

**CHAPTER 3**

**AUTOMOBILE INSURANCE**

**Authority**

N.J.S.A. 17:1C-6(e) and 17:1-8.1.

**Source and Effective Date**

R.1996 d.58, effective January 4, 1996.  
See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).

**Executive Order No. 66(1978) Expiration Date**

Chapter 3, Automobile Insurance, expires on January 4, 2001.

**Chapter Historical Note**

Chapter 3, New Jersey Automobile Insurance Plan, became effective January 31, 1972 as R.1972 d.20. See: 3 N.J.R. 223(d), 4 N.J.R. 49(d). Subchapter 7, Automobile Repairation Reform Act, became effective December 4, 1972 as R.1972 d.244. See: 4 N.J.R. 270(a), 5 N.J.R. 13(c).

1973 Revisions: Amendments became effective January 3, 1973 as R.1973 d.3. See: 4 N.J.R. 307(a), 5 N.J.R. 47(d). Further amendments became effective January 25, 1973 as R.1973 d.30. See: 4 N.J.R. 305(b), 5 N.J.R. 48(a). Further amendments became effective January 26, 1973 as R.1973 d.35. See: 5 N.J.R. 20(b). Further amendments became effective May 31, 1973 as R.1973 d.140. See: 5 N.J.R. 150(a), 5 N.J.R. 229(b). Further amendments became effective August 31, 1973. See: 5 N.J.R. 350(b). Further amendments became effective December 4, 1973 as R.1973 d.337. See: 6 N.J.R. 15(d).

1974 Revisions: Amendments became effective July 24, 1974 as R.1974 d.208. See: 6 N.J.R. 322(b).

1975 Revisions: Amendments became effective July 1, 1975 as R.1975 d.130. See: 7 N.J.R. 113(a), 7 N.J.R. 276(d).

1976 Revisions: Subchapter 10, Auto Physical Damage Claims, became effective May 1, 1976 as R.1976 d.46 and R.1976 d.47. See: 8 N.J.R. 38(b), 8 N.J.R. 136(b). Amendments became effective October 18, 1976 as R.1976 d.328. See: 8 N.J.R. 421(a), 8 N.J.R. 516(a). Further amendments became effective November 22, 1976 as R.1976 d.371. See: 8 N.J.R. 481(b), 8 N.J.R. 559(c).

1977 Revisions: Amendments became effective March 23, 1977 as R.1977 d.100. See: 9 N.J.R. 178(b). Further amendments became effective March 31, 1977 as R.1977 d.114. See: 9 N.J.R. 127(a), 9 N.J.R. 239(a).

1978 Revisions: Amendments became effective January 1, 1978 as R.1977 d.437. See: 9 N.J.R. 435(d), 9 N.J.R. 586(b). Further amendments became effective January 19, 1978 as R.1978 d.12. See: 9 N.J.R. 585(c), 10 N.J.R. 69(c).

1979 Revisions: Amendments became effective August 17, 1979 as R.1979 d.155. See: 11 N.J.R. 142(a), 11 N.J.R. 250(a).

1982 Revisions: Amendments became effective August 16, 1982 as R.1982 d.246. See: 14 N.J.R. 543(b), 14 N.J.R. 917(d).

1983 Revisions: Subchapter 8, Nonrenewal of Automobile Insurance Policies, was readopted effective June 6, 1983 as R.1983 d.190. 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, became effective October 3, 1983 as R.1983 d.424. 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, became effective October 17, 1983 as R.1983 d.467. See: 15 N.J.R. 1342(a), 15 N.J.R. 1769(b). Subchapter 6, Insurance Identification Card, was

readopted effective December 29, 1983 as R.1983 d.648. See: 15 N.J.R. 1919(a), 16 N.J.R. 145(c).

1984 Revisions: Sections 13.3, 13.4 and 13.5 were originally amended as an emergency amendment effective January 4, 1984 as R.1984 d.3. See: 15 N.J.R. 1961(a), 16 N.J.R. 246(c). Amendments became effective January 17, 1984 as R.1983 d.648. See: 15 N.J.R. 1919(a), 16 N.J.R. 145(c). Public Notice for automobile insurance written notice/buyer's guide coverage selection form as contained in Subchapter 15. See: 16 N.J.R. 254(d). Subchapter 15, Standards for Written Notice: Buyer's Guide and Coverage Selection Form, became effective April 2, 1984 as R.1984 d.114. See: 15 N.J.R. 2142(a), 16 N.J.R. 733(a). Subchapter 14, Personal Injury Protection Options, became effective April 2, 1984 as R.1984 d.116. See: 15 N.J.R. 2139(a), 16 N.J.R. 730(b). Subchapter 7 was scheduled to expire August 17, 1984. The Governor granted a waiver of the scheduled expiration date from August 17, 1984 to November 15, 1984. On November 15, 1984, the Governor granted a second waiver from November 15, 1984 to February 13, 1985. Amendments became effective November 5, 1984 as R.1984 d.480. See: 16 N.J.R. 1692(a), 16 N.J.R. 3037(b).

1985 Revisions: Subchapter 7 was readopted pursuant to Executive Order No. 66(1978) effective February 13, 1985 with amendments effective March 18, 1985. See: 17 N.J.R. 43(a), 17 N.J.R. 707(b). Further amendments became effective February 19, 1985 (operative April 22, 1985) as R.1985 d.72. See: 16 N.J.R. 3285(a), 17 N.J.R. 458(c). Subchapter 17, Rating Organizations, became effective October 6, 1985 as R.1985 d.609. See: 16 N.J.R. 2936(a), 17 N.J.R. 2905(a). Further amendments became effective December 16, 1985 as R.1985 d.629. See: 16 N.J.R. 3170(a), 17 N.J.R. 2988(a).

1986 Revisions: Pursuant to Executive Order No. 66(1978), Chapter 3, Automobile Insurance was readopted effective January 6, 1986 (operative May 6, 1986) as R.1985 d.654. See: 16 N.J.R. 3286(a), 17 N.J.R. 89(b). Subchapter 20, Reporting Financial Disclosure and Excess Profit Reports, became effective April 7, 1986 as R.1986 d.111. See: 17 N.J.R. 2597(a), 18 N.J.R. 692(a). Subchapter 8, Nonrenewal of Automobile Insurance Policies, was revised effective October 6, 1986 as R.1986 d.418. See: 18 N.J.R. 1079(a), 18 N.J.R. 2039(a). Subchapter 17, Rating Organizations, was repealed and new rules became effective October 6, 1986 as R.1986 d.419. 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, became effective November 17, 1986 as R.1986 d.463. See: 18 N.J.R. 1344(b), 18 N.J.R. 2329(a).

1987 Revisions: Subchapter 7 was extensively revised effective March 16, 1987 as R.1987 d.140. See: 19 N.J.R. 44(a), 19 N.J.R. 453(a). Sections 1 through 4 were repealed, section 5 was recodified to section 6 and new rules were adopted for sections 1 through 5. As part of R.1987 d.142, section 13.3 was amended, effective March 16, 1987. See: 19 N.J.R. 46(a), 19 N.J.R. 455(a). Further amendments became effective June 15, 1987 as R.1987 d.249. See: 18 N.J.R. 2415(a), 19 N.J.R. 1096(a). Subchapter 23, Dangerous Drivers or Drivers with Excessive Claims, became effective December 21, 1987 as R.1987 d.527. 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).

1989 Revisions: 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 new rules by 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 replaced 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 new rules by 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 new rules by 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 new rules by R.1989 d.584, effective November 20, 1989. See: 21 N.J.R. 2876(a), 21 N.J.R. 3666(b).

1990 Revisions: Subchapter 31, Examination of the Financial Experience of Private Passenger Automobile Insurers, was adopted as new rules by 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 new rules by 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 new rules by 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 replaced by Subchapter 1, Commercial Automobile Insurance Plan, 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 new rules by R.1990 d.161, effective March 19, 1990. See: 21 N.J.R. 3719(a), 22 N.J.R. 963(a). Amendments to Subchapter 31 were adopted as R.1990 d.290, effective June 4, 1990. See: 22 N.J.R. 1026(a), 22 N.J.R. 1725(b). 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). See: 22 N.J.R. 3847(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). See: 22 N.J.R. 3861(a). 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). See: 22 N.J.R. 3874(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). See: 22 N.J.R. 3809(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. See: 22 N.J.R. 3777(a). Subchapter 35, Private Passenger Automobile Insurance Underwriting Rules, was adopted as emergency new rules by R.1990 d.627, effective November 26, 1990. See: 22 N.J.R. 3856(a). Subchapter 19, Standard/Non-Standard Rating Plans, was adopted as emergency new rules by R.1990 d.628, effective November 26, 1990. See: 22 N.J.R. 3804(a).

1991 Revisions: Pursuant to Executive Order No. 66(1978), Chapter 3 was readopted as R.1991 d.45, effective January 4, 1991, with amendments effective February 4, 1991. As part of R.1991 d.45, Subchapters 2 through 5, concerning the Automobile Insurance Plan (AIP), were repealed effective February 4, 1991. See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b). Subchapter 37 was 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 19 was 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). Subchapter 34 was 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 35 was 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 36 was 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 29 was readopted as R.1991 d.96, effective January 15, 1991, with changes effective February 19, 1991. See: 22 N.J.R. 3809(a), 23 N.J.R. 536(a). Subchapter 38 was 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 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 new rules by 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).

1992 Revisions: Subchapter 33, Appeals from Denial of Automobile Insurance, was adopted as new rules by 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 new rules by 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 (expires November 3, 1992). See: 24 N.J.R. 3421(a). Subchapter 42 was 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).

1993 Revisions: 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; expires April 30, 1993). See: 25 N.J.R. 1290(a). Subchapter 44 was readopted as R.1993 d.238, effective April 30, 1993. See: 25 N.J.R. 1290(a), 25 N.J.R. 2479(a).

1994 Revisions: 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 (expires April 30, 1994). See: 26 N.J.R. 1393(a). Subchapter 2B was 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 new rules by R.1994 d.477, effective September 19, 1994. See: 26 N.J.R. 1939(a), 26 N.J.R. 3866(a).

1995 Revisions: 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 new rules by R.1995 d.235, effective May 1, 1995. See: 27 N.J.R. 289(a), 27 N.J.R. 1803(a).

1996 Revisions: Pursuant to Executive Order No. 66(1978), Chapter 3 was readopted as R.1996 d.58, effective January 4, 1996, with amendments effective February 5, 1996. As part of R.1996 d.58, 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 effective February 5, 1996. 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 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 eligible 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 eligible 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).

#### 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” 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.

“Eligible 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 eligible 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.

"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 semi-trailers, 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 and 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 and unincorporated association, governmental agency, or registered to a professional designation (that is, T/A, PA or P.C.) where such autos are furnished to individuals and 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.

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

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".

### 11:3-1.3 Creation of the plan

(a) There is created in the State of New Jersey a plan for the administration and apportionment of automobile insurance for qualified applicants to be known as the Commercial Automobile Insurance Plan hereafter referred to as "CAIP."

(b) CAIP shall be administered by the governing committee pursuant to this subchapter and a plan of operation approved by the Commissioner.

(c) Every insurer admitted to transact and transacting motor vehicle insurance in the State of New Jersey shall participate in CAIP to the extent required by this subchapter and the plan of operation.

Amended by R.1996 d.502, effective October 21, 1996.  
See: 27 N.J.R. 4489(a), 28 N.J.R. 4586(a).

#### 11:3-1.4 Governing committee

(a) CAIP shall be administered by a governing committee of 14 members.

1. Eight members shall be salaried employees of an insurer which is a participant of CAIP.
2. Three members shall be licensed producers.
3. One member shall be public representative who is knowledgeable about automobile insurance matters but who is not employed by, or otherwise affiliated with, insurance producers, or other entities of the insurance industry.
4. One member shall be a salaried employee of a servicing carrier for the CAIP, provided that neither the servicing carrier nor any affiliate of the servicing carrier otherwise serves as a member of the governing committee.
5. The Commissioner or his or her designee shall be an ex-officio member of the committee.

(b) The following organizations shall each nominate two members to represent participants of CAIP:

1. The Alliance of American Insurers;
2. The American Insurance Association; and
3. The National Association of Independent Insurers.

(c) Participants which are not members of the organizations in (b) above shall nominate two members to represent participants in accordance with a fair method set forth in the plan of operation.

(d) The following organizations shall each nominate one member to represent producers:

1. Independent Insurance Agents of New Jersey;
2. Insurance Brokers Association of New Jersey; and
3. Professional Insurance Agents of New Jersey.

(e) All members shall be appointed by the Commissioner and shall serve for one year or until a successor is appointed. Each member may designate an alternate. In the event the Commissioner fails to appoint a nominee, the organization shall nominate another representative.

