CHAPTER 3

AUTOMOBILE INSURANCE

Authority

N.J.S.A. 17:1C–6(e).

Source and Effective Date

R.1991 d.45, effective January 4, 1991.
See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).

Executive Order 66(1978) Expiration Date

Chapter 3, Automobile Insurance, expires on January 4, 1996.

Chapter Historical Note

This chapter was formerly entitled "New Jersey Automobile Insurance Plan". The chapter 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 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 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 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 became effective October 3, 1983 as R.1983 d.424. See: 15 N.J.R. 1170(a), 15 N.J.R. 1666(a). Subchapter 6 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 and 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 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 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 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 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: Subchapter 20 became 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 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 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 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 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 readopted with amendments 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. R.1987 d.142 also amended section 13.3 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 became effective December 21, 1987 as R.1987 d.527. See: 19 N.J.R. 1880(a), 19 N.J.R. 2403(b). See individual sections for further amendments.

1990 Revisions: Chapter 3 had been due to expire on January 6, 1991 established by R.1985 d.654, effective January 6, 1986. See: 16 N.J.R. 3286(a), 17 N.J.R. 89(b). Pursuant to Executive Order No. 66(1978), Chapter 3 was readopted by R.1991 d.45. See: Source and Effective Date. Subchapters 2 through 5, concerning the defunct Automobile Insurance Plan (AIP), were repealed by R.1991 d.45, effective February 4, 1991. See subchapter and section levels for specific rulemaking activity.

Prior rulemaking activity in repealed Subchapter 2 was as follows:

11:3–2.11 Classification of private passenger automobiles used in car pools.

Amended by R.1973 d.337, effective December 4, 1973.

See: 6 N.J.R. 15(d).

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SUBCHAPTER 45. INSURERS REQUIRED TO PROVIDE SURVEY INFORMATION

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APPENDIX. New Jersey Automobile Insurance Premium Comparison Survey

SUBCHAPTER 1. COMMERCIAL AUTOMOBILE INSURANCE PLAN

Source and Effective Date

R.1990 d.118, effective February 5, 1990.
See: 21 N.J.R. 3613(a), 22 N.J.R. 392(b).

Subchapter Historical Note

Subchapter 1, formerly entitled Provisions and Operations was repealed and replaced by R.1990 d.118, effective February 5, 1990. See: Source and Effective Date.

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 Automobile Full Insurance Underwriting Association;

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;

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; and

4. To encourage risk management to prevent accidents and losses.

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 Procedure pursuant to this subchapter.

"Commissioner" means the Commissioner of the New Jersey Department of 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 not in good faith qualified for automobile insurance coverage in any residual market mechanism created by statute other than the CAIP. For multistate operations, the applicant must have its operating headquarters in New Jersey but vehicles may be registered in other states. Members of the United States military forces with vehicles registered in other states shall be deemed eligible applicants if they are otherwise eligible; are stationed in New Jersey; and the vehicle is garaged in New Jersey at the time application is made. 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.

"Eligible for depopulation credit" means business which meets all of the following criteria:

1. Business first written voluntarily by the participant after February 5, 1990;

2. Business that was insured through CAIP or the New Jersey Automobile Insurance Plan Commercial Automobile Insurance Procedure for at least one year immediately prior to being written voluntarily by the participant;

3. Business first written voluntarily during the period for which the credit is being claimed. Credits shall be claimed for only the first or second year written voluntarily, but must be claimed annually. Servicing Carriers may claim credits for the second and third year of business written voluntarily (for business which is ineligible for a credit the first year in accordance with paragraph 2 above); and

4. Business which was not written by the participant as a servicing carrier for CAIP or the New Jersey Automobile Insurance Plan Commercial Automobile Insurance Procedure for one year before being written voluntarily by the participant.

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

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

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

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

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

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

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

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

"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 residual market mechanism created by statute, and is owned by an individual or husband and wife.

"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."

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 New Jersey Commercial Automobile Insurance Procedure, 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.

11:3–1.4 Governing committee

(a) CAIP shall be administered by a governing committee of 13 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. Two members shall be public representatives who are knowledgeable about automobile insurance matters but who are not employed by, or otherwise affiliated with, insurers, insurance producers, or other entities of the insurance industry.

4. The Commissioner or his 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 New Jersey Automobile Insurance Plan Commercial Automobile Insurance Procedure 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 New Jersey Automobile Insurance Plan Commercial Automobile Insurance Procedure on behalf of the member insurers;

2. To assume the rights and obligations of the New Jersey Automobile Insurance Plan Commercial Automobile Insurance Procedure on behalf of the member insurers;

3. To develop and submit for approval by the Commissioner:

i. A plan of operation;

ii. Premium rules, rates, surcharges, pursuant to N.J.S.A. 17:29A–1 et seq.; and

iii. A plan for a producer certification program.

4. To appoint, conditionally appoint or terminate:

i. A CAIP manager;

ii. At least two servicing carriers; and

iii. Other employees, professionals, and contractors required to administer CAIP.

5. To budget expenses, levy assessments, and disburse funds;

6. To investigate complaints and hear appeals from applicants, insureds, producers, servicing carriers or participants about any matter pertaining to the proper administration of the CAIP;

7. To arrange for an independent audit of CAIP each year which shall include all servicing carriers;

8. To furnish all participants with:

i. An annual written operations report;

ii. The approved annual budget upon request;

iii. A copy of the annual audit upon request;

iv. A copy of the plan of operation, and all amendments;

v. A copy of all rates, rules and manuals upon request; and

vi. A copy of the minutes from all meetings upon request;

9. To audit the records of any participant relating to the subject matter of CAIP and establish such policies, records, books of account, documents and related material which shall be maintained for the proper administration of CAIP;

10. To perform such other functions as may be necessary and proper to administer CAIP in accordance with this subchapter and the approved plan of operation; and

11. To indemnify on behalf of the member insurers each member of the governing committee, and employees for any and all claims, suits, costs of investigations, costs of defense, settlements or judgments against them on account of an act or omission in the scope of the member's duties or employee's employment. CAIP shall refuse to indemnify if it determines that the act or failure to act was due to actual fraud, willful misconduct or actual malice.

11:3–1.5 Participation

(a) At the end of each fiscal period, CAIP's operating profit or loss shall be determined separately for each policy year. Profit shall be credited or distributed to each participant and loss shall be charged against each participant in proportion to each participant's "net participation percentage" for the second prior year which resulted in the profit or loss.

(b) If the Commissioner finds that the continuation of the depopulation credit program is no longer in the best interests of the public, he or she may order that business first written voluntarily after that date may no longer be eligible for depopulation credit.

1. The Commissioner may also order that specific lines or sublines are no longer eligible for depopulation credit.

2. The Commissioner may also reinstate the depopulation credit program for specific lines or sublines.

(c) All data necessary to comply with the foregoing participation procedures shall be reported to the CAIP's central statistical agent in the manner described in the approved statistical plan.

(d) Groups of participants under the same ownership and management shall be treated as a single participant. Groups of participants under either the same ownership or management, but not both, may elect to be treated either separately or as a single company.

(e) In the event a participant discontinues writing motor vehicle liability or physical damage insurance in this State, it shall continue to pay assessments, provided, however, that if the automobile liability or physical damage business of a participant discontinuing the writing of automobile liability or physical damage insurance in this State has been purchased by, transferred to, or reinsured by another company, the latter shall receive the assessments of the former.

(f) In the event a participant is merged with another company or there is a consolidation of companies, the continuing company shall receive the assessments of the company merged or consolidated, provided, however, the continuing company may be relieved from such obligations if another company has agreed, in a manner satisfactory to the governing committee, to assume such obligations.

(g) Participation shall be suspended upon order of the Commissioner of Insurance if he or she finds that such action is required by the financial condition of that participant.

(h) All participants in CAIP shall participate in the business written by the New Jersey Automobile Insurance Plan Commercial Automobile Insurance Procedure pursuant to an approved plan of operation.

11:3–1.6 Plan of operation

(a) The plan of operation shall provide for the prompt and efficient provision of automobile insurance to eligible applicants. The plan of operation shall provide for, among any other matters:

1. The internal organization and proceedings of the governing committee;

2. Standards and procedures for the appointment, compensation, and termination of and performance standards for servicing carriers, the CAIP manager, other employees, professionals and contractors required to administer CAIP along with a producers certification program;

3. The extent of coverage to be offered by CAIP to eligible applicants;

4. Procedures to apply for coverage;

5. Premium rules, surcharges and minimum premiums;

6. Provisions for the cancellation or the nonrenewal of policies;

7. Methods and means for the collection, investment and disbursement of funds;

8. Development and maintenance of a statistical plan, and manuals incorporating that plan, which shall be subject to the prior approval by the Commissioner in the same manner as the plan of operation; and

9. Development and maintenance of a risk management plan which shall provide for safety inspections, safety education, follow-up on hazardous conditions and operations and procedures for the cancellation of insureds who fail to comply with the procedures of the plan. The risk management plan shall be subject to the prior approval by the Commissioner in the same manner as the plan of operation.

(b) The governing committee shall, by May 6, 1990, submit to the Commissioner, for his or her review and approval, a proposed plan of operation. The governing committee may propose an amendment to the plan of operation at any time.

(c) The proposed plan and any amendments shall be reviewed by the Commissioner and approved by him or her if he or she finds it fulfills the purposes provided by this subchapter. If approved, the Commissioner shall certify approval to the governing committee and the plan of operation or amendments shall take effect 10 days after such certification.

1. If the Commissioner disapproves all or any part of the plan of operation or any amendment he or she shall return same to the governing committee with a statement, that sets forth the reasons for his or her disapproval and may include other recommendations he or she may wish to make.

2. If the governing committee does not submit a plan of operation by May 6, 1990, or a new plan which is acceptable to the Commissioner within 90 days after the disapproval of a proposed plan, the Commissioner may promulgate a plan of operation and certify same to the governing committee.

3. Any such plan approved by the Commissioner shall take effect 10 days after the certification to the governing committee; provided, however, that until a plan of operation is in effect pursuant to the provisions of this subchapter, the existing New Jersey Automobile Insurance Plan Commercial Automobile Insurance Procedure temporary placement facility shall be continued in effect. Each participant shall continue to comply with the New Jersey Automobile Insurance Plan Commercial Automobile Insurance Procedure with respect to all business written under that procedure prior to the effective date of the CAIP plan of operation.

(d) The Commissioner may propose an amendment to the plan of operation by communicating the proposed amendment to the governing committee.

Case Notes

Former New Jersey assigned risk scheme in automobile liability coverage mentioned in discussion of methods available to a state to deal with the social consequences of adverse risk selection. Owens v. Aetna Life & Casualty Co., 654 F.2d 218 (3rd Cir.1981), certiorari denied 102 S.Ct. 657, 454 U.S. 1092, 70 L.Ed.2d 631 (1981).

11:3–1.7 Coverage

(a) CAIP shall provide to eligible applicants, bodily injury liability and property damage liability coverages as follows:

1. CAIP shall provide basic combined single limit of $35,000 and statutory uninsured motorist coverage except:

i. When limits in excess of the basic combined single limit of $35,000 are required by law, the plan

shall offer limits adequate to comply with the minimum requirements of that law, except with respect to limits over $5 million in which case excess coverage is conditioned upon the plan being able to secure facultative reinsurance. CAIP shall provide a policy for limits less than the minimum requirements of the law when evidence of adequate excess insurance is provided by the producer or the insured.

ii. CAIP shall provide limits adequate to comply with the provisions of the financial responsibility law of any state in which the motor vehicle will be operated, but only while the vehicle is being operated in that state.

iii. CAIP shall also offer the optional limits of liability as specified in the plan of operation.

(b) CAIP shall offer to eligible applicants, additional uninsured or underinsured motorist coverage as follows:

1. Additional uninsured and underinsured motorist coverage shall be provided as an option to the named insured up to the limits set forth in N.J.S.A. 17:28–1.1b and subject to the deductibles specified in the plan of operation. The limits for uninsured and underinsured motorist coverage shall not exceed the insured's motor vehicle liability policy limits for bodily injury and property damage respectively.

2. Uninsured and underinsured motorist coverage shall not be increased by stacking the limits of coverage of multiple motor vehicles covered under the same policy of insurance nor shall these coverages be increased by stacking the limits of coverage of multiple policies available to the insured. If the insured had uninsured motorist coverage available under more than one policy, any recovery shall not exceed the higher of the applicable limits of the respective coverages and the recovery shall be prorated between the applicable coverages as the limits of each coverage bear to the total of the limits.

3. Uninsured motorist coverage shall be subject to the policy terms, conditions and exclusions approved by the Commissioner, including, but not limited to, unauthorized settlements, nonduplication of coverage, subrogation and arbitration.

(c) CAIP shall provide to eligible applicants, basic and additional personal injury protection coverage as follows:

1. With respect to those automobiles subject to the New Jersey Automobile Reparation Reform Act, CAIP shall provide basic personal injury protection coverage under every automobile liability policy as required by the Act and shall also offer to the named insured Additional Personal Injury Protection as required by the Act and by regulations promulgated by the Commissioner thereunder.

(d) CAIP shall provide to eligible applicants, physical damage coverage as follows:

1. CAIP shall only offer physical damage coverage to:

i. Private passenger vehicles;

ii. Private passenger type vehicles;

iii. Light trucks;

iv. Motorcycles;

v. Recreational trailers (excluding trailers used as residences); and

vi. Social services vehicles of the private passenger, station wagon, van or mini-bus type owned by or operated on behalf of a non-profit entity used to transport, without charge, the elderly or handicapped.

2. Notwithstanding (d)1 above, CAIP shall not offer physical damage coverage to:

i. Risks consisting of fleets of 10 or more vehicles not including trailers and semi-trailers;

ii. Vehicles more than 25 or more years old;

iii. Vehicles with an original cost new of $40,000 or more;

iv. Vehicles with a seating capacity in excess of 20;

v. Any emergency type vehicle; and

vi. Any vehicle which is operated under a registration plate not issued for a specific vehicle.

3. Comprehensive and collision coverage shall be provided on an actual cash value basis subject to a minimum deductible specified in the plan of operation applicable to each loss to each vehicle. CAIP shall also offer optional higher deductibles as specified in the plan of operation.

4. Physical damage coverage shall be offered only in connection with a policy written by the plan affording bodily injury and property damage coverage.

5. Upon request, CAIP shall issue a loss payable clause for the benefit of a lienholder.

11:3–1.8 Eligibility

(a) As a prerequisite for insurance from CAIP, a prospective insured must attempt, within 60 days prior to the date of the application, to obtain automobile insurance in New Jersey, and be unable to obtain such insurance. The prospective insured must certify, in the application form prescribed by CAIP, that the applicant has attempted, but has been unable, to obtain automobile insurance in New Jersey through ordinary methods.

(b) For any risk consisting of 10 or more vehicles, the applicant must also provide:

1. A copy of the notice of cancellation or nonrenewal from the applicant's previous insurer, or an explanation concerning why the applicant was not insured; and

2. A certification that the applicant has been refused insurance within 60 days of the date of application from at least three named insurers licensed to transact automobile business in New Jersey. Such certification shall list the three insurers.

(c) No producer shall bind a risk for CAIP or submit an application for insurance to CAIP if such producer knows that the risk currently has or has been offered coverage from the voluntary market.

(d) An eligible applicant shall not be afforded coverage until it:

1. Submits an application as prescribed in the plan of operation;

2. Pays the premium, or portion thereof, required in the plan of operation;

3. Is accepted for coverage by CAIP as provided for in the plan of operation; and

4. Completes such other requirements as set forth in the plan of operation.

11:3–1.9 Rates and policy forms

(a) CAIP shall continue to use the rates, rules, surcharges, minimum premiums, classifications and policy forms approved for the New Jersey Automobile Insurance Plan Commercial Automobile Insurance Procedure until modified or changed pursuant to this subchapter.

(b) The governing committee shall file all rates, rules, surcharges, minimum premiums, classifications and policy forms to be used by CAIP for the prior approval of the Commissioner. Proceedings to review these filings shall be conducted pursuant to N.J.S.A. 17:29A–1 et seq. All rates shall consider the experience of risks insured by the plan and shall not be excessive, inadequate or unfairly discriminatory.

(c) For any risk with less than 10 vehicles, the premium shall be subject to a merit rating plan established in the plan of operation. Every rate filing shall include an analysis of the adequacy of the merit rating plan.

(d) Any risk with 10 or more vehicles not including trailers and semi-trailers shall be considered as a fleet. CAIP shall file base rates for fleets with the Commissioner for his or her prior approval which are different than the rates for non-fleet risks if CAIP determines that the loss expectancy of fleet risks insured by CAIP is different than the loss expectancy of non-fleet risks insured by CAIP.

(e) Fleet risks shall be subject to an experience rating plan established in the plan of operation, which shall set forth the criteria for eligibility of the experience rating plan. If any fleet risk is determined to be ineligible for the experience rating plan, the risk shall be subject to a merit rating plan established in the plan of operation.

(f) Any risk with basic limits premium of $100,000 or greater shall also be subject to a retrospective rating plan established in the plan of operation. In the event CAIP finds that the premium from all retrospectively rated risks combined is inadequate, or excessive, CAIP shall file with the Commissioner for his or her prior approval a change in the retrospective rating formulas, including a percentage surcharge on all retrospectively rated risks if necessary, so that the total premium from retrospectively rated risks is adequate based on the combined experience of retrospectively rated risks insured by the plan.

11:3–1.10 Right to petition for appeal to the Commissioner

(a) An applicant, insured, producer, servicing carrier or participant may petition for appeal to the Commissioner from an adverse decision of the governing committee by filing a request in writing within 20 days of the date of receipt of the written decision of the governing committee.

1. The written request to appeal shall set forth the facts upon which it is based and include a copy of the written decision of the governing committee.

2. The Commissioner shall notify the petitioner and the governing committee within 30 days whether the request to appeal shall be granted.

3. Notice from the Commissioner that an appeal has been granted shall also provide a statement about whether the action of the governing committee has been stayed pending the disposition of the appeal.

(b) An appeal to the Commissioner granted pursuant to this rule shall be conducted in accordance with applicable provisions of the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq.

SUBCHAPTER 2. NEW JERSEY PERSONAL AUTOMOBILE INSURANCE PLAN

Authority

N.J.S.A. 17:1C–6(e), 17:1–8.1 and 17:29D–1.

Source and Effective Date

New Rules, R.1992 d.370, effective September 21, 1992.
See: 24 N.J.R. 331(a), 24 N.J.R. 3400(a).

11:3–2.1 Purpose and scope

(a) This subchapter establishes a plan pursuant to N.J.S.A. 17:29D–1 for the providing and apportionment of

personal private passenger automobile insurance coverage for automobiles which are owned or operated by qualified applicants.

(b) The purposes of this subchapter are:

1. To provide the coverages described herein, subject to the conditions stated;

2. To establish a procedure for the equitable distribution of risks assigned to insurance companies; and

3. To preserve to the public the benefits of price competition by encouraging maximum use of the voluntary private insurance system.

(c) The provisions of this subchapter shall apply to all insurers admitted to transact private passenger automobile insurance in this State and all qualified applicants for automobile insurance through the PAIP, except as otherwise provided in this subchapter.

11:3–2.2 Definitions

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

An "affiliate" of, or a person "affiliated" with, a specific person, means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

"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; a motor vehicle with a pickup body, a delivery sedan, a van, or a panel truck or camper type vehicle used for recreational purposes, owned by an individual or jointly by individuals who are residents of the same household, not customarily used in the occupation, profession or business of the insured other than farming or ranching; and solely for the purpose of this plan, a motorcycle as defined in N.J.S.A. 39:1–1. An automobile owned by a farm family copartnership or corporation, which is principally garaged on a farm or ranch and otherwise meets this definition, shall be considered a private passenger automobile owned by two or more relatives resident in the same household.

"Automobile insurance" means direct insurance against injury or damage, including the legal liability therefor, arising out of the ownership, operation, maintenance or use of automobiles, including, but not limited to, personal injury protection insurance, bodily injury liability insurance, property damage liability insurance, physical damage insurance, and uninsured and underinsured motorist insurance.

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

"Department" means the New Jersey Department of Insurance.

"Insurer" means any person or persons, corporation, association, partnership, company, or other legal entity authorized to transact the business of private passenger automobile insurance in this State, except any residual market mechanism created by or pursuant to statute.

"LAD carrier" means a limited assignment distribution carrier which is a participating insurer which agrees to accept the assignments of another insurer pursuant to this subchapter and procedures set forth in the plan of operation.

"PAIP" means the Personal Automobile Insurance Plan established pursuant to this subchapter.

"Personal private passenger automobile insurance" means a policy of automobile insurance principally used to provide primary insurance on private passenger automobiles which are owned individually, or jointly by individuals who are residents of the same household, and used for personal, family, or household needs.

Amended by R.1993 d.548, effective November 15, 1993.
See: 25 N.J.R. 2212(a), 25 N.J.R. 5215(a).

11:3–2.3 Creation of the plan

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

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

(c) The administrative offices of the PAIP shall be located within the State of New Jersey.

11:3–2.4 Exemptions

(a) Every insurer shall participate in the PAIP to the extent required by this subchapter and the plan of operation.

(b) The requirements of this subchapter shall not apply to the following:

1. Insurers that have not issued or renewed policies of private passenger automobile insurance in New Jersey since December 31, 1983;

2. Insurers that have issued or renewed policies of private passenger automobile insurance in New Jersey since December 31, 1983, but only in accordance with a commercial lines rating system filed and approved pursuant to N.J.S.A. 17:29AA–1 et seq.

3. Insurers transacting private passenger automobile insurance business in New Jersey subject to a plan of orderly withdrawal approved in accordance with N.J.A.C. 11:2–29, but only to the extent that waiver of participation in the PAIP is explicitly provided by the terms of the approved plan of orderly withdrawal; or

4. Insurers transacting private passenger automobile insurance business in New Jersey subject to an order issued by the Commissioner in accordance with N.J.S.A. 17:33B–23 and 24, but only to the extent provided by the terms of the order.

(c) Insurers that currently insure, or have insured since December 31, 1983, only certain types of automobiles (for example, motor homes, recreational vehicles, antique automobiles or motorcycles) shall participate in the PAIP but only for the particular types of automobiles currently being insured.

(d) Insurers claiming to be excluded from participation pursuant to the provisions of (b) or (c) above shall comply with the following:

1. Such insurers shall file with the PAIP no later than 60 days from the effective date of this rule a certified statement containing the following information:

i. The insurer's name, including the NAIC group number;

ii. A statement that the insurer is not required to participate in the PAIP or receive assignments through the PAIP;

iii. The factual basis upon which the insurer relied to determine that it is not required to comply fully with this subchapter;

iv. The particular provision of this rule under which the insurer is included; and

v. A certification by an officer of the insurer that the statement is complete, correct and accurate to the best of the officer's information, knowledge and belief based upon the officer's personal review of all relevant records.

2. The certified statement shall be sent to the PAIP at the following address:

PAIP Exemptions
New Jersey Personal Automobile Insurance Plan
2000 Midlantic Drive
Laurel Corporate Center
Suite 450
Mt. Laurel, NJ 08054

3. A copy of the information filed pursuant to (c)1 and 2 above shall be filed with the Department at the following address:

ARM Unit
New Jersey Department of Insurance
20 West State Street
CN–325
Trenton, New Jersey 08625–0325

New Rule, R.1993 d.548, effective November 15, 1993.
See: 25 N.J.R. 2212(a), 25 N.J.R. 5215(a).

11:3–2.5 Governing committee

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

1. Eight members shall be salaried employees of an insurer which is a participant in PAIP.

2. Three members shall be licensed producers.

3. One member shall be a public representative who is knowledgeable about automobile insurance matters but who is not employed by, or otherwise affiliated with, insurers, insurance producers, or other entities of the insurance industry.

4. One member shall be a salaried employee of an approved LAD carrier for the PAIP, provided that neither the LAD carrier nor any affiliate of the LAD carrier otherwise serves as a member of the governing committee.

5. The Commissioner shall be an ex-officio, non-voting member of the committee. The Commissioner may designate an alternate.

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

1. The Alliance of American Insurers;

2. The American Insurance Association; and

3. The National Association of Independent Insurers.

(c) Insurers which are not members of the organizations in (b) above shall nominate two members to represent insurer 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. The members of the initial governing committee appointed pursuant to this subchapter shall serve for two years or until a successor is appointed. Thereafter, all members 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) All meetings of the governing committee shall be conducted in accordance with this subchapter and the plan of operation.

(g) The governing committee shall have the power and duty to:

1. Develop and submit for approval to the Commissioner:

i. A plan of operation;

ii. A rating system, including rates, rules and forms; and

iii. A plan for a producer certification program, which may not exclude those producers with no affiliation with an insurer.

2. Appoint, conditionally appoint or terminate:

i. A PAIP manager, subject to approval by the Commissioner, which shall be located in this State, to be responsible for the conduct and administrative affairs of the PAIP; and

ii. Other employees, professionals, and contractors required to administer the PAIP.

3. Enter into contracts as are necessary or proper to carry out the provisions of this subchapter;

4. Sue or be sued in the name of the PAIP, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against members. A judgment against the PAIP shall not create any direct liability against the governing committee or its individual members, or the individual participating members of the PAIP. The PAIP shall not be liable for claims made on or pursuant to individual policies issued through the PAIP;

5. Budget expenses, levy assessments, and disburse funds;

6. Investigate complaints and hear appeals from applicants, insureds, producers, LAD carriers, or insurers about any matter pertaining to the proper administration of the PAIP;

7. Arrange for the independent audit of the PAIP each year;

8. Furnish all insurers with:

i. An annual written operations report;

ii. The approved annual budget upon request;

iii. A copy of the annual audit upon request;

iv. A copy of the plan of operation, and all amendments;

v. A copy of all policy forms, rates, rules and manuals upon request; and

vi. A copy of the minutes from all meetings upon request;

9. Audit the records of any insurer relating to the subject matter of PAIP and establish such policies, records, books of account, documents and related material which shall be maintained for the proper administration of PAIP;

10. Indemnify each member of the governing committee and PAIP employees for any and all claims, suits, costs of investigations, cost of defense, and settlements or judgments against them on account of an act or omission in the scope of the member's duties or employee's employment. The PAIP shall refuse to indemnify if it is determined that the act or failure to act was due to actual fraud, willful misconduct or actual malice;

11. Appoint from among its members or from qualified nonmembers appropriate legal, actuarial, claims, and other committees as necessary to provide technical assistance in the operation of the PAIP, policy and other contract design, and any other function within the authority of the PAIP;

i. The Commissioner may serve as an ex-officio, non-voting member of any committee established pursuant to this section. The Commissioner may designate an alternate; and

12. Perform such other functions as may be necessary and proper to administer PAIP in accordance with this subchapter and the approved plan of operation.

Amended by R.1993 d.548, effective November 15, 1993.
See: 25 N.J.R. 2212(a), 25 N.J.R. 5215(a).

11:3–2.6 Plan of operation

(a) The plan of operation shall provide for the prompt and efficient provision of personal private passenger automobile insurance to qualified applicants. The plan of operation shall provide for, among other matters:

1. The internal organization and proceedings of the governing committee;

2. Standards and procedures for:

i. The appointment, compensation, and termination of producers, the PAIP manager, and other employees, professionals and contractors required to administer the PAIP;

ii. The appointment, compensation, and termination by insurers of LAD carriers (consistent with any requirements established by regulation by the Commissioner);

3. Performance standards for insurers, producers, LAD carriers, the PAIP manager, and other employees, professionals and contractors required to administer the PAIP;

4. A producer certification program, which may not exclude producers with no affiliation with a voluntary market insurer;

5. The extent of coverage to be offered by PAIP to qualified applicants;

6. Procedures to apply for coverage;

7. Commissions to be paid producers;

8. Procedures for cancellation or the nonrenewal of policies;

9. Methods and means for the collection, investment and disbursement of funds;

10. Development and maintenance of a statistical plan and manuals incorporating that plan, which shall be subject to the prior approval by the Commissioner in the same manner as the plan of operation; and

11. Such other provisions as are deemed necessary by the governing committee for the operation of the PAIP.

(b) The governing committee shall, by May 1, 1992, submit to the Commissioner, for his or her review and approval, a proposed plan of operation. The governing committee may propose an amendment to the plan of operation at any time.

(c) The proposed plan and any amendments shall be submitted to the Commissioner for his or her review and approval. If approved, the Commissioner shall certify approval to the governing committee.

1. If the Commissioner disapproves all or any part of the plan of operation or any amendment, he or she shall return same to the governing committee with a statement that sets forth the reasons for his or her disapproval and may include other recommendations he or she may wish to make.

2. If the governing committee does not submit a plan of operation by May 1, 1992, or a new plan which is acceptable to the Commissioner within 30 days after the disapproval of a proposed plan, the Commissioner may promulgate a plan of operation and certify same to the governing committee.

3. The Commissioner may review the plan of operation at any time and may propose amendments to the governing committee. If the governing committee does not adopt amendments acceptable to the Commissioner within 30 days, the Commissioner may certify amendments and their effective date to the governing committee. For good cause shown, the Commissioner may certify proposed amendments two days after copies of the proposal are provided to the governing committee.

Amended by R.1993 d.548, effective November 15, 1993.
See: 25 N.J.R. 2212(a), 25 N.J.R. 5215(a).

11:3–2.7 Coverage

(a) PAIP shall provide to qualified applicants bodily injury liability, property damage liability, personal injury protection, uninsured/underinsured motorists and physical damage coverages at the minimum levels required by law, including all options related thereto.

(b) PAIP shall provide a variety of increased limits for the above coverages up to the following:

1. $250,000 per person/$500,000 per accident for bodily injury liability coverage, and $100,000 for property damage liability coverage, or a combined single limit of $500,000 for bodily injury liability and property damage liability coverage;

2. $250,000 per person/$500,000 per accident for uninsured/underinsured motorists bodily injury liability coverage and $100,000 for uninsured/underinsured motorists property damage liability coverage, or a combined single limit of $500,000 for uninsured/underinsured bodily injury liability and property damage liability coverages.

(c) The PAIP shall provide additional personal injury protection coverages as set forth in N.J.S.A. 39:6A–10.

(d) The PAIP shall provide physical damage coverages with no less than the minimum deductibles required pursuant to N.J.S.A. 17:29A–39. PAIP shall offer higher deductibles as provided by N.J.A.C. 11:3–13.3.

1. All physical damage coverages shall be on an "actual cash value" basis, less deductible, subject to a maximum loss payable of $30,000, or such amount at which physical damage coverage may be placed in the surplus lines market as set forth on the exportable list promulgated by the Commissioner pursuant to N.J.S.A. 17:22–6.43.

2. For purposes of this section, "actual cash value" means the replacement cost of the automobile, less physical depreciation.

11:3–2.8 Eligibility

(a) The PAIP shall not provide coverage to an eligible person as defined in N.J.S.A. 17:33B–13 and N.J.A.C. 11:3–34.

(b) PAIP shall provide coverage to all qualified applicants. For purposes of this subchapter, a "qualified applicant" means:

1. A person who is not an "eligible person" as defined in N.J.A.C. 11:3–34.2; and

2. A person domiciled in New Jersey, who is an owner of an automobile registered and principally garaged in this State or will be registered and principally garaged in this State within 60 days.

(c) "Qualified applicant" shall also include a member of the United States military forces, if otherwise eligible for insurance coverage insured by the PAIP, with respect to an automobile if, at the time application is made, the applicant is a nonresident who is stationed in this State, whose automobile is registered in another State and garaged in this State.

(d) No person shall, however, be deemed a qualified applicant, if the principal operator of the automobile to be insured does not hold a driver's license which is valid in this State; or if a regular operator of the automobile other than the principal operator does not hold such a license; or if timely payment of premium is not tendered; or if the principal operator of the automobile does not furnish the information necessary to effect insurance; or if such person rents or leases automobiles to others which are used for commercial purposes.

(e) As a prerequisite to consideration for assignment under the PAIP, the applicant must certify, in the prescribed application form approved by the Commissioner, that he or she has attempted, within 60 days prior to the date of application, to obtain automobile insurance in the State and that he or she is a qualified applicant as set forth in (b), (c) and (d) above. An applicant so certifying shall be considered for assignment upon making application in good faith to the PAIP. An application shall be considered in good faith if he or she reports all information of a material nature and does not willfully make incorrect or misleading statements in the prescribed application form approved by the Commissioner.

(f) The governing committee shall establish procedures in the plan of operation with respect to documentation to be provided by the applicant and producer showing the reasons for termination of previous insurance coverage, including, but not limited to:

1. Previous insurance company name and policy number;

2. Reasons for termination and effective date of termination;

3. Claim history for the preceding three years;

4. Driving history for each operator; and

5. Copies of vehicle registration(s).

(g) The governing committee shall establish procedures for the cancellation or nonrenewal of policies to persons who are not or are no longer qualified applicants.

Emergency Rule, R.1993 d.135, effective March 1, 1993, operative March 8, 1993 (expires April 30, 1993).
See: 25 N.J.R. 1290(a).
Adopted Concurrent Proposal, R.1993 d.238, effective April 30, 1993.
See: 25 N.J.R. 1290(a), 25 N.J.R. 2479(a).

11:3–2.9 Rates and policy forms

(a) The governing committee shall file for prior approval by the Commissioner, a rating system including rates, rules and forms which shall be used by insurers writing risks through the PAIP. Proceedings to review rate filings shall be conducted pursuant to N.J.S.A. 17:29A–1 et seq. All rates shall reflect the experience of the risks insured by the PAIP and shall not be excessive, inadequate or unfairly discriminatory.

1. Rates established for liability insurance coverages with limits in excess of $50,000 per person and $100,000 per accident for bodily injury or death and $25,000 for property damage, or in lieu thereof, $100,000 for a combined single limit of liability, shall be experience rated with respect to the rate applicable to the coverage in excess of those limits;

2. Rates established for collision and comprehensive coverages on automobiles with a value of $25,000 or more at the time those coverages are issued or renewed shall be experience rated, and for automobiles with a value of more than $15,000, but less than $25,000 at the time those coverages are issued or renewed, that part of the rate applicable to the value between $15,000 and $25,000 shall be experience rated.

(b) For purposes of this subchapter, "experience rated" means that rates for liability coverages with limits in excess of the amount specified in (a)1 above, or for collision and comprehensive coverages for automobiles with a value over the amount specified in (a)2 above, shall reflect the experience of those risks insured by the PAIP with liability coverages with limits, and collision and comprehensive coverages on automobiles valued over, the amounts specified in (a)1 and (a)2 above. "Experience rated" shall not be construed to mean retrospectively rated.

11:3–2.10 Installment payment option

(a) The PAIP shall provide for an installment premium payment option in accordance with procedures established by the governing committee in the plan of operation. With respect to the installment premium payment option, the plan of operation shall specify:

1. The minimum initial deposit required, which shall be no more than 30 percent of the estimated total premium;

2. The schedule for the payment of premiums on an installment basis which shall provide for installment payments over a period of not less than nine months;

3. Installment charges;

4. The minimum "per installment" amounts; and

5. Any other procedures deemed necessary by the governing committee.

(b) Additional premium in excess of an amount set by the governing committee in the plan of operation resulting from changes to the policy shall be spread over the remaining installments, if any, or may be billed immediately as a separate transaction.

(c) Return premium resulting from changes to the policy shall be used to reduce the outstanding balance. If the outstanding balance is eliminated, any amount remaining in excess of an amount set by the governing committee in the plan of operation shall be returned within 30 days. If an outstanding balance remains, the number and amounts of the remaining installments shall be adjusted accordingly, except when the return amount is less than $20.00, in which event it may be treated as a separate transaction.

11:3–2.11 Determination and fulfillment of quotas

(a) The governing committee shall establish procedures in the plan of operation to distribute risks eligible for coverage to insurers on an equitable basis based on the proportion that the insurer's share of the voluntary market for personal private automobile insurance (including the insurer's apportionment share for the depopulation of the Market Transition Facility pursuant to N.J.S.A. 17:33B–11c(5)) relates to the Statewide total of the voluntary market for personal private passenger automobile insurance in the State.

1. The PAIP shall not provide insurance coverage for more than 10 percent of the aggregate number of private passenger automobile non-fleet exposures being written in the total private passenger automobile insurance market in this State.

2. The PAIP shall cease acceptance of applications for new policies upon certification by the Commissioner that the Plan has reached or exceeded 10 percent of the private passenger automobile non-fleet exposures.

3. The PAIP shall resume acceptance of applications for new policies upon certification by the Commissioner that the PAIP is insuring less than 10 percent of the aggregate number of private passenger automobile non-fleet exposures being written in the total private passenger automobile market in the State.

4. Each insurer shall receive credit against its respective portion of assigned risks for private passenger automobile risks written voluntarily in the State that are garaged in those urban territories designated by the Commissioner. Such credit shall be given in the amount of one assigned risk credit for every two voluntary risks written in those designated territories. Each insurer shall also receive one assigned risk credit for each risk which is not an eligible person written in accordance with the insurer's approved rating system, regardless of the territory in which the risk is located.

5. No insurer whose surplus as regards policyholders is less than $1,500,000, as reported on page three of the most recent statutory annual statement, shall be assigned a risk requesting or required by law to carry limits of liability in excess of 50/100/10 or in excess of a combined single limit of $100,000.

(b) An insurer that issues only policies that provide physical damage coverage shall not be subject to assignments from the PAIP, but shall be entitled or obligated, as the case may be, to receive or pay a cash settlement of its obligation, in lieu of receiving assignments, for the current year, in accordance with procedures established by the governing committee in the plan of operation.

(c) Each insurer or statistical agencies designated by such insurers shall report to the PAIP manager all data necessary to comply with the distribution procedures. Each insurer shall permit its statistical agent to release such data to the PAIP manager and shall permit its statistical agent to furnish the PAIP manager with statements of its PAIP experience.

(d) There shall be no exceptions to the type or class of risks assigned to an insurer other than as provided in this subchapter nor shall there be any agreement with an insurer to refrain from assigning risks in any territory or area of the State.

(e) The PAIP shall not suspend assignments to an insurer for any period of time, for any reason, other than a suspension of insurer obligations granted by the Commissioner pursuant to N.J.S.A. 17:33B–23, 17:33B–24 and N.J.A.C. 11:2–35. The PAIP shall promptly notify all insurers of such action.

(f) If an insurer is ordered or permitted to discontinue writing automobile insurance in this State in accordance with a plan of orderly withdrawal approved pursuant to N.J.A.C. 11:2–29, or other Order of the Commissioner, or Order by a court of competent jurisdiction, the insurer's obligations to pay assessments, receive assignments and run-off existing business shall be pursuant to such Order of the Commissioner or Order of a court of competent jurisdiction.

(g) In the event an insurer is merged with another insurer, there is a consolidation of insurers, or an insurer acquires another insurer's book of business, the continuing insurer shall receive the assignments and assessments of the insurer merged, consolidated, or acquired until the quota of such merged, consolidated, or acquired insurer, as established by its writings prior to such merger, consolidation, or acquisition has been filled; provided, however, the continuing insurer may be relieved from such obligations if another insurer has agreed, in a manner satisfactory to the governing committee, to assume such obligations.

(h) Groups of insurers under the same ownership and management shall be treated as a single insurer. Groups of insurers under either the same ownership or management,

but not both, may elect to be treated either separately or as a single company.

(i) The governing committee shall establish procedures in the plan of operation permitting an insurer by mutual agreement to transfer its obligations to accept assignments to another insurer (to be known as a LAD carrier). The basic contract to be entered into between insurers and LAD carriers, including the minimum duration of such agreement, shall be approved by the governing committee and the Commissioner. Any substantive modifications to the approved contract shall be submitted to the governing committee and Commissioner for approval prior to its use. With respect to the transfer of an insurer's obligations to accept assignments to a LAD carrier, the plan shall address the following:

1. Eligibility criteria for an insurer to act as a LAD carrier and accept additional assignments;

2. The maximum number of additional assignments a LAD carrier may assume;

3. Minimum provisions for contracts between insurers and LAD carriers, including the minimum time duration for such contracts;

4. The parameters for fees to be paid to LAD carriers by the participating insurer for the assumption of the insurer's assigned risk quota;

5. Procedures by which the allocation of assignments to LAD carriers are adjusted to reflect additional assignments as a result of entering into a contract to assume additional assigned risks; and

6. Any other procedures deemed necessary to provide for a LAD carrier distribution system.

Amended by R.1993 d.548, effective November 15, 1993.
See: 25 N.J.R. 2212(a), 25 N.J.R. 5215(a).

11:3–2.12 Right to petition for appeal to the Commissioner

(a) An applicant, insured, producer, LAD carrier, person applying to act as a LAD carrier, or insurer may petition for appeal to the Commissioner from an adverse decision of the governing committee by filing a request in writing within 20 days of the date of receipt of the written decision of the governing committee.

1. The written request to appeal shall set forth the facts upon which it is based and include a copy of the written decision of the governing committee.

2. The Commissioner shall notify the petitioner and the governing committee within 30 days whether the request to appeal shall be granted.

3. Notice from the Commissioner that an appeal has been granted shall also provide a statement about whether the action of the governing committee has been stayed pending the disposition of the appeal.

(b) An appeal to the Commissioner granted pursuant to this rule shall be conducted in accordance with applicable provisions of 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.

Amended by R.1993 d.548, effective November 15, 1993.
See: 25 N.J.R. 2212(a), 25 N.J.R. 5215(a).

11:3–2.13 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of penalties as authorized by law.

SUBCHAPTER 2A. NEW JERSEY AUTOMOBILE FULL INSURANCE UNDERWRITING ASSOCIATION CLAIMS PAYMENT DEFERRAL

11:3–2A.1 Purpose and scope

(a) This subchapter implements the provisions of N.J.S.A. 17:33B–3b(2) which authorizes the Trustee to defer the payment of residual bodily injury claims over a period not to exceed four years. This subchapter is intended to ensure the orderly payment of all Association claims in accordance with the priorities established by the Trustee pursuant to N.J.S.A. 17:33B–3b(2) by deferring payment of residual bodily injury claims, in accordance with certain terms, conditions and procedures.

(b) This subchapter shall apply to the Trustee, the Association, the Association's servicing carriers and claimants of the Association.

11:3–2A.2 Definitions

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

"Assets" means, but is not limited to, sources of income as enumerated in N.J.S.A. 17:30E–8 and any funds made available to the New Jersey Automobile Full Insurance Underwriting Association from the New Jersey Automobile Insurance Guaranty Fund created pursuant to N.J.S.A. 17:33B–5, monies, funds, accounts receivable, premium payments, payments and surcharges collected on any and all private passenger automobile policies, interest income, contracts, causes of action, books, records and property of the Association wherever located, including such property of the Association which may be discovered hereafter.

"Association" means the New Jersey Automobile Full Insurance Underwriting Association.

"Closing papers" means a release which includes the Association deferral language set forth in N.J.A.C. 11:3–2A.1(b)2 and which is signed by the claimant releasing the Association and its insured(s) from liability for the claim, or a warrant of satisfaction of judgement and/or other closing documents.

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

"Covered claim" means an unpaid claim which arises out of and is within the coverage provided by the Association to an insured and is not in excess of the applicable limits of an insurance policy to which N.J.S.A. 17:30E–1 et seq., as amended, applies.

"Date of deferral" means the date upon which the Association's appropriate servicing carrier physically receives the proper closing papers associated with a residual bodily injury claim.

"New Jersey Automobile Insurance Guaranty Fund" ("NJAIGF") means the Guaranty Fund created pursuant to N.J.S.A. 17:33B–5.

"Plan of Operation" means the plan of operation promulgated pursuant to N.J.S.A. 17:33B–3b(2) by the Trustee and approved by the Commissioner.

"Residual bodily injury claim" means a liability claim for loss of any kind whatsoever, other than present economic loss, resulting from liability imposed by law for, or as a result of, bodily injury or death.

"Servicing carrier" means a member company or other entity that had or presently has a contract with the Association to underwrite, process and adjust automobile insurance policies for the Association pursuant to the New Jersey Automobile Full Insurance Availability Act.

"Trustee" means the person appointed by the Commissioner pursuant to N.J.S.A. 17:33B–3b(1) to carry out the obligations set forth in N.J.S.A. 17:33B–1 et seq. and the Plan of Operation.

Amended by R.1994 d.274, effective June 6, 1994.
See: 26 N.J.R. 898(a), 26 N.J.R. 2287(b).

11:3–2A.3 Deferral of payment for residual bodily injury claims

(a) Payments by the Association of any residual bodily injury claims, including uninsured motorist claims and underinsured motorist claims, are deferred from payment for a period not to exceed 18 months, except such claims as may be granted a hardship exemption from deferral by the Trustee as provided in N.J.A.C. 11:3–2A.5.

(b) The deferral of claim payments provided in (a) above shall apply to all claims for which closing papers have not been physically received in the offices of the servicing carriers before December 18, 1992. Facsimile transmissions shall not constitute physical receipt by the servicing carriers.

(c) Payment of a claim which has been deferred pursuant to this subchapter shall occur no later than the first day of the eighteenth month following the date of deferral, that is the date upon which closing papers are received in the office of the Association's servicing carrier.

(d) The deferral of claim payments as provided in this subchapter shall continue until December 31, 1995.

(e) When claims deferred pursuant to this subchapter are paid by the Association, the payment shall include simple interest at the rate of six percent per annum beginning on the date of deferral. If claims deferred pursuant to this rule are paid prior to the first day of the eighteenth month following physical receipt of the closing papers by the Association's servicing carrier, the payment of interest will be pro-rated to the date of payment.

(f) Payment of claims for current economic loss shall not be deferred.

Amended by R.1994 d.274, effective June 6, 1994.
See: 26 N.J.R. 898(a), 26 N.J.R. 2287(b).

11:3–2A.4 Administrative provisions

(a) In accordance with the provision of N.J.S.A. 17:33B–3b(3) and the Plan of Operation, the Trustee shall monitor the financial condition of the Association and shall issue a report to the Commissioner on a biannual basis.

(b) The Trustee shall develop, review and, where necessary, amend, uniform operating procedures necessary to implement these rules consistent with this subchapter including procedures for the implementation of hardship exemptions as provided in N.J.A.C. 11:3–2A.5; servicing carrier procedures; and the uniform handling of deferred claim payments.

1. Claims shall not be considered settled and ready for deferral until the servicing carrier physically receives the appropriate closing papers. Facsimile transmissions shall not be accepted for these purposes.

2. Deferral releases shall include the following language:

Payment: In consideration for making this Release, you have agreed to pay me a settlement of $_____ plus simple interest at the rate of 6 percent per annum for a total amount of $_____, to be paid no later than the first day of the eighteenth month after receipt of this Release by the Servicing Carrier. It is further understood that, if by further order of the Commissioner of Insurance for the State of New Jersey, the settlement amount may be released earlier, the interest will be pro-rated. I further understand and agree that I

will not seek anything further including any other payments from you.

3. Orders for Judgment shall include language similar to that in (b)2 above specifically referring to the deferral of any payment until the first day of the eighteenth month following physical receipt by the Association's servicing carrier of the Order, the inclusion of per annum, simple interest at six percent in any final payment, and the understanding that if any such payment is made early, the amount of interest will be pro-rated to the date of payment.

4. The date of deferral shall be deemed to be the date upon which closing papers are physically received in the office of the Association servicing carrier. Such date shall govern the period of deferral applicable to the deferred claim.

(c) Disputes regarding the date of deferral shall be resolved in the first instance by the Trustee in accordance with the following procedures:

1. A claimant who disputes the date of deferral as indicated by the servicing carrier shall notify the Trustee in writing of the factual basis for the dispute and shall include therewith all supporting documentation. The servicing carrier shall also provide all relevant documentation in opposition to the date of claim settlement alleged by the claimant.

2. The Trustee may adjust the ultimate pay-out date of a deferred claim upon a finding of inordinate delay by defense counsel or the servicing carrier in the handling or processing of the closing papers.

3. The Trustee shall establish appropriate procedures for obtaining additional information when required during the course of review.

4. The Trustee's written decision shall be mailed to the applicant by regular and certified mail, return receipt requested.

(d) Servicing carriers shall not utilize their own funds to pay claims subject to deferral unless specifically authorized to do so by the Trustee. Regardless of the source of funds utilized, the Association shall not reimburse servicing carriers for the unauthorized payment of claims subject to deferral made on or after the effective date of these rules.

(e) Servicing carriers shall continue their efforts to resolve all outstanding claims. During negotiations and/or other discussions with claimants or their attorneys, the servicing carrier and defense counsel shall advise all parties that payment will be deferred for 18 months.

Amended by R.1994 d.274, effective June 6, 1994.
See: 26 N.J.R. 898(a), 26 N.J.R. 2287(b).

11:3–2A.5 Hardship exemptions

(a) Notwithstanding the provisions of N.J.A.C. 11:3–2A.3, an exemption from the deferral of a claim payment shall be permitted in limited circumstances upon the filing of a written application with the Office of the Trustee which:

1. Demonstrates, through a written statement and sufficient supporting documentation, the existence of an extreme and immediate financial emergency; and

2. In which the applicant attests that the emergency cannot be resolved through use of any other reasonably available financial resources. "Reasonably available financial resources" includes, but is not limited to, resources such as reimbursement or compensation through insurance coverage, reasonable liquidation of assets to the extent that liquidation would not cause further economic hardship, or borrowing from commercial sources on reasonable commercial terms.

(b) Some examples which may constitute acceptable grounds for a hardship exemption are as follows:

1. The claimant, spouse or dependent has incurred substantial medical expenses (over $5,000) not related to the subject motor vehicle accident and not covered by insurance. Copies of all medical bills and insurance coverages must be provided.

2. The claimant, spouse or dependant cannot pay for essential food and shelter. For this exemption to apply, the applicant, spouse or dependant must face imminent eviction or foreclosure from their principal residence. A copy of the imminent foreclosure or eviction notice must be provided.

3. The claimant, spouse or dependant faces immediate removal from a nursing home, hospital or other medical care institution due to the inability to pay, although continued medical care is prescribed by medical health care providers and not related to the subject motor vehicle accident. Copies of bills for treatment and medical insurance coverages, along with an original written statement by a doctor prescribing further medical treatment and an original written statement from the medical institution advising that removal due to the inability to pay is imminent, must be provided.

4. The applicant cannot pay funeral expenses of the claimant, spouse or dependant and the death is not related to the subject motor vehicle accident. Copies of the unpaid funeral bills must be provided.

5. Such other financial emergency or situations of an unusual or emergent nature which may be deemed to be appropriate based upon information provided.

(c) Applications for a hardship exemption may be obtained from the Association's servicing carriers or by submitting a written request to the Office of the NJAFIUA Trustee, 160 Avenue at the Common, Suite 2, Shrewsbury, New Jersey 07702.

1. A hardship application shall contain the following information:

i. The name, address, social security number, telephone number and date of birth of the claimant;

ii. The claim number and policy number;

iii. The caption of the case;

iv. The name of the association insured;

v. The amount deferred and date deferred;

vi. A description of the examples which constitute a hardship as set forth at (b) above;

vii. The documents required to be appended to the application as set forth at (c)2 below;

viii. The amount of exemption being sought and the grounds for the exemption; and

ix. An appropriate certification executed by the applicant.

2. Completed applications shall be submitted directly to the Trustee at the address noted above and shall include a certified-to-be-true copy of the associated judgment or fully-executed deferral release, a copy of the written acknowledgment of receipt of the deferral release or order for judgment issued by the Association's servicing carrier, copies of all unpaid medical bills, insurance coverages, foreclosure notices, eviction notices, funeral bills and other appropriate documentation. Original documents shall be available for review upon the request of the Office of the Trustee.

(d) The amount requested and the amount released from deferral, if a hardship exemption is granted, shall not exceed the minimum amount required to meet the financial emergency, nor the net amount due the claimant.

(e) The Trustee shall establish appropriate procedures for obtaining additional information when required during the course of review.

(f) The Trustee's written decision shall be delivered to the applicant or his or her legal representative by certified mail, return receipt requested or by an express mail service of the Trustee's choice.

(g) Where an exemption is granted, the decision shall include a hardship exemption release amendment, prepared by the Office of the Trustee, to be reviewed by the applicant or his or her legal representative, executed by the applicant, and forwarded directly to the Association's servicing carrier. Additionally, where an exemption is granted, the appropriate servicing carrier shall be notified, in writing, with instructions to make the appropriate payment directly to and in the name of the claimant, upon receipt of the fully-executed hardship exemption release amendment. The servicing carriers shall proceed in accordance with procedures developed by the Trustee.

(h) Where an exemption is either denied or only partially granted, the Trustee's decision shall enclose a copy of the appropriate documents required to file an appeal.

Amended by R.1994 d.274, effective June 6, 1994.
See: 26 N.J.R. 898(a), 26 N.J.R. 2287(b).

11:3–2A.6 Appeal to the Commissioner

(a) An appeal by an applicant of the decision of the Trustee denying a request for a hardship exemption as provided in N.J.A.C. 11:3–2A.5 or from the Trustee's decision regarding a dispute about the date of deferral as provided in N.J.A.C. 11:3–2A.4(c), shall be filed with the Commissioner within 20 days of receipt of the Trustee's written decision.

1. A copy of the appeal shall be simultaneously filed by the claimant with the Trustee.

2. The Trustee, upon receipt of notice of the appeal, shall forward the claimant's file to the Commissioner for his or her review.

(b) The Commissioner's final decision shall be provided to the Trustee and shall be mailed to the applicant or his or her legal representative by certified mail, return receipt requested and regular mail.

Amended by R.1994 d.274, effective June 6, 1994.
See: 26 N.J.R. 898(a), 26 N.J.R. 2287(b).

11:3–2A.7 Public records

(a) Pursuant to N.J.S.A. 47:1A–1, the following documents shall be considered public documents:

1. The Trustee's request to the Commissioner for approval of the deferral plan, or any extension, and the supporting analysis and data;

2. The written Department staff evaluation and recommendation, if any; and

3. The Commissioner's Final Decision.

(b) Interested parties may, by appointment only, review the above documents set forth at (a) above at the Offices of the Department of Insurance between the hours of 10:00 A.M. and 4:00 P.M., Monday through Friday, except holidays.

1. An appointment may be scheduled by telephoning the Department at (609) 984–3602.

(c) Interested persons may obtain copies of the documents set forth in (a) above by remitting, in advance, the following fees:

1. First page to 10th page: $.75 per page;

2. Eleventh page to 20th page: $.50 per page; and

3. All pages over 20: $.25 per page.

(d) Original documents shall not be released from the Department.

Amended by R.1994 d.274, effective June 6, 1994.
See: 26 N.J.R. 898(a), 26 N.J.R. 2287(b).

SUBCHAPTER 2B. MARKET TRANSITION FACILITY OF NEW JERSEY PAYMENT PRIORITIZATION AND CLAIMS PAYMENT DEFERRAL

Authority

N.J.S.A. 17:1C–6(e), 17:1–8.1, and 17:33B–11.

Source and Effective Date

R.1994 d.261, effective April 29, 1994.
See: 26 N.J.R. 1393(a), 26 N.J.R. 2288(a).

Subchapter Historical Note

Subchapter 2B, Market Transition Facility of New Jersey Suspension of Claims, was adopted as Emergency New Rule R.1994 d.164, effective March 1, 1994, to expire April 30, 1994. See: 26 N.J.R. 1393(a). Concurrently proposed new rules were adopted as R.1994 d.261. See: Source and Effective Date.

11:3–2B.1 Purpose and scope

(a) This subchapter provides the general procedures to be utilized for the resumption of certain claims payments by the MTF that had been suspended pursuant to this subchapter, and the deferral of certain claims payments by the MTF pursuant to amendments certified to the MTF Plan of Operation by the Commissioner on July 26, 1994 pursuant to N.J.S.A. 17:33B–11c as amended by P.L. 1994, c.57, section 17.

(b) This subchapter shall apply to the MTF and the MTF's servicing carriers, former MTF policyholders and persons or entities having any unpaid claims against the MTF or former MTF policyholders.

Amended by R.1995 d.50, effective January 17, 1995.
See: 26 N.J.R. 4590(a), 27 N.J.R. 368(a).

11:3–2B.2 Definitions

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

"Assets" means any funds made available to the MTF through any payments received from a member insurer for its apportioned share of the MTF's operating losses pursuant to N.J.S.A. 17:33B–11d, monies, funds, accounts receivable, premium payments, payments collected on any and all private passenger automobile insurance policies, interest income, contracts, causes of action, books, records, and property of the MTF wherever located, including such property of the MTF that may be discovered hereafter.

"Claim" means a request for payment for a loss which arises out of and is within the coverage provided by the MTF to an insured pursuant to N.J.S.A. 17:33B–11.

"Closing papers" means the original, fully-executed release(s) containing the proper deferral language set forth in this subchapter and which is signed by the claimant releasing the MTF and its insured(s) from liability for the claim, or a warrant of satisfaction of judgment and/or other closing documents.

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

"Infrastructure" means those items or components necessary for the MTF to operate and fulfill its obligations to policyholders and claimants, including MTF central staff, contracted servicing carriers, defense attorneys and certain independent consultants. Infrastructure costs include, but are not limited to, payroll expenses (including salaries, benefits and payroll taxes), rent, utilities, bank charges, investment charges, data processing, office and computer supplies, licensing fees for computer software, insurance coverages (such as workers' compensation coverages), legal fees (including defense of claims directly against the MTF), postage, telephone, consultant fees (including auditors and actuaries), MTF servicing carrier fees, and defense costs (that is, payments to defense counsel to protect the MTF's interests in litigation involving MTF policyholders for which the MTF is liable for payment under the MTF policy).

"Member insurer" means any insurer authorized to transact private passenger automobile insurance in this State.

"MTF" means the Market Transition Facility of New Jersey created pursuant to N.J.S.A. 17:33B–11.

"Person" means any individual, corporation, partnership, association or private or public entity which seeks payment of a claim.

"Plan of Operation" means the Plan of Operation promulgated by the Commissioner pursuant to N.J.S.A. 17:33B–11c as amended by P.L. 1994, c.57, section 17.

"Private passenger automobile" is as defined at N.J.S.A. 39:6A–2.

"Private passenger automobile insurance" means direct insurance against injury or damage, including the legal liability therefor, arising out of the ownership, operation, maintenance, or use of private passenger automobiles, including, but not limited to, personal injury protection coverage (including extended medical expense coverage), bodily injury liability coverage, property damage liability coverage, uninsured motorists coverage (including underinsured motorists coverage), towing and labor coverage, rental reimbursement coverage, and collision and comprehensive (other than collision) coverage.

"Residual bodily injury claim" means a liability claim for the loss of any kind whatsoever, other than present economic loss, resulting from liability imposed by law for or as a result of bodily injury or death.

"Servicing carrier" means a member insurer or other entity that had or presently has a contract with the MTF to underwrite, process, and settle claims for the MTF pursuant to the MTF Plan of Operation approved by the Commissioner pursuant to N.J.S.A. 17:33B–11c.

Amended by R.1995 d.50, effective January 17, 1995.
See: 26 N.J.R. 4590(a), 27 N.J.R. 368(a).

11:3–2B.3 Priority of claims

(a) Subject to N.J.A.C. 11:3–2B.4 and Part IV of the MTF Plan of Operation, the MTF shall have the power to make distributions from the assets of the MTF in the following order of priority:

1. Expenses of administration;

2. Claims for taxes and debts due to Federal, State or local government;

3. Covered claims by policyholders and beneficiaries thereof arising from and within the coverage of, and not in excess of, the applicable limits of insurance policies and contracts issued by the MTF, in the following order of priority:

i. Present economic loss;

ii. Collision or comprehensive loss and third party property damage loss;

iii. Residual bodily injury loss; and

iv. Other creditor claims.

Repeal and New Rule, R.1995 d.50, effective January 17, 1995.
See: 26 N.J.R. 4590(a), 27 N.J.R. 368(a).
Formerly "Suspension of payment of claims by the MTF".

11:3–2B.4 Resumption of payment of certain claims previously suspended; deferral of payment for residual bodily injury claims

(a) The servicing carriers shall resume making claim payments previously suspended pursuant to this subchapter as follows:

1. Payments for claims that are due for payment that have been suspended shall be issued for the following coverages:

i. Personal injury protection;

ii. Collision;

iii. Comprehensive;

iv. Property damage;

v. Other payments for present economic loss; and

vi. Residual bodily injury claims that were resolved and for which the releases and other necessary closing papers were received and date stamped by the servicing carrier on or before March 1, 1994.

(b) The servicing carrier shall not pay interest on the suspended claims described in (a) above, except where such payment is required by law or explicitly authorized by the Commissioner.

(c) During the period when the previously suspended claims are being paid, servicing carriers shall be permitted to make payments on newly received bills for the claims described in (a)1i through v above, provided that such payment of new claims does not delay the payment of suspended claims.

(d) Payments by the MTF of any residual bodily injury claims, including uninsured motorist claims and underinsured motorist claims, are deferred from payment for a period not to exceed 18 months, except such claims as may be granted a hardship exemption from deferral as provided in N.J.A.C. 11:3–2B.6.

(e) The deferral of claim payments set forth in (d) above applies to all such residual bodily injury claims, regardless of settlement date or jurisdiction, for which closing papers have not been physically received in the offices of the appropriate MTF servicing carrier before March 2, 1994. Receipt by defense counsel or facsimile transmissions shall not constitute receipt by the appropriate MTF servicing carrier.

(f) With regard to those residual bodily injury claims for which closing papers were received in the offices of the servicing carrier after March 2, 1994, but before August 31, 1994, the servicing carriers shall prepare an amended release including proper reference to the Deferral Program and send the amended release to the claimant or the claimant's attorney for execution. If the release is properly executed and received back in the offices of the servicing carrier within 60 days after it is mailed, then the deferral date shall relate back to the date on which the original release was received in the office of the servicing carrier. Failure by claimant or the claimant's attorney to return the amended release with proper reference to the Deferral Program so as to be received by the servicing carrier within 60 days shall be deemed an election that the claimant wishes to dissolve the original settlement and reopen the claim. The date of deferral for any reopened claim shall be the date described in N.J.A.C. 11:3–2B.5(c).

(g) Payment of a claim which has been deferred pursuant to this subchapter shall occur no later than the first day of the eighteenth month following the date of deferral.

(h) When claims deferred pursuant to this subchapter are paid by the MTF, the payment shall include simple interest calculated at a rate of six percent per annum beginning on

the date of deferral. If claims deferred pursuant to this section are paid prior to the first day of the eighteenth month following physical receipt of the closing papers by the MTF's servicing carrier, then payment of interest shall be pro-rated to the day of payment.

(i) Payment of claims for current economic loss shall not be deferred.

New Rule, R.1995 d.50, effective January 17, 1995.
See: 26 N.J.R. 4590(a), 27 N.J.R. 368(a).

11:3–2B.5 Administrative provisions

(a) Claims shall not be considered settled and ready for deferral until the servicing carrier physically receives the appropriate closing papers. Receipt by defense counsel or facsimile transmissions shall not be accepted for these purposes.

(b) Deferral releases shall contain the following language:

Payment: In consideration for making this Release, you have agreed to pay me a settlement of $_____, plus simple interest at a rate of 6 percent per annum for a total amount of $_____, to be paid no later than the first day of the eighteenth month after receipt of this Release by the servicing carrier or its designee. It is further understood that, if by further Order of the Commissioner of Insurance for the State of New Jersey, the settlement amount is released earlier, the interest will be pro-rated. I further understand and agree that I will not seek anything further including any other payments from you.

1. Orders for Judgment shall include language similar to that in (b) above specifically referring to the deferral of any payment until the first day of the eighteenth month following physical receipt by the MTF's servicing carrier of the Order, the inclusion of per annum, simple interest at six percent in any final payment, and the understanding that if any payment is made early, the amount of interest will be pro-rated to the date of payment.

(c) The date of deferral shall be deemed to be the date upon which closing papers are physically received in the office of the servicing carrier, except as otherwise provided in N.J.A.C. 11:3–2B.4(f) and 2B.6. Such date shall govern the period of deferral applicable to the deferred claim.

(d) Disputes regarding the date of deferral shall be resolved in the first instance by the MTF in accordance with the following procedures:

1. A claimant who disputes the date of deferral as indicated by the servicing carrier shall notify the MTF in writing of the factual basis for the dispute and shall include therewith all supporting documentation. The servicing carrier shall also provide all relevant documentation in opposition to the date of claim settlement alleged by the claimant.

2. The MTF may adjust the ultimate pay-out date of a deferred claim upon a finding of inordinate delay by defense counsel or the servicing carrier in the handling or processing of the closing papers.

3. The MTF shall establish appropriate procedures for obtaining additional information when required during the course of review.

4. The MTF's written decision shall be mailed to the applicant by regular and certified mail, return receipt requested.

(e) Servicing carriers shall not utilize their own funds to pay claims subject to deferral unless instructed and authorized to do so by the MTF, the Commissioner or his or her designated representative. Regardless of the source of funds utilized, the MTF shall not reimburse servicing carriers for the unauthorized payment of claims subject to deferral.

(f) Servicing carriers shall continue their efforts to resolve all outstanding claims. During negotiations and/or other discussions with claimants or their attorneys, the servicing carrier and defense counsel shall advise all parties that payment will be deferred for 18 months.

(g) The Plan of Operation shall set forth uniform operating procedures necessary to implement these rules consistent with this subchapter including procedures for the implementation of hardship exemptions as provided at N.J.A.C. 11:3–2B.6; servicing carrier procedures; and the uniform handling of deferred claim payments.

New Rule, R.1995 d.50, effective January 17, 1995.
See: 26 N.J.R. 4590(a), 27 N.J.R. 368(a).

11:3–2B.6 Hardship exemption procedure

(a) Notwithstanding the provisions of N.J.A.C. 11:3–2B.4, and subject to the availability of funds, an exemption from the deferral of a claim payment shall be permitted in limited circumstances upon the filing of a written application with the MTF which:

1. Demonstrates, through a written statement and sufficient supporting documentation, the existence of an extreme immediate financial emergency; and

2. Includes a statement in which the applicant attests that the emergency cannot be resolved through use of any other reasonably available financial resources. "Reasonably available financial resources" includes, but is not limited to, resources such as reimbursement or compensation through insurance coverage, reasonable liquidation of assets to the extent that liquidation would not cause further economic hardship, or borrowing from commercial sources on reasonable commercial terms.

(b) Some examples which may constitute acceptable grounds for a hardship exemption are as follows:

1. The claimant, spouse or dependant has incurred substantial medical expenses (over $5,000) not related to the subject motor vehicle accident and not covered by insurance. Copies of all medical bills and insurance coverages must be provided.

2. The claimant, spouse or dependant cannot pay for essential food and shelter or household services. For this exemption to apply, the applicant, spouse or dependant must face imminent eviction or foreclosure from their principal residence or loss of essential household services such as utility or telephone. A copy of the imminent foreclosure eviction notice or utility shut-off notification must be provided.

3. The claimant, spouse or dependant faces immediate removal from a nursing home, hospital or other medical care institution due to the inability to pay, although continued medical care is prescribed by medical health care providers and such care is not related to the subject motor vehicle accident. Copies of bills for treatment and medical insurance coverages, along with an original written statement from the medical institution advising that removal due to the inability to pay is imminent, must be provided.

4. The applicant cannot pay funeral expenses of the claimant, spouse or dependant and the death is not related to the subject motor vehicle accident. Copies of the unpaid funeral bills must be provided.

5. Such other emergency or situation of an unusual nature which may be deemed to be appropriate based upon information provided.

(c) Applications for a hardship exemption may be obtained from the servicing carriers or by submitting a written request to the Market Transition Facility of New Jersey, 293 Eisenhower Parkway, Livingston, New Jersey 07039.

1. A hardship application shall contain the following information:

i. The name, address, social security number, telephone number and date of birth of the claimant;

ii. The claim number and policy number;

iii. The caption of the case;

iv. The name of the MTF insured;

v. The amount deferred and date deferred;

vi. A description of the examples which constitute a hardship as set forth at (b) above;

vii. The documents required to be appended to the application as set forth at (c) below;

viii. The amount of exemption being sought and the grounds for the exemption; and

ix. An appropriate certification executed by the applicant.

2. Completed applications shall be submitted directly to the MTF at the address noted in (c) above and shall include a certified-to-be-true copy of the associated judgment or fully-executed deferral release, a copy of the written acknowledgment of receipt of the deferral release or order for judgment issued by the MTF's servicing carrier, copies of all unpaid medical bills, insurance coverages, foreclosure notices, eviction notices, funeral bills and other appropriate documentation. Original documents shall be available for review upon the request of the MTF.

(d) The amount requested and the amount released from deferral, if a hardship exemption is granted, shall not exceed the minimum amount required to meet the financial emergency, nor the net amount due the claimant.

(e) The MTF shall establish appropriate procedures for obtaining additional information when required during the course of review.

(f) The MTF's written decision shall be delivered to the applicant or his or her legal representative by certified mail, return receipt requested or by an express mail service of the MTF's choice.

(g) Where an exemption is granted, the decision shall include a hardship exemption release amendment, prepared by the MTF, to be reviewed by the applicant or his or her legal representative, executed by the applicant, and forwarded directly to the MTF's servicing carrier. Additionally, where an exemption is granted, the appropriate servicing carrier shall be notified, in writing, with instructions to make the appropriate payment directly to and in the name of the claimant, upon receipt of the fully-executed hardship exemption release amendment. The servicing carriers shall proceed in accordance with procedures developed by the MTF.

(h) Where an exemption is either denied or only partially granted, the MTF decision shall enclose a copy of the appropriate documents required to file an appeal.

Recodified from 11:3–2B.4 and amended by R.1995 d.50, effective January 17, 1995.
See: 26 N.J.R. 4590(a), 27 N.J.R. 368(a).

11:3–2B.7 Appeal to the Commissioner

(a) An applicant may appeal the decision of the MTF denying a request for a hardship exemption or from the MTF's decision regarding a dispute about the date of deferral within 20 days of receipt of the MTF's written decision by submitting to the Commissioner an appeal of the MTF's decision addressed to the Residual Markets Unit, Department of Insurance, 20 West State Street, CN 325, Trenton, NJ 08625.

(b) The Notice of Appeal shall include those items presented in the initial request, a written statement explaining why the decision of the MTF denying the request was

incorrect, and any additional documentation in support of the exemption request.

1. A copy of the appeal shall be simultaneously filed by the claimant with the MTF.

2. The MTF, upon receipt of notice of the appeal, shall forward the claimant's file to the Commissioner for his or her review.

(c) The Commissioner's final decision shall be provided to the MTF and shall be mailed to the applicant or his or her legal representative by certified mail, return receipt requested and by regular mail.

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).

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. LIMITED ASSIGNMENT DISTRIBUTION SERVICING CARRIERS

Authority

N.J.S.A. 17:1–8.1; 17:1C–6(e); 17:23–1 et seq., and 17:29D–1.

Source and Effective Date

R.1992 d.371, effective September 21, 1992.
See: 24 N.J.R. 519(a), 24 N.J.R. 3414(a).

11:3–3.1 Purpose and scope

(a) The purpose of this subchapter is to set forth application and procedural requirements for insurers or other qualified entiribution servicing carrier as referenced in N.J.S.A. 17:29D–1c. A limited assignment distribution servicing carrier under these rules is a person or perribution servicing carrier as referenced in N.J.S.A. 17:29D–1c. A limited assignment distribution servicing carrier under these rules is a person or persons to whom an insurer delegates the authority to perform substantially all of the functions related to policy administration or claims administration for any policy of private passenger automobile insurance of the insurer. A person with whom an insurer contracts to perform only certain aspects of policy administration or claims administration (including, but not limited to, data processing, loss appraisal, policy coverage verification and rate pursuit) shall not be deemed to be a limited assignment distribution servicing carrier for purposes of these rules.

(b) This subchapter applies to all insurers and other qualified entities which seek to become a limited assignment distribution servicing carrier and to all insurers which seek to appoint a limited assignment distribution servicing carrier. These rules shall not apply to arrangements entered into between affiliates, provided that services are provided solely to members of the group.

Amended by R.1994 d.210, effective May 2, 1994.
See: 25 N.J.R. 1327(b), 26 N.J.R. 1869(a).

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:

"Affiliate" means an entity within the same holding company system as the LAD servicing carrier.

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

"Department" means the New Jersey Department of Insurance.

"Insurer" means an entity authorized to transact the business of property and casualty insurance in this State pursuant to N.J.S.A. 17:17–1 et seq., N.J.S.A. 17:32–1 et seq., or N.J.S.A. 17:50–1 et seq.

"LAD servicing carrier" means an insurer or other qualified entity registered as a limited assignment distribution servicing carrier in this State pursuant to this subchapter.

"Person" means any individual, insurer, corporation, association, organization, society, partnership, syndicate, trust, company or other legal entity.

Amended by R.1994 d.210, effective May 2, 1994.
See: 25 N.J.R. 1327(b), 26 N.J.R. 1869(a).

11:3–3.3 General requirements

(a) No person shall act as, offer to act as, or hold itself out to be a LAD servicing carrier in this State unless registered as a LAD servicing carrier pursuant to the subchapter.

(b) Any person licensed to transact private passenger automobile insurance in this State registered as a LAD servicing carrier shall retain not less than 25 percent of the risk which the LAD servicing carrier services on behalf of the insurer, except as provided pursuant to (g) below.

(c) Except as provided at (g) below, any person which is not licensed to transact private passenger automobile insurance in this State registered as a LAD servicing carrier pursuant to this subchapter shall:

1. Within two years from the date of appointment as a LAD servicing carrier, retain, either directly or through an affiliate licensed to transact private passenger automobile insurance in this State, not less than 10 percent of the risk which the LAD servicing carrier services on behalf of the insurer; and

2. Within four years from the date of appointment as a LAD servicing carrier, retain, either directly or through an affiliate licensed to transact private passenger automobile insurance in this State, not less than 25 percent of the risk which the LAD servicing carrier services on behalf of the insurer.

(d) The LAD servicing carrier shall become licensed to transact private passenger automobile insurance in this State pursuant to N.J.S.A. 17:17–1 et seq. and N.J.A.C. 11:1–28 or N.J.S.A. 17:32–1 et seq. and N.J.A.C. 11:1–10, as applicable, so that it may retain risk within the time frames set forth in (c) above. However, a LAD servicing carrier may retain risk which it services through an affiliate licensed to transact private passenger automobile insurance in this State.

(e) All LAD servicing carriers or their affiliates, as applicable, licensed to transact insurance in this State shall be subject to all applicable laws in subtitle 3 of Title 17 of the Revised Statutes and all applicable regulations in Title 11 of the New Jersey Administrative Code.

(f) If the LAD servicing carrier is not licensed to transact private passenger automobile insurance or otherwise in a position to retain risk as set forth in (d) above so that it may retain risk within the time frames set forth in (c) above, or if at any time the Commissioner determines that the financial condition of the LAD servicing carrier is such that retention of risk by the LAD servicing carrier may render the insurer's and/or LAD servicing carrier's method of operation hazardous to the public or policyholders, after notice and opportunity for 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, the Commissioner may nonrenew or revoke the LAD servicing carrier's Certificate of Registration.

(g) The requirements set forth in (b) through (f) above shall apply to any LAD servicing carrier which, either directly or through one or more affiliates, has been delegated the authority to perform all of the functions related to both policy administration and claims administration on behalf of the insurer. The requirements set forth in (b) through (f) above shall not apply to any LAD servicing carrier which has been delegated the authority to perform all or substantially all of the functions related to policy administration or claims administration, but not both. The Commissioner, may, however, require that a LAD servicing carrier comply with the requirements set forth in (b) through (f) above if it has been delegated the authority to perform all or substantially all of the functions related to one of the administration services (that is, policy or claims) and certain aspects of the other (for example, loss appraisal, policy coverage verification, or underwriting). The Commissioner shall make this determination based on consideration of the following:

1. The degree to which the LAD servicing carrier has been delegated the authority to perform the functions related to the relevant administrative service;

2. The degree to which the LAD servicing carrier may exercise independent judgment in the performance of its duties related to the authority delegated; and

3. The degree to which the exercise of independent judgment is constrained by requirements that the LAD servicing carrier adhere to specific guidelines of the insurer and by the general oversight by the insurer of the LAD servicing carrier's actions.

Amended by R.1994 d.210, effective May 2, 1994.
See: 25 N.J.R. 1327(b), 26 N.J.R. 1869(a).

11:3–3.4 Registration

(a) Persons, other than insurers licensed in this State, seeking to act as a LAD servicing carrier in this State shall make an application to the Commissioner for a certificate of Registration. The application shall be on a form approved by the Commissioner and include or be accompanied by the following information and documents:

1. All basic organizational documents of the applicant, including articles of incorporation, articles of association, partnership agreements, trade name certificate, trust agreement, shareholder agreement, other applicable documents, and all amendments to such documents;

2. The bylaws, rules, regulations or similar documents regulating the internal affairs of the applicant;

3. The names, addresses, official positions and professional qualifications of the individuals who are responsible for the conduct of affairs of the applicant; including the following:

i. All members of the board of directors, board of trustees, executive committee or other governing board or committee;

ii. The principal officers, in the case of a corporation, or the partners or members, in the case of a partnership or association;

iii. Shareholders holding directly or indirectly 10 percent or more of the voting securities of the applicant; and

iv. Any other person who exercises control or influence over the affairs of the applicant;

4. Annual financial statements or reports for the two years immediately preceding the date of application audited by a certified public accountant, and such other information as the Commissioner may request in order to review the current financial condition of the applicant;

5. A plan of operation, including information on staffing levels and activities proposed for handling business in this State. The plan shall provide details setting forth the applicant's capability for providing a sufficient number of experienced and qualified personnel in various areas including, but not limited to, claims processing, recordkeeping, accounting, underwriting, customer service and producer relations;

6. A copy of the proposed contracts between the LAD servicing carrier and the insurer;

i. The applicant shall highlight or otherwise indicate on the contract the provisions of the contract that satisfy the specific requirements set forth in N.J.A.C. 11:3–3.5(a), and provide a separate summary that references each requirement in N.J.A.C. 11:3–3.5(a)1 through 15 to the appropriate provision in the contract;

7. The application fee set forth in N.J.A.C. 11:1–32.4(b)12;

8. If required to retain risk pursuant to N.J.A.C. 11:3–3.3, a statement certified by an officer of the applicant that:

i. The applicant has filed, or intends to file within 180 days of the date of its application for a Certificate of Registration, an application for authorization or admission to transact private passenger automobile insurance in this State pursuant to N.J.S.A. 17:17–1 et seq. and N.J.A.C. 11:1–28, or N.J.S.A. 17:32–1 et seq. and N.J.A.C. 11:1–10, as applicable; or that the applicant otherwise will satisfy the requirement that it retain a portion of the risk of the insurer as set forth in N.J.A.C. 11:3–3.3(c) by retaining the risk through an affiliate licensed to transact private passenger automobile insurance in this State;

ii. The applicant is familiar with the requirements to become licensed to transact private passenger automobile insurance in this State pursuant to N.J.A.C. 11:1–28 or 11:1–10, as applicable; and

iii. The applicant will possess and maintain the minimum required capital and surplus to become licensed to transact private passenger automobile insurance in this State and that the applicant or affiliate, as applicable, will maintain adequate capital and surplus to have the capacity to retain the minimum amounts of risk from all insurers on whose behalf the LAD servicing carrier intends to act; and

9. Such other information as the Commissioner may request.

(b) An insurer licensed in this State which seeks to obtain a Certificate of Registration shall submit, in lieu of all of the requirements in (a) above, a plan of operation which contains the information set forth in (a)5 above, a copy of the proposed contract as set forth in (a)6 above, the certification set forth in (a)8iii above, if required to retain risk pursuant to N.J.A.C. 11:3–3.3 and the application fee as set forth in (a)7 above.

(c) Upon a finding that the applicant has satisfied all of the requirements set forth in (a) or (b) above, that it is or will be in a position to retain risk as required under N.J.A.C. 11:3–3.3(b) or (c), as applicable, and that its proposed methods of operation are not such as would render its operation hazardous to the public or policyholders, the Commissioner shall issue a Certificate of Registration to the applicant which shall authorize the applicant to act as a LAD servicing carrier in this State. The Commissioner may refuse to issue a Certificate of Registration if he or she determines that the applicant, or any individual responsible for the conduct of affairs of the applicant, is not competent, trustworthy, financially sound or of good personal and business reputation, or in the case of an insurer, has had an insurance license denied or revoked for cause by any state.

(d) A Certificate of Registration issued pursuant to (c) above shall remain in effect from the date of issuance until June 30 immediately following, and shall be renewed each year prior to June 30, unless surrendered, suspended or revoked by the Commissioner, for so long as the LAD servicing carrier continues in business in this State and remains in compliance with this subchapter and any other applicable laws.

(e) A LAD servicing carrier seeking to renew its certificate shall submit the following information to the Department by June 1 of the year of the expiration of the certificate:

1. A financial statement for the year immediately preceding the date of expiration of the certificate;

2. Any other information that is substantially different from the information provided in the original application or from information provided in the last renewal period; and

3. The renewal fee set forth in N.J.A.C. 11:1–32.4(b)12.

(f) A LAD servicing carrier shall immediately notify the Commissioner of any material change in its ownership, control, plan of operation, contract with the insurer or other fact or circumstance affecting its qualification for a Certificate of Registration in this State.

(g) The Commissioner shall require a LAD servicing carrier to submit a bond or deposit in an amount not less than $250,000, in a form acceptable to the Commissioner.

(h) The Commissioner may require the LAD servicing carrier to maintain an errors and omissions policy in a form and amount acceptable to the Commissioner.

Recodified from 11:3–3.3 and amended by R.1994 d.210, effective May 2, 1994.
See: 25 N.J.R. 1327(b), 26 N.J.R. 1869(a).

11:3–3.5 LAD servicing carriers; contract provisions

(a) No entity shall act as a LAD servicing carrier on behalf of an insurer unless there is in force a written contract between the parties which sets forth the responsibilities of each party, and where both parties share responsibility for a particular function, specifies the division of such responsibilities, and which contains the following minimum provisions:

1. All insurance charges or premiums collected by a LAD servicing carrier on behalf of an insurer or insurers, and the return of premiums received from that insurer or insurers, shall be immediately remitted to the person or persons entitled to them, or shall be deposited promptly in a fiduciary account established and maintained by the LAD servicing carrier in a Federally or state insured financial institution for each insurer with whom it has contracted. The written contract between the LAD servicing carrier and the insurer shall also provide for the LAD servicing carrier to render, at least quarterly, an accounting to the insurer detailing all transactions performed by the LAD servicing carrier pertaining to the business underwritten by the insurer;

2. If insurance charges or premiums are deposited in fiduciary accounts on behalf of or for one or more insurers, the LAD servicing carrier shall keep records clearly recording the deposits in, and withdrawals from, the separate account for each insurer. The LAD servicing carrier shall keep copies of all the records and, upon request of an insurer, shall furnish the insurer with copies of the records pertaining to such deposits and withdrawals;

3. The LAD servicing carrier shall not pay any claim by withdrawal from a fiduciary account in which premiums or insurance charges are deposited. Withdrawals from such account shall be made as provided in the contract between the LAD servicing carrier and the insurer. With respect to withdrawals from the fiduciary account, the contract shall address, but not be limited to, the following:

i. Remittance to the insurer for whom the fiduciary account is maintained;

ii. Deposit in an account maintained in the name of the insurer;

iii. Transfer to and deposit in a claims-paying account, with claims to be paid as provided in (a)4 below;

iv. Payment to the LAD servicing carrier of its commissions, fees or charges; and

v. Remittance of return premium to the person or persons entitled to such return premium;

4. All claims paid by the LAD servicing carrier from funds collected on behalf of or for an insurer shall be paid only on drafts or checks of the insurer and as authorized by the insurer;

5. If the contract provides for contingency-based compensation of the LAD servicing carrier (for example, contingent upon savings effected in adjustment, settlement and payment of losses, or upon premiums or charges collected or number of claims paid or processed), the contract shall so specify. The Commissioner may disapprove the contract based on such provision if he or she believes that such method of compensation may render the insurer's and/or LAD servicing carrier's methods of operation hazardous to the public or its policyholders. The Commissioner may, in lieu of disapproving the contract, condition approval upon modification of the compensation provision made as he or she shall deem necessary;

6. The LAD servicing carrier shall maintain and make available to the insurer complete books and records of all transactions performed on behalf of the insurer. The books and records shall be maintained in accordance with prudent standards of insurance recordkeeping and shall be maintained for a period of not less than the longer of either:

i. Five years from the date of their creation; or

ii. Until the filing of the next financial condition examination by the insurer's state of domicile;

7. The Commissioner shall have access to books and records maintained by a LAD servicing carrier for the purposes of examination, audit and inspection. Any trade secrets contained in such books and records, including the identity and addresses of policyholders and certificateholders, shall be kept confidential, except that the Commissioner may use such information in any proceeding instituted by him or her against the LAD servicing carrier;

8. The insurer shall own the records generated by the LAD servicing carrier pertaining to the business of the insurer. The LAD servicing carrier shall nevertheless retain the right to continuing access to books and records to permit the LAD servicing carrier to fulfill all of its contractual obligations to insured parties, claimants, and the insurer;

9. In the event the insurer and the LAD servicing carrier cancel their agreement, notwithstanding the provisions of (a)7 above, the LAD servicing carrier may, by written agreement with the insurer, transfer all records to a new LAD servicing carrier rather than retain them for the time period set in (a)6i and ii above. In such cases, the new LAD servicing carrier shall acknowledge, in writing, that it is responsible for retaining the records of the prior LAD servicing carrier as required by (a)6 above;

10. The contract may not be assigned in whole or part by the LAD servicing carrier;

11. The insurer shall provide and make available to the LAD servicing carrier the current rates, rules, policy forms and underwriting guidelines of the insurer to be used by the LAD servicing carrier;

12. If the contract permits the LAD servicing carrier to settle claims on behalf of the insurer, the LAD servicing carrier shall comply with N.J.S.A. 17:29B–4(9), and any administrative rules promulgated by the Commissioner thereunder. In addition:

i. All claims shall be reported to the insurer in a timely manner; and

ii. A copy of the claim file shall be sent to the insurer at its request or as soon as it becomes known that the claim has the potential to exceed, or exceeds the limit set forth in the contract;

13. Where electronic claims files are in existence, the contract shall address the timely transmission of the data;

14. If the contract provides for a sharing of interim profits by the LAD servicing carrier, the contract shall specify the manner and the LAD servicing carrier's authority with respect to the determination of interim profits. The Commissioner may disapprove the contract based on such provision if he or she believes that such method of compensation may render the insurer's and/or LAD servicing carrier's methods of operation hazardous to the public or its policyholders. The Commissioner may, in lieu of disapproving the contract, condition approval upon modifications made as he or she deems necessary; and

15. The LAD servicing carrier shall not, without the prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net or reinsurance, which amount shall not exceed one percent of the insurer's policyholder's surplus as of December 31 of the last completed calendar year.

Recodified from 11:3–3.4 and amended by R.1994 d.210, effective May 2, 1994.
See: 25 N.J.R. 1327(b), 26 N.J.R. 1869(a).

11:3–3.6 Requirements for insurers appointing LAD servicing carriers

(a) The LAD servicing carrier shall retain on file an annual independent financial audit of a certified public accountant, directed and paid for either individually or jointly by all insurers with which it does business, in a form acceptable to the Commissioner.

(b) The insurer shall, at least semi-annually, conduct an on-site procedural review of the underwriting, financial and claims processing operations (including the establishment of any case basis reserves), of the LAD servicing carrier.

(c) If a LAD servicing carrier establishes loss reserves for an insurer, the insurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the LAD servicing carrier. Such loss reserve opinion shall be in the format of and otherwise satisfy all requirements of N.J.A.C. 11:1–21.

(d) Within 30 days of executing or terminating a contract with a LAD servicing carrier, the insurer shall provide written notification of such appointment or termination to the Commissioner. In the case of the appointment of a LAD servicing carrier, the insurer shall provide with such notification a copy of the contract, and shall provide a statement describing any differences between the contract entered into and the proposed contract submitted pursuant to N.J.A.C. 11:3–3.4. The appointment of the LAD servicing carrier shall take effect 60 days after written notification thereof is filed with the Department, unless disapproved by the Commissioner prior to that date. In the case of the termination of the appointment of a LAD servicing carrier, or the nonrenewal or revocation of the LAD servicing carrier's Certificate of Registration by the Commissioner, the insurer shall provide a statement that sets forth the manner and methods by which it intends to service the business and perform the duties delegated to the LAD servicing carrier. Any agreement to terminate shall take effect 90 days after the date of the execution of the agreement.

(e) The acts of the LAD servicing carrier shall be considered the acts of the insurer on whose behalf it is acting. The Commissioner may examine a LAD servicing carrier as if it were the insurer. Pursuant to N.J.S.A. 17:23–4, expenses of examinations shall be borne by the insurer or insurers on whose behalf the LAD servicing carrier is acting.

Recodified from 11:3–3.5 and amended by R.1994 d.210, effective May 2, 1994.
See: 25 N.J.R. 1327(b), 26 N.J.R. 1869(a).

11:3–3.7 Application of rules to persons currently acting as LAD servicing carriers and insurers utilizing LAD servicing carriers

(a) Any person acting as a LAD servicing carrier and any insurer utilizing the services of a LAD servicing carrier prior to the effective date of this subchapter, as amended shall, within 30 days after the effective date of this subchapter, as amended:

1. Notify the Department in writing of the existence of such relationship; and

2. Certify that it intends to comply with the requirements of this subchapter by within 120 days.

(b) Any person acting as a LAD servicing carrier prior to the effective date of this subchapter, as amended may continue to act in such capacity provided the person satisfies the requirements set forth in (a) above.

Recodified from 11:3–3.6 and amended by R.1994 d.210, effective May 2, 1994.
See: 25 N.J.R. 1327(b), 26 N.J.R. 1869(a).

11:3–3.8 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of penalties as authorized by law.

Recodified from 11:3–3.7 and amended by R.1994 d.210, effective May 2, 1994.
See: 25 N.J.R. 1327(b), 26 N.J.R. 1869(a).

SUBCHAPTERS 4 THROUGH 5. (RESERVED)

SUBCHAPTER 6. INSURANCE IDENTIFICATION CARD

11:3–6.1 Scope

In order to properly implement and administer the compulsory insurance law of New Jersey, all insurance companies are required to issue an insurance identification card to all named insureds.

As amended, R.1983 d.648, effective January 17, 1984.
See: 15 N.J.R. 1919(a), 16 N.J.R. 145(c).
Reference to dates deleted.

Case Notes

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

11:3–6.2 Permanent identification card (form IV–1)

(a) Permanent Insurance identification cards shall be issued in accordance with the specifications contained in either (b) or (c) below.

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

1. The size shall be approximately 3½ inches by 5 inches (tolerance of ⅛ inch permitted).

2. The weight shall be 24 pounds white ledger paper stock (minimum).

3. The color shall be white stock, black print.

4. The front of card shall include the following:

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

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

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

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

v. Effective date and expiration date: Month, day and year must be shown;

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

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

viii. Red or blue ink is to be used in printing of one or more of the following areas:

(1) Company name; or

(2) Authorized signature; or

(3) Company logo (if logo is used);

ix. The insurance company code will be printed immediately preceding the insurance company name. This code will be the same code presently used to identify companies licensed to do business in New York;

x. The name and address of the office of agency issuing the identification cards must be shown. The cards must contain a signature of an agent or other authorized representative of the named company (facsimile signatures are acceptable);

xi. Assignment of form number IV2A(1/73), to be shown in the upper left corner;

xii. Inclusion of an unlabeled block directly above the title to be used by the motor vehicle examiner for insertion of license plate number for insurance verification.

(c) Insurers may, as an alternative to (b) above utilize the design and format copyrighted by the ACORD 50 (1–83) insurance identification card.

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

As amended, R.1973 d.140, eff. May 31, 1973.
See: 5 N.J.R. 150(a), 5 N.J.R. 229(b).
As amended, R.1973 d.247, eff. August 31, 1973.
See: 5 N.J.R. 350(b).
As amended, R.1983 d.648, eff. January 17, 1984.
See: 15 N.J.R. 1919(a), 16 N.J.R. 145(c).
Further specifications for ID cards added and alternative type of card introduced.
Amended by R.1991 d.45, effective February 4, 1991.
See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).
In (d): deleted NJAFIUA reference and added text referring to "residual market mechanism authorized by statute."

Case Notes

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

11:3–6.3 Temporary identification card (form IV–2)

(a) The specifications for temporary insurance identification cards are set forth below:

1. The size shall be the same as the permanent identification card;

2. The weight shall be 24 pound white stock (minimum);

3. The color shall be the same as the permanent identification card;

4. Number of copies: Original and one duplicate;

5. The content of the temporary card shall be the same as the permanent identification card except as noted below:

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

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

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

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

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

11:3–6.4 General provisions

(a) The order of the information to be contained on the identification cards may be rearranged in order to accommodate fixed printout systems already established by a company. No drastic changes shall be made without obtaining approval of the New Jersey Division of Motor Vehicles.

(b) Additional information may be printed on the reverse side of the identification cards, provided the additional information is appropriately captioned, and does not interfere or detract from the information required as per the attached samples.

(c) One permanent identification shall be issued for each vehicle insured under the policy. The temporary identification card shall be issued in duplicate. The insured will be required to surrender one copy of the temporary identification card at time of vehicle inspection. This copy will be used in insurance verification procedures. Replacement identification card or cards will be issued at the request of insured in the event of loss of same.

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

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

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

(g) New Jersey law authorizes the Director of Motor Vehicles, after consultations with the Commissioner of Insurance, to promulgate rules concerning notice by insurers of termination of insurance. All terminations of insurance shall be forwarded to the Director of Motor Vehicles pursuant to N.J.S.A. 39:3–4.

As amended, R.1973 d.35, effective January 26, 1973.
See: 5 N.J.R. 20(b).
As amended, R.1983 d.648, effective January 17, 1984.
See: 15 N.J.R. 1919(a), 16 N.J.R. 145(c).
Dated material at (e) deleted.

11:3–6.5 Commercial motor vehicles; exemption

Commercial motor vehicles regulated by the Interstate Commerce Commission or the New Jersey Department of Public Utility Commissioners shall be exempted from this regulation.

NOTE: To require an I.C.C. or P.U.C. carrier to carry such an identification card would be an unnecessary duplication. The insurance and filing requirements of the I.C.C. and the P.U.C. present a comparable safeguard to that sought by the newly required identification insurance cards.

R.1973 d.3, effective January 3, 1973.
See: 4 N.J.R. 307(a), 5 N.J.R. 47(d).

SUBCHAPTER 7. AUTOMOBILE REPARATION REFORM ACT

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(e), 39:6A–1 et seq., and 39:6A–10.

Source and Effective Date

R.1987 d.140, effective March 16, 1987.
See: 19 N.J.R. 44(a), 19 N.J.R. 453(a).

Subchapter Historical Note

All provisions to this subchapter were filed and became effective December 4, 1972 as R.1972 d.244. See: 4 N.J.R. 270(a), 5 N.J.R. 13(c). Section 5 became effective August 17, 1979 as R.1979 d.155. See: 11 N.J.R. 142(a), 11 N.J.R. 250(a). Amendments to sections 2 and 4 became effective August 16, 1982 as R.1982 d.246. See: 14 N.J.R. 543(b), 14 N.J.R. 917(d). This subchapter 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. Pursuant to Executive Order 66(1978), subchapter 7 was readopted effective February 13, 1985 with amendments effective March 18, 1985. See: 17 N.J.R. 43(a), 17 N.J.R. 707(b). Sections 1 through 4 were repealed, section 5 was recodified to section 6 and new rules were adopted for sections 1 through 5 effective March 16, 1987 as R.1987 d.140. See: 19 N.J.R. 44(a), 19 N.J.R. 453(a). See chapter and section levels for further amendments.

11:3–7.1 Purpose

This subchapter implements certain provisions of the Automobile Reparation Reform Act, N.J.S.A. 39:6A–1 et seq., including the Commissioner's authority to establish the amounts and terms of additional personal injury protection benefits which must be provided in policies covering automobiles as defined in N.J.S.A. 39:6A–2.

Case Notes

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

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

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

(a) In addition to the basic personal injury protection benefits which insurers must provide pursuant to N.J.S.A. 39:6A–4, insurers shall make available to the named insured, and, at his or her option, to any resident relatives in the named insured's household additional income continuation benefits, essential services benefits, death benefits and funeral expense benefits pursuant to N.J.S.A. 39:6A–10 and this subchapter.

(b) The additional benefit indicated in each option that an insurer may offer for income continuation benefits and essential services benefits represents the aggregate of the basic and additional personal injury protection benefits.

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

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

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

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

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

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

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

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

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

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

Amended by R.1990 d.580, effective November 19, 1990 (operative January 1, 1991).
See: 22 N.J.R. 1681(a), 22 N.J.R. 3488(b).
New (h) added enabling insurers to make available additional first party medical expense benefit coverage in excess of $250,000 as per P.L. 1990 c.8.

Case Notes

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

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

11:3–7.3 Personal injury protection policy forms or endorsements

(a) All policy forms or endorsements that provide personal injury protection benefits required by N.J.S.A. 39:6A–4 shall specify that such benefits shall be afforded by the insurer of the injured person subject to any deductibles or exclusions elected by the policyholder pursuant to N.J.S.A. 39:6A–4.3. The required personal injury protection benefits are set forth below:

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

(b) Each policy form or endorsement covering an automobile as defined at N.J.S.A. 39:6A–2 shall include excess medical payments coverage, corresponding to Section II, Extended Medical Expense Benefits Coverage of the personal automobile policy. Insurers must include a minimum coverage of $1,000 and may offer coverage of $10,000.

(c) Each policy form or endorsement providing additional personal injury protection benefits shall specify that, pursuant to N.J.S.A. 39:6A–10, as amended by P.L. 1985, c.520, section 16, additional death benefits under the policy shall be payable without regard to the period of time elapsing between the date of the accident and the date of death provided death occurs within two years of the accident and results from bodily injury from that accident.

Law Review and Journal Commentaries

Auto Insurance—PIP. Steven P. Bann, 138 N.J.L.J. No. 16, 49 (1994).

Case Notes

Extended medical-expense benefits coverage; not included within antistacking provision. Ingersoll v. Aetna Cas. and Sur. Co., 138 N.J. 236, 649 A.2d 1269 (1994).

Absence of income continuation benefits covering either named insured and/or household relatives did not require reformation of policy. Olivero by Olivero v. New Jersey Mfrs. Ins. Co., 227 N.J.Super. 367, 547 A.2d 710 (A.D.1988), certification denied 115 N.J. 76, 556 A.2d 1219.

Insurer of automobile in which injured party was riding had to reimburse injured party's insurer on pro rata basis for PIP benefits paid. Colonial Penn Ins. Co. v. Allstate Ins. Co., 214 N.J.Super. 453, 519 A.2d 935 (App.Div.1986).

Driver who was neither a relative nor resident of named insured's household, held not entitled to coverage. Kuzan v. Prudential Property & Casualty Insurance Co., 195 N.J.Super. 553, 480 A.2d 960 (Law Div.1984).

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

Insurer of car owned by insured's wife held entitled to contribution from insurer of car leased by insured in which insured was injured in a one-car accident. Federal Insurance Co. v. Liberty Mutual Insurance Co., 190 N.J.Super. 605, 464 A.2d 1197 (App.Div.1983).

Minor passenger on moped which collided with automobile held not a "pedestrian" and, therefore, not entitled to medical benefits under automobile's personal injury protection coverage. McKenna v. Wiskowski, 181 N.J.Super. 482, 438 A.2d 355 (Ch.Div.1981).

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

Insurer's declaratory judgment action held not barred by pendency of New York action between parties. Lumbermens Mutual Casualty Co. v. Carriere, 163 N.J.Super. 7, 394 A.2d 132 (App.Div.1978) on remand 170 N.J.Super. 437, 406 A.2d 994.

11:3–7.4 Minimum schedule of additional personal injury protection coverage benefits

(a) Every rate filer's schedule of rates for additional personal injury protection benefits, other than medical expense benefits, shall provide at least the benefit schedules set forth in Table 1 in (b) below.

(b) The additional personal injury protection coverage table follows:

Table 1

Option	Income Weekly	Income Total	Essential Services Per Day	Essential Services Total	Death	Funeral Expense
1	$100	$10,400	$12	$ 8,760	$10,000	$2,000
2	125	13,000	20	14,600	10,000	2,000
3	175	18,200	20	14,600	10,000	2,000
4	250	26,000	20	14,600	10,000	2,000
5	400	41,600	20	14,600	10,000	2,000
6	500	52,000	20	14,600	10,000	2,000
7	600	62,400	20	14,600	10,000	2,000
8	700	72,800	20	14,600	10,000	2,000
9	100	unlimited	12	8,760	10,000	2,000
10	125	unlimited	20	14,600	10,000	2,000
11	175	unlimited	20	14,600	10,000	2,000
12	250	unlimited	20	14,600	10,000	2,000
13	400	unlimited	20	14,600	10,000	2,000
14	500	unlimited	20	14,600	10,000	2,000
15	600	unlimited	20	14,600	10,000	2,000
16	700	unlimited	20	14,600	10,000	2,000

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).
Changes required by "The Fair Automobile Insurance Reform Act of 1990", P.L. 1990 c.8.

