eligible beneficiaries and process the claim in accord with N.J.S.A. 39:6A–5 and the applicable provisions of N.J.A.C. 11:2–17.1 et seq.

(g) In addition to the minimum schedule of additional personal injury protection benefits set forth at N.J.A.C. 11:3–7.4(b), any insurer may provide other additional personal injury protection benefit options subject to review and approval of its filing by the Department of Banking and Insurance. Any additional options offered by the insurer must be in compliance with the standards and requirements set forth in this subchapter.

(h) Insurers may also make available to named insureds covered under N.J.S.A. 39:6A–4, and at their option, to resident relatives in the household of the named insured or to other persons provided medical expense coverage pursuant to this statutory provision, or both, additional first party medical expense benefit coverage pursuant to N.J.S.A. 39:6A–10.

Amended by R.1990 d.580, effective November 19, 1990 (operative January 1, 1991).
See: 22 N.J.R. 1681(a), 22 N.J.R. 3488(b).
New (h) added enabling insurers to make available additional first party medical expense benefit coverage in excess of $250,000 as per P.L. 1990 c.8.
Amended by R.1998 d.591, effective December 21, 1998 (operative March 22, 1999).
See: 30 N.J.R. 3202(a), 30 N.J.R. 4390(b).
In (a), deleted "basic" preceding "personal" and inserted "who are not named insureds on another standard or basic policy" following "household".
Amended by R.2001 d.44, effective February 5, 2001.
See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).
In (a), inserted an N.J.S.A. reference.

Case Notes

Insurer made sufficient offer of basic income continuation benefits for as long as disability exists. Werts v. New Jersey Mfrs. Ins. Co., 250 N.J.Super. 580, 595 A.2d 1110 (A.D.1991), certification denied 127 N.J. 554, 606 A.2d 366.

After death of named insured in accident, maximum scheduled income continuation and essential services benefits held payable to husband of named insured. Muschette v. The Gateway Insurance Co., 149 N.J.Super. 89, 373 A.2d 406 (App.Div.1977) certification denied 75 N.J. 27, 379 A.2d 258, affirmed 76 N.J. 560, 388 A.2d 964 (1978).