(f) The governing committee of the existing Commercial Automobile Insurance Plan shall act as the governing committee for CAIP until the CAIP governing committee is appointed pursuant to this section.

(g) All meetings of the governing committee shall be conducted in accordance with this subchapter and the plan of operation.

(h) Pursuant to this subchapter and the plan of operation, the governing committee shall have the following duties:

1. To assume the assets and liabilities of the Commercial Automobile Insurance Plan on behalf of the member insurers;

Recodified from 11:3-2B.5 and amended by R.1995 d.50, effective January 17, 1995.

See: 26 N.J.R. 4590(a), 27 N.J.R. 368(a).

Amended by R.1996 d.58, effective February 5, 1996.

See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).

### 11:3-2B.8 Confidentiality of documents

The information provided by a claimant pursuant to N.J.A.C. 11:3-2B.6 or 2B.7 as part of an application for a hardship exemption or appeal from a decision of the MTF shall be confidential and not subject to public inspection or copying pursuant to the "Right to Know" law, N.J.S.A. 47:1A-1 et seq.

Recodified from 11:3-2B.6 and amended by R.1995 d.50, effective January 17, 1995.

See: 26 N.J.R. 4590(a), 27 N.J.R. 368(a).

## SUBCHAPTER 3. BASIC AUTOMOBILE INSURANCE POLICY

### Authority

N.J.S.A. 17:1-8.1 and 17:1-15e and P.L. 1998, c.21.

### Source and Effective Date

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).

### 11:3-3.1 Purpose and scope

(a) This subchapter provides rules to be utilized by insurers in developing the policy forms and rates for basic automobile insurance policies to be filed with and approved by the Department in accordance with the provisions of N.J.S.A. 39:6A-3.1.

(b) This subchapter shall apply to all insurers writing private passenger automobile insurance on personal lines policy forms, including the New Jersey Personal Automobile Insurance Plan established by N.J.A.C. 11:3-2.

### 11:3-3.2 Definitions

The following words 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 that automobile insurance policy offered pursuant to N.J.S.A. 39:6A-3.1 and this subchapter.

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

"Department" means the Department of Banking and Insurance.

"Insurer" means any person or persons, corporation, association, partnership, company, reciprocal exchange, or other legal entity authorized or admitted to transact private passenger automobile insurance in this State, or any one member of a group of affiliated companies that transacts business in accordance with a common rating system.

"Medically necessary" is as defined in N.J.A.C. 11:3-4.2.

"Personal injury protection" or "PIP" means the benefits and coverages set forth at N.J.S.A. 39:6A-4 and 39:6A-3.1 and N.J.A.C. 11:3-4.

"Standard automobile insurance policy" or "standard policy" means that policy form filed by private passenger automobile insurers and approved by the Commissioner that contains the coverages and options pursuant to N.J.S.A. 39:6A-4.

### 11:3-3.3 General provisions

(a) All insurers writing private passenger automobile insurance and the Personal Automobile Insurance Plan shall file for approval with the Department their rates, rules and policy forms for a basic automobile insurance policy to be issued in accordance with N.J.S.A. 39:6A-3.1 and this subchapter.

(b) An insurer shall make available the basic policy at either a single tier rate or at multiple tier rates, consistent with its tier rating system filed and approved pursuant to N.J.A.C. 11:3-19A. If more than one basic policy rate is offered, each shall be identified as part of a standard, non-standard or preferred tier.

(c) If a named insured has elected basic automobile insurance coverage and other immediate family members or resident relatives of the named insured have higher policy limits under a standard policy, the provisions of N.J.S.A. 39:6A-4.2 shall apply and the named insured shall only be entitled to the coverages provided under his or her basic policy.

(d) Basic policies shall provide the tort option provided under N.J.S.A. 39:6A-8a.

(e) Initial rates by coverage for basic policies filed in accordance with this subchapter shall demonstrate consistency with the rates in the insurer's standard policy, adjusted for reduced coverage limits.

(f) Insurers shall file for approval an initial basic policy rating system by January 20, 1999.

### 11:3-3.4 Coverages; mandatory and optional

(a) The following coverages shall be included in all basic policies:

1. Personal injury protection medical expense benefits coverage in an amount not to exceed \$15,000 per person,

per accident; except that all medically necessary treatment of permanent or significant brain injury, spinal cord injury or disfigurement or medically necessary treatment of other permanent or significant injuries rendered at a trauma center or acute care hospital immediately following the accident and until the patient is stable, no longer requiring critical care and can be safely discharged or transferred to another facility in the judgment of the attending physician shall be covered in an amount not to exceed \$250,000, including the \$15,000 above. The medical expense benefits provided herein shall be in accordance with N.J.A.C. 11:3-4; and

2. Liability insurance coverage insuring against loss resulting from liability imposed by law for property damage sustained by any person arising out of the ownership, maintenance, operation or use of an automobile in an amount or limit of \$5,000, exclusive of interest and costs, for damage to property in any one accident.

(b) Insurers shall also make available in the basic policy, at the option of the insured, liability insurance coverage for bodily injury or death in an amount or limit of \$10,000, exclusive of interest and costs, on account of the injury or death of one or more persons in any one accident.

(c) Insurers may make available with the basic policy, at the option of the insured, comprehensive and collision coverage with deductibles filed and approved pursuant to N.J.A.C. 11:3-13.

(d) Basic policies shall not contain any other coverages, options, limits or deductibles other than those which are set forth in (a) through (c) above. Increased policy limits, the health insurance primary option for automobile medical expense coverage and uninsured/under-insured motorist coverages shall not be provided in basic policies.

### **11:3-3.5 Election of basic automobile insurance policy coverage and reporting**

(a) No insurer shall issue a basic automobile insurance policy unless the named insured has signed a written document entitled "basic automobile insurance policy coverage selection form" set forth in N.J.A.C. 11:3-15.7.

(b) For the years 1999 through 2003, each insurer writing basic automobile insurance policies shall report the number of basic automobile insurance in-force exposures as of December 31 together with the age of the named insured and the territories in which the named insured resides on a form prescribed by the Commissioner, and filed no later than the next occurring February 15.

### **11:3-3.6 Filing requirements**

(a) Insurers initially filing basic policy rating systems shall include the following:

1. A complete set of policy forms and endorsements that provide the mandatory and optional coverages as set forth in this subchapter;

2. Rates and rules as necessary;

3. An actuarial memorandum that supports the rate differentials from the insurer's standard policy rates;

4. The declaration page;

5. The rating information form; and

6. The personal lines filing forms as set forth in N.J.A.C. 11:3-16.3(f) and (g).

(b) Subsequent amendments to the rating systems shall be filed pursuant to N.J.A.C. 11:3-16 and other applicable statutes and rules.

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

### **Authority**

N.J.S.A. 17:1-8.1, 17:1-15c, 39:6A-3.1a and 39:6A-4a.

### **Source and Effective Date**

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).

### **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.

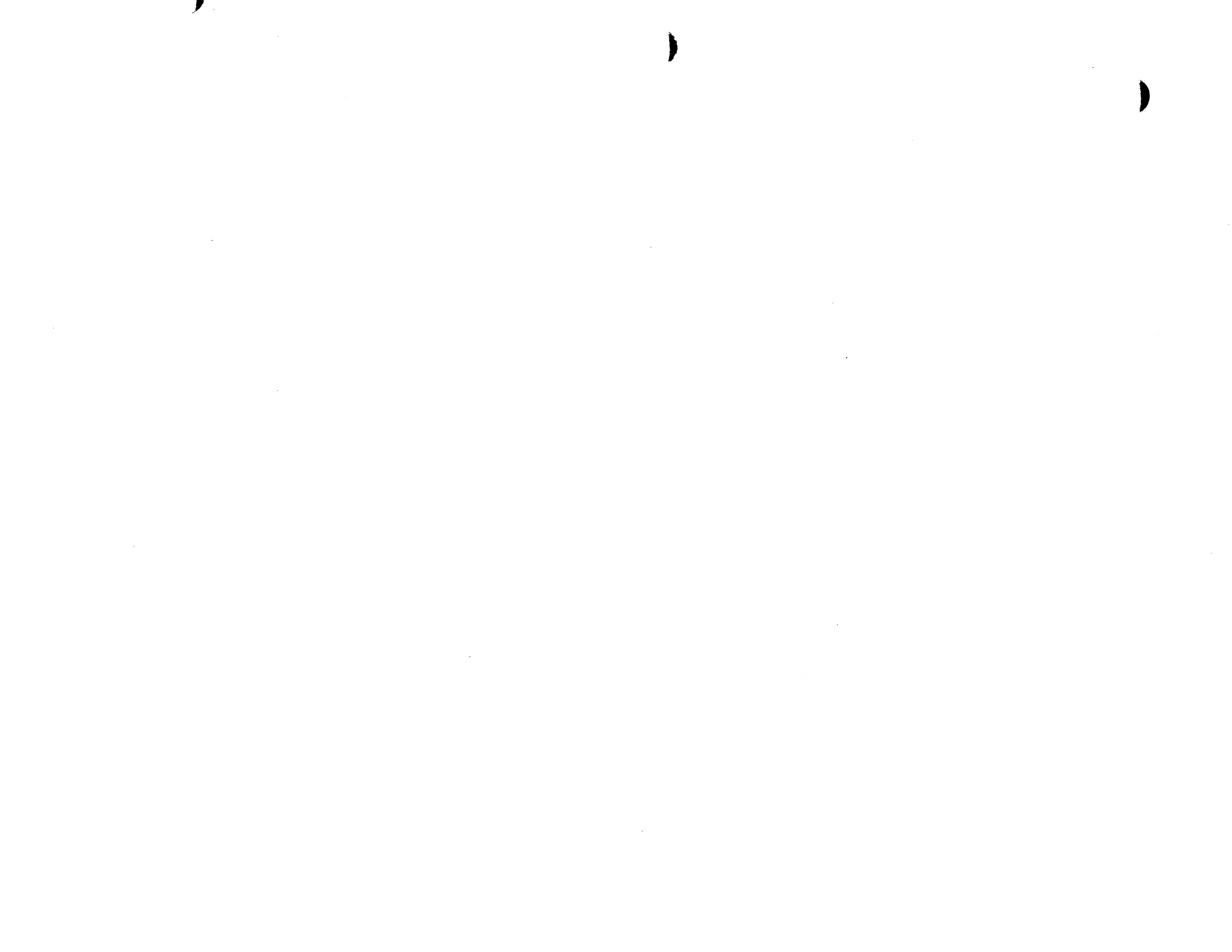
### **Case Notes**

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).

**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).

“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.

### 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) 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.

### 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. Brain mapping;
7. Surface electromyography (surface EMG);
8. (Reserved); and
9. 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 staph 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. Somatosensory 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. Videofluoroscopy 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.

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. CAT Scan is not appropriate

for TMJ/D. Repeat CAT Scans should not be undertaken unless there is clinically supported indication of an adverse change in the patient's condition.

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, sonogram/ultrasound are not necessary. These tests should not be used to evaluate TMJ/D. However, echocardiogram is appropriate in the evaluation of possible cardiac injuries when clinically supported.

(c) The terms "normal," "normally," "appropriate" and "indicated" as used above in (b), are intended to recognize that no single rule can replace the good faith educated judgment of a trained medical professional. 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 or course of treatment. The unusual circumstances shall be based on clinically supported findings of a trained medical professional. 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.

#### 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) Notwithstanding the requirements of (b) above, a pre-certification plan filed and approved pursuant to N.J.A.C. 11:3-4.8 shall satisfy the requirement to have a decision point review plan.

(d) 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.

(e) 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.

#### 11:3-4.8 Pre-certification plans

(a) Insurers may file for approval policy forms that provide for a pre-certification of certain medical procedures, treatments, diagnostic tests, or other services, non-medical expenses and durable medical equipment by the insurer or its designated representative.

(b) No pre-certification requirements shall apply within 10 days of the insured event.

(c) Pre-certification shall be based exclusively on medical necessity and shall not encourage over or under utilization of the treatment or test.

(d) An insurer that wishes to use a pre-certification plan 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 retroactively 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.

(e) The insurer shall include with its filing, the information about its pre-certification plan that will be given to consumers with new and renewal policies after the pre-certification plan is approved 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).

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

(g) 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 an approved pre-certification plan.

(h) Pre-certification plans shall avoid undue interruptions in a course of treatment.

(i) Insurers are encouraged to provide pre-certification plans that permit a treating provider to submit a comprehensive treatment plan for pre-certification so as to minimize the need for piecemeal review.

#### 11:3-4.9 Assignment of benefits

Insurers may file for approval policy forms including reasonable procedures for, or restrictions on, the assignment of personal injury protection benefits, consistent with the efficient administration of the coverage.

## 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.

**Chronic Disease**—a disease with long duration that changes little and progresses slowly. The opposite 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

dent 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.