Case Notes

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

Absence of income continuation benefits covering either named insured and/or household relatives did not require reformation of policy. Olivero by Olivero v. New Jersey Mfrs. Ins. Co., 227 N.J.Super. 367, 547 A.2d 710 (A.D.1988), certification denied 115 N.J. 76, 556 A.2d 1219.

Additional coverage held provided for all persons for whom basic coverage was provided (citing former N.J.A.C. 11:3–7.7). Clendaniel v. New Jersey Manufacturers Insurance Co., 190 N.J.Super. 286, 463 A.2d 369 (App.Div.1983), affirmed in part, reversed in part 96 N.J. 361, 476 A.2d 263 (1984).

Surviving spouse held entitled to lump sum payment of survivor benefits; doubling of benefits due to payment of two premiums for additional protection denied. Riccio v. New Jersey Manufacturers Insurance Co., 179 N.J.Super. 65, 430 A.2d 641 (App.Div.1981).

Insured held entitled to policy reformation due to statutory deficiency of insurer's letter notifying insured of optional coverage selection. Lumbermens Mutual Casualty Co. v. Carriere, 170 N.J.Super. 437, 406 A.2d 994 (Law Div.1979).

11:3–7.5 Notice requirements

(a) Additional personal injury protection benefits that are required to be offered by an insurer shall be offered by the insurer at least annually as part of the Coverage Selection Form required pursuant to N.J.S.A. 39:6A–23 and N.J.A.C. 11:3–15.

1. The buyer's guide and coverage selection form specified at N.J.S.A. 39:6A–23 and any rules promulgated thereunder shall meet the requirements of (a) above.

(b) Insurers shall provide written notice advising policyholders of the change effected by the enactment of P.L. 1985, c.520, section 16 in all applications for an automobile insurance policy and notices of renewal of an automobile insurance policy that are issued on or after the effective date of this subchapter.

1. The buyer's guide specified at N.J.S.A. 39:6A–23 and any rules promulgated thereunder shall meet the requirements of (b) above.

(c) Each insurer shall distribute copies of this subchapter to every person responsible for the handling and settlement of claims subject to this subchapter. Every insurer shall satisfy itself that all such responsible persons are thoroughly conversant with and are complying with this subchapter.

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).
Changes required by "The Fair Automobile Insurance Reform Act of 1990", P.L. 1990 c.8.

Case Notes

Genuine issue of material fact existed as to whether seller of policy was insurer's agent. Lilly v. Allstate Ins. Co., 218 N.J.Super. 313, 527 A.2d 903 (App.Div.1987).

Insured held entitled to policy reformation to due to statutory deficiency of insurer's letter notifying insured of optional coverage selection. Lumbermens Mutual Casualty Co. v. Carriere, 170 N.J.Super. 437, 406 A.2d 994 (Law Div.1979).

11:3–7.6 Cancellation of automobile coverage for nonpayment of premium

(a) This rule applies to all automobile policies delivered or issued for delivery in this State, insuring a single individual or husband and wife resident of the same household, as named insured, and under which the insured vehicles therein designated are of the following types only:

1. A motor vehicle of the private passenger or station wagon type that is not used as a public or livery conveyance for passengers, not rented to others; or

2. Any other four-wheel motor vehicle with a load capacity of 1,500 pounds or less which is not customarily used in the occupation, profession or business of insured, other than farming or ranching, provided, however, that this rule shall not apply to any policy insuring more than four automobiles, or to any policy covering garage, automobile sales agency, repair shop, service station or public parking place operation hazards.

(b) The effective date of the cancellation of a policy for nonpayment of premium shall not be earlier than 10 days prior to the last full day of which premium received by the company prior to the date of preparation of the cancellation notice, would pay for coverage on a pro rata basis. In calculating the effective date of the cancellation as provided in this section, the premium applicable to the coverage provided by the policy and the premium received by the company at or prior to the time cancellation notice was prepared shall be the premium used for the calculation and determination of such effective date.

(c) Cancellation for nonpayment of premium does not include cancellation at the request of a premium finance company or of a producer of record under N.J.A.C. 11:1–3.1.

(d) No cancellation notice shall be mailed prior to 30 days in advance of its effective date.

(e) The rule shall not apply to deposits accompanying New Jersey Automobile Insurance Plan applications which are insufficient under Plan rules or those of any succeeding residual market availability plan.

Case Notes

Cancellation notice of automobile policy for nonpayment was ineffective to cancel policy. Christian v. Ormsby, 267 N.J.Super. 237, 631 A.2d 158 (L.1992).

Genuine issue of material fact existed as to whether seller of policy was insurer's agent, precluding summary judgement on issue of coverage. Lilly v. Allstate Ins. Co., 218 N.J.Super. 313, 527 A.2d 903 (App.Div.1987).

Pedestrian held entitled to benefits under No–Fault Law when struck first by a commercial vehicle and then by a private automobile. Berg v. The Ohio Casualty Insurance Companies, 166 N.J.Super. 239, 399 A.2d 675 (Law Div.1979).

SUBCHAPTER 8. NONRENEWAL OF AUTOMOBILE INSURANCE POLICIES

11:3–8.1 Scope

This subchapter applies to all automobiles as defined in N.J.S.A. 39:6A–2a, excluding those owned by business entities or insured through any statutorily mandated residual market mechanism, and to all policies or contracts of insurance insuring such automobiles.

New Rule, R.1983 d.190, effective June 6, 1983.
See: 15 N.J.R. 231(a), 15 N.J.R. 927(a).
Section was "General provisions".
Amended by R.1986 d.418, effective October 6, 1986.
See: 18 N.J.R. 1079(a), 18 N.J.R. 2039(b).

Case Notes

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

The extension of N.J.A.C. 11:3–8.1, establishing procedures for the nonrenewal of "No–Fault" coverages to include physical damage coverages is a valid and enforceable exercise of the commissioner's rule making power. Atty.Gen.F.O.1982, No. 8.

11:3–8.2 Definitions

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

"Automobile insurance eligibility points" or "eligibility points" means points calculated under the schedule set forth in N.J.A.C. 11:3–34.

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

"Department" means the New Jersey Department of Insurance.

"Eligible person" means an individual that meets the qualifications set forth in N.J.A.C. 11:3–34.

"Insurer" includes a group of affiliated companies.

"Renew" means to issue and deliver at the end of the policy period a policy superseding a policy previously issued and delivered, or to issue and deliver a certificate or notice extending the term of a policy beyond its policy period or term, by the same individual insurance company, or by another of a group of affiliated companies pursuant to a standard/nonstandard rating plan filed and approved in accordance with N.J.A.C. 11:3–19.

"Standard/non-standard rating plan" means a rating system used by an insurer that provides different base rates for different risks to those insureds who qualify in accordance with the insurer's approved underwriting rules, which has been filed and approved in accordance with N.J.A.C. 11:3–19.

Emergency New Rule, R.1990 d.626, effective November 26, 1990, Operative April 1, 1991 (expired January 25, 1991).
See: 22 N.J.R. 3766(b).
Adopted Concurrent Proposal R.1991 d.89, effective January 25, 1991.
See: 22 N.J.R. 3766(b), 23 N.J.R. 507(a).
Provisions of emergency new rule, R.1990 d.626 readopted without change, operative April 1, 1991.

Case Notes

Where offer to renew insurance is conditioned upon timely premium payment, that fact should be clearly set forth. Cervone v. New Jersey Auto. Full Ins. Underwriting Ass'n, 239 N.J.Super. 25, 570 A.2d 999 (A.D.1990).

Renewal policy need not be issued until premium is paid. Lopez v. New Jersey Auto. Full Ins. Underwriting Ass'n, 239 N.J.Super. 13, 570 A.2d 994 (A.D.1990), certification denied 122 N.J. 131, 584 A.2d 206.

Notices of nonrenewal must be sent in strict compliance with statutory provisions. Lopez v. New Jersey Auto. Full Ins. Underwriting Ass'n, 239 N.J.Super. 13, 570 A.2d 994 (A.D.1990), certification denied 122 N.J. 131, 584 A.2d 206.

Insurer held liable for fire loss where it failed to give notice of policy expiration. Barbara Corp. v. Bob Maneely Insurance Agency, 197 N.J.Super. 339, 484 A.2d 1292 (App.Div.1984) (dissenting opinion).

Provision that no insurer shall refuse to renew coverage without consent of the Commissioner upheld against constitutional challenges. Sheeran v. Nationwide Mutual Insurance Co., Inc., 80 N.J. 548, 404 A.2d 625 (1979).

Insurance company cancelling agencies was required to give insureds renewal options indefinitely unless like coverage was available in the market. Sheeran v. Nationwide Mutual Insurance Co., Inc., 159 N.J.Super. 417, 388 A.2d 272 (Ch.Div.1978), affirmed per curiam 163 N.J.Super. 40, 394 A.2d 149 (App.Div.1978), modified and affirmed 80 N.J. 548, 404 A.2d 625 (1979).

11:3–8.3 General provisions

(a) Every insurer shall make an offer to the insured named in a policy subject to this subchapter to renew such policy upon its expiration date, unless a valid notice of nonrenewal or conditioned renewal as specified in (h) below has been sent by the insurer to the insured in accordance with this subchapter.

(b) Each renewal offer shall be in the usual form of either a renewal policy, a certificate, or a renewal bill. With respect to payment of the renewal premium, notice shall be given not more than 45 days or less than 30 days prior to the due date of the premium and shall clearly state the effect on nonpayment of the premium by the due date.

(c) Subject to changes approved by the Commissioner that had become effective prior to the expiration of the current policy, each renewal shall offer coverage, limits and terms at least as favorable to the insured as the expiring policy, including but not limited to:

1. Schedule of premium payments, if any; and
2. Duration of policy term;

i. Whenever an insurer, pursuant to changes approved by the Commissioner, alters the duration of the insured's policy term, the insurer shall permit the insured to revert to the prior duration of policy term upon request.

ii. The renewal offer shall include or be accompanied by a statement advising the insured of his or her right to revert to the prior duration of policy term.

(d) Payment by the insured in accordance with the terms stated in the billing notice or in accordance with terms agreed to with the company or producer shall constitute acceptance of the renewal offer by the insured.

(e) The requirements of (b) above shall not preclude the insurer from offering physical damage coverage with a higher deductible than that in the expiring policy, provided the insured is informed that a lower deductible is available at an appropriate rate.

(f) No notice of nonrenewal shall be valid unless it is mailed or delivered by the insurer to the insured no less than 60 days and no more than 90 days prior to the expiration of the current policy, setting forth the reason(s) for such nonrenewal.

1. No notice of nonrenewal shall be valid unless it includes the designated provision(s) of this subchapter under which action is being taken and the correct facts which bring the insured under the provision(s), including dates and any other facts necessary for identification of the incidents.

i. In the event action is being taken under N.J.A.C. 11:3–8.4(a) (ineligible person), the notice shall provide the basis by which the insured fails to qualify as an eligible person. When notice of nonrenewals is based on automobile insurance eligibility points, the notice shall identify the number of eligibility points and the events and sources which resulted in their assessment.

ii. In the event action is being taken under N.J.A.C. 11:3–8.4(b) (underwriting rules) to nonrenew an insured who is not an eligible person in accordance with the approved underwriting rules applicable to the nonstandard rate level of an approved standard/non-standard rating plan, the notice shall provide the basis by which the insured fails to qualify as an eligible person and shall reference the specific underwriting rule by which the insured is disqualified. The notice shall set forth the specific facts upon which the insurer relied to determine that the insured is not an eligible person and is no longer qualified to be insured in accordance with the insurer's approved underwriting rules.

iii. In the event action is being taken under N.J.A.C. 11:3–8.5(a)1, the notice shall specify that the action is being taken in accordance with N.J.A.C. 11:3–8.5(a)1 (two percent territorial nonrenewal) and shall be consecutively numbered in each territory.

iv. In the event action is being taken under N.J.A.C. 11:3–8.5(a)2, the notice shall specify that the action is being taken in accordance with N.J.A.C. 11:3–8.5(a)2 (one nonrenewal for each two newly insured automobiles) and shall be consecutively numbered in each territory.

2. Each notice of nonrenewal shall include or be accompanied by the statement prescribed in (f)2i below which shall be clearly and prominently set out in boldface type or other manner which draws the reader's attention.

i. Each notice of nonrenewal must set forth: "If you have reason to believe that our decision to nonrenew your policy is not in compliance with New Jersey Regulation N.J.A.C. 11:3–8, you should file a written complaint with the New Jersey Department of Insurance, Division of Enforcement and Consumer Protection, CN 329, Trenton, New Jersey 08625–0329. Your written complaint should indicate the facts on which you are basing your complaint."

(g) Nothing in this subchapter shall be construed as prohibiting a renewal policy from being issued for higher limits of coverage and/or additional coverage(s), provided that such additional protection is specifically requested by the insured and the insurer is willing to provide it. Conversely, nothing shall prohibit the renewal policy from being issued for lower limits of coverage and/or fewer coverages

provided that such reduction in protection is specifically requested by the insured and further provided that coverage in no case shall fall below the level or levels otherwise required by law.

(h) In any instance in which an insurer may, pursuant to the provisions of this subchapter, nonrenew an automobile policy, it may, in lieu of the nonrenewal and in compliance with such provisions, condition the renewal of the policy upon a change of limits or elimination of any coverage not required by law.

(i) No notice of nonrenewal for any coverage subject to this subchapter shall be valid unless it is based upon one or more of the standards set forth in N.J.A.C. 11:3–8.3 or is otherwise authorized by the Commissioner of Insurance pursuant to N.J.A.C. 11:3–8.4.

Amended by R.1973 d.30, effective January 25, 1973.
See: 4 N.J.R. 305(b), 5 N.J.R. 48(a).
Amended by R.1976 d.328, effective October 18, 1976.
See: 8 N.J.R. 421(a), 8 N.J.R. 516(e).
Amended by R.1977 d.100, effective March 23, 1977.
See: 9 N.J.R. 178(b).
Amended by R.1977 d.437, effective January 1, 1978.
See: 9 N.J.R. 435(d), 9 N.J.R. 586(b).
Amended by R.1983 d.190, effective June 6, 1983.
See: 15 N.J.R. 231(a), 15 N.J.R. 927(a).
Recodified from 11:3–8.1. Replaced (d).
Amended by R.1986 d.418, effective October 6, 1986.
See: 18 N.J.R. 1079(a), 18 N.J.R. 2039(a).
Emergency Amendment, R.1990 d.626, effective November 26, 1990, operative April 1, 1991 (expired January 25, 1991).
See: 22 N.J.R. 3766(b).
Recodified from 11:3–8.2. In (f)1i, added notice of eligibility points and added ii-iv.
Adopted Concurrent Proposal, R.1991 d.89, effective January 25, 1991, operative April 1, 1991.
See: 22 N.J.R. 3766(b), 23 N.J.R. 507(a).
Provisions of emergency amendment R.1990 d.626 readopted without change.
Amended by R.1991 d.45, effective February 4, 1991.
See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).
In (f): revised address in (f)2i and deleted NJAFIUA reference in (f)3, adding text "... a residual market mechanism created by statute."

Case Notes

Renewal policy need not be issued until premium is paid. Lopez v. New Jersey Auto. Full Ins. Underwriting Ass'n, 239 N.J.Super. 13, 570 A.2d 994 (A.D.1990), certification denied 122 N.J. 131, 584 A.2d 206.

Notices of nonrenewal must be sent in strict compliance with statutory provisions. Lopez v. New Jersey Auto. Full Ins. Underwriting Ass'n, 239 N.J.Super. 13, 570 A.2d 994 (A.D.1990), certification denied 122 N.J. 131, 584 A.2d 206.

Insurance agent who continued to service insurer's policyholders subsequent to termination with insurance company, established prima facie case of quasi-contract. Cohen v. Home Ins. Co., 230 N.J.Super. 72, 552 A.2d 654 (A.D.1989).

Policy binder in effect for more than 60 days held to provide coverage in absence of formal notice of cancellation, despite lack of any premium payment and knowledge that insurer would not issue policy. Miney v. Baum, 170 N.J.Super. 282, 406 A.2d 234 (Law Div.1979).

Under assigned risk automobile insurance plan, 45 day notice sufficed for non-renewal expiration; broker held to have breached duty to insured in failing to advise him of ramifications of expiration. Commercial Union Assurance Companies v. State Farm Mutual Automobile Insurance Co., 158 N.J.Super. 326, 385 A.2d 1286 (Law Div.1978).

Provision that no insurer shall refuse to renew coverage without consent of the Commissioner upheld against constitutional challenges. Sheeran v. Nationwide Mutual Insurance Co., Inc., 80 N.J. 548, 404 A.2d 625 (1979).

Proof of mailing of notice of cancellation held to be conclusive proof of provision of such notice to insured. Weathers v. Hartford Insurance Group, 77 N.J. 228, 390 A.2d 548 (1978).

11:3–8.4 Standards of nonrenewal applicable to all automobile policies

(a) An insurer may issue a notice of nonrenewal to any person who is not an eligible person as defined in N.J.A.C. 11:3–34.

1. For the purpose of determining whether a person is an eligible person who must be renewed, an insurer shall consider those eligibility points accrued only in the 36–month period ending 90 days prior to the expiration of the current policy.

2. An insurer shall not issue a notice of nonrenewal for the reason that a member of the insurer's household is not an eligible person unless the member of the insured's household usually accounts for 10 percent or more of the use of the vehicle insured for the purpose of this section:

i. Any driver who is the principal driver of an automobile shall be presumed not to account for 10 percent or more of the use of any other automobile in the household.

ii. Except when there are more automobiles than drivers in the household, a person shall be presumed not to be the principal driver of more than one automobile.

3. No insurer shall issue a notice of nonrenewal to any person qualified to be renewed in accordance with the insurer's underwriting rules filed and approved pursuant to N.J.A.C. 11:3–35.

(b) An insurer which has filed a standard/non-standard rating plan pursuant to N.J.A.C. 11:3–19 may issue notices of intention not to renew any insured who is not an eligible person and who no longer qualifies for any rate level in accordance with its approved underwriting rules.

Amended by R.1983 d.190, effective June 6, 1983.
See: 15 N.J.R. 231(a), 15 N.J.R. 927(a).
Recodified from 11:3–8.1(e)–(g).
Amended by R.1986 d.418, effective October 6, 1986.
See: 18 N.J.R. 1079(a), 18 N.J.R. 2039(a).
Emergency Repeal and New Rule, R.1990 d.626, effective November 26, 1990, operative April 1, 1991 (expired January 25, 1991).
See: 22 N.J.R. 3766(b).
Recodified from 11:3–8.3.
Adopted Concurrent Proposal, R.1991 d.89, effective January 25, 1991, operative April 1, 1991.
See: 22 N.J.R. 3766(b), 23 N.J.R. 507(a).

Provisions of emergency repeal and new rule R.1990 d.626 readopted with changes.

11:3–8.5 Additional nonrenewals

(a) Any insurer may:

1. For each calendar year period, issue notices of intention not to renew an automobile insurance policy in the voluntary market in an amount not to exceed two percent of the total number of voluntary market automobile insurance policies of the insurer, rounded to the nearest whole number, which are in force at the end of the previous calendar year in each of the insurer's territories; and

2. For every two newly insured automobiles which an insurer voluntarily writes in each territory during each calendar year period, issue a notice of intention not to renew one additional automobile in that territory. For the purpose of this subsection, "voluntarily writes" shall not include any exposure voluntarily written by or assigned to an insurer to meet any quota established pursuant to N.J.S.A. 17:30E–14 and N.J.S.A. 17:33B–11 and shall not include any new business cancelled by the insurer pursuant to N.J.S.A. 17:29C–7.

(b) Any insurer that does not write its apportionment share of any quota established by the Commissioner pursuant to N.J.S.A. 17:30E–14 and N.J.S.A. 17:33B–11 within the applicable time shall be precluded from nonrenewing automobile insurance policies pursuant to (a) above during the following year.

(c) Nothing in this rule shall be construed to authorize insurers to act in contravention of any applicable State or Federal law prohibiting discrimination on impermissible bases.

New Rule, R.1986 d.418, effective October 6, 1986.
See: 18 N.J.R. 1079(a), 18 N.J.R. 2039(a).
Emergency Adopted Repeal and New Rule, R.1990 d.626, effective November 26, 1990, operative April 1, 1991 (expired January 25, 1991).
See: 22 N.J.R. 3766(b).
Recodified from 11:3–8.4.
Adopted Concurrent Proposal, R.1991 d.89, effective January 25, 1991, operative April 1, 1991.
See: 22 N.J.R. 3766(a), 23 N.J.R. 507(a).
Provisions of emergency repeal and new rule, R.1990 d.626 readopted without change.

11:3–8.6 Suspension of nonrenewals

Notwithstanding the provisions of this subchapter, if the plan for automobile insurance established pursuant to N.J.S.A. 17:29D–1 is not accepting new applications for coverage pursuant to N.J.S.A. 17:29D–1(d), no insurer transacting automobile insurance in this State shall refuse to renew any private passenger automobile insurance policy in this State.

Emergency New Rule, R.1990 d.626, effective November 26, 1990, operative April 1, 1991 (expired January 25, 1991).
See: 22 N.J.R. 3766(b).
Adopted Concurrent Proposal, R.1991 d.89, effective January 25, 1991, operative April 1, 1991.
See: 22 N.J.R. 3766(a), 23 N.J.R. 507(a).
Provisions of emergency new rule readopted without change.

11:3–8.7 Reporting requirements

(a) Insurance companies shall maintain records of nonrenewals for not less than five years which shall include a copy of the notice of nonrenewal, data concerning the allowable number of nonrenewals in each territory computed in accordance with N.J.A.C. 11:3–8.5(a)1, and data concerning the actual number of newly insured automobiles and nonrenewals in each territory for each category, computed in accordance with N.J.A.C. 11:3–8.5(a)2. Such records and data shall be made available to the Department upon request. In addition, each insurer shall file summary reports of its nonrenewals as follows:

1. For insurers with approved standard/non-standard rating plans, in the form of report set forth as Exhibit A of the Appendix incorporated herein by reference; or

2. For all other insurers, in the form of report set forth as Exhibit B of the Appendix, incorporated herein by reference.

(b) An insurer shall submit summary reports of their nonrenewals for the year to date on or before February 15 and August 15 of each year to the following address:

New Jersey Department of Insurance
Division of Enforcement and Consumer Protection
20 West State Street
CN–329
Trenton, New Jersey 08625–0329

New Rule, R.1986 d.418, effective October 6, 1986.
See: 18 N.J.R. 1079(a), 18 N.J.R. 2039(a).
Emergency Repeal and New Rule, R.1990 d.626, effective November 26, 1990, operative April 1, 1991 (expired January 25, 1991).
See: 22 N.J.R. 3766(b).
Recodified from 11:3–8.5.
Adopted Concurrent Proposal, R.1991 d.89, effective January 25, 1991, operative April 1, 1991.
See: 22 N.J.R. 3766(a), 23 N.J.R. 507(a).
Provisions of emergency repeal and new rule, R.1990 d.626 readopted without change.

11:3–8.8 Separability

If any provision of this subchapter or its application to any person or circumstances is held invalid, the remainder of this subchapter and its application to other persons or circumstances shall not be affected.

New Rule, R.1986 d.418, effective October 6, 1986.
See: 18 N.J.R. 1079(a), 18 N.J.R. 2039(a).
Recodified from 11:3–8.6 as part of Emergency Amendments filed as R.1990 d.626, effective November 26, 1990, operative April 1, 1991.
See: 22 N.J.R. 3766(b).
Adopted Concurrent Proposal, R.1991 d.89, effective January 25, 1991, operative April 1, 1991.
See: 22 N.J.R. 3766(a), 23 N.J.R. 507(a).

11:3–8.9 Penalties

(a) Any person violating the provisions of this subchapter shall be subject to such penalties as may be authorized by law.

(b) In addition to any such penalties, the Commissioner may, after notice and hearing, suspend or revoke the rights of any insurer or group of insurers under N.J.A.C. 11:3–8.4.

New Rule, R.1986 d.418, effective October 6, 1986.
See: 18 N.J.R. 1079(a), 18 N.J.R. 2039(a).
Recodified from 11:3–8.7 as part of Emergency Amendments filed as R.1990 d.626, effective November 26, 1990, operative April 1, 1991.
See: 22 N.J.R. 3766(b).
Adopted Concurrent Proposal, R.1991 d.89, effective January 25, 1991, operative April 1, 1991.
See: 22 N.J.R. 3766(a), 23 N.J.R. 507(a).

APPENDIX

EXHIBIT A

NONRENEWAL REPORT—A

Standard/Nonstandard Rating System

Insurer Group Name: _____ NAIC Group No. _____

Company Name: _____ NAIC Company No. _____

(list all companies in _____

standard/nonstandard plan) _____

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
Territory	Vehicles Insured 12/31/—	Vehicles Cancelled	Vehicle N/R by Insured	Vehicles N/R for cause N.J.A.C. 11:3-8.4(a)1	Vehicles N/R Underwriting N.J.A.C. 11:3-8.4(b)	Vehicles N/R 2% Rule N.J.A.C. 11:3-8.5(a)1	Vehicles N/R 2:1 Rule N.J.A.C. 11:3-8.5(a)2	*Vehicles Newly Insured	*(JUA Depopulation)* *Voluntary Market* Quota	Vehicles Insured -/-/
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
Totals:										

Notes:
Column (1) shall be numbered in accordance with insurer's approved rating plan.
Column (2) shall be dated as of previous year.
Columns (3) through (11) shall contain information as of date in column (11).
No cancellation or nonrenewal shall be double counted by including it in more than one column.
Renewals within standard/nonstandard system are not to be reported as nonrenewals or cancellations.
Nonrenewals for underwriting (column 6) do not qualify for highest rated tier of standard/nonstandard plan.
Column (7) cannot be greater than .02 X column (2).
Report total only for column (10).
Column (11) equals column (2) plus column (9) minus columns (3), (4), (5), (6), (7) and (8).
Columns (4), (5), (6), (7) and (8) may be reported together as a single number for each territory, but if the insurer is eligible to do 2% or 2:1 nonrenewals, then the single number reported cannot exceed the permissible total of 2% and 2:1 nonrenewals for that territory.

*Does not include a vehicle cancelled within the first 60 days.

Date Submitted _____

Emergency Repeal and New Rule filed as R.1990 d.626, effective November 26, 1990, operative April 1, 1991 (expired January 25, 1991). See: 22 N.J.R. 3766(b).
Adopted Concurrent Proposal, R.1991 d.89, effective January 25, 1991, operative April 1, 1991.
See: 22 N.J.R. 3766(b), 23 N.J.R. 507(a).
Provisions of emergency repeal and new rule readopted without change.

EXHIBIT B

NONRENEWAL REPORT—B

Individual Company

Company Name: _____ NAIC Company No. _____

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	
Territory	Vehicles Insured 12/31/—	Vehicles Cancelled	Vehicle N/R by Insured	Vehicles N/R for cause N.J.A.C. 11:3-8.4	Vehicles N/R 2% Rule N.J.A.C. 11:3-8.5(a)1	Vehicles N/R 2:1 Rule N.J.A.C. 11:3-8.5(a)2	*Vehicles Newly Insured	Depopulation)* *Voluntary Market*	*(JUA Vehicles Insured Quota	-/-/
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
Totals:										

Notes: Column (1) shall be numbered in accordance with insurer's approved rating plan.
Column (2) shall be dated as of previous year.
Columns (3) through (10) shall contain information as of date in column (10).
No cancellation or nonrenewal shall be double counted by including it in more than one column.
Column (6) cannot be greater than .02 X column (2).
Report total only for column (9).
Column (10) equals column (2) plus column (8) minus columns (3), (4), (5), (6) and (7).
Columns (4), (5), (6), (7) and (8) may be reported together as a single number for each territory, but if the insurer is eligible to do 2% nonrenewals of 2:1 nonrenewals, then the single number reported cannot exceed the permissible total of 2% and 2:1 nonrenewals for that territory.

*Does not include a vehicle cancelled within the first 60 days.

Date Submitted _____

Emergency Repeal and New Rule filed as R.1990 d.626, effective November 26, 1990, operative April 1, 1991 (expired January 25, 1991). See: 22 N.J.R. 3766(b).
Adopted Concurrent Proposal, R.1991 d.89, effective January 25, 1991, operative April 1, 1991.
See: 22 N.J.R. 3766(b), 23 N.J.R. 507(a).
Provisions of emergency repeal and new rule readopted without change.

SUBCHAPTER 9. RATING INFORMATION; AUTOMOBILE INSURANCE ON PRIVATE PASSENGER CARS

11:3–9.1 Rating information; private passenger cars; automobile insurance

(a) Every automobile insurance policy subject to New Jersey rates and providing coverage for an individually owned (or jointly owned by husband and wife; or two or more relatives resident of the household) private passenger automobile and/or any motor vehicle rates as a private passenger automobile shall be accompanied by rating information applicable to the premium determination. Such information must include the criteria pertaining to any individual driver classification plan used by the company and shall recite any rules that apply to the chargeability of accidents and convictions.

(b) If the declaration page or extension certificate or similar documents to the insured identifies the insured's car by a code, or other abbreviation, the rating information may be supplied by a rating information form that interprets the code number or abbreviation.

(c) Every company shall develop a rating information format adapted to the classification system approved for and used by the company in this State. Such format shall be submitted to the Commissioner of Insurance for approval initially within 30 days of the effective date of this regulation, and subsequently within 15 days of any revision of the classification system approved for the company. Filings of the rating information format by a rating organization shall be applicable to members and subscribers of such organization unless such companies deviate from the rating organization's classification system.

(d) This regulation shall be effective August 31, 1973. Use of approved forms will be required on all new and renewal business with effective dates January 1, 1974 and thereafter.

R.1983 d.206, effective August 31, 1973.
See: 5 N.J.R. 150(b), 5 N.J.R. 282(b).
Amended by R.1991 d.45, effective February 4, 1991.
See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).
Deleted subsection (b) regarding New Jersey Automobile Insurance Plan and recodified existing (c)-(e) as (b)-(d) with no change in text.

11:3–9.2 Private passenger automobile rating class; revoked or suspended operator

Within the context of any private passenger automobile classification rating system, an individual whose automobile operator's license is under revocation or suspension shall not be considered an operator of the vehicle. In the event such revocation or suspension terminates and the license is restored, premium adjustments reflecting such operator's rating criteria for the current policy period may be made on a pro rata basis.

R.1975 d.130, eff. July 1, 1975.
See: 7 N.J.R. 113(a), 7 N.J.R. 276(d).

SUBCHAPTER 10. AUTO PHYSICAL DAMAGE CLAIMS

11:3–10.1 Scope

This subchapter applies to claims arising under motor vehicle collision and comprehensive coverages.

Amended by R.1985 d.629, effective December 16, 1985.
See: 16 N.J.R. 3170(a), 17 N.J.R. 2988(a).
Section heading was Application.

Case Notes

Insurers' activities in estimating repair costs held not an Antitrust Act violation. Chick's Auto Body v. State Farm Mutual Automobile Insurance Co., 168 N.J.Super 68, 401 A.2d 722 (Law Div.1979), affirmed per curiam 176 N.J.Super. 320, 423 A.2d 311 (App.Div.1980).

11:3–10.2 Definitions

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

"Actual cash value", unless otherwise specifically defined by law or policy, means the lesser of the amounts for which the insured or the designated representative can reasonably be expected to:

1. Repair the motor vehicle to its condition immediately prior to the loss; or

2. Replace the motor vehicle with a substantially similar vehicle. The amount shall include all moneys paid or payable as sales taxes on the motor vehicle repaired or replaced. This paragraph shall not be construed to prevent an insurer from issuing a policy where the amount of damages to be paid in the event of a total loss is a specified dollar amount.

"Agreed price" or "figure" means the amount agreed to by the insurer and the insured, or their representatives, as the reasonable cost to replace the motor vehicle or to repair damages to the motor vehicle resulting from the loss, without considering any deductible or deductions.

"Designated representative" means a person designated by the insured to represent the insured in negotiations with the insurer in an attempt to settle the claim. The designated representative may be any person authorized by the insured who may act legally in his or her behalf.

"Motor vehicle" shall have the meaning ascribed in N.J.S.A. 39:1–1.

"Substantially similar vehicle" means a vehicle of the same make, model, year and condition, including all major options of the insured vehicle. Mileage must not exceed that of the insured vehicle by more than 4,000 miles. Mileage differences of more than 4,000 miles may, at the option of the insured, be exchanged for the presence or absence of options or a cash adjustment.

Amended by R.1985 d.629, effective December 16, 1985.
See: 16 N.J.R. 3170(a), 17 N.J.R. 2988(a).

Case Notes

Insurers' activities in estimating repair costs held not an Antitrust Act violation. Chick's Auto Body v. State Farm Mutual Automobile Insurance Co., 168 N.J.Super 68, 401 A.2d 722 (Law Div.1979), affirmed per curiam 176 N.J.Super. 320, 423 A.2d 311 (App.Div.1980).

Measure of value applicable under policy's theft coverage held to be fair market value; insured, owner of modified vehicle, held entitled to recover only the average market value of an ordinarily equipped automobile of the same make, model and year. Titus v. West American Insurance co., 143 N.J.Super. 195, 362 A.2d 1236 (Law Div.1976).

11:3–10.3 Adjustment of partial losses

(a) If the insurer intends to exercise its right to inspect, or cause to be inspected by an independent appraiser, damages prior to repair, the insurer shall have seven working days following receipt of notice of loss to inspect the insured's damaged vehicle, which is available for inspection, at a place and time reasonably convenient to the insured; commence negotiations; and make a good faith offer of settlement.

(b) Negotiations must be conducted in good faith, with the basic goal of promptly arriving at an agreed price. Early in negotiations, the insurer must inform and confirm in writing to the insured or the insured's designated representative all deductions that will be made from the agreed price, including the amount of applicable deductible.

(c) If the insurer inspects the damaged vehicle or causes it to be inspected, the insurer shall promptly upon completing the inspection furnish the insured or the designated representative of the insured with a detailed written estimate of the cost of repairing the damage resulting from the loss, specifying all appropriate deductions.

(d) No insurer shall negotiate the settlement of any physical damage claim involving an automobile as defined at N.J.S.A. 39:13–1b with an unlicensed auto body repair facility or in any manner utilize an unlicensed facility in the adjustment, negotiation or settlement of such a claim. It shall be the responsibility of the insurer to make a reasonable and diligent effort to determine whether the facility is properly licensed.

(e) Subject to the requirements of (d) above, the insured may use any repair facility of his or her own choice. The insured's selection of facilities may be made upon entering into a contract for insurance by affirmatively accepting optional policy provisions that provide that only certain specified facilities will be used for automobile repairs, and a selection so made is binding on the insured. With respect to automobile damage claims, the insurer shall notify in writing any insured who elects to use his or her own repair facility that, pursuant to law, any entity engaged in the business of auto body repairs must be duly licensed. The notice shall further advise the insured that the insurer is prohibited by law from negotiating, adjusting or settling an automobile damage claim with an unlicensed facility. The written notice shall be furnished at the time of acknowledgment of the claim as provided at N.J.A.C. 11:2–17.6 or upon the furnishing of its written estimate, as specified at (c) above, whichever is sooner. The insurer must make all reasonable efforts to obtain an agreed price with the facility selected by the insured. The insurer may recommend, and if the insured requests, must recommend a qualified repair facility at a location reasonably convenient to the insured motor vehicle who will repair the damaged motor vehicle at the insurer's estimated cost of repairs, but in either event the provisions of (g) below apply.

(f) All estimates, including revisions and adjustments, prepared by any repair facility, estimator or appraiser must be included in each claim file.

(g) If the insured's vehicle is repaired at a repair facility whose name is furnished by the insurer under (e) above for a sum estimated by the insurer as the reasonable cost to repair the vehicle the insurer:

1. Shall select a repair facility that issues written guarantees that any work performed in repairing damaged vehicles meets generally accepted standards for safe and proper repairs;

2. Shall cause the damaged vehicle to be restored to the condition it was in prior to the loss, at no additional cost to the insured and within a reasonable time, if the repair facility does not repair the damaged vehicle in accordance with generally accepted standards for a safe and proper repair.

(h) Whenever an insurer elects to repair its insured's vehicle, that is, physically take the vehicle and have it repaired, the election must be in writing addressed to the insured and contain a reasonable estimate of the time period within which the vehicle will be repaired. The insurer shall guarantee, in writing, that the work performed meets generally accepted standards for safe and proper repairs.

(i) Deductions for betterment and depreciation are permitted only for parts normally subject to repair and replacement during the useful life of the insured motor vehicle. Deductions for betterment and depreciation shall be limited to the lesser of an amount equal to the proportion that the expired life of the part to be repaired or replaced bears to the normal useful life of that part, or the amount by which the resale value of the vehicle is increased by the repair or replacement. Calculations for betterment, depreciation and normal useful life must be included in the insurer's claim file.

(j) Deductions for previous damage or prior condition of the vehicle must be measurable, discernible, itemized and specific as to the dollar amount, and those deductions must be included in the insurer's claim file. The deductions shall be limited to the amount by which the resale value of the motor vehicle is increased by the estimation of the previous damage or the correction of the prior condition.

(k) The insurer must mail or hand deliver to the insured or the designated representative its proof of loss or payment within five working days after the insured has accepted the insurer's offer.

(*l*) The insured shall have the right to receive the proceeds of any settlement. The insurer may not insist on making settlement proceeds jointly payable to the insured and the repair facility, or payable to the repair facility only. If the insured has exercised his or her right to accept the optional policy provisions that provide that only certain specified facilities will be used for automobile repairs, the insurer may pay settlement proceeds directly to the repair facility.

(m) The insured may elect to have the insurer pay the repair facility directly in order to expedite recovery of the motor vehicle. The insured must make this election in writing.

Amended by R.1985 d.629, effective December 16, 1985.
See: 16 N.J.R. 3170(a), 17 N.J.R. 2988(a).
Substituted "the insurer" for "it".
Amended by R.1987 d.249, effective June 15, 1987.
See: 18 N.J.R. 2415(a), 19 N.J.R. 1096(a).
Substantially amended.
Amended by R.1995 d.471, effective August 21, 1995 (operative January 1, 1996).
See: 27 N.J.R. 437(a), 27 N.J.R. 3172(a).
In (e) allowed limitation of insured's choice of repair facilities as optional part of insurance contract and in (*l*) allowed payment directly to repair facility under such contract.

Case Notes

Insurers' activities in estimating repair costs held not an Antitrust Act violation. Chick's Auto Body v. State Farm Mutual Automobile Insurance Co., 168 N.J.Super. 68, 401 A.2d 722 (Law Div.1979), affirmed per curiam 176 N.J.Super. 320, 423 A.2d 311 (App.Div.1980).

11:3–10.4 Adjustment of total losses

(a) If the insurer elects to make a cash settlement, it must bear in mind at all times that the insured's position is that of a retail consumer and the settlement value arrived at must be reasonable and fair for a person in that position. If the insurer elects to make a cash settlement, its offer, subject to applicable deductions, must be one of the following plus applicable sales tax:

1. The average of the retail value for a substantially similar motor vehicle as listed in the current editions of the two valuation manuals approved by the Commissioner.

i. The average figure arrived at may be reduced by considering all factors, including but not limited to mileage tables and presence or absence of extras.

ii. If the destroyed vehicle included an option which is listed in one manual but not in the other, the value of the option shall not be averaged. The insured shall receive full value for the option by carrying over the amount listed to the other manual. The option carryover shall apply only in those instances where the option has not been considered by the used vehicle guide either as a separate item or included in the vehicle's base value.

iii. Manuals approved for use on and after January 1, 1976, are the "Redbook", published by National Market Reports, Inc., and the "N.A.D.A. Official Used Car Guide", published by the National Automobile Dealers Association Used Car Guide Company. The use of any other manuals may be approved by the Commissioner upon demonstration of need, suitability and accuracy.

2. A quotation obtained by the insurer for a substantially similar motor vehicle, obtained from a dealer or individual located within a reasonable distance from the principal place of garagement of the insured vehicle. The insured must be able to purchase the substantially similar vehicle at the quoted location for the insurer's cash offer plus applicable deductions.

3. If it is not possible to value the damaged vehicle by using alternative methods, paragraphs 1 or 2 of this subsection, the insurer must determine the retail value by the best available method and must fully explain in writing to the insured how its offer was calculated.

(b) If the insurer elects to replace the vehicle, the replacement vehicle must be an immediately available, substantially similar vehicle that is both furnished and paid for by the insurer, subject to the deductible, if any, and including applicable sales tax.

(c) If the insured vehicle is a private passenger automobile of the current model year, meaning that the vehicle has not been superseded in the market place by an officially introduced succeeding model, the insurer shall utilize one of

the following methods in the settlement of the loss, unless the utilization of (a) or (b) above is more favorable to the consumer.

1. Either the insurer shall pay the insured an amount equal to the reasonable purchase price on the date of the loss of a new identical vehicle, less any applicable deductible and an allowance for depreciation in accordance with the schedule below; or

2. The insurer shall provide the insured with a new identical replacement vehicle charging the insured for any applicable deductible and for depreciation in accordance with the schedule below:

Depreciation Schedule

Purchase Price	Depreciation per mile
Up to $ 6,500	$0.10
$ 6,501–$ 8,000	0.12
8,001– 10,000	0.15
10,001– 12,000	0.18
12,001– 15,000	0.21
15,001– 20,000	0.25
More than $20,000	0.29

(d) In the event of a total loss, any parts of the insured vehicle included in its valuation which are removed by the insured or the designated representative shall have their value deducted from the final settlement figure. This section shall not be construed to grant a right of removal.

(e) The following provisions of N.J.A.C. 11:3–10.3 also shall apply to the adjustment of total losses, except that the insurer shall have a total of 14 working days to comply with the requirements of subsections (a), (b), (c), (h), (i), (j) and (k) of N.J.A.C. 11:3–10.3.

(f) This section does not prohibit an insurer from issuing a stated value policy insuring against physical damage where the amount of damages to be paid in the event of a total loss is a specified dollar amount.

(g) If the vehicle is a total loss, the insurer may require that the insured transfer ownership of the vehicle to recoup salvage as a condition of settlement.

As amended, R.1976 d.371, eff. November 22, 1976.
See: 8 N.J.R. 481(b), 8 N.J.R. 559(c).
Amended by R.1985 d.629, effective December 16, 1985.
See: 16 N.J.R. 3170(a), 17 N.J.R. 2988(a).
(a)1ii added; new depreciation schedule.
Administrative correction to (e).
See: 21 N.J.R. 3173(b).
Amended by R.1987 d.249, effective June 15, 1987.
See: 18 N.J.R. 2415(a), 19 N.J.R. 1096(a).
Substantially amended.

Case Notes

Compilation of used vehicle valuations did not automatically fall into public domain and lose its copyright protection. CCC Information Services, Inc. v. Maclean Hunter Market Reports, Inc., C.A.2 (Conn.)1994, 44 F.3d 61, 33 U.S.P.Q.2d 1183, petition for certiorari filed.

11:3–10.5 Unreasonable delay

(a) Unless a clear justification exists, physical damage claims will have a maximum payment period of 30 calendar days. A payment period is the period between the date of the receipt of the notice of loss by the insurer, and:

1. The date the settlement check is mailed; or

2. The date on which the damaged vehicle is returned to use when the insurer elects to repair or have repaired the insured vehicle; or

3. The date on which the damaged vehicle is replaced by the insurer.

(b) If any element of a physical damage claim remains unresolved more than 30 calendar days from the date of receipt of notice of loss by the insurer, the insurer shall provide the insured with a written explanation of the specific reasons for delay in the claim settlement. An updated letter of explanation shall be sent again every 30 calendar days thereafter until all elements of claim are either honored or rejected.

(c) Any letter of explanation, rejection or acceptance of any element of a claim shall contain in the upper right hand corner the date of receipt of notice of loss by the insurer and be identified as such. The letter shall also contain the identity and claim processing address of the insurer, and the insured's policy number and claim number.

(d) A copy of the second update letter sent 60 days after the date of receipt of notice of loss, and all thereafter sent to any New Jersey insured, shall be mailed simultaneously to the insured and the Division of Enforcement and Consumer Protection, 20 West State Street, CN 325, Trenton, New Jersey 08625.

Amended by R.1985 d.629, effective December 16, 1985.
See: 16 N.J.R. 3170(a), 17 N.J.R. 2988(a).
Substituted "Marketplace Regulation and Consumer Assistance Division" for "Consumer Services Division".
Amended by R.1991 d.45, effective February 4, 1991.
See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).
In (d): revised address.

Law Review and Journal Commentaries

Damages—First Party Claims—Insurance. Judith Nallin, 133 N.J.L.J. No. 12, 65 (1993).

Case Notes

Insurer owes duty of good faith to insured in processing first-party claim. Pickett v. Lloyd's, 131 N.J. 457, 621 A.2d 445 (1993).

Cause of action exists for insured's bad-faith refusal to pay first-party claims. Pickett v. Lloyd's, 131 N.J. 457, 621 A.2d 445 (1993).

Insured who did not submit proof of loss until loss of seniority was not barred from recovery against insurer. Pickett v. Lloyds, 252 N.J.Super. 477, 600 A.2d 148 (A.D.1991), certification granted 127 N.J. 563, 606 A.2d 373, affirmed 131 N.J. 457, 621 A.2d 445.

Finding that insurer and agent breached duty of fair dealing by failing to timely pay claim was supported by the evidence. Pickett v. Lloyds, 252 N.J.Super. 477, 600 A.2d 148 (A.D.1991), certification granted 127 N.J. 563, 606 A.2d 373, affirmed 131 N.J. 457, 621 A.2d 445.

Insured could to recover for lost income as result of insurer's delay in paying claim. Pickett v. Lloyds, 252 N.J.Super. 477, 600 A.2d 148 (A.D.1991), certification granted 127 N.J. 563, 606 A.2d 373, affirmed 131 N.J. 457, 621 A.2d 445.

Insured acted reasonably in not reading proof of loss form. Pickett v. Lloyds, 252 N.J.Super. 477, 600 A.2d 148 (A.D.1991), certification granted 127 N.J. 563, 606 A.2d 373, affirmed 131 N.J. 457, 621 A.2d 445.

11:3–10.6 Loss of use

In the event of the theft of the entire vehicle the insurer at the time of notification shall advise the insured of his or her right under the policy to be reimbursed for transportation expenses. The notification must be confirmed in writing immediately after receipt of notice of theft. All conditions and benefits related to this coverage as stated in the policy must be contained in the notification to the insured.

Amended by R.1985 d.629, effective December 16, 1985.
See: 16 N.J.R. 3170(a), 17 N.J.R. 2988(a).
Deleted "it shall be the duty of".

11:3–10.7 Subrogation agreements

(a) If an insured has received payment under his or her physical damage coverage that is subject to a deductible, the insured shall share, pro rata, with the insurer any net recovery received by the insurer from third parties.

(b) Net recovery shall be the total recovery less the insurer's allocated loss adjustment expenses attributable to such recovery. The formula for computing net recovery and the insured's share of recovery of the deductible may be stated as follows:

1. Total recovery - Allocated loss adjustment expenses = Net recovery.

$$\frac{\text{Deductible}}{\text{Total loss}} \times \text{Net recovery} = \text{Insured's Share of recovery.}$$

2. Application of formula: Assume a loss of $500.00 subject to a $100.00 deductible with $50.00 in allocated loss adjustment expenses:

i. If there is full recovery of $500.00: computation of net recovery:

$500.00 - $50.00 = $450.00

Computation of insured's share of recovery:

$$\frac{\$100.00}{\$500.00} \times \$450.00 = \$90.00$$

ii. If there is a partial recovery of $300.00: computation of new recovery: $300.00 - $50.00 = $250.00

Computation of insured's share of recovery:

$$\frac{\$100.00}{\$500.00} \times \$250.00 = \$50.00$$

(c) Unless the insurer returns its insured's full deductible the insured shall attempt to effect full recovery in clear liability cases and shall not enter into any intercompany agreements that provide for the acceptance of lesser amounts on a formula basis.

(d) If an insurer has paid a physical damage claim that is subject to a deductible and it elects not to pursue its subrogation claim where the probability of recovery exists, the insurer shall so notify its insured in writing within 60 calendar days after it has paid the claim, except that the notification shall be given at least 30 days prior to the running of any applicable statute of limitations or period required for notice of claim. If an insurer does not notify its insured within the time periods prescribed above and the statue of limitations or period required for notice or claim has expired, the insurer shall forthwith remit to its insured the full amount of the insured's deductible.

Amended by R.1985 d.629, effective December 16, 1985.
See: 16 N.J.R. 3170(a), 17 N.J.R. 2988(a).
Substituted "the insured" for "it".

11:3–10.8 Repair estimates

If the insurer requires that its insured obtain more than one estimate of motor vehicle damage, the reasonable cost of such additional estimates, if any, shall be borne by the insurer unless the estimator does the work.

11:3–10.9 Referral of insured to the at-fault party

There shall be no attempt to discourage an insured from filing a physical damage claim, nor shall an insurer encourage its insured to assert a claim against a third party in lieu of filing a physical damage claim under the insured's policy.

11:3–10.10 Examinations by the New Jersey Insurance Department

To ensure compliance with this rule, the Department of Insurance personnel will investigate the market performance of insurers. To enable department personnel to reconstruct an insurer's activities pursuant to the provisions of this rule, each insurer must maintain a complete file on each claim settled pursuant to this rule. The claim file shall contain all communications, transactions, notes and work papers relating to the claim. With respect to automobile damage

claims, the file also shall include the name, address, telephone number and license number of any auto body repair facility that has been utilized by the insurer in the adjustment of the loss or repair of the automobile. All papers in the file must be accurately dated by the insurer.

Amended by R.1985 d.629, effective December 16, 1985.
See: 16 N.J.R. 3170(a), 17 N.J.R. 2988(a).
"Rule" substituted for "regulation".
Amended by R.1987 d.249, effective June 15, 1987.
See: 18 N.J.R. 2415(a), 19 N.J.R. 1096(a).
Added text "With respect to ... of the automobile."

Case Notes

Insurers' activities in estimating repair costs held not an Antitrust Act violation. Chick's Auto Body v. State Farm Mutual Automobile Insurance Co., 168 N.J.Super 68, 401 A.2d 722 (Law Div.1979), affirmed per curiam 176 N.J.Super. 320, 423 A.2d 311 (App.Div.1980).

SUBCHAPTER 11. MOPED INSURANCE

11:3–11.1 Required coverages for mopeds

(a) No policy insuring against loss resulting from liability imposed by law for bodily injury, death and property damage sustained by any person arising out of the ownership, operation or use of a motorized bicycle as defined in N.J.S.A. 39:1–1, as amended, shall be issued in the State to the owner (or parent or guardian of an owner under 18 years of age) of any motorized bicycle principally garaged or operated in this State unless it includes coverage for the owner and operator in the following minimum amounts or limits.

1. Bodily injury;

i. An amount or limit of $15,000, exclusive of interest and costs, on account of injury to, or death of, one person, in any one accident; and

ii. An amount or limit, subject to such limit for any one person so injured or killed, of $30,000, exclusive of interest and costs, on account of injury to or death of more than one person, in any one accident.

2. Property damage: An amount or limit of $5,000 in the aggregate for damage to property of others resulting from one accident.

(b) Every liability insurance policy as described in (a) above, issued or renewed on or after the operative date of this subsection, shall provide personal injury protection coverage benefits, in accordance with N.J.S.A. 39:6A–4, to pedestrians who sustain bodily injury in this State caused by the named insured's motorized bicycle or caused by being struck by or from the motorized bicycle.

1. Every rating organization and insurer making its own rates for policies covering motorized bicycles shall submit to the Commissioner of Insurance filings of rules, rates and forms within 30 days of the effective date of this subsection.

(c) Every business entity or individual owner who rents motorized bicycles shall maintain liability insurance coverage pursuant to P.L. 1977, chapter 267, in the minimum amounts or limits set forth in subsection (a) of this section.

(d) Any such coverages as described in subsections (a), (b) and (c) above shall describe the make and model, piston displacement, and serial number (VIN) of each motorized bicycle insured. This information shall also constitute the description of vehicle required on insurance identification cards, and N.J.A.C. 11:3–5.1 through 6.4 shall apply to moped coverage except where the language is clearly inappropriate.

(e) The policy period for the coverages described in subsection (a) of this section shall commence at 12:01 A.M. of the effective date shown in the policy declaration page, unless expressly set forth in the policy or in a binder or other contracts for temporary insurance.

(f) Any insurer authorized to write motor vehicle coverage may write moped coverage.

R.1978 d.12, eff. January 19, 1978.
See: 9 N.J.R. 585(c), 10 N.J.R. 69(c).
Amended by R.1985 d.72, effective February 19, 1985 (operative April 22, 1985).
See: 16 N.J.R. 3285(a), 17 N.J.R. 458(c).
(b) added; old (b)-(d) recodified to (c)-(e).

SUBCHAPTER 12. AUTOMOBILE RATE FILERS: FLATTENING OF PREMIUM TAXES AND ASSESSMENTS MADE FOR THE UNSATISFIED CLAIM AND JUDGMENT FUND

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(e) and the New Jersey Automobile Insurance Reform Act of 1982, P.L. 1983, c.65, N.J.S.A. 17:29A–33 et seq.

Source and Effective Date

R.1983 d.424, eff. October 3, 1983.
See: 15 N.J.R. 1170(a), 15 N.J.R. 1666(a).

11:3–12.1 Purpose

The New Jersey Automobile Insurance Reform Act of 1982 (P.L. 1983, c.65, N.J.S.A. 17:29A–33 et seq.) requires that each insurer calculate and collect, on a flat and uniform basis per insured automobile statewide, the taxes which are paid pursuant to N.J.S.A. 54:18A–1 et seq. and certain assessments made pursuant to N.J.S.A. 39:6–64, 66 and 67. This subchapter provides rules for the implementation of these requirements.

11:3–12.2 Scope

(a) This subchapter applies to every insurer authorized to transact the business of automobile insurance in the State and every rating organization engaged in the business of rate-making for such insurers.

(b) The provisions of this subchapter are not intended to supersede or amend any other law or regulation.

11:3–12.3 Definitions

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

"Assessments" mean any assessment to be made pursuant to N.J.S.A. 39:6–64, 66 and 67, excluding assessments made to reimburse a filer for medical benefits payable under N.J.S.A. 39:6A–4 in excess of $75,000.

"Commissioner" means the Commissioner of Insurance.

"Filer" means a rating organization or any insurer making its own rates.

"Insurer" means any person or persons, corporation, association, partnership, or company authorized by the laws of this State to transact the business of insurance in this State.

"Rating organization" means every person or persons, corporation, partnership, company, society, or association engaged in the business of rate-making for two or more insurers.

"Taxes" mean those taxes required to be paid pursuant to N.J.S.A. 54:18A–1 et seq.

11:3–12.4 Tax and assessment fees; general provisions

(a) Pursuant to N.J.S.A. 17:29A–33 et seq., each automobile filer shall calculate and collect taxes and assessments for its insureds on a flat uniform fee basis per insured automobile statewide.

1. The flat and uniform fee per insured automobile required in (a) above shall be included in all new or renewal automobile policies issued on or after January 1, 1984.

(b) The fee shall be charged on any additional automobile which is acquired during the policy period. The amount of the fee shall be proportional to the remainder of the policy term.

(c) In the event of the cancellation of the policy or the deletion of the automobile from a policy, the fee shall be refunded in proportion to the earned premium for the period that the policy or coverage on the deleted automobile was in force.

11:3–12.5 Filing and reporting requirements

(a) Each automobile shall submit to the commissioner for approval a rate filing designed to place the premium structure of the filer in compliance with the requirements of the New Jersey Automobile Insurance Reform Act of 1982 and this subchapter.

1. The rate filing submitted to the Commissioner shall include the uniform tax and assessment fee to be used by the filer.

2. Each filer shall submit to the Commissioner for approval any alteration, amendment or supplement to the rate filing specified in (a) above.

(b) Within 30 days of the effective date of this subchapter, every automobile filer shall submit to the Commissioner for approval the rate filing specified in (a) above including the uniform tax assessment fee to be used by the filer in the calendar year commencing January 1, 1984.

(c) All filings required to be submitted pursuant to this subchapter shall be prepared in accordance with insurance laws and regulations including applicable provisions of N.J.S.A. 17:29A–1 et seq. and N.J.A.C. 11:1–2 and the Department's existing filing procedures.

(d) The filing of a rating organization shall be applicable to the members and subscribers of the organization.

1. Members or subscribers may submit to the Commissioner for approval a separate filing which deviates from the rating organization's filing. Such filings shall be prepared and submitted in accordance with the requirements of this subchapter.

(e) The Commissioner may require the filing of such additional date or information as he deems necessary to implement the provisions of this subchapter, including, but not limited to, premium information on miscellaneous coverages such as rental reimbursement, additional personal injury protection and underinsured motorists as well as excess limits premiums for bodily injury and property damage liability coverages.

SUBCHAPTER 13. AUTOMOBILE RATE FILERS: DEDUCTIBLES FOR PRIVATE PASSENGER AUTOMOBILE COLLISION AND COMPREHENSIVE COVERAGES

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(e) and the New Jersey Automobile Insurance Reform Act of 1982.
P.L.1983, c. 65, N.J.S.A. 17:29A–33 et seq., specifically 17:29A–39.

Source and Effective Date

R.1983 d.467, eff. October 17, 1983.
See: 15 N.J.R. 1342(a), 15 N.J.R. 1769(b).
This rule was originally adopted on an emergency basis, see 15 N.J.R. 1961(a).

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

11:3–13.1 Purpose

(a) The New Jersey Automobile Insurance Reform Act of 1982, as amended (P.L. 1983, c.65, P.L. 1983, c.359, N.J.S.A. 17:29A–39) requires that each insurer offer a range of deductibles up to at least $2,000 for private passenger automobile collision and comprehensive coverages. This subchapter provides rules for the implementation of this requirement.

As amended, R.1984 d.3, effective January 4, 1984. Originally filed as an emergency amendment R.1983 d.537.
See: 15 N.J.R. 1961(a), 16 N.J.R. 246(c).
Range of deductibles increased to $2,000; coinsurance options added.
Amended by R.1987 d.142, effective March 16, 1987.
See: 19 N.J.R. 46(a), 19 N.J.R. 455(a).
Deleted (a)1 through i.

11:3–13.2 Scope

This subchapter applies to every insurer authorized to transact the business of automobile insurance in this State and every rating organization engaged in the business of rate-making for such insurers.

Case Notes

Insured had no right to jury trial in action seeking personal injury protection benefits from insurer. Manetti v. Prudential Property and Casualty Insurance Co., 196 N.J.Super. 317, 482 A.2d 520 (App.Div. 1984).

11:3–13.3 Deductibles for private passenger automobile collision and comprehensive coverages

(a) Paragraphs 1 and 2 below set forth the minimum schedules of deductibles for private passenger automobile collision and comprehensive coverages which each insurer shall offer, effective January 1, 1984, pursuant to N.J.S.A. 17:29A–39.

1. Deductibles for collision coverage:

$100.00	$1,000.00
$150.00	$1,500.00
$250.00	$2,000.00
$500.00	

i. An insurer may offer a $200.00 collision deductible in lieu of, or in addition to, the $250.00 deductible contained in (a)1 above.

2. Deductibles for comprehensive coverage:

$ 50.00	$ 500.00
$100.00	$1,000.00
$150.00	$1,500.00
$250.00	$2,000.00

i. An insurer may offer a $200.00 comprehensive deductible in lieu of, or in addition to, the $250.00 deductible contained in (a)2 above.

(b) In addition to the required schedules in (a) above, an insurer may offer other intermediary ranges of deductibles as well as deductibles which are in excess of $2,000.

1. The offering of such intermediary and additional deductibles shall be subject to the Commissioner's approval as set forth in N.J.A.C. 11:3–13.4.

(c) Insurers may offer actual case value comprehensive coverage.

As amended, R.1984 d.3, effective January 4, 1984. Originally filed as an emergency amendment R.1983 d.537.
See: 15 N.J.R. 1961(a), 16 N.J.R. 246(c).
Deductibles of $1,500.00 and $2,000.00 added.
Amended by R.1987 d.142, effective March 16, 1987.
See: 19 N.J.R. 46(a), 19 N.J.R. 455(a).

11:3–13.4 Filing and reporting requirements

(a) Within 30 days of the effective date of this subchapter, every automobile filer shall submit to the Commissioner for approval filings of rates or manual rules which provide at least the minimum schedules of deductibles set forth at N.J.A.C. 11:3–13.3(a).

(b) All filings of collision and comprehensive deductibles and all changes and amendments thereto, shall be prepared in accordance with insurance laws and regulations, including the applicable provisions of N.J.S.A. 17:29A–1 et seq. and N.J.A.C. 11:1–2 and the Department's existing filing procedures.

(c) The filing of a rating organization shall be applicable to the members and subscribers of the organization who have authorized the organization to file on their behalf.

1. Members or subscribers may submit to the Commissioner for approval a separate filing which deviates from the rating organization's filing. Such filings shall be prepared and submitted in accordance with the requirements of this subchapter.

As amended, R.1984 d.3, eff. January 4, 1984. Originally filed as an emergency amendment R.1983 d.537.
See: 15 N.J.R. 1961(a), 16 N.J.R. 246(c).
The text of 13.4 was recodified to this cite and amended to reference coinsurance options.
Amended by R.1987 d.142, effective March 16, 1987.
See: 19 N.J.R. 46(a), 19 N.J.R. 455(a).
This section was recodified from section 5. The old section 4 "Coinsurance options applicable separately to private passenger automobile collision and comprehensive coverages" was originally filed as an emergency amendment as R.1983 d.537 and was readopted effective January 4, 1984 as R.1984 d.3.

11:3–13.5 (Reserved)

As amended, R.1984 d.3, effective January 4, 1984. Originally filed as an emergency amendment R.1983 d.537.
See: 15 N.J.R. 1961(a), 16 N.J.R. 246(c).
The text at this cite was recodified from 13.5.
Amended by R.1987 d.142, effective March 16, 1987.
See: 19 N.J.R. 46(a), 19 N.J.R. 455(a).
Recodified from 13.6.
Repealed by R.1989 d.117, effective February 21, 1989.
See: 20 N.J.R. 2984(a), 21 N.J.R. 558(b).
Section was "notice requirements".

SUBCHAPTER 14. PERSONAL INJURY PROTECTION OPTIONS

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

11:3–14.1 Purpose

The New Jersey Automobile Insurance Freedom of Choice and Cost Containment Act of 1984 (P.L. 1983, c.362) requires each automobile insurer offering personal injury protection coverage to provide, at appropriately reduced premiums, optional deductibles and/or exclusions. This subchapter establishes rules for the implementation of these requirements.

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".

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 benefit deductibles for personal injury protection coverage

(a) Effective December 3, 1983, each insurer must provide, at appropriately reduced premiums, the option to select medical expense benefit deductibles of $500.00, $1,000 and $2,500 on all automobile policies which include personal injury protection coverages.

(b) The medical expense deductibles shall apply on a per accident basis.

(c) A 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–4.

(d) The buyer's guide and written notice specified in N.J.S.A. 39:6A–23 shall satisfy the requirements of this subchapter.

(e) 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.

(f) Should an applicant or policyholder fail to elect a deductible, the basic $250.00 deductible provided by N.J.S.A. 39:6A–23 shall apply and an appropriate premium shall be charged.

(g) 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 written request to eliminate or change the deductible.

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).

Case Notes

Economically independent mother-in-law who resided with insured, was not bound by insured's cost containment options. Swydersky 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 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 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.

(f) A premium credit calculated and represented as a percentage of the applicable premium shall be provided for the exclusion. The premium percentage shall be uniform by filer on a statewide basis.

(g) The buyer's guide and written notice specified in section 17 of P.L. 1983, c.362 shall satisfy the requirements of this subchapter.

(h) Should an applicant or named insured fail to elect the exclusion, full personal injury protection coverage shall be deemed to have been selected and an appropriate premium shall be charged.

(i) The exclusion elected by a named insured shall continue in force as to subsequent renewal or replacement policies until the insurer or its authorized representative receives a properly executed written request for its elimination.

As amended, R.1984 d.480, eff. November 5, 1984.
See: 16 N.J.R. 1692(a), 16 N.J.R. 3037(b).
(c): added "household, who is ... insurance policy".

11:3–14.5 Option to choose health care insurance coverage as primary coverage

(a) Pursuant to N.J.S.A. 39:6A–4.3, for policies issued or renewed on or after January 1, 1991, an insurer shall provide the option that other health insurance coverage or benefits of the insured, including health care services provided by a health maintenance organization and any coverage or benefits provided under any Federal or State program, are the primary coverage for medical expense benefits for personal injury protection coverage; provided, however, that this option shall not apply to any coverage or benefits provided pursuant to Medicare or Medicaid.

(b) The Coverage Selection Form (see N.J.A.C. 11:3–15.7) shall require insureds or prospective insureds to identify the health insurer(s) providing primary personal injury protection medical expense benefits. This identification shall fulfill the requirement in N.J.S.A. 39:6A–4.3 that named insureds provide proof that they and members of their family residing in the household are covered by health insurance coverage or benefits.

As amended, R.1984 d.480, eff. November 5, 1984.
See: 16 N.J.R. 1692(a), 16 N.J.R. 3037(b).
(b): added "who is not ... insurance policy".
Repealed by R.1989 d.117, effective February 21, 1989.
See: 20 N.J.R. 2984(a), 21 N.J.R. 558(b).
This section was "Setoff option entitling an automobile insurer paying PIP medical expense benefits to reimbursement under certain conditions".
New Rule, 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).

11:3–14.6 Refund or credit of unearned premium

Every automobile insurer offering personal injury protection coverage shall establish a fair, practicable and nondiscriminatory plan for the refund or application of credit of any unearned premium resulting from the selection of any deductible and/or exclusion option pursuant to this subchapter.

Amended by R.1989 d.117, effective February 21, 1989.
See: 20 N.J.R. 2984(a), 21 N.J.R. 558(b).
Deleted "setoff".

11:3–14.7 Filing requirements

(a) Every automobile filer shall submit to the Commissioner for approval filings of rates or manual rules which provide the optional medical expense benefit deductibles for personal injury protection coverage.

(b) Within 30 days of the effective date of this subchapter, every automobile filer shall submit to the Commissioner for approval filings of rates or manual rules which provide the optional exclusion from personal injury protection coverage of income continuation benefits, essential service benefits, death benefits, and funeral expense benefits.

(c) All filings submitted for approval pursuant to this subchapter, and all changes and amendments thereto, shall be prepared in accordance with insurance laws and regulations, including the applicable provisions of N.J.S.A. 17:29A–1 et seq. and N.J.A.C. 11:1–2 and the Department's existing filing procedures.

(d) The filing of a rating organization shall be applicable to the members and subscribers of the organization who have authorized the organization to file on their behalf.

Amended by R.1989 d.117, effective February 21, 1989.
See: 20 N.J.R. 2984(a), 21 N.J.R. 558(b).
Repealed (c) and recodified (d)-(e) as (c)-(d).

11:3–14.8 Application of the option to choose health care insurance coverage as the primary insurer

When an insured or prospective insured elects to have a health insurer provide primary personal injury protection medical expenses benefits, the medical expenses benefits available to the insured under his or her automobile policy's personal injury protection provisions shall become a secondary benefits provider. The order of benefit determination shall be in accordance with N.J.A.C. 11:3–37.

Emergency New Rule, R.1990 d.625, effective November 26, 1990 (expires January 25, 1991).
See: 22 N.J.R. 3777(a).
Adopted Concurrent Proposal, R.1991 d.90, effective January 25, 1991.
See: 23 N.J.R. 3777(a), 23 N.J.R. 697(a).
Provisions of emergency new rule R.1990 d.625 readopted without change.

SUBCHAPTER 15. STANDARDS FOR WRITTEN NOTICE: BUYER'S GUIDE AND COVERAGE SELECTION FORM

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

11:3–15.1 Purpose

(a) N.J.S.A. 39:6A–23 requires the Commissioner of the Department of Insurance to promulgate standards for the written notice to be provided to applicants for automobile insurance and to policyholders seeking renewal of coverage. This written notice includes a Buyer's Guide and a Coverage Selection Form as required by N.J.S.A. 39:6A–23. This subchapter implements this statutory requirement and establishes the necessary minimum standards insurance companies authorized to transact the business of private passenger automobile insurance, including any residual market mechanism created by any New Jersey statute, shall use in giving notice of available coverages, options and rate credits.

(b) The purpose of the standards is to help consumers understand the choices they will make. The standards prescribe an attractive format and plain language describing the choices in general, thereby encouraging consumers to read the documents and to make informed choices about the auto insurance coverages and options available to them.

New rule, R.1989 d.117, effective February 21, 1989.
See: 20 N.J.R. 2984(a), 21 N.J.R. 558(b).
Old text was repealed.
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 delete references to the NJAFIUA and to substitute therefor a general reference to residual market mechanisms created by New Jersey statute consistent with "The Fair Automobile Insurance Reform Act of 1990", P.L. 1980 c.8.

11:3–15.2 Scope

This subchapter applies to every insurance company authorized to transact the business of private passenger automobile insurance in this State and to any residual market mechanism created by any New Jersey statute.

New rule, R.1989 d.117, effective February 21, 1989.
See: 20 N.J.R. 2984(a), 21 N.J.R. 558(b).
Old text was repealed.
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 delete references to the NJAFIUA and to substitute therefor a general reference to residual market mechanisms created by New Jersey statute consistent with "The Fair Automobile Insurance Reform Act of 1990", P.L. 1980 c.8.

11:3–15.3 Definitions

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

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

"Insurance company" means any person, corporation, association, partnership, company and any other legal entity issuing a contract of private passenger automobile insurance, including any residual market mechanism established pursuant to any New Jersey statute. As appropriate, "insurance company" shall also mean a servicing carrier for a residual market mechanism.

New rule, R.1989 d.117, effective February 21, 1989.
See: 20 N.J.R. 2984(a), 21 N.J.R. 558(b).
Repealed old rule, "effective date."
Amended by R.1989 d.624, effective December 18, 1989 (operative January 1, 1990).
See: 21 N.J.R. 3244(a), 21 N.J.R. 3922(a).
NJAFIUA added to definition of "insurance company".
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).
Changed definition of "Insurance Company" for consistency with "The Fair Automobile Insurance Reform Act of 1990", P.L. 1990 c.8.

Case Notes

Insurer and agent were not liable in allegedly failing to inform insured about higher levels of underinsured motorist coverage. Pinto v. Garretson, 237 N.J.Super. 444, 568 A.2d 119 (A.D.1989).

Insured was not entitled to underinsured motorist benefits; insurance carried by two vehicles which struck his was greater than the amount of uninsured coverage which he could have obtained. Pinto v. Garretson, 237 N.J.Super. 444, 568 A.2d 119 (A.D.1989).

11:3–15.4 Compliance

Pursuant to N.J.S.A. 39:6A–23, as amended by P.L. 1988, c.119, no new private passenger automobile insurance policy or renewal shall be issued on or after January 1, 1989, unless the application for the policy or renewal is accompanied by a written notice which meets the minimum standards prescribed in this subchapter.

New rule, R.1989 d.117, effective February 21, 1989.
See: 20 N.J.R. 2984(a), 21 N.J.R. 558(b).
Repealed "General context of written notice".

Case Notes

Insurance agent had no obligation to contact insureds to provide explanation of notice provided by insurance carrier. Bruce v. James P. MacLean Firm, 238 N.J.Super. 501, 570 A.2d 49 (L.1989), affirmed 238 N.J.Super. 408, 570 A.2d 1.

"Notice of coverage" provisions imposed duty on carrier to prove only that it mass mailed requisite materials concerning optional coverage to its insureds. Bruce v. James P. MacLean Firm, 238 N.J.Super. 501, 570 A.2d 49 (L.1989), affirmed 238 N.J.Super. 408, 570 A.2d 1.

11:3–15.5 Content of written notice; receipt by public

(a) The written notice shall include the New Jersey Auto Insurance Buyer's Guide and the Coverage Selection Form as they appear in this subchapter.

(b) Each named insured of an automobile insurance policy shall receive a Buyer's Guide and a Coverage Selection Form:

1. When application is made for a new policy;
2. As part of a notice of renewal; and
3. When mid-term changes are requested which require the use of a Coverage Selection Form (see N.J.A.C. 11:3–15.9).

(c) The Coverage Selection Form shall be used in accordance with the requirements of N.J.A.C. 11:3–15.9.

New rule, R.1989 d.117, effective February 21, 1989.
See: 20 N.J.R. 2984(a), 21 N.J.R. 558(b).
Repealed "General content of buyer's guide".
Amended by R.1989 d.624, effective December 18, 1989 (operative January 1, 1990).
See: 21 N.J.R. 3244(a), 21 N.J.R. 3922(a).
(c) deleted.
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 clarify when a Buyer's Guide and Coverage Selection Form are required to be received by the public, and, for convenience to the reader, to reference the use of the Coverage Selection Form (see section 13 of the "Fair Automobile Insurance Reform Act of 1990").

Case Notes

Insured could not have jury trial in reformation action for agent's failure to inform insured of available underinsured motorist coverage. Weinisch v. Sawyer, 123 N.J. 333, 587 A.2d 615 (1991).

Direct writing insurer was not responsible for insured's inadequate underinsured motorist (UIM) coverage. Andriani v. New Jersey Mfrs. Ins. Co., 245 N.J.Super. 252, 584 A.2d 875 (A.D.1991), certification denied 126 N.J. 327, 598 A.2d 886.

Client-initiated contacts with insurance brokers can result in broker's duty to exercise skill and possess knowledge concerning coverages. Avery v. Arthur E. Armitage Agency, 242 N.J.Super. 293, 576 A.2d 907 (A.D.1990).

Insurer's buyer's guide and coverage selection form complied with regulations. Avery v. Arthur E. Armitage Agency, 242 N.J.Super. 293, 576 A.2d 907 (A.D.1990).

Insurer that was already voluntarily offering underinsured motorist coverage prior to January 1, 1984 did not have adjustment period until July 1, 1984. Sikking v. Nelson, 242 N.J.Super. 185, 576 A.2d 311 (A.D.1990).

"Notice of coverage" provisions required carrier to prove only that it mass mailed requisite materials. Bruce v. James P. MacLean Firm, 238 N.J.Super. 501, 570 A.2d 49 (L.1989), affirmed 238 N.J.Super. 408, 570 A.2d 1.

Insurer and agent were not liable in allegedly failing to inform insured about higher levels of underinsured motorist coverage. Pinto v. Garretson, 237 N.J.Super. 444, 568 A.2d 119 (A.D.1989).

Insured was not entitled to underinsured motorist benefits; insurance carried by two vehicles which struck his was greater than the amount of uninsured coverage which he could have obtained. Pinto v. Garretson, 237 N.J.Super. 444, 568 A.2d 119 (A.D.1989).

Whether insured was contributorily negligent was for jury. Weinisch v. Sawyer, 237 N.J.Super. 195, 567 A.2d 259 (A.D.1989), certification granted 121 N.J. 658, 583 A.2d 345, reversed 123 N.J. 333, 587 A.2d 615.

11:3–15.6 Minimum standards for New Jersey Auto Insurance Buyer's Guide

(a) Any insurance company may comply with this subchapter by using a camera-ready typeset Buyer's Guide produced by the Department. To obtain this camera-ready Buyer's Guide, an insurance company may contact the Division of Public Affairs, Department of Insurance, 20 West State Street, CN 325, Trenton, New Jersey 08625–0325.

(b) Insurance companies that wish to produce their own plates may do so according to the requirements prescribed in this subchapter.

(c) In preparing the Buyer's Guide, insurance companies shall use the text provided in this subchapter. Insurance companies which do not offer all the coverages described in the Buyer's Guide shall delete those sections and shall indicate clearly that they do not offer those coverages. Insurance companies may add information to the Buyer's Guide provided that the additional information is consistent with the purpose of the written notice.

(d) To assure conformity with this subchapter, each insurance company shall file its Buyer's Guide with the Division of Public Affairs. The filing shall include a sample copy of the insurance company's Buyer's Guide and a letter listing all alterations and additions, if any, made from the text appearing in this section. The filing shall be made once when the first Buyer's Guide is issued by the insurance company and again whenever changes are made.

(e) When changes are made in a Buyer's Guide, the new Buyer's Guide shall be filed with the Division of Public Affairs within seven days of its use, and the bottom of the last page shall clearly state the month and year in which the changes were implemented.

(f) The size of the pages of the Buyer's Guide shall not be smaller than three and a half inches by eight and one-half inches. The camera-ready Buyer's Guide produced by the Department shall use pages measuring five and one-half inches by eight and one-half inches.

(g) An insurance company which uses the Department's camera-ready Buyer's Guide shall not reduce the image or the size of its pages. The Buyer's Guide shall be bound by glue or staples. If an insurance company intends to fit this printed booklet in a common-size four-inch by nine-inch business envelope, the booklet may be folded once lengthwise.

(h) The Buyer's Guide shall be printed on paper of a quality sufficient to assure that printing does not bleed from one side to the other. The cover may be of the same or better paper quality as the pages.

(i) The type size used in the Buyer's Guide shall be at least 10–point. The camera-ready material provided by the Department shall be 12–point type.

(j) The type style used shall be within the discretion of the insurance company, but it shall be suitable for the use of boldface type for emphasis. In the text required by this subchapter, material which appears in boldface shall be printed in boldface type. The type style used in the camera-ready material provided by the Department shall be Times Roman.

(k) To provide adequate white space for an attractive format, the typeset shall be paragraphed consistent with the text of the Buyer's Guide in (m) below. Additionally, at least one line shall be skipped between each paragraph.

(*l*) The Buyer's Guide shall have a cover with the following title in large type: "New Jersey Auto Insurance Buyer's Guide." In regular type, the cover shall state, "This contains only general information and is not a legal document." An insurance company may include its name and/or company logo on the cover.

(m) An insurance company which writes at least two percent of the New Jersey private passenger automobile market, and each NJAFIUA servicing carrier, shall print its name and toll-free telephone number on the last page of the Buyer's Guide.

(n) An insurance company which does not offer additional medical expense benefits above limits of $250,000 per person, per accident, shall not include any reference to this optional coverage in its Buyer's Guide, nor shall any reference be made to such coverage in its Coverage Selection Form.

(*o*) The text of the New Jersey Auto Insurance Auto Buyer's Guide follows:

New Jersey

Auto Insurance

Buyer's Guide

This contains only general information

and is not a legal document.

Summary

There have been several important changes in New Jersey law that affect your insurance coverage.

The changes give New Jersey consumers additional rights.

For instance, if the insurance company you choose will not sell you auto insurance, the company has to tell you why, and, if you request it, the company has to respond in writing. If you are not satisfied, you can ask the New Jersey Department of Insurance for help. Under certain circumstances, you may also ask for a hearing. Any consumer who believes his/her insurance company has improperly charged him/her for an at-fault accident can contact the Department, which will investigate the allegations.

The insurance agent or the insurance company also must tell you whether you qualify for auto insurance from one of its other insurance companies or affiliates. Insurance applicants with eight or fewer eligibility points can obtain coverage from the company to which they apply, providing they fulfill all other eligibility requirements.

You also have the right to receive from your agent auto insurance premium rates from **all** the insurance companies he represents for which you qualify.

The law requires that you maintain auto liability coverage which, subject to the terms and limits of the policy, protects you in case you are sued, and pays for damages that you cause to someone else's property. **Please see page XX.**

You are also required to purchase personal injury protection which pays the auto accident-related medical bills for you and your family. **Please see page XX.**

You can choose whether your health insurance will pay first for injuries stemming from auto accidents (if you have health insurance which pays for such injuries), or whether you want your auto insurer to pay medical expenses first. You may save on your auto premiums by choosing the health insurance option. To find out more about this option, please see the section beginning on **page XX.**

Your medical benefits are capped at $250,000. That means your auto insurer can only pay up to $250,000 per person, per accident. But, for an additional premium, you may be able to purchase more coverage for yourself or your family.

You must also carry uninsured motorist coverage, which pays for damages caused by a driver who has no insurance. **Please see page XX.**

If you want additional coverage, you can buy collision or comprehensive which pays for damages to your own car or for auto theft. These will add to your total insurance cost. In many cases, State law requires a special insurance inspection of a vehicle before this coverage takes effect. You can save on your collision or comprehensive coverage by choosing higher deductibles. **Please see page XX.**

The law also allows you to choose whether you want an unlimited right to sue for auto-related damages—the "no threshold" option—or to save money by limiting your right to sue for serious injuries only—the "lawsuit threshold" option (also known as the "verbal threshold"). **Please see page XX.**

The Buyer's Guide will explain each of these terms. It will help you fill out the Coverage Selection Form. You can also learn how to get a comparison of premiums for all auto insurers **(page XX).**

Explanation of Coverages

Your auto insurance policy is actually several kinds of policies, or coverages, rolled into one.

For each coverage, you are charged a separate price which is known as the premium.

You pay only one price for auto insurance, but that price is determined by adding the premiums for all the coverages you buy.

Use your Coverage Selection Form to indicate what coverages you will buy in accordance with New Jersey law.

The coverages are:

LIABILITY

PERSONAL INJURY PROTECTION

UNINSURED/UNDERINSURED MOTORIST

COLLISION

COMPREHENSIVE

Use these explanations to help you complete the Coverage Selection Form.

Liability Coverage
(Required by Law)
Item 1 on the Coverage Selection Form

Liability coverage pays for injuries to other people or damages to their property if you are legally responsible for their losses. The company will pay damages only up to the amount of coverage you have chosen.

There are two kinds of liability coverage:

Bodily injury coverage involves cases in which another person is hurt or dies as a result of an auto accident. If you are legally responsible, it will compensate for pain, suffering or other personal hardships, and will also pay for some economic damages such as lost wages.

Property damage coverage will reimburse other people if you are legally liable for damage to their belongings as a result of an auto accident.

If a liability claim is filed against you, your insurance company will investigate the claim and will decide whether it should be paid, negotiated, or defended in court. Your insurance company will pay the legal bills.

Under State law, you must buy coverage which will pay, for each accident, at least in the following amounts:

- $15,000 for any one person's injuries;
- $30,000 when more than one person is injured;
- $ 5,000 for property damage.

Some companies sell a combined single limit which must be at least $35,000 per accident.

Higher limits of liability coverage are available at relatively low cost.

If you cause an accident and do not have enough insurance to cover your legal responsibilities, you then are personally responsible and could lose some of your assets or spend years paying this debt.

PREMIUM COST SAVER: Lawsuit Threshold (Verbal Threshold)
Item 2 on the Coverage Selection Form

In order to hold down insurance premiums, New Jersey motorists may choose to limit when they may sue for non-economic loss which means pain, suffering and inconvenience resulting from an auto accident.

The **"Lawsuit Threshold"** option, also known as the **"Verbal Threshold,"** uses words, rather than a dollar amount of medical bills, to describe when a suit may be filed. If you select this limitation, then you, your spouse and children living with you who are not covered by name by another auto insurance policy will not be able to sue unless the injury sustained appears on this list:

- **death;**
- **dismemberment;**

- **significant disfigurement;**

- **a fracture;**

- **loss of a fetus;**

- **permanent loss of use of a body organ, member, function or system;**

- **permanent consequential limitation of use of a body organ or member;**

- **significant limitation of use of a body function or system; or**

- **a medically determined injury or impairment of a non-permanent nature which prevents the injured person from performing substantially all of the material acts which constitute that person's usual and customary daily activities for not less than 90 days during the 180 days immediately following the occurrence of the injury or impairment. (N.J.S.A. 39:6A–8, effective January 1, 1989)**

You can reject this threshold and retain the right to sue for any auto-related injury. This option, called **"No Threshold,"** will increase the price of your insurance policy.

Under state law, you must choose either the Lawsuit Threshold or the No Threshold option. The same choice should be made under all policies that you have. **If you do not choose one of these options, you are considered by law to have selected the Lawsuit Threshold option.**

Personal Injury Protection (PIP)

(Required by Law)

Item 3 on the Coverage Selection Form

New Jersey law requires Personal Injury Protection, sometimes called PIP or no-fault coverage, which pays all reasonable medical bills up to a maximum of $250,000 per person, per accident regardless of who caused an auto accident.

However, you may also have the option to select your health insurer or health maintenance organization to pay your auto accident no-fault claims.

Basic PIP Coverage provides:

- **Medical Expenses:** Payment of reasonable and necessary medical expenses within certain limits set by state law—a $250 deductible for each accident, only 80 percent reimbursement for the expenses from $251 through $5,000 for each accident, and a maximum benefit of $250,000 per person per accident.

- **Income Continuation:** If you cannot work because of an auto accident injury, you can collect up to $100 a week up to a total limit of $5,200 for lost wages.

- **Essential Services:** You can collect as much as $12 a day up to a total limit of $4,380, to pay someone to do necessary services that you normally do yourself, such as cleaning your house, mowing your lawn, shoveling snow or doing laundry.

- **Death Benefit:** If you die from auto accident injuries, your family or estate will receive any benefits you have not already collected under the income continuation and essential services coverages.

- **Funeral Expense Benefit:** In addition to the death benefit, reasonable funeral expenses are covered up to $1,000.

PREMIUM COST SAVER: PIP Medical Expenses Only Coverage

If you wish, you can buy PIP medical coverage without any income continuation, essential services, death benefits and funeral expense benefits. This is called PIP Medical Expenses Only.

You might want this cost-saving option if you and relatives who live with you would not lose income if any of you were disabled by an auto accident. For example, this option should be considered if your sources of income are pensions, Social Security or investments which would continue regardless of an auto accident, and if someone is always available to care for your personal needs, and if your funeral expenses are covered in some other way.

But the option is a package deal. Either you keep all four of these non-medical expense PIP benefits, or you drop them all. You cannot pick and choose.

Additional PIP Coverage

On the other hand, you and relatives who live with you and who do not have their own auto insurance policies might want higher benefits. You can purchase higher benefits for income protection and essential services, funeral expenses and higher death benefits, than the amounts provided in the basic PIP plan.

Additional Medical Expense Coverage

Your auto insurance company may also offer additional medical expense benefits above limits of $250,000 per person, per accident.

If you buy additional benefits, the price of your insurance will be higher.

(NOTE: Reference to Additional Medical Expense Coverage shall be deleted by those companies which do not offer the coverage.)

Personal Injury Protection (PIP)

Health Insurance Option Premium (Cost Saving Option)

Item 4 on Coverage Selection Form

Most New Jersey residents have the option of selecting their health coverage provider, rather than their auto insurance company, to pay for their no-fault medical expense claims. A health coverage provider may be an insurance company, an HMO or some other type of benefit plan provided by your employer.

Medicare and Medicaid will NOT provide primary coverage. If your health benefits are provided by either Medicare or Medicaid, you cannot choose this option.

If you select your health coverage provider to be the primary payer of auto no-fault claims, you may save on your auto premium. **Before selecting this option, however, check to make sure that your health coverage provider will pay for auto accident injury treatment expenses.** If your employer supplies your health coverage, your company should be able to give you this information; otherwise, check with your health coverage provider directly.

Deductibles and co-pays of your health policy or plan will still apply. And coverage limits of your health policy or plan will be in effect.

Most HMOs offer unlimited coverage. Most other health coverage providers offer lifetime benefit limits of $1 million.

That means the health coverage provider will pay all eligible health claims, as long as they do not total more than $1 million during your lifetime. **Be sure to ask your health coverage provider what limits apply under your policy or plan.**

Your health policy or plan may not cover all procedures or treatments. Exclusions listed in your policy or plan will apply. But your auto insurer should pay for necessary expenses not covered by your health policy or plan.

If you choose your health coverage provider to be responsible for paying auto accident-related medical bills, you must provide the name of your health coverage provider and the policy, plan, membership or group certificate number on the Coverage Selection Form. You must also maintain your health coverage.

If you are in an accident and your health coverage is no longer in effect, your auto insurer must pay PIP medical benefits. However, you will be required to pay a $750 additional deductible.

PIP Medical Expenses Deductible

Auto Insurer Option

Item 5 on Coverage Selection Form

This option involves only the medical bills paid by PIP, not the income continuation, essential services, death benefits or funeral expense benefits, which will be paid under Basic PIP coverage regardless of whether you select your health insurer or auto insurer to be the primary payer of your auto-accident related medical bills.

Under New Jersey law, unless you choose your health insurer to pay your auto-accident related medical bills, your auto insurance policy will cover your reasonable and necessary medical bills up to a maximum of $250,000 per person, per accident, if you are injured in an auto accident.

However, for the first $5,000 of medical bills per accident, your auto policy will pay only part of the cost of your treatment or the treatment of others covered by your policy. There is a $250 deductible, meaning the first $250 will not be covered. The deductible applies only once per accident regardless of the number of people injured.

There is also a 20 percent co-payment which means that for the bills from $251 to $5,000, the policy will pay only 80 percent. Medical bills above $5,000 are paid up to $250,000 per person, per accident.

(NOTE: Companies offering higher PIP limits may state that benefits above $5,000 are paid up to the limit selected.)

You can choose a $250 deductible, a $500 deductible, a $1,000 deductible or a $2,500 deductible. A way to lower the price of your auto insurance is to have a larger PIP deductible. The 20 percent co-payment still applies to expenses between the deductible chosen and $5,000.

You should consider the $2,500 PIP deductible if you are already covered by a health insurance policy or a health maintenance organization (HMO). In most cases, those plans will pay part of the medical bills which auto insurance will not pay.

Before taking this option, ask your health insurance company or HMO two things:

Will your health policy or HMO cover auto-related medical bills not paid by auto insurance? The Department of Insurance requires that health insurance sold in New Jersey cover treatment for auto-related injuries the same as other injuries. But your policy may not follow this rule because you may be covered by a health insurance group sold out of state or by an employer self-insurance plan. Find out.

What are your health policy's or HMO's own deductible, co-payments and exclusions? Find out what your health plan covers. For instance, it may cover only hospitalization but not doctor visits. Also, your health insurance or HMO has its own rules regarding what you pay out of your pocket for medical treatment. Those rules will apply if you use your health plan to cover the PIP deductible.

Uninsured/Underinsured Motorist Coverage (Required by Law) Item 6 on the Coverage Selection Form

Despite New Jersey law, which requires auto insurance, many cars are not covered by insurance. Some motorists break the law. Many other motorists are residents of other states which do not require auto insurance by law.

Because these motorists can cause accidents, you are required to buy uninsured motorist coverage. This coverage does not benefit the uninsured driver. It will provide benefits to **you**, your passengers or relatives living with you if a motorist without insurance is legally liable for injuries to these persons or for damage to your car or its contents.

There are other motorists who have auto insurance coverage but with very low limits. When you buy uninsured motorist coverage, you are also provided coverage to protect you from those motorists who are underinsured. If you are in an accident caused by such a motorist, underinsured motorist coverage will pay damages up to the difference between your underinsured motorist coverage limit and the other driver's liability coverage limit.

You must by law purchase uninsured motorist coverage which will pay, for each accident, at least the following amounts:

- $15,000 for any one person's injuries;
- $30,000 when more than one person is injured;
- $ 5,000 for property damage.

Many companies sell a combined single limit which must be at least $35,000. The property damage coverage has a basic $500 deductible, which means you pay the first $500 of a claim under that coverage.

You can buy higher uninsured/underinsured motorist coverage limits, but only as high as the liability coverages you have purchased. Most companies sell up to $250,000/ $500,000/$100,000 coverage or a combined single limit of $500,000.

Collision and Comprehensive Coverages (Optional) Items 7 and 8 on Coverage Selection Form

Collision coverage and comprehensive (also known as "other than collision") coverage pay for damage to your car. These coverages will pay to repair your car or pay for its value at the time of the loss if it is stolen or declared a total loss.

These coverages are **not** required by law. But, if you borrowed money to buy your car or if you are leasing the car, the lender or lessor may require you to buy these coverages. Note that some companies will provide collision coverage only if you buy comprehensive coverage too. Contact your company for details.

Collision pays for damage to your car caused by your car hitting things like other cars, trees or telephone poles, or for the car overturning, or for other moving objects hitting your car.

Comprehensive insurance pays for nearly every other kind of damage to your car, such as fire, theft, flood, vandalism, or contact with a bird or animal.

In order to obtain collision or comprehensive coverage for a newly insured vehicle, you must notify your auto insurance company **immediately.** Under a new State law, in most cases, collision or comprehensive coverage cannot be provided on a newly acquired vehicle until the auto insurance company is notified. Also, many such vehicles must be inspected for insurance purposes before coverage can be provided. See the section entitled "Mandatory Insurance Inspection" for more details.

PREMIUM COST SAVER: No Collision or No Comprehensive

If your car is older and is paid for, consider eliminating collision or comprehensive coverage, or both. This decision will reduce your premium.

To make the decision, consider what you will pay for these coverages versus the possible benefit if you file a claim.

Collision and comprehensive coverage will reimburse you only up to the actual cash value of your car. The insurance payment probably will be less than the actual cash value because of deductibles.

PREMIUM COST SAVER: Collision and Comprehensive Deductibles

If you decide that you need collision or comprehensive coverage or both, a significant way to hold down the price of your insurance policy is to select higher deductibles.

If you file a claim, a deductible is the amount of money you will pay before the insurance company starts paying. Deductibles are a way of reducing insurance company costs, and thereby lowering the price of your insurance policy.

The standard deductible for auto insurance in New Jersey is $500. You still have the right to buy collision or compre-

hensive coverage with higher or lower deductibles. The lower the deductible, the higher the price of your insurance policy.

MANDATORY INSURANCE INSPECTION

For Newly Insured Vehicles

Under the new State law, many vehicles to be insured for collision or comprehensive (also known as "other than collision") coverage must first be inspected for insurance purposes. The law is intended to reduce insurance fraud by documenting the condition of newly insured private passenger automobiles.

Whenever you acquire a vehicle and desire collision or comprehensive coverage on it, the most important thing to do is to notify your auto insurance company **immediately**. They will tell you everything necessary to comply with the law and obtain the coverage you desire.

> Until you notify your auto insurance company the vehicle may not be covered for collision or comprehensive.

It is important to understand that the Mandatory Insurance Inspection is in addition to the Motor Vehicle Inspection program conducted by the State of New Jersey. Two separate inspections take place.

In many cases, an insurance inspection may not be necessary. The law says that insurance inspections may be waived for vehicles which are older than seven model years. The law also says that an insurance inspection may not be necessary for a "new automobile" purchased from a franchised dealer if you submit an invoice documenting your purchase. If your auto insurance policy has been in effect for four years or longer, an inspection may not be required by law. Your auto insurance company will explain when you call.

Otherwise, an inspection is required for newly insured vehicles. If your vehicle must be inspected, your auto insurance company can provide temporary coverage for only seven days after the day you notify them about the vehicle.

The only way to make sure that you meet the State requirements and receive the coverage you want is to call your auto insurance company before or as soon as any change of a vehicle occurs.

Anti-Theft Device Discount—Your auto insurance company encourages the use of anti-theft and vehicle recovery devices as another means to reduce losses. The following types of devices are among those which may qualify for a reduction in the Comprehensive premium:

1. Alarm System;
2. Fuel Cut–Off;
3. Hydraulic Brake Lock;
4. Ignition or Starter Cut–Off;
5. Steering Wheel Collar;
6. Transmitter which enables the location of the vehicle to be traced; or
7. Window Etching Vehicle Identification System.

Other types may also qualify.

If your auto is equipped with an anti-theft or vehicle recovery device, contact your auto insurance company for more details and an Anti–Theft Questionnaire.

Safety Feature Discount—Your auto insurance company encourages the use of safety features as another means to reduce losses. The following types of safety features are among those which may qualify for a reduction in the Collision premium.

1. Anti-Lock Braking System;
2. Traction Control Systems;
3. Five mile per hour bumpers;

Other types may also qualify.

If your auto is equipped with a safety feature, contact your auto insurance company for more details. The rates of insurers which use make and model rating for collision coverage already include these discounts.

Price Comparison

If you would like a copy of the annual auto insurance premium comparison published by the New Jersey Department of Insurance, please send a stamped, self-addressed envelope to:

Auto Comparison
Division of Public Affairs
NJ Department of Insurance
CN 325
Trenton, NJ 08625–0325

(p) As appropriate, an insurance company may substitute its name in the Buyer's Guide.

(q) As appropriate, an insurance company which offers only split limits may delete language in the Buyer's Guide explaining combined limits, and an insurance company which offers only combined limits may delete language regarding split limits. If an insurance company does not offer limits as low as the minimums required by law, that information may be inserted in this paragraph.

(r) An insurance company which offers higher benefits than described in the text of the Buyer's Guide may modify the relevant paragraph to explain those higher benefits.

(s) An insurance company which uses only one term, "Comprehensive" or "Other Than Collision," to describe this coverage, may delete reference to the inappropriate term.

As amended, R.1984 d.479, eff. November 5, 1984.
See: 16 N.J.R. 1693(a), 16 N.J.R. 3038(a).
(a)3: added "as amended by P.L. 1984 c.40".
New rule, R.1989 d.117, effective February 21, 1989.
See: 20 N.J.R. 2984(a), 21 N.J.R. 558(b).
Repealed "Specific coverages and options to be included in written notice and buyer's guide".
Amended by R.1990 d.580, effective November 19, 1990 (operative January 1, 1990).
See: 22 N.J.R. 1681(a), 22 N.J.R. 3488(b).
Subsection (n) of this section is amended to delete in its entirety the text of the Buyer's Guide and to substitute new text therefor. The new text is written in plain language pursuant to the requirement of section 13 of the "Fair Automobile Insurance Reform Act of 1990" and incorporated several changes required to be made in the Coverage Selection Form by the Act; also amended to delete the provision that the Department, upon request from an insurer, will prepare a coverage-ready final page of the Buyer's Guide.
R.1992 d.218, effective May 18, 1992.
See: 24 N.J.R. 523(a), 24 N.J.R. 1898(b).
In (c), "Insurance companies ... shall delete those sections" was "may delete ...". Added new (n), regarding additional medical benefits, and redesignated existing (n) as (*o*), with extensive revisions to Buyer's Guide. Redesignated existing (*o*) through (r) as (p) through (s).

Case Notes

The Automobile Reparation Reform Act limits on recovery from tort-feasor. Roig v. Kelsey, 135 N.J. 500, 641 A.2d 248 (1994).

Motorist could reasonably and objectively expect to be buying protection up to declared legal limits. Clegg v. New Jersey Auto. Full Underwriting Ass'n By and Through Cigna Ins. Co., 254 N.J.Super. 634, 604 A.2d 179 (A.D.1992).

There was common-law duty on part of insurance carriers or their agents to advise insureds concerning possible need for higher policy limits upon policy renewal. Wang v. Allstate Ins. Co., 125 N.J. 2, 592 A.2d 527 (1991).

Insured could not have jury trial in reformation action for agent's failure to inform insured of available underinsured motorist coverage. Weinisch v. Sawyer, 123 N.J. 333, 587 A.2d 615 (1991).

Direct writing insurer was not responsible for insured's inadequate underinsured motorist (UIM) coverage. Andriani v. New Jersey Mfrs. Ins. Co., 245 N.J.Super. 252, 584 A.2d 875 (A.D.1991), certification denied 126 N.J. 327, 598 A.2d 886.

Client-initiated contacts with insurance brokers can result in broker's duty to exercise skill and possess knowledge concerning coverages. Avery v. Arthur E. Armitage Agency, 242 N.J.Super. 293, 576 A.2d 907 (A.D.1990).

Insurer's buyer's guide and coverage selection form complied with regulations. Avery v. Arthur E. Armitage Agency, 242 N.J.Super. 293, 576 A.2d 907 (A.D.1990).

Automobile insurer that was already voluntarily offering underinsured motorist coverage prior to January 1, 1984 did not have adjustment period until July 1, 1984. Sikking v. Nelson, 242 N.J.Super. 185, 576 A.2d 311 (A.D.1990).

"Notice of coverage" provisions required carrier to prove only that it mass mailed requisite materials. Bruce v. James P. MacLean Firm, 238 N.J.Super. 501, 570 A.2d 49 (L.1989), affirmed 238 N.J.Super. 408, 570 A.2d 1.

Whether insured was contributorily negligent was question for jury. Weinisch v. Sawyer, 237 N.J.Super. 195, 567 A.2d 259 (A.D.1989), certification granted 121 N.J. 658, 583 A.2d 345, reversed 123 N.J. 333, 587 A.2d 615.

Model coverage selection form, was not arbitrary, unreasonable or capricious, and was substantially consistent with statutory language. Emmer v. Merin, 233 N.J.Super. 568, 559 A.2d 845 (A.D.1989), certification denied 118 N.J. 181, 570 A.2d 950.

Two statutes, one requiring that coverage selection form state the percentage difference in premium rates or dollar savings between the two tort options for suing for noneconomic loss and the other requiring that coverage selection form identify range of premium rate credit or dollar savings or both; were not inconsistent. Emmer v. Merin, 233 N.J.Super. 568, 559 A.2d 845 (A.D.1989), certification denied 118 N.J. 181, 570 A.2d 950.

Commissioner's regulations did not have to require that coverage selection form inform consumers of exact dollar amount of premium savings arising from election. Emmer v. Merin, 233 N.J.Super. 568, 559 A.2d 845 (A.D.1989), certification denied 118 N.J. 181, 570 A.2d 950.

