

“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.

“Network” means an entity other than an insurer that contracts with providers to render health care services or provide supplies at predetermined fees or reimbursement levels.

“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.

“PIP vendor” means a company used by an insurer to administer its decision point review plan.

“Precertification” or “precertification request” means the procedures in an insurer’s approved decision point review plan for the insurer to receive notice and respond to requests for listed specific medical procedures, treatments, diagnostic tests, other services and durable medical equipment that are not subject to decision point review and that may be subject to overutilization.

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

Amended by R. 2000 d.454, effective November 6, 2000.

See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c).

Inserted “Diagnostic test”.

Amended by R.2004 d.218, effective June 7, 2004 (operative October 27, 2004).

See: 35 N.J.R. 3072(a), 36 N.J.R. 2890(a), 36 N.J.R. 4319(a).

Rewrote “Decision point”, added “Decision point review”, “Emergency personal injury protection coverage”, “Insurer”, “Network”, “PIP vendor” and rewrote “Pre-certification”.

Case Notes

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

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

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

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

11:3-4.4 Deductibles and co-pays

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

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

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

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

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

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

(d) Failure to request decision point review or precertification where required or failure to provide clinically supported findings that support the treatment, diagnostic test or durable medical equipment requested shall result in an additional co-payment not to exceed 50 percent of the eligible charge for medically necessary diagnostic tests, treatments or durable medical goods that were provided

between the time notification to the insurer was required and the time that proper notification is made and the insurer has an opportunity to respond in accordance with its approved decision point review plan.

Example: Assume that all days are business days and the insurer's Decision Point Review Plan gives the insurer three days to respond to decision point review and precertification requests. By the terms of the insurer's Decision Point Review Plan, a treating medical provider is required to make a decision point review request on day 21 of treatment (time notification was required). The provider does not give the required notification in a timely manner but continues to treat the patient. The provider then makes the notification and it is received by the insurer on day 35 (time proper notification made). The insurer responds on day 38 that the treatment can proceed (time for insurer to respond). Assuming that the treatment made between day 21 and 38 was medically necessary, it is subject to the 50 percent co-payment.

1. 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 review plan to request further information, modify or deny reimbursement of further treatment, diagnostic tests or durable medical equipment.

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

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

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

- i. Twenty-five percent when received 30 or more days after the accident; or
- ii. Fifty percent when received 60 or more days after the accident.

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

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

(f) An insurer may impose an additional co-payment not to exceed 30 percent of the eligible charge for failure to use an approved network pursuant to N.J.A.C. 11:3-4.8 for medically necessary diagnostic tests as specified in N.J.A.C. 11:3-4.8(b), durable medical equipment and/or prescriptions.

(g) For the purpose of the co-payments permitted in (d), (e) and (f) above, the percentage reduction shall be applied to the amount that the insurer would otherwise have paid to the insured or the provider after the application of the provisions of N.J.A.C. 11:3-29. Such amount may have already been reduced by the application of the co-payments and/or deductibles in (a) and (b) above.

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

Amended by R. 2000 d.454, effective November 6, 2000.

See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c).

Inserted a new (e); and recodified former (e) as (f).

Amended by R.2004 d.218, effective June 7, 2004 (operative October 27, 2004).

See: 35 N.J.R. 3072(a), 36 N.J.R. 2890(a), 36 N.J.R. 4319(a).

Rewrote (d); added (f); recodified former (f) as (h).

Amended by R.2004 d.218, effective June 7, 2004 (operative March 4, 2005).

See: 35 N.J.R. 3072(a), 36 N.J.R. 2890(a), 36 N.J.R. 4319(a).

Rewrote (g).

11:3-4.5 Diagnostic tests

(a) The personal injury protection medical expense benefits coverage shall not provide reimbursement for the following diagnostic tests, which have been determined to yield no data of any significant value in the development, evaluation and implementation of an appropriate plan of treatment for injuries sustained in motor vehicle accidents:

1. (Reserved)
2. Spinal diagnostic ultrasound;
3. Iridology;
4. Reflexology;
5. Surrogate arm-mentoring;
6. Surface electromyography (surface EMG);
7. (Reserved); and
8. Mandibular tracking and stimulation.