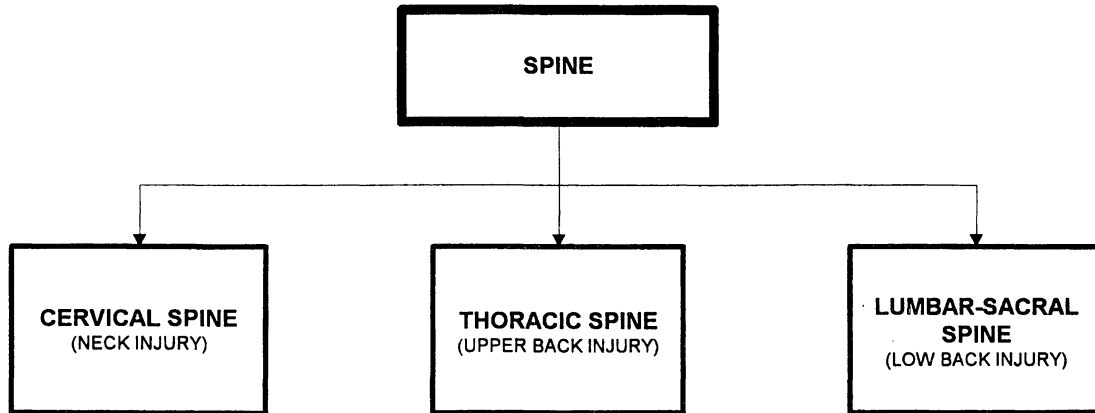
**Strain**—an injury caused by the over-stretching or tearing of a muscle or tendon. In its most severe form, the muscle ruptures.

**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 injuries sustained in automobile accidents, e.g., physical therapy, surgery, administration of medications, etc.

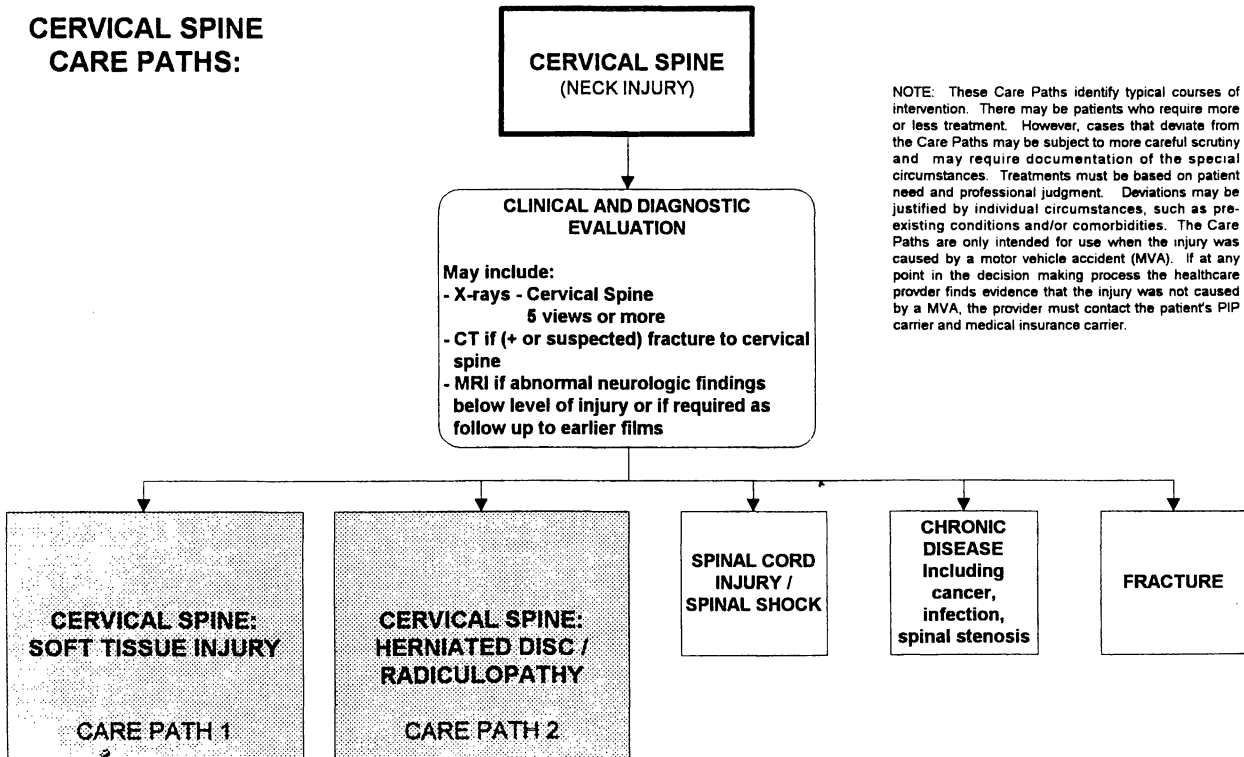
EXHIBIT 2

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

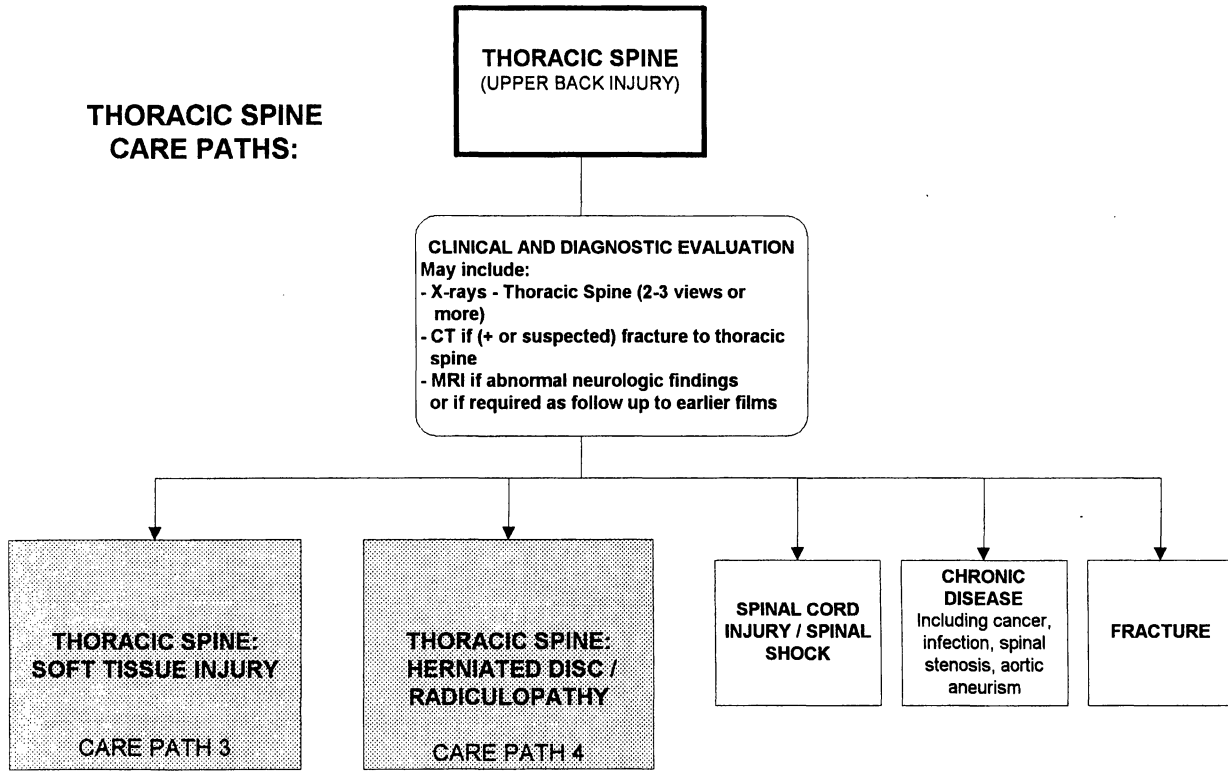


The following flow charts address the three anatomical areas of spinal injuries; Care Paths 1 through 6 have been developed for the conditions noted in the shaded boxes.