Commissioner's use of term "lawsuit threshold" in buyer's guide and coverage selection form, as opposed to "verbal threshold" did not lead to confusion. Emmer v. Merin, 233 N.J.Super. 568, 559 A.2d 845 (A.D.1989), certification denied 118 N.J. 181, 570 A.2d 950.

Buyer's guide and coverage selection form did not contain inherent bias or confusion on basis that Commissioner made reference to "basic limit" as opposed to "basic tort option." Emmer v. Merin, 233 N.J.Super. 568, 559 A.2d 845 (A.D.1989), certification denied 118 N.J. 181, 570 A.2d 950.

Buyer's guide and coverage selection form which gave basic tort option, as opposed to no-threshold option, a favorite status, was justifiable. Emmer v. Merin, 233 N.J.Super. 568, 559 A.2d 845 (A.D. 1989), certification denied 118 N.J. 181, 570 A.2d 950.

Insurance Commissioner acted properly when he required that coverage selection form contain provision referring consumers to their automobile insurance companies in event of questions on coverage. Emmer v. Merin, 233 N.J.Super. 568, 559 A.2d 845 (A.D.1989), certification denied 118 N.J. 181, 570 A.2d 950.

11:3–15.7 Minimum standards for Coverage Selection Form

(a) The Coverage Selection Form shall be printed on at least two pages of paper, size eight and one-half inches by 11 inches. A space shall be provided at the top of the front page for the consumer's name to be handprinted, and a space shall be provided at the bottom of the last page for the consumer's signature and date.

(b) The insurance company may include additional lines for application number, policy number or other necessary information.

(c) An insurance company may expand the form to solicit additional information, including, but not limited to, the names of resident relatives eligible for PIP benefits, or different collision and comprehension deductibles applying to different vehicles covered by the same policy.

(d) The type size shall be at least 12–point.

(e) The Department will not provide camera-ready typeset for the Coverage Selection Form.

(f) The Coverage Selection Form shall include the range of premium rate differences as indicated by this subchapter.

Each insurance company shall determine the numbers for use in these sections. When the numbers on the Coverage Selection Form change for any reason, including, but not limited to, rate changes, a new Coverage Selection Form with the current numbers shall be printed.

(g) The Coverage Selection Form shall include the language in (h) below, except that language marked "(NOTE)", which describes language which the insurance company shall insert.

(h) The text of the Coverage Selection Form follows:

(NOTE: Company's name may be included here.)

(NOTE: If a company has more than two percent of the New Jersey private passenger automobile market, it shall include its name and toll-free number here.)

COVERAGE SELECTION FORM

Name:_____

For new policies, you must choose one option for each item below. For changes upon renewal and mid-term policy changes, you must use this Form when you:

(a) elect the "No Threshold" option;

(b) change from the "No Threshold" option to the "Lawsuit Threshold" option;

(c) desire collision or comprehensive deductibles other than $500;

(d) desire to change to the $500 deductible for collision or comprehensive coverage;

(e) desire your health insurer to be the primary insurer to pay for your auto accident-related medical bills; or

(f) desire your auto insurance carrier to be the primary insurer for your auto accident-related medical bills.

The following item numbers match the explanations in the New Jersey Auto Insurance Buyer's Guide. Read the Buyer's Guide for information and help in completing this form.

1. Liability Coverage

How much coverage do you choose for damage you may do to others?

☐ _____

☐ _____

☐ _____

☐ _____

(NOTE: At least four of the most popular coverage limits shall be listed, including the lowest limit offered)

(NOTE: If a complete list is not provided, state that other coverage limits are available.)

2. Lawsuit Threshold (Otherwise known as the "Verbal Threshold")

Do you accept the basic limit on the right to sue if injured in an auto accident?

☐ Yes. I want the Lawsuit Threshold.

☐ No. I want No Threshold. My bodily injury liability premium will be ___% to ___% higher if I select the No Threshold option instead of the Lawsuit Threshold, depending upon where my car is garaged, my bodily injury liability coverage limit, and other factors. Per vehicle, my bodily injury liability premium at current rates will be $___ to $___ higher on each _____ renewal of my policy if I select the No Threshold option instead of the Lawsuit Threshold. I understand that I can contact my insurance company or my insurance producer i.e., agent or broker) for specific details.

(NOTE: Insurance companies writing six month policies should insert the word "semi-annual" in the blank space above. Companies writing 12 month policies should insert the word "annual.")

(NOTE: Insurance companies writing single limit liability coverage may add a footnote to inform insureds that the policy declaration page will not include a specific premium for "bodily injury liability" coverage.)

NOTE: Insurance companies or their producers or representatives shall not be held liable in an action for damages either on account of the choice of a tort option (lawsuit threshold/verbal threshold or no threshold) made by an insured or on account of the tort option imposed by law if no choice is made, except for damages caused as the result of a willful, wanton or grossly negligent act of commission or omission.

3. Personal Injury Protection (PIP). Choose the kind of coverage you want.

☐ Basic PIP Coverage which includes income continuation, essential services, death benefits and funeral expense benefits as well as medical expense benefits, or

☐ PIP Medical Expenses Only Coverage, for a ___% to ___% savings in the _____ premium. (NOTE: Include the range of percentage savings and the base, i.e., basic PIP premium.);

☐ Additional PIP Coverage at an extra cost. NOTE: This option is not available if you have selected PIP Medical Expenses Only Coverage. Contact your insurance company or insurance producer (i.e., agent or broker) for details. (NOTE: Company's name may be used here or a chart listing options may be enclosed.)

☐ Additional Medical Expense Coverage.

(NOTE: Reference to Additional Medical Expense Coverage shall be deleted by those companies which do not offer the coverage.)

4. PIP Health Insurance Option. Choose if you want your health insurer, other than Medicare or Medicaid, to be your primary carrier to pay your auto accident-related medical benefits. Check with your employer or health insurer to see if you are eligible and request an answer in writing. To choose this option, health coverage must cover the named insured and members of his family residing in the household.

☐ Yes, I choose the PIP health insurer option.

(NOTE: Your auto insurance company may invalidate this option selection and request payment of the discounted premium amount if it checks but cannot verify that (1) your health coverage is in effect, and (2) your health insurer will provide primary coverage for your auto accident-related medical expenses.

The name of my health insurer(s) is (are):

1. _____
Number: _____
Policy, Plan, Membership or Group Certificate Number (circle one)

2. _____
Number: _____
Policy, Plan, Membership or Group Certificate Number (circle one)

☐ No, I do not want the PIP health insurer option.

5. PIP Medical Expenses Deductible. Choose only one:

☐ $250 deductible, minimum required by law.

☐ $500 deductible, for a ___% to ___% reduction in the Basic PIP premium.

☐ $1,000 deductible, for a ___% to ___% reduction in the Basic PIP premium.

☐ $2,500 deductible, for a ___% to ___% reduction in the Basic PIP premium.

6. Uninsured/Underinsured Motorists Coverage

How much coverage do you choose for damage which another driver who has little or no insurance may do to your car, your family, your passengers or yourself? Your auto insurance company must offer this coverage up to the bodily injury and property damage liability limits you have selected.

☐ _____

☐ _____

☐ _____

☐ _____

(NOTE: List the same options available for liability coverage above. Other options may also be listed.)

NOTE: Insurance companies or their producers or representatives shall not be held liable in an action for damages either on account of the choice of a given level of motor vehicle insurance coverage made by an insured, as long as those limits provide at least the minimum coverage required by law, or on account of the insured not choosing to purchase underinsured motorists coverage, collision coverage or comprehensive coverage, except for damages caused as the result of a willful, wanton or grossly negligent act of commission or omission.

7. Do you choose "collision" coverage?

☐ No. I do not wish to be covered for collision damage.

☐ Yes, with the basic $500 deductible.

☐ Yes, with the deductible circled here: $1,000, $1,500 or $2,000. This premium will be proportionately **less** than the premium with the basic $500 deductible. Details available from company or insurance producer (i.e., agent or broker).

☐ Yes, with the deductible circled here: $100, $150, $200 or $250. This premium will be proportionately **more** than the premium with the basic $500 deductible. Details available from company or insurance producer (i.e., agent or broker).

(WARNING: YOU MAY NOT BE ABLE TO ADD COLLISION COVERAGE TO AN EXISTING VEHICLE OR TO ADD AN ADDITIONAL OR REPLACEMENT VEHICLE TO YOUR EXISTING POLICY WITHOUT FIRST HAVING THAT VEHICLE INSPECTED; CONTACT YOUR INSURANCE COMPANY OR INSURANCE AGENT IMMEDIATELY.)

8. Do you choose "comprehensive" coverage? (NOTE: If appropriate, use the term "other than collision" coverage throughout this section.)

☐ No. I do not wish to be covered for comprehensive damage.

☐ Yes, with the basic $500 deductible.

☐ Yes, with the deductible circled here: $1,000, $1,500 or $2,000. This premium will be proportionately **less** than the premium with the basic $500 deductible. Details available from company or insurance producer (i.e., agent or broker).

☐ Yes, with the deductible circled here: $50, $100, $150, $200 or $250. This premium will be proportionately **more** than the premium with the basic $500 deductible. Details available from company or insurance producer (i.e., agent or broker).

(NOTE: For both collision and comprehensive, if either the $200 deductible or $250 deductible is not offered, that option may be deleted from this form. Also, all other available collision and comprehensive deductibles shall be listed where appropriate.)

(WARNING: YOU MAY NOT BE ABLE TO ADD COMPREHENSIVE COVERAGE TO AN EXISTING VEHICLE OR TO ADD AN ADDITIONAL OR REPLACEMENT VEHICLE TO YOUR EXISTING POLICY WITHOUT FIRST HAVING THAT VEHICLE INSPECTED; CONTACT YOUR INSURANCE COMPANY OR INSURANCE AGENT IMMEDIATELY.)

I have read the Buyer's Guide outlining the coverage options available to me. The limits available for uninsured and underinsured motorists coverage have been explained to me. My choices are shown above. I agree that each of these choices will apply for all vehicles insured by my policy and to each subsequent renewal, continuation, replacement or amendment until the insurance company or its insurance producer (i.e., agent or broker) with the company's binding authority receives my request that a change be made.

For new policyholders, I understand that:

(a) if I do not make a written choice for Item 2, I will receive the Lawsuit Threshold option;

(b) if I carry collision or comprehensive coverage without making a written choice for Item 7 or Item 8, I will receive the $500 deductible; and

(c) if I do not make a written choice for the PIP health insurer option in Item 4, my auto insurer will be the primary health insurer for PIP medical expense benefits.

I understand that if this is a policy renewal and I do not complete choices, I will receive the same coverage as in my previous policy except when changes are required by a law becoming effective during the term of my previous policy.

I understand that these choices take effect in the following manner:

(1) for new policies and mid-term policy changes, the choices on this Form are effective the day following the date of postmark or, when personal delivery is made or the postmark is illegible, the day following receipt of this Form by the insurance company or by an insurance producer (i.e., agent or broker) with the company's binding authority; and

(2) for changes upon renewal, the changes to be made on this Form are effective on the date of the next policy renewal if postmarked or received by the insurance company or by an insurance producer (i.e., agent or broker) with the company's binding authority prior to the renewal date.

ANY PERSON WHO KNOWINGLY MAKES AN APPLICATION FOR MOTOR VEHICLE INSURANCE COVERAGE CONTAINING ANY STATEMENT THAT THE APPLICANT RESIDES OR IS DOMICILED IN THIS STATE WHEN, IN FACT, THAT APPLICANT RESIDES OR IS DOMICILED IN A STATE OTHER THAN THIS STATE, IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

Please check the appropriate box to which this form applies
☐ NEW POLICY ☐ Mid-Term Change ☐ Renewal Change

SIGNATURE _____ DATE _____

(i) To assure conformity with this subchapter, each insurance company shall file its Coverage Selection Form with the Division of Public Affairs. Whenever the Coverage Selection Form is changed, the new form shall be filed, and the month and year the changes were implemented shall be clearly stated at the bottom of the revised form. Deadlines for implementation and filing requirements regarding the Coverage Selection Form shall be the same as for the Buyer's Guide. See N.J.A.C. 11:3–15.6(e).

(j) Insurance company shall be required to calculate the percentage and dollar change in premium (or rate) arising from the selection of the No Threshold option as indicated in (j)1 through 4 below. In these calculations, premium (or rate) shall include any expense fee, but shall not include any policy constant or RMEC.

1. The Percentage Change Calculation: The percentage increase in the bodily injury liability premium arising from the selection of the No Threshold option shall be determined by calculating the No Threshold rate as a percentage increase relative to the comparable Lawsuit Threshold rate. The low end of the percentage range shall be produced by calculating the percentage increase in the bodily injury liability premium of a policy with a $250,000/$500,000 split limit or a $500,000 single limit when the motorist goes from the Lawsuit Threshold option to the No Threshold option. This calculation shall be made for the territory with the lowest basic limit Lawsuit Threshold rate, and shall assume pleasure usage by an age 30–64, married male principal operator. The high end of the percentage range shall be produced by making the same type of calculation using a policy with basic limits for the territory with the highest basic limit Lawsuit Threshold rate, and shall assume business usage by a youthful, unmarried male principal operator.

2. The Dollar Change Calculation: The dollar increase in the bodily injury liability premium arising from the selection of the No Threshold option shall be determined by subtracting the Lawsuit Threshold rate from the comparable No Threshold rate. The low end of the dollar range shall be produced by calculating the dollar change using a policy with basic limits for the territory with the lowest basic limit Lawsuit Threshold rate, and shall assume personal usage by an age 30–64, married male principal operator. The high end of the dollar range shall be calculated using a $250,000/$500,000 split limit or a $500,000 single limit policy for the territory with the highest basic limit (verbal) Lawsuit Threshold rate, and shall assume business usage by a youthful, unmarried male principal operator. Because the range of the possible additional dollar cost will depend upon territory, bodily injury liability loss limits, and other factors, insurers shall be permitted to use round numbers to represent the approximate range of the cost increase. For example, if the smallest dollar rate increase was $56.00 and the largest $305.00, the insurer may use the range $50.00 to $310.00 on its Coverage Selection Form.

3. Premium Basis for Single Limit Liability Coverage:

i. For single limit liability coverage, the percentage range calculation that is described in (j)1 above shall be based upon the applicable bodily injury liability rate. This calculation shall not be made on the basis of a combined rate containing a charge for bodily injury liability, personal injury protection (PIP), and property damage liability.

ii. For single limit liability coverage, the dollar range calculation that is described in (j)2 above shall be based upon the applicable liability rate. In contrast to the procedure in (j)3i above, the dollar change calculation shall be made on the basis of a complete rate containing a charge for bodily injury liability, personal injury protection (PIP), and property damage liability.

4. Insurance companies shall submit to the Division of Public Affairs, New Jersey Department of Insurance, CN 325, Trenton, New Jersey 08625, within seven days of its first use, a copy of the Coverage Selection Form prepared pursuant to this subsection together with:

i. An example showing the calculation of the high and low values for the percentage and dollar change ranges;

ii. Data about the insurance company's territorial rates to confirm that the highest and lowest basic limit Lawsuit Threshold rates have been used in the example. The filing of a rating page showing a list of basic limit rates by territory shall be sufficient;

iii. Data about the insurance company's increased limits liability rating, vehicle usage, and type of driver factors to confirm that the proper relativities have been used in the example. The filing of the appropriate rating pages shall be sufficient; and

iv. For those insurance companies offering only single limit liability coverage, an explanation of the procedure used to develop the bodily injury liability rate from which the percentage and dollar change amounts have been determined. This explanation shall include an example of the calculation methodology.

(k) Insurance companies which do not offer all the coverages described in the Coverage Selection Form shall list those coverages on the form and shall clearly state that those coverages are not available from that company.

New rule, R.1989 d.117, effective February 21, 1989.
See: 20 N.J.R. 2984(a), 21 N.J.R. 558(b).
Section was "Statement on the possible coordination of other health benefits coverage with the personal injury protection medical expense options".
Amended by R.1989 d.624, effective December 18, 1989 (operative January 1, 1990).
See: 21 N.J.R. 3244(a), 21 N.J.R. 3922(a).
Amendments made to bring rule in line with changes in N.J.S.A. 39:6A–23 made by P.L. 1988 c.119.
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 be consistent with N.J.A.C. 11:3–15.6; the text of the Coverage Selection Form is amended both to clarify the current Form and requirements and to respond to changes required by the "Fair Automobile Insurance Reform Act of 1990".
R.1992 d.218, effective May 18, 1992.
See: 24 N.J.R. 523(a), 24 N.J.R. 1898(b).
In (h), added Note to 3, Warning statement to 7 and 8, and prohibition against domicile misstatement to (2).
Amended by R.1994 d.195, effective April 18, 1994.
See: 26 N.J.R. 85(a), 26 N.J.R. 1659(a).

Case Notes

Model coverage selection form, proposed by regulations promulgated by Insurance Commissioner for implementing legislative revisions to no-fault automobile insurance law requiring consumers to select between two options of coverage for automobile accident-related bodily injury. Emmer v. Merin, 233 N.J.Super. 568, 559 A.2d 845 (A.D.1989), certification denied 118 N.J. 181, 570 A.2d 950.

Statute requiring that no-fault automobile insurance coverage selection form state the percentage difference in premium rates or dollar savings between the two tort options for suing for noneconomic loss was not inconsistent with statute requiring that coverage selection form identify range of premium rate credit or dollar savings or both. Emmer v. Merin, 233 N.J.Super. 568, 559 A.2d 845 (A.D.1989), certification denied 118 N.J. 181, 570 A.2d 950.

Insurance Commissioner's proposed regulations, which implemented revisions to nonfault automobile insurance law requiring consumers to select between two options of coverage for automobile accident-related bodily injury, did not have to require that coverage selection form inform consumers of exact dollar amount of premium savings arising from election. Emmer v. Merin, 233 N.J.Super. 568, 559 A.2d 845 (A.D.1989), certification denied 118 N.J. 181, 570 A.2d 950.

When promulgating regulations to implement revisions to no-fault automobile insurance law, Commissioner's use of term "lawsuit threshold" in buyer's guide and coverage selection form, as opposed to "verbal threshold", did not lead to confusion. Emmer v. Merin, 233 N.J.Super. 568, 559 A.2d 845 (A.D.1989), certification denied 118 N.J. 181, 570 A.2d 950.

Buyer's guide and coverage selection form in regulations promulgated by Insurance Commissioner to implement revisions to no-fault automobile insurance law did not contain inherent bias or confusion on basis that Commissioner made reference to "basic limit" as opposed to

"basic tort option." Emmer v. Merin, 233 N.J.Super. 568, 559 A.2d 845 (A.D.1989), certification denied 118 N.J. 181, 570 A.2d 950.

Buyer's guide and coverage selection form which gave basic tort option, as opposed to no-threshold option, a favorite status, was justifiable. Emmer v. Merin, 233 N.J.Super. 568, 559 A.2d 845 (A.D. 1989), certification denied 118 N.J. 181, 570 A.2d 950.

Insurance Commissioner acted properly when he required that coverage selection form contain provision referring consumers to their automobile insurance companies in event of questions on coverage. Emmer v. Merin, 233 N.J.Super. 568, 559 A.2d 845 (A.D.1989), certification denied 118 N.J. 181, 570 A.2d 950.

11:3–15.8 (Reserved)

New rule, R.1989 d.117, effective February 21, 1989.
See: 20 N.J.R. 2984(a), 21 N.J.R. 558(b).
Section was "selection of coverage options".
Repealed by R.1989 d.624, effective December 18, 1989 (operative January 1, 1990).
See: 21 N.J.R. 3244(a), 21 N.J.R. 3922(a).

11:3–15.9 Use of Coverage Selection Form

(a) For all new policies, an insurance company or an insurance producer with the company's binding authority shall receive a signed Coverage Selection Form indicating the prospective insured's coverage choices. Coverage shall not become effective until the signed Coverage Selection Form is received from the named insured, unless otherwise authorized by law.

(b) For all policy renewals, the insurance company shall provide its Coverage Selection Form to the named insured with the notice of renewal. For mid-term policy changes, the insurance company shall provide its Coverage Selection Form to the named insured upon his request for a mid-term change when the change is required to be made on the Form. Coverage may be renewed or amended, with or without the signed Coverage Selection Form from the named insured, except as set forth in (b)1i through vi below where a signed Coverage Selection Form is required.

1. An insurance company may require the receipt by it or an insurance producer with the company's binding authority of a signed Coverage Selection Form for any coverage change; provided, however, that an insurance company shall require the receipt by it or an insurance producer with the company's binding authority of a signed Coverage Selection Form for any of the coverage changes in (b)1i to vi below.

i. The election of the "No Threshold" option;

ii. Changing from the "No Threshold" option to the "Lawsuit Threshold" option;

iii. When the named insured desires collision or comprehensive deductibles other than $500.00;

iv. When the named insured desires to change to the $500.00 deductible for collision or comprehensive coverage;

v. When the named insured desires his health insurance carrier to be the primary insurer for PIP medical expense coverage benefits; or

vi. When the named insured desires his auto insurance carrier to be the primary insurer for PIP medical expense coverage benefits.

(c) The coverage changes in (b)1i through vi above shall become effective in the following manner, except when coverage for comprehensive or collision is effected by a required inspection pursuant to N.J.A.C. 11:3–36.

1. For all new policies and mid-term policy changes required to be made on the Coverage Selection Form, the choices on the Coverage Selection Form shall be effective the day following the date of postmark or, when personal delivery is made or the postmark is illegible, the day following receipt of the Form by the insurance company or an insurance producer with the company's binding authority;

2. For changes upon renewal, the changes required to be made on the Coverage Selection Form shall be effective on the date of the next policy renewal if postmarked or received by the insurance company or by an insurance producer with the company's binding authority prior to the renewal date.

New Rule: R.1989 d.624, effective December 18, 1989 (operative January 1, 1990).
See: 21 N.J.R. 3244(a), 21 N.J.R. 3922(a).
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 clarify when a Coverage Selection Form must be used and when the changes made thereon become effective.
R.1992 d.218, effective May 18, 1992.
See: 24 N.J.R. 523(a), 24 N.J.R. 1898(b).
In (c), added exception regarding comprehensive and collision.

Case Notes

Insured was not entitled to jury trial in suit for reformation of automobile policy. Weinisch v. Sawyer, 123 N.J. 333, 587 A.2d 615 (1991).

Direct writing insurer was not responsible for insured's inadequate underinsured motorist (UIM) coverage. Andriani v. New Jersey Mfrs. Ins. Co., 245 N.J.Super. 252, 584 A.2d 875 (A.D.1991), certification denied 126 N.J. 327, 598 A.2d 886.

Client-initiated contacts with insurance brokers can result in broker's duty to exercise skill and possess knowledge concerning coverages. Avery v. Arthur E. Armitage Agency, 242 N.J.Super. 293, 576 A.2d 907 (A.D.1990).

Insurer's buyer's guide and coverage selection form complied with regulations regarding optional underinsured motorist coverage. Avery v. Arthur E. Armitage Agency, 242 N.J.Super. 293, 576 A.2d 907 (A.D.1990).

Insurer and agent were not liable in allegedly failing to inform insured about higher levels of underinsured motorist coverage. Pinto v. Garretson, 237 N.J.Super. 444, 568 A.2d 119 (A.D.1989).

Insured was not entitled to underinsured motorist benefits for bodily injury; insurance carried by two vehicles which struck his automobile was greater than the amount of uninsured motorist coverage which he could have obtained. Pinto v. Garretson, 237 N.J.Super. 444, 568 A.2d 119 (A.D.1989).

11:3–15.10 Effect on other notice requirements

The Buyer's Guide and written notice incorporate and therefore satisfy any and all other notice requirements previously set forth for the coverage options required by the New Jersey Automobile Reparation Reform Act, the New Jersey Automobile Insurance Reform Act of 1982 and the New Jersey Automobile Insurance Freedom of Choice and Cost Containment Act of 1984.

Recodified from N.J.A.C. 11:3–15.9, R.1989 d.624, effective December 18, 1989 (operative January 1, 1990).
See: 21 N.J.R. 3244(a), 21 N.J.R. 3922(a).

11:3–15.11 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of penalties as prescribed by law.

New rule, R.1989 d.117, effective February 21, 1989.
See: 20 N.J.R. 2984(a), 21 N.J.R. 558(b).
Recodified from N.J.A.C. 11:3–15.10, R.1989 d.624, effective December 18, 1989 (operative January 1, 1990).
See: 21 N.J.R. 3244(a), 21 N.J.R. 3922(a).

SUBCHAPTER 16. RATE FILING REQUIREMENTS: VOLUNTARY MARKET PRIVATE PASSENGER AUTOMOBILE INSURANCE

Authority

N.J.S.A. 17:1–8.1; 17:1C–6(e); 17:29A–1 et seq.; 17:29A–36.2 and 36.3; 17:29A–44 and P.L. 1990, c.8.

Source and Effective Date

R.1990 d.116, effective February 5, 1990.
See: 21 N.J.R. 2182(a), 22 N.J.R. 399(a).

11:3–16.1 Purpose and scope

(a) This subchapter establishes data, filing format and preferred ratemaking requirements for all private passenger automobile rate filings for the voluntary market, in implementation of N.J.S.A. 17:29A–1 et seq. and as required by N.J.S.A. 17:29A–36.2.

(b) This subchapter applies to all insurers making private passenger automobile insurance rate filings for the voluntary market in this State.

(c) These requirements apply to all rate filings made by insurers for the revision of base rates; informational filings to be made on July 1 of each year pursuant to N.J.S.A. 17:29A–36.2b; and those filings made under the flex rate provisions of N.J.S.A. 17:29A–44.

(d) Any insurer wishing to effect the rate level by changing rates, rules or forms must file data pursuant to this subchapter.

Emergency Amendment, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).
See: 22 N.J.R. 3790(a).
Expanded (d) to require filing of data pursuant to this subchapter. Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.
See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).
Provision of emergency amendment, R.1990 d.621, readopted without change.

11:3–16.2 Definitions

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

"Accident year" means the 12–month period covering the occurrences during that period.

"Advisory organization" means every group, association or other organization of insurers, whether located within or outside this State, which assists insurers which make their own filings or rating organizations, in ratemaking, by the collection and furnishing of loss or expense statistics, but which does not make filings.

"Affiliate" means an insurer that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the insurer making a filing.

"AIP" means the Automobile Insurance Plan which, prior to January 1, 1984, issued policies providing insurance coverage for personal private passenger automobiles in accordance with N.J.S.A. 17:29D–1.

"AIRE" means the Automobile Insurance Risk Exchange, established pursuant to N.J.S.A. 39:6A–21.

"All other coverages" means insurance for towing and labor, accidental death and dismemberment, extended medical benefits, additional personal injury protection, rental reimbursement and any other items included in Lines 19.1, 19.2 or 21.1 of Page 14 of the Statutory Annual Statement, which are for private passenger automobile non-fleet exposures, except those items defined as "coverages".

"Amount(s) paid to the MTF" includes all payments actually made by insurers to the MTF, which are to be credited as all or part of the insurer's apportionment share of MTF losses, pursuant to N.J.S.A. 17:33B–11d and the MTF Plan of Operation, including any payment made on account of the insurer's liability or in response to an Order of the Commissioner directing that payment be made.

"Base rate" means the rate inclusive of expense fee by coverage for basic limit of liability or $500.00 deductible collision or comprehensive for a single car adult pleasure risk.

"Case reserves" means the reserves for reported claims whether determined by judgment or set by formula.

"Claim" means a request for payment for a loss which comes under the terms of an insurance contract.

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

"Consistent levels" means the same point in time, but not a future point in time.

"Control" is as defined in N.J.S.A. 17:27A-1.

"Coverages" means insurance for bodily injury liability, property damage liability, basic personal injury protection, collision, comprehensive and uninsured/underinsured motorists.

"Department" means the New Jersey Department of Insurance.

"Exposure" means one car insured for one year, or two cars insured for six months each, etc.

"External trend data" means trend data derived from experience other than on policies issued by the filer.

"Filer" means any insurer who makes an annual informational filing, flex rate filing or rate filing requiring prior approval pursuant to these rules.

"Flex rate" means a Statewide average rate change as set forth in N.J.S.A. 17:29A-44.

"Flex rate filing" means a filing made to adjust rates within the limits provided by N.J.S.A. 17:29A-44 and any applicable Orders of the Commissioner issued pursuant to N.J.A.C. 11:3-16A.

"Group of coverages" means liability coverages (to include bodily injury liability, property damage liability, personal injury protection and uninsured/underinsured motorists) and physical damage coverages (to include collision and comprehensive).

"IBNR" or "incurred but not reported loss" means losses which have been incurred but have not yet been reported as of a specified date.

"Informational filing" means a filing made annually on July 1 in accordance with N.J.S.A. 17:29A-36.2b.

"Internal trend data" means trend data derived from the experience of the filer related to the policies it issues.

"Loss development triangle" means a display of losses showing accident year data by evaluation date. The accident years shall be shown vertically and the evaluation dates shown horizontally. The first evaluation date shall be three months after the end of the accident year; subsequent evaluations shall be at 12-month intervals. IBNR shall be shown as a separate number at the latest evaluation date for each year displayed.

"MTF" means the Market Transition Facility established pursuant to N.J.S.A. 17:33B-11.

"NJAFIUA" means the New Jersey Automobile Full Insurance Underwriting Association established pursuant to N.J.S.A. 17:30E-1 et seq.

"Public Advocate" means the Division of Rate Counsel, New Jersey Department of the Public Advocate.

"Rating organization" means every person or persons, corporation, partnership, company, society, or association engaged in the business of ratemaking for two or more insurers.

"Rating system" means every schedule, class, classification, rule, guide, standard, manual, table or rating plan by whatever name described containing the rates and rules used by any insurer in determining or ascertaining a rate.

"Reasonable total rate of return" means that rate of return appropriate for an enterprise given the risk involved.

"Small filer" means a filer with less than 0.5 percent of the New Jersey written premiums in the voluntary market for private passenger automobile insurance for the most recently available prior calendar year.

"Total rate of return" means underwriting return and investment return on both reserves plus capital and surplus, related as a percentage to capital and surplus.

"UCJF" means the Unsatisfied Claim and Judgment Fund, established pursuant to N.J.S.A. 39:6-61 et seq.

Emergency Amendment, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).
See: 22 N.J.R. 3790(a).
Added definitions for "advisory organization", "affiliate", "base rate", "control", "group of coverages", "MTF", "NJAFIUA" and "rating organization".
Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.
See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).
Provision of emergency amendment, R.1990 d.621, readopted with changes effective February 19, 1991.
Amended by R.1993 d.158, effective April 5, 1993.
See: 24 N.J.R. 4486(a), 24 N.J.R. 56(a), 25 N.J.R. 1543(a).
Added "Amount(s) paid to the MTF".

11:3-16.3 General requirements and filing format

(a) The data requirements set forth in this subchapter are minimum requirements. The filer may submit any other data it believes to be relevant in justifying proposed rate changes. If the filer has not collected portions of this information in the past, or has not collected it in a form so as to facilitate reporting, it is not required to compile it retrospectively. All filers shall begin collecting this information in a manner so as to facilitate reporting no later than January 1, 1991 and report data so collected on filings made or required to be made on or after April 1, 1992. If a filer has collected this information, it may be included on filings made or required to be made prior to April 1, 1992.

(b) Separate insurance companies that are affiliated by a parent-subsidiary or any group relationship and that choose to submit a single filing for the group shall provide the minimum data requirements set forth in N.J.A.C. 11:3–16.8 and 16.9, and make the rate level calculation set forth in N.J.A.C. 11:3–16.10, either:

1. Separately for each company with a different rate level or different underwriting guidelines; or

2. Combined for those companies of the group which use a common rating system, including both base rates and underwriting guidelines, or when the difference is based only on expense differences.

(c) Small filers need not provide all of the information required by N.J.A.C. 11:3–16.8(c) and (d); more limited requirements are set forth in those sections. Notwithstanding this, any filing by a small filer for a rate change shall include sufficient justification for all factors used.

(d) All filings shall be submitted to the Department at the following address:

New Jersey Department of Insurance
Property/Liability Division
20 West State Street
CN 325
Trenton, New Jersey 08625–0325

(e) A copy of all rate change filings submitted pursuant to N.J.S.A. 17:29A–14 or N.J.S.A. 17:29A–44 shall be submitted simultaneously to the Public Advocate at the following address:

Department of the Public Advocate
Division of Rate Counsel
31 Clinton Street
P.O. Box 46005
Newark, New Jersey 07101

(f) All filings shall be accompanied by a New Jersey Department of Insurance transmittal form (Form AMB–10, incorporated herein by reference Exhibit D in the Appendix).

(g) All filings shall be accompanied by the following certification signed by an officer of the filer: "I _____ certify that the attached filing complies with all statutory and regulatory requirements and that all the information it contains is true and accurate. I further certify that I am authorized to execute this certification on behalf of the filer."

(h) Each filer shall submit prior approval filings in loose leaf form inserted into standard three-ring binders. The loose leaf sheets used in the filing shall be eight and one-half inches wide and 11 inches long and punched for three hole standard binders. Only one side of the page shall be used. Each page shall be consecutively numbered.

(i) The margin at the top of each page shall show the filer's name, filer's identifying number for this filing, NAIC company number(s) and NAIC group number. The right hand side of the page shall show the section, exhibit and sheet number.

(j) Except for filers with less than 40,000 exposures in the prior year, after January 1, 1991, each flex rate filing when made, or other rate change filing when effective, shall be accompanied by a computer disk(s) that contains the rating system to be implemented.

1. The computer disk may be either 5.25 inch 360 KB or 3.5 inch 1.44 MB.

2. The computer disk shall include a program and data such that when an insured's characteristics (for example, coverage, policy limits, use of auto, territory, etc.) are input, the rate to be charged by coverage is determined. The program shall allow both the input and the output information to be printed in hard copy.

3. The computer disk(s) shall be accompanied by complete and straightforward instructions for use of the program.

(k) All data shall be reported on a direct basis exclusive of business ceded to reinsurers or reinsurance assumed from other companies. Notwithstanding this provision, transactions with the UCJF shall be reported as set forth in N.J.A.C. 11:3–16.8(d)1, 11:3–16.9(a)3 and 11:3–16.10(c)3.

(*l*) Data submitted in any rate filing shall report only voluntary market experience and shall not include experience derived from risks insured through any assigned risk plan established pursuant to N.J.S.A. 17:29D–1.

For the purpose of this subsection, "voluntary market" shall include risks insured by the filer in the voluntary market during any period of time certified by the Commissioner for the cessation of acceptance of applications or the issuance of new policies by the assigned risk plan pursuant to N.J.S.A. 17:29D–1d.

Emergency Amendment, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).
See: 22 N.J.R. 3790(a).
Provisions added to confirm that rate filings should contain only voluntary market data and not include data from risks that may be insured through the assigned risk plan to be instituted pursuant to section 34 of the Act.
Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.
See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).
Provision of emergency amendment, R.1990 d.621, readopted with changes effective February 19, 1991.

11:3–16.4 Insurer informational filings due July 1 of each year

(a) Informational filings shall be made by all insurers transacting private passenger automobile insurance in the voluntary market, including all individual members and sub-

scribers of rating organizations, pursuant to N.J.S.A. 17:29A–36.2b.

(b) The information filing shall consist of the following documents:

1. The insurer's Excess Profits Report for each company filed pursuant to N.J.A.C. 11:3–20. In lieu of providing copies, the filer may submit a certification of an officer that the report has been filed and is incorporated by reference.

2. Such other specific information on a particular subject at a particular time as the Commissioner may require by Order.

Emergency Amendment, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).
See: 22 N.J.R. 3790(a).
Deleted (b)2. through 8.; added new 2.
Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.
See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).
Provision of emergency amendment, R.1990 d.621, readopted with changes effective February 19, 1991.
Amended by R.1995 d.171, effective March 20, 1995.
See: 27 N.J.R. 41(a), 27 N.J.R. 1190(b).

11:3–16.5 Insurer flex rating filings

(a) Any insurer that desires to increase its rates in accordance with the flex rate provisions of N.J.S.A. 17:29A–44 and applicable Orders of the Commissioner issued pursuant to N.J.A.C. 11:3–16A shall provide the following information in support of its flex rate filing:

1. A cover letter notifying the Department of its intention to adjust rates according to the provisions of N.J.S.A. 17:29A–44 and applicable Orders of the Commissioner issued pursuant to N.J.A.C. 11:3–16A; a statement of the percentage and total dollar amount of the increase in rates by coverage for each company included in the filing with subtotals by group of coverages and a grand total (including the variable portion plus expense fees but excluding the policy constant and RMEC) in the format of Exhibit E in the Appendix incorporated herein by reference; a statement containing the effective date of the change; and the name, telephone number and mailing address of the company officer familiar with the filing to whom inquiries about the filing may be directed;

2. A checklist that sets forth the information in Exhibit AI in the Appendix incorporated herein by reference;

3. The Excess Profits Report (required by N.J.A.C. 11:3–20). In lieu of providing copies, the filer may submit a certification by an officer that the document has been filed and is incorporated into the filing by reference.

4. An exhibit that illustrates that the new rates are within the range permitted by Order of the Commissioner issued pursuant to N.J.A.C. 11:3–16A.

i. When coverages are combined (for example, bodily injury liability and property damage liability) the method of combining shall be shown.

ii. When bodily injury liability is combined with any other coverage or coverages, the method of combining shall be shown separately for each tort threshold.

5. The manual rating pages and computer disk(s) containing the flex rate system to be implemented, accompanied by an explanatory memorandum showing the calculation of the new manual rates, using the current manual rates as the starting point in the calculation, and showing the calculation of the current and proposed average rates, including the average variable portion and average expense fees for each coverage. The memorandum shall also include the Department's file number and effective data of use for the current rates.

Emergency Amendment, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).
See: 22 N.J.R. 3790(a).
Amended to implement provisions of the Fair Automobile Insurance Reform Act of 1990, P.L. 1990, c.8.
Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.
See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).
Provision of emergency amendment, R.1990 d.621, readopted without change.
Amended by R.1992 d.189, effective April 20, 1992.
See: 23 N.J.R. 3199(a), 24 N.J.R. 1504(a).
Rate calculation to be included in memo.
Amended by R.1995 d.171, effective March 20, 1995.
See: 27 N.J.R. 41(a), 27 N.J.R. 1190(b).

11:3–16.6 Insurer filings for rates requiring prior approval

(a) Any insurer that desires to modify its rates or rating system in a manner other than that provided by N.J.S.A. 17:29A–44 and Orders of the Commissioner issued pursuant to N.J.A.C. 11:3–16A regarding flex rates shall provide the following information in support of its application:

1. A cover letter notifying the Department of its intention to modify its rating system in a manner that requires prior approval, pursuant to N.J.S.A. 17:29A–14; a statement describing the proposed changes, which shall include the percentage and total dollar amount of any change in rates for each company included in the filing with subtotals by groups of coverages and a grand total (including the variable portion plus expense fees, but excluding the policy constant and RMEC) by coverage and overall; and the name, telephone number and mailing address of the company officer familiar with the filing, to whom further inquiries about the filing may be directed;

2. A checklist that sets forth the information in Exhibit AII in the Appendix incorporated herein by reference;

3. A narrative overview that sets forth the contents of the filing, and explains the reasons and procedures used to derive the rate change requested;

4. Data concerning the premiums, losses and loss adjustment expenses, as specified in N.J.A.C. 11:3–16.8;

5. Data concerning the expense and profit provisions, as set forth in N.J.A.C. 11:3–16.9;

6. Rate calculation, as set forth in N.J.A.C. 11:3–16.10; and

7. Data described in N.J.A.C. 11:3–16.8, 16.9 and 16.10 shall be submitted in written copy and, except for purely textual information, on an MS–DOS formatted disk(s). Filers with fewer than 20,000 exposures in the prior year are exempt from submitting the formatted disk. The disk(s) may be either 5.25 inch 360 KB or 3.5 inch 1.44 MB. The information shall be provided in a Lotus 1–2–3 or compatible spreadsheet. The left and top margins of each page shall indicate the row and column respectively of all data on the page. Each page of written copy shall also display in the bottom right corner the name of computer file and disk on which it is contained. All calculated values shall be given as a formula in the spreadsheet.

(b) All rate filers shall submit data in support of their application for approval of their proposed rating system based on their own loss experience to the extent it is credible (N.J.A.C. 11:3–16.8), their own expense and profit provisions (N.J.A.C. 11:3–16.9) and their own rate calculation (N.J.A.C. 11:3–16.10).

(c) Upon approval insurers shall file manual rating pages and computer disk(s) containing the rating system on or before the effective date of the rates.

Emergency Amendment, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).
See: 22 N.J.R. 3790(a).
Provisions to implement the Fair Automobile Insurance Reform Act of 1990, P.L. 1990, c.8.
Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.
See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).
Provision of emergency amendment, R.1990 d.621, readopted without change.

11:3–16.7 Jointly developed historical data

(a) In connection with the dissemination of historical data by rating organizations or advisory organizations for ratemaking purposes, insurers shall comply with the following:

1. Historical data that may be compiled and disseminated by rating organizations or advisory organizations for use by insurers in ratemaking includes:

i. Written and earned premiums and exposures which may be adjusted to consistent levels;

ii. Losses paid;

iii. Reserves for reported claims (whether determined by judgment or set by formula by the insurers); and

iv. Claim counts.

2. For the purposes of this section, "compilation of historical data" includes:

i. Checking the data for accuracy and completeness and excluding data which is inaccurate or incomplete;

ii. Selection of experience (for example, type of business, type of vehicles, accident year or calendar year basis, and deductibles for physical damage);

iii. Selection of number of years;

iv. Calculation of claim cost and frequency, pure premiums, the combination of paid and outstanding losses into incurred losses and the conversion of car months into car years;

v. Compiling losses on a basic and excess limits basis for liability and adjusting losses to a common deductible level for physical damage; and

vi. The organization of or calculations on historical data according to classification detail such as territory, class, etc.

3. The following are not historical data and may not be disseminated for use in ratemaking:

i. Estimates of future values of any data compiled under (a)1 and 2 above;

ii. Reserves for claims which have been incurred but not reported (IBNR);

iii. Operating expenses and profit provisions, including unallocated loss adjustment expenses; and

iv. Trending.

4. Except for activities as a designated statistical agent or activities involved in the creation and maintenance of vehicle series rating systems for private passenger automobile collision and comprehensive coverages, the following are not historical data and may not be disseminated for use in ratemaking:

i. Credibility weights to be used to project future values;

ii. Loss smoothing when used to project future values;

iii. Selection of weights when it is done to select future values;

iv. Relativities and relativity analysis when it is performed as part of a projection of future values; and

v. Final trended "pure premium" or "loss cuts".

(b) For purposes of this section, "losses paid" and "reserves for reported claims" may include allocated loss adjustment expenses if it is indicated that allocated loss adjustment expenses are included and are limited to the following expenses which can be allocated to a particular claim:

i. Attorneys fees for claims in suit; and

ii. Court and other specific items of expense such as: medical examinations to determine the extent of a

company's liability; expert, medical or other testimony; laboratory, x-ray and autopsy; stenographic; witnesses and summonses; and copies of documents.

(c) For the purposes of this section, "allocated loss adjustment expenses" shall not include: salaries and traveling expenses of company employees other than amounts allocated as attorneys' fees for costs in suit; overhead; and fees paid to independent adjusters, or attorneys, for adjusting claims.

(d) For purposes of this section, "trending" includes all projections of future costs and any representation of past costs adjusted by a mathematical or non-mathematical process. It does not, however, include displays of historical average costs or frequency, or the display of historical data (for example, loss development triangles with historical link ratios) from which an insurer can independently calculate future loss development.

(e) Projections of the number and dollar value of incurred and/or paid known claims at future evaluation dates may not be disseminated.

(f) Data on the number and dollar value of claims which have been closed but are expected to reopen may not be disseminated.

(g) Projections of the increase in number and dollar value of claims due to changes in the judicial and regulatory environments, legislative changes and economic variables such as inflation may not be disseminated.

(h) Except as provided in (a) above, marketing data, rate data and rate manuals may not be exchanged.

(i) Insurers may use symbol, vehicle series and model year rating programs for physical damage coverages; jointly develop symbol assignments, vehicle series and model year data; and jointly determine adjustments to symbol assignments.

Emergency Repeal and New Rule, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).
See: 22 N.J.R. 3790(a).
Formerly entitled Rating Organization Filings; new rule to implement section 69 of the Fair Automobile Insurance Reform Act of 1990, P.L. 1990, c.8.
Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.
See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).
Provision of emergency amendment, R.1990 d.621, readopted with changes effective February 19, 1991.
Amended by R.1995 d.288, effective June 5, 1995.
See: 27 N.J.R. 1356(a), 27 N.J.R. 2232(b).
Rewrote (i), extending its application indefinitely.

11:3–16.8 Premium, loss and loss adjustment expense data

(a) Filers shall provide the following data regarding New Jersey premium, loss and loss adjustment expense:

1. For each coverage, or combined coverages when the premium is inseparable, calculate earned premium at present rates using either the extension of exposures or on level factor methodologies. Provide the rate level history. Provide the underlying calculations and indicate how such calculations were produced and supply supporting documentation for a sample of such calculations and justification of any factors used where the on level factor methodology is used. Provide the justification for the selected use of a particular method in calculating the rate level. Provide this information either at basic limits or at total limits.

2. For each coverage and each experience year used in setting the overall rate level, the following information at total limits and, at the filer's option, basic limits:

i. Direct earned exposures measured in car years;

ii. Incurred losses;

iii. Applicable loss development factor (aged to ultimate);

iv. Paid or incurred allocated loss adjustment expenses;

v. Paid or incurred unallocated loss adjustment expenses;

vi. Ultimate incurred losses and loss adjustment expenses;

vii. Trend factor; and

viii. Trended ultimate incurred losses and loss adjustment expenses.

3. Whenever New Jersey losses are separated into catastrophe and non-catastrophe losses, include a clear description and justification of the standard used to separate such losses. In determining a catastrophe loading, include as many years of data as available but at least 10 years. Provide an explanation if the data base from which the catastrophe loading is derived differs from that on which the rate level change is based.

4. Territorial rate calculations including earned premiums, earned exposures, incurred losses, and the number of claims by territory separately for each coverage and each of the years used to determine the territorial relativities, or for each of the last three years, whichever is greater.

5. All information related to the derivation of classification differentials contained in the filing. Include the following minimum information:

i. All data and worksheets used and judgments made;

ii. A description of the methodology used to arrive at the differentials; and

iii. A description of the application of the methodology to this filing.

6. For all incurred loss adjustment expense data contained in the filing, show the related incurred losses used to determine any loss adjustment expense loadings.

(b) Filers shall provide all information related to the derivation of credibility factors contained in the filing, specifically including the following information:

1. All data and worksheets used and judgments made;

2. A description of the methodology used to derive the factors; and

3. A description of the application of the methodology to this filing.

(c) Each filer, except small filers, shall provide the data in (c)1 through 9 below. Small filers shall provide the data in (c)4, 5, and 6 below:

1. All information related to the derivation of loss development factors contained in the filing specifically including:

i. All data and worksheets used and judgments made;

ii. A description of the methodology used to derive the factors; and

iii. A description of the application of the methodology to this filing.

2. For each coverage, complete loss development triangles for the 10 latest available accident years at each and every annual evaluation date from 15 months to 123 months for basic Personal Injury Protection ("PIP") and Bodily Injury Liability ("BI"), 15 months to 75 months for Property Damage Liability ("PD") and uninsured/underinsured motorists, and 15 months to 51 months for collision and comprehensive if accident year data is used by the filer to develop its rate level indications for collision and comprehensive coverages. Provide the corresponding nine-year, five-year and three-year average loss development factors derivable from these triangles. (These are minimum requirements. The filer may present additional accident years, further evaluations and other averages of factors);

3. The information in (c)2 above for total limits paid losses;

4. The information in (c)2 above for total limits incurred losses;

5. The information in (c)2 above for basic limits incurred losses if used by the filer to develop its rate level indications;

6. For liability coverages only, the information in (c)2 above for allocated loss adjustment expenses on a paid or incurred basis. Alternatively, if allocated loss adjustment expenses are not available separately, the filer shall provide incurred losses and allocated loss adjustment expenses combined and so indicate on the filing;

7. The information in (c)2 above for the number of paid claims;

8. The information in (c)2 above for the number of incurred claims; and

9. A statement regarding any changes in the filer's case loss reserving practices during the last five years.

(d) Each filer, except small filers, shall provide the following data regarding trend factors and their application:

1. All internal loss trend data on a calendar year paid and, at the filer's option, incurred basis shown separately for frequency and severity for the latest available five calendar years on a quarterly year ending basis for all coverage on both a countrywide and New Jersey basis. Bodily injury liability and property damage liability trend data shall be given at total limits and, at the filer's option, basic limits. Basic personal injury protection ("PIP") data shall be given at a per person limit retained by the insurer according to N.J.S.A. 39:6–73.1 ($75,000 of insurer payments). Physical damage coverages shall be shown on the basis of the $500.00 deductible or all deductibles combined adjusted to the $500.00 deductible basis. In the latter case the filer shall provide an explanation of the methodology for adjusting other than $500.00 deductible data to the $500.00 deductible level.

2. For all trend data described above, calculate annual trend factors along with "T" statistics and the coefficient of correlation. This shall be done from a least-squares regression with time being the independent variable.

i. Include trend results calculations for at least two of the latest six, nine, 12, 16 and 20–point periods;

ii. Include a side-by-side comparison of the actual data and fitted data; and

iii. Include calculations on both an exponential and straight line basis.

3. All information related to the derivation of trend factors contained in the filing specifically including:

i. All data used, worksheets used, and judgments made;

ii. A description of the methodology used to derive the factors; and

iii. A description of the application of the methodology to this filing.

4. Information, including studies, analyses, and fact sheets regarding the effects (both countrywide and in New Jersey) of the items described in (d)4i through vi below if the filer has either compiled the information itself or relied upon outside information in the support of the filing. If the effects of such studies, etc., have been

incorporated into the rate filing, describe in detail the methodologies used. Provide this information for the following:

i. Changes in seatbelt use;

ii. Use of passive restraint systems, including air bags, and any other safety or anti-theft devices including, but not limited to, anti-lock braking systems; and automatic traction control systems;

iii. Changes in the drinking age;

iv. Changes in the price and amount of gasoline purchased;

v. Changes in the average miles driven; and

vi. Other legislative, regulatory, social, or economic factors that have an impact on loss frequency or severity, including, but not limited to, the effects of the Fair Automobile Insurance Reform Act of 1990, P.L. 1990, c.8.

(e) Each filer shall provide the following regarding changes in the New Jersey premium base and exposures:

1. Data on the mix of written exposures by different policy terms for the latest three years. Include both the number of written exposures and the amount of written premium for different policy terms;

2. Calculate the trend in the average model year and symbol relativities for collision and comprehensive coverages separately during the most recent five calendar years. Explain how these trends were calculated and provide all intermediate calculations. Show the average age/model year and average symbol relativity for each of the latest five calendar years. Include the distributions of written exposure by age/model year and symbol for comprehensive and collision coverages separately for each of the latest five calendar years; and

3. The most recent five-year history of the distribution, by deductible amount, of written exposures and premium of comprehensive and collision coverages purchased.

(f) Filers shall provide the following regarding limitations applicable to the filing:

1. Limitations on losses and/or loss adjustment expenses included in the statistical data used in the filing;

2. Limitations on the extent of the rate level change by coverage;

3. Limitations on the extent of territorial rate changes;

4. Limitations on the extent of classification rate changes; and

5. Any other limitations applied.

(g) Filers shall provide the following New Jersey calendar year data on a direct business basis by coverage and group of coverages:

1. The amount of earned premium, incurred losses, incurred allocated and unallocated loss adjustment expenses for each of the latest five complete calendar years; and

2. The number of incurred claims (all limits combined and all deductibles combined) by coverage and allocated loss adjustment expenses for each of the latest five complete calendar years.

(h) Filers shall show the overall Statewide rate change indicated by coverage.

(i) Filers shall provide any additional information specifically requested by the Department which may be necessary to constitute a proper rate filing.

Emergency Amendment, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).
See: 22 N.J.R. 3790(a).
Changes to implement the Fair Automobile Insurance Reform Act of 1990, P.L. 1990, c.8.
Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.
See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).
Provision of emergency amendment, R.1990 d.621, readopted with changes effective February 19, 1991.
Amended by R.1992 d.189, effective April 20, 1992.
See: 23 N.J.R. 3199(a), 24 N.J.R. 1504(a).
Basic limits included at filer's option.

11:3–16.9 Data requirements for expense and profit provisions

(a) Filers shall provide the data in (a)1 through 6 below regarding expenses:

1. All information related to the derivation of expense provisions contained in the filing specifically including:

i. All data and worksheets used and judgment made;

ii. A complete description of the methodology used to derive the provisions; and

iii. Details on the application of the methodology to this filing;

2. Average incurred expenses per exposure on a New Jersey basis (explain the basis of allocation) and on a countrywide basis for each of the last five complete calendar years for the following expense categories:

i. Commission and brokerage;

ii. Other acquisition expenses;

iii. General expenses; and

iv. Taxes, licenses and fees;

3. The derivation of the expense flattening as required by N.J.S.A. 17:29A–37. The expense flattening calculation shall exclude the UCJF assessment for the excess medical benefits reimbursed to insurers by that fund. The expense shall be applied by coverage;

4. All data shall be on a direct basis excluding AIRE assessments and reimbursements;

5. New Jersey private passenger automobile insurance expense data separately for the most recent three complete calendar years using the format of the Underwriting Investment Exhibit, Part 4—Expenses of the Statutory Annual Statement; and

6. AIRE assessment and reimbursements in dollars and as a percent of bodily injury liability paid losses for the most recent five complete accident years evaluated as of March 31 of the current year.

(b) Filers shall provide the following data regarding proposed rates:

1. Proposed rates for each territory and coverage together with their derivation;

2. Classification differentials, with descriptions, if any proposed changes are being made to the currently approved classification plan;

3. The calculations showing that the proposed rates are in compliance with N.J.S.A. 17:29A–36. The base class rates for the territorial calculations shall be inclusive of expense fees but exclusive of residual market equalization charges and policy constants, and all driving record surcharges and discounts. The filer's Statewide average base rate shall be determined from the territorial distribution for the latest year of data contained in the filing. In determining rates for principal operators 65 years of age or older, ratios of rates shall be inclusive of expense fees and exclusive of surcharges, discounts and policy constants (Residual Market Equalization Charges do not apply to these risks); and

4. By coverage, a comparison of average Statewide variable rates and expense fees proposed and currently in use, along with the number of exposures by coverage.

(c) Filers shall provide the following data regarding investment earnings:

1. The amount of investment income earned on loss, loss adjustment expense and unearned premium reserves in relation to earned premium for private passenger automobile insurance in New Jersey shall be calculated for the latest two years and estimated for the current year and the two following years. Calculations should be provided in detail including the amount of the composite reserves of each type (that is, loss, loss adjustment expense and unearned premium) at the beginning and end of each of the specified years;

2. The cash flow pattern from policy inception date until receipt of premium. This shall be provided by coverage;

3. The cash flow pattern from policy inception date for commission and brokerage, other acquisition expenses, general expenses, assessments, premium taxes, licenses and fees and any other expense payments; and

4. The cash flow pattern from policy inception date for losses, allocated loss adjustment expenses, and unallocated loss adjustment expenses.

(d) Filers shall provide the following regarding identification and certification of statistical plans:

1. Identification of all statistical plans used or consulted in preparing the filing; and

2. A certification by an officer on behalf of the filer that the data utilized in the rate filing was collected in accordance with such plans and is a true and accurate representation of the insurer's experience. The certification shall identify any data included in the filing that was not collected in accordance with the statistical plan.

(e) Filers shall provide the following information regarding investment earnings on capital and surplus:

1. Given the selected underwriting profit and contingency loadings contained in the filing, the resulting rate of return on equity capital and on total assets, showing the derivation on all factors used to produce the calculations; and

2. Justification that these rates of return are fair and reasonable. These calculations shall be performed by group of coverages.

(f) Filers shall provide also the following:

1. The amount of finance and other miscellaneous charges collected in New Jersey in connection with the sale of private passenger automobile insurance;

2. A description of all products and services supplied or received in transactions between the filer and a parent company, a wholly-owned subsidiary or an affiliated company; and

3. Any additional information specifically requested by the Commissioner which may be necessary to constitute a proper rate filing.

Emergency Amendment, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).
See: 22 N.J.R. 3790(a).
Changes to implement the Fair Automobile Insurance Reform Act, P.L. 1990, c.8.
Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.
See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).
Provision of emergency amendment, R.1990 d.621, readopted with changes effective February 19, 1991.

11:3–16.10 Rate calculation using standard ratemaking methodology

(a) Investment income shall be treated by group of coverages as follows:

1. The calculation of the underwriting profit and contingency loading taking into account investment income on loss, loss adjustment expense, and unearned premium reserves shall be calculated in accordance with the Clifford Formula methodology, wherein the combined after-tax profit from underwriting and investment income on loss, loss adjustment expense, and unearned premium reserves is 3.5% of premium.

2. No deductions shall be made for prepaid expenses unless there is specific documentation included in the filing that supports the prepayment of those expenses, which shall include the cash flow pattern from policy inception date for commission and brokerage, other acquisition expenses, general expenses, assessments, premium taxes, licenses and fees and any other expense payments.

3. No deductions shall be made for the delayed remission in premiums unless there is specific supporting documentation in the filing verifying such delay in the remission of premiums, which shall include the cash flow pattern from policy inception date until receipt of premium.

4. The ratio of unearned premium reserves to premium shall be obtained from the appropriate line of business from Page 14 of the statutory Annual Statement for New Jersey. The calculations shall be the direct unearned premium reserve divided by the direct premiums written.

5. The ratio of loss reserves to incurred losses shall be on a direct business basis derived from the appropriate line of business from Page 14 of the Statutory Annual Statement for New Jersey. The calculations shall be as follows:

i. The average of the loss reserve (excluding the reserves for excess medical benefits claims over $75,000 and AIP reserves) at the beginning of the year and at the end of the year divided by the corresponding incurred losses during the year;

ii. The ratio of these reserves to corresponding losses incurred shall be calculated for the most recent four calendar years; and

iii. If there is a monotonic change in these ratios, either up or down, the most recent ratio shall be used in the calculation. If no such trend exists, the unweighted average of the four ratios shall be used in the calculation.

6. The ratio of loss adjustment expense reserves to loss reserves shall be derived from the appropriate line of business from Part 3A—Unpaid Losses and Loss Adjustment Expenses of the Annual Statement. The calculations shall be as follows:

i. The unpaid loss adjustment expense divided by the net losses unpaid excluding loss adjustment expense;

ii. This ratio shall be calculated for the most recent four calendar years; and

iii. If there is a monotonic change in these ratios, either up or down, the most recent ratio shall be used in the calculation. If no such trend exists, the unweighted average of the four ratios shall be used in the calculation.

7. The expected loss and loss adjustment expense ratio shall be one minus the underwriting expense ratio, minus the underwriting profit and contingency ratio derived from the Clifford Formula.

8. The interest rate used in the calculation shall be a simple average of the most recent six monthly numbers for the Moody's seasoned AAA corporate bond rate as published in the Federal Reserve statistical release "Selected Interest Rates," or the insurer's actual prospective yield, whichever is higher.

(b) Underwriting expense provisions shall be determined as follows:

1. New Jersey specific data shall be used to determine the expense provision for commission and brokerage. Countrywide data for commissions and brokerage is not acceptable.

2. New Jersey specific data shall be used for premium taxes, licenses and fees.

3. New Jersey specific data shall be used for assessments.

4. New Jersey specific data shall be used, if available, for general expenses and other acquisition expenses. When New Jersey specific data is not available, countrywide data allocated to New Jersey may be used. In such cases, the basis of allocation of countrywide data to New Jersey shall be explained in specific detail.

5. The projected provision for other acquisition expenses and general expenses shall be based on a separate trending of the dollar amounts of these items. These shall not be determined by simply assuming the same ratio of these items to premium in the future as has been the case in the past. The basis of the trend shall be a 50/50 weighting of the trend during the past two years of the monthly All Items Consumer Price Index and monthly average weekly wages for fire and casualty insurance employees as published by the Federal Bureau of Labor Statistics. This shall be performed by calculating through regression analysis the annual trends for the two indices and then averaging these values on an equal basis.

6. In determining the historic expense provision for commission and brokerage, other acquisition expenses and general expenses on a combined basis, the percentage to premium for each year of experience shall be limited to a maximum of the weighted average of the percentages shown in "Best's Aggregates and Averages" for the same period for those property/casualty insurance companies which most closely approximate the insurer's method of marketing automobile insurance as set forth in Exhibit H to the Appendix, incorporated herein by reference.

i. If an insurer uses salaried employees which deal directly with the public, the filer shall use the weighted average percentage for insurers which use salaried employees which deal directly with the public; if an insurer uses exclusive agents, the filer shall use the weighted average percentage for insurers which use exclusive agents; and if an insurer uses independent agents, the filer shall use the weighted average percentage for insurers which use independent agents.

ii. For the purposes of this section, the calculation of the weighted average shall be based upon written premiums in New Jersey in the year prior to making the filing.

7. The percentage loading for the UCJF assessment shall be the most recent value established by the Commissioner.

8. The following expense items shall not be incorporated into the expense base for determining rates:

i. Fines against the company;

ii. Lobbying expenses;

iii. Charitable contributions;

iv. Political contributions;

v. Awards against the company itself for punitive damages and for bad faith claims;

vi. Advertising and other expenses incurred in connection with proposed changes in the regulation of insurance; and

vii. Assessments and surtaxes imposed pursuant to N.J.S.A. 17:30A–8(9) and 17:33B–49, respectively.

9. The filing shall include for each of the categories in (b)8 above the dollars of expense that were excluded from the rate base, separately for each year of historic information and separately for each of the above seven categories. If the filer submits a ratemaking methodology that includes these expenses pursuant to (f) below, specific justification for including these expenses shall be included.

10. Commissions for bodily injury liability coverage for the $0 and verbal threshold shall be equalized in accordance with the Exhibit C in the Appendix incorporated herein by reference.

(c) The data base to be used shall be as follows:

1. Accident year data shall be used for all liability coverages. Accident year or calendar year data shall be used for physical damage coverages.

2. The most recent accident year data used in the filing shall end no more than 15 months prior to the date of submission of the filing. Data may be from either a fiscal year or year ending December 31, so long as the period is within 15 months of the filing.

3. Personal injury protection experience shall be limited to the direct "before reinsurance" exposure retained by the insurance company according to N.J.S.A. 39:6–73.1. Any losses reimbursed or subject to reimbursement to the insurer by the UCJF for excess medical benefits shall not be included with the experience contained in the filing.

(d) The trend methodology to be used shall be as follows:

1. With regard to loss trends, the filing shall contain separate determinations of the loss severity from loss frequency trends.

2. The filing shall contain an adjustment for symbol drift, and where appropriate for model year rating.

(e) The filer shall demonstrate that a reasonable total rate of return on its capital investment attributable to the New Jersey private passenger automobile insurance market will result from the proposed rates.

(f) The ratemaking methodology set forth in (a) through (e) above is the Department's preferred procedure and must be included in the filing. The filer may, however, propose an alternate procedure in total or in part and support it with such calculations and other information it deems appropriate to demonstrate the superiority of the alternate procedure in the determination of the filer's rates.

1. In the event the filer has computed the rates using an alternate methodology, it shall provide all information related to the derivation of the profit and contingency loading contained in the filing, specifically including:

i. All data and worksheets used and judgments made;

ii. A description of the methodology used to arrive at the selected loading; and

iii. Details on the application of the methodology to this filing.

2. Filers which propose an alternate ratemaking methodology shall show the overall statewide rate change by coverage by both the standard and alternate methodologies.

Emergency Amendment, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).
See: 22 N.J.R. 3790(a).

Changes to implement the Fair Automobile Reform Act, P.L. 1990, c.8.
Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.
See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).
Provision of emergency amendment, R.1990 d.621, readopted with changes effective February 19, 1991.
Amended by R.1992 d.189, effective April 20, 1992.
See: 23 N.J.R. 3199(a), 24 N.J.R. 1504(a).
Interest rate changed to 36 months of Moody bond rates or actual prospective yield.
Petition for Rulemaking.
See: 25 N.J.R. 4523(a).
Amended by R.1994 d.46, effective January 18, 1994.
See: 25 N.J.R. 4436(a), 26 N.J.R. 378(b).

Case Notes

Regulatory amendment more accurately reflected actual yield rate than previous calculation method and had to be applied in calculating yield on premiums. Matter of Private Passenger Auto. Rate Revision on Behalf of Aetna Cas. and Sur. Co., 256 N.J.Super. 46, 606 A.2d 401 (A.D.1992).

Insurer's establishment of reserve for payment of its share of anticipated market transition facility (MTF) losses was premature. Matter of Private Passenger Auto. Rate Revision on Behalf of Aetna Cas. and Sur. Co., 256 N.J.Super. 46, 606 A.2d 401 (A.D.1992).

Fair Automobile Insurance Reform Act prohibiting pass throughs to policyholders of costs did not violate takings clause. State Farm Mut. Auto. Ins. Co. v. State, 124 N.J. 32, 590 A.2d 191 (1991).

Commissioner should make determinations on individual insurers' special rate-increase applications resulting from surtaxes and assessments imposed by Fair Automobile Insurance Reform Act before challenges to constitutionality. State Farm Mut. Auto. Ins. Co. v. State, 124 N.J. 32, 590 A.2d 191 (1991).

11:3–16.11 Rate filings reflecting assessments and surtaxes

(a) All insurers who submit a rate filing which reflects assessments or surtaxes imposed pursuant to N.J.S.A. 17:30A–8(a), and 17:33B–49, respectively shall submit such rate filing independently of any prior approval rate filing submitted pursuant to N.J.A.C. 11:3–16.6.

(b) Any insurer desiring to modify its rates to reflect assessments or surtaxes imposed pursuant to N.J.S.A. 17:30A–8(9) and 17:33B–49, respectively shall provide the following information in support of its application:

1. All of the data required for prior approval filings submitted pursuant to N.J.A.C. 11:3–16.6;

2. A copy of the statutory property and casualty Annual Statement, Exhibit of Premiums and Losses (page 14) for New Jersey for each of the most recent 10 years. The insurer shall also file information combining this data for each of the most recent 10 years for all states and the District of Columbia, if applicable, in which the insurer is authorized to transact business; and shall provide a list of these jurisdictions;

3. The following data for all of its insurance affiliates for each of the most recent 10 years on a Statewide and countrywide basis;

i. For property and casualty affiliates, Exhibit of Premiums and Losses (page 14) of the statutory property and casualty Annual Statement;

ii. For title insurance affiliates, Operations and Investment Exhibit (page 4) and Schedule T—Exhibit of Premiums Written (page 39) of the statutory title insurance Annual Statement;

iii. For life and health affiliates, Liabilities, Surplus and Other Funds (page 3); Analysis of Operations by Lines of Business (page 5); and Exhibit 1 Part 1 and Part 2 (pages 7 and 7A) of the statutory life and health Annual Statement; and

iv. An estimate of the amount of business in other lines that is produced by the synergistic effects of the insurer writing private passenger automobile insurance in this State.

4. Certifications/representations by the insurer's Chief Financial Officer and President containing the information set forth in Exhibit F in the Appendix incorporated herein by reference;

5. A schedule of Key Performance Indicators (KPI's), as set forth in Exhibit G in the Appendix incorporated herein by reference, for the year of the rate filing and each of the preceding two years;

6. For the current year and preceding two years, a schedule of premiums, incurred losses and operating expenses by New Jersey lines of business corresponding to line items one (1) through twenty-two (22) of Part II of the IEE. In addition, provide a schedule of operating expenses by classification corresponding to line items one (1) through twenty-two (22) of Part I of the IEE. The aggregate of expenses reported by line item must agree with the total operating expenses related to New Jersey policies reported by line of business in Part II of the IEE, (sum of lines four (4) through eight (8));

7. For each line item expenditure included in the schedule required pursuant to (b)6 above, the following:

i. A description of all allocation methodologies used to allocate corporate-wide costs (including worldwide, countrywide and regionalwide costs) to New Jersey lines of business;

ii. A description of all allocation methodologies used to allocate operating expenses to New Jersey private passenger automobile liability and physical damage lines of business and to all other New Jersey lines of business;

iii. An explanation for any changes in allocation methodologies between years;

iv. For NJAFIUA/MTF servicing entities which are also insurers, an explanation for differences between allocation methodologies used to prepare the schedule required pursuant to (b)6 above and the methodologies used to prepare Exhibit P of the NJAFIUA/MTF reporting package; and

v. For each operating expense classification by each New Jersey line of business, a schedule which shows the expenses directly charged to a line of business; and indirect expenses allocated to various lines of business using a reasonable allocation methodology;

8. For each New Jersey line of business (including private passenger automobile), the following:

i. The number of named insureds;

ii. The number of employees directly dedicated to the line of business;

iii. The square feet of office space dedicated to the line of business (excluding allocations of corporate or administrative office space);

iv. The hours of data processing time charged;

v. The volume of exposures;

vi. The number of policies in force; and

vii. The number of claims reported during each of the three years requested;

9. A report, based on a study and evaluation of the insurer's system of internal accounting control and signed by an independent public accountant. The report shall state that in the accountant's opinion, the system of internal accounting control of the insurer in effect during the current year, taken as a whole, was sufficient to meet the objectives of a system of internal accounting control insofar as those objectives pertain to the prevention or detection of errors or irregularities in amounts that would be material in relation to the insurer's financial statements;

10. A listing of all internal audits performed of the operations of the New Jersey private passenger automobile lines of business during the current year, including the scope of procedures performed;

11. Copies of all internal audit reports issued during the current year pursuant to (b)10 above and management responses to all internal audit findings, which are deemed to be confidential pursuant to N.J.S.A. 17:23–6;

12. Access to source documents which, in the opinion of the Commissioner, are necessary to support any and all transactions reported on the insurer's statutory annual statement filed with the Department or to support any other schedules referred to herein;

13. An explanation why the insurer believes that the assessment imposed by N.J.S.A. 17:30A–8(9) should be reflected in the requested private passenger automobile rates since the assessment, by statute, is classified as a loan; and

14. Any additional information specifically requested by the Commissioner which may be necessary to evaluate the request for rate relief.

(c) Upon written application and for good cause shown, the Commissioner may, in his or her discretion, waive any of the data filing requirements set forth in (b) above.

(d) The Commissioner shall not approve any increase in an insurer's rates on the basis that the insurer is required to pay assessments pursuant to N.J.S.A. 17:30A–8(9), or surtaxes pursuant to N.J.S.A. 17:33B–49, unless he or she shall find that an increase in revenue is necessary to ensure that the insurer earns a constitutionally adequate return. In making that determination the Commissioner shall consider:

1. The insurer's experience on all lines of its business in New Jersey, and in the case of insurers operating in an insurance holding company system, the experience of all of the lines of business of all affiliated companies in New Jersey, for a period of time over which an insurer could reasonably plan to earn a target rate of return;

2. Whether the insurer and its affiliates, if any, are reasonably efficient in their operations, including claims handling, subrogation and salvage, by comparison to insurers on a statewide and countrywide basis;

3. Whether the insurer and its affiliates, if any, have allocated expenses to New Jersey operations in a fair and equitable manner; and

4. The synergistic effect of mandated private passenger automobile insurance on the sale of other lines of insurance that the filer writes, including, but not limited to, higher premium volumes, lower operating costs and lower acquisition costs.

(e) Each filer shall present in its filing a formula it believes appropriate for determining the return required by relevant constitutional principles, with supporting analysis and data fully explaining why such formula should be utilized.

(f) The Commissioner may determine whether an insurer's rates are, as a result of the payment of the surtaxes and assessments, constitutionally adequate. In the event that the Commissioner determines that rate relief is deemed to be necessary, the Commissioner shall determine whether the rates should be adjusted immediately or over time, as may be appropriate.

Emergency New Rule, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).
See: 22 N.J.R. 3790(a).
Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.
See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).
Provision of emergency amendment, R.1990 d.621, readopted with changes effective February 19, 1991.

Law Review and Journal Commentaries

Auto Insurance. Steven P. Bann, 134 N.J.L.J. No. 18, 45 (1993).

Case Notes

Commissioner of Insurance was required to apply emergency "pass-through" regulation to Fair Automobile Insurance Reform Act surtax and assessment payments. Matter of Commissioner of Insurance's Decision on Liberty Mut. Fire Ins. Company's N.J.A.C. 11:3-16 Rate Filing, 266 N.J.Super. 457, 630 A.2d 295 (A.D.1993).

Five percent surtax on premiums and assessment based on percentage of insurer's market share did not violate due process or equal protection. American Fire and Cas. Co. v. New Jersey Dept. of Ins., 256 N.J.Super. 423, 607 A.2d 196 (A.D.1992).

Provision of Fair Automobile Insurance Reform Act of 1990 directing Property Liability Insurance Guaranty Association (PLIGA) to assess its member insurers and pay those collected assessments into the Automobile Insurance Guaranty Fund was not unconstitutionally vague. Matter of Loans of New Jersey Property Liability Ins. Guar. Ass'n, 124 N.J. 69, 590 A.2d 210 (1991).

Fair Automobile Insurance Reform Act prohibiting pass throughs to policyholders of costs Act did not violate takings clause. State Farm Mut. Auto. Ins. Co. v. State, 124 N.J. 32, 590 A.2d 191 (1991).

Commissioner should make determinations on individual insurers' special rate-increase applications resulting from surtaxes and assessments imposed by Fair Automobile Insurance Reform Act before challenges to constitutionality. State Farm Mut. Auto. Ins. Co. v. State, 124 N.J. 32, 590 A.2d 191 (1991).

11:3–16.12 Filings reflecting paid, apportioned MTF expenses and losses

(a) Upon approval of the Commissioner pursuant to this section, an insurer may charge and collect a special surcharge to recover from policyholders amounts paid to the MTF by the insurer as its apportioned share of MTF operational losses and expenses. An amount so charged and collected shall not be considered premium except for the limited purpose of allowing cancellation of the policy for non-payment of the surcharge pursuant to N.J.S.A. 17:29C–7 and N.J.A.C. 11:3–7.6.

(b) An insurer desiring to provide for a policyholder surcharge pursuant to this section shall provide the following information:

1. All of the data required for prior approval filings submitted pursuant to N.J.A.C. 11:3–16.6, which shall include an exhibit of the insurer's overall percent rate change indication, calculated in accordance with the Department's standard ratemaking methodology as set forth in N.J.A.C. 11:3–16.10, but without any consideration of its apportioned share of MTF operational expenses and losses;

2. A certified statement signed by an officer of the insurer that sets forth the amount paid to the MTF and the date of payment;

3. An exhibit that sets forth the calculation of the proposed policyholder surcharge, in accordance with the methodology set forth at (d) below; and

4. The proposed effective date and termination date of the policyholder surcharge.

(c) Upon receipt of a filing made pursuant to this section, the Department shall review it for completeness pursuant to N.J.A.C. 11:3–18.6(b), which review shall specifically include a determination that (b)2 above is complete and accurate.

(d) The filer shall use the following methodology to determine the proposed amount of the policyholder surcharge:

1. Its current overall percent rate change indication shall be calculated in accordance with the standard ratemaking methodology at N.J.A.C. 11:3–16.10, excluding all apportioned MTF operational expenses and losses.

2. If the current overall percent rate change indication is negative, the amount of policyholder surcharge shall be calculated as follows. The filer shall:

i. Convert the amount paid to the MTF to a percentage of premium by dividing it by earned premium;

ii. Add the result of (d)2i above to the current overall rate change indication;

iii. If the result of (d)2ii above is positive, multiply it by earned premium to obtain the amount of gross policyholder surcharge; and

iv. Divide the result of (d)2iii above by earned exposures, including exposures insured pursuant to the Personal Automobile Insurance Plan created at N.J.A.C. 11:3–2, to obtain the per automobile policyholder surcharge in dollars.

3. If the current overall percent rate change indication is zero or positive, the amount of policyholder surcharge shall be calculated by dividing the amount paid to the MTF by earned exposures to obtain the per automobile policyholder surcharge in dollars.

4. The calculation of the policyholder surcharge shall include a provision that permits the filer to recover interest at the rate set forth in N.J.A.C. 11:3–16.10(a)8 from the due date of the cash call made pursuant to the MTF Plan of Operation.

5. If the per automobile policyholder surcharge, including any interest as provided in (d)4 above, exceeds $50.00, then the Commissioner in his or her discretion may provide that the policyholder surcharge be collected over a period of up to three years; otherwise, it shall be collected over one year.

6. The Commissioner's approval of a policyholder surcharge shall include a termination date, after which the policyholder surcharge shall be deleted from future billing statements.

(e) Subsequent amounts paid to the MTF by the insurer may be charged and collected from policyholders only after a further filing is approved by the Commissioner as provided in this section. Nothing in the proceedings concerning any subsequent filing shall affect the approval of a prior filing.

(f) No more than one policyholder surcharge shall be approved pursuant to this section with an effective date between April 16 of any year and April 15 of the subsequent year.

1. A filing when made may include more than one payment by the insurer to the MTF.

2. A pending filing may be amended pursuant to N.J.A.C. 1:1–6.2 to reflect additional amounts paid to the MTF by the insurer.

3. Insurers shall make filings that request approval of a policyholder surcharge no more than 12 months after payment of the assessment for which the insurer seeks relief.

(g) Should a policyholder surcharge be approved, the Commissioner shall direct whether it shall be set forth as a separate item on the premium bill, and if so, how it shall be identified.

(h) The procedures for review and approval of filings made pursuant to this section shall be in accordance with N.J.A.C. 11:3–18.6, Insurer filings for rates requiring prior approval, and, as applicable to filings requiring prior approval, N.J.A.C. 11:3–16.3.

(i) If so requested by the filer, when the overall percent rate change indication as calculated in (d)1 above is positive, proceedings to approve the policyholder surcharge in accordance with this rule may include consideration of a prior approval rate change pursuant to N.J.A.C. 11:3–16.6.

New Rule, R.1993 d.148, effective April 5, 1993.
See: 24 N.J.R. 4486(a), 24 N.J.R. 56(a), 25 N.J.R. 1543(a).

11:3–16.13 Incomplete filings and further proceedings

(a) Failure to submit the data and calculations required by this subchapter may result in a finding that the filing is incomplete. The Department shall promptly notify a filer of a finding that its filing is incomplete.

(b) No finding that a filing is incomplete shall be based solely on the filer's failure to include data that was either not being collected, or was not collected in a manner so as to facilitate reporting, on February 5, 1990, provided that the filer includes with the filing a statement that identifies the item or items not included; specifies the reason; and certifies that the filer is undertaking action to collect and report such data in the future pursuant to N.J.A.C. 11:3–16.3(a).

(c) For informational filings, failure to submit a filing or failure to cure the deficiency of an incomplete filing within 30 days of notice shall authorize the Department to impose penalties as provided by N.J.S.A. 17:29A–23. Any penalty imposed shall be in addition to penalties imposed for failure to file an Excess Profits Report.

(d) For flex rate filings, failure to cure the deficiency of an incomplete filing within 30 days of notice, or failure to request a hearing on the issue of incompleteness within 30 days of notice, shall authorize the Commissioner to issue an Order directing the filer to cease using any flex rate increase, to refund any increased premiums collected, and to impose penalties as provided by N.J.S.A. 17:29A–23.

(e) For filings requiring prior approval, a notice that the filing is incomplete shall include a statement that the filing is disapproved as a nonconforming filing. The filer may thereafter resubmit the filing for approval with the deficiencies cured as noted.

Recodified from N.J.A.C. 11:3–16.11, effective November 26, 1990 (expired January 25, 1991).
See: 22 N.J.R. 3790(a).
Recodification adopted effective January 25, 1991.
See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).

Case Notes

Documents were not protected from disclosure under the deliberative process privilege. In the Matter of the Commissioner of Insurance's December 29, 1992 Certification of Amendments, 94 N.J.A.R.2d (INS) 31.

11:3–16.14 Rate adjustments upon repayment of assessments

(a) At such time that the loans provided for in N.J.S.A. 17:30A–8(a)(10) from the Property–Liability Insurance Guaranty Association to the Automobile Insurance Guaranty Fund are repaid, the Guaranty Association shall determine the proportion of the repayment which is to be allocated to each insurer which paid assessments pursuant to N.J.S.A. 17:30A–8(a)(9).

(b) The Guaranty Association shall advise each insurer in writing of the amount of the repayment which is to be allocated to that insurer, and shall further advise the insurer that it must comply with the provisions of N.J.A.C. 11:3–16.13(c) before the funds will be remitted.

(c) Prior to receiving repayment of any funds attributable to the assessments paid to the Guaranty Association pursuant to N.J.S.A. 17:30A–8(a)(9), an insurer shall file a plan with the Commissioner for a reduction of rates commensurate with such repayment. Upon the Commissioner's review and approval of such plan, the Commissioner shall order the repayment of funds from the Guaranty Association to the insurer.

Emergency New Rule, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).
See: 22 N.J.R. 3790(a).
Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.
See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).

Provision of emergency amendment, R.1990 d.621, readopted without change.

Case Notes

Act's provision requiring assessments to be deposited in guaranty fund was not unconstitutional. Matter of Loans of New Jersey Property Liability Ins. Guar. Ass'n, 124 N.J. 69, 590 A.2d 210, (1991).

APPENDIX

EXHIBIT A I

FLEX RATE FILINGS

COMPANY: _____
COMPANY FILE NO._____

RATE FILING REQUIREMENTS:	PAGE #
(1) COVER LETTER NOTIFYING THE DEPARTMENT OF INTENTION TO INCREASE RATES IN ACCORDANCE WITH N.J.S.A. 17:29A–44	_____
(2) STATEMENT OF PERCENT OF INCREASE BY COVERAGE (INCLUDING VARIABLE PORTION AND EXPENSE FEES EXCLUDING POLICY CONSTANT AND RMEC)	_____
(3) STATEMENT OF DOLLAR AMOUNT OF INCREASE BY COVERAGE	_____
(4) EFFECTIVE DATE OF CHANGE	_____
(5) NAME, ADDRESS AND TELEPHONE NUMBER OF COMPANY OFFICER FAMILIAR WITH FILING	_____
(6) MANUAL PAGES CONTAINING THE FLEX RATES	_____
(7) A COPY OF THE FILING MUST BE SUBMITTED TO THE NEW JERSEY PUBLIC ADVOCATE'S OFFICE	_____
(8) FORM AMB 10 MUST BE INCLUDED	_____
(9) CERTIFICATION BY COMPANY OFFICER THAT FILING MEETS STATUTORY AND REGULATORY REQUIREMENTS AND INFORMATION IS ACCURATE AND TRUE	_____
(10) FILER'S NAME SHOWN	_____
FILER'S IDENTIFYING NUMBERS	_____
FILER NAIC #	_____
GROUP NAIC #	_____
(11) CERTIFICATION BY COMPANY OFFICER THAT EXCESS PROFITS REPORT REQUIRED BY N.J.A.C. 11:3–20 HAS BEEN FILED	_____
(12) CERTIFICATION BY COMPANY OFFICER THAT FINANCIAL EXPERIENCE REPORT AS REQUIRED BY N.J.A.C. 11:3–31 HAS BEEN FILED	_____
(13) CERTIFICATION BY COMPANY OFFICER THAT ANNUAL INFORMATION FILING AS REQUIRED BY N.J.A.C. 11:3–16.4 HAS BEEN FILED	_____
(14) THE MOST RECENT FIVE COMPLETE CALENDAR YEAR HISTORY OF THE DISTRIBUTION, BY LIMIT OF LIABILITY OF WRITTEN EXPOSURES AND PREMIUMS FOR:	
BODILY INJURY LIABILITY	_____
PROPERTY DAMAGE LIABILITY	_____
COMBINED SINGLE LIMIT LIABILITY	_____
UNINSURED/UNDERINSURED MOTORISTS	_____
(15) EXHIBIT SHOWING COVERAGE WEIGHTS AND CALCULATION OF NEW VARIABLE BASE RATES IF COVERAGES ARE COMBINED	_____
(16) COMMISSION EQUALIZATION WORKSHEET	_____

Emergency Repeal and Replacement, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).
See: 22 N.J.R. 3790(a).
Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.
See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).
Repeal and Replacement, R.1990 d.621, readopted without change.

EXHIBIT A II

PRIOR APPROVAL FILINGS

COMPANY_____
COMPANY FILE NO._____

RATE FILING DATA REQUIREMENTS:	PAGE #
(1) Cover Letter notifying department of intention to modify rates which requires prior approval.	_____
Statement of % of change by coverage and overall by company (including variable portion and expense fees exc. policy constant and RMEC).	_____
Statement of dollar amount of change by coverage and overall by company.	_____
Proposed Date of the Change.	_____
Name, address and telephone number of company officer familiar with filing.	_____
An overview of the contents of filing and the reasons and procedures used to derive the rate change requested.	_____
Manual pages on or before the effective date of the rates.	_____
Computer Disk containing rating system if over 40,000 exposures.	_____
Data Disk if over 20,000 exposures.	_____
(2) The following data must be filed by:	
PREMIUM DATA:	
Earned premium at present rates for each coverage or combined coverages using extension of exposures or on level factors.	_____
A rate level history.	_____
Explanation as to how calculations were produced and documentation for sample of such calculation and justification for factors used including the rate level history.	_____
Justification for the selected method.	_____
Data on a basic or total limits basis.	_____
LOSS DATA:	
For each coverage and each year used in calculating rate level loss data is provided on a basic or total limits basis.	_____
Each year and each coverage includes:	
Earned Exposures	_____
Incurred Losses	_____
Loss Development Factor	_____
Unallocated Loss Adjustment Expense	_____

RATE FILING DATA REQUIREMENTS:	PAGE #
Allocated Loss Adjustment Expense	_____
Ultimate Incurred Losses and Loss Adjustment Expense	_____
Trend Factor Expenses	_____
Trended Ultimate Incurred Losses and Loss Adjustment Expenses	_____
If New Jersey losses are separated into catastrophic and non-catastrophic, a description of method used to separate losses.	_____
If the number of years used to determine catastrophe loading is different than number of years available, an explanation is provided, at least 10 years needed.	_____
Territorial Rate Calculations include earned premiums, earned exposures, incurred losses, and number of claims by territory for each coverage and each of the years used to determine territorial relativities or last three years, whichever is greater.	_____
Provide the following information with regard to classification differentials:	
Data used, worksheets used and judgments made.	_____
Methodology used to arrive at differentials.	_____
Description of application of the methodology to this filing.	_____
For loss adjustment expense data showing related incurred losses used to determine any loss adjustment expense loadings.	_____
(3) DERIVATION OF CREDIBILITY FACTORS	
Provide all data used and judgments made.	_____
Provide description of methodology used to derive factors.	_____
(4) LOSS DEVELOPMENT	
All data used, worksheets used and judgments made.	_____
Description of the methodology used to derive the loss development factors.	_____
By coverage provide total limits paid loss development parallelograms for the latest 10 accident years at each annual evaluation date from 15 months to 123 months for PIP and BI, 15 months to 75 months for PD and Uninsured/Underinsured Motorist, 15 months to 51 months for collision and comprehensive if on an accident year basis.	_____
Nine, five, and three year average loss development factors by coverage.	_____
Loss Development Data must be provided by:	
Total Limits Paid Losses	_____
Total Limits Incurred Losses	_____
Basic Limits Incurred Loss if used for rate level	_____
Allocated Loss Adjustment Expenses	_____
Incurred Losses Allocated Loss Adjustment Expenses	_____
Number of Paid Claims	_____
Number of Incurred Claims	_____
Statement regarding any changes in loss reserving practices during last five years.	_____
(5) TREND FACTORS:	
All internal loss trend data on either a calendar year paid or incurred basis for the latest five years on a quarterly year ending basis.	_____

RATE FILING DATA REQUIREMENTS:	PAGE #
Bodily Injury Liability data on a basic or total limits basis (Frequency & Severity shown separately).	_____
Property Damage Liability shown on a basic or total limits basis (Frequency & Severity shown separately).	_____
PIP shown at a per person limit retained by insurer.	_____
Collision and Comprehensive shown on basis of:	
$500 Deductible or adjusted to $500 Deductible.	_____
Calculate Annual Trend Factors, T-statistics, and coefficient of correlation using least squares regression for all trend data.	_____
Calculations for at least 2 of 6, 9, 12, 16, 20 point periods on both exponential and straight line basis.	_____
Side by side comparison of actual data, fitted data and differences.	_____
All data used, worksheets used and judgments made regarding trend.	_____
Description of methodology used to derive factors.	_____
Description of application of the methodology used to this filing.	_____
If filer has included the effects of any studies, analyses, or fact sheets, describe in detail the methodologies used for the following:	
Changes in seatbelt use.	_____
Changes in use of passive restraint system.	_____
Changes in drinking age.	_____
Changes in price and amount of gasoline purchased.	_____
Changes in average miles driven.	_____
Legislative, regulatory, social or economic factors.	_____
(6) NEW JERSEY PREMIUM BASE AND EXPOSURES	
a. Data on mix of written exposures by different policy terms for latest 3 years. Include both written exposures and amount of written premiums for different policy terms.	_____
b. Calculation of trend showing all steps for average model year and symbol relativities for most recent 5 calendar years.	_____
c. Actual model year and symbol written exposure and distribution for comprehensive and collision separately for each of the last 5 calendar years.	_____
d. Five year history of distribution by written exposures and premium of comprehensive and collision by deductible amount.	_____
(7) LIMITS ON FILING	
Limitations on losses and/or loss adjustment expenses included in statistical data used in filing.	_____
Limitations on extent of rate level change by coverage.	_____
Limitations on extent of territorial rate changes.	_____
Limitations on extent of classification rate changes.	_____
Limitations not provided for above.	_____

RATE FILING DATA REQUIREMENTS: PAGE #

(8) BY COVERAGE AND GROUP OF COVERAGES:
Amount of Earned Premium, incurred losses, incurred allocated and unallocated loss adjustment expense for each of the latest 5 calendar years. _____
Number of claims incurred for all limits and deductibles by coverage. _____
Allocated loss adjustment expenses for each of latest 5 calendar years. _____

(9) EXPENSE AND PROFIT PROVISIONS
For each filer provide all information related to derivation of expense provisions including:
All data used, worksheets used, and judgments made. _____
Description of methodology used to derive provisions. _____
For each of the latest 5 calendar years provide:
Average Incurred Expenses per exposure on a New Jersey basis for:
Commission & Brokerage _____
Other Acquisition _____
General Expense _____
Taxes, Licenses, Fees _____
Explanation of Basis of Allocation Taxes _____
Average Incurred Expenses per exposure on a countrywide basis for:
Commission & Brokerage _____
Other Acquisition _____
General Expense _____
Taxes, Licenses, Fees _____
Provide Derivation of Expense Flattening (Exclude UCJF assessment for excess medical). _____
Three years New Jersey auto expenses as in Part 4. _____
Underwriting Investment Exhibit, Annual Statement. _____
Five years AIRE assessments and reimbursements. _____

(10) DATA REGARDING PROPOSED RATES
Proposed rates for each territory and coverage with their deviation. _____
If classification plan is changed describe classification differentials. Provide explanation of how classification rates are determined and provide a sample calculation. _____
Provide calculations showing how base rates are in compliance with N.J.S.A. 17:29A–36. _____
Base class not greater than 1.35 statewide average base rate (include expense fees). _____
Principal operator over 65 not greater than 1¼ times statewide average rate for principal operators over 65. _____
Comparison of average statewide variable rates and expense fees proposed and currently in use and # of exposures by coverage. _____

(11) INVESTMENT EARNINGS:
Amount of investment income earned on loss, loss adjustment expense and unearned premiums reserve to earned premium for the latest 2 years, estimated for current and two following years. _____
Reserves at beginning and end of specified years:
Loss Reserve _____
Loss Adjustment Reserve _____
Unearned Premium Reserve _____
By coverage cash flow pattern from policy inception until premium received. _____
Cash flow pattern from inception for commission and brokerage, other acquisition expenses, general expenses, assessments, premium taxes, licenses, fees, other expense payments. _____
Cash flow pattern from inception for losses, allocated loss adjustment expense, and unallocated loss adjustment expense. _____

(12) STATISTICAL PLANS
Identify plans used or consulted in preparing filing. _____
Describe data compiled by each plan. _____
Certification by officer that data was collected by such plans and is true and accurate. _____
Identify data not collected in accordance with plan and used in filing. _____

(13) OTHER
Using the underwriting profit and contingency loadings selected for use in the filing, provide the rate of return on equity and assets by group of coverages. _____
Provide justification that rates of return are fair and reasonable. _____
Provide amount of finance and other miscellaneous charges collected in New Jersey for auto. _____
Provide a description of all products, and services supplied between filer and a parent company. _____

(14) STANDARD RATEMAKING METHODOLOGY INVESTMENT INCOME
Underwriting profit calculated using the Clifford Formula so that after tax profit from underwriting and investment income on loss and LAE and unearned premium reserve is 3.5% of premium. _____
If there is deduction for prepaid expenses or delayed remission of premiums support is provided. _____
The ratio of unearned premium reserves to premium from Page 14 of annual statement. (Direct E.P. divided by Direct Premium Written) is provided. _____
The ratio of loss reserves to incurred losses from Page 14 of annual statement for 4 years (Avg. of LR at beg. of yr. & at end of yr. divided by incurred losses during yr.) Monotonic change use latest ratio, otherwise use average of 4 years. _____
The ratio of loss adjustment expense reserves to loss reserves from annual statement for 4 years. (Unpaid LAE divided net losses unpaid exc. LAE). Monotonic change use latest ratio, otherwise use average of 4 years. _____
The expected loss and LAE ratio 1—(Underwriting Exp. Ratio + Underwriting Profit & Cont. Ratio). _____
Interest Rate = Treasury 3–year constant maturity rate 12 months. _____

(15) UNDERWRITING EXPENSE PROVISIONS
NJ data for commission and brokerage. _____
NJ data for taxes, licenses, fees. _____
Basis of allocation for general expenses if NJ data is not used. _____

RATE FILING DATA REQUIREMENTS: PAGE #

Provision for other acquisition and general expense based on separate trending of dollar amounts for these items. (50/50 weighting of trend using AICP index and MAWWFCIE index and regression analysis). _____
Historic Exp. Provisions limited by % in Best Aggregates & Averages for comparable company. _____
UCJF loading = latest year. _____
Fines against companies, lobbying expenses, charitable and political contributions awards against company for punitive damages, advertising legal and expenses in connection with changes in regulation of insurance and assessments and surtaxes are not included. Company must show dollar amount of expense excluded separately and by year. _____
Commissions for BI for $0 and verbal threshold are equalized. _____

(16) DATA BASE
Accident year used for either calendar or accident year for physical damage. _____
Most recent data year ends no more than 15 months prior to submission. _____
PIP limited to direct exposure retained by company. _____

(17) TREND
Separate determinations of loss severity and frequency trends. _____
Adjustment for symbol drift and model year rating. _____

(18) TOTAL RATE OF RETURN
Demonstrate reasonable rate of return from capital investment will result from proposed rates. _____

(19) ALTERNATIVE RATEMAKING METHODOLOGY
Is one used? _____
If yes, provide: all data used, worksheets used, description of methodology to arrive at selective loading. _____
Details on application of methodology to this filing. _____
Overall statewide rate change and by coverage standard and alternate methodology. _____

(20) GENERAL AND FORMAT REQUIREMENTS
Separate insurance companies make rate calculation separately and combined as a group if separate rate levels or underwriting guidelines are used. _____
Form AMB 10 must be included. _____
Certification by company officer (meets statutory and regulatory requirements). _____
Loose leaf binder, one side of page, consecutively numbered. _____
Filer's name shown _____
Filer's identifying numbers _____
Filer's NAIC # _____
Group NAIC # _____

(21) List of items the filer states are not included and the reason why. _____

RATE FILING DATA REQUIREMENTS: PAGE #

(22) IF SURTAX AND GUARANTY ASSOCIATION ASSESSMENT REFLECTED IN FILING:
Annual Statement, New Jersey, Page 14, for 10 years. _____
Annual Statement, Countrywide, Page 14 equivalent 10 years. _____

(A) EACH AFFILIATE, NEW JERSEY AND COUNTRYWIDE
PROPERTY AND CASUALTY
Annual Statement, New Jersey, Page 14, for 10 years. _____
Annual Statement, Countrywide, Page 14 equivalent 10 years. _____
TITLE INSURANCE AFFILIATES
Operations and Investment Exhibit, Page 4, 10 years. _____
Premiums Written, Schedule T, page 39, 10 years. _____
LIFE AND HEALTH AFFILIATES
Liabilities, Surplus and Other Funds, page 3, 10 years. _____
Analysis of Operations by lines of business, page 5, 10 years. _____
Exhibit I, Part 1 and Part 2, pages 7 and 7A, 10 years. _____

(B) ADDITIONAL DATA AND CERTIFICATIONS
Estimated amounts of business in other lines because the insurer writes private passenger automobile in New Jersey. _____
Certifications and representations by both Chief Financial Officer and President on information in Exhibit F. _____
Schedule of Key Performance Indicators in Exhibit G. _____
Current year and preceding two years operating expenses by classification for each New Jersey line of business. (Insurance Expense Exhibits Parts I and II.) _____
Description of all allocation methodologies used to allocate corporatewide costs to New Jersey lines of business. _____
Description of allocation methodologies to New Jersey private passenger automobile liability and physical damage lines of business. _____
Explanation of any allocation changes between the years. _____
For NJAFIUA/MTF servicing entities which we also insure. Differences in allocation methodologies for IEE and Exhibit P of NJAFIUA/MTF reporting package. _____
Each operating expense classification by each New Jersey line of business, directly charged expenses, and indirectly allocated expenses. _____

(23) DATA FOR EACH NEW JERSEY LINE OF BUSINESS:
Number of insureds. _____
Number of employees directly dedicated to business. _____
Square feet of office space dedicated to line of business. _____
Hours of data processing time. _____
Number of exposures. _____
Number of policies in force. _____
Number of claims in each of 3 years requested. _____

RATE FILING DATA REQUIREMENTS: PAGE #

(24) ACCOUNTING REPORTS AND AUDITS
Report by independent public accountant evaluating the insurer's system of internal accounting controls. _____
Listing of internal audits for New Jersey private passenger lines of business current year. _____
Copies of all internal audits issued during the current year with management responses. _____

(25) OTHER INFORMATION
Why the assessment (17:30A–8(9)) should be reflected in rates since it is a loan. _____

RATE FILING DATA REQUIREMENTS: PAGE #

Formula filer believes appropriate for determining constitutional rate of return with supporting analysis and data. _____

Emergency Repeal and Replacement, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).
See: 22 N.J.R. 3790(a).
Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.
See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).
Provision of emergency amendment, R.1990 d.621, readopted with changes effective February 19, 1991.

EXHIBIT B

CAUSE OF LOSS REPORT

COMPREHENSIVE

NEW JERSEY

Calendar Year Ending 12/31_____

	Written Exposures	Earned Exposures	Written Premium	Earned Premium	No. of Losses	Losses Paid	% Loss Paid	Loss Freq.	Avg. Loss	Pure Premium (Loss Cost)
FIRE										
THEFT										
GLASS										
ALL OTHER CAUSES										
TOTAL										

EXHIBIT C

Worksheet to Determine Zero Threshold Premium and Commission for BI and UMBI

Page 1 of 4

Insurance Group Name _____

Insurance Company Name _____

Group NAIC Number _____

Company NAIC Number _____

Check one:
BI _____
UMBI _____

This is a filing for (check one):
Flex Rating Increase _____
Prior Approval Increase _____
Prior Approval Decrease _____

BEFORE COMPLETING THIS FORM, PLEASE READ THE INSTRUCTIONS ON PAGE 4.

Section A
Section A develops the revised verbal threshold base rate after the rate change.
Item 1A: Current verbal threshold base rate
State the territory number _____
Number of exposures _____
Percent of statewide total _____
Item 2A: Verbal threshold rate change, expressed as a multiplicative factor _____
Item 3: Revised verbal threshold base rate _____
(Item 1A multiplied by Item 2A)
NOTE: Item 3A is the new verbal threshold base rate after the rate change.

Section B
The dollars of commission for the verbal threshold base rate and the zero threshold base rate are to be identical after the rate change. Section B develops the dollars of commission which can be included in the rate. The insurer may pay a higher commission. However, the portion of the commission above the amount stated in Item 2B is not to be included in the rate and is not to be charged to the policyholder.

Page 2 of 4
Item 1B: Current filed and approved commission rate for the VERBAL threshold base rate, expressed as a decimal and rounded to the third decimal place _____
State the relevant DOI filing number: _____
Item 2B: Dollars of commission for the increased/decreased verbal threshold base rate
(Item 3A multiplied by Item 1B) _____
NOTE: Item 2B is the dollars of commission for the verbal threshold base rate after the rate change, and it is also the dollars of commission for the zero threshold base rate after the rate increase/decrease.