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

Amended by R.2001 d.44, effective February 5, 2001.
See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

11:3-30.5 Certificate of self-insurance

(a) Any person applying for a certificate of self-insurance shall submit the following to the Commissioner:

1. A completed application form on forms to be provided by the Commissioner;

2. The most current financial statement and financial statements for the two years immediately preceding the date of such current financial statement:

i. All financial statements shall be certified by a Certified Public Accountant;

ii. If the applicant is a subsidiary of a corporation, the applicant shall also submit the financial statements of the subsidiary's ultimate parent corporation;

iii. If the applicant is a corporation, the Commissioner may also include the name of any subsidiary corporation under the control of that corporation in the certificate of self-insurance if the ultimate parent corporation guarantees that it will discharge the subsidiary's liability as evidenced by the filing of an indemnity agreement. If the ultimate parent corporation does not provide such a guarantee, the subsidiary shall make a separate application and receive independent qualification as a self-insurer. If the name of the subsidiary is included in the certificate of self-insurance of the ultimate parent corporation and ownership of the ultimate parent or subsidiary corporation changes, the ultimate parent or subsidiary shall reapply for a certificate of self-insurance within 30 days of the ownership change; and

3. A \$1,000 filing fee.

(b) After the submission of an application, the Commissioner may require an additional fee to cover the costs of further examinations which may include a credit report to be prepared by a credit agency acceptable to the Commissioner.

(c) If an application is approved and the Commissioner receives notification from the Association that the applicant has paid any applicable policy constant or RMEC pursuant to N.J.S.A. 17:29A-37.1 and 17:30E-1 et seq., respectively, the Commissioner shall issue a certificate of self-insurance to the applicant.

(d) All certificates of self-insurance are valid from the date of issuance until June 30 immediately following and may be renewed thereafter, pursuant to N.J.A.C. 11:3-30.6, for a one year period beginning July 1 and ending June 30 the following year.

11:3-30.6 Renewals

(a) Any certificate holder applying for renewal shall submit the following so that it is received by the Commissioner not later than June 1 of the year of the expiration date of such certificate:

1. An accident and claim activity report on forms to be provided by the Commissioner;

2. A financial statement for the calendar year immediately preceding the expiration date of the certificate of self-insurance certified by a Certified Public Accountant;

3. An updated vehicle listing which shall include a listing of the vehicles subject to any applicable policy constant or RMEC pursuant to N.J.S.A. 17:29A-37.1 and 17:30E-1 et seq., respectively;

4. A \$1,000 renewal fee; and

5. Any other information that is substantially different from the information provided in the original application form or from the information provided in the last renewal period.

(b) After the submission of an application for renewal, the Commissioner may require an additional fee to cover the costs of further examinations which may include a credit report to be prepared by a credit agency acceptable to the Commissioner.

(c) If an application for renewal is approved and the Commissioner receives notification from the Association that the certificate holder has paid any applicable policy constant or RMEC pursuant to N.J.S.A. 17:29A-37.1 and 17:30E-1 et seq., respectively, the Commissioner shall issue a new certificate of self-insurance.

11:3-30.7 Surety bond requirement

(a) The Commissioner may require the furnishing of a surety bond and/or evidence of excess insurance.

(b) If the applicant or certificate holder is required to furnish a surety bond, the surety bond shall be in an amount of not less than \$300,000, with an additional \$10,000 for each vehicle registered or leased in the applicant's or certificate holder's name over the minimum required to qualify as self-insurer under this subchapter, up to a maximum amount of \$1,000,000.

11:3-30.8 Audits and examinations

(a) The Commissioner may make or cause to be made audits or examinations as may be necessary to determine the ability of the applicant or the certificate holder to discharge its financial obligations as a self-insurer.

(b) The applicant or certificate holder shall pay the reasonable expenses of the audit or examination.

11:3-30.9 Public entities

(a) This subchapter does not apply to any motor vehicle owned by the United States, this State, any political subdivision of this State or any municipality therein; nor to any motor vehicle which is subject to the requirements of law requiring insurance or other security on certain types of vehicles, other than the requirements of N.J.S.A. 39:6A-1 et seq. or N.J.S.A. 39:6B-1 et seq.

(b) Notwithstanding the provisions in (a) to the contrary, any public entity that currently has or will establish in the future a self-insurance program or plans to discontinue a self-insurance program currently in effect, shall notify the Commissioner in writing that it currently has, will establish or discontinue such a program.

11:3-30.10 Cancellation of certificate of self-insurance

After a hearing conducted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1, upon not less than five days' notice, the Commissioner may cancel a certificate of self-insurance upon reasonable grounds including, but not limited to, failure to pay any judgment within 30 days after such judgment has become final.

SUBCHAPTER 31. (RESERVED)

**SUBCHAPTER 32. CERTIFICATION OF
COMPLIANCE: MANDATORY LIABILITY
COVERAGES**
11:3-32.1 Purpose and scope

(a) This subchapter establishes the procedures and requirements for automobile or motor vehicle insurers to certify that automobile or motor vehicle insurance liability policies issued outside of New Jersey provide coverage pursuant to N.J.S.A. 39:6A-3, 39:6A-4, 39:6B-1a, 17:28-1.3 and 17:28-1.1, as required under N.J.S.A. 17:29-1.4, whenever the automobile or motor vehicle insured under such a policy is used or operated in this State.