**CERVICAL SPINE CARE PATHS:**



**THORACIC SPINE  
CARE PATHS:**



**LUMBAR-SACRAL  
SPINE CARE PATHS:**

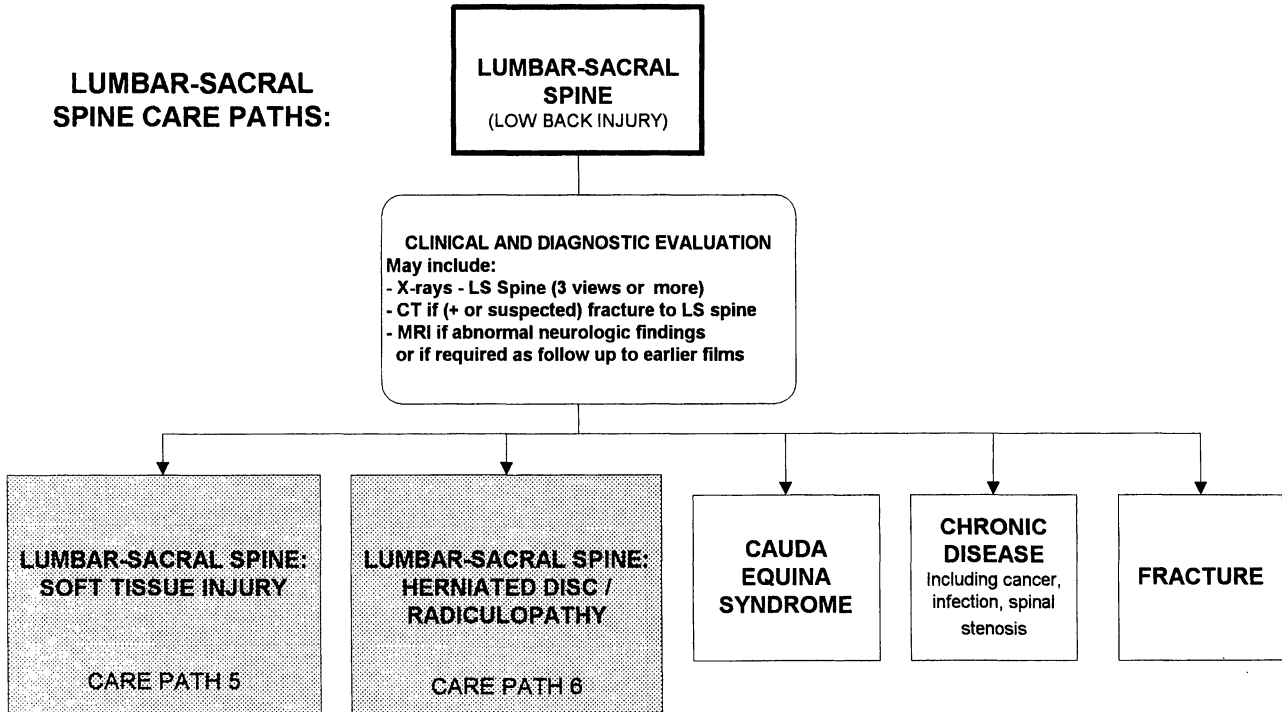


EXHIBIT 3

CARE PATH 1

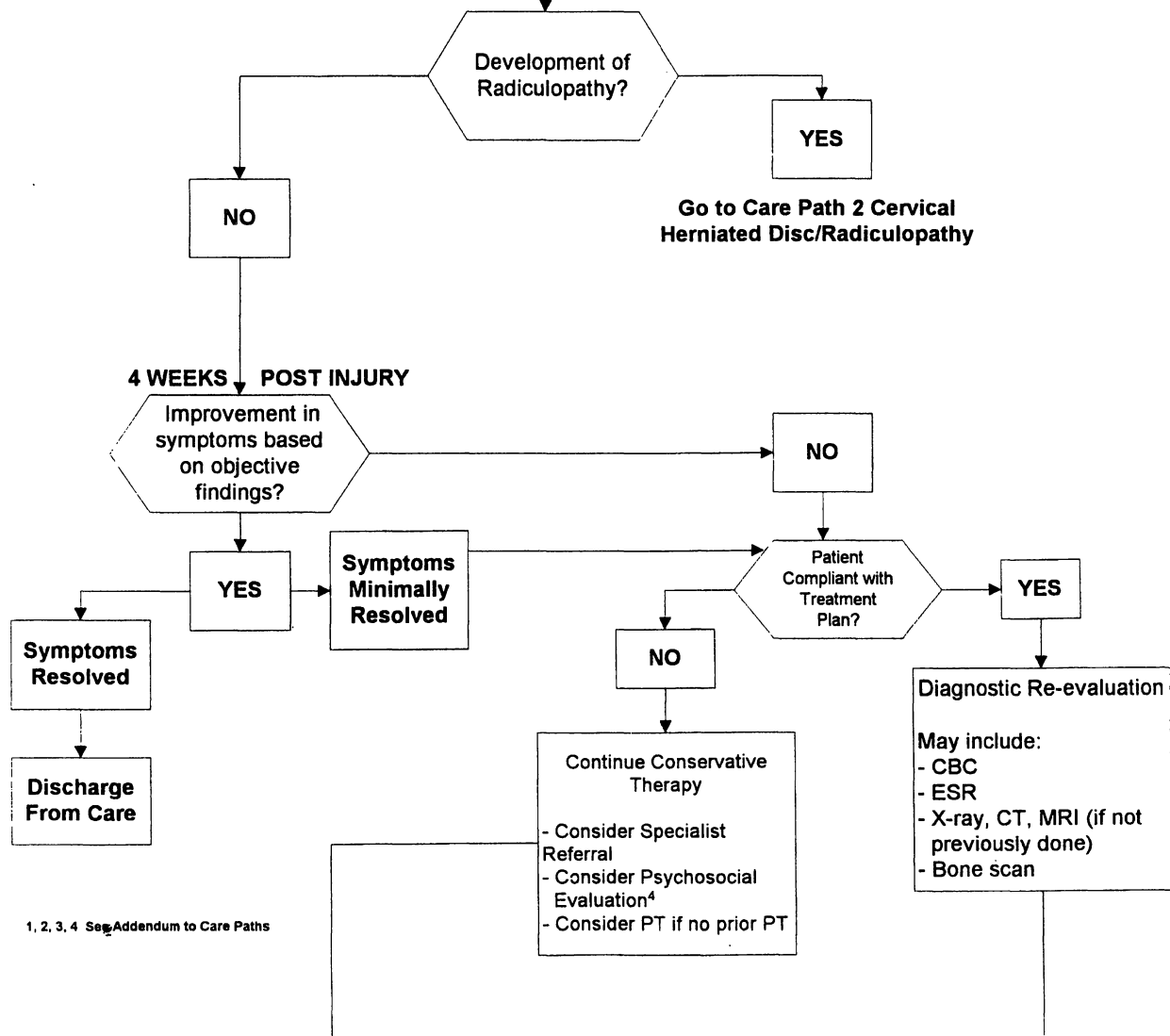
NOTE: These Care Paths identify typical courses of intervention. There may be patients who require more or less treatment. However, cases that deviate from the Care Paths may be subject to more careful scrutiny and may require documentation of the special circumstances. Treatments must be based on patient 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 provider finds evidence that the injury was not caused by a MVA, the provider must contact the patient's PIP carrier and medical insurance carrier

**CERVICAL SPINE  
SOFT TISSUE INJURY  
(STRAIN/SPRAIN/CONTUSION WHIPLASH)  
OF THE NECK**

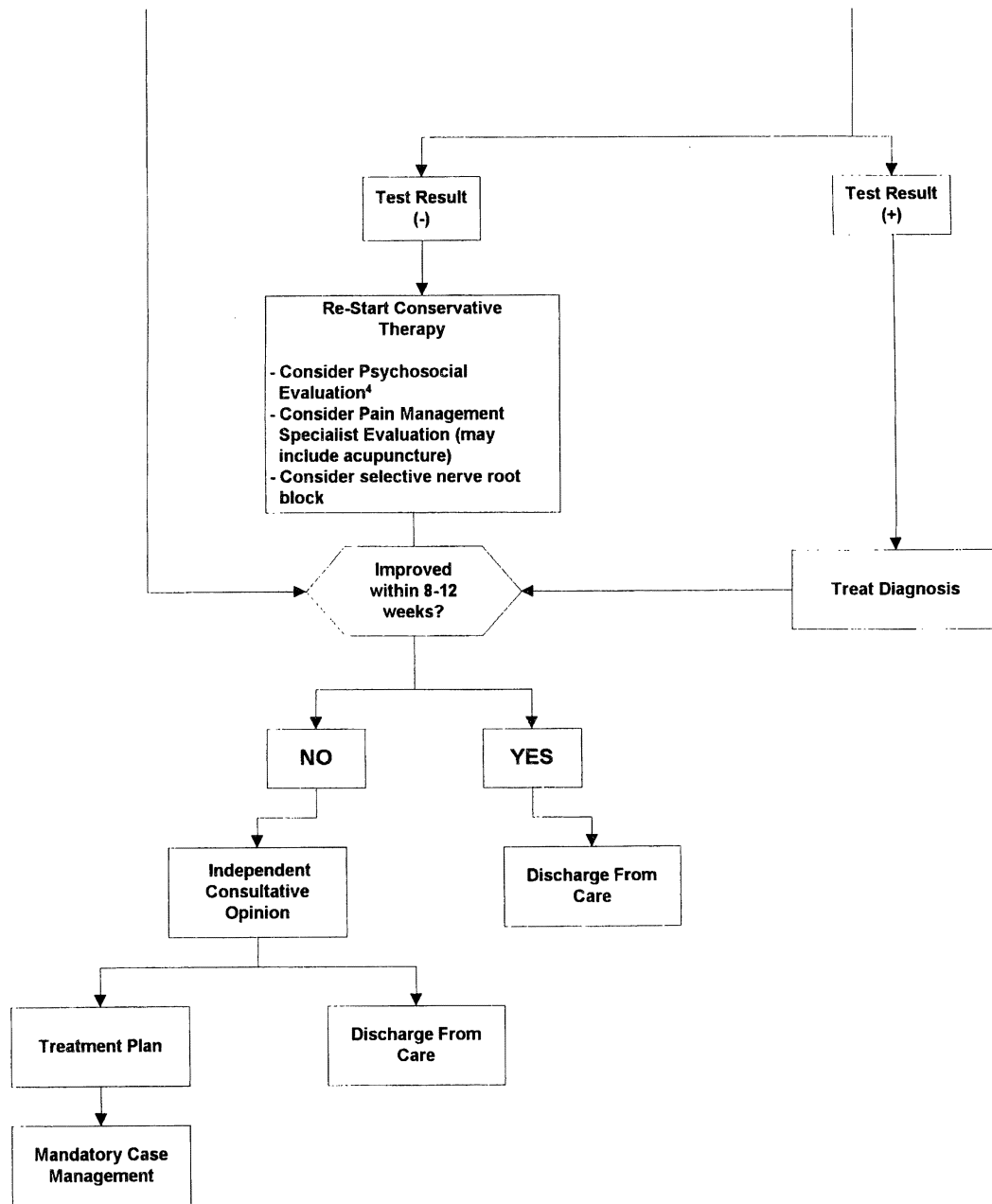
**CONSERVATIVE THERAPY  
(up to 4 weeks)**

- Provider office visits (up to 5)
- Medications<sup>1</sup>
- Consider soft neck collar (maximum 48 hours)
- Increasing exercise
- Consider PT program (2-3 times per week, up to 4 weeks)<sup>3</sup>
- Spinal manipulation<sup>2</sup> (1-3 visits per week, up to 4 weeks)

(The total number of visits for physical therapy and spinal manipulation should not exceed 12.)