Section C
Section C develops the zero threshold rate change.
For a prior approval rate increase, or a flex rating increase, complete Item 1C, Item 2C, Item 3C, and Item 4C. For a rate decrease, complete Item 5C, Item 6C, Item 7C, and Item 8C.
COMPLETE ITEMS 1C, 2C, 3C, AND 4C ONLY FOR A PRIOR APPROVAL RATE INCREASE, OR A FLEX RATING RATE INCREASE, BUT NOT FOR A RATE DECREASE.
Item 1C: Item 2A minus 1.000
Item 2C: Item 1C times 2.000
Item 3C: Item 2C plus 1.000
Item 4C: Zero threshold rate increase expressed as a multiplicative factor
NOTE: Item 4C is the amount the insurer selects as the zero threshold rate increase. However, for a flex filing rate increase, Item 4C cannot be smaller than Item 3C.

Page 3 of 4
COMPLETE ITEMS 5C, 6C, 7C, AND 8C ONLY FOR A PRIOR APPROVAL RATE DECREASE, AND NOT FOR A PRIOR APPROVAL RATE INCREASE, AND NOT FOR A FLEX RATING INCREASE.
Item 5C: 1.000 minus Item 2A
Item 6C: Item 5C divided by 2.000
Item 7C: 1.000 minus Item 6C
Item 8C: Zero threshold rate decrease expressed as a multiplicative factor
NOTE: Item 8C is the amount the insurer selects as the zero threshold rate decrease.

Section D
Item 5D of Section D is the zero threshold base rate with the rate increase/decrease.
Item 1D: Current zero threshold base rate
Item 2D: Filed and approved dollars of commission for the current zero threshold base rate
State the relevant DOI filing number:
Item 3D: Current zero threshold base rate excluding commissions (Item 1D minus Item 2D)
Item 4D: Increased/decreased zero threshold base rate, excluding commissions
(Item 3D multiplied by Item 4C, or Item 3D multiplied by Item 8C, as appropriate.)
Item 5D: Increased/decreased zero threshold base rate, including commissions (Items 2B plus Item 4D)

Page 4 of 4
Instructions:
1. Data are for base rates for the territory with the largest number of the filer's exposures. Following Item 1A state the number of the territory in question; the number of exposures in that territory; and the portion of the statewide exposures for the filer in that territory.
2. File one worksheet for BI and one for UMBI.
3. For combined single limits, fill out the worksheets using the BI and UMBI portions of the rate.
4. Item 2A is to be expressed as a decimal and rounded to the third digit. For example, if the rate change is an increase of 2%, Item 2A is 1.020. As another example, if the rate change is a decrease of 3.2%, then Item 2A is 0.968.
5. The commission rate in Item 1B to be expressed as a decimal and rounded to the third digit. For example, if the commission rate is 15.3%, Item 1B is 0.153. As another example, if the commission rate is 19%, Item 1B is 0.190.
6. The commission allowable in the zero threshold base rate is Item 2B. The insurer may pay a higher commission. However, the portion of the commission above the amount stated in Item 2B is not to be included in the rate and is not to be charged to the policyholder.
7. Following Items 1B and 2D, provide the DOI filing number of the filing in which the commission rate was approved.

EXHIBIT E

Bodily Injury	Percentage Change	Dollar Effect
Verbal		
Zero		
Property Damage		
Personal Injury Protection		
Uninsured Motorists		
Verbal		
Zero		
Total Liability		
Comprehensive		
Collision		

Bodily Injury	Percentage Change	Dollar Effect
Total Physical Damage		
Overall Total		

Expense Fees	Current	Proposed
Single Limit Liability		
Bodily Injury		
Property Damage		
Personal Injury Protection		
Comprehensive		
Collision		

Emergency Repeal and Replacement, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).
See: 22 N.J.R. 3790(a).
Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.
See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).
Repeal and Replacement, R.1990 d.621, readopted with changes effective February 19, 1991.

EXHIBIT F

The Chief Financial Officer and President must make the following representations regarding rate filing documents:
1. The schedule of operating expenses for the insurer's New Jersey private passenger automobile lines of business (corresponding to columns 19.1 through 19.4 and in columns 21.1 and 21.2 of the insurance expense exhibit (IEE)). Include only those costs which were incurred to support the insurer's New Jersey private passenger automobile insurance operations.
2. The allocation of expenses to each line of business on the insurance expense exhibit and the required schedule was made in accordance with the Instructions for Uniform Classifications of Expenses.
3. The allocation of corporate-wide (worldwide, countrywide and regionalwide) expenses to New Jersey lines of business represents only those corporate-wide costs that are properly allocable to New Jersey operations based on reasonable and prudent allocation methodologies.
4. The allocation methodologies used to allocate certain New Jersey general and administrative or indirect costs to New Jersey private passenger automobile lines of business were reasonable, adequately supportable, and did not result in costs being allocated which were incurred by reason of non-private passenger automobile insurance operations.
5. Allocation methodologies used were applied consistently from year to year or, if there were any changes in allocation methodologies, the insurer has stated the reasons for the changes and has quantified the effect of changing the methodologies.
6. The methodologies used to allocate indirect costs is consistent with the methodologies used to allocate indirect costs by the insurer's internal reporting system and, if the company is also an NJAFIUA/MTF servicing entity, the methodologies were consistent with those used in preparing the NJAFIUA/MTF operating statement (Exhibit P).
7. If the insurer operated separate cost centers for its New Jersey private passenger automobile lines of business, but expenses for these cost centers were allocated rather than accounted for directly, the insurer has accurately quantified the effect of not accounting for such expenses directly. Also, reasons for not using direct costing for the separate New Jersey private passenger auto cost centers have been provided.
8. The methodologies used to allocate indirect costs to the New Jersey private passenger automobile lines of business

are consistent with the methodologies used to allocate indirect costs to other New Jersey lines of business.
9. The total pool of allocated costs (before allocating to the various lines of business in each state) represents all and only such costs as are reflected in the insurer's annual audited financial statements prepared under statutory accounting principles.
10. All paid allocated loss adjustment expenses reported for New Jersey private passenger automobile lines of business were incurred to settle specific claims and the guidelines used for determining these loss adjustment expenses are the same as those used for the insurer's other lines of business.
11. A reasonable, prudent person would not determine that there are allocation methodologies which could have been used that would clearly have resulted in a more accurate allocation of operating expenses.
12. Financial information on the IEE properly reconciles with the insurer's annual statements as reported to the Department.
13. The schedule provided for premiums, incurred losses and operating expenses (on a direct basis) by New Jersey lines of business properly reconciles to the insurer's total premiums, incurred losses and operating expenses by line of business (on a net basis) as reported in the IEE.
14. Net direct written premiums reported in the current year for each New Jersey line of business were determined in the same manner as in the preceding two years.
15. The Insurance Expense Exhibits for the current and preceding two years and the required supporting schedules were prepared in conformity with statutory accounting principles.
16. Adequate provision has been made for all incurred losses in each of the periods reported.
17. There were no violations of laws or regulations during the periods reported whose effects have not been considered in the results of operations reported.
18. The accounting records underlying the financial information provided accurately and fairly reflect, in reasonable detail, the transactions of the insurer's private passenger automobile and other lines of business.
19. The filer has complied with all aspects of contractual agreements that would have a material effect on the financial information provided in the event of noncompliance.
20. No events have occurred subsequent to the date of the most recent Insurance Expense Exhibit that would require adjustment to the financial information provided on the Insurance Expense Exhibits or to the financial information provided on the other schedules required.
21. There have been no:
    a. Irregularities involving management or employees who have significant roles in the internal control structure.
    b. Irregularities involving other employees that could have a material effect on the financial information provided.
    c. Communications from regulatory agents concerning noncompliance with, or deficiencies in, financial reporting practices that could have a material effect on the financial information provided.

EXHIBIT G

KEY PERFORMANCE INDICATORS

The following data ratios should be provided for each line of business (for New Jersey business only). All of the ratios shall be calculated for the current year and preceding two years. Information on surplus as regards policyholders, accounts receivable, underwriting employees and number of adjusters shall be provided as of the last day of each year reported.

1. Salvage Recoveries/Paid Losses (Collision Only)
2. Subrogation Recoveries/Paid Losses (Liability Coverages Only)
3. Premiums Collected/Earned Premiums
4. Accounts Receivable/Earned Premiums
5. Incurred Losses (excl. IBNR)/Earned Premiums
6. Earned Premiums/Earned Exposures
7. Exposures Written/Underwriting Employees
8. Underwriting Expenses/Exposures Written
9. Paid Losses/Claims Paid and Closed
10. Claims Outstanding/Number of Adjusters
11. Claim Expenses/Claims Reported
12. Other ratios as deemed necessary by the Department of Insurance

In addition, the following data should be provided:

13. Annual Net Written Premiums/Surplus as Regards Policyholders
14. Reduction to Surplus as Regards Policyholders during the current and preceding two years.

Emergency New Rule, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).
See: 22 N.J.R. 3790(a).
Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.
See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).
Provision of emergency new rule, R.1990 d.621, readopted without change.

EXHIBIT H

Marketing Methods for the Top 20 Private Passenger Auto Insurers in New Jersey

Independent Agents:
- Aetna Casualty and Surety Co.
- Atlantic Employers Insurance Co.
- Camden Fire Insurance Association
- Continental Insurance Co. of New Jersey
- Hanover Insurance Co.
- Harleysville Garden State Insurance Co.
- Liberty Insurance Corp.
- Newark Insurance Co.
- Ohio Casualty Insurance Co.
- Parkway Insurance Co.
- Selective Insurance Co.
- Twin City Fire Insurance Co.
- United States Fidelity & Guaranty Co.

Captive Agents:
- Allstate Insurance Co.
- Keystone Insurance Co. of New Jersey (formerly Keystone Insurance Co.)
- Prudential Property and Casualty Insurance Co. of NJ
- State Farm Mutual Auto Insurance Co.

Direct Writers:
Liberty Mutual Fire Insurance Co.
New Jersey Manufacturers Insurance Co.
United Services Auto Association

SUBCHAPTER 16A. FLEX RATE PERCENTAGE CALCULATIONS FOR PRIVATE PASSENGER AUTOMOBILE INSURANCE

Subchapter Historical Note

Subchapter 16A was adopted as R.1990 d.161, effective March 19, 1990. See: 21 N.J.R. 3719(a), 22 N.J.R. 963(a).

11:3–16A.1 Purpose and scope

(a) The purpose of this subchapter is to set forth the methodology for determining the flex rate percentage increase for private passenger automobile insurance permitted by N.J.S.A. 17:29A–44.

(b) This subchapter shall apply to rates filed by:

1. All insurers writing or transacting private passenger automobile insurance in the voluntary market in this State;

2. All rating organizations authorized in this State; and

3. All coverages described herein, subject to the conditions stated for private passenger automobile insurance.

11:3–16A.2 Definitions

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

"Commissioner" means the Commissioner of Insurance of the State of New Jersey.

"Flex rate" means a Statewide average rate change as set forth in N.J.S.A. 17:29A–44.

"Flex rate percentage" means the maximum rate change permitted by N.J.S.A. 17:29A–44 that is calculated and modified, if required, in accordance with this subchapter.

"Private passenger automobile" means a vehicle that meets the definition in N.J.S.A. 39:6A–2a.

11:3–16A.3 Flex rate percentage calculations for private passenger automobile insurance

(a) The flex rate percentage shall be based upon the following:

1. For personal injury protection coverage, bodily injury liability and property damage liability coverage, the flex rate percentage shall be calculated from the last published increase in the medical care service components of the National Consumer Price Index (CPI), all urban consumers, U.S. City Average, plus three percentage points; and

2. For physical damage coverage, the flex rate percentage shall be calculated from the last published increase in the automobile maintenance and repair components of the National Consumer Price Index, U.S. City Average, plus three percentage points.

(b) The CPI used for determining the flex rate percentage may be calculated annually by using the factors set forth in (a) above by:

1. Fitting an exponential curve to a 12 month moving average starting in December and ending 14 months later in February of the current year. This method provides a stabilized yearly average of the month-to-month changes in the CPI;

2. Using the annual change from February of the previous year to February of the current year. This method produces a rate that is responsive to recent market changes reflected by changes in the CPI; and

3. Averaging the two figures in (b)1 and 2 above. This calculation permits the Commissioner to utilize the strengths of both methods by striking a balance between stability and responsiveness.

(c) The flex rate percentage may be modified pursuant to N.J.S.A. 17:29A–44(d) if the Commissioner finds that the flex rate percentage as calculated in (b) above will produce rate levels that are excessive.

Case Notes

Commissioner of insurance is not required to provide notice and comment of the calculation of flex-rates. Matter of Department of Insurance's Order Nos. A89–119 and A90–125, 129 N.J. 365, 609 A.2d 1236, (1992).

11:3–16A.4 Establishment of the flex rate

(a) The Commissioner shall annually issue an order establishing the allowable flex rate.

1. The order issued by the Commissioner shall set forth the flex rate for the following coverages:

i. Personal Injury Protection;

ii. Bodily Injury Liability (Underinsured/Uninsured):

(1) Verbal Threshold; and

(2) Zero Threshold;

iii. Property Damage Liability; and

iv. Physical Damage:

(1) With model year rating; and

(2) Without model year rating.

2. If a modification to the flex rate pursuant to N.J.S.A. 17:29A–44 has been made by the Commissioner, the order shall set forth the amount of and reason for the modification.

i. New Jersey currently has no actuarial data under P.L. 1988, c.119 to compare bodily injury liability rates for the verbal threshold and zero threshold optional coverages. Until sufficient New Jersey data is developed, the relative flex rate between the verbal and zero thresholds may be based on the Department's examination of the rate of trends in states with no-fault or tort systems. States with no-fault systems would be the basis for data for the verbal threshold, and tort system states would be the basis for data for the zero threshold.

(1) If the Commissioner finds that the rate of trend is different in no-fault states than in states using the tort system, the flex rate for the verbal threshold shall be set at a different rate than the zero threshold flex rate.

ii. Individual classification rating factors (for example, territory, deductibles, increased limits, factors, age, etc.) shall be subject to prior approval and shall not be changed through the use of the flex rate, except to the extent needed to comply with N.J.S.A. 17:29A–36.

(1) The purpose of flex rating is to permit insurers to increase their overall revenue. The use of flex rating was not intended to permit insurers to alter the relative premium paid by various classes of insureds without first obtaining prior approval by the Department.

iii. The Commissioner may modify the flex rate for physical damage based on an insurer's or rating organization's use of the following rating systems:

(1) For insurers and rating organizations using both model year and vehicle series/symbol group rating systems: Model year rating systems and vehicle series/symbol group rating systems, when used in conjunction, provide for built-in premium increases from year to year and therefore may contain appropriate yearly premium increases for physical damage coverages. A flex rate increase in addition to the yearly automobile premium increases may result in rate levels that are excessive.

(2) For insurers and rating organizations using only vehicle series/symbol group rating systems, a partial flex rate shall be set forth by the Commissioner in an order to be issued annually. Vehicle series/symbol group rating systems provide some built-in premium increases from year to year and therefore are entitled to a portion of the flex rate increase as set forth by the Commissioner in an order.

(b) All insurers and rating organizations may implement the flex rate on a combined basis for both physical damage coverages. The overall flex rate for collision and comprehensive on a combined basis shall not exceed the physical damage flex rate pursuant to N.J.S.A. 29A–44(2).

Case Notes

Commissioner cannot modify the "three percentage point" component of the flex-rate provision, and is not required to provide notice and comment in the calculation of flex–rates. Matter of Department of Insurance's Order Nos.A89–119 and A90–125, 129 N.J. 365, 609 A.2d 1236 (1992).

SUBCHAPTER 17. (RESERVED)

Subchapter Historical Note

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). Subchapter 17, was repealed and replaced by a new rule as R.1986 d.419, effective October 6, 1986. See: 18 N.J.R. 1171(b), 18 N.J.R. 2045(a). Subchapter 17 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 18. PRIVATE PASSENGER AUTOMOBILE INSURANCE: RATE FILING REVIEW PROCEDURES

Subchapter Historical Note

Subchapter 18 was adopted as R.1990 d.109, effective February 5, 1990. See: 21 N.J.R. 3422(b), 22 N.J.R. 421(a).

11:3–18.1 Purpose and scope

(a) This subchapter sets forth the procedures used by the Department to review voluntary market private passenger automobile insurance rate filings and implements N.J.S.A. 17:29A–1 et seq. It is intended to provide for the expeditious review and disposition of automobile insurance rate filings consistent with applicable statutes regarding insurance and administrative procedures.

(b) This subchapter applies to the following kinds of automobile insurance rate filings submitted to the Department:

1. Annual informational filings made pursuant to N.J.S.A. 17:29A–36.2b;

2. Flex rate filings made pursuant to N.J.S.A. 17:29A–44; and

3. Rate change filings that require prior approval of the Commissioner made pursuant to N.J.S.A. 11:29A–14.

(c) This subchapter shall be construed so as to be compatible with the rules that set forth requirements for rate filings, N.J.A.C. 11:3–16; the provisions of the Administrative Procedures Act, N.J.S.A. 52:14B–1 et seq.; and the administrative procedure rules, N.J.A.C. 1:1 and 1:11 concerning the disposition of matters after they have been determined to be a contested case.

11:3–18.2 Definitions

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

"Annual informational filing" means a filing made in accordance with the provisions of N.J.S.A. 17:29A–36.2b and N.J.A.C. 11:3–16.4 or 16.7(a).

"Contested case" means any proceeding so defined in N.J.S.A. 52:14B–2(b), specifically including a prior approval filing when request for a hearing has been made by any party or when the Commissioner determines that a hearing on the filing is necessary.

"Day" means a calendar day.

"Department" means the New Jersey Department of Insurance.

"Filer" means a rating organization or any insurer making its own rates or a portion thereof, establishing or proposing to establish a new rate or rate change, or making an annual informational filing.

"Flex rate filing" means a filing made pursuant to N.J.A.C. 11:3–16.5 or 16.7(c) to adjust rates within limits set in accordance with the provisions of N.J.S.A. 17:29A–44 and applicable orders of the Commissioner issued pursuant to N.J.A.C. 11:3–16A.

"Parties" includes the filer, the Public Advocate, and any other person with a legal right to participate in the proceedings who has served notice on the Commissioner of its intention to participate.

"Prior approval filing" means a filing made pursuant to N.J.S.A. 17:29A–14 and N.J.A.C. 11:3–16.6 or 16.7(d) to alter, supplement, or amend rating systems or any part thereof, except flex rate filings.

"Public Advocate" means the Division of Rate Counsel, Department of the Public Advocate of New Jersey.

"Qualified member" of a rating organization means an insurer member or subscriber of a rating organization whose total written private passenger car years insured on a calendar year basis, is less than 1.5 percent on January 1, 1990 and one percent on or after January 1, 1991, of the total written private passenger car years insured by all insurers writing motor vehicle insurance in this State in the voluntary market, pursuant to N.J.S.A. 17:29A–6.1a2.

"Rating organization" means every person or persons, corporation, partnership, company, society, or association engaged in the business of making rates or a portion thereof for two or more insurers and licensed in accordance with N.J.S.A. 17:29A–2.

11:3–18.3 General provisions applicable to all filings

(a) Filings may be submitted by insurers or licensed rating organizations which are authorized to file rates for insurers which are members or subscribers of the rating organization.

1. Insurers required to make their own rates pursuant to N.J.S.A. 17:29A–6.1a(2), which are not qualified members of rating organizations as defined in N.J.A.C. 11:3–18.2 shall make filings themselves.

2. Filings submitted by rating organizations shall be submitted only for and on behalf of their qualified member companies.

(b) In computing any period of time fixed by this subchapter, the day of the act or event from which the designated period begins to run is not to be included. The last day of the period so computed is to be included, unless it is on a Saturday, Sunday or legal holiday, in which event the period runs until the end of the next day which is neither a Saturday, Sunday nor legal holiday.

(c) All documents filed with the Commissioner, except initial filings, shall contain a statement certifying that the item is being submitted within the time provided by this subchapter.

(d) Provisions of this subchapter that establish time limits may be relaxed or modified by the Commissioner for good cause shown.

(e) A determination by the Department that a filing is complete relates solely to the presence in the filing of the items required by N.J.A.C. 11:3–16 and shall not be considered a finding regarding the accuracy or reasonableness of the information or calculations.

(f) All filings and other items submitted to the Commissioner shall be sent to the Department at the following address:

New Jersey Department of Insurance
Property/Liability Division
20 West State Street
CN 325
Trenton, New Jersey 08625–0325

(g) Any filing or other item submitted to the Public Advocate shall be sent to the Public Advocate at the following address:

Department of the Public Advocate
Division of Rate Counsel
744 Broad Street—30th Floor
Newark, New Jersey 07102

Case Notes

Insurers' filings for rate increases were ruled complete due to commissioner's failure to timely respond. Allstate Ins. Co. v. Fortunato, 248 N.J.Super. 153, 590 A.2d 690 (A.D.1991).

11:3–18.4 Procedures for review of annual informational filings

(a) The time period for the Department's review of an annual informational filing shall commence upon the day that the filing is received.

(b) If the filing is incomplete, the Department shall so advise the filer not later than 60 days after receipt of the filing.

1. The filing shall be deemed to be complete if the filer is not notified that the filing is incomplete.

2. Notice to the filer that the filing is incomplete shall specify the missing item(s) or information. The notice shall advise the filer that the deficiency must be cured within 30 days of receipt of notice, and that failure to cure the deficiency within 30 days of receipt of notice may result in imposition of penalties as provided by law.

(c) If any annual informational filing is not made, or if an incomplete filing is not cured within 30 days of receipt of notice, the Commissioner may commence proceedings to impose penalties on the filer as provided by law.

11:3–18.5 Procedures for review of flex rate filings

(a) The time period for the Department's review of a flex rate filing shall commence upon the day that the filing is received.

(b) The Department shall advise the filer if the filing is incomplete not later than 60 days after receipt of the filing.

1. The filing shall be deemed to be complete if the filer is not notified that the filing is incomplete.

2. A notice to the filer that the filing is incomplete shall specify the missing item(s) or information. The notice shall advise the filer that the deficiency must be cured within 30 days of receipt of the notice. The notice shall further advise the filer of its right to a hearing on the issue of completeness, and of the consequences of failure to cure the deficiency, as provided in (c) below.

(c) If the filer has not cured the deficiency within 30 days of notice, or if the filer has not requested a hearing in writing within 30 days of notice, the Commissioner may enter an Order directing the filer to cease using the flex rates set forth in the filing; directing the filer to use its rates in effect prior to making the flex rate filing; and directing the filer to file a plan to refund or adjust the rates of any insured whose policy was issued or renewed using the rates set forth in the flex rate filing.

(d) A filer may request a hearing on the issue of completeness. Any such request shall be made in writing and shall contain facts or legal arguments that adequately support the filer's contention that the filing is complete as submitted.

(e) Not later than 10 days after receipt of a request for hearing, the Commissioner shall determine whether the matter requires a hearing and so notify the filer in writing.

1. If the matter is found to require a hearing, the Commissioner may hear the matter; direct that the matter be transmitted to the Office of Administrative Law for further proceedings; or appoint a salaried employee of the Department to hear the matter pursuant to N.J.S.A. 17:29A–14c.

2. As a condition to scheduling the hearing, the Commissioner may order the filer to establish a separate interest-bearing escrow account, into which the funds collected on account of the flex rate increase shall be deposited, pending the outcome of the hearing.

(f) Further proceedings on the matter shall be conducted in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq.

11:3–18.6 Procedures for review of prior approval filings

(a) The time period for the Department's review of a prior approval filing shall commence the day the filing is received. The filer shall serve a copy of the filing on the Public Advocate simultaneously with making the filing with the Department, pursuant to N.J.A.C. 11:3–16.3(e), and the filing shall contain a certification by an officer of the filer that a copy was so served.

(b) The Public Advocate shall notify the Department and the filer if it intends to intervene no later than 10 days after receipt of a filing.

(c) The Department shall advise the filer if the filing is incomplete not later than 25 days after receipt of the filing.

1. The filing shall be deemed to be complete if the filer is not notified that the filing is incomplete.

2. Notice to the filer that the filing has been found to be incomplete shall specify the missing item(s) or information.

3. The Department shall send a copy of the notice that the filing is incomplete to the Public Advocate, if notice of intent to intervene has been received.

4. The Department may return the filing to the filer with the notice that it is incomplete with a statement that it has been disapproved as a nonconforming filing. Any resubmission of the filing after the deficiency has been cured shall be considered initial receipt.

(d) If the Department requests further information from the filer, which information must be provided to the Department upon request pursuant to N.J.A.C. 11:3–16.8, 16.9 or 16.10, the filer shall submit the information to the Department, and simultaneously to the Public Advocate, within 15 days of the receipt of the request.

(e) The Department deems the filing requirements set forth in N.J.A.C. 11:3–16 to be sufficient information to review and evaluate any rate change requested. Therefore, no supplemental information beyond limited discovery to seek clarifying or explanatory information should be required. The following procedures may be used to obtain clarifying, explanatory or supplemental information if necessary:

1. Not later than 20 days after receipt of a filing, the Public Advocate may request in writing that the filer provide information that may be necessary to clarify or explain information contained in the filing. Not later than 10 days after receipt of any such request, the filer shall provide the clarifying or explanatory information to the Public Advocate and simultaneously to the Department.

2. Not later than 20 days after receipt of a filing, the Public Advocate may petition the Commissioner for an Order directing the filer to provide additional data, information or documents, other than that required to clarify or explain information contained in the filing.

i. The petition shall include a list of the data, information or documents to be provided and show good cause why the additional information or documents are required. A copy of the petition shall be sent simultaneously to the filer, which may file a responsive statement within five days.

ii. Upon receipt of such a petition, and after consideration of any responsive statement by the filer, the Commissioner may either direct the filer to provide all or part of the information or documents within a specified time, or deny the petition.

iii. A decision of the Commissioner directing the filer to provide additional data, information or documents in accordance with this section may include a reasonable extension of time within which the Public Advocate may file its report and recommendation, and further include a reasonable extension of time within which any party may request a hearing.

iv. Copies of any correspondence between the parties, and any additional information or documents supplied at the direction of the Commissioner, shall also be provided to the Department.

(f) Not later than 60 days after receipt of a filing, the Public Advocate shall file with the Department its report and recommendations, and simultaneously submit a copy to the filer.

(g) Not later than 60 days after receipt of a filing by the Department, either the Public Advocate or the filer may request in writing a hearing on the filing. A request for hearing shall include a statement of facts and issues in sufficient detail so as to notify the Department and any other party of the matters in dispute.

(h) Upon receipt of a request for a hearing, or not later than 75 days after receipt of a filing by the Department, the Commissioner shall determine whether the matter is a contested case and notify all parties in writing.

1. If no hearing is requested the Commissioner shall enter an appropriate final order disposing of all issues raised by the filing. The final order shall be issued not later than 90 days from receipt of the filing, except for good cause the Commissioner may extend the time to issue a final Order by not more than 30 days.

2. If a hearing is requested the Commissioner may hear the matter; direct that the matter be transmitted to the Office of Administrative Law; or may appoint a salaried employee of the Department to hear the matter pursuant to N.J.S.A. 17:29A–14c.

(i) The hearing shall be conducted pursuant to the provisions of N.J.S.A. 17:29A–14c and the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq., and applicable administrative rules, N.J.A.C. 1:1 and 1:11.

Case Notes

Insurers' filings for rate increases were ruled complete due to commissioner's failure to timely respond. Allstate Ins. Co. v. Fortunato, 248 N.J.Super. 153, 590 A.2d 690 (A.D.1991).

11:3–18.7 Other remedies preserved

Nothing in this subchapter shall prevent the Commissioner from at any time initiating an action pursuant to N.J.S.A. 17:29A–1 et seq. to direct that rating systems be altered or revised if found to provide for, result in, or produce rates which are unreasonable, inadequate, or which discriminate unfairly between risks in this State involving essentially the same hazards and expense elements.

SUBCHAPTER 19. STANDARD/NON–STANDARD RATING PLANS

Authority

N.J.S.A. 17:1–8.1; N.J.S.A. 17:1C–6(e); N.J.S.A. 17:29A–45.

Source and Effective Date

R.1991 d.92, effective January 25, 1991.
See: 22 N.J.R. 3804(a), 23 N.J.R. 532(a).

Subchapter Historical Note

Subchapter 19, Standard/Non–Standard Rating Plans, was filed as emergency new rule R.1990 d.628, effective November 26, 1990, with a January 25, 1991 expiration date. See: 22 N.J.R. 3804(a). The subchapter was readopted as R.1991 d.92 with changes effective February 19, 1991. See: Source and Effective Date.

11:3–19.1 Purpose and scope

(a) This subchapter implements N.J.S.A. 17:29A–45 as amended by section 37 of P.L.1990, c.8, by establishing standards for standard/non-standard rating plans in the voluntary automobile insurance market. It sets forth the items to be filed and approved by the Commissioner in order to create a standard/non-standard rating plan; standards to be applied by the Department in approving a plan; and standards for the functioning of a plan in the market.

(b) This subchapter applies to all insurers that are licensed and authorized to transact personal private passenger automobile insurance in the voluntary market. It applies to groups of affiliated companies which insure risks through separate individual insurance companies.

11:3–19.2 Definitions

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

"Affiliated companies" means two or more individual insurance companies that are authorized to transact private passenger automobile insurance business in New Jersey and that are under both common ownership and common management.

"Applicant" means a person applying to an insurer for a policy of automobile insurance who is not currently a named insured under a policy of automobile insurance issued by that insurer.

"Automobile insurance eligibility points" or "eligibility points" means points accrued in accordance with the schedule set forth in N.J.A.C. 11:3–34.

"Commissioner" means the Commissioner of Insurance of the State of New Jersey.

"Department" means the New Jersey Department of Insurance.

"Individual insurance company" means an insurance company separately licensed and authorized to transact private passenger automobile insurance business in New Jersey, regardless of whether it is one of a group of affiliated companies.

"Insured" when used as a noun means a policyholder or other person insured under a policy of automobile insurance and not insured elsewhere.

"Insurer" includes a group of affiliated companies.

"Standard/non-standard rating plan" means a rating system used by an insurer that provides different rates for different risks to those insureds who qualify in accordance with the insurer's approved underwriting rules.

"Public Advocate" means the Division of Rate Counsel of the New Jersey Department of the Public Advocate, established pursuant to N.J.S.A. 52:27E–16.

"Renew" means to issue and deliver at the end of the policy period a policy superceding a policy previously issued and delivered, or to issue and deliver a certificate or notice extending the term of a policy beyond its policy period or term, by the same individual insurance company, or by another of a group of affiliated companies pursuant to a standard/non-standard rating plan filed and approved in accordance with this subchapter.

"Risk" means the person or property exposed to loss or damage that is insured under an automobile insurance policy.

11:3–19.3 Filing requirements for standard/non-standard rating plans

(a) All insurers which write personal private passenger automobile insurance shall file standard/non-standard rating plans that provide different rates for risks separately described by the insurer's approved underwriting rules. No insurer shall implement or use a standard/non-standard rating plan that has not been filed and approved in accordance with N.J.S.A. 17:29A–45 and this subchapter.

(b) Merit rating surcharges, which are permitted to be included in rating systems by N.J.S.A. 17:29A–35, shall be incorporated only into the non-standard rate level of the voluntary market.

(c) An insurer shall initially establish a standard/non-standard rating plan by filing with the Commissioner the following items:

1. A narrative description of the plan, which shall include:

i. The percentage difference between the standard and non-standard rate levels;

ii. The variation of the difference by eligibility points;

iii. Any variation of the difference by coverage;

iv. The insurer's plan for determining upon renewal to which rate level a risk will be assigned; and

v. If the plan is submitted by a group of affiliated companies, the identity of all individual insurance companies in the group that transact private passenger automobile insurance business in New Jersey and the rate level to be used by each;

2. A complete set of underwriting rules that set forth qualifications for each rate level, which rules shall conform to the standards set forth in N.J.A.C. 11:3–35; and

3. Within 30 days of the date of approval of the underwriting rules or the effective date of the plan, whichever is later, manual rate pages for each rate level.

(d) A group of affiliated companies may file a standard/non-standard rating plan that provides that different individual insurance companies write risks at different rate levels.

11:3–19.4 Standards for disapproval or modification

(a) A standard/non-standard rating plan shall be disapproved for any of the following reasons:

1. If the average non-standard rate is in excess of 135 percent of the average of the combined standard and non-standard rates;

2. If the plan does not provide for an equitable graduated scale of non-standard rates based on accrued automobile insurance eligibility points;

3. If the plan does not provide that the insurer shall, after April 1, 1992, insure at either its standard or non-standard rate level all applicants and insureds defined as "eligible persons" in N.J.A.C. 11:3–34;

4. If the plan does not provide that the insurer shall insure at its standard rate level all insureds who have accrued no automobile insurance eligibility points during the previous three years;

5. If the underwriting rules do not meet the standards set forth in N.J.A.C. 11:3–35;

6. If the insurer fails to submit the items required for filing pursuant to N.J.A.C. 11:3–19.3; or

7. If the plan otherwise fails to meet any of the standards of this subchapter.

(b) The Commissioner may by rule or order direct an insurer with an approved standard/non-standard rating plan to modify its plan to conform to rules which may be adopted pursuant to N.J.S.A. 17:29A–45f that further define the non-standard voluntary market.

(c) A standard/non-standard rating plan may provide that any applicant who is not an "eligible person" as defined in N.J.A.C. 11:3–34 may be insured at the non-standard rate level during any period of time certified by the Commissioner for the cessation of the acceptance of applications or the issuance of new policies by the assigned risk plan, pursuant to N.J.S.A. 17:29D–1d.

11:3–19.5 Renewal of policy at proper rate level

(a) An insurer which has implemented a standard/non-standard rating plan shall issue and renew its policies at the appropriate rate level for which the risk qualifies in accordance with the insurer's approved underwriting rules based upon eligibility points accrued in the 36 month period ending 90 days prior to the expiration of the current policy. The transfer of a risk from one rate level to another within an insurer's standard/non-standard rating plan shall not be deemed to be a nonrenewal of the policy as provided by N.J.S.A. 39:6A–3 and N.J.A.C. 11:3–8 if the insurer complies with the provisions set forth below.

1. If the insured qualifies for the standard rate level after having been insured at the non-standard rate level, the insurer shall renew the insured at the standard rate level in accordance with procedures set forth in N.J.A.C. 11:3–8.3(a) through (e).

2. If the insured qualifies for the non-standard rate level after having been insured at the standard rate level, the insurer shall renew the insured at the non-standard rate level in accordance with procedures set forth in N.J.A.C. 11:3–8.3(a) through (e) after providing notice to the insured as follows:

i. Written notice shall be sent to the insured at least 30, but not more than 45, days before expiration of the policy;

ii. The written notice shall advise the insured that he or she no longer meets the insurer's approved underwriting rules for the standard rate level;

iii. The notice shall set forth a summary of the provisions of the underwriting rule that applies to the insured and the specific facts upon which the insurer relies to determine that the insured no longer is qualified for the standard rate level, including the specific events that resulted in the accrual of automobile insurance eligibility points; and

iv. The notice shall advise the insured of his or her right to contact other insurers to determine whether comparable insurance can be purchased elsewhere at less cost.

(b) An insurer which has implemented a standard/non-standard rating plan shall state on the policy declaration page, or some other writing accompanying the policy, the number of eligibility points that were used to rate the policy.

11:3–19.6 Procedural provisions

(a) An individual insurance company operating pursuant to a rating plan approved on or before November 14, 1989 may initially file a standard/non-standard rating plan in which the modification is expressed as a percentage increase or decrease of the existing rate level.

(b) Contemporaneously with filing a standard/non-standard rating plan with the Department, an insurer operating pursuant to a rating plan approved on or before November 14, 1989, shall deliver a copy of the filing to the Public Advocate at the following address:

Department of the Public Advocate
Division of Rate Counsel
31 Clinton Street
P.O. Box 46005
Newark, New Jersey 07101

1. The Public Advocate may intervene in the proceedings by filing notice with the Department within 10 days of date of receipt of the filing. A copy of the notice shall be contemporaneously sent to the insurer filing the plan.

2. The Public Advocate shall file with the Department its comments regarding the insurer's proposed rating plan and underwriting rules no later than 30 days after receipt of the filing. A copy of the comments shall be contemporaneously delivered to the insurer filing the plan.

3. The insurer may submit to the Department a response to the comments within 10 days of receipt. A copy shall be sent contemporaneously to the Public Advocate.

4. The decision of the Commissioner to approve or disapprove the rates and underwriting rules shall be based upon the documents submitted.

5. The Commissioner shall promptly notify the insurer whether the rating plan and underwriting rules have been approved or disapproved. A copy of the decision shall also be sent to the Public Advocate if it has filed a notice of its intention to intervene. Pursuant to N.J.S.A. 17:29A–45c, rates initially filed as a percentage increase or decrease of the existing rate level by an insurer which had rates approved on November 14, 1989, shall be deemed approved if not disapproved within 60 days.

(c) An individual insurance company which did not have a rating plan approved on or before November 14, 1989 may file a standard/non-standard rating plan by complying with the provisions of N.J.A.C. 11:3–19.3 and N.J.A.C. 11:3–16.5 (rate filing requirements for prior approval filings) even if it is one of a group of affiliated companies of which one or more companies has approved rates.

(d) All insurers which write personal private passenger automobile insurance shall file for approval on or before March 1, 1991 a standard/non-standard rating plan that meets the requirements of this subchapter.

11:3–19.7 Penalties

Failure to comply with the provisions of this subchapter shall subject the insurer to penalties as provided by N.J.S.A. 17:33–2.

SUBCHAPTER 20. REPORTING FINANCIAL DISCLOSURE AND EXCESS PROFITS

Subchapter Historical Note

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).

11:3–20.1 Purpose

This subchapter sets forth the financial disclosure and excess profits reporting requirements pursuant to P.L. 1988, c.118 (N.J.S.A. 17:29A–5.6 to 17:29A–5.16).

Case Notes

Insurance commissioner failed to utilize statutory rule-making procedures in changing evaluation of excess profits. American Employers' Ins. Co. v. Commissioner of Ins., Dept. of Ins., State of N.J., 236 N.J.Super. 428, 566 A.2d 202 (A.D.1989).

11:3–20.2 Scope

The provisions of this subchapter apply to all insurers authorized to transact private passenger automobile insurance business in this State.

11:3–20.3 Definitions

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

"Actual investment income" means that portion of income generated by investment of policyholder-supplied funds.

"Actuarial gain" means the remainder obtained by subtracting the allowance for profit and contingencies from underwriting income which remainder may be positive or negative.

"AIRE charges" and "AIRE compensation" mean, respectively, amounts paid to or received from the New Jersey Automobile Insurance Risk Exchange pursuant to N.J.S.A. 39:6A–22.

"Anticipated investment income" means the amount obtained by multiplying earned premium by the percentage of premium representing investment income used in the insurer's approved rate filings or filings made pursuant to N.J.S.A. 17:29A–42, during the period of the three calendar-accident years being calculated, to calculate the allowance for profit and contingencies.

"Calendar-accident year" means the period from January 1 to December 31, during which, in the appropriate context:

1. Premium or investment income was earned;

2. Expenses were incurred; or

3. Accidents occurred which resulted in losses, loss adjustment expenses or AIRE compensation.

"Car year" means the unit of exposure equivalent to the insuring of one automobile for 12 months, two automobiles for six months each, three automobiles for four months each, and so on.

"Combined profits report" means the Excess Profits Report consisting of the aggregated profits results of all members within an insurance holding company system and the individual profits results for each individual member within that holding company system.

"Commissioner" means the Commissioner of Insurance.

"Development adjustment", for a given calendar-accident year, means the difference obtained by subtracting:

1. The sum of:

i. Loss and loss adjustment expenses for that calendar-accident year, developed to an ultimate basis and evaluated as of March 31 of the year preceding the year in which the profits report required by N.J.A.C. 11:3–20.5 is due; plus

ii. AIRE compensation for that calendar-accident year, developed to an ultimate basis and evaluated as of March 31 of the year in which the profits report is due; from

2. The sum of:

i. Losses and loss adjustment expenses for that calendar-accident year, developed to an ultimate basis and evaluated as of March 31 of the year in which the profits report is due; plus

ii. AIRE compensation for that calendar-accident year, developed to an ultimate basis and evaluated as of March 31 of the year preceding the year in which the profits report is due.

"Excess investment income" means the remainder obtained by subtracting the anticipated investment income from the actual investment income earned by the insurer, which remainder may be positive or negative.

"Insurer" means an entity authorized or admitted to transact private passenger automobile insurance business in New Jersey. Where an insurer is part of an insurance holding company system, insurer means each individual insurer within the insurance holding company system as defined in N.J.S.A. 17:27A–1 et seq. Insurer does not include any residual market mechanism for automobile insurance for the purposes of this subchapter.

"Non-excessive subsidization" means the number of dollars of excess profit, as calculated pursuant to this subchapter, for an individual insurer within an insurance holding company system, that is less than or equal to .5 percent (one half of one percent) of its earned premiums for the three calendar-accident years immediately preceding the year in which the Excess Profits Report is due to the extent that this excess profit has not been refunded or credited to policyholders.

"Private passenger automobile insurance business" means direct insurance on private passenger automobiles as defined in N.J.S.A. 39:6A–2, excluding personal excess liability insurance and insurance on commercial vehicles.

"Subsidization" means the number of dollars of excess profit as calculated pursuant to this subchapter, for a member of an insurance holding company system, which has not been refunded or credited to policyholders.

"Total actuarial gain" means the sum of actuarial gains for the three calendar-accident years immediately preceding the due date of the profits report required by N.J.A.C. 11:3–20.5 less the development adjustments for the calendar-accident years beginning with the seventh calendar-accident year immediately preceding the due date of the profits report and ending with the fourth calendar-accident year immediately preceding the due date of the profits report.

"Underwriting income" means the remainder obtained by subtracting the sum of losses developed to an ultimate basis, loss adjustment expenses developed to an ultimate basis, and other expenses exclusive of UCJF assessments, from the sum of premiums earned and AIRE compensation developed to an ultimate basis, which remainder may be positive or negative.

"UCJF assessments" means amounts paid by insurers to the Unsatisfied Claim and Judgement Fund pursuant to N.J.S.A. 39:6–63.

"UCJF reimbursements" means amounts received by an insurer from the Unsatisfied Claim and Judgement Fund as a result of excess medical expense benefit payments by the insurer pursuant to N.J.S.A. 39:6–73.1.

Amended by R.1991 d.17, effective January 7, 1991.
See: 22 N.J.R. 2082(b), 23 N.J.R. 106(a).
Definitions added for "combined profits report", "non-excessive subsidization" and "subsidization".

Amended by R.1991 d.45, effective February 4, 1991.
See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).
Revised "Insurer" definition by deleting NJAFIUA reference and added "... any residual market mechanism for automobile insurance ..." to text.

11:3–20.4 General reporting requirements

(a) The data in the reports required by this subchapter shall be for New Jersey voluntary private passenger automobile insurance only.

(b) Each private passenger automobile insurer, except as provided in (e) below, shall annually file with the Commissioner the data and information required by this subchapter on or before July 1 of each year. Filings shall be sent:

New Jersey Department of Insurance
Division of Property and Liability
20 West State Street
CN 325
Trenton, New Jersey 08625
Attention: Excess Profits

(c) The data required by this subchapter shall be submitted on an MS–DOS formatted disk(s), and in written copy using the forms and record layouts contained in the Appendix to this subchapter. The disk(s) may be either 5.25 inch double sided, double density, or 3.5 inch high density. The information shall be presented in a Lotus 1–2–3 or compatible spread sheet. The written copy shall include in the left and top margins the row and column location respectively of all the data in the worksheets. Each page shall also display in the bottom right corner the name of the computer file and disk on which it is contained. All calculated values shall be given as a formula in the spreadsheet.

(d) The information shall be provided with respect to the insurer's New Jersey private passenger automobile insurance business separately for each of the following coverages and for all these coverages combined:

1. Personal injury protection, including all options;
2. Bodily injury liability, reported at total limits;
3. Other liability, consisting of property damage liability and uninsured and underinsured motorist coverages, all reported at total limits; and
4. Physical damage, consisting of comprehensive and collision coverages, including all deductibles.

(e) Any insurer having fewer than 150 earned car years of exposure in New Jersey during the three calendar-accident years immediately preceding the date the profits report is due shall file a certification to that effect, in lieu of all other requirements of this subchapter.

11:3–20.5 Profits report

(a) Each insurer shall submit a complete and accurate profits report in the format of the exhibits appended to this subchapter, which exhibits are hereby incorporated by reference as part of these rules.

(b) The profits report shall contain the following information for each of the seven most recent calendar-accident years, with an evaluation date as of March 31 of the year in which the profits report is due:

1. Losses paid;
2. Losses developed to an ultimate basis;
3. Loss adjustment expenses paid;
4. Loss adjustment expenses developed to an ultimate basis;
5. AIRE compensation received; and
6. AIRE compensation developed to an ultimate basis.

(c) In addition to the requirements in (b) above, each insurer shall file in the format of the exhibits appended to this subchapter, the following information for the calendar-accident year ending December 31 immediately preceding the date the profits report is due:

1. Premiums written;
2. Premiums earned;
3. Other expenses, itemized separately as follows:
   i. Commissions and brokerage fees;
   ii. Taxes, licenses and fees;
   iii. AIRE charges;
   iv. UCJF assessments;
   v. Other acquisition costs and general expenses;
   vi. Policyholder dividends including any excess profits refunded or credited to policyholders;
4. Allowance for profit and contingencies (obtained by multiplying premiums earned by the profit and contingency factors authorized for use with the insurer's approved rate filings);
5. Anticipated investment income;
6. Actual investment income; and
7. UCJF reimbursements received.

(d) The profits report shall include a calculation of each of the following items in the format of the exhibits appended to this subchapter:

1. Underwriting income for each of the three calendar-accident years immediately preceding the date of the profits report;

2. Actuarial gain for each of the three calendar-accident years immediately preceding the date of the profits-report;

3. Excess investment income for each of the three calendar-accident years immediately preceding the date of the profits report;

4. Development adjustment for the calendar-accident years beginning with the seventh calendar-accident year immediately preceding the due date of the profits report and ending with the fourth calendar-accident year immediately preceding the due date of the profits report;

5. Total actuarial gain; and

6. Excess profits.

(e) No expenses included in the Excess Profits Report shall include assessments paid to the New Jersey Property Liability Insurance Guaranty Association pursuant to N.J.S.A. 17:30A–8a(9) or surtaxes paid pursuant to N.J.S.A. 17:33B–49, except to the extent the insurer was permitted to reflect the assessments and surtaxes in its approved rates for private passenger automobile insurance pursuant to N.J.A.C. 11:3–16.11 for any of the three years reported in the Excess Profits Report.

(f) An officer of the insurer shall certify on the profits report forms that the report complies with all statutory and regulatory requirements to the best of his or her information, knowledge and belief. The officer shall sign his or her name and provide title and date, and phone number.

(g) An insurer may reflect as an expense the net amounts paid to the MTF in calculating its excess profits. The expense shall be reported in the "BI Liability and Uninsured/Underinsured Motorists Coverages" of Exhibit Ten in the Appendix.

1. The net amounts paid to the MTF includes only payments actually made by the insurer to the MTF, which are to be credited as all or part of the insurer's apportionment share of MTF losses pursuant to N.J.S.A. 17:33B–11d and the MTF Plan of Operation, including any payment made on account of the insurer's liability or in response to an Order of the Commissioner directing that payment be made, less any amount recovered by the insurer from policyholders pursuant to N.J.A.C. 11:3–16.12.

2. If an insurer makes a payment to the MTF pursuant to Article XIV, section 5 of the MTF Plan of Operation prior to the issuance of an Order of the Commissioner directing payment, the insurer may reflect the payment either in the year when paid or in the year when payment is due pursuant to the Order of the Commissioner.

Amended by R.1992 d.254, effective June 15, 1992.
See: 24 N.J.R. 529(a), 24 N.J.R. 2264(a).
Text added at (e) regarding Excess Profits Report expenses.
Amended by R.1994 d.24, effective January 3, 1994.
See: 25 N.J.R. 1829(a), 26 N.J.R. 241(a).

Law Review and Journal Commentaries

Auto Insurance. Steven P. Bann, 137 N.J.L.J. No. 16, 50 (1994).

Case Notes

Challenge to validity of regulation was justiciable. Matter of Commissioner of Insurance's Issuance of Orders A-92-189 and A-92-212, 274 N.J.Super. 385, 644 A.2d 616 (A.D.1993), affirmed 137 N.J. 93, 644 A.2d 576.

Commissioner of Insurance did not exceed his authority in prohibiting automobile insurers from deducting surtaxes and assessments under Fair Automobile Insurance Requirement Act as expenses. Matter of Commissioner of Insurance's Issuance of Orders A-92-189 and A-92-212, 274 N.J.Super. 385, 644 A.2d 616 (A.D.1993), affirmed 137 N.J. 93, 644 A.2d 576.

Insurance commissioner failed to utilize statutory rule-making procedures in changing evaluation of excess profits. American Employers' Ins. Co. v. Commissioner of Ins., Dept. of Ins., State of N.J., 236 N.J.Super. 428, 566 A.2d 202 (A.D.1989).

11:3–20.6 Reporting requirements for insurance holding companies

(a) A separate profits report shall be filed for each insurer and each insurer in an insurance holding company system.

(b) For each insurance holding company system, a combined profits report for all insurers in its system shall be filed with the Commissioner. The excess profits computation for an insurance holding company system shall be performed on its combined profits report, except the Commissioner shall order an adjustment in the combined profits report if, upon examining each insurer's profits report in the insurance holding company system, one or more of the insurers in that system is excessively subsidizing other insurers in that system.

(c) Excessive subsidization shall exist if the number of dollars of excess profit, as calculated pursuant to this subchapter, for an individual insurer within an insurance holding company system, exceeds .5 percent (one half of one percent) of its earned premiums for the three calendar-accident years immediately preceding the year in which the Excess Profits Report is due to the extent that this excess profit has not been refunded or credited to policyholders.

(d) Notwithstanding any provision of this section to the contrary, for purposes of evaluating the Excess Profits Reports due July 1, 1994 and July 1, 1995, the excess profits computation shall be performed solely on the insurance holding company system's combined profits report.

Amended by R.1991 d.17, effective January 7, 1991.
See: 22 N.J.R. 2082(b), 23 N.J.R. 106(a).
New subsection (c) added, provision for determining excessive subsidization.
Amended by R.1994 d.425, effective August 15, 1994.
See: 26 N.J.R. 1938(b), 26 N.J.R. 3441(b).

11:3–20.7 Determination of excess profits

(a) Excess profits shall exist if for the three calendar-accident years immediately preceding the date the profits report is due, the sum of an insurer's total actuarial gain and excess investment income for all private passenger automobile coverages combined exceeds 2.5 percent of earned premiums.

(b) The effect of negative excess investment income shall be limited in the computation of excess profits, at the discretion of the Commissioner. This discretion shall be exercised pursuant to a standard on the investment of policyholder supplied funds pursuant to rules promulgated by the Commissioner not later than April 1 of the year in which excess profits reports are filed.

Case Notes

Insurance commissioner failed to utilize statutory rule-making procedures in changing evaluation of excess profits. American Employers' Ins. Co. v. Commissioner of Ins., Dept. of Ins., State of N.J., 236 N.J.Super. 428, 566 A.2d 202 (A.D.1989).

11:3–20.8 Refund or credit of excess profits

(a) If the Commissioner determines that an insurer is required to refund excess profits, the Commissioner shall issue written notice to the insurer of his or her determination. The notice shall contain a written explanation of the basis on which such a determination was made and shall advise the insurer that it may request a reevaluation of the determination as set forth at (b) below.

(b) An insurer may request a reevaluation of the determination that it is required to refund excess profits by submitting a written request to the Department within 30 days of the receipt of the notice in (a) above.

1. The written request shall set forth the legal or factual basis for the requested reevaluation.

2. If the basis for the requested reevaluation is good faith error or excusable mistake, the request shall be accompanied by a written request to make a supplemental filing pursuant to N.J.A.C. 11:3–20.11.

3. The Commissioner shall notify the insurer in writing of his or her determination within 60 days, which shall constitute a final agency decision. If no written request for a reevaluation is made as set forth in (b)1 and 2 above, the original notice of determination shall constitute a final agency decision.

(c) The insurer shall submit to the Commissioner a fair, practicable and nondiscriminatory plan to refund or credit to policyholders the excess profits within 30 days after the written notice in (a) or (b) above, as applicable, has been given to the insurer by the Commissioner.

1. The refund or credit plan shall be subject to approval by the Commissioner.

2. If the refund or credit plan is disapproved, the Commissioner shall issue a written notice to the insurer containing the reasons for disapproval, and specifications for corrections of the plan.

(d) Upon approval of the insurer's refund or credit plan, the Commissioner shall issue an order requiring the insurer to distribute all excess profits according to the approved plan.

(e) Within 15 days after the excess profits have been refunded or credited to policyholders, the insurer's corporate official shall certify that such refund or credit has occurred.

(f) Any refund or credit shall be deemed a policyholder dividend applicable to the year in which it is incurred for reporting in subsequent excess profits reports.

Amended by R.1991 d.17, effective January 7, 1991.
See: 22 N.J.R. 2082(b), 23 N.J.R. 106(a).
Provision at (a) added to require certain information in notice; new (b) added describing procedure and content of request for reevaluation.

11:3–20.9 Excess profits carry forward

(a) In the event an excess profit is returned by an insurer in accordance with this subchapter and subsequent development demonstrates that an excess profit did not exist or was overstated, an excess profit carry forward in the amount of the excess profit refunded or the amount overstated, whichever is less, shall be established.

(b) This excess profit carry forward shall be applied by such insurer as a credit against future determinations of excess profits until such credit is exhausted or the end of a 15 year period from the date the excess profits carry forward was established, whichever occurs first.

(c) In order to take credit in the form of an excess profits carry forward in any filing of an excess profits report, the filer shall file the following which shall be attached to the excess profits report in which the carry forward is to be taken:

1. A copy of the excess profit report which originally showed the existence of an excess profit; and

2. Excess Profits Exhibits One through Six containing the data that shows the adverse development of the pertinent accident year or years.

Amended by R.1990 d.470, effective September 17, 1990.
See: 22 N.J.R. 1025(a), 22 N.J.R. 2969(c).
New (c) added providing procedure by which insurer establishes "excess profit carry forward" credit.

11:3–20.10 Order for further information

(a) If, after examination of the insurer's excess profits report, the Commissioner finds that any information or calculation contained in such report contains, results in or is based upon aberrant, unusual or irregular data, the Commissioner shall issue, in writing, an order to such insurer, directing that the information or calculation be altered in a manner necessary to eliminate the effect of the aberrant, unusual or irregular data.

(b) Such insurer shall submit the revised information to the Commissioner within 15 days after receiving an order pursuant to (a) above.

11:3–20.11 Supplemental filings

(a) An insurer may request permission to supplement its Excess Profits Report filing due to good faith error or excusable mistake by submitting a written request to the Department containing the following:

1. The reasons why the insurer believes that a supplemental filing is necessary;

2. A brief but complete description of the nature of the information to be contained in the supplemental filing (Note: The actual supplemental filing should not be submitted until the insurer is notified that the request has been approved); and

3. The reasons why the insurer failed to provide this information in its initial Excess Profits Report filing.

(b) The Commissioner shall either approve or disapprove the request, in writing, within 30 days after the request is received by the Department. If the insurer is notified that its request is approved, the insurer shall submit the supplemental filing to the Department within 10 days after the receipt of such notification.

New Rule, R.1991 d.17, effective January 7, 1991.
See: 22 N.J.R. 2082(b), 23 N.J.R. 106(a).
Old 20.11, Compliance dates, has been recodified to 20.12.

11:3–20.12 Compliance dates

(a) The due date for the first profits report required by this subchapter is July 1, 1989.

(b) For the first report required by this subchapter:

1. The seven most recent calendar-accident years referred to in N.J.A.C. 11:3–20.5(b) are 1982 through 1988, inclusive.

2. The three calendar-accident years immediately preceding the due date referred to in N.J.A.C. 11:3–20.4(d), 20.5(d) and 20.7 are 1986, 1987 and 1988.

3. The seventh calendar-accident year immediately preceding the due date referred to in N.J.A.C. 11:3–20.5(d)4 is 1982.

4. The fourth calendar-accident year immediately preceding the date the profits report is due referred to in N.J.A.C. 11:3–20.5(d)4 is 1985.

5. The calendar-accident year immediately preceding the date the profits report is due referred to in N.J.A.C. 11:3–20.5(c) is 1988.

Recodified from 11:3–20.11, by R.1991 d.17, effective January 7, 1991.
See: 22 N.J.R. 2082(b), 23 N.J.R. 106(a).

11:3–20.13 Penalties

Failure to file a complete and accurate excess profits report so that it is received by the Commissioner on or before July 1 shall constitute a violation of this subchapter, and may result in the imposition of penalties as provided by statute.

Recodified from 11:3–20.12, by R.1991 d.17, effective January 7, 1991.
See: 22 N.J.R. 2082(b), 23 N.J.R. 106(a).

APPENDIX

EXCESS PROFIT EXHIBITS—INSTRUCTIONS

In all Exhibits, dollars are stated as whole numbers, ratios and fractions are expressed as decimals and rounded to the third decimal place. Where a three year sum is expressed as a ratio, the ratio required is the ratio of three years' dollar figures and not the sum of three ratios.

The Exhibits attached are 1990 exhibits. Where exhibits for prior years or later years must be reported, the filer is required to submit Exhibits which are substantially similar to the attached Exhibits to report the prior years' or later years' data, and which contain all information, including dates, adjusted accordingly.

Exhibit One

General Instructions

Exhibit One is to be completed using data for calendar year 1990. Exhibits substantially similar to Exhibit One are to be completed for each of the years 1983 through 1989.

The filer is completing and submitting five Exhibits One (i.e. one for each of four coverages and a total of all four coverages) for each of eight calendar years (i.e. 1983 through 1990, inclusive) for a total of forty Exhibits One.

Item 1 is the premium and loss data as shown on Page 14 for New Jersey of the statutory annual statement for the various calendar years. For the various private passenger auto coverages, for 1990, use the data shown on Page 14 of the 1990 annual statement as follows:

BI Liability and Uninsured/Underinsured Motorists Coverage included in	Page 14 Line 19.2
PD Liability included in	Page 14 Line 19.2
No fault	Page 14 Line 19.1
Physical Damage	Page 14 Line 21.1

For years prior to 1990, use corresponding Page 14 data for those years. In Item 1, fill in the Page 14 line which is the source of the data. Item 1A is the UCJF Assessment for the year. Items 2 through 10 are deductions from Item 1 for loss data (see Col (3), Col (4), or Col (7)) or Item 1B for premium data (see Col (1) or Col (2)), as described below. Items 2 through 10 are to be completed ONLY IF

PREMIUM, LOSS OR DIVIDEND DATA FOR ITEMS 2 THROUGH 10 ARE INCLUDED IN ITEM 1.

In listing the exclusions in Items 2 through 10, note that where a premium, loss or dividend amount is contained in an Item, it is not to be contained in another Item.

For example, all excess medical benefits are to be contained in Item 2 (see below), and not contained in any of the other Items 3 through 10. Therefore, any excess medical benefits paid on a motorcycle policy are to be included in Item 2, and not in Item 3. Item 3 is to contain motorcycle premiums, losses and dividends not included in Item 2.

As another example, premiums, losses and dividends contained in Item 6, Excess and Umbrella Policies are premiums, losses and dividends on Excess/Umbrella policies that are not contained in Items 2 through 5.

Individual Items

Item 2 is the dollars of losses included in Item 1 which are excess medical benefits, and for which the insurer may be reimbursed by the UCJF, per NJSA 39:6–61 et seq.

With regard to Item 5, please note that the New Jersey Automobile Full Insurance Availability Act (NJSA 17:30E–1 et seq.), which established the "JUA", was effective 01 January 1984, and the Market Transition Facility established pursuant to the Fair Automobile Insurance Reform Act of 1990 which was operative as of October 1, 1990.

Premiums, losses and dividends for private passenger type commercial vehicles are to be listed in Item 7 as a "write in", but only if they are contained in Item 1, for loss data, or Item 1B, for premium data, and then only the dollars of premiums and losses not contained in Items 2 through 6.

Provision is made for other "write in" exclusions in Items 8 and 9. A filer may modify the form to add more lines for exclusions if three lines are not sufficient.

Where any "write in" exclusion is used, a written explanation as to what is listed as an exclusion, and why it is appropriate to list the exclusion, is to be provided on a piece of paper attached to Exhibit One.

Premiums and losses for private passenger motor homes are NOT to be listed as exclusions.

Item 12 states the premiums, losses and dividends which are to be used for the excess profits calculation. For premium data, Item 12 is Item 1B minus Item 11. For loss data, Item 12 is Item 1 minus Item 11.

Item 13, Col (3) states the claim settlement costs paid during 1990 that are directly assignable to specific claims for which loss data is included in Item 12. Item 13, Col (4) states the claim settlement costs incurred during 1990 that are directly assignable to specific claims for which loss data is included in Item 12.

Item 14, Col (3) states the costs associated with the claim settlement function that were paid during 1990, which are not directly assignable to specific claims, but which are assignable to claims for which loss data is included in Item 12. Item 14, Col (4) shows the costs associated with the claim settlement function that were incurred during 1990, which are not directly assignable to specific claims, but which are assignable to claims for which loss data is included in Item 12.

Item 15 states unpaid claim settlement costs as of 31 December 1990, which are assignable to unpaid losses shown in Item 12, Col (7).

Exhibit Two

A corresponding Exhibit Two is to be completed for each calendar year and coverage for which an Exhibit One is to be completed. Therefore, the filer is completing and submitting forty Exhibits Two. The six parts of Exhibit Two show incurred and paid losses and expenses by calendar/accident year during each calendar year for which data is reported in an Exhibit One, and also during the first three months of 1991.

For example, for the Exhibit Two that corresponds to Exhibit One for 1990, Exhibit Two—Part One shows:

(a) payments for losses that occurred during calendar/accident year 1990, and were paid during 1990, and during the first three months of 1991.

(b) payments for losses that occurred during calendar/accident year 1989, and were paid during 1990, and during the first three months of 1991.

(c) etc.

For example, for the Exhibit Two that corresponds to Exhibit One for 1989, Exhibit Two—Part One shows:

(a) payments for losses that occurred during calendar/accident year 1989, and were paid during 1989, and during the first three months of 1990.

(b) payments for losses that occurred during calendar/accident year 1988, and were paid during 1989, and during the first three months of 1990.

(c) etc.

A description of each part of Exhibit Two follows.

Exhibit Two—Part One states the calendar year losses paid, as stated in Exhibit One, Item 12, Col (3), according to calendar/accident year. Col (2) shows losses paid during 1990, and Col (3) shows further losses paid during the first three months of 1991.

Exhibit Two—Part Two states the calendar year losses incurred in Exhibit One, Item 12, Col (4), according to calendar/accident year. Col (2) states losses incurred during 1990, and Col (3) shows further losses incurred during the first three months of 1991.

Exhibit Two—Part Three states the calendar year allocated loss adjustment expenses paid in Exhibit One, Item 13, Col (3), according to calendar/accident year. Col (2) states the allocated loss adjustment expenses paid during 1990, and Col (3) shows further allocated loss adjustment expenses paid during the first three months of 1991.

Exhibit Two—Part Four states the calendar year allocated loss adjustment expenses incurred in Exhibit One, Item 13, Col (4), according to calendar/accident year. Col (2) states incurred allocated loss adjustment expenses incurred during 1990, and Col (3) shows further allocated loss adjustment expenses incurred during the first three months of 1991.

Exhibit Two—Part Five states the calendar year unallocated loss adjustment expenses paid in Exhibit One, Item 14, Col (3), according to calendar/accident year. Col (2) states unallocated loss adjustment expenses paid during 1990, and Col (3) shows further unallocated loss adjustment expenses paid during the first three months of 1991.

Exhibit Two—Part Six states calendar year unallocated loss adjustment expenses incurred in Exhibit One, Item 14, Col (4), according to calendar/accident year. Col (2) shows unallocated loss adjustment expenses incurred during 1990, and Col (3) shows further unallocated loss adjustment expenses incurred during the first three months of 1991.

Exhibit Three states the "development triangles" of incurred losses for BI Liability and Uninsured/Underinsured Motorists and PIP.

Exhibit Three—Part One states the losses incurred for the various calendar/accident years during various intervals (the first 15 months, the next 12 months, etc.).

Exhibit Three—Part Two states the accumulated losses for each calendar/accident year as of the various stages of development (15 months, 27 months, etc.).

Exhibit Three—Part Three states the historical development factors based on the accumulated losses shown in Exhibit Three—Part Two.

In Exhibit Three—Part Three the "selected factor" stated in Col (5A) is determined as follows. Of the various historical factors for each development interval (15–27 months, 27–39 months, etc.) a simple mean is determined with the high and low values omitted. Where there are fewer than three factors, the low and high values are not to be omitted from the calculation. The "projection factor" stated in Col (6A) is the group of factors from Col (5A) accumulated to project losses at each stage of development to ultimate. The projection factor for 87 months to ultimate is the selected factor for development from 75 to 87 months.

In Exhibit Three—Part Three the "Ultimate Incurred" stated in Col (3) is determined by multiplying the calendar/accident year losses evaluated as of 31 March 1991 by the Projection Factor from Col (6A). Each "Projection Factor to Ultimate" in Col (2) of Exhibit Three—Part Three is identical to the "Projection Factor" stated in Col (6A).

Exhibit Four summarizes data from Exhibit Two to get the "development triangles" of paid losses, for Property Damage Liability and Physical Damage. The various parts of Exhibit Four analyze paid losses in the same way that Exhibit Three analyzes incurred losses. The only difference is that, for Physical Damage and Property Damage Liability, ultimate paid is deemed to be reached at 51 months of development.

Exhibits Five and Six analyze the sum of losses and loss adjustment expenses in the same way that Exhibits Three and Four analyze losses.

Note that Exhibit Five, Parts Four, Five and Six are to be completed with data through calendar/accident year 1989. The projections based on data through calendar/accident year 1989 are used to produce the "Development Adjustment" in Exhibit Five—Part Seven.

Note that Exhibit Six, Parts Four, Five and Six are to be completed with data through calendar/accident year 1989. The projections based on data through calendar/accident year 1989 are used to produce the "Development Adjustment" in Exhibit Six—Part Seven.

Exhibit Seven, Part One, states countrywide premiums and expenses from the statutory Insurance Expense Exhibit. An Exhibit Seven, Part One, is to be completed for each of the years 1990, 1989 and 1988. Other Acquisition and General Expenses are to be stated, in Col (2) and Col (3A) as ratios to Net Earned Premium. Commission and Brokerage and Taxes, Licenses and Fees are to be stated, in Col (2) and Col (3A) as ratios to Net Written Premium. Loss Adjustment Expenses Incurred are to be stated in Col (2) and Col (3A) as ratios to Losses Incurred.

Exhibit Seven—Part Two

Exhibit Seven, Part Two, states New Jersey expenses for each coverage, with ratios, in Col (2), to earned premium, written premium and losses as described for Exhibit Seven—Part One above.

Exhibit Seven, Parts Three–A, Three–B and Three–C develop the Commission and Brokerage expenses to be stated in Exhibit Seven, Part Two. Exhibits substantially similar to Parts Three–A, Three–B and Three–C are to be completed to develop the Taxes, Licenses and Fees expenses to be stated in Exhibit Seven, Part Two.

Exhibit Seven, Parts Four–A, Four–B and Four–C develop the General Expense expenses to be stated in Exhibit Seven, Part Two. Exhibits substantially similar to Parts Four–A, Four–B and Four–C are to be completed to develop the Other Acquisition expenses stated in Exhibit Seven, Part Two and to develop the Loss Adjustment expenses stated in Exhibit Seven, Part Two.

Exhibit Seven, Part Two, Prepaid Expenses, Item 9, Col (1) = (½ × (Item 2, Col (1), + Item 3, Col (1)) + Item 5 + Item 6.

Exhibit Seven, Part Two, Item 9, Col (2) = (Item 9, Col (1))/(Item 4, Col (1)).

Exhibit Seven, Parts Two, Three and Four are to be completed for each of the calendar years 1990, 1989 and 1988.

Exhibit Eight, Part One shows investment income attributable to New Jersey private passenger auto for the purpose of completing excess profits reports.

Item 1 is countrywide data from the 1990 statutory annual statement, page 2, column 1, the sum of lines 9.1, 9.2, 9.3, 10 and 11.

Item 2 is countrywide data from the statutory annual statement, page 3, column 1, line 9.

NOTE: Limit Item 3 to a maximum of 1.000.

Item 4 is Exhibit Seven—Part Two, Col (1), Item 9.

Item 5 is Exhibit One, Col (1), Item 12.

NOTE: Limit Item 6 to a maximum of 1.000.

Item 7 is Exhibit One, Col (6), Item 12, for 1990.

Item 8 is Exhibit One, Col (6), Item 12, for 1989.

Item 9A = Item 9 × (1–Item 3–Item 6). Limit Item 9A to a minimum of zero.

Item 10 is Exhibit One, Col (7), Item 12, for 1990.

Item 11 is Exhibit One, Col (7), Item 12, for 1989.

Item 13 is Exhibit One, Col (7), Item 15, for 1990.

Item 14 is Exhibit One, Col (7), Item 15, for 1989.

Item 16G is the expected loss and loss adjustment expense ratio which is used to determine the investment income offset in the filer's filed and approved rate filings. The filer must submit a copy of the portion of the filing showing this figure, and show how it was used to determine the investment income offset.

Item 18 is Exhibit Eight Part One–A, Item 7, for 1990.

Item 19 is Actual Investment Income for 1990.

Exhibit Eight—Part Two shows Anticipated Investment Income and Excess Investment Income.

Item 1 is Exhibit One, Col (2), Item 12.

Item 2 shows the filed and approved investment income offset, expressed as a ratio to premiums, for the filer's approved filings over the interval 1988 through 1990. The investment income offset is the percent used in the company's rate filing to reduce the "Clifford" target 3.5% rate of return to premiums for the effect of investment income. A copy of the portion of the filing showing this calculation is to be attached to Exhibit Eight—Part Two. If the filer submits no documentation of the investment income offset that has been approved by the Department, then Item 2 is the number zero.

Item 3 is Item 1 multiplied by Item 2.

Item 4 is Exhibit Eight—Part One, Item 19.

Item 5 = Item 4–Item 3.

Exhibit Nine shows the estimate of the ultimate amount the filer reasonably expects to receive, as "AIRE Compensation", provided by NJSA 39:6A–22 et seq. In estimating the ultimate value of the compensation, keep in mind that there are few data points of actual experience. The estimate involves projecting to ultimate paid reimbursement for liability claims. For these reasons, the Department believes significant development beyond payments already received may be reasonable.

Exhibit Ten uses the data developed in Exhibits One through Nine to calculate excess profits.

The sources of data for Exhibit Ten follow.

Item 1: Direct Calendar Year Written Premium, Exhibit One, Item 12.

Item 2: Direct Calendar Year Earned Premium, Exhibit One, Item 12.

Item 2A: Exhibit Nine—Part Three, Col (3).

Item 2B: AIRE Charges are the amounts the filer is assessed, according to NJSA 39:6A–22. The calendar/accident year in which an AIRE charge is assigned is the calendar year in which the filer is informed of the AIRE charge and not the calendar year in which the filer pays the AIRE charge, if different.

Item 2D: MTF Policyholder surcharge collected (to be reported only on the "BI Liability and Uninsured/Underinsured Motorists Coverages" and "Total" Exhibits.

Item 2E: Apportioned share of MTF operating loss paid (to be reported only on the "BI Liability and Uninsured/Underinsured Motorists Coverages" and "Total" Exhibits.

Item 3: For BI Liability and Uninsured/Underinsured Motorists and PIP, "Ultimate Incurred", per Exhibit Five—Part Three, Col (3). For Property Damage Liability and Physical Damage, "Ultimate Incurred", per Exhibit Six—Part Three, Col (3).

Item 5: Exhibit Seven—Part Two.

Item 7: Exhibit Seven—Part Two.

Item 9: Exhibit Seven—Part Two.

Item 11: Exhibit Seven—Part Two.

Item 13: Exhibit One, Item 12B.

Item 14: Exhibit One, Item 12A.

Item 18: Insurer's filed and approved allowance for profits and contingencies in the filer's approved rate filing, expressed as a ratio, and multiplied by the earned premium stated in Item 2.

Item 19 = Item 17–Item 18.

Item 20: Exhibit Five—Part Seven, Total, Col (3), for BI Liability and Uninsured/Underinsured Motorists and PIP; Exhibit Six—Part Seven, Col (3), for Property Damage Liability and Physical Damage.

Item 21 = Item 19–Item 20.

Item 22: Exhibit Eight—Part Two, Item 5.

Item 24 = Item 21 + Item 22–Item 23.

Item 25 is .005 × Item 2 for a filer that is a member of a holding company system, and 0 for all other filers.

Item 26 is Item 24 minus Item 25.

Exhibit Eleven must be completed for calendar years 1988, 1989 and 1990.

Item 1 states what PIP losses would have been without the portion that is assumed by the UCJF.

Items 2, 3, 4, and 5 are self-explanatory.

Exhibit 1
Private Passenger Auto
THESE EXHIBITS MUST BE SENT SO THAT THEY ARE RECEIVED BY THE DEPARTMENT OF INSURANCE BY 01 JULY 1991

Group Name _____

Group NAIC Number _____

Company Name _____

Company NAIC Number _____

BEFORE COMPLETING THE EXHIBITS, PLEASE READ THE ACCOMPANYING INSTRUCTIONS
NEW JERSEY
Private Passenger Auto Data

Exhibit One

Check One:

BI Liability & Uninsured/Underinsured Motorists _____

Property Damage Liability _____

PIP _____

Physical Damage _____

Total of above four coverages _____

Calendar Year 1990
(This exhibit is also to be completed for each of the years 1983 through 1989)

		Col (1) Direct Premiums Written	Col (2) Direct Premiums Earned	Col (3) Direct Losses Paid	Col (4) Direct Losses Incurred	Col (5) Dividends on Direct Business	Col (6) Direct Unearned Premium Reserves	Col (7) Direct Losses Unpaid
Item 1	Source line ____ of Page 14	____	____	____	____	____	____	____
Item 1A	UCJF Assessments	____	____	X	X	X	X	X
Item 1B	Item 1 minus Item 1A	____	____	X	X	X	X	X

NOTE: LIST DATA IN EXCLUSIONS (ITEMS 2 THROUGH 10) ONLY IF THE DATA IS INCLUDED IN ITEM ONE.

Exclusions:

Item 2	Excess Medical Benefits	X	X	____	____	X	X	____
Item 3	Motorcycles	____	____	____	____	____	____	____
Item 4	"Off Road" Vehicles	____	____	____	____	____	____	____
Item 5	JUA/MTF Business	____	____	____	____	____	____	____
Item 6	Excess/Umbrella Policies	____	____	____	____	____	____	____
Other Exclusions (list):								
Item 7	____	____	____	____	____	____	____	____
Item 8	____	____	____	____	____	____	____	____
Item 9	____	____	____	____	____	____	____	____
Item 10	Finance and Service Charges	____	____	X	X	X	____	X
Item 11	Subtotal (Sum Items 2 through 10)	____	____	____	____	____	____	____
Item 12	Excess Profits Data	____	____	____	____	____	____	____
Item 12A	Refund of Excess Profits Included in Item 12, Col (5)	X	X	X	X	____	X	X
Item 12B	All Other Dividends Included in Item 12, Col (5)	X	X	X	X	____	X	X

Item 13	Allocated loss adjustment expenses corresponding to Item 12, Cols. (3) and (4), respectively	X	X	(Col 3) Paid Allocated LAE ____	(Col 4) Incurred Allocated LAE ____
Item 13A	Ratio Item 13, Col (3), to Item 12, Col (3)	X	X	____	X

Item 13B	Ratio Item 13, Col (4), to Item 12, Col (4)	X	X	X	____			
				Col (3) Paid Unallocated LAE	Col (4) Incurred Unallocated LAE			
Item 14	Unallocated loss adjustment expenses corresponding to Item 12, Cols. (3) and (4), respectively	X	X	____	____			
Item 14A	Ratio Item 14, Col (3), to Item 12, Col (3)	X	X	____	X			
Item 14B	Ratio Item 14, Col (4), to Item 12, Col (4)	X	X	X	____			
Item 15	Unpaid less adjustment expenses (allocated plus unallocated) corresponding to unpaid losses shown in Item 12, Col (7)	X	X	X	X	X	X	____

Exhibit Two
Calendar year 1990
(This Exhibit is also to be completed for each of the calendar years 1983 through 1989)

Check one:

BI Liability & Uninsured/Underinsured Motorists ____

Property Damage Liability ____

PIP ____

Physical Damage ____

Total of above four coverages ____

Exhibit Two—Part One

Calendar/Accident Years:	Col (2) Losses Paid During 1990	Col (3) Losses Paid During 1Q 1991
1990	____	____
1989	____	____
1988	____	____
1987	____	____
1986	____	____
1985	____	____
1984	____	____
prior	____	____
Total	____	____

Exhibit Two—Part Two

Calendar/Accident Years:	Col (2) Losses Incurred During 1990	Col (3) Losses Incurred During 1Q 1991
1990	____	____
1989	____	____
1988	____	____
1987	____	____
1986	____	____
1985	____	____
1984	____	____
prior	____	____
Total	____	____

Exhibit Two—Part Three

Calendar/Accident Years:	Col (2) ALAE Paid During 1990	Col (3) ALAE Paid During 1Q 1991
1990	____	____
1989	____	____
1988	____	____
1987	____	____
1986	____	____
1985	____	____
1984	____	____
prior	____	____
Total	____	____

Exhibit Two—Part Four

Calendar/Accident Years:	Col (2) ALAE Incurred During 1990	Col (3) ALAE Incurred During 1Q 1991
1990	____	____
1989	____	____
1988	____	____
1987	____	____
1986	____	____
1985	____	____
1984	____	____
prior	____	____
Total	____	____

Exhibit Two—Part Five

Calendar/Accident Years:	Col (2) ULAE Paid During 1990	Col (3) ULAE Paid During 1Q 1991
1990		
1989		
1988		
1987		
1986		
1985		
1984		
prior		
Total		

Exhibit Two—Part Six

Calendar/Accident Years:	Col (2) ULAE Incurred During 1990	Col (3) ULAE Incurred During 1Q 1991
1990		
1989		
1988		
1987		
1986		
1985		
1984		
prior		
Total		

Exhibit Three

Check One:

BI Liability & Uninsured/Underinsured Motorists _____

PIP _____

Exhibit Three—Part One
Development of Incurred Losses
Calendar/Accident Year

Losses Incurred During	84	85	86	87	88	89	90
0-15 months							
15-27 months							
27-39 months							
39-51 months							
51-63 months							
63-75 months							
75-87 months							

Exhibit Three—Part Two
Development of Incurred Losses
Calendar/Accident Year

Losses Incurred As Of	84	85	86	87	88	89	90
15 months							
27 months							
39 months							
51 months							
63 months							
75 months							
87 months							

Exhibit Three—Part Three
Incurred Loss Development Factors
Calendar/Accident Year

Development Factors	84	85	86	87	88	89	Col (5A) Selected Factor	Col (6) Incurred Losses As Of	Col (6A) Projection Factor
15-27 months								15 months	
27-39 months								27 months	
39-51 months								39 months	
51-63 months								51 months	
63-75 months								63 months	
75-87 months								75 months	
								87 months	

Calendar/ Accident Year	Col (1) Losses at 3/91	Col (2) Projection Factor to Ultimate	Col (3) Ultimate Incurred
90			
89			
88			
87			
86			
85			
84			

Exhibit Four

Check One:

Property Damage Liability _____

Physical Damage _____

Exhibit Four—Part One
Development of Paid Losses
Calendar/Accident Year

Losses Paid During	84	85	86	87	88	89	90
0-15 months							
15-27 months							
27-39 months							
39-51 months							

Exhibit Four—Part Two
Development of Paid Losses
Calendar/Accident Year

Losses Paid As Of	84	85	86	87	88	89	90
15 months							
27 months							
39 months							
51 months							

Exhibit Four—Part Three
Development of Paid Losses
Calendar/Accident Year

Development Factors	84	85	86	87	88	89	Col (5A) Selected Factor	Col (6) Paid Losses As Of	Col (6A) Projection Factor
15-27 months								15 months	
27-39 months								27 months	
39-51 months								39 months	

Calendar/ Accident Year	Col (1) Losses at 3/91	Col (2) Projection Factor to Ultimate	Col (3) Ultimate Incurred
90			
89			
88			

Exhibit Five

BI Liability & Uninsured Motorists _____

PIP _____

Exhibit Five—Part One
Development of Incurred Losses and LAE
Calendar/Accident Year

Losses and LAE Incurred During	84	85	86	87	88	89	90
0-15 months							
15-27 months							
27-39 months							
39-51 months							
51-63 months							
63-75 months							
75-87 months							

Exhibit Five—Part Two
Development of Incurred Losses and LAE
Calendar/Accident Year

Losses and LAE Incurred During	84	85	86	87	88	89	90
15 months							
27 months							
39 months							
51 months							
63 months							
75 months							
87 months							

Exhibit Five—Part Three
Incurred Loss and LAE Development Factors
Calendar/Accident Year

Development Factors	84	85	86	87	88	89	Col (5A) Selected Factor	Col (6) Incurred Losses and LAE As Of	Col (6A) Projection Factor
15-27 months								15 months	
27-39 months								27 months	
39-51 months								39 months	
51-63 months								51 months	
63-75 months								63 months	
75-87 months								75 months	
87 mos-ultimate								87 months	

Calendar/ Accident Year	Col (1) L+LAE at 3/91	Col (2) Projection Factor to Ultimate	Col (3) Ultimate Incurred
90			
89			
88			
87			
86			
85			
84			

Exhibit Five—Part Four
Development of Incurred Losses and LAE
Calendar/Accident Year

Losses and LAE Incurred During	83	84	85	86	87	88	89
0-15 months							
15-27 months							
27-39 months							
39-51 months							
51-63 months							
63-75 months							
75-87 months							

Exhibit Five—Part Five
Development of Incurred Losses and LAE
Calendar/Accident Year

Losses and LAE Incurred As Of	83	84	85	86	87	88	89
15 months							
27 months							
39 months							
51 months							
63 months							
75 months							
87 months							

Exhibit Five—Part Six
Incurred Loss and LAE Development Factors
Calendar/Accident Year

Development Factors	83	84	85	86	87	88	Col (5A) Selected Factor	Col (6) Incurred Losses and LAE As Of	Col (6A) Projection Factor
15-27 months								15 months	
27-39 months								27 months	
39-51 months								39 months	
51-63 months								51 months	
63-75 months								63 months	
75-87 months								75 months	
87 mos-ultimate								87 months	

Calendar/ Accident Year	Col (1) L+LAE at 3/90	Col (2) Projection Factor to Ultimate	Col (3) Ultimate Incurred
89			
88			
87			
86			
85			
84			
83			

Exhibit Five—Part Seven
Development Adjustment

Check One:

BI Liability & Uninsured/Underinsured Motorists _____

PIP _____

Calendar/ Accident Year	Col (1) Ultimate Incurred per Exhibit Five—Part Six Col (3)	Col (2) Ultimate Incurred per Exhibit Five—Part Three Col (3)	Col (3) Difference Col (2) minus Col (1)
87			
86			
85			
84			
Total	X	X	

Exhibit Six

Check One:

Property Damage Liability _____

Physical Damage _____

Exhibit Six—Part One
Development of Paid Losses and LAE
Calendar/Accident Year

Losses and LAE Paid During	84	85	86	87	88	89	90
0-15 months							
15-27 months							
27-39 months							
39-51 months							

Exhibit Six—Part Two
Development of Paid Losses and LAE
Calendar/Accident Year

Losses and LAE Paid As Of	84	85	86	87	88	89	90
15 months							
27 months							
39 months							
51 months							

Exhibit Six—Part Three
Paid Loss and LAE Development Factors
Calendar/Accident Year

Development Factors	84	85	86	87	88	89	Col (5A) Selected Factor	Col (6) Paid Losses and LAE As Of	Col (6A) Projection Factor
15-27 months								15 months	
27-39 months								27 months	
39-51 months								39 months	

Calendar/ Accident Year	Col (1) L+LAE at 3/91	Col (2) Projection Factor to Ultimate	Col (3) Ultimate Incurred
90	____	____	____
89	____	____	____
88	____	____	____
87	____	1,000	____

Exhibit Six—Part Four
Development of Paid Losses and LAE
Calendar/Accident Year

Losses Paid During	83	84	85	86	87	88	89
0-15 months	____	____	____	____	____	____	____
15-27 months	____	____	____	____	____	____	
27-39 months	____	____	____	____	____		
39-51 months	____	____	____	____			

Exhibit Six—Part Five
Development of Paid Losses and LAE
Calendar/Accident Year

Losses Paid As Of	83	84	85	86	87	88	89
15 months	____	____	____	____	____	____	____
27 months	____	____	____	____	____	____	
39 months	____	____	____	____	____		
51 months	____	____	____	____			

Exhibit Six—Part Six
Paid Loss and LAE Development Factors
Calendar/Accident Year

Development Factors	83	84	85	86	87	88	Col (5A) Selected Factor	Col (6) Paid Losses As Of	Col (6A) Projection Factor
15-27 months	____	____	____	____	____	____	____	15 months	____
27-39 months	____	____	____	____	____		____	27 months	____
39-51 months	____	____	____	____			____	39 months	____

Calendar/ Accident Year	Col (1) L+LAE at 3/90	Col (2) Projection Factor to Ultimate	Col (3) Ultimate Incurred
89	____	____	____
88	____	____	____
87	____	____	____

Exhibit Six—Part Seven
Development Adjustment

Calendar/ Accident Year	Col (1) Ultimate Incurred per Exhibit Six—Part Six Col (3)	Col (2) Ultimate Incurred per Exhibit Six—Part Three Col (3)	Col (3) Difference Col (2) minus Col (1)
87	____	____	____

Exhibit Seven
Part One—Countrywide Expenses From Insurance Expense Exhibit
Calendar Year 1990
(This Exhibit is also to be completed separately for calendar years 1989 and 1988.)

	Private Passenger Auto Liability Col (1)	Col (2)	Private Passenger Auto Physical Damage Col (3)	Col (3A)
Net Earned Premium	____	1.000	____	1.000
Other Acquisition	____	____	____	____
General Expenses	____	____	____	____
Net Written Premium	____	1.000	____	1.000
Commission and Brokerage	____	____	____	____
Taxes, Licenses, Fees	____	____	____	____
Losses Incurred	____	1.000	____	1.000
Loss Adjustment Expenses Incurred	____	____	____	____

Exhibit Seven
Part Two—New Jersey Expenses
Calendar/Accident Year 1990
(This Exhibit is also to be completed for calendar/accident years 1989 and 1988.)

Check One:

BI Liability & Uninsured/Underinsured Motorists ____

Property Damage Liability ____

PIP ____

Physical Damage ____

Total of above four coverages ____

		Col (1)	Col (2)	Col (3)	Col (3A)
Item 1:	Direct Earned Premium	____	1.000	____	1.000
Item 2:	Direct Other Acquisition	____	____	____	____
Item 3:	Direct General Expenses	____	____	____	____
Item 4:	Direct Written Premium	____	1.000	____	1.000
Item 5:	Direct Commission and Brokerage	____	____	____	____
Item 6:	Direct Taxes, Licenses, Fees	____	____	____	____
Item 7:	Direct Losses Incurred	____	1.000	____	1.000
Item 8:	Direct Loss Adjustment Expenses Incurred	____	____	____	____
Item 9:	Prepaid Expenses	____	____		

Exhibit Seven—Part Three—A

Check One:

BI Liability & Uninsured/Underinsured Motorists _____

Property Damage Liability _____

PIP _____

Physical Damage _____

Total of above four coverages _____

Allocation of Commission and Brokerage Fees to Calendar/Accident Year 1990

		Col (2)
Item 1:	1990 Direct Written Premium	_____
Item 2:	Commission and Brokerage Fees that arise from the writing of policies, the premium of which is listed in Item 1	_____
Item 3:	Dollars of 1990 Direct Written Premium that are earned in 1990	_____
Item 4:	Ratio Item 3 divided by Item 1	_____
Item 5:	Item 2 multiplied by Item 4	_____
Item 6:	1989 Direct Written Premium	_____
Item 7:	Commission and Brokerage Fees that arise from the writing of policies, the premium of which is listed in Item 6	_____
Item 8:	Dollars of 1989 Direct Written Premium that are earned in 1990	_____
Item 9:	Ratio Item 8 divided by Item 6	_____
Item 10:	Item 9 multiplied by Item 7	_____
Item 11:	1990 Commission and Brokerage Incurred Item 10 plus Item 5	_____

Exhibit Seven—Part Three—B

Check One:

BI Liability & Uninsured/Underinsured Motorists _____

Property Damage Liability _____

PIP _____

Physical Damage _____

Total of above four coverages _____

Allocation of Commission and Brokerage Fees to Calendar/Accident Year 1989

		Col (6)
Item 1:	1989 Direct Written Premium	_____
Item 2:	Commission and Brokerage Fees that arise from the writing of policies, the premium of which is listed in Item 1	_____
Item 3:	Dollars of 1989 Direct Written Premium that are earned in 1989	_____

Item 4:	Ratio Item 3 divided by Item 1	_____
Item 5:	Item 2 multiplied by Item 4	_____
Item 6:	1988 Direct Written Premium	_____
Item 7:	Commission and Brokerage Fees that arise from the writing of policies, the premium of which is listed in Item 6	_____
Item 8:	Dollars of 1988 Direct Written Premium that are earned in 1989	_____
Item 9:	Ratio Item 8 divided by Item 6	_____
Item 10:	Item 9 multiplied by Item 7	_____
Item 11:	1989 Commission and Brokerage Item 10 plus Item 5	_____

Exhibit Seven—Part Three—C

Check One:

BI Liability & Uninsured/Underinsured Motorists _____

Property Damage Liability _____

PIP _____

Physical Damage _____

Total of above four coverages _____

Allocation of Commission and Brokerage Fees to Calendar/Accident Year 1988

		Col (11)
Item 1:	1988 Direct Written Premium	_____
Item 2:	Commission and Brokerage Fees that arise from the writing of policies, the premium of which is listed in Item 1	_____
Item 3:	Dollars of 1988 Direct Written Premium that are earned in 1988	_____
Item 4:	Ratio Item 3 divided by Item 1	_____
Item 5:	Item 2 multiplied by Item 4	_____
Item 6:	1987 Direct Written Premium	_____
Item 7:	Commission and Brokerage Fees that arise from the writing of policies, the premium of which is listed in Item 6	_____
Item 8:	Dollars of 1987 Direct Written Premium that are earned in 1988	_____
Item 9:	Ratio Item 8 divided by Item 6	_____
Item 10:	Item 9 multiplied by Item 7	_____
Item 11:	1988 Commission and Brokerage Incurred Item 10 plus Item 5	_____

Exhibit Seven—Part Four—A

Check One:

BI Liability & Uninsured/Underinsured Motorists _____

Property Damage Liability _____

PIP _____

Physical Damage _____

Total of above four coverages _____

General Expenses
Calendar Year 1990

		Col (3)
Item 1:	General Expenses Paid During 1990	_____
Item 2:	General Expenses Unpaid at 12/31/90	_____
Item 3:	General Expenses Unpaid at 12/31/89	_____
Item 4:	Item 1 + Item 2 – Item 3	_____

Exhibit Seven—Part Four—B

Check One:

BI Liability & Uninsured/Underinsured Motorists _____

Property Damage Liability _____

PIP _____

Physical Damage _____

Total of above four coverages _____

General Expenses
Calendar Year 1989

		Col (7)
Item 1:	General Expenses Paid During 1989	_____
Item 2:	General Expenses Unpaid at 12/31/89	_____
Item 3:	General Expenses Unpaid at 12/31/88	_____
Item 4:	Item 1 + Item 2 – Item 3	_____

Exhibit Seven—Part Four—C

Check One:

BI Liability & Uninsured/Underinsured Motorists _____

Property Damage Liability _____

PIP _____

Physical Damage _____

Total of above four coverages _____

General Expenses
Calendar Year 1988

		Col (12)
Item 1:	General Expenses Paid During 1988	_____
Item 2:	General Expenses Unpaid at 12/31/88	_____
Item 3:	General Expenses Unpaid at 12/31/87	_____
Item 4:	Item 1 + Item 2 – Item 3	_____

Exhibit Eight

Check One:

BI Liability & Uninsured/Underinsured Motorists _____

Property Damage Liability _____

PIP _____

Physical Damage _____

Total of above four coverages _____

Exhibit Eight—Part One
Actual Investment Income
Calendar Year 1990
(This exhibit is also to be completed for each calendar year 1988 and 1989.)

		Col (2)
Item 1	Agents Balances—Countrywide	_____
Item 2	Unearned Premium Reserve—Countrywide	_____
Item 3	Ratio (Item 1)/(Item 2)	_____
Item 4	Direct Prepaid Expenses	_____
Item 5	Direct Premiums Written	_____
Item 6	Ratio (Item 4)/(Item 5)	_____
Item 7	Direct Unearned Premium Reserves—1990	_____
Item 8	Direct Unearned Premium Reserves—1989	_____
Item 9	(Item 7 + Item 8)/2	_____
Item 9A	Investable Unearned Premiums	_____
Item 10	Direct Losses Unpaid—1990	_____
Item 11	Direct Losses Unpaid—1989	_____
Item 12	(Item 10 + Item 11)/2	_____
Item 13	Direct Loss Adjustment Expenses Unpaid—1990	_____
Item 14	Direct Loss Adjustment Expenses Unpaid—1989	_____
Item 15	(Item 13 + Item 14)/2	_____
Item 16	(Item 12 + Item 15)	_____
Item 16A	Exhibit One, Item 12, Col (4)	_____
Item 16B	Exhibit One, Item 13, Col (4)	_____
Item 16C	Exhibit One, Item 14, Col (4)	_____
Item 16D	Item 16A + Item 16B + Item 16C	_____
Item 16E	Ratio Item 16/Item 16D	_____
Item 16F	Exhibit One, Item 12, Col (2)	_____
Item 16G	Filed and Approved Expected Loss Ratio	_____
Item 16H	Item 16E × Item 16F × Item 16G	_____
Item 17	(Item 16H + Item 9A)	_____
Item 18	Exhibit Eight—Part One—A Item 7	_____
Item 19	(Item 18) × (Item 17)	_____

Exhibit Eight—Part One—A

Note: The data for Exhibit Eight—Part One—A is the investments made during the three (3) years 1990, 1989 and 1988 as contained in the data reported in the statutory annual statement for each calendar year at the pages indicated.

ADJUSTED INVESTED INCOME	Year Investment Purchased 1990	1989	1988
Data is for investments purchased during 1990, 1989 & 1988			
Item 1 TOTAL OF INT, DIVS & R/EST INCOME pg. 6, part 1, col 8, line 10	____	____	____
Item 2 TOTAL INVESTMENT EXPENSES INC'D pg. 6, part 1, line 11	____	____	____
Item 3 DEPRECIATION ON REAL ESTATE pg. 6, part 1, line 12	____	____	____
Item 4a PREFERRED STOCKS (unaffiliated) pg. 6, part 1, col 8, line 2.1	____	____	____
Item 4b PREFERRED STOCKS OF AFFILIATES pg. 6, part 1, col 8, line 2.11	____	____	____
Item 4c COMMON STOCKS (unaffiliated) pg. 6, part 1, col 8, line 2.2	____	____	____
Item 4d COMMON STOCKS OF AFFILIATES pg. 6, part 1, col 8, line 2.21	____	____	____
Item 5 TOTAL DEDUCTIONS Item 2 + 3 + 4a + 4b + 4c + 4d	____	____	____
Item 6 ADJUSTED INVESTMENT INCOME Item 1–Item 5	____	____	____
ADJUSTED MEAN INVESTED ASSETS			
Data is for investments purchased during 1990, 1989 & 1988			
Item 1.1 BONDS (pg. 2, col 1, line 1 + pg. 2, col 2, line 1)/2 for years 1989 and 1990. 1988 = pg. 2, col 1, line 1.	____	____	____
Item 2.1 MORTGAGE LOANS ON REAL ESTATE (pg. 2, col 1, line 3 + pg. 2, col 2, line 3)/2 for years 1989 and 1990. 1988 = pg. 2, col 1, line 3.	____	____	____
Item 2.2 REAL ESTATE (occupied + other props) ((pg. 2, col 1, line 4.1 + line 4.2) + (pg. 2, col 2, line 4.1 + line 4.2))/2 for years 1989 and 1990. 1988 = pg. 2, col 1, line 4.1 + line 4.2	____	____	____
Item 3.1 COLLATERAL LOANS (pg. 2, col 1, line 5 + pg. 2, col 2, line 5)/2 for years 1989 and 1990. 1988 = pg. 2, col 1, line 5.	____	____	____
Item 4.1 CASH ON HAND AND ON DEPOSIT (pg. 2, col 1, line 6.1 + pg. 2, col 2, line 6.1)/2 for years 1989 and 1990. 1988 = pg. 2, col 1, line 6.1.	____	____	____
Item 4.2 SHORT-TERM INVESTMENTS (pg. 2, col 1, line 6.2 + pg. 2, col 2, line 6.2)/2 for years 1989 and 1990. 1988 = pg. 2, col 1, line 6.2	____	____	____
Item 5.1 OTHER INVESTED ASSETS (pg. 2, col 1, line 7 + pg. 2, col 2, line 7)/2 for years 1989 and 1990. 1988 = pg. 2, col 1, line 7.	____	____	____
Item 6.1 ADJUSTED MEAN INVESTED ASSETS Item 1.1 + 2.1 + 2.2 + 3.1 + 4.1 + 4.2 + 5.1	____	____	____
Item 7 INVESTMENT INCOME AS % OF INVESTED ASSETS Item 6/Item 6.1 Note: The value of Item 7 may be subject to a minimum as provided by a regulation issued pursuant to N.J.S.A. 17:29A-5.8	____	____	____

Exhibit Eight—Part Two

Check One:

BI Liability & Uninsured/Underinsured Motorists _____

Property Damage Liability _____

PIP _____

Physical Damage _____

Total of above four coverages _____

Anticipated Investment Income

	Calendar/Accident Year	1988	1989	1990
Item 1:	Earned Premium			
Item 2:	Filed and Approved Investment Income Offset			
Item 3:	Anticipated Investment Income			
Item 4:	Actual Investment Income			
Item 5:	Excess Investment Income			

Exhibit Nine—Part One
Development of AIRE Compensation to Ultimate

AIRE Compensation Received During	Calendar/Accident Year 88	89	90
0-15 months			
15-27 months			
27-39 months			

Exhibit Nine—Part Two
Development of AIRE Compensation to Ultimate

AIRE Compensation Received As Of	Calendar/Accident Year 88	89	90
15 months			
27 months			
39 months			

Exhibit Nine—Part Three
AIRE Compensation Development Factors
Calendar/Accident Year

Development Factors	88	89
15-27 months		
27-39 months		

Calendar/ Accident Year	Col (1) AIRE Comp'n at 3/91	Col (2) Projection Factor to Ultimate	Col (3) Ultimate Comp'n
90			
89			
88			
87			
86			

Exhibit Ten
Excess Profit Calculation

Check One:

BI Liability & Uninsured/Underinsured Motorists _____

Property Damage Liability _____

PIP _____

Physical Damage _____

Total of above four coverages _____

		1988	1989	1990	Three Year Total
Item 1:	Direct Calendar Year Written Premium				
Item 2:	Direct Calendar Year Earned Premium				
Item 2A:	AIRE Compensation, Developed to Ultimate				
Item 2B:	AIRE Charges				
Item 2C:	Item 2A–Item 2B				
Item 2D:	MTF Policyholder Surcharge Collected				
Item 2E:	Apportioned Share of the MTF Operating Loss Paid				
Item 2F:	Item 2D – Item 2E				
Item 3:	Direct Calendar/Accident Year Losses and Loss Adjustment Expenses Incurred, Developed to Ultimate				
Item 4:	Item 3 as a Ratio to Item 2				
Item 5:	Direct Commission and Brokerage Fees Incurred				
Item 6:	Item 5 as a Ratio to Item 1				
Item 7:	Direct Other Acquisition, Field Supervision and Collection Expenses Incurred				
Item 8:	Item 7 as a Ratio to Item 1				
Item 9:	Direct General Expenses Incurred				
Item 10:	Item 9 as a Ratio to Item 2				
Item 11:	Direct Taxes, Licenses and Fees Incurred				
Item 12:	Item 11 as a Ratio to Item 1				
Item 13:	Direct Policyholder Dividends Other Than Excess Profits, Refunds or Credits Incurred				
Item 14:	Credit or Refund of Excess Profits				
Item 15:	Subtotal Item 13 + Item 14				
Item 16:	Item 15 as a Ratio to Item 2				
Item 17:	Underwriting Income = Item 2 + Item 2A + Item 2D – Item 2B – Item 2E – Item 3 – Item 5 – Item 7 – Item 9 – Item 11 – Item 15				
Item 18:	Allowance for Profit and Contingencies				
Item 19:	Actuarial Gain				
Item 20:	Total Development Adjustment	X	X	X	
Item 21:	Total Actuarial Gain	X	X	X	
Item 22:	Excess Investment Income				
Item 23:	Item Two times .025				
Item 24:	Excess Profit	X	X	X	
Item 25:	Non-excessive Subsidization (.005 times Item 2)	X	X	X	
Item 26:	Excessive Subsidization	X	X	X	

Exhibit Eleven—Supplementary Data
Year _____

Item 1:	PIP Incurred Losses exclusive of limitation due to reimbursement by UCJF, as provided by N.J.S.A. 39:6-61 et seq.	
Item 2:	Dollars of PIP Losses Assumed by UCJF	
Item 3:	UCJF Assessments Paid	
Item 4:	UCJF Reimbursements Rec'd	
Item 5:	Item 2 + Item 4 – Item 3	

Amended by R.1991 d.17, effective January 7, 1991.
See: 22 N.J.R. 2082(b), 23 N.J.R. 106(a).
Amended by R.1992 d.254, effective June 15, 1992.
See: 24 N.J.R. 529(a), 24 N.J.R. 2264(a).
Appendix deleted and replaced with new appendix.