(b) This subchapter applies to each insurer authorized to transact automobile or motor vehicle insurance business in the State pursuant to N.J.S.A. 17:28-1.4.

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

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

Amended by R.2001 d.44, effective February 5, 2001.

See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

In (a), amended the N.J.S.A. reference.

11:3-32.2 Definitions

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

“Certification” means a written statement certified or sworn to be true and signed by a duly authorized officer of the insurer.

“Commissioner” means the Commissioner of the New Jersey Department of Banking and Insurance.

“Control” (including the terms “controlling,” “controlled by” and “under common control”) 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 with 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 this subchapter.

“NAIC” means the National Association of Insurance Commissioners.

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).

11:3-32.3 Certification compliance requirements

(a) Each insurer authorized to transact automobile or motor vehicle insurance business in this State pursuant to N.J.S.A. 17:28-1.4 shall file a certification of compliance with the Department on its own behalf and on behalf of:

1. Any insurer that is controlled by the insurer authorized to transact insurance business in this State, which sells a policy providing automobile or motor vehicle liability insurance coverage;
2. Any insurer that controls the insurer authorized to transact automobile or motor vehicle liability insurance in this State, which sells a policy providing automobile or motor vehicle liability insurance coverage; and
3. Any insurer under common control by or with the insurer authorized to transact automobile or motor vehicle liability insurance in this State.

(b) The certification insurers are required to file in accordance with (a) above shall include the following information:

1. The name of the insurance company authorized to transact automobile or motor vehicle insurance in New Jersey;

2. The names of insurance companies that transact automobile or motor vehicle insurance in other states or provinces of Canada, that are controlling or controlled by, or are under common control by, or with, the insurer named in (b)1 above;

3. The NAIC group and company number for each insurer named in (b)1 and 2 above;

4. The name, signature, title and telephone number of the company officer authorized to complete the certification; and

5. A statement that the company will provide the coverages required in N.J.S.A. 39:6B-1a, 39:6A-3, 39:6A-4, 17:28-1.3, and 17:28-1.1, whenever the automobile or motor vehicle insured under the policy is used or operated in this State.

(c) Any insurer that acquires control of, is acquired by or comes under common control of another insurer shall file the required certification of compliance within 30 days of this change in control and include the following information:

1. A certification that contains the information provided in (b)1 through 5 above; and

2. The effective date of the changes in control described in (c) above.

(d) Each insurer required to file a certification shall do so by October 19, 1994.

(e) All certifications shall be submitted to the Department at the following address:

New Jersey Department of Banking and Insurance
Property/Liability Division
20 West State Street
PO Box 325
Trenton, NJ 08625-0325

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).

Amended by R.2001 d.44, effective February 5, 2001.

See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

In (b)5, amended the N.J.S.A. reference.

11:3-32.4 Requests for copies of certifications

(a) Any person requesting a copy of a certification on file with the Department shall make the request in writing and include the complete name of the company or companies for which the certification is requested.

(b) Requests for copies of certification on file with the Department shall be directed to:

New Jersey Department of Banking and Insurance
Division of Property and Casualty
20 West State Street
PO Box 325
Trenton, New Jersey 08625-0325

Amended by R.2001 d.44, effective February 5, 2001.

See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

SUBCHAPTER 33. APPEALS FROM DENIAL OF AUTOMOBILE INSURANCE

11:3-33.1 Purpose; scope

This subchapter sets forth an appeal procedure for a person who has been either denied personal private passenger automobile insurance or nonrenewed in the voluntary market by an insurer on the basis that they are not an eligible person as defined in N.J.A.C. 11:3-34.4. This subchapter applies to such persons, agents and insurers required to write personal private passenger automobile insurance pursuant to State statutes and rules.

11:3-33.2 Definitions

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

“Applicant” means an insured or prospective insured who has made a request for personal private passenger automobile insurance on either a first time or renewal basis.

“Automobile” means a private passenger automobile of a private passenger or station wagon type that is owned or hired and is neither used as a public or livery conveyance for passengers nor rented to others with a driver; and a motor vehicle with a pickup body, a delivery sedan, a van, or a panel truck or a camper type vehicle used for recreational purposes owned by an individual or by husband and wife who are residents of the same household, not customarily used in the occupation, profession or business of the insured other than farming or ranching. An automobile owned by a farm family copartnership or corporation, which is principally garaged on a farm or ranch and otherwise meets the definitions contained in this section, shall be considered a private passenger automobile owned by two or more relatives resident in the same household.

“Cancellation” means termination of insurance during the policy term pursuant to the provisions of N.J.S.A. 17:29C-7.