1, 2, 3, 4 See Addendum to Care Paths



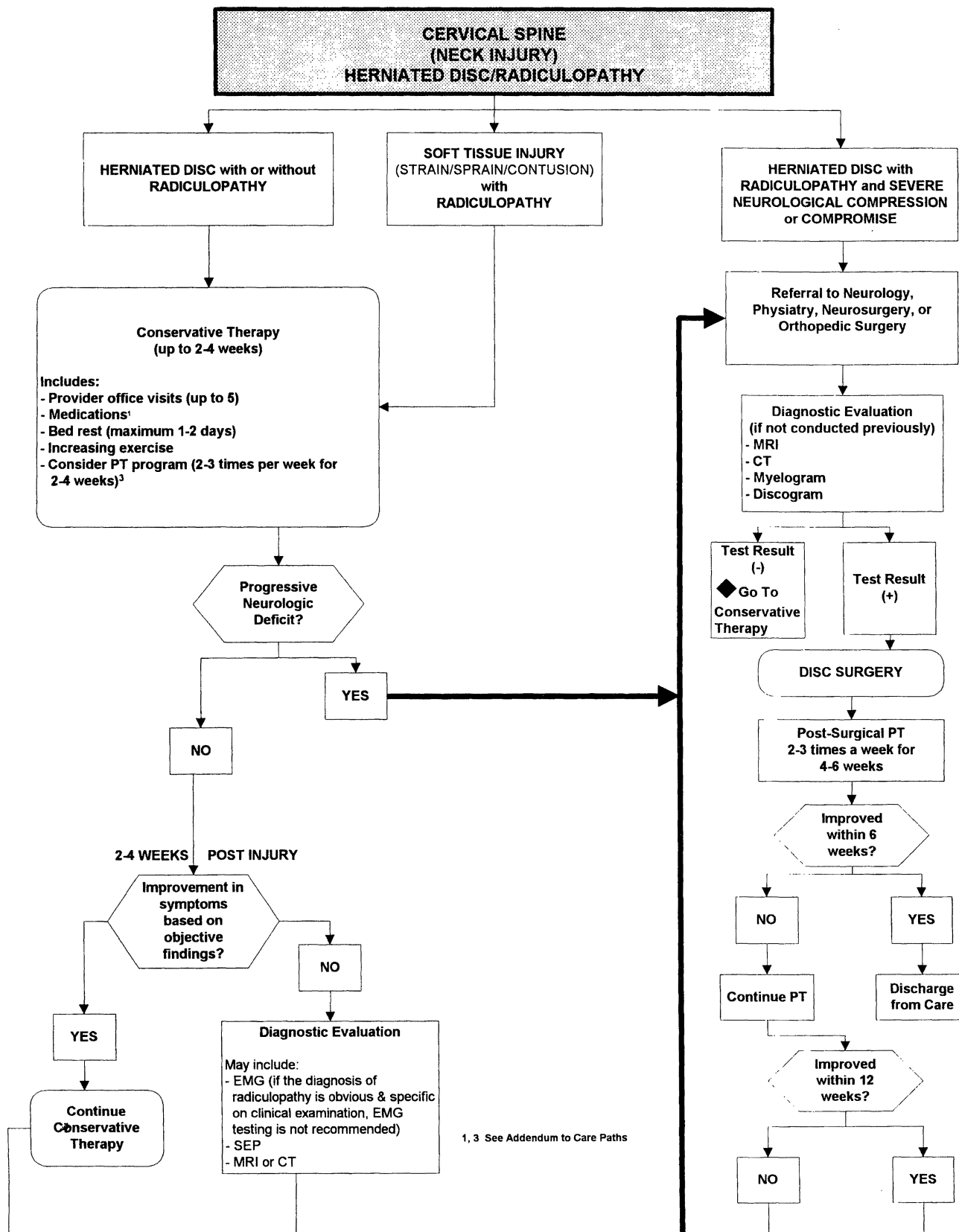
ICD-9 CODES

- 728.0
- 728.85
- 739.0
- 739.1
- 847.0
- 847.9
- 922.3
- 922.31
- 953.0

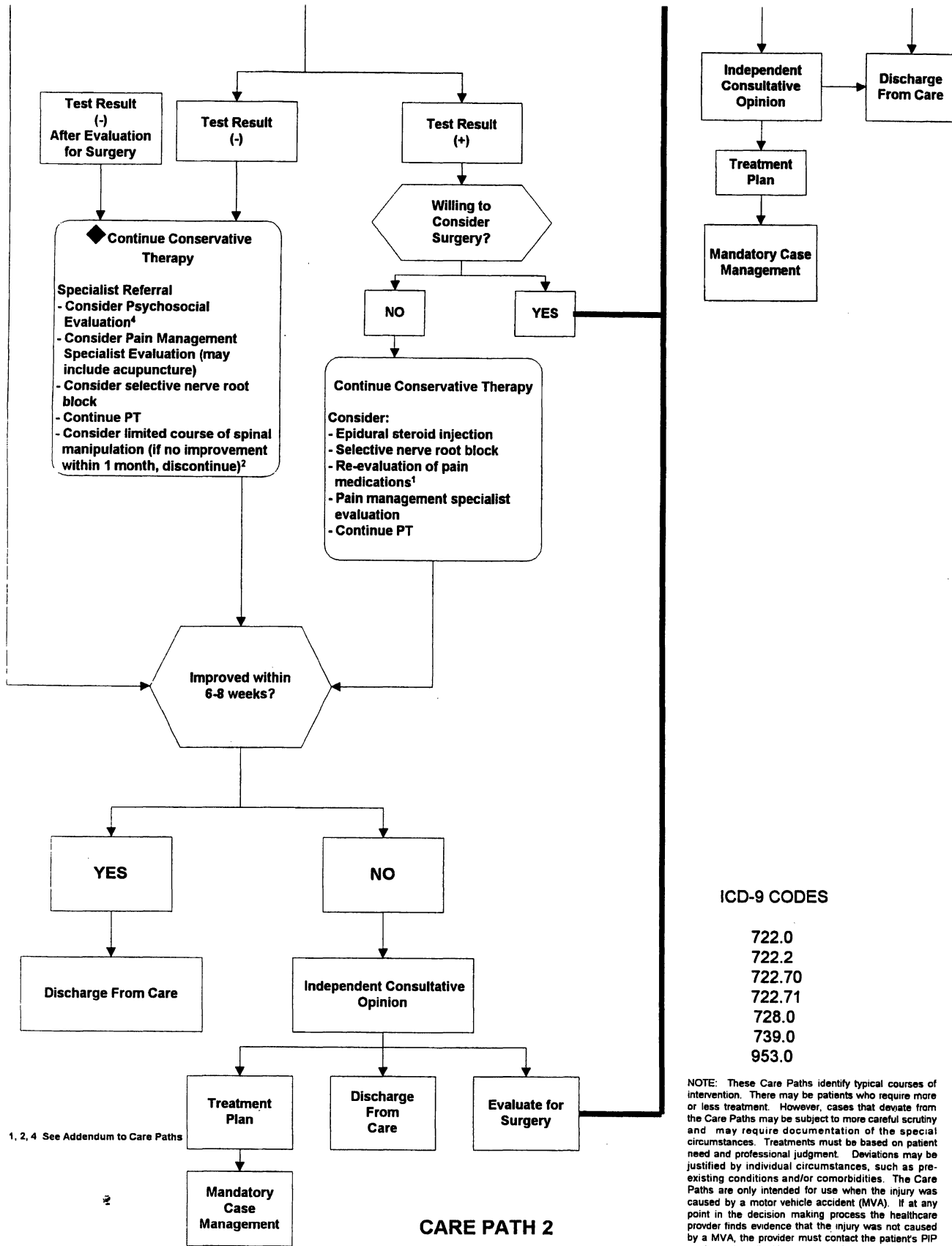
4 See Addendum to Care Paths

CARE PATH 1

EXHIBIT 4  
CARE PATH 2



1, 3 See Addendum to Care Paths



1, 2, 4 See Addendum to Care Paths

2

**CARE PATH 2**

**ICD-9 CODES**

- 722.0
- 722.2
- 722.70
- 722.71
- 728.0
- 739.0
- 953.0

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 provider finds evidence that the injury was not caused by a MVA, the provider must contact the patient's PIP carrier and medical insurance carrier.

EXHIBIT 5

CARE PATH 3

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 provider finds that the injury was not caused by a MVA, the provider must contact the patient's PIP carrier and medical insurance carrier.

**THORACIC SPINE  
SOFT TISSUE INJURY  
(STRAIN/SPRAIN/CONTUSION)  
OF THE UPPER BACK**

**CONSERVATIVE THERAPY  
(up to 4 weeks)**

- Provider office visits (up to 5)
- Medication<sup>1</sup>
- Bed rest (maximum 2-4 days)
- Increasing exercise
- Consider PT program (2-3 times a week for 2-4 weeks)<sup>3</sup>
- Spinal manipulation<sup>2</sup> (1-3 visits per week, up to 4 weeks)

(The total number of visits for physical therapy and spinal manipulation should not exceed 12.)

4 WEEKS POST INJURY

Improvement in symptoms based on objective findings?

YES

NO

Symptoms Resolved

Symptoms Minimally Resolved

Symptoms Worse or Unresolved

Discharge from Care

Patient Compliant with Treatment Plan?

Development of Radiculopathy?

NO

YES

NO

YES

Continue Conservative Therapy

- Begin or continue PT
- Consider Specialist Referral
- Consider Psychosocial Evaluation<sup>4</sup>

Continue Conservative Therapy

- Begin or continue PT
- Consider Specialist Referral
- Pain Management up to 3 visits (may include acupuncture)

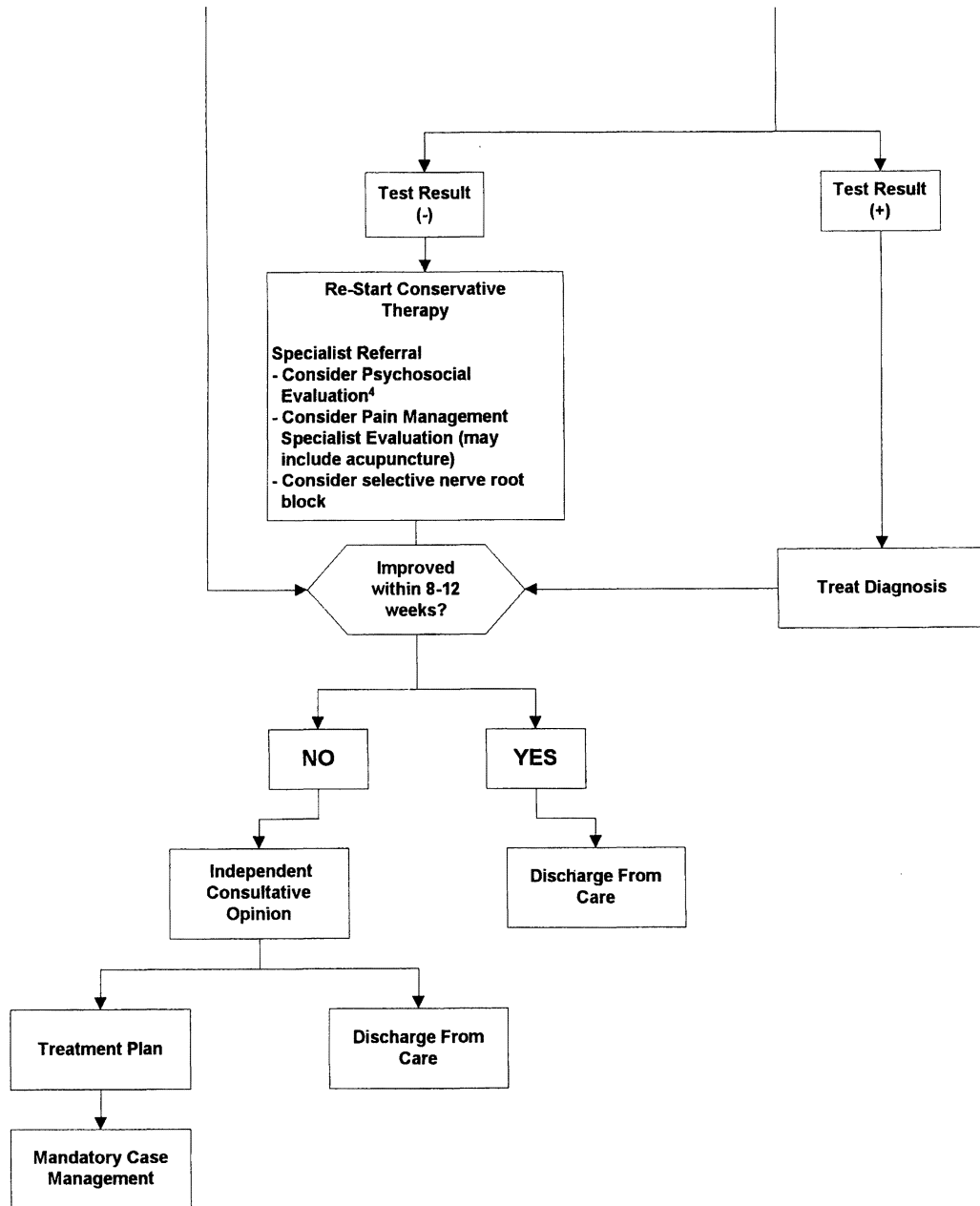
Diagnostic Re-evaluation

May include:

- CBC
- ESR
- X-ray AP & Lateral
- Bone scan

Go to Care Path 4  
Thoracic Spine  
Herniated Disc/  
Radiculopathy

1, 2, 3, 4 See Addendum to Care Paths



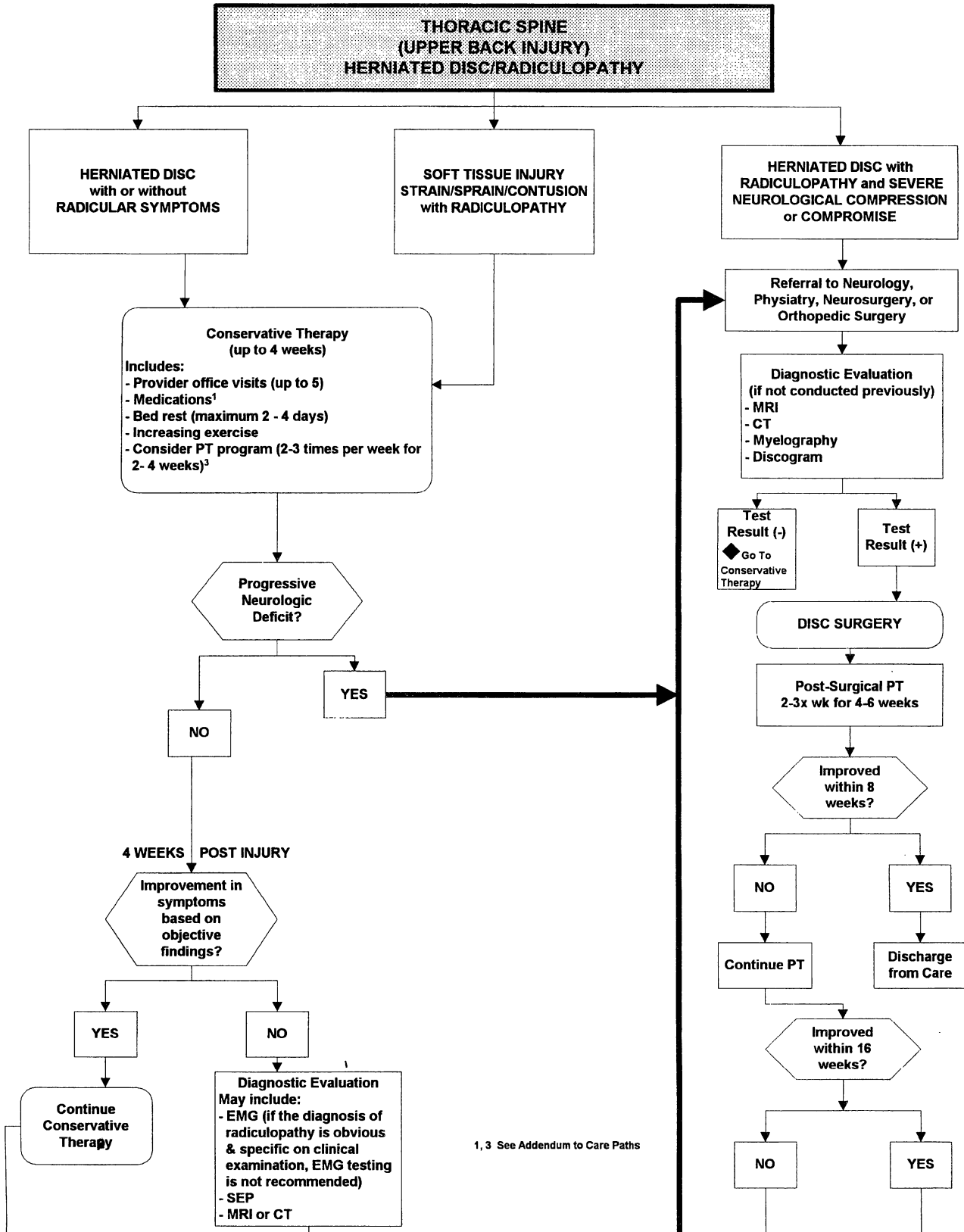
ICD-9 CODES

- 728.0
- 728.85
- 739.0
- 739.7
- 739.8
- 847.1
- 847.9
- 922.3
- 922.33
- 953.2