Amended by R.1994 d.24, effective January 3, 1994.
See: 25 N.J.R. 1829(a), 26 N.J.R. 241(a).

SUBCHAPTER 20A. STANDARD LIMITING EFFECT OF NEGATIVE EXCESS INVESTMENT INCOME IN THE COMPUTATION OF EXCESS PROFITS

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(e), 17:29A–5.8.

Source and Effective Date

R.1989 d.306, effective June 5, 1989.
See: 21 N.J.R. 842(a), 21 N.J.R. 1517(c).

11:3–20A.1 Standard on the investment of policyholder-supplied funds

To complete Item 7 of Exhibit Eight, Part One–A (see N.J.A.C. 11:3–20 Appendix), an insurer filing an excess profits report, in accordance with N.J.A.C. 11:3–20, shall use a ratio of .080, or the actual ratio calculated in Exhibit Eight, Part One–A, whichever is higher.

Amended by R.1994 d.24, effective January 3, 1994.
See: 25 N.J.R. 1829(a), 26 N.J.R. 241(a).

SUBCHAPTER 21. PERSONAL INJURY PROTECTION COVERAGE REDUCED PIP PREMIUM CHARGE FOR ADDITIONAL AUTOS IN ONE–DRIVER HOUSEHOLDS

11:3–21.1 Purpose

The purpose of this rule is to implement N.J.S.A. 39:6A–4.1, which provides for reduced personal injury protection premiums for additional automobiles in one-driver households.

11:3–21.2 Reduction of PIP premium

(a) In any instance where a named insured is the owner, the only designated operator of two or more automobiles insured by the same insurer under one or more policies, and the only licensed driver residing in the household, the full basic PIP rate shall be charged on one automobile, and a percentage discount shall be given on the PIP premium charge on each additional auto. For the three-year period commencing with the operative date of this rule, the premium reduction shall be at least 50 percent of the approved charge for the applicable territory of garaging for the additional automobile(s), exclusive of expense fees and policy constants or residual market equalization charges.

11:3–21.3 Automobiles eligible for premium reduction

(a) Except as provided in paragraph 1 below, the reduced premiums shall only apply to a private passenger automobile of a private passenger or station wagon type that is owned or hired by an individual or by husband and wife who are residents of the same household 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 pick-up 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.

1. The reduced premium shall not apply to automobiles for which the basic PIP premium charge is less than $25.00, exclusive of expense fees and policy constants or residual market equalization charges, and which are of the following types:

i. Automobiles 10 years or older and maintained primarily for use in exhibitions, parades and club activities, or

ii. A self-propelled vehicle with a living area that is an integral part of the chassis or a pick-up with a permanently attached camper body.

(b) A reduced premium charge for PIP coverage as specified in (a) above shall apply to all policies which are in force, issued or renewed on or after the operative date of this rule.

1. With respect to in force policies, the insurer shall calculate the reduce premium charge in (a) above, and shall issue a refund check in this amount to the insured or apply a credit in this amount to the insured's renewal policy.

i. In the event a policy is nonrenewed or otherwise terminated prior to renewal, the insurer shall calculate a return premium in accordance with the operative date of this rule and the effective termination date of the policy. The insurer shall issue a refund check in this amount to the insured.

11:3–21.4 Filing and statistical requirements

(a) Each automobile filer shall, within 60 days of the effective date of this rule, submit to the Commissioner for approval filings of rates and manual rules for implementing the reduced PIP premium charges for additional automobiles required by this rule.

1. Each statistical organization shall, within 60 days of the effective date of this rule, submit to the Commissioner for approval amendments to its statistical plan designed to effectuate the purposes of N.J.S.A. 39:6A–4.1 and this subchapter.

2. All filings required in this subsection must be submitted simultaneously to the Department and to the Department of the Public Advocate, Division of Rate Counsel pursuant to N.J.A.C. 11:1–2.5.

(b) Every insurer, rating organization and statistical organization shall segregate and maintain the exposure, premium, loss and expense statistics with respect to the payment of PIP benefits that are attributable to additional automobiles in one-driver households.

1. Any loss or loss adjustment expense for a PIP claim shall be charged to the automobile for which the full premium was paid unless the injury was sustained while in the automobile with the reduced PIP premium.

(c) Every insurer, rating organization and statistical organization shall amend their statistical plans to segregate and maintain the exposure, premium, loss and expense statistics with respect to the payment of PIP benefits that are attributable to households in which the number of automobiles insured by the same insurer exceeds the number of licensed drivers customarily operating such automobiles.

(d) The statistics required in (b) and (c) above shall be subject to examination by the Commissioner or his or her designee and shall be reported annually to the Department.

(e) Three years after the operative date of this rule, each automobile filer shall submit to the Commissioner for approval filings of rates or manual rules reflecting the actual loss experience of the filer with respect to the payment of PIP benefits which are attributable to additional automobiles described in 11:3–21.3.

(f) All filings submitted pursuant to this subchapter, and all changes and amendments thereto, shall be prepared in accordance with insurance laws and regulations, including the applicable provisions of N.J.S.A. 17:29A–1 et seq. and N.J.A.C. 11:1–2 and the Department's filing procedures.

SUBCHAPTER 22. COVERAGE OPTION SURVEY: PERSONAL INJURY PROTECTION AND TORT THRESHOLD OPTIONS

11:3–22.1 Purpose

This subchapter requires the submission of data concerning policyholder selection of the various options provided under the New Jersey Automobile Insurance Freedom of Choice and Cost Containment Act of 1984 (P.L. 1983, c.362 as amended by P.L. 1984 c.40 as amended by P.L. 1988, c.119) in order to monitor the implementation and effectiveness of the Act.

Amended by R.1989 d.267, effective May 15, 1989.
See: 21 N.J.R. 619(a), 21 N.J.R. 1358(a).
Added cite to P.L. 1988, c.119.

11:3–22.2 Scope

(a) This subchapter applies to every insurer authorized to transact the business of automobile insurance in this State.

(b) For the purpose of the reporting requirements of this subchapter, "automobile" means a private passenger automobile of a private passenger or station wagon type that is owned or hired by an individual 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 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 an individually owned private passenger automobile owned by two or more relatives resident in the same household.

11:3–22.3 Coverage option survey requirements

(a) Every automobile insurer, on a biannual basis, shall complete and file with the Commissioner the coverage option survey required by this subchapter. The insurer's biannual survey shall reflect the total number of automobiles with in force coverage as of December 31 and as of June 30 of each year, and shall indicate the personal injury protection and lawsuit threshold or no threshold options selected with respect to each such automobile. Insurers shall use forms A and B, appended to and incorporated by reference in this subchapter, to report the information required by this section.

(b) Survey forms reflecting coverage option selections as of December 31 of each year shall be filed with the Commissioner by January 21 of that year. Survey forms reflecting coverage option selections as of June 30 of each year shall be filed with the Commissioner by July 22 of that year.

(c) Completed coverage option survey forms shall be submitted to:

Director of Public Affairs
State of New Jersey, Department of Insurance
20 West State Street
CN 325
Trenton, New Jersey 08625

(d) Companies may submit the data required by this rule on a group basis, provided that each company included in the group is identified on the coverage option survey forms.

(e) Insurers which act as servicing carriers for a residual market mechanism created by statute shall report directly to the Department only the coverage options selected by their voluntary policyholders. The options selected by residual market mechanism insureds shall be reported directly to the residual market mechanism.

(f) Failure to provide the data required by this subchapter by the due dates in (b) above will result in Departmental sanctions as authorized by law.

Amended by R.1991 d.45, effective February 4, 1991.
See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).
In (c): revised address; in (e) deleted NJAFIUA reference and added residual market mechanism text to subsection.

Form A
STATE OF NEW JERSEY—DEPARTMENT OF INSURANCE
AUTOMOBILE INSURANCE COVERAGE OPTION SURVEY

Company/Group:_____

Total Number of Automobiles with Insurance Policy Coverage in Force as of December 31 or June 30, 19

Options	**Number of Automobiles**
PIP Coverages for Medical Expenses Only	
PIP Medical Expense Benefits Deductible:	
$ 250	
500	
$1,000	
$2,500	
Excess of $250,000	
Health Insurance Primary for PIP	
Auto Insurance Primary for PIP	
Tort Threshold	
Lawsuit Threshold	
No Threshold	

Form B
STATE OF NEW JERSEY—DEPARTMENT OF INSURANCE
AUTOMOBILE INSURANCE COVERAGE OPTION SURVEY

Company/Group: _____

Total Number of Automobiles with Insurance Policy Coverage in Force as of December 31 or June 30, 19

PIP Option	**Auto Insurance Primary Full PIP with**		**Auto Insurance Primary Medical PIP Only With**		**Health Insurance Primary Full PIP with**	
	Lawsuit Threshold	**No Threshold**	**Lawsuit Threshold**	**No Threshold**	**Lawsuit Threshold**	**No Threshold**
$250 deductible						
$500 deductible						
$1,000 deductible						
$2,500 deductible						
Excess $250,000						

Amended by R.1988 d.65, effective February 1, 1988.
See: 19 N.J.R. 2237(a), 20 N.J.R. 295(a).
Change of reporting dates for coverage option selections.
Amended by R.1989 d.267, effective May 15, 1989.
See: 21 N.J.R. 619(a), 21 N.J.R. 1358(a).
Changed "tort threshold" to "lawsuit threshold", added $250 PIP Deductible to both forms.
Amended by R.1991 d.45, effective February 4, 1991.
See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).

SUBCHAPTER 23. DANGEROUS DRIVERS OR DRIVERS WITH EXCESSIVE CLAIMS

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(e), 17:29C–2.1 and 17:30E–20.

Source and Effective Date

R.1987 d.527, effective December 21, 1987.
See: 19 N.J.R. 1880(a), 19 N.J.R. 2403(b).

11:3–23.1 Purpose

The purpose of this subchapter is to implement N.J.S.A. 17:29C–2.1 (P.L. 1985, c.520) which authorizes insurers in the voluntary market to refuse to issue or nonrenew physical damage coverages to drivers who are identified as dangerous drivers or drivers with excessive claims. The statute permits voluntary market insurers to issue physical damage coverages to drivers identified as dangerous drivers or drivers with excessive claims on the basis of their experience. N.J.S.A. 17:29C–2.1 requires that the Commissioner adopt standards and guidelines for the identification of dangerous drivers and drivers with excessive claims which take into consideration the total driving record of the driver including serious driving offenses and at-fault accidents occurring within a three year period.

Amended by R.1991 d.45, effective February 4, 1991.
See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).
Deleted reference to NJAFIUA in "Purpose".

11:3–23.2 Scope

This subchapter shall apply to all insurers authorized to write private passenger automobile insurance in this State.

Amended by R.1991 d.45, effective February 4, 1991.
See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).
Deleted reference to NJAFIUA and statute in "Scope".

11:3–23.3 Definitions

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

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

"DMV" means the New Jersey Division of Motor Vehicles.

"DMV abstract" means the New Jersey Division of Motor Vehicles Abstract of Driver History Record.

"Insurer" means an insurance company authorized to write private passenger automobile insurance in this State, including any residual market mechanism created by statute.

"Physical damage coverages" means collision coverage or comprehensive coverage or both coverages.

"Voluntary market insurer" means an insurance company authorized to write private passenger automobile insurance in this State, except any residual market mechanism created by statute.

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 "Association"; revised text of "Insurer" and "Voluntary market insurer" by deleted NJAFIUA reference and adding "... any residual market mechanism created by statute" text.

11:3–23.4 Availability of physical damage coverages for dangerous drivers or drivers with excessive claims

(a) Any voluntary market insurer may refuse to issue or may nonrenew physical damage coverages for any policy covering a driver who is identified as a dangerous driver or driver with excessive claims pursuant to criteria set forth at N.J.A.C. 11:3–23.5. The form and content of any nonrenewal made pursuant to this subchapter shall be subject to the standards and requirements set out at N.J.A.C. 11:3–8.

(b) Any voluntary market insurer may issue or renew physical damage coverages for any policy covering a driver who is identified as a dangerous driver or driver with excessive claims pursuant to N.J.A.C. 11:3–23.5 at rates based on their experience and approved by the Commissioner. Any voluntary market insurer wishing to impose higher rates for physical damage coverage for dangerous drivers or drivers with excessive claims shall submit to the Commissioner filings of rates and manual rules prepared in accordance with N.J.S.A. 17:29A–1 et seq., N.J.A.C. 11:1–2 and any applicable insurance laws, rules, and the Department's current filing procedures.

(c) Any residual market mechanism created by statute shall issue physical damage coverages to its insureds identified as dangerous drivers and drivers with excessive claims pursuant to the requirements and procedures found in its Plan of Operation.

Amended by R.1991 d.45, effective February 4, 1991.
See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).
In (b): deleted text regarding filing of a rating organization.
In (c): deleted NJAFIUA reference and added residual market mechanism text.
Deleted citation to "Operating principles."

11:3–23.5 Identification of dangerous drivers or drivers with excessive claims

(a) A dangerous driver or driver with excessive claims shall mean:

1. A driver who has been involved within the three-year period ending 60 days prior to the date of application or renewal in:

i. Three or more at-fault accidents as defined in N.J.A.C. 11:3–23.7;

ii. Three or more comprehensive claims resulting in payment by the insurer of at least $300.00 per claim; or

iii. Four or more combined at-fault accidents or comprehensive claims; or

2. A driver who has been convicted within the three-year period ending 60 days prior to the date of application or renewal of any of the offenses listed in N.J.A.C. 11:3–23.8; or

3. A driver who has accumulated nine or more DMV points. DMV point accumulation shall apply regardless of any annual safe driving point credits granted by DMV.

Case Notes

No constitutional right to jury trial for first or second DWI offense. State v. Graff, 121 N.J. 131, 577 A.2d 1270 (1990).

11:3–23.6 Application of dangerous driver designation

(a) Dangerous driver designations arising from conviction of the offenses described in N.J.A.C. 11:3–23.7 shall include similar violations in other states.

(b) For the purpose of identifying dangerous drivers or drivers with excessive claims as set forth in N.J.A.C. 11:3–23.5, each accident and/or claim shall be assigned to the driver of the vehicle at the time of the incident. In the event that there was no driver when the incident occurred, the accident or claim shall be assigned to the named insured.

11:3–23.7 At-fault accidents

(a) An at-fault accident is any accident involving a driver insured under the policy which occurred within the three-year period ending 60 days prior to the date of application or renewal and which resulted in payment by the insurer of at least a $300.00 claim. Provided, however, that for the purposes of this subchapter, an accident shall not be considered at-fault and shall not be counted toward the dangerous driver or driver with excessive claims designation unless it has been determined that the driver was at least 50 percent at fault in the occurrence and that none of the exceptions set forth in (b) below are applicable.

1. The degree of driver responsibility for an accident shall be investigated and determined by the insurer for each accident that results in its paying a claim of at least $300.00 under any of the following coverages or combinations thereof:

i. Bodily injury liability;

ii. Property damage liability;

iii. Personal injury protection; or

iv. Collision.

2. In determining whether a $300.00 claim payment has been made, the insurer shall include any applicable sales tax, but shall exclude any interest or other costs that it must pay pursuant to N.J.S.A. 39:6A–5c.

3. The insurer shall conduct its investigation and render its determination in compliance with N.J.S.A. 17:29B–4 and any rules promulgated pursuant thereto. The requirement of determining the degree of driver responsibility shall include those accidents which involve a claim payment only under first party coverages, such as collision or PIP, where payment is actually made by the insurer without regard to fault.

(b) Any accident occurring under the following circumstances shall not be considered an at-fault occurrence:

1. The named insured, or other insured driver obtained a judgment against, or a settlement from or on behalf of the person responsible for the accident and no judgment was obtained against nor any amount paid in settlement by or on behalf of the named insured or other insured driver as a result of the accident;

2. The accident occurred while the motor vehicle owned or operated by a driver insured under the policy was lawfully parked. An automobile rolling from a parked position shall not be considered as lawfully parked, but shall be considered as in the operation of the last operator;

3. The automobile was struck in the rear by another vehicle and the named insured or other insured driver has not been convicted of a moving traffic violation in connection with this accident;

4. The operator of the other automobile involved in the accident was convicted of a moving traffic violation and the named insured or other insured driver was not convicted of a moving traffic violation in connection with the accident;

5. The automobile was struck by a hit and run driver, if such accident was reported to the proper authority within 24 hours;

6. The accident occurred when using the automobile in response to an emergency if the insured driver at the time of the accident was a paid or volunteer member of any Police or Fire Department, First Aid Squad, or any law enforcement agency. This exception does not include an accident occurring after the automobile ceases to be used in response to such emergency; or

7. Physical damage losses other than collision.

11:3–23.8 Convictions

(a) Table I below sets forth those offenses and, where applicable, corresponding Event Identifier Codes for violations that appear on the DMV Abstract, which shall result in a dangerous driver or driver with excessive claims designation pursuant to N.J.A.C. 11:3–23.5.

Table I

Conviction Description	Event Identifier Code
1. Allowing unlicensed driver to operate vehicle.	339b
2. Altered driver's license/registration.	3381
3. Obtaining a license or registration through deception of any kind.	0337, 0312, MSOS, MSNJ I312, C312, 05D5
4. Operating a motor vehicle without a license or registration.	0310, 0304
5. Operating during a period of suspension or revocation.	0340
6. No liability insurance on motor vehicle.	06B2
7. Failure to verify insurance—accident or termination.	FVIA, FVIT, ACCD, TERM
8. Vehicular homicide.	C115
9. Fatal accident, emergent or nonemergent.	EFTL, NFTL

Conviction Description	Event Identifier Code
10. Possession of narcotic drugs.	4491
11. Use of counterfeit plates or plates other than issued.	0338
12. Consuming alcohol while operating/riding.	451A
13. Any driver insured under the policy has had a vehicle registered in New Jersey during the preceding year but has failed to carry compulsory liability insurance or has had a lapse in compulsory liability coverage for more than 30 days.	Inapplicable
14. Operating under the influence of liquor or drugs.	0450, 3261
15. Refuse alcohol breath test.	4504
16. Racing on highway.	0452, 05C1
17. Reckless driving.	0496
18. Following too closely.	0489
19. Leaving the scene of an accident; Personal Injury.	129A
20. Passing school bus.	1281
21. Exceeding maximum speed 15 or more mph over limit.	9124, 4984, A114, 4985, 9125, 8124, A115, 8125, 12A4, 12A5, 12B4, 12B5, SPED
22. Any individual covered under the policy has been found by a court of competent jurisdiction to have committed any act which is in violation of the New Jersey Insurance Fraud Prevention Act (N.J.S.A. 17:33A–1) or has been convicted of any crime in any jurisdiction involving insurance fraud.	Inapplicable

NOTE: No conviction represented by the Event Identifier Code "SPED" shall result in a dangerous driver designation under item 21 above unless the "Pts" column on the Abstract displays a 4 or 5. Convictions with the Event Identifier Code "SPED" where the "Pts" column on the abstract shows a 2 shall not result in a dangerous driver designation. However, the DMV points assessed for the conviction shall be included toward a dangerous driver designation resulting from accumulation of nine or more DMV points as specified at N.J.A.C. 11:3–23.5(a)3.

(b) With respect to any conviction of a violation that is disclosed on the DMV abstract, the insurer shall use the Event Responsibility Codes shown on column two of the abstract to determine whether the listed violation reflects a Court Code (including foreign state violations listed on the abstract) or a Division Code.

1. The dangerous driver designation for Court Code violations shall apply only where the Event Type column of the abstract (column three on the abstract) contains a "V" designation; court code violations where the Event Type column contains an "O" designation shall be disregarded. The dangerous driver designation for Division Code violations shall apply only where the Event Type column of the abstract contains an "O" designation; Division Code violations where the Event Type column contains an "S" designation shall be disregarded.

2. The three year period specified at N.J.A.C. 11:3–23.5(a) shall be computed based upon the date shown in the event date column (column one) of the abstract.

3. With respect to out-of-state violations for driving under the influence of alcohol or drugs and refusal to take an alcohol breath test (compact and non-compact states) the dangerous driver designations shall apply only where the Event Type column contains a "V" designation. Subsequent entries reflecting administrative action by DMV based upon the out-of-state violation (Division Code, Event Type "O") shall be disregarded.

Case Notes

No constitutional right to jury trial for first or second DWI offense. State v. Graff, 121 N.J. 131, 577 A.2d 1270 (1990).

11:3–23.9 Severability

If any provision of this subchapter or its application to any person or circumstance is held invalid, the remainder of this subchapter and its application to other persons or circumstances shall not be affected.

SUBCHAPTER 24. (RESERVED)

Subchapter Historical Note

Subchapter 24, Policy Constants, was adopted as a new rule by R.1989 d.278, effective May 15, 1989. See: 20 N.J.R. 3104(a), 21 N.J.R. 1358(b). Subchapter 24, Policy Constants, was repealed by R.1991 d.216, effective April 15, 1991. See: 22 N.J.R. 3441(a), 23 N.J.R. 1132(a).

SUBCHAPTER 25. (RESERVED)

Subchapter Historical Note

Subchapter 25, Residual Market Equalization Charges (RMECs), was adopted as a new rule by R.1989 d.278, effective May 15, 1989. See: 21 N.J.R. 278(a), 21 N.J.R. 1361(a). Administrative correction to 25.3, Collection of RMECs; remittance in (a)1. See: 21 N.J.R. 1708(b). Administrative correction to 25.4, Definition of private passenger automobile, in (b)8. See: 21 N.J.R. 1708(b). 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 26. ACCIDENT CLAIMS

Authority

N.J.S.A. 39:6–61 et seq., 39:6–64a, 39:6–64.1 and 39:6–73.1.

Source and Effective Date

R.1989 d.268, effective May 15, 1989.
See: 21 N.J.R. 688(a), 21 N.J.R. 1363(a).

11:3–26.1 Claim information

(a) Notice of intention to make claim under N.J.S.A. 39:6–55 shall contain the following information:

1. The claimant's name, address, date of birth and social security number;

2. The time and place of accident, the municipality and county in which the loss occurred and the date of loss;

3. The identity of the operators and vehicles involved in the accident, including the name and address of the

owner and operator and the license plate number of the vehicle;

4. Such witnesses to said accident as are then known;

5. A short description of the accident, including the claimant's role or position therein;

6. A description of the injuries then known, and attached thereto a medical certificate if then available. In any event the medical certificate shall be filed as soon as available;

7. A description of the damage sustained to property, and attached thereto an estimate of the cost of repairs if then available; and

8. The policy number of any insurance applicable to the accident, including the name and address of all insurance companies involved.

Amended by R.1991 d.45, effective February 4, 1991.
See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).
In (a)1–5: added text to contents of claim information notice. Added new (a)8.

11:3–26.2 Claim filing; form

(a) A Notice of Intention to Make Claim under N.J.S.A. 39:6–65 may be filed on a form of the Unsatisfied Claim and Judgment Fund Board designated as a "Notice of Intention to Make Claim."

(b) A written notice to the Board in any other form that contains the information required by this section shall be acceptable.

(c) A notice of intention to make a claim that does not contain the items identified in N.J.A.C. 11:3–26.1(a)1 through 8 shall be returned to the sender and deemed to be unfiled with the Unsatisfied Claim and Judgment Fund (UCJF) for the purpose of complying with N.J.S.A. 39:6–6.5. A notice of intention which is deemed to be unfiled does not toll the statute of limitations.

Amended by R.1991 d.45, effective February 4, 1991.
See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).
Added new subsection (c).

SUBCHAPTER 27. UNSATISFIED CLAIM AND JUDGMENT FUND BOARD

Authority

N.J.S.A. 39:6–61 et seq., 39:6–64a, 39:6–64.1 and 39:6–73.1.

Source and Effective Date

R.1989 d.268, effective May 15, 1989.
See: 21 N.J.R. 688(a), 21 N.J.R. 1363(a).

11:3–27.1 Uninsured's current financial status

(a) Upon review of a case by the Unsatisfied Claim and Judgment Fund Board, if the Board does not have sufficient current information to determine whether or not the uninsured's installment payment is reasonable, a request will be addressed to the uninsured asking for a statement of current financial status.

(b) If the uninsured fails to furnish a completed statement of current financial status within a time period to be established by the executive director, the Unsatisfied Claim and Judgment Fund Board will request the Director of Motor Vehicles to suspend the license and all registrations of the uninsured pursuant to N.J.S.A. 39:5–30 and 39:5–87, for failure to furnish this information.

SUBCHAPTER 28. UNSATISFIED CLAIM AND JUDGMENT FUND'S REIMBURSEMENT OF EXCESS MEDICAL EXPENSE BENEFITS PAID BY INSURERS

Authority

N.J.S.A. 39:6–61 et seq., 39:6–64a, 39:6–64.1 and 39:6–73.1.

Source and Effective Date

R.1989 d.268, effective May 15, 1989.
See: 21 N.J.R. 688(a), 21 N.J.R. 1363(a).

11:3–28.1 Purpose and scope

(a) The purpose of this subchapter is to establish procedures to ensure that only appropriate, reimburseable claims are submitted to the Fund by insurers by requiring investigation of the medical necessity for certain claims; requiring the audit of claims of $10,000 or more submitted by licensed providers of health care services or claims of $25,000 or more by health care facilities; and requiring prior approval of claims for alterations to vehicles and residences. This subchapter also requires insurers to pursue the proper, alternative sources for reimbursement where such other sources of funds are available.

(b) This subchapter applies to all insurers authorized in this State to write the kinds of insurance specified in paragraphs d and e of N.J.S.A. 17:17–1.

Repeal and New Rule, R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).
Section was "Notification of potential for payment of excess medical expense benefits".

11:3–28.2 Definitions

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

"Board" means the Unsatisfied Claim and Judgment Fund Board created in accordance with N.J.S.A. 39:6–64.

"Diagnosis related groups" or "DRG" means a patient classification scheme in which cases are grouped by shared characteristics of principal diagnosis, secondary diagnosis, age, surgical procedure, and other complications. Each DRG exhibits a consistent amount of resource consumption as measured by some unit (for example, length of stay or dollars).

"Excess medical expense benefits" means medical expense benefits paid in accordance with N.J.S.A. 39:6A–4a which are in excess of $75,000 resulting from personal injury to any one person in any one accident.

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

"Health care facility" means a facility or institution, whether public or private, engaged principally in providing services for diagnosis of treatment of pain, injury, deformity or physical condition, including, but not limited to, a general hospital, special hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, outpatient clinic, dispensary or residential health care facility.

"Health care service" means the preadmission, outpatient, inpatient and postdischarge care provided in or by a health care facility, and such other items or services as are necessary for such care, which are provided by or under the supervision of a physician for the purpose of diagnosis or treatment of pain, injury, disability, deformity or physical condition, including, but not limited to, nursing service, home care nursing and other paramedical service, ambulance service, service provided by an intern, resident in training or physician whose compensation is provided through agreement with a health care facility, laboratory service, medical social service, drugs, biologicals, supplies, appliances, equipment, bed and board.

"Insurer" means any person authorized or admitted in this State to write the kinds of insurance specified in paragraphs d and e of N.J.S.A. 17:17–1.

"Licensed nursing personnel" or "licensed nurse" means a nurse licensed by the New Jersey State Board of Nursing or the equivalent from another jurisdiction.

"Medical expense benefits" means medical expense benefits paid in accordance with N.J.S.A. 39:6A–4a.

"Medically necessary" means services or supplies including tests or examinations that are needed for the medical care of a diagnosed injury. To be considered "needed" a service or supply must be ordered by a licensed physician and be commonly and customarily recognized throughout the medical profession as appropriate in the treatment of the particular injury for which it was ordered. Neither educational, experimental nor investigational procedures will be deemed "needed" or "medically necessary" for purposes of these rules.

"Per diem" means a daily fixed charge which includes room and board and other fees for services and supplies.

"PIP coverage" means personal injury protection coverage as described at N.J.S.A. 39:6A–4.

"Person" means any individual, association, company, corporation, insurer, joint stock company, organization, partnership, society, syndicate, trust, any combination of the foregoing acting in concert or any other entity.

"Pre-screen" means an off-site review of the billings from a health care facility to determine whether the care given and amounts charged are appropriate.

"Provider" means any person that furnishes services or equipment for medical expense benefits for which payment is required to be made under PIP coverage in automobile insurance policies, but does not include health care facilities.

"Reimbursement" refers to reimbursement to insurers by the Fund as provided at N.J.S.A. 39:6–73.1.

"Uninsured motorist claims" means claims submitted against operators of uninsured vehicles and hit and run claims submitted pursuant to N.J.S.A. 39:6–61.

New Rule, R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).
Amended by R.1994 d.597, effective December 5, 1994.
See: 26 N.J.R. 2190(a), 26 N.J.R. 4772(a).

11:3–28.3 Report of such claims when the carrier has paid at least $50,000 for medical expense benefits

In cases where the potential exposure to the automobile liability insurer exceeds $75,000, the insurer shall report on form UC–321 (incorporated herein by reference as Exhibit 1 in Appendix A) whenever medical expense benefits in a total amount of $50,000 have been paid on account of personal injury to any one person in any one accident.

Recodified from 11:3–28.2 and amended by R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).

11:3–28.4 Notice of change in the amount of reserves

Whenever an automobile liability insurer has paid medical expense benefits on account of personal injury to any one person in any one accident in a total amount of $50,000, said insurer shall notify the Fund of any changes in the amount of reserves established for payment of the claim or closing of the file.

Recodified from 11:3–28.3 and amended by R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).

11:3–28.5 Supplemental form to be submitted to the Fund

A two-sided reimbursement and reserve form, UCJF–REIMB./91 (incorporated herein by reference as Exhibit 2 in Appendix A), shall be filed with the Fund within 90 days after an automobile insurer has paid medical expense benefits on account of personal injury to any one person in any one accident in a total amount in excess of $75,000. Such form together with form UC–323(93) (incorporated herein by reference as Exhibit 3 in Appendix A) shall be filed each quarter that the insurer seeks reimbursement.

Recodified from 11:3–28.4 and amended by R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).

11:3–28.6 Insurer's continuing obligation to investigate claims

(a) An automobile liability insurer shall be required to discharge its duty of investigating claims where the potential exposure to the insurer exceeds $75,000. Said insurer's duty and obligation with regard to claim handling shall exist and continue to exist notwithstanding this rule. The Executive Director may direct such investigations as often as he or she deems necessary. All expenses relating to the investigation of claims, including expenses for medical examinations, file maintenance and cost containment measures, are the responsibility of the automobile liability insurer.

(b) The failure to properly discharge the duty of investigating a claim may result in the imposition of a penalty, to be determined by the UCJF Board of Directors, against the insurer's request for reimbursement.

Amended by R.1991 d.45, effective February 4, 1991.
See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).
Added new subsection (b) to text, therein creating subsection (a) to existing text.
Recodified from 11:3–28.5 and amended by R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).

Case Notes

Insurer may request claimant to undergo physical or mental examination after cessation of benefits. New Jersey Auto. Full Ins. Underwriting Ass'n v. Jallah, 256 N.J.Super. 134, 606 A.2d 839 (A.D.1992).

Insurer may seek examination under oath of claimant after termination of benefits or demand of arbitration. New Jersey Auto. Full Ins. Underwriting Ass'n v. Jallah, 256 N.J.Super. 134, 606 A.2d 839 (A.D. 1992).

Insurer's denial of benefits to claimant who refused examination under oath was not warranted. New Jersey Auto. Full Ins. Underwriting Ass'n v. Jallah, 256 N.J.Super. 134, 606 A.2d 839 (A.D.1992).

11:3–28.7 Reimbursement of excess medical expense benefits paid by insurers

(a) Insurers shall submit to the Fund itemized accounts with supporting documentation of excess medical expense benefit claim payments as soon as practicable after the close of the quarter for which reimbursement is sought. The Fund shall reimburse automobile liability insurers for excess medical expense benefits on a quarterly basis. Insurers shall not be reimbursed for interest, attorney fees or punitive damages.

1. For a period of one year from the date of payment of a claim for excess medical expense benefits by an insurer, the insurer may submit to the Fund a request for reimbursement of a claim which was not included in the insurer's quarterly submission. The insurer shall include with its request, specific documentation to identify the subject payment.

2. Failure to comply with the requirements set forth in (a)1 above shall result in a denial by the Fund of the reimbursement request which was omitted from the quarterly submission.

(b) The Fund shall not reimburse an insurer for excess medical expense benefits if it is determined that there are multiple insurance policies applicable to a claim unless an insurer has expended medical benefits in an amount exceeding $75,000 on account of personal injury to any one person in any one accident. Where there are two or more different primary insurers liable, the Fund shall not reimburse such an insurer for excess medical expense benefits unless each primary insurer has expended medical benefits in an amount exceeding $75,000 on account of personal injury to any one person in any one accident.

(c) Where the Fund has reimbursed an insurer for excess medical expense benefits and thereafter determines that there were or are multiple insurance policies applicable to the underlying claim, the insurer shall return all moneys paid from the Fund. The insurer(s) shall apportion the medical benefits payment and make individual application to the Fund where the potential exposure to the insurer(s) exceeds $75,000 on account of personal injury to any one person in any one accident.

(d) Whenever an insurer recovers amounts expended by it for medical benefits, it shall not be reimbursed for excess medical expense benefits unless it has fully repaid the amount previously reimbursed by the Fund.

Recodified from 11:3–28.6 and amended by R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).

Case Notes

Unsatisfied Claim and Judgment Fund not required to reimburse insurers of out-of-state vehicles for PIP benefits in excess of $75,000. Martin v. Home Ins. Co., 141 N.J. 279, 661 A.2d 808 (1995).

11:3–28.8 Audits

Upon request of the Fund, the insurer(s) shall present for audit at the direction of the Executive Director at a New Jersey location all policy and claim records on which notice of potential for payment of excess medical expense benefits have been submitted.

Recodified from 11:3–28.7 and amended by R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).

11:3–28.9 Reporting of losses for personal injury protection payments in excess of $75,000

(a) For purposes of completing page 14, Exhibit of Premiums and Losses, of the annual statement filed pursuant to N.J.S.A. 17:23–1, the insurer shall include the total amount of losses for private passenger automobile and commercial automobile personal injury protection payments (lines 19.1 and 19.3), including those in excess of $75,000. Insurers shall also provide a footnote on page 14 that indicates the amount of losses reported, excluding losses from payments of private passenger automobile and commercial automobile personal injury protection payments in excess of $75,000.

(b) For purposes of completing Schedule F of the annual statement, insurers shall consider the assumption and reimbursement by the Fund of private passenger automobile and commercial automobile personal injury protection payments in excess of $75,000 as a reinsurance transaction. Insurers shall consider assessments paid to the UCJF pursuant to N.J.S.A. 39:6–63 based on the insurer's premiums for private passenger automobile liability insurance (including PIP) and commercial automobile liability insurance (including PIP) as ceded premium, pro rated for the appropriate line of business on which the assessment was based.

(c) Insurers shall comply with the provisions of this section beginning with the annual statement due March 1, 1994 (covering the calendar year ended December 31, 1993). For purposes of completing the annual statement due March 1, 1993 (covering the calendar year ended December 31, 1992), insurers shall file by no later than July 1, 1993 a supplemental page 14 and schedule F of the annual statement in accordance with the provisions of this section.

New Rule, R.1993 d.178, effective April 19, 1993.
See: 24 N.J.R. 3215(a), 24 N.J.R. 1769(a).
Recodified from 11:3–28.8 and amended by R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).

11:3–28.10 Insurers' obligations to investigate and audit bills for medical benefits

(a) For purposes of reimbursement by the Fund, an insurer shall conduct an investigation and audit of claims submitted by health care facilities where such claims are equal to or in excess of $25,000.

1. Failure of an insurer to complete an audit in accordance with these rules shall result in a 20 percent reduction in payment to the insurer by the Fund of the unaudited, reimbursable bill.

2. Per diem billings for health care facilities are not subject to the audit requirements set forth in this subchapter.

3. An insurer shall conduct an initial on-site audit for charges by health care facilities to determine whether the level of care, need and charges are appropriate.

4. An insurer may pay 80 percent of the provider's bill prior to completion of the initial on-site audit. The remaining amount due, if any, shall be paid following completion of the insurer's audit.

5. Annual on-site audits shall be completed in 12–month intervals, from the initial on-site audit and shall be filed with the Fund within 90 days of completion of the audit; and

6. Whenever a change in services occurs such as, but not limited to, the level of care, the daily room rate or additional charges, an insurer shall conduct an on-site audit and shall provide the audit and auditor's statement to the Fund with the next reimbursement request.

7. All other audits shall be conducted prior to payment to the health care facility and may be performed on a pre-screen basis as set forth in (e) below.

(b) For purposes of reimbursement by the Fund, an insurer shall conduct an investigation and audit of claims submitted by providers where such claims are equal to or in excess of $10,000.

1. Failure of an insurer to complete an audit in accordance with this subchapter shall result in a 20 percent reduction in payment to the insurer by the Fund of the unaudited, reimbursable bill.

(c) The thresholds in (a) and (b) above are cumulative for each confinement associated with damages resulting from bodily injuries arising out of the ownership, maintenance or use of a motor vehicle in this State and shall incorporate all claims submitted per confinement by the health care facility or by each individual provider.

(d) To be eligible for reimbursement by the Fund, insurers shall audit, prior to payment, bills submitted for continuous treatment from any health care facility or provider which exceed or may exceed the applicable threshold.

(e) Audits of all providers and health care facilities conducted pursuant to this subchapter, including the audit of DRG bills and any successor pricing, shall be performed by:

1. Licensed nursing personnel with two years experience or training in required auditing and hospital practices; or

2. An outside auditing firm retained by the insurer for such purposes.

(f) Audits performed shall include, but not be limited to, confirmation of compliance with the medical fee schedule set forth at N.J.A.C. 11:3-29 including those situations where the insurer does not provide the primary coverage to the claimant.

(g) An insurer is not required to conduct a separate, independent audit, if it has obtained a true copy of an audit conducted by the primary insurer or health insurer.

(h) Insurers shall append copies of audits conducted, including those conducted by the primary insurer or health insurer, and the auditor's statements with the reimbursement request filed with the Fund in accordance with N.J.A.C. 11:3-28.7.

New Rule, R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).

11:3-28.11 Modifications to vehicles

(a) An insurer shall obtain prior approval from the Fund for modifications to a claimant's vehicle, or vehicle to be used for the benefit of the claimant, the cost of which may be reimbursed by the Fund.

(b) An insurer shall submit a written request to the Fund, seeking approval of modifications which are equal to or in excess of $1,000, within 30 days of a claimant's request for modifications.

(c) A request to obtain prior approval from the Fund shall include the following:

1. A written recommendation for the modification by the claimant's primary care physician including:

i. Where the claimant is the operator of the vehicle, current findings on the claimant's physical ability to drive and a copy of the claimant's current driver's license;

ii. A brief analysis of the medical necessity and medical purpose for the requested modifications;

iii. A description of the purpose for which the vehicle will be used; and

iv. Verification that the requested modifications are necessitated by injuries sustained by the claimant in the subject accident;

2. A cost benefit analysis, supported by appropriate documentation, comparing the cost of modifying the claimant's vehicle to the cost of alternate methods of transporting the claimant. This analysis shall incorporate an evaluation of the anticipated miles to be driven per year for medically necessary health care services, including a breakdown reflecting the number of miles to be driven to obtain health care service and the frequency of such services, the cost per mile of alternate means of such transportation, as well as the useful life of the vehicle;

3. An agreement between the insurer and the claimant setting forth, but not limited to:

i. The claimant's responsibility to maintain insurance on the vehicle; and

ii. The claimant's responsibility to repair and maintain the vehicle; and

4. Any additional information specifically requested by the Fund with regard to a particular application for approval.

(d) The insurer may independently evaluate, or be required by the Fund to evaluate, the claimant by a physician chosen by the insurer and approved by the Fund, at the insurer's cost, to determine whether a medical necessity and medical purpose exist for modifications to the vehicle. The evaluation shall include a review of the elements considered in the primary evaluation as set forth at (c) above.

(e) The Fund shall not approve modifications to a vehicle unless it is demonstrated that the modifications are required for purposes of medical necessity resulting from injuries sustained by the claimant in the subject accident, are required for a medical purpose and the modifications are shown to be cost effective or as the Fund may otherwise determine.

(f) A request for modifications may be denied for failure to fulfill any of the above conditions.

New Rule, R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).

11:3-28.12 Modifications to a claimant's residence

(a) An insurer shall obtain prior approval from the Fund for any modifications to a claimant's primary residence the cost of which may be reimbursed by the Fund.

(b) An insurer shall submit a written request to the Fund, seeking approval of modifications which are equal to or in excess of $10,000, within 30 days of a claimant's request for modifications.

(c) A request to obtain prior approval from the Fund shall include the following:

1. A written recommendation for the modification by the claimant's primary care physician including:

i. A brief analysis of the medical necessity for the requested modifications; and

ii. Verification that the requested modifications are necessitated by injuries sustained by the claimant in the subject accident;

2. Medical documentation estimating the claimant's life expectancy;

3. A cost benefit analysis, supported by appropriate documentation, which establishes that the proposed modifications are more cost effective than long term residential care services. The analysis shall include, in accordance with Appendix B incorporated herein by reference, an evaluation based on the life expectancy of the claimant and a comparison between the costs of the modifications and home care to be provided, to the costs of other residential care alternatives;

4. An evaluation prepared by an independent consultant experienced in barrier free designs that sets forth the type of modifications required and the costs of such modifications;

5. An agreement setting forth the responsibilities regarding the obligations of the claimant, the owner of the property or both and the insurer for, but not limited to:

i. The claimant's or property owner's responsibility for:

(1) The expenses for upkeep of the residence;

(2) Maintenance of insurance on the property; and

(3) Repayment to the insurer in the event of the claimant's relocation, death or upon the sale of the modified premises; and

ii. The insurer's obligation to remove nonessential equipment;

6. A repayment agreement with an amortization provision which provides an amortization term and amount, once a modification is determined to be cost effective, calculated in accordance with the formula provided in Appendix B to this subchapter; and

7. Any other additional information specifically requested by the Fund with regard to a particular application for approval.

(d) The insurer may independently evaluate, or be required by the Fund to evaluate, the claimant by a physician chosen by the insurer and approved by the Fund, at the insurer's cost, to determine whether a medical necessity for the modifications exist. The evaluation shall include a review of the elements considered in the primary evaluation as set forth at (c) above.

(e) The Fund shall not approve modifications to a residence unless it is demonstrated that the modifications are required for purposes of medical necessity resulting from injuries sustained by the claimant in the subject accident and the modifications are shown to be cost effective or as the Fund may otherwise determine.

(f) A request for modification may be denied for failure to fulfill any of the above requirements.

(g) Where a request for modifications is approved, the insurer shall record a lien against the modified property in the county in which the property is located and shall file a copy of the recorded lien with the Fund within 30 days.

1. This provision shall not apply to rental property.

(h) Where a claimant seeks to modify rental property, the insurer shall obtain:

1. A written consent from the owner of the property which permits the modifications and indemnifies the insurer and the Fund from any other liabilities relating thereto; and

2. A written agreement between the claimant and the insurer, in which the claimant agrees to reimburse the insurer for the unamortized costs of the improvements in the event of the claimant's relocation or death.

(i) Upon the claimant's relocation or death, the claimant, the claimant's estate or the owner of the property against which the lien is recorded, shall reimburse the insurer for the unamortized cost of the modifications to the claimant's residence.

(j) The claimant, the claimant's estate or the owner of the property against which the lien was recorded, shall have a reasonable period in which to reimburse the insurer.

(k) Where repayment by the claimant or the claimant's estate is required pursuant to this section, interest shall accrue at the prevailing rate of post judgment interest as set forth in the rules governing civil practice in the New Jersey Court Rules in effect at the time of execution of the repayment agreement, until the amount owed is paid in full.

(*l*) Within 30 days from the date of the claimant's relocation or death, the insurer shall so notify the Fund in writing and shall include the terms of repayment by the claimant to the insurer. The insurer shall repay the Fund for such reimbursement.

1. The insurer shall be required to repay the Fund within 60 days from receipt of any and all partial payments or from the receipt of a payment made in full by the claimant.

(m) A warrant discharging the lien shall be filed by the insurer when the full amount owed to the insurer, in accordance with the amortization agreement, is satisfied.

New Rule, R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).

11:3–28.13 Insurer's obligation to obtain recovery of payments for paid medical expense benefit claims

(a) The Fund shall deny reimbursement to insurers for paid medical expense benefit claims if an insurer has failed

to pursue any and all responsible tortfeasors within the time prescribed by law at N.J.S.A. 39:6A–13.1.

1. An insurer's failure to diligently pursue its right of recovery of medical expense benefit claim payments shall result in the denial of reimbursement by the Fund for these claims.

2. The Fund shall recover any reimbursement payments which were made to an insurer, where the insurer failed to diligently pursue its right of recovery against a tortfeasor.

3. An insurer shall obtain prior approval from the Fund before settling or compromising a claim against a tortfeasor.

(b) Any and all expenses and fees incurred by the insurer as a result of the pursuit of a right of recovery against a tortfeasor, shall be borne by the insurer.

New Rule, R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).

11:3–28.14 Insurer's responsibility upon assignment of an uninsured motorist claim

(a) An insurer shall, within 10 business days of receipt of a claim assignment and accompanying instruction sheet (see Appendix B, Item 1, incorporated herein by reference) from the Fund, submit a letter to the Fund which:

1. Acknowledges receipt of the assignment and the accompanying instruction sheet; and

2. Provides the names and telephone numbers of the case handler or manager, the claim investigator and the claim adjuster.

(b) An insurer shall, within 10 business days from the date it assigns the claim to defense counsel, provide the Fund with the name, address and telephone number of defense counsel.

(c) An insurer shall, within 10 business days, provide written notice to the Fund of any changes, substitutions or replacements which occur with respect to any of the persons identified pursuant to (a)2 or (b) above.

New Rule, R.1994 d.597, effective December 5, 1994.
See: 26 N.J.R. 2190(a), 26 N.J.R. 4772(a).

11:3–28.15 Procedures for handling an assigned uninsured motorist claim

(a) Each insurer shall:

1. Perform an investigation in accordance with the procedures set forth in the instruction sheet and obtain the following:

i. Confirmation that there is no insurance available for the claim;

ii. Confirmation of the claimant's eligibility based on N.J.S.A. 39:6–70 or 39:6–78;

iii. A police report;

iv. Witness statements;

v. Copies of medical reports, bills and hospital records; and

vi. A central index bureau ("C.I.B.") report;

2. Forward to assigned defense counsel a copy of the instruction sheet for reference; and

3. Forward to the Fund's claim adjuster for certification responses to interrogatories propounded upon the Commissioner in hit and run cases.

(b) An insurer or assigned defense counsel shall obtain and file with the Fund, within five business days of receipt, all documents which relate to the claim including, but not limited to:

1. Documents relating to the discovery of information including, but not limited to:

i. Interrogatories propounded by the claimant and any responses thereto;

ii. Responses to interrogatories propounded by the insurer;

iii. Deposition notices; and

iv. Deposition transcripts;

2. Documents filed with the court including, but not limited to:

i. Motion papers;

ii. Briefs; and

iii. Settlement or consent agreements; and

iv. Orders entered by the Court; and

3. Scheduling notices, notices of arbitration and any results thereof; other correspondence from the courts; and any judgments or court decisions which affect the claim in whole or in part and copies of trial or hearing transcripts upon the request of the Fund.

(c) Within 60 days of receipt of a claim assignment, an insurer shall file with the Fund a completed 60–day Report as set forth in Appendix B, Item 2, incorporated herein by reference, and the following information:

1. The results of the investigation conducted in accordance with (a)1 above;

2. An estimate of the amount of damages involved;

3. A brief synopsis of the status of the case;

4. All answers to interrogatories not previously filed, which have been propounded on the Fund, the Commissioner or any known defendants;

5. Answers to interrogatories propounded by the insurer; and

6. Any other pertinent documents filed with the court in connection with the matter which were not previously forwarded to the Fund.

(d) At six-month intervals, following the initial receipt of a case assignment, an insurer shall file with the Fund an updated, detailed Six–Month Summary Report as set forth at Appendix B, Item 3, incorporated herein by reference, and the following information:

1. An update of the information set forth in (b) and (c) above;

2. A brief summary which describes the status of the case, outlines the action taken to date, sets forth anticipated future action and/or strategy; and the anticipated outcome;

3. The discovery of any evidence of a fraudulent claim. Such information shall be referred to an insurer's special investigation unit. The unit shall, thereafter, forward its findings to the Department's Fraud Unit with a copy to the Fund; and

4. All other relevant information discovered during the pendency of the claim.

(e) An insurer shall provide notice to the Fund of any and all hearings, motions, arbitration and trial dates in a manner which provides sufficient notice to facilitate the Fund's review of the file prior thereto. An insurer shall provide notice to the Fund's claim adjuster either by telephone and confirming letter, facsimile transmission or mail.

(f) An insurer shall consult with the Fund and obtain prior approval from the Board before:

1. Entering into a settlement or judgment by consent in accordance with N.J.S.A. 39:6–72 or 6–82;

2. Proceeding to trial; or

3. Filing a motion for reconsideration.

(g) An insurer shall consult with the Fund and obtain prior approval from the Board before filing an appeal from an order or judgment adverse to the Fund.

(h) Prior approval from the Board shall be obtained by telephoning the Fund at (609) 292–3100 or by writing to:

Fund Adjuster
Unsatisfied Claim and Judgment Fund
CN 325
Trenton, NJ 08625

(i) For each assigned claim, an insurer shall review all medical bills submitted by claimants to ensure compliance with the medical fee schedule set forth at N.J.A.C. 11:3–29. Where a medical bill is not in compliance with N.J.A.C. 11:3–29, the insurer shall immediately notify the Fund of the discrepancy.

New Rule, R.1994 d.597, effective December 5, 1994.
See: 26 N.J.R. 2190(a), 26 N.J.R. 4772(a).

11:3–28.16 (Reserved)

New Rule, R.1994 d.597, effective December 5, 1994.
See: 26 N.J.R. 2190(a), 26 N.J.R. 4772(a).

11:3–28.17 Penalties

Failure of an assigned insurer to comply with these rules shall result in the imposition of penalties prescribed by law.

New Rule, R.1994 d.597, effective December 5, 1994.
See: 26 N.J.R. 2190(a), 26 N.J.R. 4772(a).

APPENDIX A

EXHIBIT 1

UNSATISFIED CLAIM AND JUDGMENT FUND
EXCESS MEDICAL BENEFITS FIRST NOTICE FORM

This form shall be completed by the Carrier anticipating reimbursement from the Fund of Medical Expense Benefits. This form shall be sent to the Fund at the time the Carrier has made payments in a total amount of $50,000 and the Carrier expects the payments will exceed a total of $75,000.

PLEASE PRINT OR TYPE

NAME OF CARRIER UNDER WHICH POLICY IS WRITTEN		NAIC NUMBER
ADDRESS		
CITY	STATE	ZIP CODE
CONTACT PERSON	TELEPHONE NUMBER INCLUDING AREA CODE	
CARRIER FILE NUMBER	CARRIER POLICY NUMBER	POLICY EFFECTIVE DATES FROM: _____ TO: _____
DATE OF ACCIDENT	LOCATION OF ACCIDENT INCLUDING CITY, COUNTY AND STATE	
NAME OF NAMED INSURED ON POLICY		
NAME OF INJURED PARTY		
ADDRESS		
AGE OF INJURED PARTY AT TIME OF ACCIDENT	SEX	
DESCRIPTION OF INJURIES		
PROGNOSIS AS TO INJURIES		
AMOUNT OF MEDICAL PAYMENTS MADE TO DATE: $	TOTAL AMOUNT OF EXPECTED FUTURE MEDICAL PAYMENTS: $	

RECOMMENDED RESERVE FOR THE TOTAL VALUE OF THE CLAIM TO ITS ULTIMATE DISPOSITION:
$_____.
RECOMMENDED RESERVE FOR THE AMOUNT OF PAYMENTS TO BE MADE IN THE NEXT TWO YEARS:
$_____.
DATE ON WHICH THE $75,000 THRESHOLD MAY BE REACHED: _____.

NAME OF SUPERVISOR RESPONSIBLE FOR INVESTIGATION FILE AND PHONE NUMBER:

COMPLETED BY _____ TITLE _____

PHONE NUMBER _____ DATE _____

UC-321 (R1/91)

EXHIBIT 2

UNSATISFIED CLAIM AND JUDGEMENT FUND
REIMBURSEMENT AND RESERVE FORM

This form shall be completed by the Carrier seeking reimbursement from the fund for Medical Expenses Benefits in excess of $75,000. The reverse side of this form must be completed upon submission of the first request for reimbursement only. A separate form shall be submitted with each request.

PLEASE PRINT OR TYPE

NAME OF CARRIER UNDER WHICH POLICY IS WRITTEN ADDRESS	CARRIER'S FILE NUMBER
NAME OF INJURED PARTY	EMB FILE NUMBER
SET FORTH PROGNOSIS AS TO INJURIES AND EXPECTED FUTURE MEDICAL PAYMENTS	

RECOMMENDED RESERVE FOR TOTAL VALUE OF CLAIM TO ITS ULTIMATE DISPOSITION, NOT INCLUDING THE $75,000 THRESHOLD ..... $_____

TOTAL AMOUNT OF ANTICIPATED PAYMENTS DURING THE NEXT 2 YEARS ..... $_____

TOTAL AMOUNT OF EXPECTED PAYMENTS DURING THE NEXT 90 DAYS ..... $_____

THE PIP PAYMENT RECORD AND ADDING MACHINE TAPE(S) ARE TO BE ATTACHED TO THIS FORM. THE PIP PAYMENT RECORD SHOULD INCLUDE THE DATE PAID, AMOUNT PAID, NAME OF THE PARTY PAID AND TREATMENT DATES. THE PIP PAYMENT RECORD SHOULD INDICATE TO WHICH PAYMENTS THE PIP DEDUCTIBLE AND CO-PAYMENT WAS APPLIED.

AMOUNT OF REIMBURSEMENT NOW BEING SOUGHT FROM THE FUND ..... $_____

AMOUNT OF REIMBURSEMENT PREVIOUSLY RECEIVED, IF ANY ..... $_____

☐ NO FURTHER REIMBURSEMENT ON THIS CLAIM IS ANTICIPATED. WE HAVE CLOSED OUR MEDICAL EXPENSE FILE.

COMPLETED BY
TITLE
DATE COMPLETED
TELEPHONE NUMBER

*COMPLETE REVERSE SIDE ON INITIAL REQUEST FOR REIMBURSEMENT.

UCJF–REIMB./91

ANSWER THE FOLLOWING QUESTIONS "YES OR NO". IF AUDITS, MEDICAL REPORTS, ETC. ARE REQUIRED, ATTACH TO PIP PAYMENT RECORD AT TIME OF SUBMISSION FOR REIMBURSEMENT.

YES	NO	
_____	_____	CONCURRENCY APPLIES
_____	_____	WORKER'S COMPENSATION COVERAGE INVOLVED
_____	_____	SUBROGATION APPLIES
_____	_____	PIP REIMBURSEMENT OPTION SELECTED (IF YES, ATTACH COPY OF LETTER TO INSD)
_____	_____	CIB WAS FILED
_____	_____	AUDIT REPORTS FOR PAYMENTS OVER $10,000
_____	_____	COMPREHENSIVE MEDICAL AND/OR REHABILITATION REPORTS
_____	_____	PIP PAYMENT RECORDS WITH ADDING MACHINE TAPE(S).
_____	_____	COMPLETED AND SIGNED TREASURY INVOICE
_____	_____	IS CLAIM IN LITIGATION? IF SO, BY WHOM?

PLEASE STATE ADDITIONAL COMMENTS:

_____

_____

_____

_____

_____

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EXHIBIT 3

UNSATISFIED CLAIM AND JUDGMENT FUND
EXCESS MEDICAL BENEFITS PAYMENT RECORD

CARRIER: _____ PAGE NUMBER: _____

CARRIER'S FILE NO.: _____ EMB FILE NO.: _____

INJURED PARTY: _____ DATE OF LOSS: _____

DATE RECEIVED	PROVIDER AND NATURE OF SERVICE	AMOUNT CHARGED	DATES OF SERVICE	AMOUNT PAID	DATE OF PAYMENT
			PAGE TOTAL:		

INDICATE WITH AN ASTERISK (*) NEXT TO THE PAYMENT OR PAYMENTS THE PIP DEDUCTIBLE COPAYMENT WAS APPLIED.

AN ADDING MACHINE TAPE WHICH CORRESPONDS WITH THE PAYMENTS LISTED SHOULD BE ATTACHED TO EACH PAGE. IF THERE IS MORE THAN ONE PAGE OF PAYMENTS SUBMITTED WITH THE REQUEST, A SEPARATE ADDING MACHINE TAPE SHOULD BE ATTACHED SUMMARIZING THE TOTAL OF PAYMENTS ON ALL OF THE PAGES.

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APPENDIX B

AMORTIZATION FORMULA

The Fund shall evaluate the cost effectiveness of modifications to a residence and shall establish an amortization schedule based on information submitted to the Fund by the insurer. The insurer shall file with the Fund the information in categories (a) through (d) below. This information shall be accompanied by the documentation which supports the information in those categories. The factors which shall be considered by the Fund include:

(a) Cost of modifications;

(b) Annual cost of home care, including but not limited to, nursing care, therapy, transportation for medical treatment and medical supplies;

(c) Life expectancy of the injured person;

(d) Annual cost of other residential care alternatives;

(e) Monthly amount amortized; and

(f) Term of amortization in months.

1. The formula which the Fund shall evaluate to determine the cost effectiveness of requested home modifications is as follows:

$$(a + (b \times c)) < (d \times c)$$

The Fund shall only approve modifications where the above formula applies.

2. The formula to determine the amount to be amortized monthly is as follows:

$$(d - b)/12 = e$$

3. The formula to determine the term of the amortization schedule is as follows:

$$a/e = f$$

The following examples demonstrate how the formulas shall be applied:

	Example One	Example Two	Example Three
Cost of Modifications	100,000	100,000	100,000
Annual Cost of Home Care	60,000	6,000	60,000
Life Expectancy of Injured Party	30	10	20
Annual Cost of Other Residential Care Alternatives	84,000	120,000	60,000
Cost Effective Formula			
Cost for Home Care	1,900,000	160,000	1,300,000
Cost for Alternative Care	2,520,000	1,200,000	1,200,000
Is Home Modification Cost Effective?	Yes	Yes	No
Amortization Schedule			
Amount Amortized Monthly	$2,000	$9,500	
Term of Amortization	50 months	11 months	

APPENDIX B
ITEM 1

UNSATISFIED CLAIM AND JUDGMENT FUND

INSTRUCTION SHEET

UCJF FILE NUMBER:_____

_____ Enter appearance for _____

_____

_____ OBTAIN PROOF OF SERVICE ON ALL NAMED DEFENDANTS.

_____ Proceed with immediate discovery. Serve SPECIAL UCJF ELIGIBILITY INTERROGATORIES.

_____ Schedule depositions and/or IME if indicated.

_____ Obtain conformed copy of cancellation notice.

_____ Move to dismiss improper defendants:

_____ Commissioner of Insurance
_____ Director of Motor Vehicles
_____ UCJF

_____ PIP not payable: _____ LATE NOTICE
_____ OUT OF STATE VEHICLE
_____ COMMERCIAL VEHICLE
_____ OTHER

_____ Claimant ineligible, not a resident of New Jersey.

_____ Determine if carrier notified Taxi Commission of cancellation of policy

_____ NOTICE OF INTENTION not sufficiently complete to qualify as a timely filing.

_____ File CIB. _____ Obtain Police Report _____ Obtain Medical Reports

_____ Obtain signed statement of uninsured.

_____ Obtain settlement agreement. _____ Contract witness(es)

_____ Contact claimant's employer for possible health insurance coverage and Temporary Disability Benefits.

_____ Rule out vehicle ownership in household.

_____ Obtain the names, dates of birth and driver's license numbers of all household residents.

_____ Other: _____

_____

APPENDIX B
ITEM 2

THIS FORM IS A FORMAT AND NOT TO BE USED IN SUBMITTING REPORTS TO THE FUND

60 DAY REPORT

UCJ # _____ DATE _____

CLAIMANT: SS# _____ AGE _____

CLAIMANT'S ATTORNEY:

ELIGIBILITY OF CLAIMANT:

UNINSURED:

ASSIGNED ATTORNEY:

ASSIGNED ATTORNEY'S ACTIVITY:

DATE OF ACCIDENT: PLACE OF ACCIDENT:

ACCIDENT DESCRIPTION:

LIABILITY:

WITNESSES:

POLICE INVOLVEMENT:

INJURIES:

EXPENSES:

ADJUSTER'S RECOMMENDATION:

WORK TO BE DONE:

COMPANY/CARRIER _____

ADJUSTER _____

CLAIM # _____

PHONE # _____

APPENDIX B

ITEM 3

THIS FORM IS A FORMAT AND NOT TO BE USED IN SUBMITTING REPORTS TO THE FUND

6 MONTH SUMMARY REPORT

UCJ # _____ DATE _____

SS# _____ AGE _____

CLAIMANT(S):

CLAIMANT'(S) ATTORNEY:

UNINSURED:

ATTORNEY ASSIGNED:

COMPANY ASSIGNED: CLAIM # _____
D/A: TIME: PLACE OF ACCIDENT:

SUIT: COURT: COUNTY:

ELIGIBILITY OF CLAIMANT(S):

DESCRIPTION OF ACCIDENT:

LIABILITY:

WITNESSES DESCRIPTION:

POLICE DESCRIPTION:

DESCRIPTION OF INJURIES:

UP TO DATE LIST OF MEDICAL EXPENSES:

CARRIER'S RECOMMENDATION:

ASSIGNED ATTORNEY'S RECOMMENDATION:

WORK TO BE DONE:

ADJUSTER _____

PHONE # _____

New Rule, R.1994 d.597, effective December 5, 1994.
See: 26 N.J.R. 2190(a), 26 N.J.R. 4772(a).

SUBCHAPTER 29. MEDICAL FEE SCHEDULES: AUTOMOBILE INSURANCE PERSONAL INJURY PROTECTION AND MOTOR BUS MEDICAL EXPENSE INSURANCE COVERAGE

Source and Effective Date

R.1991 d.96, effective January 15, 1991.
See: 22 N.J.R. 3809(a), 23 N.J.R. 536(a).

Subchapter Historical Note

Subchapter 29, Medical Fee Schedules: Automobile Insurance Personal Injury Protection Coverage, was filed as emergency new rule R.1990 d.624, effective November 26, 1990, with an operative date of January 1, 1991, and an expiration date of January 25, 1991. See: 22 N.J.R. 3809(a). Subchapter 29 was readopted as R.1991 d.96, with changes effective February 19, 1991. See: Source and Effective Date.

11:3-29.1 Purpose and Scope

(a) This subchapter implements the provisions of N.J.S.A. 39:6A-4.6 to establish medical fee schedules on a regional basis for the reimbursement of health care providers providing services or equipment for medical expenses benefits for which payment is required to be made by automobile insurers under PIP coverage and by motor bus insurers under medical expense benefits coverage.

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

(c) These fee schedules do not apply to the following:

1. Other coverages contained in an automobile or motor bus insurance policy such as coverage for bodily injury liability;

2. Any other kind of insurance including health insurance, even when the health insurer may be required pursuant to its health insurance contract to pay benefits to, or on behalf of, a person who sustained bodily injury as a result of an accident while occupying, entering into, alighting from or using an automobile or motor bus, or as a pedestrian, caused by an automobile or motor bus or an object propelled by or from an automobile or motor bus; and

3. Medical services or equipment provided outside of the geographic boundaries of New Jersey except as set forth in N.J.A.C. 11:3-29.4(d)2.

Amended by R.1993 d.25, effective January 4, 1993.
See: 24 N.J.R. 3605(a), 25 N.J.R. 140(a).
Added motor bus insurers under medical expense benefits coverage.

11:3-29.2 Definitions

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

"Basic Life Support" ("BLS") means volunteer ambulance services, whose personnel are not required to be Emergency Medical Technicians, and municipal and proprietary ambulance services whose personnel are required to be Emergency Medical Technicians.

"CPT-4" means Physicians Current Procedural Terminology, 4th Edition, coding system and the description of medical service provided.

"Eligible charge" means the provider's usual, customary and reasonable charge or the upper limit on the fee schedule, whichever is lower.

"Global charge" means the sum of the technical and professional components.

"HCPCS" means the Federal Health Care Financing Administration's (HCFA's) Common Procedure Code System.

"Health insurance" means a contract or agreement whereby an insurer is obligated to pay or allow a benefit of pecuniary value with respect to the bodily injury, disablement, sickness, death by accident or accidental means of a human being, or because of any expense relating thereto, or because of any expense incurred in prevention of sickness, and includes every risk pertaining to any of the enumerated risks. As used in this subchapter, health insurance includes workers' compensation coverage but does not include any PIP coverage.

"Health insurer" includes any insurer issuing a policy of health insurance as defined in this subchapter.

"Motor bus" means motor bus as defined in N.J.S.A. 17:28–1.5.

"Motor bus insurer" includes any insurer issuing a policy of insurance on a motor bus the owner, registered owner, or operator of which is required to maintain medical expense benefits coverage pursuant to N.J.S.A. 17:28–1.6.

"PIP coverage" means personal injury protection coverage described in N.J.S.A. 39:6A–4a and N.J.S.A. 39:6A–10 as amended.

"PIP insurer" includes any insurer issuing a policy of automobile insurance on any vehicle that contains PIP coverage.

"Provider" includes all persons who furnish services or equipment for medical expense benefits for which payment is required to be made under PIP coverage in automobile insurance policies or medical expense benefits coverage pursuant to N.J.S.A. 17:28–1.6 including, but not limited to, medical doctors, osteopathic physicians, medical laboratories, chiropractors, physical therapists, dentists, nurses, home health aides, home health agencies, live-in attendants, speech therapists, occupational therapists, ambulance service providers, medical equipment suppliers, acute care hospitals, trauma centers, rehabilitation facilities, other specialized hospitals, residential alcohol treatment facilities and nursing homes.

Amended by R.1992 d.170, effective April 6, 1992.
See: 23 N.J.R. 3203(a), 24 N.J.R. 1347(a).
Definition for eligible charge added.
Amended by R.1993 d.25, effective January 4, 1993.
See: 24 N.J.R. 3605(a), 25 N.J.R. 140(a).
Definitions for motor bus, motor bus insurer added.
Amended by R.1993 d.395, effective August 2, 1993.
See: 25 N.J.R. 229(b), 25 N.J.R. 3466(b).
Amended by R.1994 d.564, effective November 21, 1994 (operative January 1, 1995).
See: 25 N.J.R. 4706(a), 26 N.J.R. 4616(b).

11:3–29.3 Regions

(a) Region I, as used in this subchapter, consists of the following counties in New Jersey: Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester and Salem.

(b) Region II, as used in this subchapter, consists of the following counties in New Jersey: Hunterdon, Mercer, Middlesex, Monmouth, Ocean, Somerset, Sussex and Warren.

(c) Region III, as used in this subchapter, consists of the following counties in New Jersey: Bergen, Essex, Hudson, Morris, Passaic and Union.

11:3–29.4 Application of Medical Fee Schedules

(a) Every policy of automobile insurance and motor bus insurance issued in this State shall provide that the automobile insurer's limit of liability for medically necessary expenses payable under PIP coverage, and the motor bus insurer's limit of liability for medically necessary expenses payable under medical expense benefits coverage, is the fee set forth in this subchapter. Nothing in this subchapter shall, however, compel the PIP insurer or a motor bus insurer to pay more for any service or equipment than the provider's usual, customary and reasonable fee, even if such fee is well below the automobile insurer's or motor bus insurer's limit of liability as set forth in the fee schedules. N.J.A.C. 11:3–29.6 shall not apply to inpatient services provided by acute care hospitals, trauma centers, rehabilitation facilities, other specialized hospitals, residential alcohol treatment facilities and nursing homes, reimbursement of which shall be limited to the provider's usual, customary and reasonable fees. Insurers will not be required to pay for services or equipment which are not medically necessary.

(b) The region used to determine the proper fee set forth in the schedules shall be determined by the region in which the services were rendered or the equipment was provided or, in the case of elective services or equipment provided to New Jersey residents outside the State, by the region in which the insured resides.

(c) The fees set forth in the schedule for durable medical equipment are retail prices which may include purchase prices for both new and used equipment, and/or monthly rentals.

1. The insurer's limit of liability for monthly rental of durable medical equipment described in the schedule is 10 percent of the amount of the purchase price.

2. The insurer's total limit of liability for the rental of a single item of durable medical equipment set forth in the schedule is 15 times the monthly rental fee.

(d) The insurer's limit of liability for any medical expense benefit for service or equipment provided outside the State of New Jersey shall be as follows:

1. When the service or equipment is provided by reason of emergency or medical necessity, the reasonable and necessary costs shall not exceed fees that are usual, customary and reasonable for that provider in the geographic location where the service or equipment is provided.

2. When the service or equipment is provided by reason of the election by the insured to receive treatment outside the State of New Jersey, the reasonable and necessary costs shall not exceed fees set forth in the fee schedules for the geographic region in which the insured resides.

(e) The insurer's limit of liability for any medical expense benefit for any service or equipment not set forth in the fee schedules shall be a reasonable amount considering the fee schedule for similar services or equipment in the region where the service or equipment was provided or, in the case of elective services or equipment provided outside the State, the region in which the insured resides. Where the fee schedule does not contain a reference to similar services or equipment as set forth in the preceding sentence, the insurer's limit of liability for any medical expense benefit for any service or equipment not set forth in the fee schedules shall not exceed the usual, customary and reasonable fee.

(f) The following shall apply to multiple treatment procedures:

1. When multiple procedures are performed on the same patient by the same provider at the same time or during the same visit, it is virtually never appropriate for the fee to be the sum of the fees for each procedure. The principle procedure at a single session shall be paid at 100 percent of the eligible charge, the second procedure at no more than 50 percent of the upper limit on the fee schedule for that particular procedure, and if performed, any additional procedures at no more than 25 percent of the upper limits on the fee schedule for those particular procedures. If the total amount resulting from application of the multiple procedures reduction formula is in excess of the total amount of the billing, the billing may be submitted and paid without change assuming it is not in excess of usual, customary and reasonable charges for the services provided. If the total amount is less than the total amount of the billing, then the total amount of the billing must be reduced accordingly. When appropriate, providers may apply this multiple procedures reduction formula in the process of preparing their billings, clearly indicating that this has been done.

2. If two or more providers in different specialties perform procedures or if one provider performs multiple procedures on different body parts or regions, each individual provider, or each individual body region or body part procedure may be reimbursed separately. For purposes of such billing, the body shall be divided into: head (including skull and brain); face; neck; chest; abdomen; back; and pelvic regions. In addition, the extremities shall be subdivided into right and left: upper arm, elbow, forearm, wrist and hand; and thigh, knee, lower leg, ankle and foot. This reference to specific body parts or regions is included as a guideline to be used in billings for operative and surgical procedures. It is not intended to apply to nor should it be used in connection with billings submitted for nonsurgical or physiotherapy type services provided during the same visit except as a means of describing the treatment rendered.

3. Nothing in this subchapter shall be construed to prevent PIP insurers or motor bus insurers from paying only reasonable and appropriate fees when multiple procedures are performed at the same time or multiple services provided during the same visit.

(g) Artificially separating or partitioning what is inherently one total procedure into subparts which are integral to the whole for the purpose of increasing medical fees is prohibited. Such practice is commonly referred to as "unbundling" or "fragmented" billing. For surgery and many other procedures, it is established practice to include follow-up care and visits as part of the basic procedure charge. Such charges shall not be subject to additional billings. The existence of a CPT–4 code, per se, does not imply the right to receive separate compensation for the procedure/subprocedure so described. If a procedure is judged to be part of the major or principal procedure, only the charges for the principal procedure are eligible.

(h) The insurer's limit of liability for medically necessary assisting surgeon expenses shall be 20 percent of the primary physician's allowable fee determined pursuant to the fee schedule and rules.

(i) The insurer's limit of liability for the professional component of allowable global charges for radiology services shall be 40 percent of the global charge.

Amended by R.1992 d.170, effective April 6, 1992.
See: 23 N.J.R. 3203(a), 24 N.J.R. 1347(a).
Billing for multiple procedures clarified in (f).
Amended by R.1993 d.25, effective January 4, 1993.
See: 24 N.J.R. 3605(a), 25 N.J.R. 140(a).
Motor bus insurers added.
Amended by R.1993 d.395, effective August 2, 1993.
See: 25 N.J.R. 229(b), 25 N.J.R. 3466(b).
Amended by R.1994 d.564, effective November 21, 1994 (operative January 1, 1995).
See: 25 N.J.R. 4706(a), 26 N.J.R. 4616(b).
Administrative Correction to (a).
See: 26 N.J.R. 5041(a).

Case Notes

Examination fees were not reasonable despite being consistent with prevailing rates. Thermographic Diagnostics, Inc. v. Allstate Ins. Co., 125 N.J. 491, 593 A.2d 768 (1991).

Agency-promulgated schedule of fees was pertinent to reasonableness of fees charged. Thermographic Diagnostics, Inc. v. Allstate Ins. Co., 125 N.J. 491, 593 A.2d 768 (1991).

11:3–29.5 Balance billing prohibited

No health care provider may demand or request any payment from any person in excess of those permitted by the medical fee schedules, nor shall any person be liable to any health care provider for any amount of money which results from the charging of fees in excess of those permitted by the medical fee schedules.

11:3–29.6 Medical Fee Schedules

(a) The following is the Medical Fee Schedule for physicians' services:

STATE OF NEW JERSEY
PERSONAL AUTO INJURY FEE SCHEDULE—PHYSICIANS' SERVICES

CPT–4 Code	Description of Services	Region 1	Region 2	Region 3
10060	I&D ABSCESS, SIMPLE OR SINGLE	$91	$86	$81
10061	I&D ABSCESS, COMPLICATED OR MULTIPLE	275	269	269
10120	INCIS & REMOVAL OF FOREIGN BODY, SIMPLE	99	91	86
10121	INCIS & REMOVAL, MULTIPLE OR COMPLICATED	301	301	301
10140	I&D OF HEMATOMA, SIMPLE	80	75	84
10141	I&D OF HEMATOMA, COMPLICATED	583	583	583
10160	PUNCTURE ASPIRATION OF ABSCESS	92	102	112
11000	DEBRIDEMENT OF SKIN; UP TO 10%	37	37	37
11040	DEBRIDEMENT; SKIN, PARTIAL THICKNESS	52	43	48
11041	DEBRIDEMENT; SKIN, FULL THICKNESS	93	107	113
11042	DEBRIDEMENT; SKIN, SUBCUTANEOUS TISS	188	162	140
11043	DEBRIDEMENT; SKIN, SUB–Q TISS, MUSCLE	454	454	486
11044	DEBRIDEMENT; SKIN, SUB–Q, MUSCLE, BONE	648	648	648
11730	NAIL AVULSION, SIMP, PARTIAL OR COM	61	61	50
11750	EX NAIL/MATRIX, PART/ COMP, PERMANENT	346	372	377
11765	WEDGE EXC OF SKIN NAIL FOLD	146	146	146
12001	SIMPLE REPAIR, SCALP ETC; TO 2.5 CM	107	124	120
12002	SIMPLE REPAIR, SCALP ETC; 2.6–7.5 C	162	162	162
12004	SIMPLE REPAIR, SCALP ETC; 7.6–12.5 C	233	233	233
12011	SIMP REPAIR, FACE ETC; TO 2.5 CM	131	152	147
12013	SIMP REPAIR, FACE ETC; 2.6–5.0 CM	190	190	189
12031	INTER REPAIR, SCALP ETC; TO 2.5 CM	207	207	207
12032	INTER REPAIR, SCALP ETC; 2.6–7.5 C	277	277	277
12041	INTER REPAIR, NECK, ETC; TO 2.5 CM	218	218	218
12042	INTER REPAIR, NECK ETC; 2.6–7.5 CM	286	286	286
12051	INTER REPAIR, FACE ETC; TO 2.5 CM	438	394	482
12052	INTER REPAIR, FACE ETC; 2.6–5.0 CM	540	540	594
13101	COMPLEX REPAIR, TRUNK; 2.6–7.5 CM	491	491	491
13120	COMPX REPAIR, SCALP ETC; 1.1–2.5 CM	405	405	405
13121	COMPX REPAIR, SCALP ETC; 2.6–7.5 CM	637	637	637
13131	COMPX REPAIR, CHEEKS ETC; 1.1–2.5 CM	547	547	567
13132	COMPX REPAIR, CHEEKS ETC; 2.6–7.5 CM	846	846	809
13150	COMPX REPAIR, NOSE ETC; TO 1.0 CM	438	438	438
13151	COMPX REPAIR, NOSE ETC; 1.1–2.5 CM	639	639	648
13152	COMPX REPAIR, NOSE ETC; 2.6–7.5 CM	1040	1040	1040
13300	COMPLICATED REP; OVR 7.5 CM ANY AREA	1431	1431	1431
14000	ADJ TISS TRANSFER, TRUNK; TO 10 SQ CM	513	513	542
14001	ADJACENT TIS TRANS OR REARR, TRUNK	920	920	951
14020	ADJ TISS TRANS, SCALP ETC; TO 10 SQ CM	1096	1096	1096
14040	ADJ TISS TRANS, CHIN ETC; TO 10 SQ CM	1225	1225	1269
14060	ADJ TISS TRANS, NOSE ETC; TO 10 SQ CM	1589	1589	1589
15100	SPLIT GRAFT, TRUNK ETC; TO 100 SQ CM	1261	1261	1261
16000	INITIAL TREATMENT, FIRST DEGREE BURN	75	75	75
16020	DRESS/DEBRIDE SM BURN; NO ANESTHESIA	87	87	93
16025	DRESS/DEBRIDE MED BURN; NO ANES	124	124	124
17250	CHEMICAL CAUT OF GRANULATION TISS	57	57	54
19000	PUNCTURE ASPIRATION CYST PAST	107	118	113
20220	BIOPSY, BONE, TROCAR OR NEEDLE; SUPER	317	317	313
20550	INJ, TEND SHEATH, LIGAMENT, TRIGGER P	96	96	91
20600	ARTHROCENTESIS, ASP &/OR INJ; SM JNT	81	86	86
20605	ARTHROCEN, ASP &/OR INJ; INTER JOINT	86	92	96
20610	ARTHROCEN, ASP &/OR INJ; MAJOR JOINT	102	113	113
20670	REMOVAL OF IMPLANT; SUPERFICIAL	187	187	187
20680	REMOVAL OF IMPLANT; DEEP	806	809	864
21320	MANIP TREATMNT, NOSE FX; STABILIZATION	719	719	719
21455	CLOSE MANIP TREAT, FIXATN, MANDIB FX	2398	2398	2398
21800	RIB, FRACTURE(S), CLOSED (SIMPLE)	86	86	86
23350	INJECTION PROC, SHOULDER ARTHROGRAPH	132	132	132
23420	REPAIR SHOULDER CUFF AVULSION, CHRON	3294	3294	3294
23500	TREAT CLOSED CLAVICLE FX; NO MANIPUL	237	237	237
23505	TREAT CLOSED CLAVICLE FX; W/MANIPUL	468	468	468
23600	TREATMENT CLOSED HUMERAL FX; NO MANIP	430	430	430
23605	TREATMENT CLOSED HUMERAL FX; W/MANIP	617	617	617
23650	TREAT CLOSED SHOULDER DISLOC, W/MANIP	354	354	339

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23655	TREATMENT OF CLOSED SHOULDER DISLOC	450	450	450
24640	RADIAL HEAD SUBLUXATION, CHILD, MANI	194	194	194
24650	CLOSED RADIAL HEAD/NECK FX; NO MANIP	505	505	505
25111	EXCISION GANGLION, WRIST; PRIMARY	1000	1000	1101
25500	CLOSED RADIAL SHAFT FX; NO MANIP	452	452	452
25505	CLOSED RADIAL SHAFT FX; W/MANIP	559	559	559
25560	CLSD RADIAL & ULNAR SHAFT FX; NO MANIP	728	728	728
25565	CLSD RADIAL & ULNAR SHAFT FX; W/MANIP	843	843	843
25600	C/S DIS RAD FX/EPIPHYS SEP; NO MANIP	498	486	513
25605	C/S DIS RAD FX/EPIPHYS SEP; W/MANIP	657	594	702
25610	CLSD COMPLEX, DIST RAD FX/EPIPHY SEP	719	719	719
25635	TREATMENT CLOSED CARPAL BONE FX W M	481	481	481
26600	TX CLOSED METACARP FX, SNG; W/O MANIP	323	323	346
26605	TX CLOSED METACARP FX, SNG; W/MANIP	428	428	432
26720	TX CLOS PHALAN SHAFT FX; W/O MANIP	224	224	210
26725	TX CLOS PHALANG SHAFT FX, W/MANIP	344	344	344
26750	TX CLOS DIST PHALANG FX; W/O MANIP	156	156	156
26755	TX CLOS DIST PHALANG FX; W/MANIP	194	194	194
26770	TX CLOS INTERPHAL JNT DIS; W/O ANESTH	154	154	154
27125	PARTIAL HIP REPLACEMENT, PROSTHESIS	4429	4429	4429
27130	ARTHROPLAS; TOT HIP REPLAC W/WO GRF	4932	4618	5185
27236	OPEN TX CLOSE/OPEN FEM FX, INT FIX	3422	3422	3422
27244	OPEN TX CHANTERIC FEM FX; W INT FIX	2971	2971	2971
27370	INJECT PROCEDURE KNEE ARTHROGRAPHY	139	139	165
27447	ARTHRO, KNEE, TOT, CNDYL&PLAT; MED & LAT	5022	5022	5402
27506	OPEN TX CLOS/OPEN FEM SHAFT FX	3955	3955	3955
27520	PATELLA, FRACTURE, CLOSED (SIMPLE), WITHOUT RED	444	444	444
27750	TX CLOSED TIBIAL SHAFT FX; W/O MAN	648	648	648
27752	TIBIA, SHAFT FRACTURE, CLOSED (SIMPLE)	817	817	817
27760	TX CLOSED DISTAL TIBIAL FX; W/O MAN	451	451	451
27762	TX CLOS DIST TIBIAL FX; W/MANIP	544	544	544
27786	TX CLOSED DISTAL FIBULAR FX; W/O MAN	521	521	518
27788	TX CLOSED DISTAL FIBULAR FX; W/MAN	602	602	602
27802	TX CLOS TIB & FIB FX, SHAFT; W/MANIP	1046	1046	1046
27808	TX CLOS BIMALLEOLAR ANKL FX, W/O MAN	648	648	648
27810	TX CLOS BIMALLEOLAR ANKLE FX, W/MAN	803	803	803
27814	OPEN TX CLOS/OPEN BIMALL ANKLE FX	2522	2522	2522
27818	TX CLOS TRIMALL ANKLE FX; W/MANIP	1107	1107	1107
27822	OPEN TX CL/OP TRIMALL ANKLE FX; ONLY	3155	3155	3155
28090	EXC LES TEN, SHEATH, CAP W/SYNOV; FOOT	844	844	844
28124	PART EX, PHALANXO FASCIAL REL	687	687	687
28126	CONDYLECTOMY, PHALANX BASE SNG EA	648	648	648
28153	RESECTION, HEAD OF PHALANX	648	648	648
28160	HEMIPHALANGECTOMY/JOINT EX, SNG, EACH	917	917	917
28455	TRTM. OF CLOSED TARSAL BONE FRACTURE	347	347	366
28470	METATARSAL FX CLSD; W/O MANIP, EA W M	384	384	384
28475	METATARSAL FX CLSD; W/MANIP, EA	390	390	390
28490	PHALANGES FX, CLSD; W/O MANIPULATION	148	148	148
28510	PHAL NT GT TOE FX CLSD W/O MANIP, EA	132	132	132
28515	PHAL NT GT TOE FX CLSD W/MANIP EA	219	219	219
29065	CAST SHOULDER TO HAND (LONG ARM)	216	226	216
29075	CAST ELBOW TO FINGER (SHORT ARM)	188	216	205
29085	CAST HAND & LOWER FOREARM–GAUNTLET	185	185	185
29105	SPLINT LONG ARM (SHOULDER TO HAND)	137	137	137
29125	SPLINT SHORT ARM (FOREARM–HAND(STAT))	114	135	135
29130	SPLINT FINGER; STATIC	91	91	91
29240	STRAPPING; SHOULDER	89	89	89
29260	STRAPPING; ELBOW OR WRIST	69	69	70
29280	STRAPPING; HAND OR FINGER	58	58	62
29345	CAST LONG LEG (THIGH TO TOES)	279	279	279
29365	CAST CYLINDER (THIGH TO ANKLE)	208	208	208
29405	CAST SHORT LEG (BELOW KNEE TO TOES)	243	269	243
29425	CAST SHORT LEG; WALKING/AMBULATORY	280	291	296
29505	SPLINT LONG LEG (THIGH–ANKLE/TOES)	67	67	67
29515	SPLINT SHORT LEG (CALF TO FOOT)	128	124	135
29530	STRAPPING; KNEE	93	93	91
29540	STRAPPING; ANKLE	75	75	75
29550	STRAPPING; TOES	59	59	65
29580	STRAPPING; UNNA BOOT	90	107	102
29700	CAST REM/BIV; GAUNTLET/BOOT/BODY	90	90	90
29705	CAST REM/BIV; FULL ARM/FULL LEG	83	83	86
29870	ARTHROSCPY, KNEE, DIAG, W/WO SYNOV BX	1785	1785	1785
29874	ARTHROSCPY, KNEE, SURG; REMOVE F–BODY	2452	2452	2452
29875	ARTHROSCPY, KNEE, SURG; SYNOVECTMY, LTD	2594	2594	2594
29876	ARTHROSCPY, KNEE, SURG; SYNOVECT, COMP	2798	2798	2798
29877	ARTHROSCPY, KNEE, SURG; CHONDROPLASTY	2640	2640	2640
29880	ARTHRO, KNEE SRG, W/ MENISECTOMY	2998	2998	2998
29881	ARTHROSCOPY, W/ MENISCTMY MED OR LAT	2627	2700	3106
29882	ARTHROSCOP, W/MENSCUS REP MED OR LAT	3189	3189	3189

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29888	ARTHRO, AID ANT CRUC LGMNT, RP/AG/RC	4567	4567	4567
30200	INJECTION TURBINATE(S), THERAPEUTIC	76	76	75
30300	REMOVAL FOR BODY, INTRANSAL; OFFICE	96	96	96
30420	RHINOPLASTY; INCL MAJOR SEPTAL REP	4041	4041	4213
30520	SEPTOPLASTY W/WO CARTILAGE IMPLANT	2479	2479	2700
30901	CONTROL NASAL HEMORRHAGE, ANT SMP; U	104	107	102
30903	CONTROL NASAL HEMORRHAGE, ANT, COMP; U	159	143	162
30905	CONTROL NASAL HEMORRHAGE POST; INIT	405	405	405
31000	LAVAGE CANNULATION; MAXIL SINUS, UNI	113	113	124
31201	ETHMOIDECTOMY; INTRANASAL, TOTAL	2714	2714	2714
31250	NASAL ENDOSCOPY, DIAGNOSTIC	226	226	226
31500	INTUBATION, ENDOTRACHEAL EMERGENCY	275	275	269
31505	LARYNGOSCOPY INDIRECT; DIAGNOSTIC	121	121	129
31515	LARYNGOSCOPY, DIRECT; FOR ASPIRATION	346	346	346
31525	LARYNGOSCOPY, DIR; DIAG, EXCEPT NEWBORN	421	421	421
31575	LARYNGOSCOPY, FLEX FIBERSCOPIC; DIAG	351	377	351
31600	TRACHEOSTOMY, PLANNED	1075	1075	1075
31622	BRONCHOSCOPY, DIAG; W/WO CELL WASHNG	737	702	778
31645	BRONCHOSCOPY; W/ ASP TRACH TREE INIT	756	756	756
32000	THORACENTESIS, INITIAL/SUBSEQUENT	305	249	291
32020	TUBE THORACOSTOMY W/WO WATER SEAL	806	853	804
32405	BX LUNG/MEDASTINUM; PERCUTAN NDLE	408	408	408
32480	LOBECTOMY, TOTAL OR SEGMENTAL	5660	5660	5660
33210	INS TEMP CARD ELECT/PACEMAKER CATH	831	831	831
33212	INSERT/REPLC PULSE GENERATOR/AICD	1262	1262	1262
35301	THROMBOENDARDECTOMY; CAROTID, ETC; NCK	4215	4215	4215
35656	BYPASS GFT; FEMORAL–POPLITEAL	3937	3937	3937
36000	INTRO NEEDLE/INTRACATHETER, VEIN; UN	118	103	124
36010	INTRO CATH; SUP/INF VENA CAVA, RT HRT	470	470	446
36200	CATHETER; AORTANA CAVA, RT HRT	462	462	464
36400	VENIPUNCTURE, < 3 YR; FEM JUGULAR/SAGI	50	50	50
36410	VENIPUNCTURE, > 3 YR, DIAG/THER, COMPL	41	41	43
36415	ROUTINE VENIPUNCTURE 4 SPECMEN COLL	10	10	10
36425	VENIPUNCTURE, CUTDOWN; AGE 1 OR OVER	59	59	59
36430	TRANSFUSION, BLOOD/COMPONENTS; INDIR	153	153	162
36488	PLACE CENT VEN CATH; PERCUT; AGE 2 & <	156	156	156
36489	PLACE CENT VENOUS CAT; PERCUT, > 2	324	273	316
36491	PLCMT CENT VEN CATH HYPERAL, > 2 YR	444	442	437
36600	ART PUNCTURE, WITHDRAW BLD FOR DIAG	105	102	107
36620	ART CATH/CANNULAT FOR SAMP; PERCUTAN	216	216	216
36800	INS CANNULA HEMODIALYSIS; VEIN–VEIN	571	571	571
36830	ARTERIOVEN FIST, NONAUTOGENOUS GRAFT	2833	2833	2833
36860	CANNULA DECLOTTING; WO BALLOON CATH	73	73	73
37609	LIGATION/BIOPSY, TEMPORAL ARTERY	584	584	584
37620	INTERRUPT, INFERIOR VENA CAVA BY SUT	2539	2539	2539
43220	ESOPHAGOSC, RIG/FIBEROPT; W/DIR DILAT	918	918	918
43235	ESOPHAGOGASTRODUODENOSCOPY; DIAGNOST	594	541	648
43245	ESOPHAGOGASTRODUODENOSCOPY, DILATION	883	883	883
43246	ESOPHAGOGASTRODUODENOSCOPY, FOR TUBE	1093	1093	1093
43247	ESOPHAGOGASTRODUODENOSCOPY; W/ REM FB	988	988	988
43255	ESOPHAGOGASTRODUOD; FOR HEMORRHAGE	1053	1053	1053
43260	ERCP W/WO BX +/SPEC COLLECTION	1000	939	1026
43450	ESOPHAG, INDIRECT DILATE SOUND, INIT	152	152	152
43451	ESOPHAG, INDIRECT DILATE SOUND, SUBS	162	162	162
43830	GASTROSTOMY, TEMPORARY (SEP.PROC.)	1594	1594	1594
44005	ENTEROLYSIS	2485	2485	2485
44120	ENTERECTOMY, RES SM INTES; W/ANASTOMO	2994	2994	2994
44140	COLECTOMY, PARTIAL; W/ANASTOMOSIS	3102	3102	3284
44143	COLECTOMY, PART; END COLOST/CLS DIST	3461	3461	3461
44145	COLECTOMY, PARTIAL; W/COLOPROCTOSTOMY	3501	3501	3501
44160	COLECTMY W/REM TERM ILEUM & ILEOCOL	3354	3354	3354
45300	PROCTOSIGMOIDOSCOPY; DIAGNOSTIC (SEP)	129	129	124
45330	SIGMOIDOSCOPY, FLEX FIBEROPTIC; DIAGN	269	254	259
45355	COLONOSCOPY W/SIGMOID, TRANSAB/COLOT	354	377	335
45378	COLONOSCOPY, FIBER BEYOND SPLEN FLEX	809	702	783
46040	I & D ISCHIORECTAL/PERIRECTAL ABSCESS	466	466	466
46050	I & D PERIANAL ABSCESS, SUPERFICIAL	155	155	155
46600	ANOSCOPY, DIAGNOSTIC (SEPARATE PROC)	93	114	93
46604	ANOSCOPY, DX W/DILATE, DIRECT, INSTRUM	124	124	124
46700	ANOPLASTY FOR STRICTURE, ADULT	1296	1296	1296
47000	BIOPSY LIVER, NEEDLE, PERCUTANEOUS	396	396	396
47600	CHOLECYSTECTOMY	1991	1991	2433
47605	CHOLECYSTECTOMY W/CHOLANGIOGRAPHY	2183	2106	2296
47610	CHOLECYSTECTOMY W/EXPL COMMON DUCT	2686	2686	2686
49000	EXPLOR LAPAR/CELIOTOMY W/WO BX(S)	2114	2114	2204
49080	PERITONEOCENTESIS, ABD PARACEN; INIT	202	216	247

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49421	INS INTRAPERI CANN/ CATH DRAIN, PERM	1012	1012	1012
50230	NEPHRECTOMY, RAD, W/RGNL LYMPHADEC	3916	3916	3916
50392	INTRO OF INTRACATH-ETER RENAL PELVIS	666	666	666
50394	INJECT PROC FOR PYE-LOGRAPHY (SEPARA)	122	122	122
51600	INJ PROC CYSTOGRA-PHY/VOID URCYSTOG	80	80	80
51700	BLAD IRRIG, SIMP, LA-VAGE &/INSTILLA	70	65	78
51725	SIMPLE CYSTOMETRO-GRAMIC AGNT	166	166	166
51736	SIMPLE UROFLOWME-TRY	86	86	86
51741	ELECTRONIC URO-FLOWMETRY	178	178	178
52000	CYSTOURETHROSCOPY ETHROPX, SIMP	249	249	304
52005	CYSTOURETHROSC, W/URETERAL CATH	543	489	594
52204	CYSTOURETHROSC, W/BIOPSY	512	512	512
52276	CYSTOURETHROSC; DIR VIS INT URTHROT	964	964	964
52281	CYSTOURETHROSC W/DILAT URETH STR	464	432	486
52310	CYSTOURETHROSC; W/REM FB UR/BLAD, SIM	582	582	631
52332	CYSTOURETHROSC; W/ INS INDWELL STENT	866	866	945
52335	CYSTOURETHROSC; W/URETEROSC & PYE-LOSC	934	934	934
52500	TRNSURETH RESECT OF BLADDER NECK	1620	1620	1620
53600	DILAT URET STRICT, W/ SOUND, MALE, IN	77	78	81
53601	DILAT URET STRICT, W/ SOUND, MALE SU	64	64	63
53620	DIL UR STRIC, FILL-IFRM/FOLL, MALE, IN	132	132	132
53621	DIL UR STRIC, FILL-IFRM/FOLL, MALE, SU	124	124	124
53660	DIL FEM UR W/ SUPPOS &/INSTILL, INIT	80	75	70
53661	DIL FEM UR W/ SUPPOS &/INSTILL, SU	69	65	59
53670	CATHETERIZATION; SIMPLE	81	81	91
53675	CATHETERIZATION; COMPLICATED	155	155	155
54235	INJ CORPORA CAVER-NOSA W/PHARM AGNTS	105	105	104
58980	LAPAROSCOPY; SURGI-CAL	1747	1620	1922
59160	CURETTAGE, POSTPAR-TUM	848	848	848
59515	CESAREAN DELIV INC POSTPARTUM CARE	2968	2968	3187
59812	SPONT ABORT, TRIMEST, COMPLETE SURG	773	773	809
59820	TREAT MISS ABORT, COMP SURG, 1ST TRIM	756	809	809
62270	SPINAL PUNCTURE LUMBAR; DIAGNOSTIC	216	216	216
62278	INJ ANESTH SUB; EPI-DURAL/CAUDAL, SIM	388	354	388
62279	INJ ANESTH SUB; EPI-DURAL/CAUDAL, CON	378	378	378
62282	INJ NEUROLYTIC SUB; EPIDURAL/CAUDAL	486	486	486
62284	INJ PROC MYELOGRA-PHY, SPINAL/POST	535	535	589
62289	INJ SUB OT THAN ANES/NEUROLYT; EP/C	420	420	432
63030	LAMINOTOMY; 1 INTRSP, LMBR, UNILAT	4650	4650	4861
64440	INJ, ANESTH AGNT; PA-RAVERTEBR, NRV, SN	92	92	83
64445	INJ, ANESTHETIC AGENT; SCIATIC NERV	113	113	113
64450	INJ, ANESTH AGNT; OT PERIPH NRV/BRAN	84	84	86
64505	INJ, ANESTH AGNT; SPHENOPALATINE GAN	432	432	432
64640	DESTR BY NEUROLYTIC AGNT; OT PER NRV	118	118	118
64721	NEUR &/ TP; MEDIAN NRV @ CARPAL TUN	1380	1620	1620
65205	REM FB, EXTERN EYE; CONJUNC SUPERFI	53	53	53
65210	REM FB, EXTERN EYE; CONJUNC EMBEDDE	80	80	80
65220	REM FB, EXTERN EYE; CORN, W/O SLIT L	103	103	103
65222	REM FB, EXTERN EYE; CORN W/SLIT LM	112	112	113
65420	EX OR TRANSPOS PIER-YGIUM; W/O GRAFT	1296	1296	1296
65435	REM CORNEA EPITHELI-UM W/WO CHEMOCAU	156	156	156
67101	REP RET DETACH, CRYOTHERAPY/DIA-THERM	1646	1646	1646
67105	REP RET DETACH; PHOTCOAG, W/WO DRAIN	1635	1635	1635
67107	REP RETINAL DETACH; SCLERAL BUCKLIN	3713	3713	3713
67145	PROPHY RET DETACH; PHOTOCOAGULATION	1508	1508	1508
67500	RETROBULBAR INJEC-TION; MEDICATION	126	126	126
69420	MYRING W ASPIRE &/EUST TUBE INFLA	167	167	183
69433	MYRNG/TYMPNOSTMY, LOC/TOP ANES, TUBE	306	306	324
69436	MYRING/TYMPANOST-MY, GEN ANES; W TUBE	704	704	704
70110	X-RAY MANDIBLE, COMP, MIN 4 VIEWS	65	65	65
70150	X-RAY FACIAL BONES, COMP, MIN 3 VIEWS	69	69	69
70160	X-RAY NASAL BONES, COMP, MIN 3 VIEWS	60	60	66
70200	X-RAY ORBITS, COMP, MIN 4 VIEWS	72	72	65
70210	X-RAY SINUSES, PAR-TIAL, < 3 VIEWS	82	82	86
70220	X-RAY SINUSES, COMP, MIN 3 VIEWS	95	89	102
70250	X-RAY SKULL, < 4 VIEWS, W/WO STEREO	67	67	67
70260	X-RAY SKULL, COMP, MIN 4 VIEWS, W/WO	81	74	70
70330	X-RAY TMJ, OPEN/ CLOSED, BILATERAL	166	166	166
70336	MRI, TEMPOROMANDIB-ULAR JOINT	875	875	875
70355	ORTHOPANTOGRAMAR JOINT	70	70	70
70360	X-RAY NECK, SOFT TIS-SUE	45	45	43
70450	CAT SCAN, HEAD OR BRAIN, W/O CONTRAST	453	371	432
70460	CAT SCAN, HEAD OR BRAIN W/CONTRAST	517	428	458
70470	CAT SCAN, HEAD/BRN, WO CONT, FOL CONTR	612	535	535
70480	CAT SCAN, ORBIT/SEL-LA/FOSSA, WO CONTR	536	536	539
70481	CAT SCAN, ORBIT/SEL-LA/FOSSA, W/CONTR	505	505	505
70486	CAT SCAN, MAXILLOFA-CIAL, W/O CONTRAST	539	536	539
70487	CAT SCAN, MAXILLOFA-CIAL, W/CONTRAST	357	357	357
70490	CAT SCAN, NECK, SOFT TISSUE, W/O CONTR	539	539	539
70491	CAT SCAN, NECK, SOFT TISSUE, W/CONTR	501	501	481