“Commissioner” means the Commissioner of the Department of Banking and Insurance of New Jersey.

“Completed written application” means a signed application that contains the minimum information necessary as set

forth at N.J.A.C. 11:3-44.3(a) to determine whether the applicant is an eligible person, to rate and underwrite the policy, is accompanied by a completed coverage selection form as provided at N.J.A.C. 11:3-15.6 and, if requested, a copy of the applicant's driver's license, a copy of the motor vehicle registration of the principal vehicle to be insured, one additional proof of New Jersey residency and an acknowledgment of requirement for insurance inspection form where physical damage is requested.

"Contested case" means a proceeding, including any licensing proceeding, in which the legal rights, duties, obligations, privileges, benefits or other legal relations of specific parties are required by constitutional right or by statute to be determined by an agency by decision, determination, or other, addressed to them or disposing of their interests, after opportunity for an agency hearing, but shall not include any proceeding in the Division of Taxation, Department of the Treasury, which is reviewable de novo by the Tax Court.

"Declination," "denied" or "denial" means:

1. Refusal by an insurance agent to submit an application on behalf of an applicant to any of the insurers represented by the agent;
2. Refusal by an insurer to issue an automobile insurance policy to an applicant upon receipt of an application for automobile insurance;
3. The offer of automobile insurance coverage with less favorable terms or conditions than those requested by an applicant, including the refusal to make requested changes to an existing policy that are available to other insureds with that insurer, or the offer to insure at a rate applicable to other than eligible persons;
4. The refusal by an insurer or agent to provide, upon the request of an applicant, an application form or other means of making an application or request for automobile insurance coverage;
5. The refusal by an insurer to renew a policy of automobile insurance based on eligible person status, unless either a member of the insured's household is not an eligible person and that person accounts for 10 percent or more of the use of the subject vehicle pursuant to N.J.A.C. 11:3-8.4(a)2, that the eligible person is nonrenewed pursuant to the provisions of N.J.A.C. 11:3-8.5; or
6. The cancellation of an automobile insurance policy by the insurer pursuant to N.J.S.A. 17:29C-7 for any reason other than nonpayment of premium; or
7. Failure of an insurer to either bind coverage or issue a written denial of coverage to an applicant, or if requested to notify the applicant whether coverage will be provided or denied, within five business days of the date a completed written application is received that includes the information in N.J.A.C. 11:3-44.3(a).

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

"Eligible person" means an eligible person as defined at N.J.A.C. 11:3-34.4.

"Insurance agent" or "agent" means an insurance agent as defined at N.J.S.A. 17:22A-2 and shall also include an "insurance broker" as defined at N.J.S.A. 17:22A-2 who has a brokerage relationship with an insurer.

"Insurer" means any person transacting the business of personal private passenger automobile insurance with a duty to write personal private passenger automobile insurance in New Jersey for an eligible person, pursuant to N.J.S.A. 17:33B-15 and rules promulgated pursuant thereto by the Commissioner.

"Person" means an individual, association, corporation, partnership or other entity.

"Personal private passenger automobile insurance" or "automobile insurance" means direct insurance on private passenger automobiles issued by an insurer in accordance with a personal lines rating system filed and approved pursuant to N.J.S.A. 17:29A-1 et seq.

"Voluntary market" means automobile insurance written other than through a plan of operation established pursuant to N.J.S.A. 17:29B-1 et seq., 17:30E-1 et seq. or 17:33B-11.

"Working day" means any day except Saturday, Sunday or New Jersey State legal holidays.

Emergency Amendment R.1993 d.135, effective March 1, 1993. (Operative March 8, 1993) (expires April 30, 1993.)
See: 25 N.J.R. 1290(a).

Definition for completed written application added; item 7 added to definition of declination.

Adopted Concurrent Proposal, R.1993 d.238, effective April 30, 1993.

See: 25 N.J.R. 1290(a), 25 N.J.R. 2479(a).

New Rule, R.1994 d.598, effective December 5, 1994.

See: 26 N.J.R. 3591(a), 26 N.J.R. 4777(a).

Amended by R.2001 d.44, effective February 5, 2001.

See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

11:3-33.3 Right to appeal

Any eligible person who has been denied automobile insurance in the voluntary market by an insurer shall be entitled to appeal the denial in the manner provided by this subchapter.

11:3-33.4 Duties of insurer or insurance agent

(a) If the application or request for coverage was made in writing, the insurer or agent shall provide the applicant with an explanation of the reasons for the denial in writing. If the application or request for coverage was made orally, the insurer or agent may provide the applicant with an oral explanation instead of a written explanation but shall provide a written explanation if the applicant requests a written explanation within 90 days of the oral denial.