CARE PATH 3

<sup>4</sup> See Addendum to Care Paths

EXHIBIT 6  
CARE PATH 4



1, 3 See Addendum to Care Paths

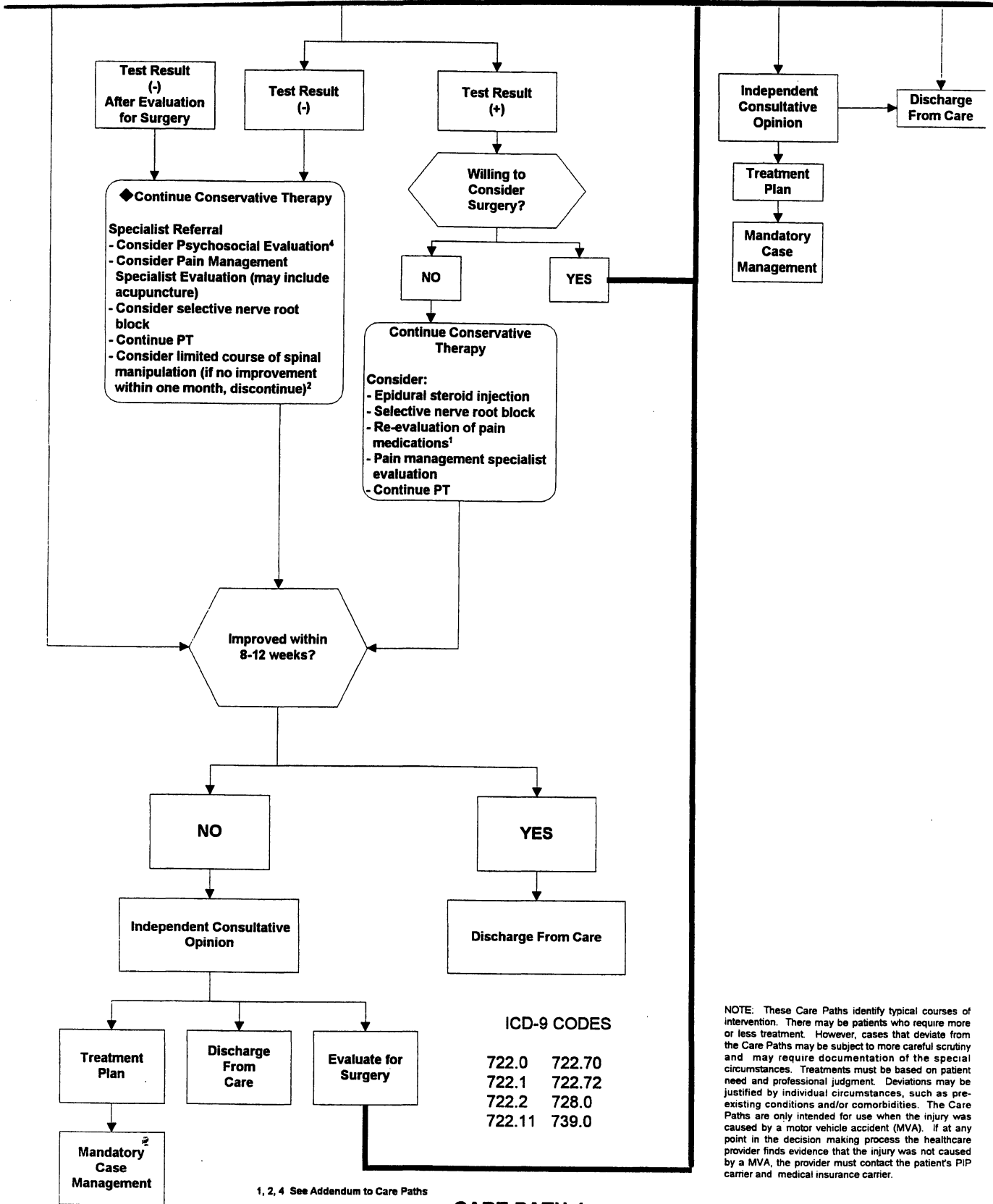


EXHIBIT 7  
CARE PATH 5

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 provider finds evidence that the injury was not caused by a MVA, the provider must contact the patient's PIP carrier and medical insurance carrier.

**LUMBAR-SACRAL SPINE  
SOFT TISSUE INJURY  
(STRAIN/SPRAIN/CONTUSION)  
OF THE LOW BACK**

**CONSERVATIVE THERAPY  
(up to 4 weeks)**

- Provider office visits (up to 5)
- Medications<sup>1</sup>
- Bed rest (maximum 2-4 days)
- Increasing exercise
- Consider PT program (2-3 times per week for 2-4 weeks)<sup>2</sup>
- Spinal manipulation<sup>2</sup> (1-3 visits per week, up to 4 weeks)

(The total number of visits for physical therapy and spinal manipulation should not exceed 12.)

4 WEEKS POST INJURY

Improvement in symptoms based on objective findings?

YES

NO

Symptoms Resolved

Symptoms Minimally Resolved

Symptoms Worse or Unresolved

Discharge from Care

Patient Compliant with Treatment Plan?

Development of Radiculopathy?

NO

YES

NO

YES

Go to Care Path 6 Lumbar-Sacral Spine Herniated Disc/Radiculopathy

**Continue Conservative Therapy**

- Begin or continue PT
- Consider Specialist Referral
- Consider Psychosocial Evaluation<sup>4</sup>

**Continue Conservative Therapy**

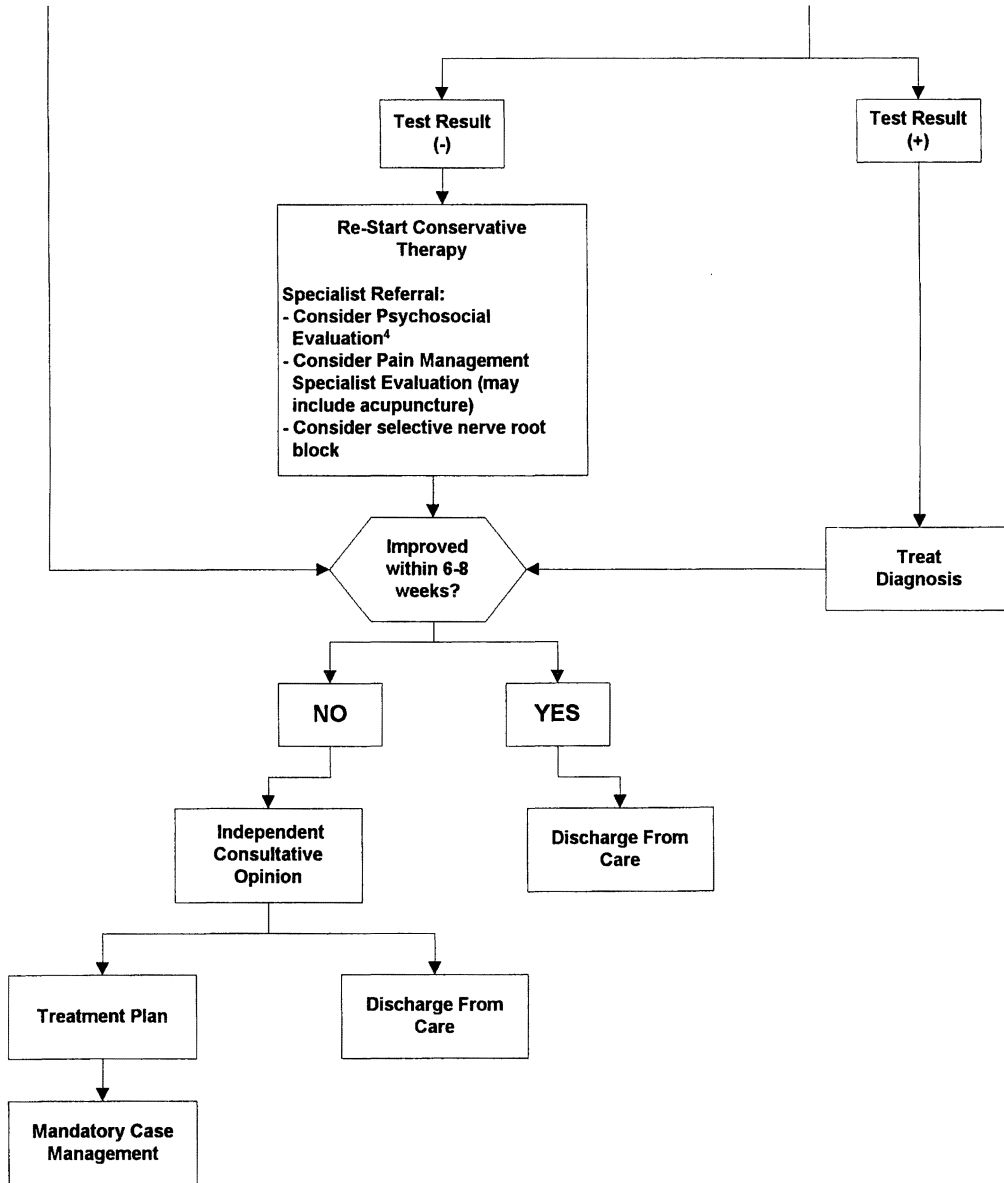
- Begin or continue PT
- Consider Specialist Referral
- Pain Management up to 3 visits (may include acupuncture)

**Diagnostic Re-evaluation**

May include:

- CBC
- ESR
- X-ray AP & Lateral
- Bone scan

1, 2, 3, 4 See Addendum to Care Paths



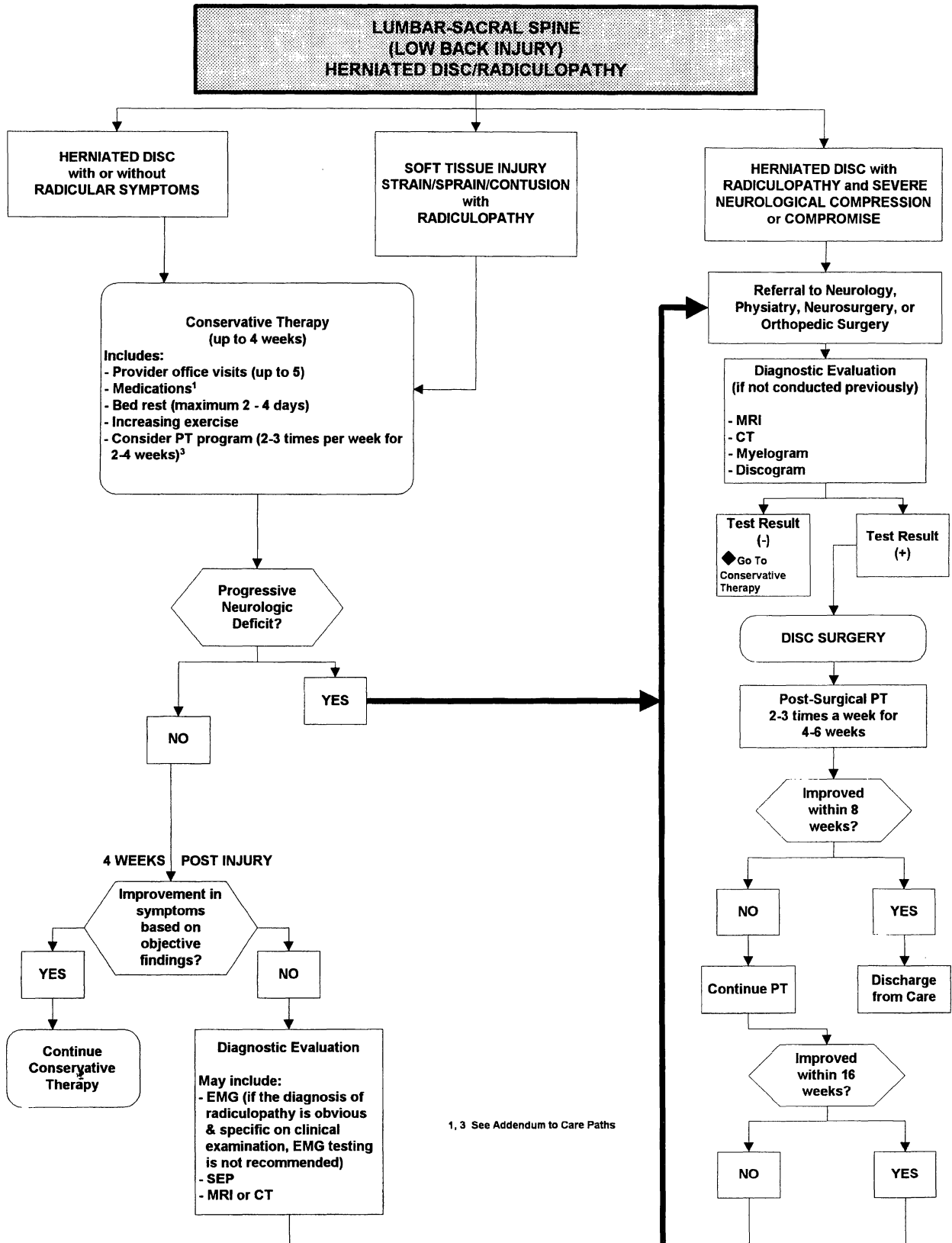
ICD-9 CODES

- 728.0 846.8
- 728.85 846.9
- 739.0 847.2
- 739.3 847.3
- 739.4 847.4
- 846 847.9
- 846.0 922.3
- 846.1 922.31
- 846.2 953.2
- 846.3 953.3