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70540	MRI, ORBIT, FACE AND NECK	918	918	918
70551	MRI, BRAIN, W/O CONTRAST	891	891	918
70552	MRI, BRAIN, W/CONTRAST	1096	1096	1096
71010	X-RAY CHEST, SINGLE, FRONTAL	43	41	48
71020	X-RAY CHEST, 2 VIEWS, FRONTAL/LATERAL	66	57	65
71021	X-RAY CHEST, 2 VIEWS, APICAL LORDOTIC	70	70	70
71022	X-RAY CHEST, 2 VIEWS, OBLIQUE PROJECT	80	80	80
71030	X-RAY CHEST, COMPLETE, MIN 4 VIEWS	73	77	77
71035	X-RAY CHEST, SPECIAL VIEWS	15	15	15
71100	X-RAY RIBS, UNILAT, 2 VIEWS	80	68	75
71101	X-RAY RIBS, UNI, INCL CHEST, 3 VIEWS	81	89	91
71110	X-RAY RIBS, BILAT, 3 VIEWS	80	80	80
71111	X-RAY RIBS, BI, INCL CHEST, 4+ VIEWS	96	96	96
71120	X-RAY STERNUM, MIN 2 VIEWS	70	70	70
71250	CAT SCAN, CHEST, W/O CONTRAST	513	467	475
71260	CAT SCAN, CHEST, W/CONTRAST	580	527	507
71270	CAT SCAN, CHEST, WO CONT, FOL BY CONTR	476	476	476
72010	X-RAY SPINE, ENTIRE, SURVEY, A/P & LAT	135	129	145
72020	X-RAY SPINE, SINGLE VIEW	53	53	43
72040	X-RAY CERVICAL SPINE, A/P & LATERAL	65	65	65
72050	X-RAY CERV SPINE, A/P LAT, MN 4 VIEWS	107	96	107
72052	X-RAY CERV SPINE, COMP, OBLIQ/FLEX/EX	117	105	113
72070	X-RAY THORACIC SPINE, A/P & LATERAL	73	71	75
72072	X-RAY THOR SPINE, AP LAT, CERVICOTHOR	61	61	61
72074	X-RAY THOR SPINE, COMP, INCL OBLIQUES	83	83	83
72080	X-RAY THORACOLUMBAR SPINE, A/P & LAT	75	72	70
72090	X-RAY SPINE, SCOLIOSIS STUDY	79	79	75
72100	X-RAY LUMBOSACRAL SPINE, A/P & LAT	75	75	75
72110	X-RAY LUMBOSACRAL SPINE, COMPLETE	129	108	118
72114	X-RAY LUMB/SAC SPINE, INCL BENDING	140	133	131
72120	X-RAY LUMB/SAC SPINE, BENDING ONLY	81	81	89
72125	CAT SCAN CERVICAL SPINE WO CONTRAST	453	453	498
72128	CAT SCAN THORACIC SPINE WO CONTRAST	572	572	572
72131	CAT SCAN LUMBOSACRAL SPINE WO CONTR	550	513	577
72141	MRI, CERVICAL SPINE, W/O CONTRAST	918	864	891
72148	MRI, LUMBOSACRAL SPINE, W/O CONTRAST	914	914	918
72170	X-RAY PELVIS, ANTERO-POSTERIOR ONLY	66	59	63
72190	X-RAY PELVIS, COMP, 3 OR MORE VIEWS	67	67	67
72192	CAT SCAN PELVIS, W/O CONTRAST	413	413	372
72193	CAT SCAN PELVIS, W/O CONTRAST	432	392	353
72194	CAT SCAN PELVIS, W/O CONT FOL BY CONT	550	550	550
72196	MRI, PELVIS	938	938	938
72200	X-RAY SACROILIAC JOINTS, < 3 VIEWS	77	77	77
72202	X-RAY SACROILIAC JOINTS, 3 OR MORE	93	93	93
72220	X-RAY SACRUM & COCCYX, MIN 2 VIEWS	73	73	75
73000	X-RAY CLAVICLE, COMPLETE	61	60	65
73010	X-RAY SCAPULA, COMPLETE	62	62	62
73020	X-RAY SHOULDER, 1 VIEW	62	62	65
73030	X-RAY SHOULDER, COMPLETE, MIN 2 VIEWS	70	70	70
73050	RADIOL EXAM, ACROMIOCLAVICULAR, BILAT	81	81	81
73060	RADIOLOGIC EXAMS, HUMERUS, 2+ VIEWS	73	66	66
73070	X-RAY ELBOW, A/P & LATERAL	65	59	65
73080	X-RAY ELBOW, COMPLETE, MIN 3 VIEWS	67	65	70
73090	X-RAY FOREARM, A/P & LATERAL VIEWS	63	59	59
73100	X-RAY WRIST, A/P & LATERAL VIEWS	62	62	59
73110	X-RAY WRIST, COMPLETE, MIN 3 VIEWS	70	65	70
73120	X-RAY HAND, 2 VIEWS	59	54	59
73130	X-RAY HAND, MINIMUM 3 VIEWS	65	65	65
73140	X-RAY FINGER(S), MINIMUM 2 VIEWS	56	51	59
73220	MRI UPPER EXTREMITY, NOT JOINT	929	929	929
73221	MRI UPPER EXTREMITY JOINT	902	902	902
73500	X-RAY HIP, UNIL, 1 VIEW	63	63	65
73510	X-RAY HIP, UNIL, COMP, MIN 2 VIEWS	81	70	75
73520	X-RAY HIPS, BIL, MIN 2 VIEWS EA SIDE	96	100	102
73540	X-RAY PELVIS & HIPS, INFNT/CHILD, MIN 2	73	73	73
73550	X-RAY FEMUR, A/P & LATERAL VIEWS	75	70	70
73560	X-RAY KNEE, A/P & LATERAL VIEWS	70	70	70
73562	X-RAY KNEE, A/P & LAT, OBLIQ, MIN 3 VIEWS	75	80	80
73564	X-RAY KNEE, COMPLETE	91	91	91
73590	X-RAY TIBIA, & FIBULA, A/P & LATERAL	65	65	75
73600	X-RAY ANKLE, A/P & LATERAL	57	57	70
73610	X-RAY ANKLE, COMPLETE PROCEDURE	75	65	70
73620	X-RAY FOOT, A/P & LATERAL	54	57	55
73630	X-RAY FOOT, COMPLETE, MIN 3 VIEWS	70	70	70
73650	X-RAY CALCANEUS, MINIMUM 2 VIEWS	59	64	65
73660	X-RAY TOE(S), MINIMUM 2 VIEWS	59	56	57
73700	CAT SCAN LEG, W/O CONTRAST	486	486	486
73720	MRI LOWER EXTREMITY, NOT JOINT	891	908	918
73721	MRI LOWER EXTREMITY JOINT	907	896	891
74000	X-RAY ABDOMEN, SINGLE A/P VIEW	54	53	59
74010	X-RAY ABDOMEN, AP, OBLIQUE, CONE VIEWS	48	44	39
74020	X-RAY ABDOMEN, COMP, DECUB/ERECT	46	54	54

CPT–4 Code	Description of Services	Region 1	Region 2	Region 3
74022	X–RAY ABDOMEN, ACUTE SERIES	61	60	60
74150	CAT SCAN ABDOMEN, W/O CONTRAST	465	423	443
74160	CAT SCAN ABDOMEN, W/ CONTRAST	575	471	513
74170	CAT SCAN ABD WO CONT FOLL BY CONT	624	578	583
74181	MRI, ABDOMEN FOLL BY CONT	958	958	958
74210	X–RAY PHARYNX & /OR CERV ESOPHAGUS	108	108	108
74220	X–RAY ESOPHAGUS ESOPHAGUS	114	112	113
74240	X–RAY UPPER GI, W/O KUB/VIDEO	159	173	178
74241	X–RAY UPPER GI, W/ KUB	182	187	221
74245	X–RAY UPPER GI, W/SM BOWEL, MULT FILM	221	220	259
74246	UPPER GI SERIES/BARIUM, W/O KUB	174	190	209
74247	UPPER GI SERIES, BARIUM, W/KUB	216	223	226
74249	UPPER GI, BARIUM, W/SM BOWEL FOLLOW	284	284	300
74250	X–RAY SMALL BOWEL, INCL MULT FILMS	153	153	162
74270	CONTRAST X–RAY COLON, BARIUM ENEMA	167	166	199
74280	CONTRAST X–RAY COLON, BARIUM, AIR CONT	232	222	229
74290	CHOLECYSTOGRAPHY, ORAL CONTRAST	104	116	127
74400	UROGRAPHY/PYELOGRAPHY, IV, W WO KUB	168	168	173
74405	UROGRAPHY, IV, W/HYPERTENSIVE CONTR	210	210	210
74410	UROGRAPHY, INFUSION, DRIP/BOLUS TECH	188	188	188
74415	UROGRAPHY, INF, W/NEPHROMATOGRAPHY	198	216	226
74420	UROGRAPHY, RETROGRADE, W WO KUB	55	55	55
75754	COR ANGIO, BI, LFT VENT/SUPVALV, S/I	178	178	178
76000	FLUOROSCOPY, UP TO ONE HOUR	67	67	65
76140	CONSULT, X/RAY MADE ELSEWHERE, WRITTEN	54	53	54
76150	XERORADIOGRAPHY	24	23	26
76375	CAT SCANS, OTHER PLANES	243	232	216
76506	ECHOENCEPHALOGRAPHY	101	101	101
76511	OPHTHALMIC ULTRASOUND, A–MODE	216	216	216
76512	OPHTHALMIC ULTRA, CONTACT B–SCAN	298	298	296
76516	OPHTHAL BIOMETRY, ULTRASOUND, A–MODE	188	196	216
76519	OPHTHAL BIOMETRY, W IOL POWER CALC	188	202	216
76536	ECHOGRAM, HEAD/NECK, B–SCAN/REAL TIME	182	182	191
76700	ECHOGRAM, ABDOMEN, W IMAGE DOCUMENT	226	213	221
76705	ECHOGRAM, ABDOMEN, LIMITED	203	168	173
76770	ECHOGRAM, RETROPERITONEAL, COMPLETE	232	221	226
76775	ECHOGRAM, RETROPERITONEAL, LIMITED	198	198	198
76805	ECHOGRAM, PREGNANT UTERUS, COMPLETE	243	216	216
76815	ECHOGRAM, PREGNANT UTERUS, LIMITED	177	146	162
76816	ECHOGRAM, PREG UTERUS, REPEAT/FOLOWUP	132	132	119
76818	FETAL BIOPHYSICAL PROFILE	223	223	216
76830	ECHOGRAM, TRANSVAGINAL	269	269	269
76856	ECHOGRAM, PELVIC, NON–OB, COMPLETE	226	185	194
76857	ECHOGRAM, PELVIC, NON–OB, LTD/FOLLOW	147	164	180
76870	ECHOGRAM, SCROTUM AND CONTENTS	291	291	269
76872	ECHOGRAM, PROSTATE, TRANSRECTAL	311	311	311
76880	ECHOGRAM, EXTREMITY, NON–VASCULAR	246	246	246
78006	THYROID IMAGING W/UPTAKE, SINGLE	233	233	243
78007	THYROID IMAGING W/UPTAKE, MULTIPLE	171	171	171
78215	LIVER & SPLEEN IMAGING, STATIC ONLY	164	164	164
78223	HEPATOBILIARY DUCT IMAGE, INCL GALL	145	145	145
78300	BONE IMAGING, LIMITED AREA	193	193	193
78305	BONE IMAGING, MULTIPLE AREAS	324	319	313
78306	BONE IMAGING, WHOLE SKELETON	296	269	269
78315	BONE SCAN, 3–PHASE TECHNIQUE	269	269	269
78351	BONE DENSITY, DUAL PHOTON ABSORPT	199	199	199
78460	MYOCARDIAL IMAGING, RESTING	258	258	254
78461	MYOCARDIAL IMAGING, EXERCISE	513	568	469
78464	MYOCARDIAL IMAGING, TOMOGRAM, REST	628	628	628
78465	MYOCARDIAL IMAGING, TOMOGR, EXERCISE	697	697	848
78472	CARD BLD POOL, WALL MOTION, REG EJ FR	339	339	339
78481	CARD BLD POOL, 1ST PASS, EJ FRACTION	205	205	205
78580	PULM PERFUSION IMAGING, PARTICULATE	115	115	113
78707	KIDNEY IMAGING, VASC & FUNCT STUDIES	310	310	310
78990	PROVISION OF DIAG RADIONUCLIDES	89	89	107
80002	1–2 CLINICAL CHEM TESTS	35	35	35
80003	3 CLINICAL CHEMISTRY TESTS	25	25	25
80004	4 CLINICAL CHEMISTRY TESTS	24	24	24
80006	6 CLINICAL CHEMISTRY TESTS	51	51	51
80007	7 CLINICAL CHEMISTRY TESTS	26	26	26
80010	10 CLINICAL CHEMISTRY TESTS	29	29	29
80012	12 CLINICAL CHEMISTRY TESTS	37	37	37
80016	13–16 BLOOD/URINE TESTS	46	51	43
80018	17–18 BLOOD/URINE TESTS	41	37	43
80019	19 OR MORE BLOOD/URINE TESTS	37	42	37
80031	DRUG MONITORING, ONE DRUG	80	80	80
80058	HEPATIC FUNCTION PANEL	45	45	45
80059	HEPATITIS PANEL	77	77	77
80062	CARDIAC EVALUATION PANEL	51	51	51
80073	RENAL PANEL	43	43	43

CPT–4 Code	Description of Services	Region 1	Region 2	Region 3
81000	URINALYSIS WITH MICROSCOPY	12	12	13
81002	URINALYSIS W/O MICROSCOPY	12	12	10
81005	URINALYSIS, ANY # OF CONSTITUENTS	11	11	11
81015	MICROSCOPIC EXAM OF URINE	8	8	8
82150	ASSAY OF SERUM AMYLASE	18	18	16
82172	APOLIPOPROTEIN IMMUNOASSAY	18	18	18
82250	ASSAY BLOOD BILIRUBIN	19	19	19
82270	TEST FECES FOR BLOOD DIRECT	12	12	15
82310	ASSAY CALCIUM IN BLOOD, CHEMICAL	16	16	16
82372	ASSAY SERUM CARBAMAZEPINE	57	57	57
82374	ASSAY BLOOD CARBON DIOXIDE	11	11	11
82643	RIA ASSAY FOR DIGOXIN	49	49	49
82660	TEST FOR DRUGS	67	67	67
82947	ASSAY BLOOD FLUID GLUCOSE	12	12	12
82948	STICK ASSAY OF BLOOD GLUCOSE	12	12	12
82950	GLUCOSE TEST	14	14	13
82951	GLUCOSE TOLERANCE TEST (GTT)	42	42	42
82952	GTT–ADDED SAMPLES	45	45	45
82977	ASSAY OF GGT ENZYME	15	15	15
83001	PITUITARY GONADOTROPIN RIA	66	66	66
83002	PITUITARY GONADOTROPINS RIA	59	59	59
83020	ASSAY HEMOGLOBINS RIA	13	13	12
83036	GLYCOSYLATED HEMOGLOBIN TEST	38	38	39
83540	ASSAY SERUM IRON	15	15	15
83545	AUTO–ASSAY SERUM IRON	24	24	24
83550	SERUM IRON BONDING TEST	31	31	31
83555	SERUM IRON BINDING, AUTO–TEST	12	12	12
83705	ASSAY BLOOD LIPID GROUPS	29	29	29
83718	ASSAY BLOOD LIPOPROTEIN, PRECIP	17	18	15
83719	BLOOD LIPOPROTEIN ASSAY, ULTRACENT	33	33	33
83720	BLOOD LIPOPROTEIN ASSAY, FRACT CALC	16	16	16
83725	ASSAY BLOOD LITHIUM-RACT CALC	27	27	26
83735	ASSAY BLOOD MAGNESIUM, CHEMICAL	25	25	25
84045	ASSAY PHENYTOIN	57	57	57
84065	ASSAY PROSTATE PHOSPHATASE, FRACTION	41	41	41
84075	ASSAY ALKALINE PHOSPHOTASE, BLOOD	15	15	15
84132	ASSAY BLOOD POTASSIUM	13	13	12
84144	ASSAY PROGESTERONE	62	62	68
84146	RIA ASSAY FOR PROLACTIN	79	79	80
84165	ASSAY SERUM PROTEINS, ELEC FRAC, QUAN	42	42	42
84180	ASSAY URINE PROTEIN FRAC, QUAN	30	30	30
84231	RADIOIMMUNOASSAY	94	94	94
84233	ASSAY ESTROGEN	43	43	43
84295	ASSAY BLOOD SODIUM	19	19	19
84403	RIA ASSAY BLOOD TESTOSTERONE	95	95	95
84420	ASSAY THEOPHYLLINERONE	54	54	54
84435	ASSAY THYROXINE (T–4)	25	25	25
84436	RIA ASSAY, TRUE THYROXINE	22	24	21
84439	RIA ASSAY, FREE THYROXINE	53	53	50
84443	ASSAY THYROID STIM HORMONE	60	59	66
84450	UV–ASSAY TRANDAMINASE (SGOT)	14	14	14
84460	UV–ASSAY TRANSAMINASE (SGPT)	14	14	14
84478	ASSAY BLOOD TRIGLYCERIDES	18	18	16
84479	ASSAY TRIIODOTHYTONINE (T–3)	16	16	15
84480	RIA ASSAY, TT–3E (T–3)	58	58	64
84520	ASSAY BLOOD, UREA, NITROGEN	12	12	13
84550	ASSAY BLOOD URIC ACID	19	19	19
84702	CHORIONIC GONADOTROPIN TEST	58	58	60
84703	CHORIONIC GONADOTROPIN ASSAY	29	29	30
84999	CLINICAL CHEMISTRY TEST	90	90	90
85005	BASOPHIL BLOOD CELL COUNT	15	15	15
85007	DIFFERENTIAL WBC COUNT, W/MORPH + PLT	12	12	11
85009	DIFFERENTIAL WBC COUNT, BUFFY COAT	9	9	9
85014	HEMATOCRIT COUNT, BUFFY COAT	12	10	12
85018	HEMOGLOBIN, COLORIMETRIC	12	10	10
85021	AUTOMATED HEMOGRAM, R/WBC, HGB, HCT, IN	17	15	16
85022	AUTOMATED HEMOGRAM, MAN DIFF, WBC	19	21	21
85023	AUTOMATED HEMOGRAM, PLAT, AUT + MAN, CBC	31	31	25
85024	AUTOMATED HEMOGRAM, PLT, AUT + AUT PART	27	30	26
85025	AUTO HEMOGRAM, PLATELET, AUT + AUT COMP	18	18	18
85027	AUTOMATED HEMOGRAM, HEM + PLAT COUNT	23	22	23
85029	AUTOMATED HEMOGRAM, RDW + MPV 1–3 IND	4	4	4
85031	MANUAL HEMOGRAM, COMPLETE CBC	21	20	21
85044	RETICULOCYTE COUNT	15	15	15
85060	BLOOD SMEAR INTERPRETATION	37	37	37
85100	BONE MARROW EXAMINATION	269	269	269
85580	BLOOD PLATELET COUNT	15	15	15
85595	ELECTRONIC PLATELET COUNT	14	15	14
85610	PROTHROMBIN TIME	16	15	14
85650	RBC SEDIMENTATION RATE, WINTROBE	16	15	16
85651	RBC SEDIMENTATION RATE, WESTERGREN	15	15	14
85730	THROMBOPLASTIN TIME, PART, PLAS/ WHOLE	23	23	22
86006	ANTIBODY, QUALITATIVE, FIRST	26	26	26
86008	ANTIBODY, QUANT., FIRST	54	54	54

CPT–4 Code	Description of Services	Region 1	Region 2	Region 3
86016	RBC SALINE ANTIBODIES, HP + ANTIHUMAN	18	18	18
86038	ANTINUCLEAR ANTIBODIES, RIA	42	42	42
86060	ANTISTREPTOLYSIN O TITER	32	32	32
86082	BLOOD TYPING, ABO & RHO(D)	23	23	20
86100	BLOOD TYPING, RHO(D) ONLY	6	6	6
86128	COLLECTION, PROCESS & STORAGE BLOOD	432	432	432
86140	C–REACTIVE PROTEIN	25	25	25
86244	ASSAY ALPHA–1 FETROPROTEIN	65	65	65
86255	FLUORESCENT ANTIBODY; SCREEN	78	78	83
86256	FLUORESCENT ANTIBODY; TITER	68	68	68
86280	HEMAGGLUTINATION INHIBITION	30	30	30
86287	HEPATITIS HAA, RIA, OR EIA	32	32	31
86289	HEPATITIS BC ANTIBODY TEST, HBCAB	49	49	49
86291	HEPATITIS BS ANTIBODY TEST, HBSAB	37	37	37
86296	HEPATITIS A ANTIBODY TEST, HAAB	51	51	51
86300	HETEROPHILE ANTIBODY SCREEN	20	20	20
86310	HETEROPHILE ANTIBODIES	35	35	35
86312	HIV ANTIBODY DETECTION	51	51	51
86316	IMMUNOASSAY, TUMOR ANTIGEN	61	61	63
86317	IMMUNOASSAY, INFECTIOUS AGENT	67	74	60
86319	IMMUNOASSAY TECHNIQUE FOR DRUGS	54	54	54
86329	IMMUNODIFFUSION, EACH	67	67	67
86357	LYMPHOCYTES, T & B DISTINCTION	178	178	178
86403	RAPID TEST, INFECTIOUS AGENT	20	20	19
86421	RADIOALLERGOSORBENT TESTS, 5/<	34	34	34
86422	RADIOALLERGOSORBENT TESTS, 6/>	346	346	346
86423	RADIOIMMUNOSORBENT TEST IGE, QUANT	58	58	58
86430	RHEUMATOID FACTOR TEST	18	18	16
86580	TB INTRADERMAL TEST	15	15	15
86585	TB TINE TEST	14	13	15
86592	BLOOD SEROLOGY, QUALITATIVE	15	15	14
86999	IMMUNOLOGY PROCEDURE	82	82	82
87015	SPECIMEN CONCENTRATION	32	32	32
87040	BLOOD CULTURE FOR BACTERIA	51	51	54
87045	STOOL CULTURE FOR BACTERIA	45	45	45
87060	NOSE/THROAT CULTURE, BACTERIA	15	15	16
87070	CULTURE SPECIMEN, BACTERIA	35	32	36
87072	CULTURE OF SPECIMEN BY KIT	20	18	21
87081	BACTERIA CULTURE SCREEN	18	16	19
87082	CULTURE OF SPECIMEN BY KIT, SINGLE	19	19	19
87084	CULTURE OF SPECIMEN BY KIT, COL EST	19	19	19
87085	CULTURE OF SPECIMEN BY KIT, COL CNT	15	15	15
87086	URINE CULTURE, COLONY COUNT	30	26	31
87087	URINE BACTERIA CULTURE, COMMERC KIT	22	22	24
87088	URINE BACTERIA CULTURE, ID + COM KIT	26	26	26
87101	SKIN FUNGUS CULTURE	25	25	25
87102	FUNGUS ISOLATION CULTURE	38	38	38
87106	FUNGUS IDENTIFICATION	26	26	26
87109	MYCOPLASMA CULTURE	74	74	74
87110	CULTURE, CHLAMYDIA	80	80	80
87177	OVA AND PARASITES SMEARS	63	63	63
87184	ANTIBIOTIC SENSITIVITY, EACH, DISC	25	25	22
87186	ANTIBIOTIC SENSITIVITY, MIC	16	16	16
87205	SMEAR, STAIN & INTERPRET, ROUTINE	17	17	17
87210	SMEAR, STAIN & INTERPRET, WET + SIMPLE	16	16	15
87253	VIRUS INOCULATION FOR TEST, ADDL STD	70	70	70
87999	MICROBIOLOGY PROCEDURE	26	26	26
88104	CYTOPATHOLOGY, W/CENTRIF, WO/CRV + VAG	73	73	71
88108	CYTOPATHOLOGY, CONCENTRATION	102	102	102
88150	CYTOPATHOLOGY PAP SMEAR, TECH	19	21	21
88151	CYTOPATHOLOGY INTERPRETATION, PHYS	21	21	21
88155	CYTOPATHOLOGY, PAP SMEAR, W/HORMONAL	25	23	21
88160	CYTOPATHOLOGY, ANY OTHER SOURCE	46	46	46
88161	CYTOPATHOLOGY, PREP, SCRN + INTERPET	9	9	9
88170	FINE NEEDLE ASPIRATION, W/WO PREP	136	136	136
88173	INTERPRETATION OF SMEAR	118	118	118
88300	SURGICAL PATHOLOGY, GROSS	28	28	26
88302	SURGICAL PATHOLOGY, COMP, NORM TISS	48	50	48
88304	SURGICAL PATHOLOGY, COMP, ABNORM TSS	73	80	75
88305	SURGICAL PATHOLOGY, COMP, WO/COMPLEX	124	124	129
88307	SURGICAL PATHOLOGY, COMP, COMPLEX	192	192	194
88309	SURGICAL PATHOLOGY, COMP, COMPLX, DIS	269	269	269
88311	DECALCIFY TISSUE, COMPLX, DIS	21	21	21
88312	SPECIAL STAINS, GROUP 1	65	65	65
88313	SPECIAL STAINS, GROUP 2 + OTHERS	21	21	21
88346	IMMUNOFLUORESCENT STUDY	42	42	42
88399	SURGICAL PATHOLOGY PROCEDURE	43	43	43
90292	HOSPITAL DISCHARGE DAY	81	81	91
90782	INJECTION SUBCU/(IM)T	27	29	26
90801	DIAGNOSTIC INTERVIEW, PSYCH	197	197	237
90843	INDIVIDUAL PSYCHOTHERAPY, 20–30 MIN	78	78	78
90844	INDIVIDUAL PSYCHOTHERAPY, 45–50 MIN	128	129	129
90900	BIOFEEDBACK TRNG BY ELECTROMYOGRAM	108	110	110
90935	HEMODIALYSIS, SINGLE EVAL	1868	1868	1868

CPT–4 Code	Description of Services	Region 1	Region 2	Region 3
92004	EYE EXAM & TREATMENT, NEW PT, COMP	75	75	75
92012	EYE EXAM & TREATMENT, COMP	57	57	59
92014	EYE EXAM & TREATMENT	75	75	75
92020	GONIOSCOPY W/ EVALUATION	59	59	59
92081	VISUAL FIELD EXAM, LIMITED	57	57	57
92082	VISUAL FIELD EXAM, INTERMEDIATE	65	65	65
92083	VISUAL FIELD EXAM, ENTENDED	89	89	89
92100	SERIAL TONOMETRY, 1 OR MORE SESSIONS	42	42	42
92225	OPHTHALMOSCOPY, EXTENDED, INITIAL	126	126	126
92226	OPHTHALMOSCOPY, EXTENDED, SUBSEQUENT	65	65	65
92235	OPHTHALMOSCOPY W/ ANGIOGRAPHY	287	287	287
92250	OPHTHALMOSCOPY W/FUNDUS PHOTOGRAPHY	74	74	74
92551	PURE TONE AUDIOMETRY, AIR ONLY	24	24	24
92552	PURE TONE AUDIOMETRY, AIR & BONE	33	33	33
92553	AUDIOMETRY, AIR & BONE	47	47	47
92557	COMPREHENSIVE AUDIOMETRY	80	80	72
92566	IMPEDANCE HEARING TEST	30	30	32
92567	TYMPANOMETRY	24	22	26
92982	PERCUT TRNSLUMINL CORN ANGIO; 1 VESL	3207	3207	3241
93000	ELECTROCARDIOGRAM, COMPLETE	54	54	59
93010	ELECTROCARDIOGRAM REPORT	38	37	43
93014	REPORT ON TRANSMITTED ECG	40	40	40
93015	CARDIOVASC STRESS TEST, TRAC/INTERP	291	269	296
93018	CARDIOVASC STRESS TEST, INTERP ONLY	182	182	188
93040	RHYTHM ECG WITH REPORT ONLY	47	47	47
93042	RHYTHM ECG, REPORT	27	27	27
93224	24 HR ECG, SCANNER, RECORD/INTERP	322	322	322
93227	24 HR ECG, SCANNER, REV/INTERP ONLY	162	162	162
93307	ECHOCARDIOGRAPHY, REALTIME, COMPLETE	342	308	376
93320	DOPPLER ECHOCARDIOGRAPHY, COMPLETE	257	257	232
93325	DOPPLER COLOR FLOW VELOCITY MAPPING	162	162	162
93501	HEART CATHETERIZATION RIGHT, ONLY	1117	1117	1117
93503	HEART CATH RT; W/ SWAN–GANZ CATH	774	756	809
93545	INJ FOR SELECT CORONARY ANGIOGRAPHY	1242	1242	1242
93547	HRT CATH LFT COR ANG & VENT ANG	1583	1620	1566
93548	HRT CAT LFT COR ANG VENT AORT RT AO	1539	1539	1539
93549	HRT CAT RT & LFT COR ANG VENT ANG	1674	1755	1993
93552	LT HRT CAT COR ANG VEN CIN; VIS BYPS	2183	2183	2183
93553	LT CT COR ANG/VEN CIN; VISL; AORTGPHY	2106	2106	2106
93762	PERIPHERAL THERMOGRAM, INCLUDING ANY SERIES	432	432	432
93870	CAROTID ARTERY IMAGING	397	397	432
93910	LOWER LIMB ARTERY STUDY	257	257	256
93950	NONINVASIVE EXTREMITY VEIN STUDIES	171	171	171
93960	QUANTITATIVE VENOUS FLOW STUDIES	269	269	269
94010	SPIROMETRY	64	57	65
94060	BRONCHOSPASM EVALUATION	127	127	135
94160	VITAL CAPACITY SCREENING	25	25	25
94240	RESIDUAL LUNG CAPACITY	81	81	81
94375	RESPIRATORY FLOW VOLUME LOOP	88	88	84
94700	BLOOD GAS ANALYSIS, REST ONLY	60	60	60
94720	CARBON MONOXIDE DIFFUSING CAPACITY	107	107	107
95020	INTRCUT TSTS, EXTRACTS, 15–20 MIN: <11	76	76	76
95021	INTRCUT TSTS, EXTRCTS, 15–20 MN:11–20	107	107	107
95117	IMMUNOTHERAPY INJECTIONS, PROF SERV	23	23	26
95155	SUPRV/PRV SNG/MLT ANTS, >1 MULT DOSE	133	133	133
95819	EEG, STANDARD/PORTABLE, SAME FACILITY	166	162	162
95860	ELECTROMYOGRAPHY, 1 LIMB	265	265	265
95861	ELECTROMYOGRAPHY, 2 LIMBS	314	314	314
95869	ELECTROMYOGRAPHY, SPECIFIC MUSCLES	179	179	179
95900	MOTOR NERVE CONDUCTION TESTING, EACH NERVE	122	116	122
95904	SENSORY NERVE CONDUCTION TESTING, EACH NERVE	116	110	122
96900	ACTINOTHERAPY (ULTRAVIOLET LIGHT)	21	21	21
96912	PHOTOCHEMOTHERAPY: PSORALENS & PUVA	32	32	32
97010	PHYS MED TRI 1 AREA HOT/COLD PACKS	31	38	34
97012	PHYS MED TRI 1 AREA, TRACTION MECH	35	35	35
97014	PHY MED TR TO ONE AREA; ELEC STIM	27	27	33
97018	PMT TO ONE AREA; PARAFFIN BATH	37	37	37
97022	PMT TO ONE AREA; WHIRLPOOL	30	30	30
97024	PMT TO ONE AREA; DIATHERMY	21	21	21
97110	PHYSIOTHERAPY: THERAPEUTIC EXERCISE	55	60	55
97118	PMT ONE AREA; INIT 30 MIN; ELEC STIM	46	46	46
97124	PMT ONE AREA; INIT 30 MIN; MASSAGE	32	32	34
97128	PHYSIOTHERAPY: ULTRASOUND	33	37	37
97145	PHYS MED TRT TO ONE AREA EA ADD'L	17	17	17
97240	POOL THERAPY/HUBBARD TANK W THERAPEUTIC	37	37	37
97260	MANIPULATION, PERFORMED BY PHYSICIAN	45	45	45
97530	KINETIC ACTIV INCREASE COORD, STRENGTH	65	65	72
97700	VISIT WITH ORTHOT/PROSTH/ADL CHECK, 30 MIN	60	60	56
97720	EXTREMITY TEST/ STRENGTH, DEXTERITY	60	60	60

CPT–4 Code	Description of Services	Region 1	Region 2	Region 3
99000	SPECIMEN HANDLING, DOC TO LAB	11	10	12
99050	AFTER HOURS, ADD TO BASIC SERVICE	54	54	54
99054	SERV SUNDAY/HOLIDAY, ADD TO BASIC	50	54	57
99058	OFFICE EMERGENCY CARE	52	52	52
99172	CRITICAL CARE, FOLLOW-UP, LIMITED	140	140	140
99173	CRITICAL CARE, FOLLOW-UP, INTERMED	220	220	220
99201	OFF OR O/P VST NP; PROB FOCUSED	66	66	69
99202	OFF OR O/P VST NP; EXP PROB FOCUSED	62	62	74
99203	OFF OR O/P VST NP; DETAILED LOW	89	89	84
99204	OFF OR O/P VST NP; COMPREHENS MOD	114	102	122
99205	OFF OR O/P VST NP; COMPREHENS HIGH	144	147	147
99211	OFF OR O/P VST EST PT; MINIMAL	34	30	34
99212	OFF OR O/P VST EST PT; PROBLM FOCUSED	39	42	44
99213	OFF OR O/P VT EST PT; EXP PRB FOCUSED	47	45	49
99214	OFF OR O/P VST EST PT; DETAILED MOD	64	64	64
99215	OFF OR O/P VST EST PT; COMPREH HIGH	99	86	99
99221	INT HOSP CARE PER DAY; COMPREH LOW	148	148	148
99222	INT HOSP CARE PER DAY; COMPREH MOD	143	143	147
99223	INT HOSP CARE PER DAY; COMPREH HIGH	184	166	196
99231	SUB HOSP CARE PER DAY; PROBLM FOCUSED	61	61	64
99232	SUB HOSP CARE PER DAY; EXP PRB FOCUSED	74	64	74
99233	SUB HOSP CARE PER DAY; DETAILED HIGH	96	96	94
99241	OFF CONSULT; PROBLEM FOCUSED	78	78	78
99242	OFF CONSULT; EXP PROBLEM FOCUSED	98	98	102
99243	OFF CONSULT; DETAILED LOW	133	133	137
99244	OFF CONSULT; COMPREHENSIVE MOD	171	171	171
99245	OFF CONSULT; COMPREHENSIVE HIGH	195	195	196
99252	INT IP CONSULT; EXP PROBLEM FOCUSED	126	126	126
99253	INT IP CONSULT; DETAILED LOW	164	164	171
99254	INT IP CONSULT; COMPREHENSIVE MOD	203	182	221
99255	INT IP CONSULT; COMPREHENSIVE HIGH	214	214	221
99261	FU IP CONSULT EST PT; PROBLEM FOCUSED	53	53	53
99262	FU IP CONSULT EST PT; EXP PROB FOCUS	64	64	64
99282	ER VISIT; EXP PROBLEM FOCUSED LOW	74	74	74
99283	ER VISIT; EXP PROBL FOC LOW–MODERATE	101	99	102
99284	ER VISIT; DETAILED MODERATE	160	160	167
99285	ER VISIT; COMPREHENSIVE HIGH	212	212	221
99291	CRITICAL CARE PROLONGED; FIRST HOUR	207	207	207

DOLLAR AMOUNTS ON THE FEE SCHEDULE DEFINE THE AUTOMOBILE INSURER'S UPPER LIMIT OF LIABILITY FOR THE SERVICE PROVIDED. REIMBURSEMENT WILL BE BASED ON WHAT IS USUAL, CUSTOMARY AND REASONABLE WITHIN THE UPPER LIMIT.

(b) The following is the Medical Fee Schedule for dental services:

STATE OF NEW JERSEY
PERSONAL AUTO INJURY FEE SCHEDULE—DENTAL SERVICES

ADA Code	Description of Services	Region 1	Region 2	Region 3
0110	INITIAL ORAL EXAM	$24	$26	$28
0120	PERIODIC ORAL EXAM	18	21	21
0121	RECALL EXAM–ADULT (W/ X RAYS & PROPHY)	68	70	79
0122	RECALL EXAM–CHILD (W/X RAYS, PROPHY, FLUOR)	68	65	72
0123	RECALL EXAM–CHILD W/ X–RAYS, PROPHY, FLUO	54	61	62
0124	RECALL EXAM–ADULT, W/ PROPHY	58	54	61
0130	EMERGENCY ORAL EXAM	27	27	30
0210	FULL MOUTH X–RAY SERIES	55	55	61
0220	X–RAY, PERIAPICAL, FIRST FILM	8	10	10
0222	X–RAY INTRA–ORAL TWO FILMS	15	15	16
0223	X–RAY INTRA–ORAL THREE FILMS	19	19	22
0224	X–RAY INTRA–ORAL FOUR FILMS	24	27	27
0225	X–RAY INTRA–ORAL FIVE FILMS	29	30	32
0226	X–RAY INTRA–ORAL SIX FILMS	33	32	37
0227	X–RAY INTRA–ORAL SEVEN FILMS	42	40	43
0228	X–RAY INTRA–ORAL EIGHT FILMS	41	43	48
0229	X–RAY INTRA–ORAL NINE FILMS	46	48	48
0230	X–RAY, PERIAPICAL, ADDITIONAL FILM	5	5	6
0240	X–RAY, INTRAORAL OCCLUSAL FILM	18	20	21
0270	X–RAY, BITEWING, SINGLE FILM	10	10	10
0272	BITEWING X–RAYS, TWO FILMS	16	16	17
0273	BITEWING X–RAYS, THREE FILMS	18	20	22
0274	BITEWING X–RAYS, FOUR FILMS	22	21	26
0280	BITEWING X–RAY, ADDITIONAL FILM	5	5	5
0290	X–RAY POST–ANT–LAT–SKLL FCL BN SURV	54	54	54
0321	X–RAY TMJ SINGLE FILM	36	36	36
0330	PANORAMIC X–RAY SERIES	48	51	55
0340	CEPHALOMETRIC FILM	50	53	55
0410	BACTERIOLOGIC CULTURE	22	24	21
0450	HISTOPATHOLOGIC EXAMINATION	63	63	64
0460	PULP VITALITY TESTS	20	21	24
0470	DIAGNOSTIC CASTS	43	46	45
0471	DIAGNOSTIC PHOTOGRAPHS	26	26	25
1110	PROPHYLAXIS, ADULT–INCL. SCALING	42	48	49
1120	PROPHYLAXIS, CHILD–INCL. SCALING	28	31	32
1201	TOPICAL APPL OF FLUORIDE W/ PROPHYLAXIS	40	40	49
1203	TOPICAL APPL OF FLUORIDE	17	18	21
1210	FLUORIDE SOD TOP APPL 4 EXCL PROPH	16	16	19

ADA Code	Description of Services	Region 1	Region 2	Region 3
1211	TOP APPL SOD FLUOR 4 INCL PROPHYL	47	53	53
1220	FLUORIDE STAN TOP APPL 1 EXCL PROPH	17	19	21
1221	TOP APPL STAN FLUOR 1 INCL PROPHYL	43	45	53
1230	TOPICAL APPL OF FLUORIDE	17	19	21
1231	APPLICATION OF FLUORIDE W/ PROPHYLAXIS	43	44	51
1330	ORAL HYGIENE INSTRUCTION	23	28	25
1340	TRAINING IN PREVENTIVE DENTAL CARE	30	30	28
1350	TOPICAL APPL OF SEALANT, PER QUAD	39	32	37
1351	TOPICAL APPL OF SEALANT, PER TOOTH	24	26	29
1510	SPACE MAINTAINER–FIXED UNILATERAL	168	196	188
1515	SPACE MAINTAINER–FIXED BILATERAL	285	306	257
1550	RECEMENTATION OF SPACE MAINTAINER	33	33	33
2110	AMALGAM, ONE SURFACE, PRIMARY TOOTH	44	43	44
2120	AMALGAM, TWO SURFACES, PRIMARY TOOTH	57	64	64
2130	AMALGAM, THREE SURFACES, PRIMARY TOOTH	76	83	83
2131	AMALGAM, FOUR SURFACES, PRIMARY TOOTH	98	101	98
2140	AMALGAM, ONE SURFACE, PERM. TOOTH	42	45	49
2150	AMALGAM, TWO SURFACES, PERM. TOOTH	57	64	65
2160	AMALGAM, THREE SURFACES, PERM. TOOTH	74	81	86
2161	AMALGAM, 4 + SURFACES, PERMANENT	91	100	107
2170	RESTORATION AMALGAM PIN RETAINED	79	79	79
2190	PIN RETENTION, EXCLSVE OF AMLGM, PER PIN	20	20	24
2210	SILICATE RESTORATION, ONE SURFACE	18	16	20
2310	ACRYLIC OR PLASTIC RESTORATION	30	30	37
2330	COMPOSITE–ONE SURFACE	52	55	60
2331	COMPOSITE–TWO SURFACES	71	77	83
2332	COMPOSITE–THREE SURFACES	92	102	105
2334	PIN RETENTION	22	26	26
2335	COMPOSITE INVOLVING INCISAL ANGLE	114	125	135
2336	LIGHT CURED COMPOSITE–INCISAL	137	151	158
2337	LIGHT CURED COMPOSITE, 1 SUR W/ ACID ETCH	59	64	70
2338	LIGHT CURED COMPOSITE, 2 SUR W/ ACID ETCH	81	86	97
2339	LIGHT CURED COMPOSITE, 3 SUR W/ ACID ETCH	112	118	135
2340	ACID ETCH FOR RESTORATION	28	26	31
2510	GOLD INLAY, 1 SURFACE	294	294	294
2520	GOLD INLAY, 2 SURFACES	423	423	415
2525	2 SURFACE INLAY INCLUDING ONLAY	545	545	551
2530	3–SURFACE GOLD FOIL	507	505	508
2535	3 SURFACE INLAY INCLUDING ONLAY	649	622	643
2540	ONLAY PER TOOTH (IN ADD'N TO INLAY)	481	501	505
2620	INLAY, PORCELAIN/CERAMIC, TWO SURFACES	511	511	511
2630	INLAY, PORCELAIN/CERAMIC, THREE SURFACES	495	495	492
2710	CROWN, PLASTIC (ACRYLIC)	201	206	246
2711	CROWN, PLASTIC (ACRYLIC–PREFABRICATED)	169	186	157
2720	CROWN, RESIN/HIGH NOBLE METAL	591	550	603
2722	CROWN, RESIN/NOBLE METAL	518	518	518
2740	CROWN, PORCELAIN	567	625	605
2750	CROWN, PORCELAIN/HIGH NOBLE	555	605	628
2751	CROWN, PORCELAIN/BASE METAL	540	552	580
2752	CROWN, PORCELAIN/NOBLE METAL	534	560	588
2790	GOLD/HIGH NOBLE METAL	626	608	648
2791	BASE METAL FULL CAST	474	438	482
2792	NOBLE METAL FULL CAST	553	537	589
2810	CROWN, ¾ CAST–GOLD	656	613	672
2830	CROWN, STAINLESS STEEL (PREFABRICATED)	131	143	160
2840	TEMPORARY CROWN–FRACTURED TOOTH	106	91	102
2891	CAST POST & CORE (IN ADD'N TO CROWN)	177	201	207
2892	PREFAB. POST & CORE (IN ADD'N TO CROWN)	158	170	182
2910	RE–CEMENT INLAY	39	41	45
2920	RECEMENT CROWN	37	41	42
2930	PREFAB STAINLESS STEEL CROWN–PRIMARY	124	133	151
2932	PREFABRICATED RESIN CROWN	153	153	153
2940	SEDATIVE FILLING	42	43	46
2950	CROWN BUILDUP, PIN OR POST RETAINED	126	134	148
2951	PIN RETN. PER TOOTH IN ADD'N TO RESTOR.	19	19	24
2952	CAST POST & CORE IN ADD'N TO CROWN	187	212	212
2954	PREFAB POST & CORE IN ADD'N TO CROWN	150	159	175
2960	LABIAL VENEER (LAMINATE) CLAIRSIDE	334	314	328
2962	LABIAL VENEER (PORCELAIN LAMINATE) LAB.	373	425	425
2980	REPAIR TO CROWN	133	123	133
3110	PULP CAP, DIRECT–OVER PULP EXPOSURE	31	30	37
3120	PULP CAP, INDIRECT	25	25	30
3130	RECALCIFICATION TEMPORARY PER TOOTH	40	40	40
3220	VITAL PULPOTOMY	85	82	80
3310	ROOT CANAL THERAPY, ONE CANAL	340	319	327
3315	RT CANAL THER 1 EXC RST–TRADITIONAL	324	351	351
3320	ROOT CANAL THERAPY, TWO CANALS	401	399	407
3325	RT CANAL THER 2 EXC RST–TRADITIONAL	405	432	459
3330	ROOT CANAL THERAPY, THREE CANALS	501	516	521
3335	RT CANAL THER 3 EXC RST–TRADITIONAL	497	541	568
3340	ROOT CANAL THERAPY, FOUR CANALS	539	610	591

ADA Code	Description of Services	Region 1	Region 2	Region 3
3410	APICOECTOMY (AND/ OR) CURETTAGE, SEP SURG PR	288	300	327
3411	APICOECTOMY PER TOOTH, EA ADD'L ROOT	186	186	186
3420	APICOECTOMY W/ ENDODONTIC PROC PER ROOT	314	318	310
3430	RETROGRADE FILLING (PER ROOT)	101	90	92
3440	APICAL CURETTAGE	147	140	132
3450	ROOT AMPUTATION (PER ROOT)	217	195	238
3920	HEMISECTION	177	166	194
3940	RECALCIFICATION	20	20	20
3950	CANAL PREP & PREFITTING PREFORMED POST	56	56	52
3960	BLEACHING DISCOLORED TOOTH	73	72	73
4210	GINGIVECTOMY/GINGIVOPLASTY PER QUAD	259	273	264
4211	GINGIVECTOMY/GINGIVOPLASTY SINGLE SITE	104	106	106
4212	GINGIVECTOMY PER TOOTH LESS THAN 5	71	81	81
4220	GINGIVAL CURETTAGE PER QUADRANT	102	109	104
4240	GINGIVAL FLAP PROCEDURES	309	325	371
4250	MUCOGINGIVAL SURGERY PER QUADRANT	330	330	330
4260	OSSEOUS SURGERY, PER QUADRANT	628	570	597
4261	OSSEOUS GRAFT, SINGLE SITE	271	244	296
4262	OSSEOUS GRAFT, MULTIPLE SITES	380	380	380
4263	OSSEOUS SURGERY, SINGLE SITE	398	398	425
4270	PEDICLE SOFT TISSUE GRAFTS	391	391	391
4271	FREE SOFT TISSUE GRAFTS	365	419	422
4272	APICALLY REPOSITIONING FLAP	334	334	334
4320	PROVISIONAL SPLINT, INTRACORONAL	94	100	97
4321	PROVISIONAL SPLINT, EXTRACORONAL	80	80	98
4330	OCCLUSAL ADJUSTMENT, LIMITED	45	50	52
4331	OCCLUSAL ADJUSTMENT, COMPLETE	199	172	176
4340	PERIO SCALING & ROOT PLANING, FULL MOUTH	112	91	105
4341	PERIO SCALING & ROOT PLANING, PER QUAD	115	108	107
4345	SCALING-GINGIVAL INFLAMMATION	55	55	55
4360	APPLIANCE TO BREAK HARMFUL HABIT	270	270	296
4361	APPLIANCE FOR BRUXISM	266	266	292
4910	PERIODONTAL PROPHYLAXIS	65	69	75
5110	COMPLETE UPPER DENTURE	630	689	739
5120	COMPLETE LOWER DENTURE	633	705	739
5130	IMMEDIATE UPPER DENTURE	694	769	796
5140	IMMEDIATE LOWER DENTURE	685	745	804
5211	PARTIAL DENTURE, UPPER	431	468	506
5212	PARTIAL DENTURE, LOWER	569	555	601
5213	PARTIAL DENTURE, UPPER	872	827	871
5214	LOWER PARTIAL	723	794	830
5215	UPPER PARTIAL DENTURE	780	810	800
5216	PARTIAL DENTURE, LOWER	745	745	781
5217	DENT PART LOWER 2 GOLD CLASPS ACR	718	718	718
5218	PARTIAL DENTURE, LOWER	796	796	847
5230	PARTIAL DENTURE–LOWER	726	726	702
5231	PARTIAL DENTURE–LOWER	676	784	730
5240	DENT PART LWR LGL BAR 2 CLSP CST BS	750	750	750
5241	DENT PART LOWER CHROME LNGL BAR CST	745	757	757
5250	PARTIAL DENTURE–UPPER	702	702	701
5251	PARTIAL DENTURE–UPPER	676	756	703
5261	DENT PART UPPER CHROME PLTL BAR CST	750	757	757
5281	UNILATERAL PARTIAL DENTURE	388	388	388
5310	DENT PART ADDTL CLASP WITH RST EACH	81	81	81
5410	DENTURE ADJUSTMENT	36	35	38
5415	DENT ADJUST COMPL OR PART U OR L	35	35	35
5421	LOWER PARTIAL DENTURE ADJUSTMENT	31	31	31
5510	REPAIR BROKEN COMPLETE DENTURE BASE	81	74	89
5520	REPL. EA. MISS/BROKEN TOOTH COM. DEN.	61	55	68
5610	DENTURE REPAIR	69	80	80
5620	DENTURE REPAIR	83	80	87
5630	DENTURE REPAIR	60	66	74
5640	DENTURE REPAIR	60	64	72
5650	DENTURE REPAIR	75	80	88
5660	DENTURE REPAIR	102	103	123
5670	DENTURE REPAIR	76	76	76
5680	DENTURE REPAIR	84	82	90
5690	DENTURE REPLACE BROKN CLSP EA ADDTL	80	80	80
5725	REBASE U/L DENTURE PART OR COMPLETE	190	190	171
5730	DENTURE RELINING: UPPER COMPLETE	142	142	145
5731	DENTURE RELINING: LOWER COMPLETE	150	150	150
5735	RELINE U/L DENT PART OR COMP OFFICE	162	162	162
5740	DENTURE RELINE PARTIAL UPPER OFFICE	118	118	121
5741	DENTURE RELINE PARTIAL LOWER OFFICE	135	135	135
5750	DENTURE RELINE UPPER COMPLETE LAB	195	199	209
5751	DENTURE RELINE LOWER COMPLETE LAB	205	205	212
5755	RELINE U/L DENT PART OR COMP LAB	198	242	216
5760	DENTURE RELINE UPPER PARTIAL LAB	205	201	214
5761	DENTURE RELINE LOWER PARTIAL LAB	203	203	212
5820	DENTURE, TEMPORARY PARTIAL UPPER	266	270	269
5821	DENT TEMP PART–STAYPLATE LOWER	270	270	270
5850	TISSUE CONDITIONING	78	71	86
5974	ENDOSSEOUS IMPLANT (IN THE BONE)	948	948	948
6210	BRIDGE PONTIC CAST HIGH NOBLE METAL	594	594	606
6212	BRIDGE PONTIC CAST NOBLE METAL	517	517	517
6240	BRIDGE PONTIC PORCELAIN FUSED/HI NOBLE	579	604	629
6241	BRIDGE PONTIC PORCELAIN FUSED/BASE METAL	552	537	581

ADA Code	Description of Services	Region 1	Region 2	Region 3
6242	BRIDGE PONTIC PORCELAIN FUSED/NOBLE	532	563	586
6250	BRIDGE PONTIC RESIN/HIGH NOBLE METAL	579	579	577
6251	BRIDGE PONTIC/PREDOM BASE METAL	438	438	438
6252	BRIDGE PONTIC RESIN WITH NOBLE METAL	533	533	533
6530	GOLD INLAY–THREE SURFACES	552	552	552
6545	BONDED RESIN RETAINER (MARYLAND BRIDGE)	197	224	233
6640	REPAIRS REPL BRKN FCNG WITH ACRYLIC	102	108	102
6710	BRIDGE ABUTMENT CROWN, PLASTIC	224	224	224
6720	BRIDGE ABUTMENT CROWN RESIN/HIGH NOBLE	565	565	574
6721	BRIDGE ABUTMENT CROWN PLASTIC/NON–PREC	486	486	486
6722	BRIDGE ABUTMENT CROWN RESIN/BASE METAL	553	553	553
6750	BRIDGE ABUTMENT CROWN RESIN/NOBLE METAL	588	612	632
6751	BRIDGE ABUTM CROWN PORCELAIN/NOBLE MTL	552	546	583
6752	BRIDGE ABUTM CROWN PORCELAIN/NOBLE MTL	538	562	588
6780	BRIDGE ABUTMENT CROWN ¾ CAST NOBLE MTL	614	614	614
6790	BRIDGE ABUTM CROWN FULL CAST HIGH NOBLE	658	592	681
6792	BRIDGE ABUTM CROWN FULL CAST NOBLE METAL	566	566	589
6930	RECEMENT BRIDGE	53	55	57
6950	PRECISION ATTACHMENT	217	219	215
6960	DOWEL PIN METAL	161	161	151
6970	REPAIRS TO CROWNS	125	125	135
6980	REPAIR TO FIXED BRIDGE	148	159	154
7110	EXTRACTION, SINGLE TOOTH	60	69	69
7111	TOOTH EXTRACT.W/ X–RAY & GENL ANAESTH	114	114	114
7120	SIMPLE EXTRACTION–ADDITIONAL TOOTH	56	64	65
7130	ROOT REMOVAL–EXPOSED ROOTS	78	70	81
7210	SURGICAL EXTRACTION	113	120	132
7220	SURGICAL EXTRACTION–TISSUE IMPACTION	161	176	170
7230	SURGICAL EXTRACTION–PARTIAL IMPACTION	236	234	232
7235	EXTRACTION SURG PARTIAL BONY IMPACT	238	243	216
7240	SURGICAL EXTRACTION–FULL IMPACTION	306	283	293
7241	SURGICAL EXTR–FULL IMPACT.–DIFFICULT	332	322	336
7245	EXTRACTION SURG COMPL BONY IMPACT	324	286	324
7250	SURGICAL REMOVAL, RESIDUAL ROOTS	110	117	124
7270	TOOTH REIMPLANTATION	233	233	233
7280	SURG. EXPOSURE OF TOOTH FOR ORTHO	272	272	296
7281	SURG. EXPOSURE OF TOOTH TO AID ERUPTION	191	207	172
7286	BIOPSY OF ORAL TISSUE, SOFT	124	131	115
7310	ALVEOPLASTY–PER QUAD W/ EXTRACTIONS	137	116	138
7320	ALVEOPLASTY–PER QUAD W/O EXTRACTIONS	189	189	177
7425	EXCISION PERICORONAL GINGIVA	119	119	131
7430	SURGICAL EXCISION	214	211	226
7431	SURGICAL EXCISION	271	271	271
7450	REMOVAL OF CYST	168	151	181
7451	REMOVAL OF CYST	359	359	362
7460	REMOVAL OF CYST	238	238	238
7461	REMOVAL OF CYST	559	559	559
7470	REMOVAL OF EXOSTOSIS	355	355	366
7510	INCISION & DRAINAGE, INTRAORAL ABSCESS	65	70	69
7910	SUTURE OF WOUND	78	78	78
7960	FRENECTOMY	227	222	236
7970	SURG. REPAIR EXCISION OF HYPERPLASTIC	158	150	174
8000	ORTHODONTIC PAYMENT	638	638	638
8001	ORTHODONTIC–FIRST PAYMENT	1657	1657	1657
8002	ORTHODONTIC–FINAL PAYMENT	1791	1791	1791
8010	ORTHODONTIC WORK–UP	183	188	186
8110	TOOTH GUIDANCE APPLIANCE REMOVABLE	308	326	293
8120	TOOTH GUIDANCE APPLIANCE FIXED	478	515	478
8210	REMOVABLE APPLIANCE THERAPY	282	278	317
8220	FIXED APPLIANCE THERAPY	357	357	357
8360	REMOVABLE APPLIANCE THERAPY	247	247	247
8370	FIXED APPLIANCE THERAPY	397	397	397
8460	ORTHO TREATMENT MIXED DENT CL 1 MAL	3354	3354	3354
8470	ORTHO TREATMENT MIXED DENT CL 2 MAL	3597	3462	3516
8560	ORTHO TREATMENT PERM DENT CL 1 MAL	3240	3340	3354
8570	ORTHO TREATMENT PERM DENT CL 2 MAL	3408	3354	3462
8580	ORTHO TREATMENT PERM DENT CL 3 MAL	3380	3380	3570
9110	EMERGENCY PALLIATIVE TREATMENT	39	41	46
9210	LOCAL ANESTHESIA	27	25	30
9220	GENERAL ANESTHESIA	115	99	102
9230	ANALGESIA	25	27	30
9240	INTRAVENOUS SEDATION	92	88	102
9310	CONSULTATION	54	47	53
9430	VISITS OFFICE REG HRS–NO OPER SV	36	31	37
9610	DRUGS THERAPEUTIC INJECTION	35	35	35
9630	DRUGS OTHER AND/OR MEDICAMENTS	18	20	21
9910	APPLICATION OF DESENSITIZING MEDICATION	21	22	22
9930	COMPLICATIONS UNUSUAL CIRCUMSTANCES	41	41	41
9950	OCCLUSION ANALYSIS MOUNTED CASE	75	75	75
9951	OCCLUSAL ADJUSTMENT	29	26	32

DOLLAR AMOUNTS ON THE FEE SCHEDULE DEFINE THE AUTOMOBILE INSURER'S UPPER LIMIT OF LIABILITY FOR THE SERVICE PROVIDED. REIMBURSEMENT WILL BE BASED ON WHAT IS USUAL, CUSTOMARY AND REASONABLE WITHIN THE UPPER LIMIT.

(c) The following is the Medical Fee Schedule for nursing and allied professional health services:

STATE OF NEW JERSEY
PERSONAL AUTO INJURY FEE SCHEDULE

NURSING AND ALLIED PROFESSIONAL HEALTH SERVICES

Service	Fee
PRIVATE NURSING CARE (PER HOUR)	
Registered nurse	40.00
Licensed practical nurse	35.00
Home health aide	15.50
Live-in attendant (per 24–hour shift)	136.00
HOME HEALTH VISITS (PER VISIT)	
Registered nurse	82.00
Licensed practical nurse	58.00
Physical therapist	77.00
Speech therapist	77.00
Occupational therapist	77.00

(d) The following is the Medical Fee Schedule for ambulance services:

STATE OF NEW JERSEY
PERSONAL AUTO INJURY FEE SCHEDULE

AMBULANCE SERVICES

Code	Description	Fee
A0010	Ambulance service basic life support (BLS), base rate, emergency transport, one way	125.00
A0020	Ambulance service (BLS) per mile, transport, one way	5.00
A0070	Ambulance service, oxygen administration and supplies, life sustaining situation	30.00
Z0224	Cardiac monitoring during an ambulance trip	50.00
A0222	Ambulance service transport patient return trip	125.00

(e) The following is the Medical Fee Schedule for durable medical equipment and prosthetic devices:

STATE OF NEW JERSEY
PERSONAL AUTO INJURY FEE SCHEDULE
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES
CODES BEGINNING WITH "A"

HCPCS Code	Description	Fee For New Equipment
A4214	Sterile saline or water, 30 cc vial	$1.37
A4310	Insertion tray without drainage bag and without catheter (accessories only)	5.56
A4311	Insertion tray without drainage bag with indwelling catheter, Foley type, two-way latex with coating (teflon, silicone, silicone elastometer, or hydrophilic, etc.)	10.68
A4312	Insertion tray without drainage bag with indwelling catheter, Foley type, two-way, all silicone	12.49
A4313	Insertion tray without drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation	12.91
A4314	Insertion tray with drainage bag with indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastometer, or hydrophilic, etc.)	16.19
A4315	Insertion tray with drainage bag with indwelling catheter, Foley type, two-way, all silicone	17.27
A4316	Insertion tray with drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation	19.57
A4320	Irrigation tray for bladder irrigation with bulb or piston syringe	5.02
A4322	Irrigation syringe, bulb or piston	2.60
A4323	Sterile saline irrigation solution, 1000 ml	7.19
A4326	Male external catheter specialty type, e.g., inflatable, faceplate, etc., each	11.02
A4327	Female external urinary collection device, metal cup, each	25.38
A4328	Female external urinary collection device; pouch, each	10.17
A4329	External catheter starter set, male/female, includes catheters/urinary collection device, bag/pouch and accessories (tubing, clamps, etc.) 7 day supply	30.36
A4330	Perianal fecal collection pouch with adhesive	6.12
A4338	Indwelling catheter; Foley type, two-way latex with coating (Teflon, silicone, silicone elastometer or hydrophilic, etc.)	8.77
A4340	Indwelling catheter; specialty type, (e.g., Coude, Mushroom, Wing, etc.)	14.25
A4344	Indwelling catheter, Foley type, two-way, all silicone	12.86
A4346	Indwelling catheter, Foley type, three-way, for continuous irrigation	18.74
A4347	Male external catheter with or without adhesive, with or without anti-reflux device; per dozen	16.90
A4351	Intermittent urinary catheter; straight tip	1.72
A4352	Intermittent urinary catheter; Coude (curved) tip	5.36
A4354	Insertion tray with drainage bag but without catheter	8.68
A4355	Irrigation tubing set for continuous bladder irrigation through a three-way indwelling Foley catheter	8.69
A4356	External urethral clamp or compression device (not to be used for catheter clamp)	36.53
A4357	Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube	6.95
A4358	Urinary leg bag; vinyl, with or without tube	6.94
A4359	Urinary suspensory; without leg bag	27.63
A4361	Ostomy faceplate	13.88
A4362	Skin barrier; solid, 4x4 or equivalent; each	4.19
A4363	Skin barrier; liquid (spray, brush, etc.) powder or paste; per oz.	4.05
A4364	Adhesive for ostomy or catheter; liquid (spray, brush, etc.) cement, powder or paste; any composition (e.g., silicone, latex, etc.); per oz.	3.83
A4367	Ostomy belt	6.99
A4397	Irrigation supply; sleeve	4.43
A4398	Irrigation supply, bags	9.43
A4399	Irrigation supply, cone/catheter	11.78
A4400	Ostomy irrigation set	42.60
A4402	Lubricant	1.78
A4404	Ostomy rings	1.31
A4454	Tape, all types, all sizes	2.03
A4455	Adhesive remover or solvent (for tape, cement or other adhesive)	2.41
A4560	Pessary	22.66

HCPCS Code	Description	Fee If New	Fee If Used	Monthly Rental
A4611	Battery, heavy duty; replacement for patient-owned ventilator	140.08	121.48	14.01
A4612	Battery cables; replacement for patient-owned ventilator	39.17	38.51	3.92
A4613	Battery charger; replacement for patient-owned ventilator	131.80	98.08	13.18
A4618	Breathing circuits	7.97	8.78	.80
A4622	Tracheostomy or laryngectomy tube	64.29	—	—
A4623	Tracheostomy, inner cannula (replacement only)	7.93	—	—
A4624	Tracheal suction catheter, any type, each	2.02	—	—
A4625	Tracheostomy care or cleaning starter kit	6.75	—	—
A4626	Tracheostomy cleaning brush, each	3.05	—	—
A4627	Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler	18.38	13.77	1.84
A4630	Replacement batteries. Medically necessary T.E.N.S. owned by patient	8.44	—	—
A4631	Replacement batteries for medically necessary electronic wheelchair owned by patient	78.87	59.15	7.89
A4635	Underarm pad, crutch, replacement, each	6.64	4.96	.66
A4636	Replacement, handgrip, cane, crutch, or walker, each	2.93	2.19	.29
A4637	Replacement, tip, cane, crutch, walker, each	1.88	1.41	.19
A4640	Replacement pad for use with medically necessary alternating pressure pad owned by patient	49.50	37.12	4.95
A5051	Pouch, closed; with barrier attached (1 piece)	2.62	—	—
A5052	Pouch, closed; without barrier attached (1 piece)	1.84	—	—
A5053	Pouch, closed; for use on faceplate	2.88	—	—

HCPCS Code	Description	Fee If New	Fee If Used	Monthly Rental
A5054	Pouch, closed; for use on barrier with flange (2 piece)	2.39	—	—
A5055	Stoma cap	1.69	—	—
A5061	Pouch, drainable; with barrier attached (1 piece)	3.78	—	—
A5062	Pouch, drainable; without barrier attached (1 piece)	3.19	—	—
A5063	Pouch, drainable; for use on barrier with flange (2 piece system)	2.92	—	—
A5064	Pouch, drainable; with faceplate attached; plastic or rubber	7.35	—	—
A5065	Pouch, drainable; for use on faceplate; plastic or rubber	5.37	—	—
A5071	Pouch, urinary; with barrier attached (1 piece)	4.18	—	—
A5072	Pouch, urinary; without barrier attached (1 piece)	4.03	—	—
A5073	Pouch, urinary; for use on barrier with flange (2 piece)	3.65	—	—
A5074	Pouch, urinary; with faceplate attached; plastic or rubber	7.75	—	—
A5075	Pouch, urinary; for use on faceplate; plastic or rubber	3.79	—	—
A5081	Continent device; plug for continent stoma	3.18	—	—
A5082	Continent device; catheter for continent stoma	10.57	—	—
A5093	Ostomy accessory; convex insert	1.68	—	—
A5102	Bedside drainage bottle, rigid or expandable	26.39	—	—
A5105	Urinary suspensory; with leg bag, with or without tube	35.03	—	—
A5112	Urinary leg bag; latex	17.84	—	—
A5113	Leg strap; latex, per set	4.26	—	—
A5114	Leg strap; foam or fabric, per set	9.16	—	—
A5119	Skin barrier; wipes, box per 50	9.73	—	—
A5121	Skin barrier; solid, 6x6 or equivalent, each	5.09	—	—
A5122	Skin barrier; solid, 8x8 or equivalent, each	7.86	—	—
A5123	Skin barrier; with flange (solid, flexible or accordian), any size, each	5.84	—	—
A5126	Adhesive; disc or foam pad	1.21	—	—
A5131	Appliance cleaner, incontinence and ostomy appliances, per 16 oz.	15.77	—	—

CODES BEGINNING WITH "E"

HCPCS Code	Description	Fee For New Eqpt	Fee For Used Eqpt	Monthly Rental
E0100	Cane, includes canes of all materials, adjustable or fixed, with tip	16.37	12.02	1.64
E0105	Cane, quad or three prong, includes canes of all materials, adjustable or fixed, with tips	40.94	29.99	4.09
E0110	Crutches forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tip	60.06	45.04	6.01
E0111	Crutch forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrip	55.60	36.08	5.56
E0112	Crutches underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips	36.96	28.66	3.70
E0113	Crutch underarm, wood, adjustable or fixed, each, with pad, tip and handgrip	24.69	12.67	2.47
E0114	Crutches underarm, aluminum, adjustable or fixed, pair with pads, tips and handgrips	51.53	36.28	5.15
E0116	Crutch underarm, aluminum, adjustable or fixed, each, with pad, tip and handgrip	22.72	14.46	2.27
E0130	Walker, rigid (pickup), adjustable or fixed height	56.05	43.47	5.61
E0135	Walker, folding (pickup), adjustable or fixed height	61.63	45.51	6.16
E0141	Walker, wheeled, without seat	99.41	71.02	9.94
E0142	Rigid walker, wheeled, with seat	231.50	154.39	23.15
E0143	Folding walker, wheeled, without seat	105.43	74.38	10.54
E0145	Walker, wheeled, with seat and crutch attachments	180.70	135.53	18.07
E0146	Walker, wheeled, with seat	116.60	87.45	11.66
E0147	Heavy duty, multiple breaking system, variable wheel resistance walker	255.83	221.57	25.58
E0153	Platform attachment, forearm crutch, each	57.41	49.15	5.74
E0154	Platform attachment, walker, each	64.20	53.32	6.42
E0155	Wheel attachment, rigid pick-up walker attachments	25.64	22.16	2.56
E0156	Seat attachment, walker	21.87	14.06	2.19
E0157	Crutch attachment, walker, each	57.41	44.26	5.74
E0158	Leg extensions for a walker	26.36	21.56	2.64
E0160	Sitz type bath, portable, fits over commode seat	22.17	12.22	2.22
E0161	Sitz type bath, portable, fits over commode seat, with faucet attachments	44.57	17.94	4.21
E0163	Commode chair, stationary, with fixed arms	92.37	63.68	9.24
E0164	Commode chair, mobile, with fixed arms	167.00	86.97	16.70
E0165	Commode chair, stationary with detachable arms	149.90	112.43	14.99
E0166	Commode chair, mobile with detachable arms	220.50	165.38	22.05
E0167	Pail or pan for use with commode chair	10.30	7.93	1.03
E0175	Foot rest, for use with commode chair, each	53.65	35.23	4.74
E0176	Air pressure pad or cushion, nonpositioning	91.90	68.93	9.19
E0177	Water pressure pad or cushion, nonpositioning	91.90	68.93	9.19
E0178	Gel pressure pad or cushion, nonpositioning	101.48	75.38	10.15
E0179	Dry pressure pad or cushion, nonpositioning (e.g., Eggcrate)	55.54	40.26	5.55
E0180	Pressure pad, alternating with pump, light duty	237.90	178.43	23.79
E0181	Pressure pad, alternating with pump, heavy duty	253.90	190.43	25.39
E0182	Pump for alternating pressure pad	288.50	216.38	28.85
E0184	Dry pressure mattress (e.g., Eggcrate)	244.03	74.85	24.40
E0185	Gel pressure pad for mattress	184.83	153.18	18.48
E0186	Air pressure mattress	196.20	147.15	19.62
E0187	Water pressure mattress	198.20	148.65	19.82
E0188	Synthetic sheepskin pad	23.85	14.04	2.39
E0189	Lambswool sheepskin pad, any size	36.30	23.31	3.63
E0191	Heel or elbow protector, each	10.42	6.73	1.04
E0192	Low pressure and positioning pad for wheelchair	317.96	237.79	31.80
E0193	Powered air flotation bed (low air loss therapy)	9798.00	7348.50	979.80
E0194	Air fluidized bed	25429.40	19072.05	2542.94
E0196	Gel pressure mattress	221.50	166.13	22.15
E0197	Air pressure pad for mattress	119.99	102.13	12.00
E0198	Water pressure pad for mattress	126.16	106.76	12.62
E0199	Dry pressure pad for mattress (e.g., Eggcrate)	54.52	53.76	5.45
E0200	Heat lamp, without stand (table model), includes bulb, or infrared element	70.04	54.44	7.00
E0202	Phototherapy (bilirubin) light with photometer	906.50	679.88	90.65
E0205	Heat lamp, with stand, includes bulb, or infrared element	110.92	63.69	11.09
E0210	Electric heat pad, standard	29.16	30.28	2.92
E0215	Electric heat pad, moist	46.64	37.18	4.66
E0220	Hot water bottle	5.51	4.16	.55
E0225	Hydrocollator unit, includes pads	177.95	172.29	16.73
E0230	Ice cap or collar	6.94	5.20	.69
E0235	Paraffin bath unit, portable	161.20	120.90	16.12
E0236	Pump for water circulating pad	316.90	237.68	31.69
E0237	Water circulating heat pad with pump	339.91	216.43	30.82

HCPCS Code	Description	Fee For New Eqpt	Fee For Used Eqpt	Monthly Rental
E0238	Non-electric heat pad moist	29.56	13.99	2.96
E0239	Hydrocollator unit, portable	372.28	303.77	37.23
E0249	Pad for water circulating heat unit	73.69	96.78	7.37
E0250	Hospital bed, fixed height, with any type side rails, with mattress	764.50	573.38	76.45
E0251	Hospital bed, fixed height, with any type side rails, without mattress	624.40	468.30	62.44
E0255	Hospital bed, variable height, Hi-lo, with any type side rails, with mattress	835.60	626.70	83.56
E0256	Hospital bed, variable height, Hi-lo, with any type side rails, without mattress	608.80	456.60	60.88
E0260	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress	1276.60	957.45	127.66
E0261	Hospital bed, semi-electric (head and foot adjustment), any type side rails, without mattress	927.10	695.33	92.71
E0265	Hospital bed, total electric (head, foot and height adjustments), any type side rails, with mattress	1580.40	1185.30	158.04
E0266	Hospital bed, total electric (head, foot and height adjustments), any type side rails, without mattress	1606.30	1204.73	160.63
E0271	Mattress, innerspring	171.14	131.08	17.11
E0272	Mattress, foam rubber	150.75	101.91	15.08
E0275	Bed pan, standard, metal or plastic	14.46	11.30	1.45
E0276	Bed pan, fracture, metal or plastic	13.07	14.14	1.31
E0277	Alternating pressure mattress	44.18	33.14	4.42
E0280	Bed, cradle, any type	30.63	20.82	3.06
E0290	Hospital bed, fixed height, without side rails, with mattress	508.20	381.15	50.82
E0291	Hospital bed, fixed height, without side rails, without mattress	363.50	272.63	36.35
E0292	Hospital bed, variable height, Hi-lo, without side rails, with mattress	595.30	446.47	59.53
E0293	Hospital bed, variable height, Hi-lo, without side rails, without mattress	565.00	423.75	56.50
E0294	Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress	922.60	691.95	92.26
E0295	Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress	917.00	687.75	91.70
E0296	Hospital bed, total electric (head, foot and height adjustments), without side rails, with mattress	1159.50	869.63	115.95
E0297	Hospital bed, total electric (head, foot and height adjustments), without side rails, without mattress	1168.50	876.38	116.85
E0305	Bed side rails, half length	124.20	93.15	12.42
E0310	Bed side rails, full length	145.92	128.13	14.59
E0325	Urinal; male, jug type, any material	6.95	6.92	.70
E0326	Urinal; female, jug type, any material	9.14	7.22	.91
E0430	Portable gaseous oxygen system, includes regulator with flow gauge, humidifier, cannula or mask and tubing	—	—	54.99
E0435	Oxygen system, liquid, portable, includes portable container, supply reservoir, flow humidifier, cannula or masks, tubing and refill adaptor	—	—	54.99
E0450	Volume ventilator; stationary	—	—	767.32
E0452	Intermittent assist device with continuous positive airway pressure device (CPAP)	—	—	159.65
E0453	Therapeutic ventilator; suitable for use 12 hours or less per day	—	—	319.30
E0457	Chest shell (cuirass)	—	—	61.36
E0459	Chest wrap	437.40	328.05	43.74
E0460	Negative pressure ventilator; portable (e.g., Porta-lung)	—	—	672.75
E0462	Rocking bed with or without side rails	2454.70	1841.02	245.47
E0480	Percussor, electric or pneumatic, home model	385.60	289.20	38.56
E0500	IPPB machines with manual valves, external power source, includes cylinder regulator, built-in nebulization	—	—	99.23
E0550	Humidifier, durable for extensive supplemental humidification during IPPB treatment or oxygen delivery (e.g., Cascade)	498.00	373.50	49.80
E0560	Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery (e.g., Cascade Jr.)	132.10	68.74	13.21
E0565	Compressor, air power source for equipment which is not self-contained or cylinder driven	435.30	326.48	43.53
E0570	Nebulizer, with compressor (e.g., DeVilbiss Pulmo–Aid)	—	—	54.62
E0575	Nebulizer, self-contained, ultrasonic	—	—	95.53
E0585	Nebulizer, with compressor and heater	—	—	73.03
E0600	Suction pump, home model, portable	—	—	66.65
E0601	Nasal continuous airway pressure (CPAP) device	—	—	93.23
E0605	Vaporizer, room type	28.60	23.79	2.86
E0606	Postural drainage board	148.00	111.00	14.80
E0607	Home blood glucose monitor	162.28	131.82	16.23
E0608	Apnea monitor	1455.70	1091.78	145.57
E0609	Blood glucose monitor with special features (e.g., voice synthesizers, automatic timers, etc.)	435.50	339.64	43.55
E0610	Pacemaker monitor self-contained (checks battery depletion, includes audible and visible check systems)	323.85	261.66	32.39
E0615	Pacemaker monitor self-contained (checks battery depletion and other pacemaker components, includes digital/visible check systems)	357.53	170.77	35.75
E0621	Sling or seat, patient lift, canvas or nylon	65.71	65.88	6.57
E0627	Seat lift mechanism incorporated into a combination liftchair mechanism	273.68	205.27	27.37
E0628	Separate seat lift mechanism for use with patient-owned furniture; electric	273.68	205.27	27.37
E0629	non-electric	273.68	205.27	27.37
E0630	Patient lift, hydraulic, with seat or sling	796.40	597.30	79.64
E0635	Patient lift, electric with seat or sling	914.30	685.73	91.43
E0650	Pneumatic compressor, non-segmental home model (lymphedema pump)	541.36	406.03	54.14
E0651	Pneumatic compressor, segmental home model (lymphedema pump) without calibrated gradient pressure	992.94	570.07	99.29
E0652	Pneumatic compressor, segmental home model (lymphedema pump) with calibrated gradient pressure	3732.98	3235.90	355.79
E0655	Pneumatic appliance for use with pneumatic compressor, half arm	86.50	93.74	8.65
E0660	Pneumatic appliance for use with pneumatic compressor, full leg	133.96	93.85	13.40
E0665	Pneumatic appliance for use with pneumatic compressor, full arm	94.13	69.80	9.41
E0666	Pneumatic appliance for use with pneumatic compressor, half leg	113.82	96.28	11.38
E0667	Pneumatic appliance for use with segmental pneumatic compressor, leg	299.32	246.51	29.31
E0668	Pneumatic appliance for use with segmental pneumatic compressor, arm	309.67	260.20	29.51
E0690	Ultraviolet cabinet, appropriate for home use	654.39	867.44	65.44
E0720	TENS, two lead, localized stimulation	447.80	—	44.78

HCPCS Code	Description	Fee For New Eqpt	Fee For Used Eqpt	Monthly Rental
E0730	TENS, four lead, larger area/multiple nerve stimulation	453.50	—	45.35
E0731	Form fitting conductive garment for delivery of TENS	249.32	—	24.93
E0744	Neuromuscular stimulator for scoliosis	854.10	640.58	85.41
E0745	Neuromuscular stimulator, electronic shock unit, non-clinical model	780.50	585.38	78.05
E0747	Osteogenesis stimulator (non-invasive)	2813.76	2058.18	281.38
E0749	Osteogenesis stimulator (surgically implanted)	2035.20	1526.40	203.52
E0776	IV pole	94.41	72.32	9.44
E0781	Ambulatory infusion pump with administrative equipment, worn by patient	1877.90	1408.43	187.79
E0782	Infusion pump, implantable	3616.95	2778.64	361.70
E0791	Parenteral infusion pump, stationary, single or multi-channel	1862.80	1397.10	186.28
E0840	Traction frame, attached to headboard, simple cervical traction	50.31	33.21	5.03
E0850	Traction stand, free standing, simple cervical traction	58.36	39.68	5.84
E0860	Traction equipment, overdoor, cervical	28.17	22.15	2.82
E0870	Traction frame, attached to footboard, simple extremity traction (e.g., Buck's)	86.94	52.94	8.69
E0880	Traction stand, free standing, simple extremity traction (e.g., Buck's)	90.73	53.32	9.07
E0890	Traction frame, attached to footboard, simple pelvic traction	93.73	70.17	9.37
E0900	Traction stand, free standing, simple pelvic traction (e.g., Buck's)	93.64	75.79	9.36
E0910	Trapeze bars, A/K/A patient helper, attached to bed, with grab bar	160.90	120.68	16.09
E0920	Fracture frame, attached to bed, includes weights	326.50	244.88	32.65
E0930	Fracture frame, free standing, includes weights	340.60	255.45	34.06
E0935	Passive motion exercise device	—	—	534.50
E0940	Trapeze bar, free standing, complete with grab bar	260.60	195.45	26.06
E0941	Gravity assisted traction device, any type	372.50	279.38	37.25
E0942	Cervical head harness/halter	16.41	12.31	1.64
E0943	Cervical pillow	29.95	26.52	3.00
E0944	Pelvic belt/harness/boot	33.95	23.16	3.40
E0945	Extremity belt/harness	35.83	28.45	3.58
E0946	Fracture, frame, dual with cross bars, attached to bed, (e.g., Balken, 4 poster)	547.20	410.40	54.72
E0947	Fracture frame, attachments for complex pelvic traction	440.23	319.92	44.02
E0948	Fracture frame, attachments for complex cervical traction	429.31	316.24	42.93
E0950	Tray	85.65	60.78	8.57
E0951	Loop heel, each	13.99	11.70	1.40
E0952	Loop toe, each	13.44	11.70	1.34
E0953	Pneumatic tire, each	56.79	42.59	5.68
E0954	Semi-pneumatic caster, each	42.53	31.18	4.25
E0958	Wheelchair attachment to convert any wheelchair to one arm drive	348.70	261.53	34.87
E0959	Amputee adapter (device used to compensate for transfer of weight due to lost limbs to maintain proper balance)	70.88	57.41	7.09
E0961	Brake extension, for wheelchair	13.84	12.56	1.33
E0962	1" cushion, for wheelchair	49.22	36.92	4.92
E0963	2" cushion, for wheelchair	58.25	37.36	5.83
E0964	3" cushion, for wheelchair	60.41	43.54	6.04
E0965	4" cushion, for wheelchair	67.55	57.15	6.76
E0966	Hook on head rest extension	53.59	41.97	5.36
E0967	Wheelchair hand rims with 8 vertical rubber tipped projection, pair	109.37	82.03	10.53
E0968	Commode seat, wheelchair	150.10	112.58	15.01
E0969	Narrowing device, wheelchair	118.04	90.74	11.80
E0970	No. 2 footplates, except for elevating legrest	61.98	60.08	5.80
E0971	Anti-tipping device wheelchairs	52.14	37.95	5.21
E0972	Transfer board, wheelchair	39.09	28.72	3.91
E0973	Adjustable height detachable arms, desk or full length, wheelchair	73.49	78.81	7.31
E0974	"Grade–Aid" (device to prevent rolling back on an incline) for wheelchair	66.90	50.68	5.08
E0975	Reinforced seat upholstery, wheelchair	47.27	33.99	4.73
E0976	Reinforced back, wheelchair, upholstery or other material	56.29	33.99	4.81
E0977	Wedge cushion, wheelchair	57.03	38.55	2.91
E0978	Belt, safety with airplane buckle, wheelchair	37.08	26.99	3.39
E0979	Belt, safety with velcro closure, wheelchair	26.88	22.84	2.69
E0980	Safety vest, wheelchair	25.79	20.10	2.58
E0990	Elevating legrest, each	80.00	71.93	8.00
E0991	Upholstery seat	36.93	28.71	3.20
E0992	Solid seat insert	65.01	44.90	6.50
E0993	Back, upholstery	31.70	34.21	2.98
E0994	Arm rest, each	14.51	10.44	1.39
E0995	Calf rest, each	23.05	20.49	2.31
E0996	Tire, solid, each	26.58	18.11	2.61
E0997	Caster with a fork	58.02	44.29	5.80
E0998	Caster without fork	33.42	25.50	3.34
E0999	Pneumatic tire with wheel	91.15	79.60	9.12
E1000	Tire, pneumatic caster	46.48	24.32	4.65
E1001	Wheel, single	79.93	89.39	7.41
E1031	Rollabout chair, any and all types with castors 5" or greater	472.20	354.15	47.22
E1050	Fully-reclining wheelchair, fixed full length arms, swing-away detachable elevating legrests	1062.10	796.57	106.21
E1060	Fully-reclining wheelchair, detachable arms, desk or full length, swing-away detachable elevating legrests	931.90	698.93	93.19
E1065	Power attachment (to convert any wheelchair to motorized wheelchair; e.g., Solo)	2400.62	1728.00	211.01
E1066	Battery charger	205.17	188.65	20.52
E1069	Deep cycle battery	96.43	68.18	8.59
E1070	Fully-reclining wheelchair, detachable arms, desk or full length, swing-away detachable footrests	976.90	732.68	97.69
E1083	Hemi-wheelchair, fixed full length arms, swing-away detachable elevating legrests	593.60	445.20	59.36
E1084	Hemi-wheelchair, detachable arms, desk or full length arms, swing-away detachable elevating legrests	827.80	620.85	82.78
E1085	Hemi-wheelchair, fixed full length arms, swing-away detachable footrests	587.40	440.55	58.74
E1086	Hemi-wheelchair, detachable arms, desk or full length, swing-away detachable footrests	786.30	589.73	78.63
E1087	High strength lightweight wheelchair, fixed full length arms, swing-away detachable elevating legrests	954.20	715.65	95.42
E1088	High strength lightweight wheelchair, detachable arms desk or full length, swing-away detachable elevating legrests	1272.10	954.07	127.21
E1089	High strength lightweight wheelchair, fixed length arms, swing-away detachable footrest	805.00	603.75	80.50
E1090	High strength lightweight wheelchair, detachable arms desk or full length, swing-away detachable footrests	967.80	725.85	96.78
E1091	Youth wheelchair, any type	854.40	640.80	85.44
E1092	Wide heavy duty wheelchair, detachable arms, desk or full length, swing-away detachable elevating legrests	1120.10	840.07	112.01
E1093	Wide heavy duty wheelchair, detachable arms, desk or full length, swing-away detachable footrests	946.20	709.65	94.62

HCPCS Code	Description	Fee For New Eqpt	Fee For Used Eqpt	Monthly Rental
E1100	Semi-reclining wheelchair, fixed full length arms, swing-away detachable elevating legrests	840.30	630.23	84.03
E1110	Semi-reclining wheelchair, detachable arms (desk or full length), elevating legrests	909.10	681.83	90.91
E1130	Standard wheelchair, fixed full length arms, fixed or swing-away detachable footrests	374.20	280.65	37.42
E1140	Wheelchair, detachable arms, desk or full length, swing-away detachable footrests	577.20	432.90	57.72
E1150	Wheelchair, detachable arms, desk or full length, swing-away detachable elevating legrests	642.70	482.03	64.27
E1160	Wheelchair, fixed full length arms, swing-away detachable elevating legrests	505.50	379.13	50.55
E1170	Amputee wheelchair, fixed full length arms, swing-away detachable elevating legrests	706.60	529.95	70.66
E1171	Amputee wheelchair, fixed full length arms, without footrests or legrests	642.50	481.88	64.25
E1172	Amputee wheelchair, detachable arms (desk or full length) without footrests or legrests	726.30	544.73	72.63
E1180	Amputee wheelchair, detachable arms (desk or full length), swing-away detachable footrests	776.40	582.30	77.64
E1190	Amputee wheelchair, detachable arms (desk or full length), swing-away detachable elevating legrests	897.00	672.75	89.70
E1195	Heavy duty wheelchair, fixed full length arms, swing-away detachable elevating legrests	814.10	610.58	81.41
E1200	Amputee wheelchair, fixed full length arms, swing-away detachable footrests	668.00	501.00	66.80
E1210	Motorized wheelchair w/micro switch fixed full length arms, swing-away detachable elevating legrests	3122.40	2341.80	312.24
E1211	Motorized wheelchair, detachable arms, desk or full length, swing-away detachable elevating legrests	3359.90	2519.93	335.99
E1212	Motorized wheelchair, fixed full length arms, swing-away detachable footrests	2512.30	1884.23	251.23
E1213	Motorized wheelchair, detachable arms, desk or full length, swing-away detachable footrests	2863.30	2147.48	286.33
E1221	Wheelchair with fixed arm, footrests	344.80	258.60	34.48
E1222	Wheelchair with fixed arm, elevating legrests	680.10	510.08	68.01
E1223	Wheelchair with detachable arms, footrests	639.10	479.33	63.91
E1224	Wheelchair with detachable arms, elevating legrests	1054.40	790.80	105.44
E1225	Semi-reclining back for customized wheelchair	302.50	226.88	30.25
E1226	Full-reclining back for customized wheelchair	499.29	328.84	32.54
E1227	Special height arms for wheelchair	229.67	172.25	22.58
E1228	Special back height for wheelchair	167.30	125.48	16.73
E1230	Power-operated vehicle (3 or 4 wheel non-highway), specify brand name & model number	1684.22	1066.31	168.42
E1240	Lightweight wheelchair, detachable arms (desk or full length), swing-away detachable elevating legrests	848.60	636.45	84.86
E1250	Lightweight wheelchair, fixed full length arms, swing-away detachable footrests	573.70	430.28	57.37
E1260	Lightweight wheelchair, detachable arms (desk or full length), swing-away detachable footrests	809.10	606.83	80.91
E1270	Lightweight wheelchair, fixed full length arms, swing-away detachable elevating legrests	631.90	473.93	63.19
E1280	Heavy duty wheelchair, detachable arms (desk or full length), elevating legrests	1010.20	757.65	101.02
E1285	Heavy duty wheelchair, fixed full length arms, swing-away detachable footrests	800.20	600.15	80.02
E1290	Heavy duty wheelchair, detachable arms (desk or full length), swing-away detachable footrests	993.00	744.75	99.30
E1295	Heavy duty wheelchair, fixed full length arms, elevating legrests	950.70	713.03	95.07
E1296	Special wheelchair seat height from floor	293.10	246.86	29.31
E1297	Special wheelchair seat depth, by upholstery	63.84	68.92	6.38
E1298	Special wheelchair seat depth and/or width, by construction	298.89	256.55	29.89
E1310	Whirlpool, non-portable (built-in type)	3390.32	1782.23	193.11
E1372	Immersion external heater for nebulizer	147.81	83.09	14.78
E1375	Nebulizer portable with small compressor, with limited flow	—	—	296.10
E1400	Oxygen concentrator, mfr spec max flow < = rate ≤ 2 liters/min at 85% or greater concentration	—	—	296.10
E1401	Oxygen concentrator, max flow rate 2–3 liters/min	—	—	296.10
E1402	Oxygen concentrator, max flow rate 3–4 liters/min	—	—	296.10
E1403	Oxygen concentrator, max flow rate 4–5 liters/min	—	—	296.10
E1404	Oxygen concentrator, max flow rate >5 liters/min at > = 85% concentration	—	—	296.10

CODES BEGINNING WITH "L"

HCPCS Code	Description	Fee For New Eqpt
L0100	Cervical, craniostenosis, helmet molded to patient model	351.53
L0110	Cervical, craniostenosis, helmet, non-molded	88.13
L0120	Cervical, flexible, non-adjustable (foam collar)	16.38
L0130	Cervical, flexible, thermoplastic collar, molded to patient	143.00
L0140	Cervical, semi-rigid, adjustable (plastic collar)	38.82
L0150	Cervical, semi-rigid, adjustable molded chin cup (plastic collar with mandibular/occipital piece)	72.34
L0160	Cervical, semi-rigid, wire frame occipital/mandibular support	126.09
L0170	Cervical, collar, molded to patient model	378.20
L0172	Cervical, collar, semi-rigid, thermoplastic foam, two-piece	90.40
L0174	Cervical, collar, semi-rigid, thermoplastic foam, two-piece with thoracic extension	156.71
L0180	Cervical, multiple post collar, occipital/mandibular supports, adjustable	228.01
L0190	Cervical, multiple post collar, occipital/mandibular supports, adjustable cervical bars (SOMI, Guilford, Taylor types)	325.67
L0200	Cervical, multiple post collar, occipital/mandibular supports, adjustable cervical bars, and thoracic extension	316.70
L0210	Thoracic, rib belt, custom fitted	26.15
L0220	Thoracic, rib belt, custom fabricated	92.33
L0300	Thoracic-lumbar-sacral-orthoses, (TLSO), flexible dorso-lumbar surgical support, custom fitted	115.80
L0310	TLSO, flexible dorso-lumbar surgical support, custom fabricated	282.69
L0315	TLSO, flexible dorso-lumbar surgical support, elastic type, with rigid posterior panel	172.38
L0317	TLSO, flexible dorso-lumbar surgical support, hyperextension, elastic type, with rigid posterior panel	215.10
L0320	TLSO, anterior-posterior control (Taylor type), with apron front	328.29
L0330	TLSO, anterior-posterior-lateral control (Knight–Taylor type), with apron front	350.22
L0340	TLSO, anterior-posterior-lateral-rotary control (Arnold, Magnuson, Steindler types), with apron front	395.88

HCPCS Code	Description	Fee For New Eqpt
L0350	TLSO, anterior-posterior-lateral-rotary control, flexion compression jacket, custom fitted	576.00
L0360	TLSO, anterior-posterior-lateral-rotary control, flexion compression jacket, molded to patient	1,035.62
L0370	TLSO, anterior-posterior-lateral-rotary control, hyperextension (Jewett, Lennox, Baker, Cash types)	322.39
L0380	TLSO, anterior-posterior-lateral-rotary control, with extensions	406.53
L0390	TLSO, anterior-posterior-lateral control (body jacket), molded to patient model	1,109.97
L0400	TLSO, anterior-posterior-lateral control (body jacket), molded to patient model, with interface material	1,253.02
L0410	TLSO, anterior-posterior-lateral control (body jacket), two-piece construction, molded to patient model	1,048.73
L0420	TLSO, anterior-posterior-lateral control (body jacket), two-piece construction, molded to patient model, with interface material	1,128.02
L0430	TLSO, anterior-posterior-lateral control (body jacket), with interface material, custom fitted	914.86
L0440	TLSO, anterior-posterior-lateral control (body jacket), with overlapping front section, spring steel front, custom fitted	817.28
L0500	Lumbar-sacral-orthoses, (LSO), flexible, (lumbo-sacral surgical support), custom fitted	87.07
L0510	LSO, flexible (lumbo-sacral surgical support), custom fabricated	163.16
L0515	LSO, flexible (lumbo-sacral surgical support), elastic type, with rigid posterior panel	110.30
L0520	LSO, anterior-posterior-lateral control (Knight, Wilcox types), with apron front	323.18
L0530	LSO, anterior-posterior control (Macausland type), with apron front	243.05
L0540	LSO, lumbar flexion, (Williams flexion type)	309.87
L0550	LSO, anterior-posterior-lateral control (body jacket), molded to patient model	989.91
L0560	LSO, anterior-posterior-lateral control (body jacket), molded to patient model, with interface material	1,135.90
L0565	LSO, anterior-posterior-lateral control (body jacket), custom fitted	667.17
L0600	Sacroiliac, flexible (sacroiliac surgical support), custom fitted	58.06
L0610	Sacroiliac, flexible (sacroiliac surgical support), custom fabricated	172.90
L0620	Sacroiliac, semi-rigid, (Goldthwaite, Osgood types), with apron front	360.05
L0700	Cervical-thoracic-lumbar-sacral-orthoses (CTLSO), anterior-posterior-lateral control, molded to patient model (Minerva type)	1,452.84
L0710	CTLSO, anterior-posterior-lateral control, molded to patient model, with interface material, (Minerva type)	1,604.90
L0810	Halo procedure, cervical halo incorporated into jacket vest	1,611.09
L0820	Halo procedure, cervical halo incorporated into plaster body jacket	1,510.92
L0830	Halo procedure, cervical halo incorporated into Milwaukee type orthosis model	1,969.94
L0860	Addition to halo procedures, magnetic resonance image compatible system	774.08
L0900	Torso support, ptosis support, custom fitted	92.81
L0910	Torso support,.ptosis support, custom fabricated	202.24
L0920	Torso support, pendulous abdomen support, custom fitted	125.38
L0930	Torso support, pendulous abdomen support, custom fabricated	236.90
L0940	Torso support, post surgical support, custom fitted	118.26
L0950	Torso support, post surgical support, custom fabricated	229.10
L0960	Torso support, post surgical support, pads for post surgical support	50.08
L0970	TLSO, corset front	84.49
L0972	LSO, corset front	72.12
L0974	TLSO, full corset	110.68
L0976	LSO, full corset	94.41
L0978	Axillary crutch extension	116.92
L0980	Peroneal straps, pair	10.31
L0982	Stocking supporter grips, set of four (4)	9.78
L1000	Cervical-thoracic-lumbar-sacral orthosis (CTLSO) (Milwaukee), inclusive of furnishing initial orthosis, including model	1,445.62
L1010	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) of scoliosis, axilla sling	41.21
L1020	Addition to CTLSO or scoliosis orthosis, kyphosis pad	51.55
L1025	Addition to CTLSO or scoliosis orthosis, kyphosis pad, floating	103.57
L1030	Addition to CTLSO or scoliosis orthosis, lumbar bolster pad	37.53
L1040	Addition to CTLSO or scoliosis, lumbar of lumbar rib pad	45.12
L1050	Addition to CTLSO or scoliosis orthosis, sternal pad	57.21
L1060	Addition to CTLSO or scoliosis orthosis, thoracic pad	73.37
L1070	Addition to CTLSO or scoliosis orthosis, trapeze sling	66.11
L1080	Addition to CTLSO or scoliosis orthosis, outrigger	37.12
L1085	Addition to CTLSO or scoliosis orthosis, outrigger, bilateral with vertical extensions	110.01
L1090	Addition to CTLSO or scoliosis or orthosis, lumbar sling	71.58
L1100	Addition to CTLSO or scoliosis orthosis, ring flange, plastic or leather	113.66
L1110	Addition to CTLSO or scoliosis orthosis, ring flange, plastic or leather, molded to patient model	154.66
L1120	Addition to CTLSO or scoliosis orthosis, cover for upright, each	23.76
L1200	Thoracic-lumbar-sacral-orthosos (TLSO), inclusive of furnishing initial orthosis only	971.24
L1210	Addition to TLSO (low profile), lateral thoracic extension	205.11
L1220	Addition to TLSO (low profile), anterior thoracic extension	207.78
L1230	Addition to TLSO (low profile), Milwaukee type superstructure	476.65
L1240	Addition to TLSO (low profile), lumbar derotation pad	56.37
L1250	Addition to TLSO (low profile), anterior asis pad	54.54
L1260	Addition to TLSO (low profile), anterior thoracic derotation pad	54.54
L1270	Addition to TLSO (low profile), abdominal pad	55.46
L1280	Addition to TLSO (low profile), rib gusset (elastic), each	61.72
L1290	Addition to TLSO (low profile), lateral trochanteric pad	51.23
L1300	Other scoliosis procedure, body jacket molded to patient model	1,307.02
L1310	Other scoliosis procedure, post-operative body jacket	1,298.69
L1500	Thoracic-hip-knee-ankle orthoses (THKAO), mobility frame, (Newington, Parapodium types)	1,138.24
L1510	THKAO, standing frame	747.52
L1520	THKAO, swivel walker	1,443.95
L1600	Hip orthosis (HO), abduction control of hip joints, flexible, freika type with cover	73.52
L1610	HO, abduction control of hip joints, flexible, frejka cover only	35.79
L1620	HO, abduction control of hip joints, flexible, Pavlik harness	103.18
L1630	HO, abduction control of hip joints, semi-flexible (Von Rosen type)	103.02
L1640	HO, abduction control of hip joints, static pelvic band or spreader bar, thigh cuffs	286.38
L1650	HO, abduction control of hip joints, static, adjustable, custom fitted (llfled type)	159.01
L1660	HO, abduction control of hip joints, static, plastic, custom fitted	98.58
L1680	HO, abduction control of hip joints, dynamic, pelvic control, adjustable hip motion control, thigh cuffs (Rancho hip action type)	740.43
L1685	HO, abduction control of hip joints post-operative hip abduction type, custom fabricated	786.30
L1686	HO, abduction control of hip joints post-operative hip abduction type, custom fitted	785.25
L1700	Legg Perthes orthosis, Toronto type	917.50
L1710	Legg Perthes orthosis, Newington type	1,066.91
L1720	Legg Perthes orthosis, trilateral, Tachdijan type	792.45
L1730	Legg Perthes orthosis, Scottish Rite type	687.24
L1750	Legg Perthes orthosis, Legg Perthes sling (Sam Brown type)	157.98
L1755	Legg Perthes orthosis, pattern bottom type	1,097.88
L1800	Knee orthosis, KO, elastic with stays	38.86
L1810	KO, elastic with joints	61.52
L1815	KO, elastic with condylar pads	59.34
L1820	KO, elastic with condylar pads and joints	94.31
L1825	KO, elastic knee cap	34.34
L1830	KO, immobilizer, canvas longitudinal	62.17
L1832	KO, adjustable knee joints, positional orthosis, rigid support, custom fitted	476.27
L1834	KO, without knee joint, rigid, molded to patient model	521.71

HCPCS Code	Description	Fee For New Eqpt
L1840	KO, derotation, medial-lateral, anterior cruciate ligament, custom fabricated to patient model	682.12
L1845	KO, double upright, thigh and calf, with adjustable flexion and extension joint, medial-lateral and rotation control, custom fitted	623.14
L1846	KO, double upright, thigh and calf, with adjustable flexion and extension joint, medial-lateral and rotation control, molded to patient model	737.98
L1850	KO, Swedish type	197.66
L1855	KO, molded plastic, thigh and calf sections, with double upright knee joints, molded to patient model	834.87
L1858	KO, molded plastic, polycentric knee joints, pneumatic knee pads (CTL)	808.65
L1860	KO, modification of supracondylar prosthetic socket, molded to patient model (SK)	752.94
L1870	KO, double upright, thigh and calf lacers, molded to patient model with knee joints	684.44
L1880	KO, double upright, non-molded thigh and calf cuffs/lacers with knee joints	491.55
L1900	Ankle-foot orthosis (AFO), spring wire, dorsiflexion assist, calf band	161.65
L1902	AFO, ankle gauntlet, custom fitted	64.64
L1904	AFO, molded ankle gauntlet, molded to patient model	356.61
L1906	AFO, multiligamentus ankle support	72.94
L1910	AFO, posterior, single bar, clasp attachment to shoe counter	234.93
L1920	AFO, single upright with static or adjustable stop, (Phelps or Perlstein type)	215.09
L1930	AFO, custom fitted, plastic	143.47
L1940	AFO, molded to patient model, plastic	435.59
L1945	AFO, molded to patient model, plastic, rigid anterior tibial section (floor reaction)	671.58
L1950	AFO, spiral, molded to patient model, (IRM type), plastic	546.81
L1960	AFO, posterior, solid ankle, molded to patient model, plastic	494.86
L1970	AFO, plastic molded to patient model, with ankle joint	450.40
L1980	AFO, single upright, free dorsiflexion, solid stirrup, calf band/cuff (single bar "BK" orthosis)	293.83
L1990	AFO, double upright free plantar dorsiflexion, solid stirrup, calf band/cuff (double bar "BK" orthosis)	373.71
L2000	Knee-ankle-foot-orthosis (KAFO), single upright, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar "AK" orthosis)	747.92
L2010	KAFO, single upright, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar "AK" orthosis), without knee joint	676.31
L2020	KAFO, double upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (double bar "AK" orthosis)	743.31
L2030	KAFO, double upright, free ankle, solid stirrup, thigh and calf bands/cuffs (double bar "AK" orthosis), without knee joint	919.05
L2036	KAFO, full plastic, double upright, free knee, molded to patient model	1,399.25
L2037	KAFO, full plastic, single upright, free, molded to patient model	1,236.66
L2038	KAFO, full plastic, without knee joint, multi-axis, molded to patient model (lively orthosis or equal)	1,282.70
L2040	HKAFO, torsion control, bilateral rotation straps, pelvic band/belt	137.71
L2050	HKAFO, torsion control, bilateral torsion cables, hip joint, pelvic band/belt	290.62
L2060	HKAFO, torsion control, bilateral torsion cables, ball bearing hip joint, pelvic band/belt	349.52
L2070	HKAFO, torsion control, unilateral rotation straps, pelvic band/belt	89.24
L2080	HKAFO, torsion control, unilateral, torsion cables, hip joint, pelvic band/belt	282.87
L2090	HKAFO, torsion control, unilateral torsion cables, ball bearing hip joint, pelvic band/belt	270.88
L2102	Ankle-foot-orthosis (AFO), fracture orthosis, tibial fracture cast orthosis, plaster type casting material, molded to patient	280.90
L2104	AFO, fracture orthosis, tibial fracture cast orthosis, synthetic type casting material, molded to patient	300.98
L2106	AFO, fracture orthosis, tibial fracture cast orthosis, thermoplastic type casting material, molded to patient	420.32
L2108	AFO, fracture orthosis, tibial fracture cast orthosis, molded to patient model	765.61
L2112	AFO, fracture orthosis, tibial fracture orthosis, soft custom fitted	334.57
L2114	AFO, fracture orthosis, tibial fracture orthosis, semi-rigid custom fitted	439.58
L2116	AFO, fracture orthosis, tibial fracture orthosis, rigid custom fitted	495.75
L2122	Knee-ankle-foot-orthosis (KAFO), fracture orthosis, femoral fracture cast orthosis, plaster type casting material, molded to patient	656.03
L2124	KAFO, fracture orthosis, femoral fracture cast orthosis, synthetic type casting material, molded to patient	734.37
L2126	KAFO, fracture orthosis, femoral fracture cast orthosis, thermoplastic type casting material, molded to patient	902.15
L2128	KAFO, fracture orthosis, femoral fracture cast orthosis, molded to patient model	1,209.09
L2132	KAFO, fracture orthosis, femoral fracture cast orthosis, soft custom fitted	663.70
L2134	KAFO, fracture orthosis, femoral fracture cast orthosis, semi-rigid custom fitted	739.97
L2136	KAFO, fracture orthosis, femoral fracture cast orthosis, rigid custom fitted	880.56
L2180	Addition to lower extremity fracture orthosis, plastic shoe insert with ankle joints	73.22
L2182	Addition to lower extremity fracture orthosis, drop lock knee joint	62.13
L2184	Addition to lower extremity fracture orthosis, limited motion knee joint	85.93
L2186	Addition to lower extremity fracture orthosis, adjustable motion knee joint, lerman type	125.95
L2188	Addition to lower extremity fracture orthosis, quadrilateral brim	249.24
L2190	Addition to lower extremity fracture orthosis, waist belt	62.86
L2192	Addition to lower extremity fracture orthosis, hip joint, pelvic band, thigh flange, and pelvic belt	272.37
L2200	Addition to lower extremity, limited ankle motion, each joint	42.96
L2210	Addition to lower extremity, dorsiflexion assist, (plantar flexion resist), each joint	53.95
L2220	Addition to lower extremity, dorsiflexion and plantar flexion assist/resist, each joint	71.09
L2230	Addition to lower extremity, split flat caliper stirrups and plate attachment	68.56
L2240	Addition to lower extremity, round caliper and plate attachment	55.90
L2250	Addition to lower extremity, foot plate, molded to patient model, stirrup attachment	253.37
L2260	Addition to lower extremity, reinforced solid stirrup (Scott–Craig type)	164.08
L2265	Addition to lower extremity, long tongue stirrup	74.03
L2270	Addition to lower extremity, varus/valgus correction ("T") strap, padded/lined or malleolus pad	47.36
L2280	Addition to lower extremity, molded inner boot	282.70
L2300	Addition to lower extremity, abduction bar (bilateral hip involvement), jointed, adjustable	222.95
L2310	Addition to lower extremity, abduction bar, straight	80.56
L2320	Addition to lower extremity, non-molded lacer	134.72
L2330	Addition to lower extremity, lacer, molded to patient model	253.59
L2335	Addition to lower extremity, anterior swing band	155.45
L2340	Addition to lower extremity, pre-tibial shell, molded to patient model	351.01
L2350	Addition to lower extremity, prosthetic type "BK" socket, molded to patient model (used for "PTB" "AFO" orthosis)	627.52
L2360	Addition to lower extremity, extended steel shank	46.52
L2370	Addition to lower extremity, patten bottom	222.30
L2375	Addition to lower extremity, torsion control, ankle joint and half solid stirrup	80.97
L2380	Addition to lower extremity, torsion control, straight knee joint, each joint	70.17
L2385	Addition to lower extremity, straight knee joint, heavy duty, each joint	79.30
L2390	Addition to lower extremity, offset knee joint, each joint	70.52
L2395	Addition to lower extremity, offset knee joint, heavy duty, each joint	92.90
L2405	Addition to knee joint, drop lock, each joint	32.97
L2415	Addition to knee joint, cam lock (Swiss, French, Bail types), each joint	122.01
L2425	Addition to knee joint, disc or dial lock for adjustable knee flexion, each joint	146.57

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L2435	Addition to knee joint, polycentric joint, each joint	118.41
L2492	Addition to knee joint, lift loop for drop lock ring	86.12
L2500	Addition to lower extremity, thigh/weight bearing, gluteal/ischial weight bearing, ring	186.08
L2510	Addition to lower extremity, thigh/weight bearing, quadrilateral brim, molded to patient model	473.01
L2520	Addition to lower extremity, thigh/weight bearing, quadrilateral brim, custom fitted	309.95
L2525	Addition to lower extremity, thigh/weight bearing, ischial containment/narrow M–L brim, molded to patient model	872.97
L2526	Addition to lower extremity, thigh/weight bearing, ischial containment/ narrow M–L brim, custom fitted	458.59
L2530	Addition to lower extremity, thigh/weight bearing, lacer, non-molded	192.13
L2540	Addition to lower extremity, thigh/weight bearing, lacer, molded to patient model	262.44
L2550	Addition to lower extremity, thigh/weight bearing, high roll cuff	173.11
L2570	Addition to lower extremity, pelvic control, hip joint, clevis type, two position hip joint, each	352.15
L2580	Addition to lower extremity, pelvic control, pelvic sling	323.83
L2600	Addition to lower extremity, pelvic control, hip joint, clevis type or thrust bearing, free, each	158.91
L2610	Addition to lower extremity, pelvic control, hip joint, clevis type or thrust bearing, lock, each	152.57
L2620	Addition to lower extremity, pelvic control, hip joint, heavy duty, each	219.37
L2622	Addition to lower extremity, pelvic control, hip joint, adjustable flexion, each	210.12
L2624	Addition to lower extremity, pelvic control, hip joint, adjustable flexion, extension, abduction control, each	197.31
L2627	Addition to lower extremity, pelvic control, plastic, molded to patient model, reciprocating hip joint and cables	1,158.68
L2628	Addition to lower extremity, pelvic control, metal frame, reciprocating hip joint and cables	1,169.36
L2630	Addition to lower extremity, pelvic control, band and belt unilateral	152.53
L2640	Addition to lower extremity, pelvic control, band and belt bilateral	280.63
L2650	Addition to lower extremity, pelvic and thoracic control, gluteal pad, each	87.36
L2660	Addition to lower extremity, thoracic control, thoracic band	105.59
L2670	Addition to lower extremity, thoracic control, paraspinal uprights	125.23
L2680	Addition to lower extremity, thoracic control, lateral support uprights	112.35
L2750	Addition to lower extremity orthosis, plating chrome or nickel, per bar	54.80
L2760	Addition to lower extremity orthosis, extension, per extension, per bar (for lineal adjustment for growth)	43.74
L2770	Addition to lower extremity orthosis, stainless steel, per bar or joint	43.46
L2780	Addition to lower extremity orthosis, non-corrosive finish, per bar	39.55
L2785	Addition to lower extremity orthosis, drop lock retainer, each	21.95
L2795	Addition to lower extremity orthosis, knee control, full knee cap	66.92
L2800	Addition to lower extremity orthosis, knee control, knee cap, medial or lateral pull	80.00
L2810	Addition to lower extremity orthosis, knee control, condylar pad	57.66
L2820	Addition to lower extremity orthosis, soft interface for molded plastic, below knee section	55.81
L2830	Addition to lower extremity orthosis, soft interface for molded plastic, above knee section	58.53
L2840	Addition to lower extremity orthosis, tibial length sock, fracture or equal, each	35.78
L2850	Addition to lower extremity orthosis, femoral length sock, fracture or equal each	43.65
L3215	Orthopedic footwear, ladies shoes, oxford	79.32
L3219	Orthopedic footwear, mens shoes, oxford	82.12
L3650	Shoulder orthosis (SO), figure of "8" design abduction restrainer	42.46
L3660	SO, figure of "8" design abduction restrainer, canvas and webbing	76.06
L3670	SO, acromio/clavicular (canvas and webbing type)	87.42
L3700	Elbow orthosis (EO), elastic with stays	48.44
L3710	EO, elastic with metal joints	79.85
L3720	EO, double upright with forearm/arm cuffs, free motion	510.77
L3730	EO, double upright with forearm/arm cuffs, extension/flexion assist	544.70
L3740	EO, double upright with forearm/arm cuffs, adjustable position lock with active control	652.96
L3800	Wrist-hand-finger-orthosis (WHFO) short opponens, no attachments	112.58
L3805	WHFO, long opponens, no attachment	265.19
L3810	WHFO, addition to short and long opponens, thumb abduction "C" bar	38.30
L3815	WHFO, addition to short and long opponens, second M.P. abduction assist	37.53
L3820	WHFO, addition to short and long opponens, I.P. extension assist with M.P. extension stop	74.42
L3825	WHFO, addition to short and long opponens, M.P. extension stop	38.39
L3830	WHFO, addition to short and long opponens, M.P. extension assist	56.63
L3835	WHFO, addition to short and long opponens, M.P. spring extension assist	60.95
L3840	WHFO, addition to short and long opponens, spring swivel thumb	41.41
L3845	WHFO, addition to short and long opponens, thumb I.P. extension assist, with M.P. stop	47.75
L3850	WHFO, addition to short and long opponens, action wrist with dorsiflexion assist	99.93
L3855	WHFO, addition to short and long opponens, adjustable M.P. flexion control	70.27
L3860	WHFO, addition to short and long opponens, adjustable M.P. flexion control and I.P.	97.11
L3900	WHFO, dynamic flexor hinge; reciprocal wrist extension/flexion, finger flexion/extension, wrist or finger driven	984.26
L3901	WHFO, dynamic flexor hinge; reciprocal wrist extension/flexion, finger flexion/extension, cable driven	1,156.39
L3902	WHFO, external powered, compressed gas	1,423.90
L3904	WHFO, external powered, electric	1,713.93
L3906	WHFO, wrist gauntlet, molded to patient model	345.54
L3907	WHFO, wrist gauntlet with thumb spica, molded to patient model	372.72
L3908	WHFO, wrist extension control cock-up, canvas or leather design, non-molded	47.88
L3910	WHFO, Swanson design	278.37
L3912	WHFO, flexion glove with elastic finger control	69.72
L3914	WHFO, wrist extension cock-up	57.04
L3916	WHFO, wrist extension cock-up, with outrigger	89.91
L3918	WHFO, knuckle bender	47.31
L3920	WHFO, knuckle bender, with outrigger	77.23
L3922	WHFO, knuckle bender, two segment to flex joints	58.67
L3924	WHFO, Oppenheimer	75.78
L3926	WHFO, Thomas suspension	71.89
L3928	WHFO, finger extension with clock spring	50.57
L3930	WHFO, finger extension, with wrist support	45.22
L3932	WHFO, safety pin, spring wire	27.49
L3934	WHFO, safety pin, modified	29.05
L3936	WHFO, Palmer	61.81
L3938	WHFO, dorsal wrist	61.81
L3940	WHFO, dorsal wrist, with outrigger attachment	74.80
L3942	WHFO, reverse knuckle bender	46.28
L3944	WHFO, reverse knuckle bender, with outrigger	73.51
L3946	WHFO, composite elastic	58.39
L3948	WHFO, finger knuckle bender	45.82
L3950	WHFO, combination Oppenheimer, with knuckle bender and two attachments	118.44
L3952	WHFO, combination Oppenheimer, with reverse knuckle bender and two attachments	119.21
L3954	WHFO, spreading hand	65.20
L3960	Shoulder-elbow-wrist-hand orthosis SEWHO, abduction positioning, airplane design	566.85
L3962	SEWHO, abduction positioning, Erbs Palsey design	526.63
L3963	SEWHO, molded shoulder, arm, forearm, and wrist, with articulating elbow joint	965.08
L3964	SEWHO, mobile arm support attached to wheelchair, balanced and fitted to patient, adjustable	517.74
L3965	SEWHO, radial arm support attached to wheelchair, balanced and fitted to patient, adjustable Rancho type	710.17
L3966	SEWHO, mobile arm support attached to wheelchair, balanced and fitted to patient, reclining	697.49

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L3968	SEWHO, mobile arm support attached to wheelchair, balanced and fitted to patient, friction arm support, (friction dampening to proximal and distal joints)	846.68
L3969	SEWHO, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type arm suspension support	523.46
L3970	SEWHO, addition to mobile arm support, elevating proximal arm	253.02
L3972	SEWHO, addition to mobile arm support, offset or lateral rocker arm with elastic balance control	170.60
L3974	SEWHO, addition to mobile arm support, supinator	139.07
L3980	Upper extremity fracture orthosis, humeral	272.10
L3982	Upper extremity fracture orthosis, radius/ulnar	255.57
L3984	Upper extremity fracture orthosis, wrist	201.68
L3985	Upper extremity fracture orthosis, forearm, hand with wrist hinge	486.86
L3986	Upper extremity fracture orthosis, combination of humeral, radius/ulnar, wrist, (example—Colles fracture)	368.78
L3995	Addition to upper extremity orthosis, sock, fracture or equal, each	21.47
L4000	Replace girdle for Milwaukee orthosis	891.37
L4010	Replace trilateral socket brim	413.32
L4020	Replace quadrilateral socket brim, molded to patient model	618.99
L4030	Replace quadrilateral socket brim, custom fitted	310.53
L4040	Replace molded thigh lacer	252.65
L4045	Replace non-molded thigh lacer	193.44
L4050	Replace molded calf lacer	274.16
L4055	Replace non-molded calf lacer	157.66
L4060	Replace high roll cuff	195.37
L4070	Replace proximal and distal upright for "AKO"	162.83
L4080	Replace metal bands "KAFO", proximal thigh	75.31
L4090	Replace metal bands "KAFO–AFO", calf or distal thigh	59.44
L4100	Replace leather cuff "KAFO", proximal thigh	80.40
L4110	Replace leather cuff "KAFO–AFO", calf or distal thigh	69.59
L4130	Replace pretibial shell	302.79
L4310	Multi–Podus or equal orthotic preparatory management system for lower extremities	275.13
L4320	Addition to AFO, Multi–Podus (or equal) orthotic preparatory management system for lower extremities, flexible foot positioner w/soft interface for AFO, with velcro closure, custom fitted	94.23
L4350	Pneumatic ankle control splint (aircast or equal)	64.30
L4360	Pneumatic walking splint (aircast or equal)	203.25
L4370	Pneumatic full leg splint (aircast or equal)	115.96
L4380	Pneumatic knee splint (aircast or equal)	76.28
L5000	Partial foot, shoe insert with longitudinal arch, toe filler	310.43
L5010	Partial foot, molded socket, ankle height, with toe filler	939.85
L5020	Partial foot, molded socket, tibial tubercle height, with toe filler	1,336.23
L5050	Ankle Symes, molded sock, Sach foot	1,767.70
L5060	Ankle Symes, metal frame, molded leather socket, articulated ankle/foot	1,966.12
L5100	Below knee, molded socket, shin, Sach foot	1,425.79
L5105	Below knee, plastic socket, joints and thigh lacer, Sach foot	2,688.46
L5150	Knee disarticulation (or through knee), molded socket, external knee joints, shin, Sach foot	3,294.44
L5160	Knee disarticulation (or through knee), molded socket, bent knee configuration, external knee joints, shin, Sach foot	2,461.44
L5200	Above knee, molded socket, single axis constant friction knee, shin, Sach foot	2,010.07
L5210	Above knee, short prosthesis, no knee joint ("stubbies"), with foot blocks, no ankle joints, each	1,938.78
L5220	Above knee, short prosthesis, no knee joint ("stubbies"), with articulated ankle/foot, dynamically aligned, each	2,168.99
L5230	Above knee, for proximal femoral focal deficiency, constant friction knee, shin, Sach foot	2,429.79
L5250	Hip disarticulation, Canadian type; molded socket, hip joint, single axis constant friction knee, Sach foot	3,964.65
L5270	Hip disarticulation, tilt table type; molded socket, locking hip joint, single axis constant friction knee, shin, Sach foot	3,329.66
L5280	Hemipelvectomy, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, Sach foot	3,313.07
L5300	Below knee, molded socket, Sach foot, endoskeletal system including soft cover and finishing	1,800.81
L5310	Knee disarticulation (or through knee), molded socket, Sach foot endoskeletal system, including soft cover and finishing	3,522.65
L5320	Above knee, molded socket, open end, Sach foot, endoskeletal system, single axis knee, including soft cover and finishing	2,611.90
L5330	Hip disarticulation, Canadian type; molded socket, endoskeletal system, single axis knee, hip joint, Sach foot, including soft cover and finishing	3,729.91
L5340	Hemipelvectomy, Canadian type; molded socket, endoskeletal system, single axis knee, hip joint, Sach foot, including soft cover and finishing	5,070.18
L5400	Immediate post surgical or early fitting, application of initial rigid dressing including fitting, alignment, suspension, and one cast change, below knee	875.51
L5410	Immediate post surgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension, below knee, each additional cast change and realignment	344.27
L5420	Immediate post surgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension and one cast change "AK" or knee disarticulation	986.87
L5430	Immediate post surgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension, "AK" or knee disarticulation, each cast change and realignment	472.21
L5450	Immediate post surgical or early fitting, application of non-weight bearing rigid dressing, below knee	276.28
L5460	Immediate post surgical or early fitting, application of non-weight bearing rigid dressing, above knee	326.14
L5500	Initial, below knee "PTB" type socket, "USMC" or equal pylon, no cover, Sach foot, plaster socket, direct formed	922.17
L5505	Initial, above knee—knee disarticulation, ischial level socket, "USMC" or equal pylon, no cover, Sach foot, plaster socket, direct formed	1,224.84
L5510	Preparatory, below knee, "PTB" type socket, "USMC" or equal pylon, no cover, Sach foot, plaster cover, molded to model	969.62
L5520	Preparatory, below knee, "PTB" type socket, "USMC" or equal pylon, no cover, Sach foot, thermoplastic or equal, direct formed	1,252.59
L5530	Preparatory, below knee, "PTB" type socket, "USMC" or equal pylon, no cover, Sach foot, thermoplastic or equal, molded to model	1,256.38
L5535	Preparatory, below knee, "PTB" type socket, "USMC" or equal pylon, no cover, Sach foot, prefabricated, adjustable open end socket	1,306.05
L5540	Preparatory, below knee, "PTB" type socket, "USMC" or equal pylon, no cover, Sach foot, laminated socket, molded to model	1,269.86
L5560	Preparatory, above knee—knee disarticulation, ischial level socket, "USMC" or equal pylon, no cover, Sach foot, plaster socket, molded to model	1,500.31
L5570	Preparatory, above knee—knee disarticulation, ischial level socket, "USMC" or equal pylon, no cover, Sach foot, thermoplastic or equal, direct formed	1,581.76
L5580	Preparatory, above knee—knee disarticulation, ischial level socket, "USMC" or equal pylon, no cover, Sach foot, thermoplastic or equal, molded to model	1,753.04
L5585	Preparatory, above knee—knee disarticulation, ischial level socket, "USMC" or equal pylon, no cover, Sach foot, prefabricated adjustable open end socket	1,638.70
L5590	Preparatory, above knee—knee disarticulation, ischial level socket, "USMC" or equal pylon, no cover, Sach foot, laminated socket, molded to model	1,608.83
L5595	Preparatory, hip disarticulation—hemipelvectomy, pylon, no cover, Sach foot, thermoplastic or equal, molded to patient model	2,844.43
L5600	Preparatory, hip disarticulation—hemipelvectomy, pylon, no cover, Sach foot, laminated socket, molded to patient model	3,045.18
L5610	Addition to lower extremity, above knee, hydracadence system	1,361.24
L5611	Addition to lower extremity, above knee—knee disarticulation, "OHC" 4–bar linkage, with friction swing phase control	1,037.38
L5613	Addition to lower extremity, above knee—knee disarticulation, "OHC" 4–bar linkage, with hydraulic swing phase control	1,618.35

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L5616	Addition to lower extremity, above knee, universal multiplex system, friction swing phase control	925.39
L5618	Addition to lower extremity, test socket, Symes	209.39
L5620	Addition to lower extremity, test socket, below knee	193.07
L5622	Addition to lower extremity, test socket, knee disarticulation	324.49
L5624	Addition to lower extremity, test socket, above knee	304.51
L5626	Addition to lower extremity, test socket, hip disarticulation	371.26
L5628	Addition to lower extremity, test socket, hemipelvectomy	381.54
L5629	Addition to lower extremity, below knee, acrylic socket	297.65
L5630	Addition to lower extremity, Symes type, expandable wall socket	355.27
L5631	Addition to lower extremity, above knee or knee disarticulation, acrylic socket	404.25
L5632	Addition to lower extremity, Symes type, "PTB" brim design socket	180.23
L5634	Addition to lower extremity, Symes type, posterior opening (Canadian) socket	217.05
L5636	Addition to lower extremity, Symes type, medial opening socket	166.63
L5637	Addition to lower extremity, below knee, total contact	219.90
L5638	Addition to lower extremity, below knee, leather socket	338.09
L5639	Addition to lower extremity, below knee, wood socket	831.38
L5640	Addition to lower extremity, knee disarticulation, leather socket	572.60
L5642	Addition to lower extremity, above knee, leather socket	443.84
L5643	Addition to lower extremity, hip disarticulation, flexible inner socket, external frame	1,011.85
L5644	Addition to lower extremity, above knee, wood socket	378.79
L5645	Addition to lower extremity, below knee, flexible inner socket, external frame	490.59
L5646	Addition to lower extremity, below knee, air cushion socket	357.30
L5647	Addition to lower extremity, below knee, suction socket	523.36
L5648	Addition to lower extremity, above knee, air cushion socket	422.90
L5649	Addition to lower extremity, ischial containment/narrow M–L socket	1,413.30
L5650	Addition to lower extremity, total contact, above knee or knee disarticulation socket	477.00
L5651	Addition to lower extremity, above knee, flexible inner socket, external frame	760.91
L5652	Addition to lower extremity, suction suspension, above knee or knee disarticulation, socket	279.79
L5653	Addition to lower extremity, knee disarticulation, expandable wall socket	372.39
L5654	Addition to lower extremity, socket insert, Symes (Kemblo, Pelite, Aliplast, Plastazote or equal)	218.93
L5655	Addition to lower extremity, socket insert, below knee (Kemblo, Pelite, Aliplast, Plastazote or equal)	228.29
L5656	Addition to lower extremity, socket insert, knee disarticulation (Kemblo, Pelite, Aliplast, Plastazote or equal)	281.78
L5658	Addition to lower extremity, socket insert, above knee (Kemblo, Pelite, Aliplast, Plastazote or equal)	245.52
L5660	Addition to lower extremity, socket insert, Symes, silicone gel or equal	407.19
L5661	Addition to lower extremity, socket insert, multi-durometer, Symes	442.77
L5662	Addition to lower extremity, socket insert, below knee, silicone gel or equal	384.40
L5663	Addition to lower extremity, socket insert, knee disarticulation, silicone gel or equal	497.21
L5664	Addition to lower extremity, socket insert, above knee, silicone gel or equal	497.21
L5665	Addition to lower extremity, socket insert, multi-durometer, below knee	330.99
L5666	Addition to lower extremity, below knee, cuff suspension	51.44
L5668	Addition to lower extremity, below knee, molded distal cushion	77.28
L5670	Addition to lower extremity, below knee, molded supracondylar suspension ("PTS" or similar)	194.85
L5672	Addition to lower extremity, below knee, removable medial brim suspension	241.93
L5674	Addition to lower extremity, below knee, latex sleeve suspension, each	43.05
L5675	Addition to lower extremity, below knee, latex sleeve suspension or equal, heavy duty, each	54.04
L5676	Addition to lower extremity, below knee, knee joints, single axis, pair	219.04
L5677	Addition to lower extremity, below knee, knee joints, polycentric, pair	309.38
L5678	Addition to lower extremity, below knee, joint covers, pair	24.23
L5680	Addition to lower extremity, below knee, thigh lacer, non-molded	229.02
L5682	Addition to lower extremity, below knee, thigh lacer, gluteal/ischial, molded	488.16
L5684	Addition to lower extremity, below knee, fork strap	39.59
L5686	Addition to lower extremity, below knee, back check (extension control)	44.11
L5688	Addition to lower extremity, below knee, waist belt, webbing	55.16
L5690	Addition to lower extremity, below knee, waist belt, padded and lined	69.30
L5692	Addition to lower extremity, above knee, pelvic control belt, light	90.91
L5694	Addition to lower extremity, above knee, pelvic control belt, padded and lined	118.09
L5695	Addition to lower extremity, above knee, pelvic control, sleeve suspension, neoprene or equal, each	130.45
L5696	Addition to lower extremity, above knee or knee disarticulation, pelvic joint	147.87
L5697	Addition to lower extremity, above knee or knee disarticulation, pelvic band	50.65
L5698	Addition to lower extremity, above knee or knee disarticulation, silesian bandage	87.99
L5699	All lower extremity prosthesis, shoulder harness	117.93
L5710	Addition, exoskeletal knee-shin system, single axis, manual lock	229.69
L5711	Addition, exoskeletal knee-shin system, single axis, manual lock, ultra-light material	376.27
L5712	Addition, exoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)	304.92
L5714	Addition, exoskeletal knee-shin system, single axis, variable friction swing phase control	351.58
L5716	Addition, exoskeletal knee-shin system, polycentric mechanical stance phase lock	514.95
L5718	Addition, exoskeletal knee-shin system, polycentric friction swing and stance phase control	595.55
L5722	Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control	601.20
L5724	Addition, exoskeletal knee-shin system, single axis, fluid swing phase control	1,195.58
L5726	Addition, exoskeletal knee-shin system, single axis, external joints, fluid swing phase control	1,268.89
L5728	Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control	1,980.69
L5780	Addition, exoskeletal knee-shin system, single axis, pneumatic hydrapneumatic swing phase control	767.47
L5785	Addition, exoskeletal system, below knee, ultra-light material (Titanium, carbon fiber or equal)	320.90
L5790	Addition, exoskeletal system, above knee, ultra-light material (Titanium, carbon fiber or equal)	451.75
L5795	Addition, exoskeletal system, hip disarticulation, ultra-light material (Titanium, carbon fiber or equal)	642.84
L5810	Addition, endoskeletal knee-shin system, single axis, manual lock	344.91
L5811	Addition, endoskeletal knee-shin system, single axis, manual lock, ultra-light material	457.76
L5812	Addition, endoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)	370.46
L5816	Addition, endoskeletal knee-shin system, polycentric, mechanical stance phase lock	535.54
L5818	Addition, endoskeletal knee-shin system, polycentric, friction swing and stance phase control	715.25
L5822	Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control	1,358.75
L5824	Addition, endoskeletal knee-shin system, single axis, fluid swing phase control	1,006.78
L5828	Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control	1,996.04
L5830	Addition, endoskeletal knee-shin system, single axis, pneumatic swing phase control	1,397.62
L5850	Addition, endoskeletal system, above knee or hip disarticulation, knee extension assist	86.19
L5910	Addition, endoskeletal system, below knee, alignable system	331.16
L5920	Addition, endoskeletal system, above knee or hip disarticulation, alignable system	326.39

HCPCS Code	Description	Fee For New Eqpt
L5940	Addition, endoskeletal system, below knee, ultra-light material (Titanium, carbon fiber or equal)	319.24
L5950	Addition, endoskeletal system, above knee, ultra-light material (Titanium, carbon fiber or equal)	607.51
L5960	Addition, endoskeletal system, hip disarticulation, ultra-light material (Titanium, carbon fiber or equal)	678.32
L5970	All lower extremity prosthesis, foot, external keel, Sach foot	124.87
L5972	All lower extremity prosthesis, flexible keel foot (Safe, Sten, Bock, Dynamic or equal)	225.20
L5974	All lower extremity prosthesis, foot, single axis ankle/foot	149.30
L5976	All lower extremity prosthesis, energy storing foot (Seattle Carbon Copy II or equal)	400.31
L5978	All lower extremity prosthesis, foot, multi-axial ankle/foot (Greissinger or equal)	187.15
L5980	All lower extremity prosthesis, flex foot system	2,828.85
L5982	All exoskeletal lower extremity prosthesis, axial rotation unit	478.23
L5984	All endoskeletal lower extremity prosthesis, axial rotation unit	377.66
L5986	All lower extremity prosthesis, multi-axial rotation unit ("MCP" or equal)	414.95
L6000	Partial hand, Robin–Aids, thumb remaining (or equal)	881.85
L6010	Partial hand, Robin–Aids, little and/or ring finger remaining (or equal)	968.62
L6020	Partial hand, Robin–Aids, no finger remaining (or equal)	890.81
L6050	Wrist disarticulation, molded socket, flexible elbow hinges, triceps pad	1,491.49
L6055	Wrist disarticulation, molded socket with expandable interface, flexible elbow hinges, triceps pad	2,047.43
L6100	Below elbow, molded socket, flexible elbow hinge, triceps pad	1,558.79
L6110	Below elbow, molded socket (Muenster or Northwestern suspension types)	1,928.42
L6120	Below elbow, molded double wall split socket, step-up hinges, half cuff	1,589.40
L6130	Below elbow, molded double wall split socket, stump activated locking hinge, half cuff	1,801.47
L6200	Elbow disarticulation, molded socket, outside locking hinge, forearm	1,871.18
L6205	Elbow disarticulation, molded socket with expandable interface, outside locking hinges, forearm	3,168.40
L6250	Above elbow, molded double wall socket, internal locking elbow, forearm	2,050.61
L6300	Shoulder disarticulation, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm	2,879.35
L6310	Shoulder disarticulation, passive restoration (complete prosthesis)	2,377.99
L6320	Shoulder disarticulation, passive restoration (shoulder cap only)	1,474.39
L6350	Interscapular thoracic, molded socket, shoulder bulkhead, humeral section internal locking elbow, forearm	3,344.81
L6360	Interscapular thoracic, passive restoration (complete prosthesis)	1,958.57
L6370	Interscapular thoracic, passive restoration (shoulder cap only)	1,876.84
L6380	Immediate post surgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension of components and one cast change, wrist disarticulation or below elbow	914.24
L6382	Immediate post surgical or early fitting, application of initial rigid dressing including fitting, alignment and suspension of components and one cast change, elbow disarticulation or above elbow	1,154.60
L6384	Immediate post surgical or early fitting, application of initial rigid dressing including fitting, alignment and suspension of components and one cast change, shoulder disarticulation	1,406.05
L6386	Immediate post surgical or early fitting, each additional cast change and realignment	313.90
L6388	Immediate post surgical or early fitting, application of rigid dressing only	273.65
L6400	Below elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping	1,638.59
L6450	Elbow disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue	1,993.94
L6500	Above elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping	2,047.91
L6550	Shoulder disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping	2,487.09
L6570	Interscapular thoracic, molded socket, endoskeletal system, including soft prosthetic tissue shaping	2,942.19
L6580	Preparatory, wrist disarticulation or below elbow, single wall plastic socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, USMC or equal pylon, no cover, molded to patient model	1,064.80
L6582	Preparatory, wrist disarticulation or below elbow, single wall socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, USMC or equal pylon, no cover, direct formed	914.24
L6584	Preparatory, elbow disarticulation or below elbow, single wall plastic socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, USMC or equal pylon, no cover, molded to patient model	1,494.44
L6586	Preparatory, elbow disarticulation or above elbow, single wall socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, USMC or equal pylon, no cover, direct formed	1,297.97
L6588	Preparatory, shoulder disarticulation or interscapular thoracic, single wall plastic socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, USMC or equal pylon, no cover, molded to patient model	2,189.21
L6590	Preparatory, shoulder disarticulation or interscapular thoracic, single wall socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, USMC or equal pylon, no cover, direct formed	2,012.22
L6600	Upper extremity additions, polycentric hinge, pair	140.17
L6605	Upper extremity additions, single pivot hinge, pair	159.25
L6610	Upper extremity additions, flexible metal hinge, pair	103.86
L6615	Upper extremity addition, disconnect locking wrist unit	138.56
L6616	Upper extremity addition, additional disconnect insert for locking wrist unit, each	59.40
L6620	Upper extremity addition, flexible-friction wrist unit	288.58
L6623	Upper extremity addition, spring assisted rotational wrist unit with latch release	467.97
L6625	Upper extremity addition, rotation wrist unit with cable lock	321.96
L6628	Upper extremity addition, quick disconnect hook adapter, Otto Bock or equal	321.81
L6629	Upper extremity addition, quick disc lamin collar w/coupling piece, Otto Bock or equal	101.79
L6630	Upper extremity addition, stainless steel, any wrist	142.36
L6632	Upper extremity addition, latex suspension sleeve, each	41.94
L6635	Upper extremity addition, lift assist for elbow	153.57
L6637	Upper extremity addition, nudge control elbow lock	253.99
L6640	Upper extremity additions, shoulder abduction joint, pair	195.19
L6641	Upper extremity addition, excursion amplifier, pulley type	132.56
L6642	Upper extremity addition, excursion amplifier, lever type	190.09
L6645	Upper extremity addition, shoulder flexion-abduction joint, each	206.87
L6650	Upper extremity addition, shoulder universal joint, each	214.36
L6655	Upper extremity addition, standard control cable, extra	47.80
L6660	Upper extremity addition, heavy duty control cable	59.15
L6665	Upper extremity addition, teflon or equal, cable lining	32.96
L6670	Upper extremity addition, hook to hand, cable adapter	43.80
L6672	Upper extremity addition, harness, chest or shoulder, saddle type	142.05
L6675	Upper extremity addition, harness, figure of "8" type, for single control	71.86
L6676	Upper extremity addition, harness, figure of "8" type, for dual control	78.27
L6680	Upper extremity addition, test socket, wrist disarticulation or below elbow	157.50
L6682	Upper extremity addition, test socket, elbow disarticulation or above elbow	192.76
L6684	Upper extremity addition, test socket, shoulder disarticulation or interscapular thoracic	223.60
L6686	Upper extremity addition, suction socket	452.96
L6687	Upper extremity addition, frame type socket, below elbow or wrist disarticulation	356.55
L6688	Upper extremity addition, frame type socket, above elbow or elbow disarticulation	371.44
L6689	Upper extremity addition, frame type socket, shoulder disarticulation	482.14
L6690	Upper extremity addition, frame type socket, interscapular thoracic	490.33
L6691	Upper extremity addition, removable insert, each	301.77

HCPCS Code	Description	Fee For New Eqpt
L6692	Upper extremity addition, silicone gel insert or equal, each	364.95
L6700	Terminal device, hook, dorrance, or equal Model # 3	325.28
L6705	Terminal device, hook, dorrance, or equal Model # 5	196.82
L6710	Terminal device, hook, dorrance, or equal Model # 5X	263.89
L6715	Terminal device, hook, dorrance, or equal Model # 5Xa	221.37
L6720	Terminal device, hook, dorrance, or equal Model # 6	556.04
L6725	Terminal device, hook, dorrance, or equal Model # 7	265.84
L6730	Terminal device, hook, dorrance, or equal Model # 7L0	431.23
L6735	Terminal device, hook, dorrance, or equal Model # 8	195.72
L6740	Terminal device, hook, dorrance, or equal Model # 8X	247.97
L6745	Terminal device, hook, dorrance, or equal Model # 88X	226.63
L6750	Terminal device, hook, dorrance, or equal Model # 10P	223.39
L6755	Terminal device, hook, dorrance, or equal Model # 10X	224.49
L6765	Terminal device, hook, dorrance, or equal Model # 12P	233.05
L6770	Terminal device, hook, dorrance, or equal Model # 99X	225.85
L6775	Terminal device, hook, dorrance, or equal Model # 555	273.03
L6780	Terminal device, hook, dorrance, or equal Model # SS555	308.63
L6790	Terminal device, hook, "ACCU" hook or equal	372.54
L6795	Terminal device, hook "2" load or equal	875.24
L6800	Terminal device, hook—APRL VC or equal	707.35
L6805	Terminal device, modifier, wrist flexion unit	252.08
L6806	Terminal device, hook, TRS grip, VC	1,176.87
L6807	Terminal device, hook, TRS adept, child, VC	895.05
L6808	Terminal device, hook, TRS adept, infant, VC	744.49
L6809	Terminal device, hook, TRS Super Sport, passive	284.88
L6810	Terminal device, hook, pincher tool, Otto Bock or equal	130.35
L6825	Terminal device, hand, dorrance, VO	859.12
L6830	Terminal device, hand, APRL, VC	993.53
L6835	Terminal device, hand, Sierra, VO	869.14
L6840	Terminal device, hand, Becker Imperial	562.76
L6845	Terminal device, hand, Becker Lock Grip	585.60
L6850	Terminal device, hand, Becker Plylite	536.26
L6855	Terminal device, hand, Robin–Aids, VO	553.52
L6860	Terminal device, hand, Robin–Aids, VO soft	514.41
L6865	Terminal device, hand, passive hand	247.26
L6867	Terminal device, hand, Detroit infant hand, (mechanical)	780.11
L6868	Terminal device, hand, Passive infant hand, (Steeper, Hosmer or equal)	162.92
L6870	Terminal device, hand, child mitt	221.05
L6872	Terminal device, hand, NYU child hand	752.69
L6873	Terminal device, hand, mechanical infant hand, Steeper or equal	295.27
L6875	Terminal device, hand, Bock, VC	705.53
L6880	Terminal device, hand, Bock, VO	435.00
L6890	Terminal device, glove for above hands, production glove	125.56
L6895	Terminal device, glove for above hands, custom glove	379.27
L6900	Hand restoration (cast, shading and measurements included), partial hand, with glove, thumb or one finger remaining	1,295.70
L6905	Hand restoration (casts, shading and measurements included), partial hand, with glove, multiple fingers remaining	1,292.16
L6910	Hand restoration (cast, shading and measurements included), partial hand, with glove no fingers remaining	1,122.97
L6915	Hand restoration (shading, and measurements included), replacement glove for above	407.73
L6920	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device	4,877.49
L6925	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal	5,479.18
L6930	Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device	4,499.94
L6935	Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	5,371.69
L6940	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch	6,343.68
L6945	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger	7,000.80
L6950	Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of	6,592.75
L6955	Above elbow, external power, molded inner socket removable humeral shell, internal locking elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charter, myoelectronic	7,861.37
L6960	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, should bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, two	8,585.21
L6965	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal	9,850.27
L6970	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, two	10,616.81
L6975	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, two	11,783.36
L7010	Electronic hand, Otto Bock, Steeper or equal switch controlled	2,225.07
L7015	Electronic hand, Systemteknik, Variety Village or equal switch controlled	4,117.35
L7020	Electronic Greifer, Otto Bock or equal switch controlled	2,556.81
L7025	Electronic hand, Otto Bock or equal, myoelectronically controlled	2,507.23
L7030	Electronic hand, Systemteknik, Variety Village or equal, myoelectronically controlled	4,255.34
L7035	Electronic Greifer, Otto Bock or equal, myoelectronically controlled	2,468.65
L7040	Prehensile actuator, Hosmer or equal, switch controlled	1,956.78
L7045	Electronic hook, child, Michigan or equal, switch controlled	947.19
L7160	Electronic elbow, Boston or equal, switch controlled	10,781.93
L7165	Electronic elbow, Boston or equal, myoelectronically controlled	12,233.01
L7170	Electronic elbow, Hosmer or equal, switch controlled	3,893.67
L7180	Electronic elbow, Utah or equal, myoelectronically controlled	23,158.53
L7185	Electronic elbow, adolescent, Variety Village or equal, switch controlled	4,178.52
L7186	Electronic elbow, child, Variety Village or equal, switch controlled	6,585.92
L7190	Electronic elbow, adolescent, Variety Village or equal, myoelectronically controlled	5,747.84
L7191	Electronic elbow, child, Variety Village or equal, myoelectronically controlled	6,915.81
L7260	Electronic wrist rotator, Otto Bock or equal	1,625.89
L7261	Electronic wrist rotator, for Utah arm	2,826.48
L7266	Servo control, Steeper or equal	618.60
L7272	Analogue control, UNB or equal	1,496.06
L7274	Proportional control, 12 volt, Utah or equal	4,656.89
L7360	Six volt battery, Otto Bock or equal, each	215.51
L7362	Battery charger, six volt, Otto Bock or equal	183.20
L7364	Twelve volt battery, Utah or equal, each	370.97
L7366	Battery charger, 12 volt, Utah or equal	472.71
L8000	Breast prosthesis, mastectomy bra	23.24
L8010	Breast prosthesis, mastectomy sleeve	59.82
L8020	Breast prosthesis, mastectomy form	169.82
L8030	Breast prosthesis, silicone or equal	200.15
L8300	Truss, single with standard pad	58.20
L8310	Truss, double with standard pads	119.68
L8320	Truss, addition to standard pad, water pad	36.38
L8330	Truss, addition to standard pad, scrotal pad	32.71
L8400	Prosthetic sheath, below knee, each	15.37
L8410	Prosthetic sheath, above knee, each	15.52
L8415	Prosthetic sheath, upper limb, each	15.28
L8420	Prosthetic sock, wool, below knee, each	17.40
L8430	Prosthetic sock, wool, above knee, each	18.76
L8435	Prosthetic sock, wool, upper limb, each	13.73
L8440	Prosthetic shrinker, below knee, each	37.82
L8460	Prosthetic shrinker, above knee, each	47.66
L8465	Prosthetic shrinker, upper limb, each	40.26

HCPCS Code	Description	Fee For New Eqpt
L8470	Stump sock, single ply, fitting, below knee, each	4.64
L8480	Stump sock, single ply, fitting, above knee, each	5.86
L8500	Artificial larynx, any type	596.58
L8501	Tracheostomy speaking valve	72.92
L8600	Implantable breast prosthesis, silicone or equal	245.90
L8605	Other prosthetic procedures-devices: tissue expander	305.06
L8610	OPPD: ocular	426.64
L8613	OPPD: ossicula	222.38
L8615	OPPD: temporomandibular joint	188.17
L8620	OPPD: radial head	179.61
L8622	OPPD: proximal ulna/radius	192.44
L8623	OPPD: distal ulna	192.44
L8624	OPPD: distal radius	205.27
L8625	OPPD: trapezium	179.61
L8626	OPPD: wrist	491.80
L8627	OPPD: lunate	325.02
L8628	OPPD: carpus	179.61
L8629	OPPD: scaphoid	179.61
L8630	OPPD: metacarpophalangeal joint	192.44
L8640	OPPD: patella	102.00
L8641	OPPD: metatarsal joint	179.61
L8642	OPPD: haliux implant	179.61
L8655	OPPD: flexor tendon in hand or finger	102.64
L8656	OPPD: extensor tendon in hand or finger	102.64
L8657	OPPD: tendon other than hand or finger	102.64
L8658	OPPD: interphalangeal joint	188.17
L8690	OPPD: testicle	149.68

CODES BEGINNING WITH "Q" THRU "V"

HCPCS Code	Description	Fee For New Eqpt	Monthly Rental Fee
Q0036	Oxygen concentrator high humidity	—	296.10
Q0038	Oxygen contents, gaseous, per unit (for use with owned gaseous stationary systems or when both a stationary and portable gaseous system are owned; 1 unit = 50 cubic feet)	204.80	—
Q0039	Oxygen contents, liquid, per unit (for use with owned stationary liquid systems or when both a stationary and portable liquid system are owned; 1 unit = 10 lbs.)	204.80	—
Q0040	Portable oxygen contents, gaseous per unit (for use only with portable gaseous systems when no stationary gas system is used; 1 unit = 5 cubic ft.)	30.81	—
Q0041	Portable oxygen contents, liquid, per unit (for use with portable liquid systems when no stationary liquid system is used; 1 unit = 1 lb.)	30.81	—
Q0042	Stationary compressed gas system rental, includes contents (per unit), regulator with flow gauge, humidifier, nebulizer, cannula or mask and tubing, 1 unit = 50 cubic ft.	—	296.10
Q0043	Stationary liquid oxygen system rental, includes content (per unit), use of reservoir, contents indicator, flowmeter, humidifier, nebulizer, cannula or mask and tubing; 1 unit of contents = 10 lbs.	—	296.10
Q0046	Portable liquid oxygen system rental, includes flowmeter, refill adapter, contents gauge, cannula and tubing	—	54.99
V2620	Prosthetic, eye, glass, stock	304.96	—
V2621	Prosthetic, eye, plastic, stock	293.40	—
V2622	Prosthetic, eye, glass, custom	671.89	—
V2623	Prosthetic, eye, plastic, custom	671.89	—

Administrative Correction.
See: 23 N.J.R. 125(a).
Administrative Correction.
See: 23 N.J.R. 861(a).
Amended by R.1992 d.170, effective April 6, 1992.
See: 23 N.J.R. 3203(a), 24 N.J.R. 1347(a).
Amended by R.1993 d.395, effective August 2, 1993.
See: 25 N.J.R. 229(b), 25 N.J.R. 3466(b).
Petition for Rulemaking.
See: 27 N.J.R. 2015(a), 27 N.J.R. 2492(a), 27 N.J.R. 3637(a).

Case Notes

Examination fees were not reasonable despite being consistent with prevailing rates. Thermographic Diagnostics, Inc. v. Allstate Ins. Co., 125 N.J. 491, 593 A.2d 768 (1991).

Agency-promulgated schedule of fees was pertinent to reasonableness of fees charged. Thermographic Diagnostics, Inc. v. Allstate Ins. Co., 125 N.J. 491, 593 A.2d 768 (1991).

SUBCHAPTER 30. MOTOR VEHICLE SELF-INSURANCE

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(e); 39:6–50.1 and 39:6–52 to 39:6–54.

Source and Effective Date

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

11:3–30.1 Purpose

This subchapter sets forth the filing requirements for motor vehicle self-insurers pursuant to N.J.S.A. 39:6–50.1, and 39:6–52 to 39:6–54.

11:3–30.2 Scope

The provisions of this subchapter apply to any person seeking to qualify as a motor vehicle self-insurer in New Jersey, except public entities pursuant to N.J.S.A. 39:6–54.

11:3–30.3 Definitions

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

"Applicant" means a person applying for a certificate of self-insurance who does not currently possess a valid certificate.

"Association" means the New Jersey Automobile Full Insurance Underwriting Association created pursuant to N.J.S.A. 17:30E–1 et seq.

"Certificate" means certificate of self-insurance.

"Certificate holder" means a person who currently possesses a valid certificate of self-insurance.

"Certified public accountant" means an independent certified public accountant or accounting firm in good standing with the American Institute of Certified Public Accountants and in all states in which they are licensed to do business.

"Commissioner" means the Commissioner of Insurance.

"Motorized bicycle" means a pedal bicycle having a helper motor characterized in that either the maximum piston displacement is less than 50 cubic centimeters (cc.) or said motor is rated at no more than 1.5 brake horsepower and said bicycle is capable of a maximum speed of no more than 25 miles per hour on a flat surface.

"Motor vehicle" means all vehicles propelled otherwise than by muscular power, excepting such vehicles as run upon rails or tracks and motorized bicycles.

"Person" means a natural person, firm, co-partnership, association or corporation.

"Public entity" means this State, any political subdivision of this State or any municipality therein.

11:3–30.4 General requirements

(a) Any person in whose name more than 25 motor vehicles are registered or in whose name more than 25 motor vehicles are leased may qualify as a self-insurer by obtaining a certificate of self-insurance issued at the discretion of the Commissioner as provided in this subchapter.

(b) All filings for certificates of self-insurance, renewals, and any other filings deemed necessary by the Commissioner pursuant to this subchapter shall be sent to:

New Jersey Department of Insurance
Financial Exams Division
20 West State Street
CN 325
Trenton, New Jersey 08625
Attention: Self-insurers

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 Historical Note

Subchapter 31, Examination of the Financial Experience of Private Passenger Automobile Insurers, was adopted as R.1990 d.108, effective February 5, 1990. See: 21 N.J.R. 3726(a), 22 N.J.R. 425(a). Amendments to the subchapter were adopted as R.1990 d.290, effective June 4, 1990, and R.1991 d.45, effective February 4, 1991. See: 22 N.J.R. 1026(a), 22 N.J.R. 1725(b); 22 N.J.R. 1678(a), 23 N.J.R. 306(b). Subchapter 31 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 32. CERTIFICATION OF COMPLIANCE: MANDATORY LIABILITY COVERAGES

Authority

N.J.S.A. 17:1C–6(e) and 17:28–1.4.

Source and Effective Date

R.1994 d.477, effective September 19, 1994.
See: 26 N.J.R. 1939(a), 26 N.J.R. 3866(a).

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–1, 17:28–1.3 and 17:28–1.1, as required under N.J.S.A. 17:28–1.4, 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.

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 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.

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–1, N.J.S.A. 39:6A–3, N.J.S.A. 39:6A–4, N.J.S.A. 17:28–1.3 and N.J.S.A. 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 Insurance
Property/Liability Division
20 West State Street
CN 325
Trenton, New Jersey 08625–0325

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 Insurance
Property/Liability Division
20 West State Street
CN 325
Trenton, New Jersey 08625–0325

SUBCHAPTER 33. APPEALS FROM DENIAL OF AUTOMOBILE INSURANCE

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(c), 17:29A–1 et seq., 17:29A–36.2 and 36.3, 17:29A–44, 17:30A–1 et seq., and 17:33B–1 et seq.

Source and Effective Date

R.1992 d.192, effective April 20, 1992.
See: 24 N.J.R. 546(a), 24 N.J.R. 1510(a).

11:3–33.1 Purpose; scope

This subchapter sets forth an appeal procedure for a person who has been either denied personal private passen-

ger 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 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 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).

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.

(b) Within 10 working days of a determination to deny automobile insurance in the voluntary market (from either a written application or from the date that an oral request is made for a written determination), an insurer or agent shall notify an applicant, in writing, of each specific reason for the denial. The reasons provided by an insurer or insurance agent shall be comprehensive and written in plain language. The reasons shall identify the specific basis for which the applicant fails to qualify as an "eligible person."

(c) An insurer or agent who has issued a written denial shall notify an applicant of his or her right to appeal the denial to the Department, pursuant to the provisions of this subchapter. That insurer or agent shall also advise the applicant of his or her obligation to obtain insurance coverage as a condition of operation of the vehicle. As part of this notification, an insurer or agent shall provide an applicant with the letter and appeal form which comprise Appendices A and B to this subchapter set forth and incorporated as part of this rule. For nonrenewals, the insurer shall provide the notice set forth in N.J.A.C. 11:3–8.3 together with the letter and appeal form when nonrenewing an applicant pursuant to N.J.A.C. 11:3–8.4.

11:3–33.5 Procedure for filing an appeal

(a) Appeals from a denial of automobile insurance in the voluntary market shall be submitted to the Department, on a form prescribed by the Department (Appendix B to this subchapter, which is incorporated herein by reference as part of this rule), within 90 days of the date of a written denial from an insurer or insurance agent. Notwithstanding an insurer's or agent's obligation to provide a person with this form upon a denial of initial coverage (see N.J.A.C. 11:3–33.4(c)), copies can also be obtained by contacting the Department by telephone (609) 984–2426 or by mail at the address below:

Department of Insurance
Division of Enforcement and Consumer Protection
Attn: Auto Insurance Denial
20 West State Street
CN 329
Trenton, New Jersey 08625

(b) The form prescribed by the Department shall be completed and submitted to the address above and shall include, at a minimum, the following information:

1. A copy of the written denial obtained from the insurer or agent pursuant to N.J.S.A. 17:33B–16 and N.J.A.C. 11:3–33.4. When an applicant receives an oral denial, he or she shall request a written denial as provided by N.J.A.C. 11:3–33.4; and

2. A statement from the applicant who has received a denial of coverage, including supporting documentation, if any, indicating the reasons why the denial is improper.

11:3–33.6 Processing appeals

(a) Upon receipt of an appeal submitted in accordance with N.J.A.C. 11:3–33.5, the Department shall send to the insurer or insurance agent (the "respondent") who provided the written denial, a copy of all pertinent documents which have been submitted by applicant (the "appellant"), and shall require a final written reply from the respondent within 30 days of the receipt of these documents.

(b) Upon the Department's receipt of the respondent's reply to the appeal, and upon a review of the papers, the Department shall render its decision on the appeal. The decision shall be in writing and shall set forth the reasons why the denial was appropriate or inappropriate under law. Copies of the Department's decision shall be mailed by certified mail to the appellant and the respondent. The Department's decision shall also include a written notice explaining the procedures to appeal the decision pursuant to N.J.A.C. 11:3–33.7.

(c) A respondent's failure to timely reply pursuant to (a) above shall result in a decision by the Department based solely upon the papers submitted by the appellant, together with any other information available to the Department at that time, pursuant to this subchapter. A respondent's failure to timely reply pursuant to (a) above shall be deemed a violation of this subchapter and may result in the assessment of penalties provided in N.J.A.C. 11:3–33.8.

(d) Upon a determination by the Department that a denial was improper, the insurer shall be required to offer the applicant the requested coverage effective as of the date of the declination. The Department may, however, determine to require the insurer to offer coverage effective on a later date upon a finding that the applicant failed to maintain insurance on an automobile as required by N.J.S.A. 39:6B–1.

11:3–33.7 Contested case hearings; pleadings

(a) An appeal from a decision of the Department made pursuant to N.J.A.C. 11:3–33.6 shall be heard as a contested case pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq., as implemented by the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(b) The procedure for filing an appeal from the Department's decision pursuant to N.J.A.C. 11:3–33.6(c) shall be as follows:

1. Upon receipt of the Department's decision, the insurer or agent denying coverage or the applicant denied automobile insurance coverage shall, within 20 calendar days of receipt of the decision, file with the Department a written request that the matter be heard as a contested case. Failure to file an appeal within the time required by this section shall result in the Department's decision becoming the final agency action. The written request for a hearing as a contested case shall contain the following information.

i. The name and address of the appellant;

ii. The Department's case or file number;

iii. If the appellant is the person denied insurance, the name and address of the insurance company and/or insurance agent which issued the denial of automobile insurance. If the appellant is the insurance company, the name and address of the insurance agent who issued the denial of coverage, if any, and the name and address of the person to whom automobile insurance was denied;

iv. A detailed statement explaining the reasons why the Department's determination is improper together with supporting documentation, if any; and

v. A statement as to whether the appellant is represented by legal counsel, or another person pursuant to N.J.A.C. 1:1–5.1, and the name, address and telephone number of said person.

(c) Upon the Department's timely receipt of the items set forth in (b) above, it shall simultaneously send a copy of the documents to the opposing party and shall transmit the matter to the Office of Administrative Law for hearing as a contested case.

11:3–33.8 Penalties

Any insurer or insurance producer who violates any provision of this subchapter shall be subject to the penalties provided by law, including, but not limited to, the suspension or revocation of a certificate of authority or licensure and a civil penalty in an amount of up to $2,000 for the first violation and up to $5,000 for the second and each subsequent violation, pursuant to N.J.S.A. 17:33B–15 and 21.

11:3–33.9 Compliance

(a) Pursuant to N.J.S.A. 39:6A–3 and 17:33B–15, compliance with the provisions of this subchapter shall be effected in the following manner:

1. Appeals from denials concerning new policies on or after April 1, 1992 may be filed in the manner prescribed by this subchapter; and

2. Appeals from denials concerning policy renewals which take effect on or after April 1, 1992, may be filed in the manner prescribed by this subchapter.

APPENDIX A

Dear Applicant,

The "Fair Automobile Insurance Reform Act of 1990" (Act) provides that on or after April 1, 1992, every insurer, either by one or more separate rating plans, shall provide automobile insurance for eligible persons.

Therefore, an insurer may deny coverage only to those applicants who are not eligible. New Jersey law provides that any person who owns or has registered an automobile in New Jersey or a person who has a valid New Jersey drivers license is eligible except a person:

1. Who, in the last three years, has been convicted of driving under the influence or refusing a chemical test in New Jersey or elsewhere;

2. Who, in the last three years, has been convicted of a crime involving an automobile;

3. Whose driving license is suspended or revoked by a court;

4. Who, in the last five years, has been convicted of fraud or intent to defraud involving an insurance claim or application;

5. Who, in the last five years, has been denied payment of an insurance claim in excess of $1,000, if there was evidence of fraud or intent to defraud;

6. Whose automobile insurance policy, in the last two years, was cancelled because of nonpayment of premium or financed premium (unless the entire annual premium for the new coverage is paid in full before issuance or renewal);

7. Who fails to maintain membership in a club, group or organization, if membership is a uniform requirement of the insurer as a condition of providing insurance;

8. Whose driving record, for the last three years, has an accumulation of nine or more eligibility points. (Eligibility points are accumulated as a result of convictions, suspensions, revocations and determination of responsibility for civil infractions in accordance with schedules adopted by the New Jersey Department of Insurance. For example, one at-fault accident has been assigned five eligibility points.)

NOTE: The above description is a simplification of the statutory definition. For a more extensive description, see the New Jersey Administrative Code at N.J.A.C. 11:3–34.4.

The Commissioner of Insurance has established an appeal process for persons who have been denied automobile insurance. The procedure for filing a written appeal can be found in the New Jersey Administrative Code at N.J.A.C. 11:3–33. Most New Jersey public libraries have this material.

To begin the appeal process, you must complete the attached form and mail it, with the necessary documentation, to the address indicated.

WARNING: You must have automobile insurance if you plan to operate and/or register a vehicle during the appeal process. Filing an appeal does not provide you with insurance.

APPENDIX B

NOTE: YOU HAVE 90 DAYS FROM THE DATE ON WHICH A WRITTEN DENIAL OF AUTOMOBILE INSURANCE IS MADE TO FILE THIS APPEAL.

NEW JERSEY DEPARTMENT OF INSURANCE
AUTOMOBILE DECLINATION APPEAL

Your Name: _____
Your Address: _____
_____
Your Telephone Number: (___) _____

Insurance Company and/or Insurance Producer (agent or broker) that declined your application for automobile insurance coverage in the voluntary market (if producer, please provide the name and address):

Company _____

Producer _____

YOU MUST ATTACH A COPY OF THE DECLINATION (If you have not received a written declination from the insurance company or producer, you must request one within 90 days from the date you first applied for insurance.)

BASIS FOR YOUR APPEAL (Please indicate with an "X" those statements or reasons that apply and attach a copy of pertinent documentation supporting your appeal. Such documentation should include a certified motor vehicle driver "abstract", where appropriate, available from the Division of Motor Vehicles, 120 South Stockton Street, CN 142, Trenton, New Jersey 08666. There is a $5.00 fee for each copy of the DMV abstract.)

- ☐ I have not been convicted of Driving Under the Influence (N.J.S.A. 39:4–50) or of refusing to submit to a chemical test (N.J.S.A. 39:4–50.4(a)), or for a similar offense in another jurisdiction, or of a crime involving an automobile or theft of a motor vehicle.
- ☐ My driver's license is not suspended or revoked, nor has it been for any 12–month period in the preceding three years.
- ☐ I have not been convicted of insurance fraud or intent to defraud, or have not had an insurance claim (in excess of $1,000) denied because of evidence of fraud within the five-year period immediately preceding application or renewal.
- ☐ My auto insurance has not been cancelled for nonpayment of premium within the last two years and I provide proof of payment OR I have had my policy cancelled for nonpayment AND I am able to pay the full annual premium for this policy.
- ☐ I am qualified as a member of a group or organization in which membership is required in order to obtain this insurance policy.
- ☐ I have fewer eligibility points accumulated than alleged in the declination letter as evidenced by the attached copy of my driving record.
- ☐ The accident record indicated in the declination letter is wrong as evidenced by the attached.
- ☐ No other person who is a member of the same household and who will drive the subject vehicle for 10 percent or more of the time is an ineligible person.
- ☐ Other (Specify and provide proof, if appropriate).

CERTIFICATION OF APPEAL

The information contained in this appeal is true and complete to the best of my knowledge and belief.

I UNDERSTAND THAT FILING THIS APPEAL DOES NOT PROVIDE ME WITH AUTOMOBILE INSURANCE. IF MY AUTO IS REGISTERED IN NEW JERSEY OR IS BEING DRIVEN, I HAVE OBTAINED OTHER AUTO INSURANCE.

Your Signature _____ Date _____

MAIL THIS COMPLETED FORM AND NECESSARY DOCUMENTATION TO:

New Jersey Department of Insurance
Division of Enforcement and Consumer Protection
CN 329
Trenton, New Jersey 08625
Attn: Auto Insurance Denial

SUBCHAPTER 34. ELIGIBLE PERSONS QUALIFICATIONS AND AUTOMOBILE INSURANCE ELIGIBILITY POINTS SCHEDULE

Authority

N.J.S.A. 17:33B–13 and 14; N.J.S.A. 17:1C–6(e).

Source and Effective Date

R.1991 d.93, effective January 25, 1991, operative April 1, 1991.
See: 22 N.J.R. 3847(a), 23 N.J.R. 572(a).

Subchapter Historical Note

Subchapter 34, Eligible Persons Qualifications and Automobile Insurance Eligibility Points Schedule, was filed as emergency new rule R.1990 d.620, effective November 26, 1990, with an expiration date of January 25, 1991. See: 22 N.J.R. 3847(a). Subchapter 34 was readopted as R.1991 d.93, with changes effective February 19, 1991. See: Source and Effective Date.

11:3–34.1 Purpose

The purpose of this subchapter is to set forth the requirements for determining who can qualify as an "eligible person", and to provide the schedule for "automobile insurance eligibility points" pursuant to P.L. 1990, c.8 (N.J.S.A. 17:33B–13 and 14).

11:3–34.2 Scope

The provisions of this subchapter apply to all insurers which write personal private passenger automobile insurance and all persons who are required to procure automobile insurance coverage in this State.

11:3–34.3 Definitions

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

"At-fault accident" is any accident involving a driver insured under the policy which resulted in a payment by the insurer of at least $500.00, and for which the driver is at least proportionately responsible based on the number of vehicles involved. A driver is proportionately responsible if 50 percent responsible for an accident involving two drivers; if 33⅓ percent responsible for an accident involving three drivers; etc. An at-fault accident shall not include the following:

1. Involvement in an accident in which the motor vehicle owned or operated by the insured or other driver insured under the policy was lawfully parked;

2. Involvement in an accident in which the motor vehicle was struck by a hit and run driver, if such accident was reported to the proper authorities within 24 hours;

3. Involvement in an accident in connection with which neither the named insured nor any other driver insured under the policy was convicted of a moving traffic violation and the owner or operator of another vehicle involved in such accident was so convicted;

4. For physical damage losses other than collision;

5. For an accident in which the motor vehicle was struck in the rear by another vehicle and a driver insured under the policy has not been convicted of a moving violation in connection with the accident; or

6. For an accident occurring as a result of operation of any motor vehicle in response to an emergency if the operator at the time of the accident was responding to the call to duty as a paid or volunteer member of any police or fire department, first aid squad or any law enforcement agency.

"Automobile" means an automobile as defined in N.J.S.A. 39:6A–2.

"Automobile insurance" means insurance for an automobile including any or all of the following coverages: bodily injury liability, and property damage liability, comprehensive and collision coverages, uninsured and underinsured motorist coverage, personal injury protection coverage, additional personal injury protection coverage and any other automobile insurance required by law.

"Automobile insurance eligibility points" means points calculated under the schedule promulgated by the Commissioner pursuant to this subchapter.

"Commissioner" means the Commissioner of Insurance of the State of New Jersey.

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

"State" means the State of New Jersey.

11:3–34.4 Eligible person qualifications

(a) An "eligible person" is a person who is an owner or registrant of an automobile registered and principally garaged in this State or who is resident and holds a valid New Jersey driver's license to operate an automobile, but does not include any person:

1. Who, during the three-year period immediately preceding application for, or renewal of, an automobile insurance policy has been convicted pursuant to N.J.S.A. 39:4–50 or N.J.S.A. 39:4–50.4a or for an offense of a substantially similar nature committed in another jurisdiction;

2. Who has been convicted of a crime of the first, second or third degree resulting from the use of a motor vehicle; or has been convicted of theft of a motor vehicle;

3. Whose driver's license to operate an automobile is under suspension or revocation;

4. Who has been convicted, within the five-year period immediately preceding application for or renewal of a policy of automobile insurance, of fraud or intent to defraud involving an insurance claim or an application for insurance;

5. Who has been successfully denied, within the immediately preceding five years, payment by an insurer of a claim in excess of $1,000 under an automobile insurance policy, if there was evidence of fraud or intent to defraud involving the automobile insurance claim or application. For the purpose of this section:

i. If the claim has been subject to litigation between the insurer and the insured in which the insurer defended against payment of the claim in whole or in part on grounds of fraud, it shall be conclusively presumed that the claim was successfully denied if judgment was entered for the insurer in the litigation; and conclusively presumed that the claim was not successfully denied if judgment was entered for the insured;

ii. If the claim has not been subject to litigation between the insurer and the insured, but the insurer denied the claim without payment by reason of fraud, it shall be presumed that the claim was successfully denied. This presumption may be overcome in an administrative proceeding pursuant to N.J.A.C. 11:3–33;

iii. If the incident was not reported to the New Jersey Department of Insurance, Fraud Division pursuant to N.J.S.A. 17:33A–9 it shall be presumed that there was no evidence of fraud or intent to defraud;

6. Whose automobile insurance policy has been cancelled for nonpayment of premiums or financed premium with a lapse of coverage of at least 30 days, within the immediately preceding two-year period, unless the premium due on a policy for which application has been made is paid in full before issuance or renewal of the policy. For the purpose of this section, "paid in full" shall not include any transaction in which a lender obtains authority from an insured to cancel the policy and receive a refund from the insurer in the event the insured defaults on a loan used to pay the premium;

7. Who fails to obtain or maintain membership or qualification for membership in a club, group, or organization, if membership is a uniform requirement of the insurer as a condition of providing insurance, and if the dues or charges, if any, or other conditions for membership or qualifications for membership are applied uniformly throughout this State, are not expressed as a percentage of the insurance premium, and do not vary with respect to the rating classification of the member or potential member except for the purpose of offering a membership fee to family units. Membership fees, if applicable, may vary in accordance with the amount or type of coverage if the purchase of additional coverage, either as to type or amount, is not a condition for reduction of dues or fees; or

8. Whose driving record for the three year period immediately preceding the application for or renewal of a policy of automobile insurance has an accumulation of nine or more automobile insurance eligibility points as determined in N.J.A.C. 11:3–34.5.

(b) An "eligible person" includes a person who is an owner or registrant of an automobile registered in this State or who holds a valid New Jersey driver's license to operate an automobile and is domiciled in this State who is temporarily residing out-of-State and whose car may be principally garaged in another state while the person either is a full time student or is in the military service and is stationed out-of-State.

Emergency Amendment, R.1992 d.380, effective September 4, 1992 (expires November 3, 1992).
See: 24 N.J.R. 3420(a).
Text added to (a)6 to specify a lapse of at least 30 days.
Adopted Concurrent Proposal, R.1992 d.481, effective November 2, 1992.
See: 24 N.J.R. 3420(a), 24 N.J.R. 4396(a).
Provisions of Emergency Amendment R.1992 d.380 readopted with changes effective December 7, 1992.
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 of eligible person added at (b).
Adopted Concurrent Proposal, R.1993 d.238, effective April 30, 1993.
See: 25 N.J.R. 1290(a), 25 N.J.R. 2479(a).

Case Notes

Decision not to renew automobile insurance policy was improper. Capasso v. State Farm Indemnity Company, 94 N.J.A.R.2d (INS) 59.

Eligibility points for accident prior to effective date of regulation not ex post facto violation. Selective Insurance Company v. Diana, 93 N.J.A.R.2d (INS) 58.

11:3–34.5 Automobile insurance eligibility points

(a) Automobile insurance eligibility points shall be accumulated as a result of convictions, suspensions, revocations and determinations of responsibility for civil infractions in accordance with the schedule set forth in the Appendix to this subchapter herein incorporated by reference.

(b) Automobile insurance eligibility points shall be deemed to accrue as follows:

1. Points for an at-fault accident shall accrue on the date that total payment by the insurer equals or exceeds $500.00. An insurer may, at its option, use the date of the accident or date of first payment provided, however, that the insurer shall not underwrite or rate any policy based on the accident until total payment by the insurer equals or exceeds $500.00; and further provided that the insurer shall use the optional date consistently in all cases.

2. Points for conviction of motor vehicle violations and other events that are set forth on an abstract of drivers license records available from the New Jersey Division of Motor Vehicles, or comparable agency of another state, shall accrue when the event is recorded in the agency's records as evidenced by an abstract.

3. Points for each full year of court-imposed driver's license suspension within the preceding three years and points for each full year within the immediately preceding three years that a person has not held a driver's license shall accrue on the date of application for insurance.

(c) Automobile insurance eligibility points are cumulative and accrue for all offenses set forth on Schedules 1 and 2, except as noted on Schedule 1.

(d) Automobile insurance eligibility points set forth on Schedule 2 of the Appendix represent motor vehicle points established by the New Jersey Division of Motor Vehicles by rule, N.J.A.C. 13:19–10.1, which is hereby incorporated by reference. Any additions, deletions or modifications to N.J.A.C. 13:19–10.1 shall likewise be incorporated as of the effective date of amendment. Schedule 2 is included in the Appendix for convenience.

Case Notes

Accident resulting in payment of $500 or more not recouped from another tort-feasor and not specifically excepted, and driver not excused under proportionate responsibility standard, was "at-fault accident" warranting eligibility points. Amica Mutual Insurance Co. v. Kern, 93 N.J.A.R.2d (INS) 55.

APPENDIX

Schedule of Automobile Insurance Eligibility Points

Schedule 1

N.J.S.A. Section Number If applicable	Event Description	DMV Event Identifier(s) If applicable	Points
39:4–50	Operating a motor vehicle under the influence of alcohol or drugs	0450; 3261	9
39:4–50.4	Refusal to submit to a chemical test	4504	9
2C:11–2	Vehicular homicide	C115	9
39:3–40	Operating a motor vehicle while driving privilege is suspended	0340	9
39:6B–2	Operating a motor vehicle without liability insurance	06B2	9
39:6A–15	Misrepresentation of insurance coverage	6A15	9
	Each at fault accident		5
	* For each full year of a court imposed driver's license suspension within the preceding 3 years		3
	* For each full year within the immediately preceding 3 years that a person has not held a driver's license		1
	Involved in a fatal accident	EFTL; NFTL	4 2
39:3–37	Obtaining a driver's license or registration through deception	0337; 0312; 05D5; 1312; MSNJ; MSOS	5
39:3–38	Make or use counterfeit plate or plates other than issued	0338	5
39:3–38.1	Make, alter or counterfeit driver's license or registration	3381	5
	Failure to verify insurance involved in an automobile accident	FVIA	2

* Points for failure to hold a driver's license in the previous three years are not cumulative to points for driver's license suspension.

Schedule 2

N.J.S.A. Section Number	Offense	Points
27:23–29	Moving against traffic—New Jersey Turnpike, Garden State Parkway, and Atlantic City Expressway	2
27:23–29	Improper passing—New Jersey Turnpike, Garden State Parkway, and Atlantic City Expressway	4
27:23–29	Unlawful use of median strip—New Jersey Turnpike, Garden State Parkway, and Atlantic City Expressway	2
39:3–20	Operating constructor vehicle in excess of 30 mph	3
39:3–76.7 & 39:4–14.3q	Operating motorcycle or motorized bicycle without protective helmet	2
39:4–14.3	Operating motorized bicycle on a restricted highway	2
39:4–14.3d	More than one person on a motorized bike	2
39:4–35	Failure to yield to pedestrian in crosswalk	2
39:4–36	Failure to yield to pedestrian in crosswalk; passing a vehicle yielding to pedestrian in crosswalk	2
39:4–41	Driving through a safety zone	2
39:4–52 & 39:5C–1	Racing on highway	5
39:4–55	Improper action or omission on grades and curves	2
39:4–57	Failure to observe direction of officer	2
39:4–66	Failure to stop vehicle before crossing sidewalk	2
39:4–66.1	Failure to yield to pedestrians or vehicles while entering or leaving highway	2
39:4–71	Operating a motor vehicle on a sidewalk	2
39:4–80	Failure to obey direction of officer	2
39:4–81	Failure to observe traffic signals	2
39:4–82	Failure to keep right	2
39:4–82.1	Improper operating of vehicle on divided highway or divider	2
39:4–83	Failure to keep right at intersection	2
39:4–84	Failure to pass to right of vehicle proceeding in opposite direction	5
39:4–85	Improper passing on right or off roadway	4
39:4–85.1	Wrong way on a one-way street	2
39:4–86	Improper passing in no passing zone	4
39:4–87	Failure to yield to overtaking vehicle	2
39:4–88	Failure to observe traffic lanes	2
39:4–89	Tailgating	5
39:4–90	Failure to yield at intersection	2
39:4–90.1	Failure to use proper entrances to limited access highways	2

N.J.S.A. Section Number	Offense	Points
39:4–91 & 39:4–92	Failure to yield to emergency vehicles	2
39:4–96	Reckless driving	5
39:4–97	Careless driving	2
39:4–97a	Destruction of agricultural or recreational property	2
39:4–97.1	Slow speed blocking traffic	2
39:4–98 & 39:4–99	Exceeding maximum speed 1–14 mph over limit	2
	Exceeding maximum speed 15–29 mph over limit	4
	Exceeding maximum speed 30 mph or more over limit	5
39:4–105	Failure to stop for traffic light	2
39:4–115	Improper turn at traffic light	3
39:4–119	Failure to stop at flashing red signal	2
39:4–122	Failure to stop for police whistle	2
39:4–123	Improper right or left turn	3
39:4–124	Improper turn from approved turning course	3
39:4–125	Improper "U" turn	3
39:4–126	Failure to give proper signal	2
39:4–127	Improper backing or turning in street	2
39:4–127.1	Improper crossing of railroad grade crossing	2
39:4–127.2	Improper crossing of bridge	2
39:4–128	Improper crossing of railroad grade crossing by certain vehicles	2
39:4–128.1	Improper passing of school bus	5
39:4–128.4	Improper passing of a frozen dessert truck	4
39:4–129	Leaving the scene of an accident	
	No personal injury	2
	Personal injury	8
39:4–144	Failure to observe "stop" or "yield" signs	2
39:5D–4	Moving violation out-of-state	2

SUBCHAPTER 35. PRIVATE PASSENGER AUTOMOBILE INSURANCE UNDERWRITING RULES

Authority

N.J.S.A. 17:1–8.1; N.J.S.A. 17:1C–6e; N.J.S.A. 17:22–6.14(a)1; N.J.S.A. 17:29A–46; P.L. 1990, c.8, Section 27B (enacted March 12, 1990).

Source and Effective Date

R.1991 d.94, effective January 25, 1991.
See: 22 N.J.R. 3856(a), 23 N.J.R. 577(a).

Subchapter Historical Note

Subchapter 35, Private Passenger Automobile Insurance Underwriting Rules, was filed as emergency new rule R.1990 d.627, effective November 26, 1990, with an expiration date of January 25, 1991. See: 22 N.J.R. 3856(a). Subchapter 35 was readopted as R.1991 d.94, with changes effective February 19, 1991. See: Source and Effective Date.

11:3–35.1 Purpose and scope

(a) This subchapter implements N.J.S.A. 17:29A–46 which requires that personal private passenger automobile insurers file for approval their underwriting rules used to accept or reject new or renewal business or to assign risks to the standard or non-standard rate levels. Approval of underwriting rules shall serve to confirm that each insurer's business practices are consistent with law regarding the acceptance of new business, the renewal of current business and the assignment of a risk to an insurer's standard or non-standard rate level.

(b) This subchapter applies to all insurers that are licensed and authorized to transact personal private passenger automobile insurance in the voluntary market. It applies to affiliated companies which insure risks through different individual insurance companies.

11:3–35.2 Definitions

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

"Affiliated companies" means two or more individual insurance companies that are authorized to transact private passenger automobile insurance business in New Jersey and that are under both common ownership and common management.

"Automobile insurance eligibility points" means points accrued as provided in accordance with the schedule set forth in N.J.A.C. 11:3–34.

"Commissioner" means the Commissioner of Insurance of the State of New Jersey.

"Department" means the New Jersey Department of Insurance.

"Individual insurance company" means an insurance company licensed and authorized to transact private passenger automobile insurance business in New Jersey, regardless of whether it is one of a group of affiliated companies.

"Insurer" includes a group of affiliated companies.

"Renew" means to issue and deliver at the end of the policy period a policy superseding a policy previously issued and delivered, or to issue and deliver a certificate or notice extending the term of a policy beyond its policy period or term, by the same individual insurance company, or by another of a group of affiliated companies pursuant to a standard/non-standard rating plan filed and approved in accordance with N.J.A.C. 11:3–19.

11:3–35.3 General requirements and filing format

(a) All insurers which write personal private passenger automobile insurance in New Jersey shall file for approval their underwriting rules used to accept or reject new business, to renew or nonrenew current business and to assign business to the standard or non-standard rate level of an approved standard/non-standard rating plan, in accordance with N.J.S.A. 17:29A–46 and this subchapter. No insurer shall use or implement any underwriting rule not filed and approved as set forth herein.

(b) Underwriting rules shall be submitted on 8½ by 11 inch paper using one side of the page. Each page shall be consecutively numbered. The first page shall show the filer's company name, the filer's identifying number for this filing, National Association of Insurance Commissioners (NAIC) company number(s), and NAIC group number. The underwriting rules filing shall clearly identify the rate level to which the underwriting rules will be applied and whether the underwriting rules apply to new business, renewal business or both. All tables shall be clearly labeled.

(c) Underwriting rules shall meet the following standards:

1. No underwriting rule shall be based on the territory in which an insured resides.

2. An underwriting rule shall be based on a reasonable and demonstrable relationship between the risk characteristics of the driver(s) insured and the hazards insured against.

3. An underwriting rule shall be based on specific and verifiable measurements. No underwriting rule shall be based on subjective judgments such as "pride of ownership evident," "poor attitude," "unsatisfactory environment to conduct business," etc.

4. No underwriting rule shall be based on race, color, creed, national origin or ancestry.

5. No underwriting rule shall be based on whether the applicant or insured was previously insured as a non-standard or sub-standard risk, was previously insured by a residual market mechanism, or whether another insurer declined to insure or terminated insurance.

6. No underwriting rule shall be based on whether the insured or a member of the insured's household purchases or continues to purchase other insurance or services from the insurer or its affiliates, agents or other companies under common management or ownership, except that this provision shall not prohibit a rate discount.

7. No underwriting rule shall be based on the lawful occupation or profession of an insured, except that this provision shall not apply to any insurer which limits all its insureds to one lawful occupation or profession, or to several related lawful occupations or professions.

8. No underwriting rule shall be based on whether the insured has changed employment in the recent past, except that this provision shall not prohibit a rate discount to an insurer's employees or agents.

9. No underwriting rule shall be based on whether the insured is impaired by physical or mental disabilities except those disabilities that impair the ability to operate an automobile safely.

11:3-35.4 Underwriting rules for eligible persons

(a) All insurers shall file for approval underwriting rules that provide that the insurer will make an offer to renew any of its insureds who is defined as an "eligible person" in N.J.A.C. 11:3-34.

(b) All insurers shall file for approval underwriting rules that provide that on or after April 1, 1992, the insurer shall not refuse to insure, refuse to renew or limit coverage available to any of its insureds, or to any applicant for insurance, which is defined as an "eligible person" in N.J.A.C. 11:3-34.

(c) An insurer may file for approval underwriting rules pursuant to which it will determine whether to insure any person not defined as an "eligible person" in N.J.A.C. 11:3-34.

(d) Underwriting rules for eligible persons applicable on and after April 1, 1992 shall not provide that coverage will be declined based on whether a member of the insured household is not an "eligible person" as defined in N.J.A.C. 11:3-34 unless the member of the insured household accounts for 10 percent or more of the use of the automobile insured or to be insured. For the purposes of this section:

1. Any driver who is the principal driver of an automobile shall be presumed not to account for 10 percent or more of the use of any other automobile in the household.

2. Except when there are more automobiles than drivers in the household, a person shall be presumed not to be the principal driver of more than one automobile.

11:3-35.5 Underwriting rules for standard/non-standard rating plans

(a) Insurers shall file underwriting rules applicable to each rate level of a standard/non-standard rating plan in accordance with N.J.A.C. 11:3-19.3(c) which filing shall be made in accordance with, and in satisfaction of, the requirements of this subchapter.

(b) Insurers shall file underwriting rules that provide that its insureds and applicants who have accrued no automobile insurance eligibility points shall be assigned to its standard rate level.

(c) An insurer may file for approval underwriting rules pursuant to which it will determine whether to insure at its standard rate level any person who has accrued one or more automobile insurance eligibility points.

(d) Underwriting rules for standard/non-standard rating plans shall provide that an automobile insured at the non-standard rate level shall be rated based upon the eligibility points of the principal driver; eligibility points of other household members may additionally be used to rate the automobile only if not used to rate any other automobile in the household.

11:3–35.6 Penalties

(a) An insurer which fails to file its underwriting rules for approval pursuant to N.J.S.A. 17:29A–46 and this subchapter by March 1, 1991 shall be subject to penalties as provided by N.J.S.A. 17:33–2.

(b) An insurer which knowingly fails to transact automobile insurance business consistently with its approved underwriting rules shall be subject to a fine of not less than $500 for each violation, pursuant to N.J.S.A. 17:29A–46a.

SUBCHAPTER 36. AUTOMOBILE PHYSICAL DAMAGE INSURANCE INSPECTION PROCEDURES

Authority

N.J.S.A. 17:33B–33.

Source and Effective Date

R.1991 d.95, effective January 25, 1991
(original operative date of March 1, 1991 rescinded;
new date to be determined.)
See: 22 N.J.R. 3861(a), 23 N.J.R. 579(a), 23 N.J.R. 1132(c).

Subchapter Historical Note

Subchapter 36, Automobile Physical Damage Insurance Inspection Procedures, was filed as emergency new rule R.1990 d.622, effective November 26, 1990, with an expiration date of January 25, 1991. See: 22 N.J.R. 3861(a). Subchapter 36 was readopted as R.1991 d.95, with changes effective February 19, 1991. See: Source and Effective Date.

11:3–36.1 Purpose and scope

(a) The purpose of this subchapter is to provide rules for the inspection of automobiles in connection with the issuance of physical damage insurance coverage by insurers pursuant to N.J.S.A. 17:33B–33 through 17:33B–40.

(b) The provisions of this subchapter apply to all insurers which write private passenger automobile insurance in this State.

11:3–36.2 Definitions

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

"Authorized representative" means any person which is authorized by the insurer to conduct insurance inspections pursuant to this subchapter; an authorized representative may be an employee of the insurer, a producer or an inspection service other than the insured, whether located inside or outside of this State.

"Automobile physical damage insurance" means a policy providing one or more of the following insurance coverages:

1. Collision;
2. Comprehensive; and
3. Fire and theft.

"Automobile physical damage insurance inspection" means a physical examination of an automobile by an authorized representative of the insurer, in accordance with the standards set forth in N.J.A.C. 11:3–36.6.

"Book of business" means all private passenger automobile insurance written by one producer with one insurer.

"Certificate of mailing" means a receipt from the United States Postal Service that the item was received by it with the proper postage affixed for delivery.

"Commissioner" means the Commissioner of Insurance of the State of New Jersey.

"Inspection service" means any person or legal entity other than the insurer, established and operated to perform the inspections required by this subchapter.

"Insured" means the named insured (as defined in the policy) or an applicant for automobile physical damage insurance.

"Insurer" means any person authorized to write automobile insurance in New Jersey, including any residual market mechanism, and includes a group of affiliated companies.

"New automobile" means an automobile not previously titled with not more than 1,000 miles recorded on the odometer.

"Nonowned automobile" means a private passenger automobile in the possession of the insured or being operated by the insured which is neither owned by nor furnished for the regular use of either the named insured or any relative (as defined in the policy), other than a temporary substitute automobile.

"Private passenger automobile" or "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.

"Renewal" means the issuance and delivery by an insurer, at the end of the policy period, of a policy superseding a policy previously issued and delivered by the same insurer, or the issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term.

"Replacement automobile" is a vehicle acquired to replace one shown in the declarations.

"Temporary substitute automobile" means any private passenger automobile not owned by the insured, while temporarily used with the permission of the owner as a substitute for an owned automobile, when the latter is withdrawn from normal use because of breakdown, repair, servicing, loss or destruction.

Amended by R.1992 d.142, effective March 16, 1992.
See: 23 N.J.R. 1262(a), 24 N.J.R. 953(b).
Definition for authorized representative amended; nonowned and temporary substitute automobile definitions added.

11:3–36.3 Mandatory inspection requirements

(a) No insurer shall provide automobile physical damage insurance coverage prior to conducting an insurance inspection in accordance with this subchapter, under the following circumstances:

1. When a new policy or endorsement adding physical damage coverage insuring a private passenger automobile is effected; and

2. When coverage is effected for an additional or replacement private passenger automobile.

(b) An insurer may require, prior to continuing physical damage coverage on an automobile, that the insured present the automobile for inspection, under the following circumstances:

1. When the automobile insured for physical damage coverage has been in an accident or otherwise damaged; or

2. As a condition of renewal.

11:3–36.4 Waivers of mandatory inspection

(a) An insurer shall waive a mandatory inspection when a new automobile is purchased from a franchised automobile dealership and the insurer is provided with the following documents in accordance with N.J.A.C. 11:3–36.7(e):

1. A copy of the bill of sale which contains a full description of the automobile, including all options and accessories;

2. A copy of the window sticker or advanced dealer shipping notice (invoice) showing the itemized options and equipment, the total retail price of the automobile, and any dealer installed option purchased by the customer; or

3. Vehicle buyer's order (contract) and/or the dealership invoice to the buyer, including all options and accessories.

(b) An insurer may waive a mandatory inspection under any of the following circumstances:

1. When the automobile is more than seven model years old. For example: in 1991 an insurer shall inspect 1984 and newer model year vehicles and in 1992 an insurer shall inspect 1985 and newer model year vehicles;

2. When a policy is being renewed or issued by a different individual insurance company within a group of affiliated companies;

3. When the insured automobile is insured under a commercially rated policy which insures five or more automobiles;

4. When an insurance producer or insurer is transferring a book of business from one insurer to another insurer(s);

5. When the automobile is a temporary substitute automobile; or

6. When the automobile is leased for less than six months.

7. When the named insured has been continuously insured for automobile insurance with the same insurer, or an affiliate of the insurer, for four or more policy years.

8. Where an individual insured's coverage is being transferred by an independent insurance agent to a new insurer and the previous insurer provides the new insurer with a copy of the inspection report.

i. If the new insurer does not receive a copy of the inspection report 60 days prior to the first annual renewal date, the insurer, upon renewal of the automobile physical damage insurance, shall require a physical inspection in accordance with N.J.A.C. 11:3–36.5(e).

(c) Insurers shall maintain a record of the waiver in the insurer's file on the insured.

(d) Insurers shall decide whether to waive an inspection based solely on underwriting criteria uniformly applied and not based on the age, race, sex or marital status of the insured, the principal place of garaging or the fact that the automobile is insured in the residual market.

Amended by R.1992 d.142, effective March 16, 1992.
See: 23 N.J.R. 1262(a), 24 N.J.R. 953(b).
Text on out of State garaging deleted; (a)8 and 9 added.

11:3–36.5 Deferral of inspections

(a) An insurer, by itself or through its authorized producers, may defer the mandatory inspection required by N.J.A.C. 11:3–36.3 for seven calendar days following the effective date of coverage, upon an insured's requests for coverage for automobile physical damage insurance on an additional or replacement automobile.

(b) An insurer may defer the mandatory inspection under any of the following circumstances:

1. On new business for seven calendar days following the effective date of coverage; and

2. On replacement automobiles, an insurer may provide the same type and level of physical damage coverage which covered the replaced automobile, without a request for coverage by the insured. Such automatic coverage prior to the insured's request for coverage shall be for a period of three days, including the day on which the automobile is acquired. The three-day period shall be extended by one day for each Saturday, Sunday or any New Jersey State legal holiday falling within the period. The insurer's election shall apply only to automobiles replacing covered automobiles which were insured by the insurer for physical damage coverage for at least the 12–month period preceding the replacement date and such election once made shall apply to all the insurer's private passenger automobile insurance. An insurer which makes an election pursuant to this clause shall file an appropriate policy endorsement with the Commissioner and furnish a copy of such endorsement to all of its insureds who have physical damage coverage.

(c) When an inspection is deferred pursuant to (a) **or (b)** above, the insurer or producer shall:

1. At the time the insurance application is completed, obtain the Acknowledgment of Requirement for Insurance Inspection form (as set forth in Appendix A and incorporated herein by reference) signed by the insured if the insured has applied for coverage in person; or

2. At the time the insurance application is completed, confirm physical damage coverage and advise the insured of the inspection requirements and mail the insured the Notice of Insurance Inspection form (as set forth in Appendix B and incorporated herein by reference) if the insured has applied for coverage by mail or by telephone. Documentation of such verbal notices shall include the name of the person giving the notice.

(d) In addition to the notice requirements set forth in (c)1 and 2 above, the insurer or producer shall furnish the insured with information about where an inspection can be conducted and the consequences of the insured's failure to have the automobile inspected.

1. The insurer shall retain documentation of the required notice in (c) above in the insurer's file on the insured.

(e) When an insurer requires an insured's automobile to be inspected as a condition for any annual renewal of physical damage coverage, the insurer shall provide notice and coverage as follows:

1. Whenever a renewal of physical damage coverage is conditioned upon inspection, the insurer shall mail or deliver a written Notice of Insurance Inspection (Appendix B) to the insured at least 30 days prior to the renewal date. The insurer's file on the insured shall reflect the mailing of such notice.

2. If the insured has not responded to the Notice of Insurance Inspection, the insurer shall, at least 10 days prior to the expiration of the above 30–day deferral period, mail a second Notice of Insurance Inspection to the insured, to the producer of record, and any lienholders, restating that failure to have the automobile inspected prior to the expiration of the deferral period will result in suspension of physical damage coverage. A certificate of mailing of the second notice to the insured shall be retained by the insurer. The insurer shall assist the insured in arranging a convenient appointment for the required inspection. The written notice of the inspection requirement shall clearly inform the insured of the failure to comply with the inspection requirement will result in the suspension of automobile physical damage coverage. The notice shall also state that a copy of the inspection report will be given to the insured.

(f) An insurer shall decide whether to defer an inspection based solely on underwriting criteria and not based on age, sex, race, or marital status of the insured, the principal place of garaging, or the fact that a policy is insured in the residual market.

Amended by R.1992 d.142, effective March 16, 1992.
See: 23 N.J.R. 1262(a), 24 N.J.R. 953(b).
Text added at (b) and (e).

11:3–36.6 Standards and procedures for inspection

(a) Inspections shall be made by an authorized representative of the insurer at a time and place reasonably convenient to the insured. A reasonably convenient time shall include, in addition to customary business hours, sufficient early morning, evening and weekend hours. A reasonably convenient place shall not be more than 10 miles from the city or town where automobile is principally garaged.

(b) If the insured acquires an additional or replacement automobile outside of New Jersey, and such automobile will be located outside New Jersey until after the expiration of the deferral period permitted by N.J.A.C. 11:3–36.5(a) or (b), the insurer shall arrange to conduct the inspection by an authorized representative during the deferral period at a place which shall not be more than 50 miles from the temporary location.

(c) If the insured automobile required to be inspected upon renewal is temporarily located outside of New Jersey

when the required notice of inspection is mailed to the insured, and such automobile will continue to be located outside of New Jersey until the expiration of the deferral period required by N.J.A.C. 11:3–36.5(e)1, the insurer shall arrange to conduct the inspection by an authorized representative before the expiration of the deferral period at a place which shall not be more than 50 miles from the temporary location.

(d) Whenever an insurer requires an automobile to be inspected pursuant to this subchapter, the insurer by itself or through its authorized producer shall provide the insured with a Notice of Inspection in the form set forth in Appendix B or an Acknowledgement of Requirement for Insurance Inspection as set forth in Appendix A. Any form so provided shall not contain the vehicle identification number (VIN) of the automobile to be inspected.

(e) The inspection shall include the following:

1. Completion of the Automobile Insurance Inspection Report as set forth in Appendix C incorporated herein by reference;

2. Two color photographs of the automobile, taken as directed on the inspection report (Appendix C), which shall be a part of the report;

3. A third close-up color photograph showing the VIN located on the Environmental Protection Agency/Federal Certification Label (EPA sticker) affixed to the driver's side door jamb. The photograph must be of sufficient clarity that the information contained on the EPA sticker and VIN is legible. If the EPA sticker is damaged, faded, missing or otherwise not legible, a photograph of the EPA sticker, or of the area of the door jamb where the sticker is normally located, is still required;

4. The authorized representative may take additional photographs showing any damaged areas, which shall also be a part of the report; and

5. The authorized representative shall provide a copy of the report, without photographs, to the insured at the time of inspection.

(f) The insurer shall utilize authorized representatives and systems to implement the provisions of this subchapter which meet the following standards:

1. Verifies the accuracy, completeness and identity of the person completing each inspection report;

2. Provides a control system for its inspection reports such as the use of sequentially numbered or coded reports;

3. Completes all required information for each automobile on the Automobile Insurance Inspection Report set forth in Appendix C;

4. Takes photographs as required in (e)2 through 3 above; and

5. Provides for the storage and retrieval of reports and photographs in a manner that facilitates their use as set forth in paragraph (j) below.

(g) There shall be no direct charge to the insured by the authorized representative or insurer in connection with an inspection.

(h) After the inspection is completed, the report and photographs shall be retained in the insurer's file on the insured for five years.

(i) The insurer shall maintain an up-to-date list of all authorized representatives and inspection sites performing inspections for the insurer. The list shall include the names, addresses and business telephone numbers of all authorized representatives. The insurer shall send a copy of the list to the Department and update it semi-annually at the following address:

New Jersey Department of Insurance
Fraud Division
CN 324
Trenton, New Jersey 08625

(j) The inspection report and photographs shall be used by the insurer to document previous damage, prior condition, options and mileage of the automobile on physical damage claims whenever:

1. The appraisal indicates prior damage and the new damage (claim) exceeds $1,000;

2. The automobile is a total loss or unrecovered theft; or

3. The new damage (claim) exceeds $3,000.

(k) A copy of the inspection report and photographs shall be utilized, and made a part of the insurer's claim file, in the settlement of all total loss claims. The inspection report shall be made a part of the claim file regardless of whether or not the payment is reduced based on the information contained therein.

(*l*) The documents set forth as Appendices A through D provide minimum standards. Insurers may enhance or alter the form of these documents provided the minimum information requirements are met.

Amended by R.1992 d.142, effective March 16, 1992.
See: 23 N.J.R. 1262(a), 24 N.J.R. 953(b).
Text added at (b) and (c).
Amended by R.1994 d.103, effective February 22, 1994.
See: 25 N.J.R. 5756(a), 26 N.J.R. 1100(a).

11:3–36.7 Suspension of physical damage coverages

(a) If the inspection is not conducted prior to the expiration of the deferral period or the expiration of the policy in the case of renewals, the insurer shall suspend automobile physical damage coverage on the automobile at 12:01 A.M. of the day following the last day for inspection. Suspension of coverage shall apply to all insureds, owners and lienholders.

(b) Whenever physical damage coverage is suspended, the insurer shall:

1. No later than the 30th calendar day after the effective date of the suspension, mail to the insured, the producer of record and any lienholders a Notice of Suspension of physical damage coverage (as set forth in Appendix D incorporated herein by reference);

2. Obtain a certificate of mailing or other evidence of mailing of the Notice of Suspension to the insured and shall retain the certificate and copy of the Notice in the insurer's file on the insured; and

3. Make a pro-rata premium adjustment (premium refund or credit) whenever there is a suspension of physical damage coverage for more than 10 days. A refund of premium, if applicable, shall be sent to the insured within 45 days of the effective date of suspension.

(c) A reinstatement of physical damage coverage shall only be effective upon inspection and payment by the insured to the insurer of the adjusted premium for the physical damage coverage in full or in accordance with the insurer's normal payment plan. Any such reinstatement shall be effective at the time of inspection.

(d) If the automobile is not inspected pursuant to this subchapter due to the fault of the insurer, or if the insurer fails to give the verbal or telephone notice required by the subchapter or mail or deliver the Notice of Insurance Inspection (Appendix B) or obtain the Acknowledgement of Requirements for Insurance Inspection (Appendix A) as set forth in this subchapter, physical damage coverage on the motor vehicle shall not be suspended. The failure of the insurer to act promptly does not relieve it of its obligation to inspect. An insurer's failure, however, to comply with (b) above shall not restore physical damage coverage, but shall subject the insurer to a penalty pursuant to N.J.S.A. 17:33B–39.

(e) Physical damage coverage on a new automobile shall not be suspended during the term of the policy due to the insured's failure to provide the documents required by N.J.A.C. 11:3–36.4(a).

1. Payment of a physical damage claim shall be conditioned upon the receipt of such document(s) by the insurer.

2. If the above document(s) are not submitted by the insured 60 days prior to the next policy renewal date, the insurer shall require an inspection upon renewal.

3. New automobiles acquired less than 90 days prior to the next policy renewal date have until 60 days prior to the following policy renewal date to submit the required document(s) or be subject to an inspection at that renewal in accordance with N.J.A.C. 11:3–36.5(e).

(f) For renewal inspections, if the insured fails to have the insured automobile inspected before the expiration of the 30–calendar day deferral period required by N.J.A.C. 11:3–36.5(e)1, physical damage coverage on the insured automobile shall be suspended effective at 12:01 A.M. on the day following the last day of the deferral and suspension shall continue until such inspection is effected. The insurer, however, must reinstate coverage for automobile physical damage if the insured thereafter completes the inspection. Any such reinstatement shall be effective at the time of the inspection and, for the purposes of this subchapter, shall not be considered new business.

1. If the insurer fails to mail or deliver the initial written notice of inspection to the insured in accordance with N.J.A.C. 11:3–36.5(e), it shall, nevertheless, give written notice of the inspection requirement, and automobile physical damage coverage shall continue without the required inspection past the renewal date for up to 30 days from the same of the delayed notice.

2. An insurer shall make every effort to conduct a renewal inspection in advance of the normal inspection period for such risk, in order to mitigate any hardship to the insured which would otherwise result.

3. If an automobile is not inspected due to the fault of the insurer, physical damage coverage on the automobile shall not lapse.

Amended by R.1992 d.142, effective March 16, 1992.
See: 23 N.J.R. 1262(a), 24 N.J.R. 953(b).
Documentation and inspection requirements added at (e) and (f).