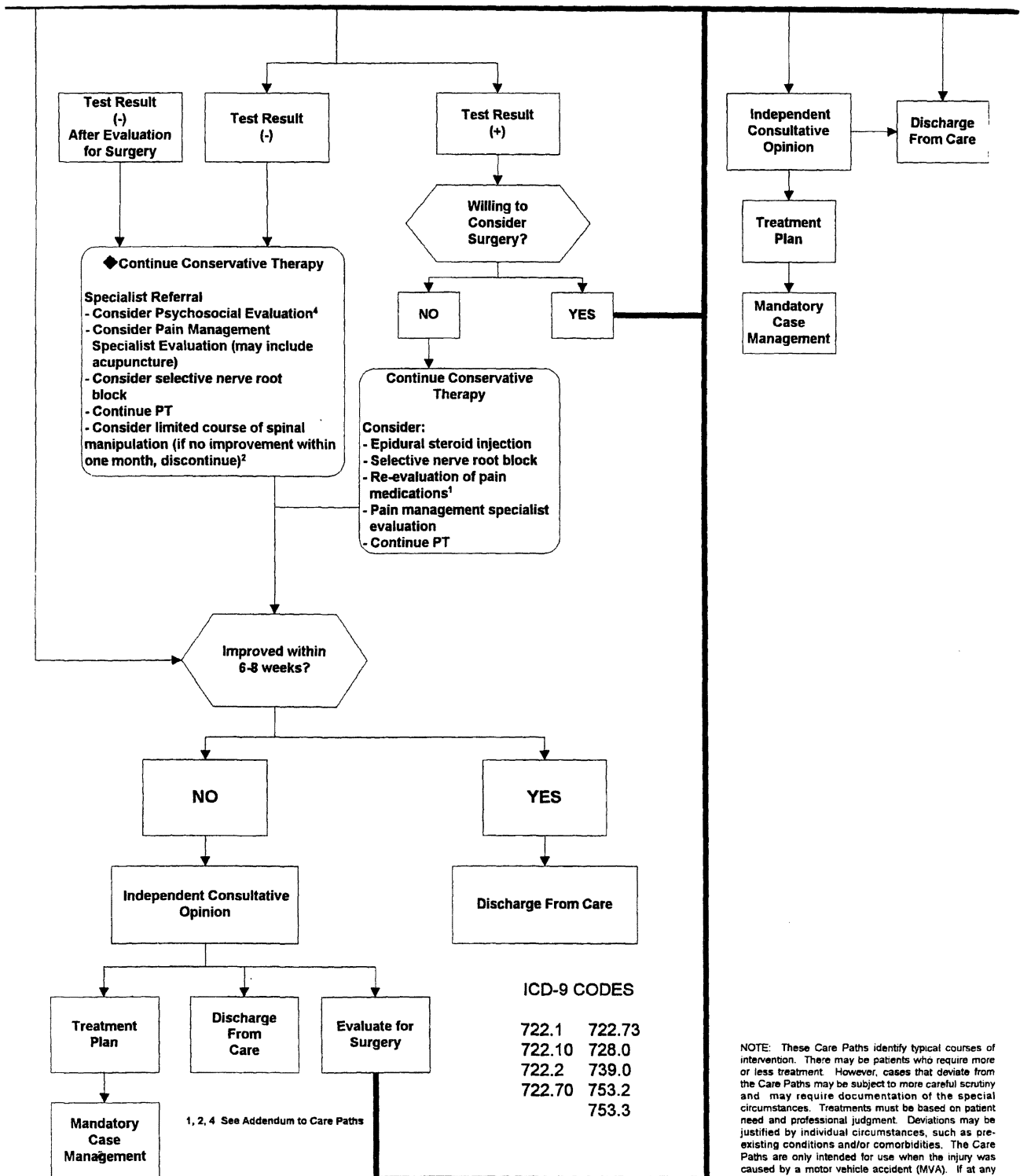
CARE PATH 5

4 See Addendum to Care Paths

EXHIBIT 8  
CARE PATH 6



1, 3 See Addendum to 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 provider finds evidence that the injury was not caused by a MVA, the provider must contact the patient's PIP carrier and medical insurance carrier.

CARE PATH 6

## EXHIBIT 9

TREATMENT OF ACCIDENTAL INJURY  
TO THE SPINE AND BACKCARE PATH  
DIAGNOSIS CODING

The following International Classification of Diseases, 9th Revision Clinical Modification—fifth edition ICD-9-CM diagnostic codes are associated with Care Path 1 through Care Path 6 for treatment of Accidental Injury to the Spine and Back and are included on each appropriate Care Path. The ICD9 codes referenced do not include codes for multiple diagnoses or comorbidity.

Care Path 1	728.0 Disorders of muscle, ligament and fascia
	728.85 Spasm of muscle
	739.0 Non allopathic lesions—not elsewhere classified
	739.1 Somatic dysfunction of cervical region
	847.0 Sprains and strains of neck
	847.9 Sprains and strains of back, unspecified site
	922.3 Contusion of back
	922.31 Contusion of back, excludes interscapular region
	953.0 Injury to cervical root
Care Path 2	722.0 Displacement of cervical intervertebral disc without myelopathy
	722.2 Displacement of intervertebral disc, site unspecified, without myelopathy
	722.70 Intervertebral disc disorder with myelopathy, unspecified region
	722.71 Intervertebral disc disorder with myelopathy, cervical region
	728.0 Disorders of muscle, ligament and fascia
	739.0 Non allopathic lesions—not elsewhere classified
	953.0 Injury to cervical root
Care Path 3	728.0 Disorders of muscle, ligament and fascia
	728.85 Spasm of muscle
	739.0 Non allopathic lesions—not elsewhere classified
	739.2 Somatic dysfunction of thoracic region
	739.8 Somatic dysfunction of rib cage
	847.1 Sprains and strains, thoracic
	847.9 Sprains and strains of back, unspecified site
	922.3 Contusion of back
	922.33 Contusion of back, interscapular region
Care Path 4	722.0 Displacement of cervical intervertebral disc without myelopathy
	722.1 Displacement of thoracic or lumbar intervertebral disc without myelopathy
	722.11 Displacement of thoracic intervertebral disc without myelopathy
	722.2 Displacement of intervertebral disc, site unspecified, without myelopathy
	722.70 Intervertebral disc disorder with myelopathy, unspecified region
	722.72 Intervertebral disc disorder with myelopathy, thoracic region
	728.0 Disorders of muscle, ligament and fascia

	739.0 Non allopathic lesions—not elsewhere classified
Care Path 5	728.0 Disorders of muscle, ligament and fascia
	728.85 Spasm of muscle
	739.0 Non allopathic lesions—not elsewhere classified
	739.3 Somatic dysfunction of lumbar region
	739.4 Somatic dysfunction of sacral region
	846 Sprains and strains of sacroiliac region
	846.0 Sprains and strains of lumbosacral (joint) (ligament)
	846.1 Sprains and strains of sacroiliac ligament
	846.2 Sprains and strains of sacrospinatus (ligament)
	846.3 Sprains and strains of sacrotuberous (ligament)
	846.8 Sprains and strains of other specified sites of sacroiliac region
	846.9 Sprains and strains, unspecified site of sacroiliac region
	847.2 Sprains and strains, lumbar
	847.3 Sprains and strains, sacrum
	847.4 Sprains and strains, coccyx
	847.9 Sprains and strains, unspecified site of back
	922.3 Contusion of back
	922.31 Contusion of back, excludes interscapular region
	953.2 Injury to lumbar root
	953.3 Injury to sacral root
Care Path 6	722.1 Displacement of thoracic or lumbar intervertebral disc without myelopathy
	722.10 Displacement of lumbar intervertebral disc without myelopathy
	722.2 Displacement of intervertebral disc, site unspecified, without myelopathy
	722.70 Intervertebral disc disorder with myelopathy, unspecified region
	722.73 Intervertebral disc disorder with myelopathy, lumbar region
	728.0 Disorders of muscle, ligament and fascia
	739.0 Non allopathic lesions—not elsewhere classified
	953.3 Injury to sacral root

The following ICD-9-CM supplemental classification of external causes of injury may be used in addition to the specific diagnostic codes noted above and on each Care Path:

- E 810 through E 819, selected E 820 series codes.

These codes may be used to indicate cause of injury as motor vehicle accident but should not be used without an associated diagnostic code.

## EXHIBIT 10

## ADDENDUM TO CARE PATHS

## 1. Medications

## Muscle Relaxants

- Muscle relaxants are an option in the treatment of patients with acute neck, thoracic, and low back problems. While probably more effective than placebo, muscle relaxants have not been shown to be more effective than NSAIDs.

- No additional benefit is gained by using muscle relaxants in combination with NSAIDs over using NSAIDs alone.
- Muscle relaxants have potential side effects in 30 percent of patients. When considering the option of using relaxants, the clinician should balance the potential patient's intolerance of other agents.

#### Opioid Analgesics

- When used for a time-limited course, opioid analgesics are an option in the management of patients with acute neck, thoracic, and low back problems. The decision to use opioids should be guided by consideration of their potential complications relative to other options.
- Opioids appear to be more effective in relieving neck, thoracic, and low back symptoms than safer analgesics, such as acetaminophen or aspirin or other NSAIDs.
- Clinicians should be aware of the side effects of opioids, such as decreased reaction time, clouded judgment, and drowsiness, which lead to early discontinuation by as many as 35 percent of patients.
- Patients should be warned about dependence and the danger of opioids while operating heavy machinery.

#### Oral Steroids

- Oral steroids are not recommended for the treatment of acute neck, thoracic, or low back problems.
- A potential for severe side effects is associated with the extended use of oral steroids or steroids in high doses.

#### 2. Who May Perform Spinal Manipulation:

Spinal manipulation may be performed by those providers licensed or certified to perform this procedure within their scope of practice.

#### 3. Spinal Manipulation

Manipulation is most helpful for patients with acute neck, thoracic, and low back problems without radiculopathy when used within the first month of symptoms. A trial of manipulation in patients without radiculopathy with symptoms longer than a month is probably safe, but efficacy is unproven.

If manipulation has not resulted in symptomatic improvement that allows increased function after 1 month of treatment, the patient should be reevaluated.

When findings suggest progressive or severe neurologic deficits, an appropriate diagnostic assessment to rule out serious neurologic conditions is indicated before beginning manipulation therapy.

There is insufficient evidence to recommend manipulation for patients with radiculopathy.

#### 4. Mental Health/Rehabilitation Assessment Option If Patient Has Not Responded To Treatment

A mental health/rehabilitation assessment can be obtained if psychological/psychosocial or psychiatric distress is obvious from the history, i.e., presence of "non-organic" physical signs, repetitive back injuries, failed previous treatments, litigation or disability compensation claims, family or financial problems, apparent secondary gain, boredom and dissatisfaction with job, frequent bouts of pain, depression, alcohol and substance abuse, extreme obesity, and apparent psychiatric behavior.

## SUBCHAPTER 5. PERSONAL INJURY PROTECTION DISPUTE RESOLUTION

### Authority

N.J.S.A. 17:1-8.1 and 17:1-15e, 39:6A-1.2, 39:6A-5.1 and 5.2.

### Source and Effective Date

R.1998 d.593, effective December 21, 1998.

See: 30 N.J.R. 3359(a), 30 N.J.R. 4437(a).

### 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.

### 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

6. The plan shall provide for the fair and efficient conduct of adversarial hearings when other methods of dispute resolution are either unsuccessful or inappropriate, consistent with traditional notions of due process and fundamental fairness. It shall address, at least, the following procedural issues;

- i. Discovery;
- ii. Receipt of evidence by the dispute resolution professional;
- iii. Submission of briefs or memoranda of law and fact;
- iv. Provision for decisions without testimony on consent of parties;
- v. Notice and place of hearing;
- vi. Methods to request adjournments;
- vii. Presentation of testimony and evidence at a hearing; and
- viii. Supplementation of the record.

(c) If consistent with its dispute resolution plan, a dispute resolution organization may utilize one or more dispute resolution professionals specifically to handle preliminary matters on actions including motions to disqualify an appointed DRP.

#### 11:3-5.5 Dispute resolution professionals

(a) A dispute resolution professional employed by the dispute resolution organization shall be either:

1. An attorney licensed to practice in New Jersey with at least 10 years' experience in cases involving personal injury or workers' compensation;
2. A former judge of the Superior Court or the Workers' Compensation Court, or a former Administrative Law Judge; or
3. Any other person, qualified by education and at least 10 years' experience, with sufficient understanding of automobile insurance claims and practices, contract law, and judicial or alternate dispute resolution practices and procedures.

(b) Dispute resolution professionals shall avoid conflicts of interest as prohibited at N.J.A.C. 11:3-5.12 in any matter assigned to them for determination.

1. Dispute resolution professionals shall complete and file with the dispute resolution organization a conflict of interest questionnaire that shall provide sufficient detail about financial interests of themselves and their immediate family so as to avoid any assignment to a particular case where there is a conflict of interest. Conflict of interest questionnaires shall remain confidential with the dispute resolution organization, and the information set forth therein shall only be disclosed as necessary to

individuals responsible for assigning cases to dispute resolution professionals, or reviewing motions to disqualify an assigned dispute resolution professional.

2. If during the course of an assignment a dispute resolution professional determines that he or she has conflict of interest, based upon facts determined in the course of the proceedings, then the DRP shall promptly advise the administrator of the circumstances, who shall assign another DRP.

3. A party may challenge the assignment of a particular DRP by submitting the specific grounds for challenge in accordance with the rules of the dispute resolution organization approved by the Commissioner.

(c) Dispute resolution professionals shall be compensated by the administrator in accordance with the terms of the contract designating the administrator. Compensation shall not be contingent in any way upon the decision or determination of the DRP.

(d) Dispute resolution professionals shall create and maintain such records as may be necessary to carry out their responsibilities and provide such records to the administrator as required in the contract designating the administrator.

#### 11:3-5.6 Conduct of PIP dispute resolution proceedings

(a) A request for dispute resolution of a PIP dispute may be made by the injured party, the insured, a provider who is an assignee of PIP benefits or the insurer, in accordance with the terms of the policy as approved by the Commissioner. The request for dispute resolution may include a request for review by a medical review organization. The request shall be made to the administrator and copies sent to other parties.

(b) Upon receipt of the request, the administrator shall promptly assign the matter to dispute resolution professional. The administrator shall notify all parties of the DRP assigned.

(c) If the request for dispute resolution includes a request for review by a medical review organization, the administrator shall refer the matter to a certified medical review organization contemporaneously with the assignment of the DRP, and shall notify the parties and the DRP that the matter has been referred. If the initial request does not include a request for review by a medical review organization, then a request for such review may be made by any party to the assigned DRP. The DRP may refer a matter to a MRO on his or her own initiative upon a finding that the dispute concerns the diagnosis, medical necessity of treatment or diagnostic test administered to the injured person, whether the injury is causally related to the accident or is the product of a preexisting condition, or the protocols utilized by a provider. Whenever a DRP receives or initiates a request for MRO review, he or she shall transmit it to the administrator for referral who shall refer the matter to a

certified MRO and notify the parties that the matter has been referred.

1. The administrator shall refer cases on a random or rotating basis to an MRO that does not have a conflict of interest, in accordance with the administrator's dispute resolution plan. Referrals shall be made in such a manner so as not to disclose the medical reviewer the identity of the insurer, nor to disclose to the insurer the identity of the medical reviewer.

2. Upon request of the MRO, a provider whose services are the subject of review shall promptly furnish a written report of the history, condition, treatment dates and results of diagnostic tests performed, and shall produce and permit the copying and inspection of all records relating to the history, treatment and condition of the injured person, and shall submit all necessary documentation as requested. Upon request of the MRO through the administrator, the insurer shall submit any and all documentation concerning its review of the treatment and testing of the injured person, and any reports by its reviewing provider why reimbursement for the treatment, test or item of durable medical equipment was denied.

3. The MRO may request an injured person to submit to a mental or physical examination by an independent provider in the same discipline as the treating providers who is not affiliated with either the treating provider, the insurer or the MRO health care provider performing the review. Any such examination shall be conducted in a place reasonably convenient to the injured person. The MRO shall make available to the examining provider any pertinent medical records.

4. If at any time the MRO determines that it has a conflict of interest in performing a particular review, it shall notify the administrator which shall refer the case to another MRO.

i. Under such circumstances, the first-assigned MRO shall transmit to the newly assigned MRO such documents from the treating provider and the insurer as it has accumulated on the case, as may be directed by the administrator.

ii. The first-assigned MRO shall not be entitled to any reimbursement for work performed on the transferred case.

(d) Determinations by the dispute resolution professional shall be in writing and shall state the issues in dispute, the DRP's findings and legal conclusions based on the record of the proceedings and the determination of the medical review organization, if any. The findings and conclusions shall be made in accordance with applicable principles of substantive law, the provisions of the policy and the Department's rules. The award shall set forth a decision on all issues submitted by the parties for resolution.

1. If the DRP finds that the determination of a medical review organization is overcome by a preponderance of the evidence, the reasons supporting that finding shall be set forth in the written determination.

2. The award shall apportion the costs of the proceedings, regardless of who initiated the proceedings, in a reasonable and equitable manner consistent with the resolution of the issues in dispute.

3. The award may include attorney's fees for a successful claimant or respondent in an amount consonant with the award and with Rule 1.5 of the Supreme Court's Rules of Professional Conduct.

(e) The award shall be signed by the dispute resolution professional. The original shall be filed with the administrator, and copies provided to each party. If the award requires payment by the insurer for a treatment or test, payment shall be made, together with any accrued interest pursuant to N.J.S.A. 39:6A-5, within 20 days of receipt of a copy of the determination.

(f) The final determination of the dispute resolution professional shall be binding upon the parties, but subject to vacation, modification or correction by the Superior Court in an action filed pursuant to N.J.S.A. 2A:23A-13 for review of the award.

#### Case Notes

N.J.A.C. 11:3-5.6(d)(3) was an invalid expression of legislative intent and was voided. *New Jersey Coalition of Health Care Professionals, Inc. v. New Jersey Department of Banking and Insurance, Division of Insurance*, 323 N.J.Super. 207, 732 A.2d 1063 (N.J.Super.A.D. 1999).

#### 11:3-5.7 Recordkeeping

(a) The administrator shall maintain records of all determinations for a period of five years.

(b) The administrator shall file a copy of each determination, except consent determinations, with the Department in either hard copy or electronic form, as provided in the contract designating the administrator.

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;

2. For mid-term policy changes, the request shall be effective the day following the date of postmark or, when personal delivery is made or if the postmark is illegible, the day following the receipt by the insurer or insurance producer of the signed Request To Exclude Named Driver form or request to reinstate the excluded driver;

3. For changes upon renewal, the changes shall be effective on the date of the next policy renewal if post-marked or received by the insurer or by an insurance producer prior to the renewal date.

(e) By February 19, 1999, all personal private passenger automobile insurers shall make a filing with the Commissioner to permit a named excluded driver. The filing shall include the following:

- 1. The named excluded driver endorsement;

2. Rule changes and rating procedures necessary to offer the option, including how the option will interface with the insurer's tier rating system; and

3. Other documents to be provided to an insured or applicant that describe or explain the named excluded driver option.

(f) The named excluded driver(s) and vehicle(s) shall be listed on the declaration page or on a supplemental declaration page.

(g) Notwithstanding any other provision of the law to the contrary, no person, including, but not limited to, an insurer or an insurance producer, shall be liable in an action for damages on account of the election of the named excluded driver endorsement.

New Rule, R.1998 d.594, effective December 21, 1998. See: 30 N.J.R. 2567(a), 30 N.J.R. 4446(a).

APPENDIX

REQUEST TO EXCLUDE NAMED DRIVER

Named insured (as shown on policy declaration)

Policy number \_\_\_\_\_

I, a Named Insured of the above policy, authorize the driver(s) listed below to be excluded from collision and comprehensive coverage (also known as "other than collision coverage") on my insurance policy for the specified vehicle(s). I understand:

1. In consideration of the premium for which the policy is written, comprehensive and collision coverages afforded by the policy will not apply to any damages, losses or claims while the designated automobile is being used or operated by the excluded driver(s) listed below.

2. This exclusion applies regardless of any provision in the policy defining insured Persons.

3. This exclusion applies to any claim of a Loss Payee shown on the Policy Declarations to the extent of the lienholder's interest in the insured auto and that I am responsible for any claim to the Loss Payee.

4. This agreement will be binding and will apply to all future renewals, reinstatements, and changes in my policy unless the specified automobile(s) is/are removed from the policy, a new automobile replaces the specified automobile on the policy, or the insurer or its representative receives my signed written request to discontinue the exclusion.

5. Notwithstanding any other provision of the law to the contrary, no person, including, but not limited to, an insurer or an insurance producer, shall be liable in an action for damages on account of the election of the named excluded driver endorsement.

Date: \_\_\_\_\_ Signature(s) of Named Insured(s) \_\_\_\_\_

	Driver Excluded	Driver's License #	Vehicle
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

New Rule, R.1998 d.594, effective December 21, 1998. See: 30 N.J.R. 2567(a), 30 N.J.R. 4446(a).

SUBCHAPTER 14. PERSONAL INJURY PROTECTION OPTIONS FOR STANDARD POLICIES

11:3-14.1 Purpose

This subchapter establishes rules for the provision of optional deductibles and benefits for personal injury protection offered under standard private passenger automobile insurance policies pursuant to N.J.S.A. 39:6A-4.

Amended by R.1989 d.117, effective February 21, 1989.

See: 20 N.J.R. 2984(a), 21 N.J.R. 558(b).

Substituted "appropriately" for "approximately" and deleted "set-offs".

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.1998 d.591, effective December 21, 1998 (operative March 22, 1999).

See: 30 N.J.R. 3202(a), 30 N.J.R. 4390(b).

Rewrote the section.

### 11:3-14.2 Scope

This subchapter applies to every insurer, including any residual market mechanism created by any New Jersey statute, authorized to transact the business of automobile insurance in this State.

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).

Amended to extend the applicability of the subchapter to all residual market mechanisms created by New Jersey statutory law consistent with the provisions of the Fair Automobile Insurance Reform Act of 1990 creating certain residual market mechanisms and eliminating, over time, the New Jersey Automobile Full Insurance Underwriting Association (NJAFIUA) (see sections 34 and 88 of the Act), also amended to delete reference to rating organizations pursuant to section 69 of the Act.

### 11:3-14.3 Optional medical expense benefits for standard policies

(a) With respect to personal injury protection under standard automobile insurance policies, issued pursuant to N.J.S.A. 39:6A-4, each insurer shall make available as an option, at appropriately reduced premiums, medical expense benefits in amounts of \$150,000, \$75,000, \$50,000, and \$15,000. If none of these options is affirmatively chosen in writing, the policy shall provide medical expense benefits in an amount not to exceed \$250,000 per person per accident.

(b) Notwithstanding (a) above, if an optional medical expense benefit option is chosen, the policy shall provide that medical expense benefits shall be paid in an amount not to exceed \$250,000, inclusive of any limit of medical expense benefits pursuant to (a) above, for all medically necessary treatment of permanent or significant brain injury, spinal cord injury or disfigurement or for medically necessary treatment of other permanent or significant injuries rendered at a trauma center or acute care hospital immediately following the accident and until the patient is stable, no longer requires critical care and can be safely discharged or transferred to another facility in the judgment of the attending physician.

As amended, R.1984 d.480, eff. November 5, 1984.

See: 16 N.J.R. 1692(a), 16 N.J.R. 3037(b).

Substantially amended (a)-(d).

Amended by R.1989 d.117, effective February 21, 1989.

See: 20 N.J.R. 2984(a), 21 N.J.R. 558(b).

Deleted (d); recodified (e)-(h) as (d)-(g) and substantially amended (d) and (f).

Amended by R.1996 d.58, effective February 5, 1996.

See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).

Repeal and New Rule, 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).

Section was "Optional medical expense benefit deductibles for personal injury protection coverage".

### Case Notes

Economically independent mother-in-law who resided with insured, was not bound by insured's cost containment options. *Swyersky v. Prudential Commercial Ins. Co.*, a Subsidiary of Prudential Ins. Co. of America, 229 N.J.Super. 608, 552 A.2d 240 (L.1988), reversed 240 N.J.Super. 37, 572 A.2d 219, on remand 263 N.J.Super. 544, 623 A.2d 310.

### 11:3-14.4 Optional exclusion of income continuation benefits, essential services benefits, death benefits and funeral expense benefits

(a) Automobile insurers offering personal injury protection coverage pursuant to N.J.S.A. 39:6A-4 shall, at an appropriate reduced premium, provide the named insured the option to exclude all of the following benefits from such coverage:

1. Income continuation benefits;
2. Essential services benefits;
3. Death benefits;
4. Funeral expense benefits.

(b) Election of the exclusion shall result in the elimination of all elements of personal injury protection coverage except medical expense benefits.

(c) An exclusion elected by the named insured in accordance with this subchapter 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 insurance policy but not to any other person eligible for personal injury protection benefits to be provided under that policy in accordance with N.J.S.A. 39:6A-4.

(d) Additional personal injury protection coverage pursuant to N.J.S.A. 39:6A-10 shall not be available to any named insured selecting the exclusion or to any relative resident in his household.

(e) No new automobile insurance policy shall be issued on or after July 1, 1984 unless the option to exclude personal injury protection benefits in accord with this section is made available to the applicant. In the case of any automobile policy expected to be in force on July 1, 1984, the named insured shall be provided not later than May 15, 1984 with the opportunity to elect, effective July 1, 1984, the personal injury protection coverage exclusion in accord with this section. Any notice of renewal of an automobile insurance policy with an effective date subsequent to July 1, 1984 shall be accompanied by a notice to the named insured providing the opportunity to elect personal injury protection coverage exclusion in accord with this subchapter.