11:3–36.8 Enforcement

(a) A violation of any provision of this subchapter by an insurer shall be punishable by a $500.00 fine pursuant to N.J.S.A. 17:33B–39.

1. Insurers shall be responsible for the conduct of their authorized representatives with respect to all duties imposed by this subchapter.

2. Each issuance, procurement, or negotiation of a policy of insurance, or maintenance of a record in violation of this subchapter shall be deemed a separate offense.

11:3–36.9 Results and audits

(a) Insurers shall maintain records as to the costs and savings related to this subchapter and shall make such records available to the Department upon request.

(b) Insurers shall report the following information to the New Jersey Department of Insurance Fraud Division on a quarterly basis:

1. The number of automobiles inspected; and

2. The number of automobiles which were not inspected by reason of the insured's failure to present the automobile for inspection.

11:3–36.10 Severability

If any section or portion of a section of this subchapter or its application to any person, entity or circumstance is held invalid by any court, the remainder of this regulation or the applicability of such provisions to other persons, entities or circumstances shall not be affected thereby.

11:3–36.11 Required amendatory endorsements

(a) For all policies providing automobile physical damage coverage issued on or after June 1, 1991, or renewed on or after July 1, 1991, insurers may adopt any one of the following procedures:

1. Amend the policy by adding thereto the endorsements as set out in (c) below, which may include the option set forth in (d) below and which is hereby deemed approved upon filing with the Department;

2. Submit for Department approval the insurer's own similar endorsement; or

3. Submit for Department approval the insurer's basic policy form incorporating the substance of the endorsements set out in (c) below, which may include the option set forth in (d) below.

(b) An insurer which adopts any of the above procedures may subsequently submit filings under any of the other procedures.

(c) The required endorsement is as follows: New Jersey Mandatory Inspection Endorsement for Physical Damage Coverage. Notwithstanding any conflicting provisions contained in the automobile physical damage coverage of this policy, it is agreed that the following conditions are added:

1. The company or its authorized representative has the right to inspect any private passenger automobile, including a nonowned automobile, insured or intended to be insured under this policy before physical damage coverage shall be effective.

2. During the term of the policy, coverage for an additional or replacement private passenger automobile shall not become effective until the insured notifies the company and requests coverage for the automobile.

3. When an inspection is required by the company the insured shall cooperate and make the automobile available for the inspection.

(d) Insurers which elect to provide physical damage coverage for a replacement automobile for three days without an insured's request for coverage in accordance with N.J.A.C. 11:3–36.5 may substitute the following provision for item 2 in the endorsement in (c) above:

1. During the term of the policy, coverage for an additional or replacement private passenger automobile shall not become effective until the insured notifies the company and requests coverage for the automobile. However, this provision does not apply to a replacement private passenger automobile, for a period of three days, including the day on which the automobile is acquired, if:

i. The automobile is acquired during the policy period; and

ii. There was Physical Damage Coverage on the vehicle replaced for at least the 12–month period preceding the replacement date.

(1) The three-day period in paragraph 1 above shall be extended by one day for each Saturday, Sunday or New Jersey State holiday falling within the three-day period.

New Rule, R.1992 d.142, effective March 16, 1992.
See: 23 N.J.R. 1262(a), 24 N.J.R. 953(b).

11:3–36.12 (Reserved)

New Rule, R.1992 d.142, effective March 16, 1992.
See: 23 N.J.R. 1262(a), 24 N.J.R. 953(b).
Repealed by R.1992 d.424, effective October 19, 1992.
See: 24 N.J.R. 2708(c), 24 N.J.R. 3729(a).
Text on October 1, 1992 operative date of N.J.A.C. 11:3–36 deleted.

APPENDIX A

IFD 30 A

(COMPANY LETTERHEAD)

ACKNOWLEDGMENT OF REQUIREMENT FOR INSURANCE INSPECTION
(THIS IS NOT A SAFETY INSPECTION)

NAME OF INSURED
OR APPLICANT: _____
ADDRESS: _____
_____
_____

EFFECTIVE DATE
OF COVERAGE: _____
(Date)
INSPECTION SHALL BE
COMPLETED BY: _____

AUTOMOBILE(S) TO BE INSPECTED

	YEAR	MAKE	MODEL
1.	_____,	_____,	_____.
2.	_____,	_____,	_____.
3.	_____,	_____,	_____.

BY MY SIGNATURE BELOW I CERTIFY THAT I HAVE BEEN INFORMED THAT MY AUTOMOBILE(S) WHICH IS (ARE) BEING INSURED FOR FIRE AND THEFT/ COMPREHENSIVE AND/OR COLLISION COVERAGE SHALL BE INSPECTED BY A REPRESENTATIVE OF THE INSURER. THIS INSPECTION SHALL BE COMPLETED NO LATER THAN THE DATE SHOWN ABOVE TO AVOID A SUSPENSION IN COVERAGE.

I UNDERSTAND THAT FAILURE TO SUBMIT TO THE REQUIRED INSPECTION(S) WILL RESULT IN THE SUSPENSION (LOSSES WILL NOT BE COVERED) OF THE PHYSICAL DAMAGE COVERAGES (FIRE AND THEFT/COMPREHENSIVE, COLLISION), AS OF 12:01 A.M. OF THE DAY FOLLOWING THE DATE BY WHICH THE INSPECTION SHALL BE COMPLETED, AS SHOWN ABOVE.

I UNDERSTAND THAT IF COVERAGE IS SUSPENDED IT WILL BE RESTORED ONLY AFTER THE INSPECTION HAS BEEN COMPLETED AND THE ADJUSTED PREMIUM DUE FOR SUCH COVERAGE(S) HAS BEEN PAID.

SIGNATURE OF INSURED OR
APPLICANT: _____ _____
(Date)

SIGNATURE OF PRODUCER
OR INSURANCE COMPANY
REPRESENTATIVE: _____ _____
(Date)

NAME, ADDRESS & TELEPHONE NUMBER OF PRODUCER OR INSURANCE REPRESENTATIVE
COMPLETING THIS FORM: _____
_____
_____
_____

INSURED/APPLICANT MUST RECEIVE A COMPLETED COPY OF THIS FORM ALONG WITH A LIST OF AUTHORIZED AUTOMOBILE PHYSICAL DAMAGE INSPECTION SITES.

cc: INSURANCE COMPANY
PRODUCER OF RECORD

APPENDIX B

IFD 30 B

(COMPANY LETTERHEAD)

NOTICE OF INSURANCE INSPECTION
(THIS IS NOT A SAFETY INSPECTION)

IMMEDIATE ACTION REQUIRED TO AVOID LOSS OF INSURANCE COVERAGE

_____
(Date of mailing)

Name of Insured: _____
Address: _____
_____
_____

EFFECTIVE DATE OF COVERAGE: _____ (Date)

INSPECTION SHALL BE COMPLETED BY: _____ (Date)

POLICY #: _____

Dear Policyholder,

This will confirm coverage for FIRE AND THEFT/COMPREHENSIVE _____; COLLISION _____; on your

1. _____, _____, _____.
2. _____, _____, _____.
3. _____, _____, _____.

YEAR MAKE MODEL

Please disregard this notice if you have already had your car inspected.

This notice will also serve as a reminder that the above described car(s) shall be inspected by the date indicated above, or your physical damage coverages will be suspended effective 12:01 A.M. on _____ (Date).

If you have your car inspected after the above deadline your coverage will only be restored after your car has been inspected and the adjusted premium due for the coverages listed above had been paid. You will have no coverage for any physical damage loss that occurs during the suspension period. Attached is a list of authorized automobile physical damage inspection sites.

FOR FURTHER INFORMATION PLEASE CALL:

_____
Name and phone number of Company Representative

Very truly yours,

_____

cc: INSURANCE COMPANY
PRODUCER OF RECORD

APPENDIX C(1)

IFD 30C

INSURANCE COMPANY LETTERHEAD
OR
INSPECTION SERVICE LETTERHEAD

CONTROL NUMBER _____ SITE ID NO. _____

DATE OF INSPECTION	TIME OF INSPECTION AM PM	INSURANCE COMPANY NAME	INSURED'S POLICY NUMBER	NUMBER OF PHOTOS

INSURED'S NAME _____ INSURED'S ADDRESS _____ TELEPHONE NO. _____

INSPECTOR'S NAME _____ INSPECTION SITE NAME AND ADDRESS _____ TELEPHONE NO. _____

	STYLE		COLOR	INTERIOR	
YEAR:_____	___ 2 DR	___ STG WGN	MAJOR _____	___ CLOTH	___ LEATHER
MAKE:_____	___ 4 DR	___ VAN	MINOR _____	___ VINYL	___ COLOR
MODEL:_____	___ CPE	___ HTCHBK			

ODOMETER READING _____ PRINCIPAL PLACE OF GARAGING _____ VEHICLE ID NUMBER (NOT FROM REGISTRATION FORM) _____ LICENSE PLATE NO. AND STATE _____

/ / / / / / / / / / / / / / / / /

V.I.N. LOCATION: _____

ACCESSORIES AND OPTIONAL EQUIPMENT
(COMPLETE FOR ALL VEHICLES INCLUDING VANS)

( ) AIR CONDITIONER
( ) MANUAL TRANSMISSION
() 3 SPD ()4 SPD () 5 SPD
( ) AUTOMATIC TRANSMISSION
( ) OVERDRIVE
( ) AM RADIO
( ) AM/FM RADIO ( ) STEREO
( ) CASSETTE PLAYER
BRAND_____
BUILT IN ( ) YES ( ) NO
( ) COMPACT DISC PLAYER
BRAND_____
( ) CAR PHONE
BRAND_____
BUILT IN ( ) YES ( ) NO
( ) CAR PHONE ANTENNA
( ) CAR PHONE TRANSMITTER
( ) C.B. RADIO
BRAND_____
BUILT IN ( ) YES ( ) NO
( ) STEREO AMPLIFIER
BRAND_____
BUILT IN ( ) YES ( ) NO

( ) CRUISE CONTROL
( ) REAR DEFROSTER
( ) REAR WIPER
( ) TILT WHEEL
( ) TINTED GLASS
( ) POWER STEERING
( ) POWER BRAKES
( ) POWER WINDOWS
( ) POWER LOCKS
( ) POWER ANTENNA
( ) VINYL TOP/ROOF
( ) T-TOP ROOF
( ) SUN ROOF
FACTORY INSTALLED
( ) YES ( ) NO
TYPE_____
( ) SPECIAL ROOF
TYPE_____
( ) BUCKET SEATS
( ) SPECIAL WHEELS
( ) SPECIAL TIRES
TYPE_____
( ) SPECIAL HUB CAPS
( ) RADAR DETECTOR
BRAND_____

( ) ANTI-THEFT DEVICE
TYPE_____
( ) CAR ALARM
BRAND_____
( ) HIGH MOUNTED BRAKE LIGHT
( ) ROOF RACK
( ) SPARE TIRE (OUTSIDE MOUNT)
( ) CARPETING
( ) INSTRUMENTATION
TYPE_____
_____
_____
( ) SPECIAL MIRRORS
TYPE_____
( ) TRAILER HITCH
( ) AUTO RECOVERY SYSTEM
TYPE_____
( ) SPECIAL CUSTOM OPTIONS OR
ADDITIONS (LIST)
_____
_____
_____
_____
_____

APPENDIX C(2)



Front and Passenger Side



Rear and Driver Side

ATTACH AT LEAST TWO (2) COLOR PHOTOGRAPHS OF THE AUTOMOBILE TAKEN FROM THE ANGLES SHOWN ON THE DIAGRAMS TO THE RIGHT. ALSO ATTACH CLOSE-UP PHOTO OF THE E.P.A. STICKER (INCLUDING THE V.I.N.) FROM DRIVER'S SIDE DOOR JAMB

PHYSICAL CONDITION OF VEHICLE

(CHECK DAMAGED AREAS OR AREAS IN POOR CONDITION AND DESCRIBE BELOW)

DAMAGED/RUSTED			DAMAGED	
( )	( )	FRONT BUMPER	( )	WINDSHIELD
( )	( )	LEFT FRONT FENDER	( )	LEFT FRONT SIDE GLASS
( )	( )	LEFT FRONT DOOR	( )	RIGHT FRONT SIDE GLASS
( )	( )	LEFT REAR DOOR	( )	LEFT REAR SIDE GLASS
( )	( )	LEFT REAR QUARTER PANEL	( )	RIGHT REAR SIDE GLASS
( )	( )	REAR BUMPER	( )	REAR WINDOW
( )	( )	REAR DOOR/TRUNK LID	( )	REAR VIEW MIRROR
( )	( )	RIGHT REAR QUARTER PANEL	( )	WHEEL COVERS
( )	( )	RIGHT REAR DOOR	( )	WORN/TORN OR SOILED INTERIOR
( )	( )	RIGHT FRONT DOOR		
( )	( )	RIGHT FRONT FENDER	( )	OTHER DAMAGE OR
( )	( )	HOOD PANEL	( )	RUST (LIST)
( )	( )	ROOF PANEL		
( )	( )	GRILL		
( )	( )	UNDER CARRIAGE		

( ) CHECK HERE IF NO EXISTING DAMAGE, RUST OR MISSING PARTS

DESCRIBE EXISTING DAMAGES OR RUST:

LIST ANY MISSING PARTS:

DESCRIBE ANY ALTERATIONS FROM FACTORY DESIGN:

THE ABOVE IS A TRUE STATEMENT OF ANY EXISTING DAMAGE, RUST, OR MISSING PARTS AS OF THE DATE OF THIS INSPECTION. I CERTIFY THAT THIS INSPECTION REPORT IS TRUE AND COMPLETE AND THAT I HAVE SEEN AND PHOTOGRAPHED THE VEHICLE IDENTIFIED ABOVE.

DATE: _____

INSPECTOR'S SIGNATURE: _____

NAME AND ADDRESS OF PERSON PRESENTING VEHICLE FOR INSPECTION TO INSURED: _____

SIGNATURE: _____ RELATIONSHIP: _____

APPENDIX D

IFD 30 D

(COMPANY LETTERHEAD)

NOTICE OF SUSPENSION OF PHYSICAL DAMAGE COVERAGE

YOU ARE NO LONGER INSURED FOR PHYSICAL DAMAGE TO YOUR CAR

_____
(Date of Mailing)

Name of Insured: _____
Address: _____
_____
_____

POLICY #: _____

Dear Policyholder,

The vehicle(s) listed below is (are) no longer covered for FIRE AND THEFT/ COMPREHENSIVE _____; COLLISION _____;

	YEAR	MAKE	MODEL
1.	_____,	_____,	_____.
2.	_____,	_____,	_____.
3.	_____,	_____,	_____.

DATE COVERAGE WAS REQUESTED _____
DATE COVERAGE WAS SUSPENDED _____

The physical damage coverage(s) indicated above, has (have) been suspended on the vehicle(s) described, effective 12:01 a.m. on the suspension date. Such coverage has been suspended due to your failure to comply with the Physical Damage Insurance Inspection Regulation (N.J.A.C. 11:3-36), as required by the Fair Automobile Insurance Reform Act of 1990, N.J.S.A. 17:33B-1 et seq.

If your coverage has been suspended for more than ten (10) days, you will receive a premium adjustment (return premium or credit) for the suspended coverage(s) within forty-five (45) days from the date of suspension.

The coverage(s) will be restored when you have your vehicle(s) inspected and the adjusted premium due for such coverage(s) has been paid.

_____
INSURER REPRESENTATIVE

_____
TELEPHONE NUMBER

cc: PRODUCER OF RECORD
LIENHOLDER

SUBCHAPTER 37. ORDER OF BENEFIT DETERMINATION BETWEEN AUTOMOBILE PERSONAL INJURY PROTECTION AND HEALTH INSURANCE

Authority

N.J.S.A. 17:1–8, 17:1C–6(e) and 39:6A–4.3.

Source and Effective Date

R.1991 d.90, effective January 25, 1991.
See: 22 N.J.R. 3777(a), 23 N.J.R. 597(a).

Subchapter Historical Note

Subchapter 37, Order of Benefit Determination Between Automobile Personal Injury Protection and Health Insurance, was filed as emergency rule by R.1990 d.625, effective November 26, 1990, with an expiration date of January 25, 1991. See: 22 N.J.R. 3777(a). Subchapter 37 was readopted as R.1991 d.90, with changes effective February 19, 1991. See: Source and Effective Date.

11:3–37.1 Purpose and scope

The purpose of this subchapter is to establish guidelines for the order of benefit determination between a plan of health insurance and personal injury protection provided through an automobile policy, when a named insured elects to have his or her personal injury protection become secondary coverage for the provision of benefits for medical expenses incurred due to injuries sustained in an automobile accident. The provisions of this subchapter shall apply to all automobile policies, as that term is defined at N.J.S.A. 39:6A–2a, issued to New Jersey residents, or renewed on or after January 1, 1991, and to all health benefits plans which have been or will be delivered or issued for delivery in this State.

11:3–37.2 Definitions

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

"Actual benefits" means those benefits determined to be payable for allowable expenses.

"Allowable expense" means a medically necessary, reasonable and customary item of expense covered by an insured's health benefits plan(s) or PIP plan as an eligible expense, at least in part. When a plan provides benefits in the form of services, the reasonable monetary value of each such service shall be considered as both an allowable expense and a paid benefit.

"Benefits" means the provision of the following in consideration of payment of premiums or fees on a prepaid or postpaid basis:

1. Services, including supplies;
2. Payment of expenses incurred;
3. A combination of 1 and 2 above; or
4. An indemnification.

"Eligible expense" means:

1. In the case of health benefits plans, that portion of the medical expenses incurred for treatment of an injury which is covered under the terms and conditions of the plan, without application of the deductible(s) and copayment(s), if any.

2. In the case of PIP plans, that portion of the medical expenses incurred for treatment of an injury which, without considering any deductible and copayment, shall not exceed:

   i. The percent or dollar amounts specified on the medical fee schedules, or the actual billed expense, whichever is less; or

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

"Health benefits provider" means any person, whether subject to the regulation of the New Jersey Department of Insurance, Department of Health, or both, or not otherwise subject to such regulation, who contracts to provide health services, provide reimbursement for the cost of health services in whole or in part, or to provide for indemnity in the event health services are used, in return for a prepaid or postpaid premium or fee or other consideration, including, but not limited to:

1. Insurers, as defined at N.J.S.A. 17B:17–2;
2. Hospital service corporations, as defined at N.J.S.A. 17:48–1;
3. Medical service corporations, as defined at N.J.S.A. 17:48A–1;
4. Health service corporations, as defined at N.J.S.A. 17:48E–1;
5. Health maintenance organizations, as defined at N.J.S.A. 26:2J–2;
6. Dental service corporations, as defined at N.J.S.A. 17:48C–2;
7. Dental plan organizations, as defined at N.J.S.A. 17:48D–2;
8. Medicare;
9. Medicaid;

10. State Employees Health Benefits Plan;

11. CHAMPUS;

12. Self-insured programs; and

13. An entity organized under the laws of any other state or jurisdiction which delivers certificates to residents of New Jersey evidencing coverage under a contract issued and delivered in a state or jurisdiction other than New Jersey.

"Hospital expenses," when used by the automobile insurance PIP plan, means those expenses defined at N.J.S.A. 39:6A–2f.

"Injury" means bodily injury sustained by an insured as a result of an accident while occupying, entering into, alighting from or using an automobile, or as a pedestrian, caused by an automobile or by an object propelled by or from an automobile.

"Insured" means a person eligible for coverage, at least in part, for medical expenses incurred for treatment of injuries, under an automobile policy PIP medical expense provision, and who meets the definition of a named insured or family member.

1. Named insured means the person or persons identified as the insured in the automobile policy and if an individual, that person's spouse, if the spouse is a resident of the same household, except that if the spouse ceases to be a resident of the household of the named insured, coverage for that spouse shall continue until the expiration of full term of any policy period in effect at the time of the cessation of residency.

2. Family member means any relative of the named insured or the named insured's spouse who:

i. Is related to the named insured or named insured's spouse by blood, marriage, adoption or guardianship;

ii. Resides in the household of the named insured or spouse of the named insured; and

iii. Is not a named insured under another automobile policy.

"Medical expenses" means expenses for medical, surgical and dental treatment, professional nursing services, hospital expenses, rehabilitation services, diagnostic services, ambulance services, prosthetic devices, medications and other reasonable and necessary expenses resulting from the treatment prescribed by persons licensed to practice medicine and surgery, dentistry, psychology or chiropractic in accordance with this State's laws, or by persons similarly licensed in other states or nations, or any nonmedical remedial treatment rendered in accordance with a recognized religious method of healing.

"Medical fee schedule" means that list of services, procedures and supplies to which have been assigned a maximum fee or percentage of a fee payable by an automobile insurer for expenses incurred as a result of the rendering to an insured any of those specific services, procedures or supplies for injuries, which list is set forth at N.J.A.C. 11:3–29.

"Out-of-State automobile insurance coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP, as PIP is defined herein, including automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey, specifically those provisions for medical expenses coverage.

"Plan" means any policy, contract, certificate, booklet, evidence of enrollment, program, or other such term which evidences the existence of a relationship between a health benefits provider or PIP carrier and an insured with respect to the provisions of hospital, medical, surgical, dental and/or other health care related benefits, at least in part.

"Primary coverage" means coverage by any plan which determines its actual benefits payable on allowable expenses incurred by an insured for treatment of injuries without taking into consideration the existence of any coverage for which the insured may be eligible provided secondary in accordance with this subchapter. There may be more than one plan providing the insured primary coverage.

"Secondary coverage" means coverage by any plan which determines its actual benefits payable on all allowable expenses incurred by an insured for treatment of injuries after all plans providing primary coverage have considered expenses incurred and paid actual benefits.

11:3–37.3 Health benefits providers

(a) Nothing in this subchapter shall be construed as requiring any health benefits provider to offer, provide, or continue coverage to or for any individual or group, except as may be set forth by other laws of this State, or of the Federal government.

(b) Nothing in this subchapter shall be construed as requiring any health benefits provider to provide coverage for any treatment or service not otherwise covered under the terms of the applicable health benefits plan.

(c) No health benefits contract or policy delivered or issued for delivery in this State, or renewed, continued or converted on or after January 1, 1991, shall contain any provision, rider, waiver of endorsement or other instrument which restricts, limits or excludes coverage, directly or indirectly, of services or expenses otherwise eligible under the policy or contract on the grounds that such expenses or services would be covered under an automobile policy PIP provision for which the insured would be eligible had the named insured on the automobile policy not selected the PIP-as-secondary coverage option.

(d) No health benefits contract or policy delivered or issued for delivery in this State, or renewed, continued or converted on or after January 1, 1991, shall contain any provision, rider, waiver or endorsement, or other instrument which restricts, limits or excludes coverage, directly or indirectly, of services or expenses otherwise eligible under the policy or contract on the grounds that:

1. Such expenses arise from an automobile-related injury;

2. Such expenses are covered or paid by PIP; or

3. Such expenses are covered or paid by OSAIC except for reductions in benefits when the health benefits contract provides secondary coverage as defined in and permitted by this rule.

(e) A health benefits contract or policy may provide that it is always primary to OSAIC, or may provide that it will determine its benefits as if it were secondary to any OSAIC. If the health benefits contract or policy provides that it will determine its benefits as if it were secondary to OSAIC and the OSAIC either contains a provision that it is always excess or secondary, or refuses to cooperate in determining the amount of benefits payable by the health benefits plan as secondary coverage provider, the health benefits plan shall provide primary coverage.

Case Notes

Secondary insurer was liable for reasonable medical expenses insured incurred as result of motor vehicle accident. Jugan v. State Farm Ins. Co., 267 N.J.Super. 338, 631 A.2d 582 (L.1993).

Code section invalidating insurance contract exclusions was within ERISA's insurance savings clause. Jugan v. State Farm Ins. Co., 267 N.J.Super. 338, 631 A.2d 582 (L.1993).

11:3–37.4 Application of the PIP-as-secondary coverage option

(a) When a named insured elects the PIP option, whereby the named insured intends that medical expenses incurred for treatment of an injury are to be covered by a health benefits provider or providers, as evidenced on the Coverage Selection Form, then the medical expense provisions of the PIP coverage shall be considered to be secondary coverage for the purposes of the order of benefit determination, and all health benefits plans of an insured subject to the PIP option elected shall be considered to be primary coverage.

(b) The election by the named insured to make PIP medical expense provisions secondary coverage shall apply to only the named insured and family members of the named insured who reside in the named insured's household and are not named insureds under other automobile policies.

(c) The election by the named insured to make PIP medical expense provisions secondary coverage shall continue in force as to subsequent renewal or replacement policies until the automobile policy insurer or its authorized representative receives a properly executed written request revoking the selection of this option.

(d) In the event that an insured is ineligible for health plan coverage of medical expenses, or is eligible for coverage under a dental expense or dental service plan only when an injury occurs, despite the selection of the PIP-as-secondary coverage option by the named insured, benefits shall be provided to the insured through PIP coverage in accordance with N.J.A.C. 11:3–37.8.

11:3–37.5 Health benefit plan standards and the PIP premium reduction

(a) An automobile insurer may eliminate the premium reduction on the base rate applicable to the amount of medical expense benefit chosen in conjunction with the PIP-as-secondary coverage option election if the automobile insurer complies with (b) below, and verifies that the coverage specified by the named insured:

1. Excludes the provision of benefits for treatment of injuries of an eligible insured when expenses incurred in relation to treatment of those injuries are eligible expenses under an automobile policy's PIP provisions; or

2. Provides that it is always secondary, or otherwise will not be a primary provider of benefits;

3. Provides benefits only for dental expenses or dental services; or

4. Provides benefits only for prescription drugs.

(b) An automobile carrier shall notify a named insured if the automobile insurer determines that the health benefits plan(s) specified by the named insured contain exclusionary or restrictive coverage provisions as set forth in (a) above, or if the automobile insurer determines that one or more of the insureds covered under the automobile insurance policy is not provided coverage by at least one of the health benefit plan(s) specified by the named insured, and, therefore, the named insured's premium reduction for PIP medical expense benefits will be eliminated.

1. The notice shall be in writing and shall specify the reasons why the automobile insurer believes the named insured's health plan coverage is not in compliance with this subchapter.

2. The automobile insurer may include in the notice a demand for payment of the premium reduction difference with an explanation that failure to pay the indicated premium reduction difference may result in early cancellation of the automobile policy in accordance with (c) below.

3. The notice shall be sent no later than 30 days prior to the date of cancellation as calculated in accordance with (c) below. A notice which is sent 30 days prior to the date of cancellation shall either contain a statement that it is a notice of cancellation, or be attached to a notice of cancellation, setting forth the effective date of cancellation.

(c) The effective date of the cancellation of a policy for nonpayment of premium shall not be earlier than 10 days prior to the last full day of which premium received by the company, prior to the date of preparation of the cancellation notice, would pay for coverage on a pro rata basis. In calculating the effective date of the cancellation, the premium applicable to the coverage provided by the policy and the premium received by the company at or prior to the time the cancellation notice was prepared shall be the premium used for the calculation and determination of such effective date.

1. No cancellation in accordance with (c) above shall be effective unless prior thereto, the automobile insurer shall have notified the named insured that the premium reduction difference had to be paid to avoid cancellation, as specified in (b)2 above.

2. No cancellation notice shall be mailed prior to 30 days in advance of its effective date.

(d) If the insured provides payment of the full premium amount and subsequently provides proof that coverage is not restricted in the manner set forth in accordance with (a) above, or that all insureds under the automobile policy were provided coverage by a health benefits plan at the time notification of noncoverage was sent, and that such coverage continues and is not restricted in the manner set forth in accordance with (a) above, the automobile insurer shall refund the monies paid in excess of the full reduction, or shall credit any excess paid on the reduced premium to the extent any premium payment is still unpaid on the policy.

11:3–37.6 Order of benefits determination when PIP is secondary coverage

(a) When the named insured of an automobile policy has selected the PIP-as-secondary coverage option, all health benefits plans for which the insured is eligible shall provide coverage for the allowable expenses incurred by the insured due to an automobile-related injury prior to any benefits for medical expenses being paid by a PIP plan.

(b) If the insured is eligible for coverage under more than one group health benefits plan, the group health benefits plans shall coordinate benefits with one another in accordance with the rules set forth for such plans at N.J.A.C. 11:4–28.

(c) The PIP plan shall provide benefits for allowable expenses remaining uncovered after all health benefits plans for which the insured is eligible have paid benefits towards those allowable expenses.

(d) The PIP plan shall continue to be liable for expenses related to the same occurrence as the expenses are incurred, whether or not the health benefits plan(s) in force at the time of the accident terminate(s) coverage, or benefits provided under the health benefits plan(s) are exhausted subsequent to the occurrence of the accident, up to the maximum PIP benefits available to the insured under the terms of the automobile policy.

(e) Total benefits paid by an insured's health benefits and PIP plans shall not exceed the amount of total allowable expenses.

11:3–37.7 Determination of PIP medical benefits payable when PIP is secondary coverage

(a) In calculating the actual benefits to be paid by the automobile insurer when the PIP-as-secondary coverage option has been selected, the automobile insurer shall first determine the amount of eligible expenses which would have been paid after application of the deductible and copayment limitations had the PIP-as-secondary coverage option not been selected.

1. In the event the remaining allowable expenses are less than the benefits calculated pursuant to (a) above, the automobile insurer shall pay actual benefits equal to the remaining allowable expenses, without reducing the remaining allowable expenses by its deductible or copayments.

2. In the event the remaining allowable expenses are greater than the benefits calculated pursuant to (a) above, the actual benefits paid by the automobile insurer shall be the benefits calculated pursuant to (a) above, without reducing the remaining allowable expenses by its deductible or copayments.

(b) In paying actual benefits, the automobile insurer shall not:

1. Reduce its actual benefits payable on account of any deductibles or copayments of the health benefits plans which have provided benefits ahead of the PIP plan due to the selection of the PIP-as-secondary coverage option; or

2. Reduce its actual benefits payable for any allowable expense remaining uncovered which item of expense otherwise would not be an eligible expense under the PIP plan, except as set forth by (c) below.

(c) In determining remaining uncovered allowable expenses, the automobile insurer shall not consider any amount for items of expense which exceed the dollar or percent amounts recognized by the medical fee schedules promulgated pursuant to N.J.S.A. 39:6A–4.6.

(d) The total amount of benefits to be provided through the PIP medical expense provisions for each insured per accident or occurrence shall not exceed the maximum PIP benefits as provided for by the terms of the policy.

11:3–37.8 Health benefits plan coverage ineligibility

(a) When, subsequent to the selection of the PIP-as-secondary coverage option by a named insured, it is determined that an insured did not have health coverage in effect at the time of an injury, or had health coverage in effect at the time of any injury which is such that the PIP-as-secondary coverage option selection could have been invalidated by the automobile insurer and elimination of the premium reduction amount effected in accordance with N.J.A.C. 11:3–37.5(a), but was not, then the insured shall be provided benefits for incurred medical expenses through the PIP medical expense provision.

1. Benefits payable shall be subject to a per accident deductible equalling the total of $750.00 plus the PIP deductible selected by the named insured of the policy.

2. Benefits payable shall be subject to a 20 percent copayment for amounts less than $5,000 after the deductible has been satisfied.

3. Determination of the amount of benefits payable shall be made in accordance with medical fee schedules promulgated pursuant to N.J.S.A. 39:6A–4.6 and set forth at N.J.A.C. 11:3–29, or on a reasonable basis, as determined by the automobile insurer, considering the medical fee schedules for similar services or equipment in the region where the service or equipment was provided, when an item of expense is not included on the medical fee schedules.

4. Total benefits paid for each insured eligible for benefits in any one accident shall not exceed the maximum PIP benefits provided for by the terms of the policy.

(b) All items of medical expense incurred by the insured for treatment of an injury shall be eligible expense to the extent the treatment or procedure from which the expenses arose is recognized on the medical fee schedules, or are reasonable medical expenses in accordance with N.J.S.A. 39:6A–4.

(c) The automobile insurer shall be entitled to recover, for the contract period in which the automobile-related injury occurred, the difference between the reduced premiums paid on the policy and the amount of premium which would have been due on the policy had the named insured not selected the PIP-as-secondary coverage option, and no premium reduction shall be provided on that policy for the PIP-as-secondary coverage option during the remainder of that current contract period.

11:3–37.9 Determination of benefits when PIP is primary coverage

(a) When no election has been made by a named insured to make his or her health benefits plan(s) primary coverage provider(s), so that the PIP plan will provide primary coverage for medical expenses incurred for treatment of injuries, the PIP plan shall provide benefits to the insured without consideration of any benefits for which the insured may be eligible under any health benefits plan.

(b) Actual benefits paid by the PIP plan shall be for all medical expenses which are eligible expenses incurred for treatment of injuries, subject to application of the deductible provided for by the terms of the automobile policy, and a 20 percent copayment requirement for amounts incurred after the deductible and up to $5,000.

(c) Actual benefits payable by a health benefits plan, when the PIP plan is providing primary coverage for medical expenses incurred for treatment of injuries, shall be the lesser of the remaining uncovered allowable expenses or the actual benefits that would have been payable had the health benefits plan been providing coverage primary to the PIP plan.

1. Actual benefits payable may be reduced by the deductible(s) and copayment requirements applicable by the terms of the health benefits plan, and shall not exceed the amount of actual benefits that would have been payable had the health benefits plan been providing coverage primary to the PIP plan.

2. Allowable expenses remaining uncovered, which the health benefits plan(s) shall consider when the PIP plan is providing primary coverage, include:

i. Any PIP deductible(s);

ii. Any PIP copayment amounts;

iii. Any expenses which exceed the medical expense coverage limits of the PIP plan per person per accident, as set forth by the terms of the automobile policy; and

iv. Any expenses not covered by the PIP plan when such expense was determined to be in excess of the reasonable charge for an item of expense not listed on the medical fee schedules, but for which the automobile insurer determined a reasonable charge based on the medical fee schedule for a similar item of expense in the region where the service or equipment was provided.

(d) When a health benefits plan provides hospital expense or service benefits only, or medical expense or service benefits only, and is not otherwise a part of a basic health benefits package, all allowable expenses remaining uncovered shall be considered by that health benefits plan for the provision of benefits, without regard as to whether the expenses are hospital-related or medical-related expenses. Actual benefits paid by that health benefits plan for the allowable expenses remaining uncovered shall not exceed the total actual benefits which would have been payable had the health benefits plan been providing coverage primary to the PIP plan.

(e) When there is one health benefits plan providing insureds hospital expense or service benefits and another health benefits plan providing insureds medical expense or service benefits as two separate parts of one basic health benefits plan package, the hospital benefits plan and the medical benefits plan shall both consider all allowable expenses remaining uncovered and shall apportion such allowable expenses between the two plans on a pro-rata basis without regard as to whether the expenses are hospital-related or medical-related expenses. Actual benefits paid by each plan of the health benefits plan package shall not exceed the total actual benefits which would have been payable by each plan had the health benefits plan package been providing primary coverage.

(f) No insured shall be liable to a health care provider for any fees for services or supplies which exceed the dollar or percentage amounts recognized for those services or supplies on the medical fee schedules.

(g) No health benefits plan shall seek repayment from or withhold payment to an insured for amounts paid to the insured in consideration of charges which were in excess of the amounts set forth in the medical fee schedules.

(h) If there is more than one group health benefits plan providing secondary coverage to an insured, these plans may coordinate their benefits with one another in accordance with N.J.A.C. 11:4–28.

Case Notes

Hospitalization insurer could be held responsible for hospital bills without regard to when they were incurred, and personal injury protection benefits could be used for specialized equipment and home modifications. Bailey v. Garden State Hospitalization Plan, 280 N.J.Super. 206, 654 A.2d 1043 (L.1994).

Costs of home renovations and specialized equipment for quadriplegic insured were "allowable expenses" within meaning of regulation mandating that actual benefits payable by health benefits plan. Bailey v. Garden State Hospitalization Plan, 280 N.J.Super. 206, 654 A.2d 1043 (L.1994).

"Primary carrier" is carrier first required to pay personal injury protection benefits preserving its right of contribution from other insurers also liable for such payments. Bailey v. Garden State Hospitalization Plan, 280 N.J.Super. 206, 654 A.2d 1043 (L.1994).

11:3–37.10 Explanation of benefits

(a) Automobile insurers shall develop and utilize an explanation of benefits form to be provided with the payment of benefits for expenses incurred for treatment of injuries which clearly identifies and explains the following:

1. Each procedure for which a claim has been made;

2. Eligible expense related to each procedure with an indication of whether the eligible expense is based on the medical fee schedules or is the reasonable charge as determined by the automobile insurer;

3. Actual benefits paid;

4. Any deductible or copayment applied;

5. A concise explanation why any item of expense is considered an ineligible expense, when this occurs; and

6. A statement to insureds that no health care provider may demand or request any payment from any person in excess of those permitted by N.J.A.C. 11:3–29, and that no person is liable to any health care provider for any amount of money which results from the charging of fees in excess of those permitted by N.J.A.C. 11:3–29 pursuant to N.J.S.A. 39:6A–4.6.

Amended by R.1994 d.564, effective November 21, 1994 (operative January 1, 1995).
See: 25 N.J.R. 4706(a), 26 N.J.R. 4616(b).

11:3–37.11 Dispute as to primacy of coverage

(a) If, subsequent to the selection of the PIP-as-secondary coverage option by the named insured, injuries are sustained by an insured eligible for health benefits plan coverage, but a dispute exists between the health benefits provider and the automobile insurer, then the health benefits provider shall provide benefit as if it were the primary coverage provider and no PIP benefits were available to the insured. In no event shall the provision of benefits be unreasonably delayed by either a health benefits provider or an automobile insurer.

(b) If the health benefits provider asserts that it is not subject to N.J.A.C. 11:3–37.3, and thus, will not act as the primary coverage provider then the automobile insurer shall assume the role of primary coverage provider, and provide its benefits in accordance with N.J.A.C. 11:3–37.8. The automobile insurer shall be entitled to recover premium reductions in accordance with N.J.A.C. 11:3–37.8(c).

11:3–37.12 Eligibility under two or more automobile policies

(a) If an insured is eligible for coverage of medical expenses under more than one automobile policy, the determination as to which automobile policy will assume coverage responsibility for that insured shall be as follows:

1. A named insured shall receive benefits for medical expenses under the terms of the automobile policy on

which he or she, or his or her spouse, is identified as the named insured.

2. A family member who is a child of a named insured or the named insured's spouse shall receive benefits for medical expenses under the automobile policy of the named insured, subject to the following:

i. If the child is a child of more than one named insured or of more than one spouse of a named insured, the child shall receive benefits under the terms of the automobile policy of the named insured who has legal custody of that child or whose spouse has legal custody of that child.

ii. If the child is a child of more than one named insured or of more than one named insured's spouse, and legal custody of that child has either never been awarded, or has been awarded jointly, then the child shall receive benefits under the terms of the automobile policy of the named insured whose birthday occurs earliest in the calendar year.

iii. If the child is a named insured or the spouse of a named insured, (a)1 above shall apply.

3. If neither (a)1 nor (a)2 above apply to an adult or child family member, then that family member shall receive benefits for medical expenses under the terms of the automobile policy of the named insured whose birthday occurs earliest in the calendar year.

4. If an automobile policy identifies more than one person as a named insured on the automobile policy, the birthday of the named insured whose birthday occurs earliest in the calendar year shall be considered the determinant birthday on that automobile policy.

(b) An insured shall not receive benefits for medical expenses under more than one automobile policy.

(c) If an automobile policy PIP plan provides benefits for medical expenses for an insured who is eligible for medical expense benefits under more than one automobile policy PIP plan, the automobile insurer of the paying PIP plan may seek equitable pro rata contributions from the other automobile policy PIP plan(s) for the benefits actually paid by the paying PIP plan.

Case Notes

Primary carrier must pay PIP benefits and may seek contribution from other carriers. U.S. Fidelity & Guar. Co. v. Industrial Indem. Co., 264 N.J.Super. 379, 624 A.2d 1014 (A.D.1993), certification denied 134 N.J. 484, 634 A.2d 530.

Double recovery of PIP benefits is prohibited. Martin v. Prudential Ins. Co., 255 N.J.Super. 524, 605 A.2d 762 (A.D.1992).

Passenger could recover PIP benefits under both driver's policy and own policy. Martin v. Prudential Ins. Co., 255 N.J.Super. 524, 605 A.2d 762 (A.D.1992).

11:3–37.13 Penalties

Each automobile policy or health benefits plan subject to the terms of this subchapter which fails to comply with the terms herein shall be in violation of this subchapter. Failure to comply with the terms of this subchapter may result in the assessment of any and all penalties in accordance with the laws of this State.

11:3–37.14 Severability

If any provision of this subchapter or application thereof to any person or circumstance is held invalid, the remainder of the subchapter and the application of such provision to other persons or circumstances shall not be affected thereby.

SUBCHAPTER 38. TOWING AND STORAGE FEE SCHEDULE

Authority

N.J.S.A. 17:33B–47 and 48.

Source and Effective Date

R.1991 d.97, effective January 25, 1991.
See: 22 N.J.R. 3874(a), 23 N.J.R. 592(a).

Subchapter Historical Note

Subchapter 38, Towing and Storage Fee Schedule, was filed as emergency new rule R.1990 d.623, effective November 26, 1990, operative January 1, 1991, with an expiration date of January 25, 1991. See: 22 N.J.R. 3874(a). Subchapter 38 was readopted as R.1991 d.97 with changes effective February 19, 1991. See: Source and Effective Date.

11:3–38.1 Purpose and scope

(a) The purpose of this subchapter is to establish towing and storage fee schedules on a regional basis pursuant to N.J.S.A. 17:33B–47 for the reimbursement of towing charges and storage charges for private passenger automobiles that are damaged in accidents or are recovered after being stolen.

(b) The provisions of this subchapter apply to all insurers which write private passenger automobile insurance in this State and to all persons who provide towing and storage services in this State for private passenger automobiles that are damaged in accidents or are recovered after being stolen.

11:3–38.2 Definitions

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

"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, or 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.

"Basic towing service" means the removal and transportation of an automobile from a highway, street or other public or private road, or a parking area, or from a storage facility, and other services normally incident thereto, but does not include recovery of an automobile from a position beyond the right-of-way or berm, or from being impaled upon any other object within the right-of-way or berm.

"Commissioner" means the Commissioner of Insurance of the State of New Jersey.

"Department" means the New Jersey Department of Insurance.

"Inside buildings" means a vehicle storage facility that is completely indoors, having one or more openings in the walls for storage and removal of vehicles and that is secured by a locking device on each opening.

"Motor vehicle accident" means an occurrence in which a private passenger automobile comes in contact with any other object for which the private passenger automobile must be towed or removed for placement in a storage facility. This includes all situations which are accidental as to the insured even if they were caused by the intentional acts of a perpetrator where the perpetrator was not the insured or not otherwise involved with the insured.

"Tow vehicle's base of service" means the towing operator's principal place of business where the tow vehicle is stationed when not in use.

"Outside secured" means an automobile storage facility that is not indoors and is secured by a fence, wall or other man-made barrier that is at lest six feet high and is installed with a passive alarm system or a similar on-site security measure. The facility is to be lighted at night.

"Outside unsecured" means an automobile storage facility that is not indoors and is not secured by a fence, wall or other man-made barrier, and all other storage facilities not defined above as inside building or outside secured.

"Storage charges for 24 hour period" means the maximum allowable amount to be charged by a storage facility for a 24 hour period or fraction thereof. A new 24 hour period begins at 12:01 A.M.

"Tow vehicle" means only those vehicles equipped with a boom or booms, winches, slings, tilt beds, wheel lifts or under-reach equipment specifically designed by its manufacturer for the removal or transport of private passenger automobiles.

11:3–38.3 Regions

(a) Region I, as used in this subchapter, consists of the following counties in New Jersey: Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Monmouth, Ocean, and Salem.

(b) Region II, as used in this subchapter, consists of the following counties in New Jersey: Bergen, Essex, Hudson, Hunterdon, Middlesex, Morris, Passaic, Somerset, Sussex, Union, and Warren.

11:3–38.4 Application of storage and towing fee schedule

(a) No person shall be liable to any person who tows or stores a private passenger automobile which was damaged in an accident or recovered after being reported stolen for any fees in excess of those permitted by the towing and storage fee schedules established in this subchapter.

(b) The region used to determine the proper fee set forth on the schedules shall be determined as follows:

1. For towing services, the fee shall be based on the region in which the tow vehicle's base of service is located.

2. For storage services, the fee shall be based on the region in which the facility is located.

(c) The fee schedules shall be reviewed by the Commissioner on an annual basis and may be revised if necessary.

(d) The fees set forth on the schedule for towing rates are the maximum charges that shall apply to a private passenger automobile for basic towing services rendered as a result of an accident or theft recovery. There shall be no additional charges other than those provided in N.J.A.C. 11:3–38.6, including, but not limited to, flatbedding, waiting time, winching, cleanup cost, and additional labor, when only basic towing services as defined are provided.

1. The towing rates shall be calculated based on the total distance travelled from the tow vehicle's base of service to the job site and return, by way of the shortest available route. Fractions shall be rounded up to the nearest whole mile.

2. Tow vehicles transporting multiple passenger cars at one time shall receive the applicable fees for each vehicle transported.

3. When towing services are required at the scene of an automobile accident, the Day rate shall apply when the time of the accident is between 8:00 A.M. and 4:30 P.M., Monday through Friday, except New Jersey State Holidays. The Night, Weekend and Holiday rate shall otherwise apply.

4. When towing services are otherwise required, the Day rate shall apply when the vehicle is transported (pickup to delivery) entirely between the hours of 8:00 A.M. and 6:00 P.M., Monday through Friday, except New Jersey State Holidays. The Night, Weekend and Holiday rate shall otherwise apply.

(e) The fees set forth on the schedule for storage fees are the maximum storage charges per 24 hour period that shall apply to a private passenger automobile that is stored by a person as a result of an accident or theft recovery.

(f) No insurer or rating organization shall include any expense for storage of a private passenger automobile for more than 30 days into the base for determining private passenger automobile rates used or to be used in this State.

11:3–38.5 Penalties

(a) Failure of a person to abide by the requirements of this subchapter may be punishable by a fine not to exceed $5,000 for the first violation, $10,000 for the second violation and $15,000 for each subsequent violation pursuant to N.J.S.A. 17:33A–5.

(b) Violators who are licensed as an automobile repair facility will be reported to the Division of Motor Vehicles. Insurers may also report violators under the provisions of N.J.S.A. 17:23–8 to 15.

11:3–38.6 Towing and storage fee schedules

(a) The following is the fee schedule for towing services:

	Region	
Days	**1**	**2**
First mile or less	$35.00	$40.00
Each additional mile	$ 1.75	$ 1.75
Nights, Weekends and New Jersey State Holidays		
First mile or less	$45.00	$50.00
Each additional mile	$ 1.75	$ 1.75

(b) The following is the fee schedule for storage services:

	Region	
Inside Building:		
Storage Facility Capacity	**1**	**2**
21 or more spaces	$13.00	$15.00
10–20 spaces	$18.00	$20.00
Less than 10 spaces	$22.00	$25.00
Outside Secured:		
Storage Facility Capacity	**1**	**2**
21 or more spaces	$13.00	$15.00
10–20 spaces	$18.00	$20.00
Less than 10 spaces	$22.00	$25.00
Outside Unsecured:		
Storage Facility Capacity	**1**	**2**
21 or more spaces	$13.00	$15.00
10–20 spaces	$18.00	$20.00
Less than 10 spaces	$22.00	$25.00

SUBCHAPTER 39. REDUCTIONS IN PREMIUM CHARGES FOR PRIVATE PASSENGER AUTOMOBILES EQUIPPED WITH ANTI-THEFT, VEHICLE RECOVERY AND SAFETY FEATURES

Authority

N.J.S.A. 17:1–8, 17:1C–6c and 17:33B–44.

Source and Effective Date

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).

11:3–39.1 Purpose

The purpose of this subchapter is to encourage consumers to invest in and use anti-theft and vehicle recovery devices and safety features in private passenger automobiles by providing that there shall be a reduction in the base rates applicable to automobile physical damage coverage, in accordance with N.J.S.A. 17:33B–44, for those private passenger automobiles equipped with anti-theft and vehicle recovery devices and safety features.

11:3–39.2 Scope

(a) This subchapter shall apply to all insurers which write private passenger automobile insurance in this State.

(b) This subchapter shall apply to all policies which include provisions for physical damage coverage and which are issued or renewed on or after September 1, 1991.

11:3–39.3 Definitions

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

"Alarm" means a device which emits sounds audible at 300 feet or more, such as a horn, bell or siren, but does not include those sounds that reasonably may be confused with police or emergency response vehicle sirens.

"Automobile physical damage insurance" means a policy providing one or more of the following coverages:

1. Collision;
2. Comprehensive; and
3. Fire and theft.

"Electronic lock or keyless lock device" means an electronic coding device possessing 10,000 possible combinations or more, which may be unlocked by use of a keyboard or similar data entry device or by means of a remote control device.

"Inspection" means a physical examination of an automobile by an authorized representative of the insurer, in accordance with the standards set forth at N.J.A.C. 11:3–36.6.

"Insured" means the named insured, as defined in the policy, or an applicant for automobile physical damage insurance.

"Insurer" means any person authorized to write automobile insurance in New Jersey, including any residual market mechanism, and includes all affiliated companies within a group.

"Nonpassive" means a device or system designed to remain inoperative and nonfunctional until actively engaged by the user.

"Passive" means a device or system designed to become automatically operative and functional when the automobile's ignition key is moved or stationed in the off position.

"Private passenger automobile" means a vehicle that meets the definition at N.J.S.A. 39:6A–2.

"Tubular lock" means a lock which may be opened by a specific cylindrically shaped key and which possesses at least 50,000 possible combinations.

11:3–39.4 Reductions in rates for anti-theft and vehicle recovery devices

(a) Every insurer writing automobile physical damage insurance shall provide a reduction in the base rates of its comprehensive and fire and theft coverages, if different, for all private passenger automobiles equipped with one or more anti-theft or vehicle recovery devices, as described at N.J.A.C. 11:3–39.5. The reductions in the base rates shall be as follows:

1. At least five percent for devices which qualify as Category I anti-theft devices;

2. At least 10 percent for devices which qualify as Category II anti-theft devices;

3. At least 15 percent for devices which qualify as Category III anti-theft or vehicle recovery devices; and

4. At least 20 percent for devices which qualify as Category IV anti-theft or vehicle recovery devices.

(b) Insurers are not required to provide greater or additional reductions in the base rates of the comprehensive and fire and theft coverages when a private passenger automobile is equipped with more than one qualified anti-theft or vehicle recovery devices, except as follows:

1. The greater category reduction shall apply when a private passenger automobile is equipped with two or more anti-theft devices qualifying from two or more categories.

2. A private passenger automobile equipped with a Category III anti-theft or vehicle recovery device and a Category IV anti-theft or vehicle recovery device in combination shall receive a reduction of at least 25 percent, (b)1 above notwithstanding.

(c) An insurer may require reasonable proof that a private passenger vehicle is equipped with or has been installed with a device which qualifies as a Category I, II, III, or IV anti-theft or vehicle recovery device, or a combination of such categories, before providing any reduction in the base rates for comprehensive and fire and theft coverages for that private passenger automobile.

1. Reasonable proof shall include, but not be limited to, an inspection for the issuance or renewal of physical damage coverages, as set forth at N.J.A.C. 11:3–36.

2. Insurers shall not refuse to provide a reduction for a private passenger automobile in which a qualifying anti-theft or vehicle recovery device has been installed solely on the grounds that the device was installed by the owner of the private passenger automobile.

(d) Insurers may elect not to provide a reduction for a private passenger automobile in which an anti-theft or vehicle recovery device has been installed for a period of up to 24 months following installation of the device, if the device is provided to the insured by the insurer without charge or at a below retail market price, where the reduction in price is equivalent to the reduced premium charges which would otherwise apply.

(e) If an insurer provides an insured with an anti-theft or vehicle recovery device pursuant to (d) above, and the insured terminates the automobile insurance policy, or elects not to renew such insurance with the insurer, prior to the end of the 24 month period, the insurer may demand payment for the cost of the anti-theft or vehicle recovery device provided.

Notice of Receipt of Petition for Rulemaking: Reductions in Premium Charges for Private Passenger Automobiles Equipped with Anti-Theft, Vehicle Recovery and Safety Devices.
See: 24 N.J.R. 305(a).
Notice of Action on Petition for Rulemaking
See: 24 N.J.R. 658(a).

11:3–39.5 Categories of anti-theft and vehicle recovery devices

(a) A device qualifies as a Category I anti-theft device if it meets the requirements of one of the devices listed below.

1. An ignition or starter cut-off switch device is qualified if a warning label announces the presence of the device, and the device is designed so that the cut-off switch:

i. Is wired into the ignition's wiring;

ii. Is tripped and activated upon exiting of the automobile;

iii. Shall be re-set in order to start the automobile; and

iv. Is installed so as not to be visible from the driver's normal seating position.

2. A nonpassive, externally operated alarm is qualified if a warning label announces the presence of the device, and the device is designed so that the alarm is:

i. Turned off and on by a key used in an externally mounted lock; and

ii. Triggered by the opening of a door, the trunk or hood, when engaged.

3. A steering column armored collar is qualified if a warning label announces the presence of the device, and the device is designed so that the collar:

i. Clamps onto the steering column, over the ignition lock;

ii. Prevents access to the ignition lock;

iii. Prevents the automobile from being steered, if the automobile is started; and

iv. Is in no manner attached to the steering column when the device is not in use.

(b) A device qualifies as a Category II anti-theft device if it meets the requirements of one of the devices listed below.

1. A nonpassive fuel cut-off device is qualified if a warning label announces the presence of the device, and the device is designed so that the device:

i. Shall be activated and deactivated by a switch or key, which is hidden from normal view; and

ii. Blocks the fuel line, when activated.

2. A nonpassive steering wheel lock device is qualified if a warning label announces the presence of the device, and the device is designed so that:

i. A steel collar and barrel, into which the shackle of a lock fits, are permanently attached to the steering column;

ii. The shackle fits over the steering wheel spoke and into the barrel of the collar;

iii. A tubular key must be used to operate the lock;

iv. When in use, the steering wheel is prevented from turning;

v. The shackle is made of case hardened alloy steel; and

vi. The shackle, collar and barrel resist cutting by a file.

3. An armored cable hood lock and ignition cut-off switch is qualified if the device is designed so that:

i. The ignition cut-off switch:

(1) Is wired into the ignition's wiring;

(2) Is tripped and activated by exiting of the automobile;

(3) Shall be re-set in order to start the automobile; and

(4) Is installed so as not to be visible from the driver's normal seating position;

ii. The armored cable hood lock:

(1) Shall be engaged and disengaged by a push button or such similar device installed within the driver's reach when the driver is seated;

(2) Shall extend through the firewall and be secured so as to prevent retraction; and

(3) Must be of a material which effectively prevents cutting.

4. An emergency handbrake lock is qualified if the device is designed so that:

i. A lock replaces the handbrake grip and is permanently attached to the handbrake lever;

ii. The lock is only released by entering a preset digital combination;

iii. The lock encasement is of all metal construction; and

iv. The handbrake cannot be released without releasing the lock.

(c) A device qualifies as a Category III anti-theft or vehicle recovery device if it meets the requirements of one of the devices listed below.

1. A passive alarm system is qualified if a warning label announces the presence of the system, and the system is designed so that:

i. The alarm is triggered by entry of the automobile's doors, hood or trunk;

ii. The alarm sounds for not more than eight minutes and is automatically re-set upon its cessation from sounding;

iii. The alarm is installed in the engine compartment so as to be inaccessible without opening the hood;

iv. The hood shall not open unless unlocked from within the automobile by a key or a keyless device;

v. The ignition or starter shall be cut-off or disabled automatically upon triggering of the alarm; and

vi. The system shall be disengaged by use of a tubular lock or an electronic keyless device within a maximum time elapse of 20 seconds following entry or re-entry of the automobile.

2. A fuel cut-off device is qualified if a warning label announces the presence of the device, and the device is designed so that:

i. The fuel line is blocked when the automobile is turned off and is not re-opened unless a switch is tripped each time the automobile is started;

ii. The switch opening the fuel line is accessible from the driver's seat, but:

(1) Is hidden from view; or

(2) Is operable only by a tubular key or an electronic keyless device;

iii. Any under-the-dash wiring installed in connection with the system shall blend with factory wiring; and

iv. Any override switch which is installed shall be hidden from view. The override switch shall either:

(1) Not be accessible from the forward passenger compartment; or

(2) If accessible from the forward passenger compartment, be subject to initiating a warning alarm which sounds while the engine is running and the override switch is engaged.

(A) If a warning alarm is required, pursuant to (c)2iv(2) above, then the system shall be designed so that disconnection of the override alarm shall result in disconnection of the entire passive fuel cut-off device.

3. An armored ignition cut-off switch is qualified if a warning label announces the presence of the device, and the device is designed so that:

i. The device, when engaged, prevents normal ignition or "hot wiring" of the automobile, interrupting the ignition current;

ii. A cable runs from a locking system, separate from the ignition lock, to the ignition coil, starter solenoid, or other engine component;

iii. The cable is of a material and a design which either effectively prevents cutting, or collapses when cut to prevent ready re-connection of cut interior wires; and

iv. The separate locking system shall be installed within the interior of the automobile in a position which is accessible to the driver in normal seating and may be of the tubular type or an electronic keyless device.

4. A passive multi-component cut-off switch is qualified if a warning label announces the presence of the device, and the device is designed so that:

i. When engaged, the primary wire to the ignition coil is disconnected, the starter is disconnected and one or more wires to the electronic ignition system, or the points and condenser are grounded to the chassis;

ii. The wiring blends with factory installed wiring;

iii. The disconnected/grounding wires shall be routed to random points in the electrical system away from the components the wires affect;

iv. The control module, if separate from the electronic locking mechanism, shall be hidden in the engine compartment or other part of the automobile, so that the control module is not easily detectable; and

v. The automobile cannot be started unless the device is deactivated through a locking system installed within the interior of the vehicle. The locking system shall be accessible to the driver in a normal seating position. The lock may be either of a tubular type or a system which uses an electronic keyless device.

5. A passive time delay ignition system is qualified if a warning label announces the presence of the system, and the system is designed so that:

i. The system allows the automobile to be started only if the operator waits a prescribed time period before moving the ignition key from on to start;

ii. The prescribed time period varies from one system to another in a range of three seconds to 20 seconds;

iii. The system requires an additional waiting period of at least 90 seconds before the operator may try to start the automobile again with success;

iv. The system includes a hood lock which is operated by a tubular key; and

v. The system shall resist tampering.

6. An armored cable or electronically operated hood lock and ignition cut-off switch system is a qualified system if a warning label announces the presence of the system, and the system is designed so that:

i. When engaged, the ignition cannot be started, or is cut-off;

ii. When an armored cable hood lock is used:

(1) The cable shall be made of case-hardened solid steel tubing which resists cutting;

(2) The cable shall extend through the firewall and be secured so as to prevent retraction;

(3) No portion of the cable may be accessible so as to be grasped from beneath the automobile, and if accessible through the grill work, the armor shall extend to the hood locking mechanism; and

(4) The system shall be engaged by a push button within the automobile's interior, or a similar device,

which is installed so as to be readily accessible to the driver in normal seating position;

iii. When an electronically operated hood lock is used:

(1) The hood lock is electronically operated and functions so as to remain locked even when wiring which operates the hood is cut;

(2) The hood lock, if accessible through the grill work, or from beneath the car, shall be shielded or armored to prevent manual operation;

(3) The system shall be passively engaged by turning the ignition key to the off position; and

(4) The system shall be disengaged through use of a separate key and lock, or an electronic keyless device; and

iv. The locks controlling the hood lock systems shall be either of the tubular type or be operated electronically.

7. A passive delayed ignition cut-off system is qualified if a warning label announces the presence of the system and the system is designed so that:

i. The ignition circuit is interrupted automatically when the engine reaches a pre-set speed, unless the system is actively disengaged;

ii. The speed is pre-set in a range between 1500 and 2000 revolutions per minute (RPM);

iii. The system is engaged when the ignition is turned off;

iv. The system may be disengaged by a push button or other specific device within the interior of the vehicle, but shall be hidden from view;

v. The system may be disengaged by use of either a lock of the tubular type or an electronic keyless device;

vi. Wiring shall blend with factory wiring, if placed under the dash;

vii. An alarm shall sound when the ignition is disabled; and

viii. If an override switch is provided, the switch shall be hidden from view, and work in conjunction with an alarm that sounds continuously while the engine is running.

8. A passive ignition lock protection system is qualified if a warning label announces the system, and the system is designed so that:

i. A case-hardened steel protective cap fits over the ignition;

ii. The cap fastens to a steel collar fitted around the steering column and over the ignition lock; and

iii. The cap contains a slotted opening through which the ignition key fits and is operable.

9. A high security replacement lock device is qualified if a warning label announces the device, and the device is designed so that it is a case-hardened steering column ignition lock conforming to the National Highway Traffic and Safety Association's Standard No. 114–1, incorporated herein by reference. A copy of Standard No. 114–1 may be obtained by writing:

National Highway Traffic and Safety Association
Docket Room
NAD–52
400 Seventh Street, S.W.
Washington, D.C. 20590

10. A hydraulic brake lock device is qualified if a warning label announces the presence of the device and the device is designed so that:

i. The device is mounted on the dash;

ii. When activated and pressurized with the brake pedal, hydraulic pressure is maintained on the brakes at two or more of the automobile's wheels;

iii. The device has a high security locking system with at least 50,000 combinations; and

iv. The lock is such that it cannot be pulled using a conventional slide hammer or lock puller equipment.

11. A window etching vehicle identification system is qualified if a warning label announces the presence of the system, and the system is designed so that:

i. A specific, identifiable set of numbers is permanently etched into all primary window glass areas, either by sandblasting or a chemical process;

ii. The set of numbers must be traceable to the automobile's registered owner; and

iii. Immediate telephonic notification or identification of the registrant must be available 24 hours a day, seven days per week.

(d) A device or system qualifies as a Category IV antitheft or vehicle recovery device if a warning label announces the presence of the device and it meets the following requirements:

1. The device or system is designed to transmit a pulse or signal by which the location of the automobile in which the device or system is installed may be tracked by those receiving the signal;

2. The device or system is activated or initiated when an automobile is stolen or reported stolen to police;

3. The pulse or signal either must be transmittable to the New Jersey State Police or to a private central monitoring station which shall have direct communication with the New Jersey State Police for the purpose of reporting, tracking and monitoring the automobile; and

4. The device or system shall be designed so that upon recovery, information concerning the automobile's location may be provided to the proper authorities and/or the automobile's owner or insurer.

(e) All warning labels announcing the presence of an anti-theft or vehicle recovery device or system shall be located so as to be visible from the automobile's exterior, preferably on the forward passenger and driver's side door windows.

(f) The lists set forth in (a) through (d) above are not exclusive, and shall not prevent an insurer from considering other devices or systems as anti-theft or vehicle recovery devices eligible for reductions in the base rates of comprehensive and theft and fire coverages, in a manner determined by the insurer.

Public Notice: Notice of receipt of and action on Petition for rulemaking for vehicle anti-theft and recovery device.
See: 23 N.J.R. 2786(c).
Notice of Receipt of Petition for Rulemaking: Reductions in Premium Charges for Private Passenger Automobiles Equipped with Anti-Theft, Vehicle Recovery and Safety Devices.
See: 24 N.J.R. 305(a).
Notice of Action on Petition for Rulemaking.
See: 24 N.J.R. 658(a).

11:3–39.6 Reductions in rates for safety features

(a) Except as (d) below may apply, every insurer writing automobile physical damage insurance shall provide a reduction in the base rates of its collision damage coverage for all private passenger automobiles equipped with one or more safety features. Reductions in the base rates shall be as follows:

1. At least five percent for a private passenger automobile equipped with one safety feature;

2. An additional 2.5 percent reduction shall be provided for each additional safety feature with which the automobile is equipped; and

3. No insurer shall be required to provide more than a 10 percent total reduction for safety features, (a)2 above notwithstanding.

(b) Insurers shall develop a list of features which will qualify as collision damage safety features. This list may include features which are standard features for some private passenger automobiles, but which are options or not available for other private passenger automobiles. This list shall include:

1. Anti-lock braking systems;

2. Traction control systems; and

3. Five-mile-per-hour bumpers.

(c) An insurer may require reasonable proof that a private passenger automobile is equipped with a safety feature before providing any reduction in the base rates for collision damage coverage for private passenger automobiles. An inspection for the issuance or renewal of physical damage coverages, as set forth at N.J.A.C. 11:3–36, shall be considered reasonable proof.

(d) The requirements of (a) through (c) above shall not be applicable to those insurers which utilize make and model rating in pricing collision coverage.

11:3–39.7 Penalties

Any insurer which fails to comply with the terms of this subchapter shall be in violation of this subchapter, and subject to the assessment of any and all penalties in accordance with the laws of this State.

11:3–39.8 Severability

If any provision of this subchapter or application thereof to any person or circumstances is held invalid, the remainder of the subchapter and application of such provisions to other persons or circumstances shall not be affected thereby.

SUBCHAPTER 40. INSURERS REQUIRED TO PROVIDE AUTOMOBILE INSURANCE COVERAGE TO ELIGIBLE PERSONS

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(e), 17:33B–1 et seq., and 17:33B–15

Source and Effective Date

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).

11:3–40.1 Purpose and scope

(a) The purpose of this subchapter is to implement N.J.S.A. 17:33B–15 by setting forth those insurers required under that statutory provision to provide automobile insurance to eligible persons.

(b) This subchapter applies to all insurers authorized or admitted to transact automobile insurance in this State, but does not include the Market Transition Facility created pursuant to N.J.S.A. 17:33B–11 et seq. or any residual market mechanism implemented pursuant to N.J.S.A. 17:29D–1 et seq.

11:3–40.2 Definitions

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

"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; 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 meeting the definition contained in this section shall be considered a private passenger automobile owned by two or more relatives residing in the same household.

"Automobile insurance" means insurance for a private passenger automobile including one or more of the following coverages: bodily injury liability and property damage liability, comprehensive and collision coverages, uninsured and underinsured motorist coverage, personal injury protection coverage, additional personal injury protection coverage and any other automobile insurance required by law.

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

"Department" means the Department of Insurance.

"Eligible person" means a natural person who meets the qualifications of an "eligible person" as set forth at N.J.A.C. 11:3–34.4.

"Insurer" means an entity authorized or admitted to write private passenger automobile insurance in New Jersey, but does not include the Market Transition Facility created pursuant to N.J.S.A. 17:33B–7 or any residual market mechanism implemented pursuant to N.J.S.A. 17:29D–1 et seq.

"Personal lines automobile insurance" means direct automobile insurance issued by an insurer for personal, family or household purposes, and written in accordance with a rating system filed and approved pursuant to N.J.S.A. 17:29A–1 et seq.

11:3–40.3 Insurers required to provide automobile insurance coverage to eligible persons

(a) In accordance with N.J.S.A. 17:33B–15, every insurer, except as provided in (b) below, shall provide automobile insurance coverage for eligible persons beginning April 1, 1992. No insurer, except as provided in (b) below, shall refuse to insure, renew, or limit coverage available for automobile insurance to an eligible person meeting the insurer's underwriting rules as filed with and approved by the Commissioner in accordance with N.J.S.A. 17:29A–46. An insurer shall provide all coverages, including physical damage coverages, in accordance with its rating system filed with the Department and approved pursuant to N.J.S.A. 17:29A–1 et seq.

(b) The requirements set forth in (a) above shall not apply to the following:

1. Insurers that have not issued or renewed policies of automobile insurance in New Jersey since December 31, 1983;

2. Insurers that have issued or renewed policies of automobile insurance in New Jersey since December 31, 1983, only in accordance with a commercial lines rating system filed and approved pursuant to N.J.S.A. 17:29AA–1 et seq.;

3. Insurers with less than 1,000 automobile inforce exposures as of December 31, 1983 and as of September 30, 1988. Insurers newly authorized to transact private passenger automobile insurance after September 30, 1988 shall be exempt from this subchapter only until such time as the insurer has 1,000 or more automobile inforce exposures;

4. Insurers transacting automobile insurance business in New Jersey subject to a plan of orderly withdrawal approved in accordance with N.J.A.C. 11:2–29, but only to the extent provided by the terms of the approved plan of orderly withdrawal; or

5. Insurers transacting automobile insurance business in New Jersey subject to an order issued by the Commissioner in accordance with N.J.S.A. 17:33B–19 and 20, but only to the extent provided by the terms of the order.

(c) Insurers that currently insure, or have insured since December 31, 1983, only certain types of automobiles (for example, motor homes, recreational vehicles or antique automobiles) shall comply with the requirements of (a) above, but only for the particular types of automobiles currently being insured.

(d) Insurers that currently provide, or have provided since December 31, 1983, only limited coverage (for example, physical damage coverage) shall comply with the requirements of (a) above, but only for the limited coverages being written.

(e) Insurers that are required to insure eligible persons, but that do not have a current personal lines automobile insurance rating system on file with the Department, shall file such a system with the Department in accordance with N.J.S.A. 17:29A–1 et seq. within 90 days of the effective date of this rule.

(f) Insurers identified within the provisions of (b), (c) or (d) above, shall comply with the following:

1. Such insurers shall file with the Department no later than 60 days from the date of adoption of this rule a certified statement containing the following information:

i. The insurer's name, including the NAIC number and NAIC group number;

ii. A statement that the insurer is not required to comply fully with N.J.S.A. 17:33B–15;

iii. The factual basis upon which the insurer relied to determine that it is not required to comply fully with N.J.S.A. 17:33B–15;

iv. The particular provision of this rule under which the insurer is included; and

v. A certification by an officer of the insurer that the statement is complete, correct and accurate to the best of the officer's information, knowledge and belief, based upon the officer's personal review of all relevant records.

2. The certified statement shall be sent to the Department at the following address:

Division of Licensing, Enforcement and Consumer Protection
New Jersey Department of Insurance
20 West State Street
CN 328
Trenton, N.J. 08625–0328

11:3–40.4 Penalties

(a) The Commissioner may suspend, revoke or otherwise terminate the certificate of authority to transact automobile business in this State of any insurer failing to comply with the provisions of this subchapter requiring that the insurer provide automobile insurance in accordance with N.J.S.A. 17:33B–15.

(b) In addition to or in lieu of the penalty set forth in (a) above, the Commissioner may impose a fine as provided in N.J.S.A. 17:33B–21 for any violation of the provisions of this subchapter.

(c) The Department shall follow the procedures set forth at N.J.A.C. 11:17D–2.1 in imposing the penalties set forth at (a) or (b) above.

SUBCHAPTER 41. (RESERVED)

SUBCHAPTER 42. PRODUCER ASSIGNMENT PROGRAM

Authority

N.J.S.A. 17:1C–6(e), 17:1–8.1 and 17:33B–9.

Source and Effective Date

Emergency New Rules, R.1992 d. 381, effective September 4, 1992 (expire November 3, 1992). See: 24 N.J.R. 3421(a).
Adopted Concurrent Proposal, R.1992 d.482, effective November 2, 1992.
See: 24 N.J.R. 3421(a), 24 N.J.R. 4397(a).
Provisions of Emergency New Rules R.1992 d.381 readopted with changes effective December 7, 1992.
See section annotations for specific changes on adoption.

Law Review and Journal Commentaries

Auto Insurance. Steven P. Bann, 133 N.J.L.J. No. 6, 73 (1993).

11:3–42.1 Purpose and scope

(a) This subchapter implements N.J.S.A. 17:33B–9c and provides for the assignment of qualified producers on an equitable basis to insurers writing private passenger automobile insurance in the voluntary market.

(b) This subchapter applies to all insurers licensed to transact private passenger automobile insurance in this State, unless otherwise exempt pursuant to this subchapter, and all qualified producers who seek to be assigned to insurers pursuant to the procedures set forth in this subchapter.

(c) Producer assignments under the Program shall cease with any assignments made pursuant to the April 1, 1993 list of qualified producers. Notwithstanding the foregoing, the Commissioner may reactivate the assignment procedure in the event he or she determines that there are geographic areas in this State that lack sufficient representation for the placement of automobile insurance business in the voluntary market.

Case Notes

Adoption of emergency regulation cured defect where order was used rather than rule making. Matter of Producer Assignment Program, 261 N.J.Super. 292, 618 A.2d 894 (A.D.1993), certification denied 133 N.J. 439, 627 A.2d 1144.

Emergency regulation was used to overcome failure by Insurance Commissioner to establish mechanism to cover residual insureds. Matter of Producer Assignment Program, 261 N.J.Super. 292, 618 A.2d 894 (A.D.1993), certification denied 133 N.J. 438, 627 A.2d 1144.

11:3–42.2 Definitions

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

"Association" means the New Jersey Automobile Full Insurance Underwriting Association established pursuant to N.J.S.A. 17:30E–1 et seq.

"Automobile" is as defined in N.J.S.A. 17:30E–3b.

"Automobile insurance" is as defined in N.J.S.A. 17:30E–3c.

"Category B Association producer" means a producer who does not have a current affiliation with a voluntary market company for the purposes of placement of private passenger automobile insurance who:

1. Had such an affiliation with an insurer that was terminated by the insurer prior to December 31, 1980; or

2. Never had such an affiliation with a voluntary market company for the purposes of placement of private passenger automobile insurance.

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

"Department" means the New Jersey Department of Insurance.

"Geographic area" means any one of the 27 rating territories in this State approved by the Commissioner for use in private passenger automobile rating systems.

"Insurer" means any person authorized to transact the business of personal private passenger automobile insurance in this State, including insurers organized pursuant to N.J.S.A. 17:50–1 et seq.

"MTF" means the Market Transition Facility established pursuant to N.J.S.A. 17:33B–11.

"Personal private passenger automobile insurance" means a policy of automobile insurance principally used to provide primary insurance on private passenger automobiles which are owned individually, or jointly by individuals who are residents of the same household, and used for personal, family, or household needs.

"Program" means the Producer Assignment Program established pursuant to N.J.S.A. 17:33B–9c and this subchapter.

"Voluntary market insurer" means an insurer authorized to transact private passenger automobile insurance in this State.

Amended by R.1994 d.112, effective March 7, 1994.
See: 25 N.J.R. 2215(a), 26 N.J.R. 1229(a).

11:3–42.3 List of qualified producers

Except for the first assignment made under this Program, the assignment of producers shall be made on a biannual basis subsequent to the conclusion of the quota periods established pursuant to N.J.S.A. 17:33B–11, commencing with the October 1, 1992 quota. The Commissioner shall annually, on October 1 and April 1, establish a list of producers who have been determined to be qualified for assignment to voluntary market insurers pursuant to this Program.

11:3–42.4 Eligible producers

(a) For the purpose of this subchapter, "eligible producer" is a producer who:

1. Is licensed in this State as a resident insurance producer;

2. Had a valid Association producer contract in force on September 30, 1990.

3. Does not have a current affiliation with a voluntary market insurer for the purposes of placement of private passenger automobile insurance, but who had such an affiliation that was terminated by the insurer between December 31, 1980 and December 31, 1992;

4. Is located in a rating territory that is determined by the Commissioner to be inadequately serviced, as defined in N.J.A.C. 11:3–42.5; and

5. Has derived not less than $7,500 in commission income from Association or MTF policies combined in calendar year 1990.

i. A producer may also use any voluntary market private passenger automobile insurance commission income he or she received during 1990 to meet the $7,500 threshold.

(b) For the purpose of this section, a producer who does not have a current affiliation with a voluntary market insurer for the purposes of placement of private passenger automobile insurance shall include the appointed representatives of insurers that have been:

1. Exempted from meeting the requirements of N.J.S.A. 17:33B–15, provided that the producer was appointed before the exemption Order and wrote at least 10 policies for the insurer during the year preceding the application for assignment;

2. Ordered by the Commissioner to cease the writing of automobile insurance; or

3. Permitted by the Commissioner to cease writing automobile insurance pursuant to a plan of orderly withdrawal approved pursuant to N.J.A.C. 11:2–29.

11:3–42.5 Designation of geographic areas

(a) For the purposes of the Program, the State shall be divided into geographic areas corresponding to the rating territories used by the Association/MTF to write private passenger automobile insurance. Each rating territory shall be designated as either adequately serviced or inadequately serviced. For the initial producer assignment to be made under this Program, the determination of whether a territory is inadequately serviced shall be as follows:

1. A territory shall be designated as adequately serviced if the proportion of voluntary market private passenger automobile non-fleet exposures to total private passenger non-fleet exposures in that territory meets or exceeds both the aggregate Statewide quota established pursuant to N.J.S.A. 17:30E–14b(2), for the quota period ending on September 30, 1990 and the aggregate Statewide quotas established pursuant to N.J.S.A. 17:33B–11c(5), for the quota periods ending March 31, 1991 and September 30, 1991.

2. A territory shall be designated as inadequately serviced if the proportion of voluntary market private passenger automobile non-fleet exposures to total private passenger non-fleet exposures in that territory is less than the aggregate Statewide quota established pursuant to N.J.S.A. 17:30E–14b(2), for the quota period ending on September 30, 1990 or pursuant to N.J.S.A. 17:33B–11c(5), for the quota periods ending March 31, 1991, or September 30, 1991.

(b) For quota periods ending after September 30, 1991, the Commissioner shall review the status of each rating territory at the conclusion of each quota period established pursuant to N.J.S.A. 17:33B–11c(5). A rating territory shall be determined by the Commissioner to be inadequately serviced:

1. If the proportion of voluntary market private passenger automobile non-fleet exposures to total private passenger automobile non-fleet exposures in that territory is below the aggregate Statewide quota for the quota period; or

2. If the territory is adequately serviced based on the criteria established in (b)1 above, but the volume of exposures insured in the voluntary market was not achieved in the territory substantially through the voluntary writing of exposures but was achieved through the mandatory assignment of exposures pursuant to any mandatory depopulation plan established by the Commissioner.

(c) Notwithstanding the foregoing, the Commissioner, in his or her discretion, may find that specific areas within a rating territory are inadequately serviced although the territory as a whole has been determined to be adequately serviced. The Commissioner's determination shall set forth the basis for his or her finding in such instances.

(d) Except as may be otherwise permitted by the Commissioner, producers shall be deemed to be located and servicing business in a single rating territory for the purposes of this Program. The producer shall be assigned to the rating territory in which the producer's principal business office is located, as reflected by the records of the Department's licensing records.

(e) The Commissioner shall annually, on May 15 and November 15, establish a list of those rating territories or, if applicable, areas within rating territories that are determined to be inadequately serviced based on a review of the results of the immediately preceding quota periods, that is, April 1 and October 1, respectively. Notice thereof shall be provided to all Association producers by bulletin.

11:3–42.6 Application procedures

(a) Any producer who is eligible for assignment to a voluntary market insurer pursuant to this Program shall make application to the Department on a form prescribed and furnished by the Department, incorporated herein by reference as Appendix A. The Department shall provide the form upon written request, within five working days of receipt of such request.

(b) All applications and accompanying documents shall be submitted to the Department. Applications premised on the May 15 list of inadequately serviced territories shall be filed with the Department no later than July 1 and applications premised on November 15 list shall be filed no later than January 1.

(c) In the event an application is not fully completed, or the information provided is inadequate or required documentation is missing, the application shall be disapproved and the producer so notified, in writing, within 10 working days of receipt of the application by the Department. The producer shall be afforded a reasonable opportunity to cure any deficiencies in the application, provided, however, that such deficiencies are cured and a completed application is filed with the Department by the filing dates specified in (b) above.

(d) The Department shall review each application to determine whether the producer meets each of the criteria established by the Commissioner pursuant to N.J.S.A. 17:33B–9c and shall advise the applicant, in writing, as to whether he or she is qualified for assignment under this Program. Disapproval of an application shall be made as provided in N.J.A.C. 11:3–42.8.

(e) Notifications to producers applying pursuant to the May 15 list of inadequately serviced territories shall be issued by the Department on or before September 1; notifications premised on the November 15 list of inadequately serviced territories shall be issued by the Department on or before March 1.

(f) Completed applications and other information required to be submitted pursuant to this subchapter shall be submitted to the Department at the following address:

ARM Unit/PAP
Department of Insurance
CN 325
Trenton, New Jersey 08625

11:3–42.7 Review of applications

(a) In determining whether a producer is qualified for participation in this Program, the Department's review shall include, but need not be limited to, the following:

1. Any records concerning the termination of the producer's affiliation with any voluntary market insurer(s) to determine whether:

i. The producer was terminated on or after December 31, 1980 (as provided at N.J.S.A. 17:33B–9c(3));

ii. The producer has violated any of the insurance laws of this State or rules promulgated pursuant thereto; and

iii. The reason for termination adversely reflects on the producer's competency, efficiency and effectiveness in servicing insurance business or otherwise indicates that the producer should not be qualified for this Program due to unworthiness, bad faith, lack of integrity, financial irresponsibility, dishonesty or other criteria deemed relevant by the Commissioner;

2. Any records relating to the appointment of the producer to act as an Association or MTF producer, his or her performance as an Association or MTF producer, any bona fide complaints filed against the producer with the Association, the MTF or any servicing carrier of these entities and any corrective or disciplinary action taken by the Association or MTF with respect to the producer;

3. Any records of bona fide complaints filed against the producer with the Department or any administrative action instituted by the Department (that is, issuance of an Order to Show Cause, issuance of an Order pursuant to N.J.S.A. 17:22A–20d etc.) with respect to the producer that has resulted in the imposition of fines or suspension or revocation of license privileges, including the imposition of such sanctions based on a Consent Order; and

4. Upon disclosure on the application or any other document reviewed by the Department of such administrative actions, any records relating to administrative actions instituted by any licensing authority of this or any other state or the Federal government with respect to the producer that has resulted in the imposition of fines, or suspension or revocation of license privileges.

11:3–42.8 Producer qualification standards

(a) An application for qualification under this Program shall be disapproved if, based on the Department's review as set forth in N.J.A.C. 11:3–42.7:

1. The producer is determined not to meet the eligibility criteria set forth in N.J.A.C. 11:3–42.4;

2. The producer has failed to comply with insurance laws and regulations and/or the producer performance standards established by the Association Plan of Operation, at Part III Operating Principles, Section 4: Producer Performance Standards, subsection 1, Performance Standards—General, or the MTF Plan of Operation, at Part III, Operating Principles, Section 4: Producer Performance Standards, subsection 1, Performance Standards—General;

3. The producer's affiliation with any voluntary market insurer has been terminated for reasons that adversely reflect on the producer's competency, efficiency or effectiveness in servicing insurance business or that otherwise indicate that the producer should not be qualified for this Program due to unworthiness, bad faith, lack of integrity, dishonesty, financial irresponsibility or other criteria deemed relevant by the Commissioner. This standard shall apply to all terminations of affiliation, including, but not limited to, agency appointments, brokerage arrangements and limited insurance representative appointments, any termination of an appointment made pursuant to the Producer Voluntary Placement Plan and any termination of an assigned appointment made under this Program;

4. The producer failed to file a completed application with the ARM Unit within the Department as provided in N.J.A.C. 11:3–42.6(c);

5. The producer knowingly withheld material information on the application or any accompanying document or intentionally made or caused to be made any false, deceptive or fraudulent statement during the application process, or otherwise qualified or attempted to qualify for this Program by fraud or material misrepresentation; or

6. The producer has been excluded from the Producer Voluntary Placement Plan or has previously been excluded from the Producer Assignment Program as provided in N.J.A.C. 11:3–42.18.

(b) An otherwise eligible producer whose application has been disapproved may reapply for the Program in a subsequent period except where such disapproval is for cause. For the purpose of this provision the term, "for cause," shall mean any willful and/or repeated violation of insurance laws or regulations, or Association or MTF performance standards, or any conduct that demonstrates unworthiness, lack of integrity, bad faith, dishonesty, financial irresponsibility or incompetency to transact business as an insurance producer.

(c) When the ARM Unit within the Department disapproves an application for assignment, the disapproval notice shall:

1. Include a written statement specifying the reasons for the rejection; and

2. Inform the producer of his or her ability to request a review of the disapproval by the Commissioner, within 10 days of receipt of the disapproval.

i. A request for review by the Commissioner shall be in writing and made within 10 days of receipt of the disapproval and shall be accompanied by all supporting documentation, if any, disputing with specificity, the reasons for disapproval. A response to this request may be made by the ARM Unit within five days thereafter.

ii. The Commissioner shall issue a written decision with reasons upholding or reversing the decision of the ARM Unit within 30 days from receipt of the last written request or response whichever is later.

11:3–42.9 Exemption from program

(a) The Program is intended to address the dual goals of protecting producers who have built businesses and developed expertise serving the residual market and of encouraging auto insurance sales and service in inadequately served territories. Therefore, assignment of producers on an equitable basis should consider whether an insurer's own marketing system has, in practice, provided reasonable access to persons in all areas of the State. When an insurer has demonstrably provided such access, it may be exempt from assignments under the Program.

1. Requests for an exemption on this basis must be supported by the following information:

i. For an insurer utilizing producers to transact private passenger automobile insurance in this State:

(1) A report showing the distribution of producers by territory within the State of New Jersey for the period between October 1, 1990 to the present. The report should specify the appointment dates of any newly appointed producer during the report period, as well as the termination date of any producer terminated during the report period;

(2) A narrative and supporting documentation demonstrating that the insurer was actively soliciting private passenger automobile insurance in inadequately serviced territories, especially the most inadequately serviced territories, for the period between October 1, 1990 to the present. The narrative and supporting documentation should also include data reflecting the results of the solicitation efforts; and

(3) Any other supplemental information that the insurer may consider relevant to the request for an exemption.

ii. For insurers who conduct business as direct writers:

(1) A narrative and supporting documentation showing that the insurer was actively soliciting private passenger automobile insurance in the inadequately serviced territories, especially the most inadequately serviced territories, for the period from October 1, 1990 to the present. The narrative and supporting documentation should also include data reflecting the results of the solicitation efforts; and

(2) Any other supplemental information that the insurer may consider relevant to its request for an exemption.

2. Requests for exemptions from this Program shall be filed with the Department no later than the end of the quota period, as set forth at N.J.A.C. 11:3–42.5, for which assignments are being made. Failure to submit a complete application by the due date may result in a denial of the insurer's request for exemption from assignments for that assignment period. An insurer that previously submitted an application for an exemption pursuant to this section may incorporate by reference information included with the previous request. However, the insurer shall submit documentation of continued or additional marketing and solicitation efforts between the time the original request was made and the time the present request is made.

3. The review of requests for exemptions from this Program shall be conducted by the ARM Unit within the Department. The ARM Unit shall review the request and shall notify the insurer in writing as to its decision within 45 days of the end of the quota period for which assignments are being made.

i. In evaluating an insurer's application for an exemption, the Department shall apply four tests. Each test shall be weighted equally so that passing or failing one test shall not automatically result in the denial of an exemption. A passing result on each test carries a score of one, and, therefore, the maximum possible score is four. A score of three or better results in the granting of an exemption.

ii. The four tests are as follows:

(1) Whether the insurer met the most recent depopulation quota;

(2) Whether the insurer's distribution of business among all the rating territories for the most recent data available matches the distribution of business in the MTF on that same date. The Department uses a Standard Compliance Index for this measurement. A compliance index of 1.000 or more demonstrates a good match between the insurer's and MTF's distributions;

(3) Whether the insurer's rate of growth in the inadequately serviced territories as defined at N.J.A.C. 11:3–42.5 between September 30, 1990 and the most recent available quarterly report information equals or exceeds the rate of growth in those same inadequately serviced territories by the voluntary market as a whole; and

(4) Whether the information submitted by the insurer pursuant to this subsection indicates that the insurer, through its system of marketing insurance and efforts at solicitation of business, provided reasonable market access in the inadequately serviced territories, especially the most inadequately serviced territories.

4. When the ARM Unit rejects an exemption request, the notice of rejection shall:

i. Include a statement in writing specifying the reasons for the rejection; and

ii. Inform the insurer of the right to request a review of the rejection by the Commissioner, no later than seven days after receipt of the notice of rejection.

(1) A request for review by the Commissioner shall be made in writing no later than seven days after receipt of the notice of rejection and shall be accompanied by all supporting documentation, if any, disputing, with specificity the reasons for rejection. A response to this request may be made by the ARM Unit within five days thereafter.

(2) The Commissioner shall issue a written decision with reasons upholding or reversing the decision of the ARM Unit within 30 days from receipt of the last written request or response whichever is later. In deciding requests for review, the Commissioner may consider such additional information submitted by the insurer that shall promote the express intention of N.J.S.A. 17:33B–9c to assign qualified producers to insurers on an equitable basis.

(b) An insurer may also be exempted from this Program:

1. As part of relief from insurer obligations under the Fair Automobile Insurance Reform Act having been granted, pursuant to the requirements of N.J.A.C. 11:2–35;

2. In accordance with a plan of orderly withdrawal from the State which has been approved pursuant to N.J.A.C. 11:2–29;

3. If the insurer had fewer than 1,000 voluntary private passenger automobile exposures in-force on December 31, 1983 and September 30, 1988; or

4. If the insurer has, as a condition of providing coverage, uniform membership requirements which have been filed and approved by the Department pursuant to N.J.S.A. 17:29A–46 and N.J.A.C. 11:3–35 and the insurer is not prohibited from using its membership requirements by N.J.S.A. 17:33B–26. Notwithstanding the foregoing, if the insurer is a member of a group that includes other insurers that are authorized to transact private passenger automobile insurance in this State, but do not have approved membership requirements as a condition of providing coverage, producer assignments shall be made to the group.

(c) An insurer that has been exempted from this Program pursuant to (b)1 or 2 above or qualifies for exemption under (b)3 or 4 above shall notify the Department at least 45 days prior to the promulgation of the lists of qualified producers.

Amended by R.1992 d.482, effective December 7, 1992.
See: 24 N.J.R. 3421(a), 24 N.J.R. 4397(a).
Text at (a)1i(2) revised to extend the period covered to the present; new application and policy information not required; incorporation by reference of previously submitted material allowed in application for exemption.
Amended by R.1994 d.112, effective March 7, 1994.
See: 25 N.J.R. 2215(a), 26 N.J.R. 1229(a).

11:3–42.10 Apportionment of producers; credits

(a) Each insurer authorized to transact the business of private passenger automobile insurance in this State shall be subject to the assignment of qualified producers pursuant to the procedures and requirements set forth in this Program. Producer assignments shall be apportioned among insurers based upon each insurer's apportionment share as determined for purposes of depopulation pursuant to N.J.S.A. 17:30E–14 and 17:33B–11(c)5, subject to any exemptions as set forth in N.J.A.C. 11:3–42.9.

(b) Any insurer that has, pursuant to the Producer Voluntary Placement Plan, appointed eligible Association producers as defined in N.J.A.C. 11:3–42.4 shall receive credit against any producer assignments to be made under this Program on a one-for-one basis. The one-for-one credit shall be premised on a calculation of the insurer's apportionment share of the total number of producers who otherwise would have been eligible for assignment under this Program in the absence of any voluntary agreements entered into by those companies subject to assignment.

1. In the event that an insurer appoints sufficient eligible Association producers to meet or exceed the insurer's apportionment share of such producers for that assignment period, the insurer shall not be subject to producer assignment during that assignment period and the excess shall be credited against any subsequent assignments made by the Commissioner.

2. The excess shall not be credited against subsequent assignments to the extent that the insurer has terminated any appointments of producers prior to the next assignment period.

3. Credits against future assignments shall apply irrespective of whether the territory where a producer is located continues to be designated as inadequately serviced pursuant to N.J.A.C. 11:3–42.5.

(c) Any insurer that has, pursuant to the Producer Voluntary Placement Plan, appointed Category B Association producers who are located in territories that have been determined by the Commissioner to be inadequately serviced pursuant to N.J.A.C. 11:3–42.5, shall receive credits against any producer assignments based on the credit allowance set forth in (d) below.

1. In the event that an insurer appoints sufficient Category B Association producers to meet or exceed the insurer's apportionment share of eligible producers for that assignment period, the insurer shall not be subject to producer assignment during that assignment period and the excess shall be credited against any subsequent assignments made by the Commissioner.

2. The excess shall not be credited against subsequent assignments to the extent that the insurer has terminated any producer appointments prior to the next assignment period.

3. Credits against future assignments shall apply irrespective of whether the territory where a producer is located continues to be designated as inadequately serviced pursuant to N.J.A.C. 11:3–42.5.

(d) The credit allowance specified in (c) above shall be calculated so as to ensure the Commissioner's ability to provide assignments for all or substantially all producers on each list of qualified producers as set forth in N.J.A.C. 11:3–42.3. The credit allowance shall be reviewed and adjusted, if necessary, on a periodic basis. For the initial implementation of this Program, an insurer shall receive one credit toward a producer assignment for every four Category B producers appointed who are located in inadequately serviced territories.

(e) In calculating any insurer's apportionment share of any producer assignments made pursuant to this Program, the following procedures shall govern:

1. The apportionment shares of producer assignments of any insurers that are subject to exemption under the Program, pursuant to N.J.A.C. 11:3–42.9, shall be calculated and such shares redistributed among the remaining carriers in the proportion that each of the remaining insurers' market shares bears to the total market share of all such insurers;

2. Credits against an insurer's apportionment share of producer assignments earned pursuant to (b) above shall be calculated and the producers redistributed among the remaining insurers in the proportion that each of the remaining insurers' producer assignments (after application of the one-for-one credit) bears to the total number of such assignments; and

3. Credits against an insurer's apportionment share of producer assignments earned pursuant to (c) above shall be calculated and the producers redistributed among the remaining insurers in the proportion that each of the remaining insurers' producer assignments (after application of any credits under (c) above) bears to the total number of such assignments.

(f) In calculating credits under this section, the Department shall utilize the number of voluntary agreements that are in force at the end of the April 1 and October 1 quota periods, as applicable. Any credits that are earned by an insurer for a given assignment period that are premised on an appointment that is subsequently terminated shall be removed and adjustments made to the insurer's apportionment share in the next assignment period.

11:3–42.11 Producer assignments

(a) Each insurer subject to the assignment of producers pursuant to this Program shall be notified by Order subsequent to the Commissioner's establishment of each list of qualified producers as set forth in N.J.A.C. 11:3–42.3. Except as provided in (a)1 and 2 below, qualified producers shall be assigned to the insurers subject to assignments on a random basis.

1. No insurer whose total private passenger automobile in-force exposures at the end of the last quota period is greater than 1,000 will be assigned a producer whose eligible book of business is greater than 25 percent of the total private passenger automobile exposures of that insurer.

2. No insurer whose total private passenger automobile in-force exposures at the end of the last quota period is less than 1,000 will be assigned a producer whose eligible book of business is greater than 15 percent of the total private passenger automobile exposures of that insurer.

3. The Department shall consider the total in-force exposures of the insurer at the end of the last quota period in making assignments under this Program.

11:3–42.12 Appointment

(a) Any producer assigned to an insurer under this Program shall be appointed by the insurer as an agent of the company pursuant to N.J.S.A. 17:22A–15 and notice thereof provided to the Department as provided in N.J.A.C. 11:17–2.9. Contracts between the insurer and the assigned producer(s) shall be executed no later than 30 days following issuance of the Order specified in N.J.A.C. 11:3–42.11.

1. With respect to insurers that are members of a group, the notice to the Department shall specify the member companies to which the producer is appointed as an agent. Where the group utilizes different member insurers for the purpose of writing standard and nonstandard risks, the producer shall be appointed as an agent for all such companies. Insurers that are members of a group are not required to appoint the producer as an agent of all the companies in the group provided that the producer is appointed to one or more companies that have approved standard and non-standard rating plans.

(b) Pursuant to N.J.S.A. 17:22–6.14a(e), an insurer may use an insurance marketing system that provides for its agents to be compensated on a salary basis without commission or provides for its agents to represent the company exclusively. Such as insurer may utilize this system for

producers assigned to it under this Program or may appoint such producers as independent agents.

Administrative Correction.
See: 25 N.J.R. 5930(a).

Case Notes

Regulation mandating contracts between insurers and producers is not unconstitutional. Matter of Producer Assignment Program, 261 N.J.Super. 292, 618 A.2d 894 (A.D.1993), certification denied 133 N.J. 438, 627 A.2d 1144.

Regulation allowing producers to place new business complied with statute. Matter of Producer Assignment Program, 261 N.J.Super. 292, 618 A.2d 894 (A.D.1993), certification denied 133 N.J. 439, 627 A.2d 1144.

11:3–42.13 Transfer of MTF business

(a) The insurer shall offer the same or equivalent automobile insurance coverage that was afforded under the MTF to each MTF insured serviced by the producer who is determined by the insurer to qualify as an eligible person pursuant to N.J.A.C. 11:3–34. Where the insurer does not have rates and rules filed and approved by the Department for the same or equivalent coverage presently afforded the insured under the MTF policy, the insurer shall offer to the insured the next broadest coverage for which the insurer has rates and rules filed and approved by the Department. The insurer is expressly prohibited from offering less coverage to the insured than the coverage afforded to such insured under the MTF policy. Examples of coverages that may be offered is set forth in Appendix B to this subchapter, incorporated herein by reference. In determining whether the MTF insured qualifies as an eligible person, insurers shall comply with N.J.A.C. 11:3–8.4. An insurer also may determine to make an offer of coverage to an insured who does not qualify as an eligible person.

(b) The transfer of the producer's MTF policies to the assigned insurer shall be accomplished through completion by the producer of a new business application and a coverage selection form for the insured. Pursuant to mutual agreement between the insurer and the producer, the new business application may be unsigned. However, a coverage selection form signed by the insured shall be submitted to the insurer.

(c) An insurer receiving assignments under this Program may make independent agreements with the servicing carriers for the exchange of electronic information or other arrangements involving the transfer of policies from the MTF to the insurer. An outline of the terms of any agreement and any copies of any written material that will be sent to insureds must be submitted in advance of its implementation to the Department. The MTF shall have no responsibility to provide coverage for insureds as a result of the failure of the servicing carrier to perform under the terms of the independent agreement.

11:3–42.14 New business

The producer shall be authorized to solicit, negotiate and effect new contracts of automobile insurance in accordance with all applicable laws and regulations and the insurer's underwriting guidelines, consistent with procedures applicable to the insurer's other representatives.

11:3–42.15 Producer compensation; company rates

(a) Where an insurer determines to use its own rates for former MTF insureds transferred to the insurer and/or new business written through the producer, the contract shall provide for the producer to be compensated based on the insurer's current schedule of commissions or other formula used to provide compensation to its agents. Policies transferred from the MTF shall be considered as new business with respect to providing producer compensation, for the assigned insurer's initial policy period.

(b) Where an insurer's compensation schedule contemplates support services, such as office space, equipment or advertising, or other employee benefits, and such services or benefits are not provided to the producer, the compensation schedule shall be adjusted to reflect accurately the value of such services or benefits so that the producer shall receive compensation that is equivalent to the compensation paid to, or on behalf of, the company's agents who receive such services or benefits.

1. For the purpose of this provision, the term "agent" shall be construed to have the broadest possible meaning, including, but not limited to, exclusive agents or independent agents.

2. Where an insurer has more than one schedule of commissions for its agents, it shall negotiate in good faith with producers assigned pursuant to this Program to determine the commission to be paid.

(c) In the case of companies that are direct writers, expenses for a direct marketing department and related support staff shall be considered in determining the commission paid to the assigned producer under (a) above.

1. The commission agreed to by any direct writer and an assigned producer under (a) above shall be comparable to the compensation paid to independent agents by insurers that utilize such agents.

2. Where an insurer that is a direct writer also maintains, through a subsidiary company or otherwise, a mechanism to accept business from producers who are not the normal, exclusive agents of the direct writers, the commission schedule applicable to such producers shall be utilized consistent with (a) above.

11:3–42.16 Producer compensation; MTF rates

Where the insurer is authorized by law to use MTF rates, rules and forms for policies written through the producer, it shall pay the producer the same commission paid by the MTF.

11:3–42.17 Duration and terms of producer assignment

(a) Any termination of an appointment of a producer assigned to an insurer pursuant to this Program shall be prohibited for two years following the date of contract, except where such termination is for cause. A termination for cause must be based on the producer's insolvency, abandonment, gross and willful misconduct or failure to pay over to the companies monies due to the company after his or her receipt of written demand therefor, or after revocation of the agent's license by the Commissioner. In addition, an appointment may be terminated for cause if the producer violates the written underwriting guidelines of the insurer in such a manner or with such frequency as to substantially affect the company's ability to underwrite or provide coverage.

1. Insurers shall provide producers with at least 45 days written notice of a termination for cause. The notice of termination shall include a detailed written explanation of the reasons for termination. A copy of the notice shall also be sent to the Department.

2. A termination for cause shall result in the exclusion of the producer from further participation in the Program. Producers may contest a termination notice pursuant to the procedures in N.J.A.C. 11:3–42.18(d).

3. In the case of a termination for cause, the insurer may reassign the producer's book of business to another active agent of the company or service it directly.

(b) At the conclusion of the two year period, the producer and insurer shall negotiate in good faith to do one of the following:

1. Irrespective of the marketing system customarily used by the insurer, appoint the producer as an independent agent, the termination of which appointment is governed by N.J.S.A. 17:22–6.14a(d) and (*l*);

2. Where the insurer, pursuant to N.J.S.A. 17:22–6.14a(e), uses an insurance marketing system that provides for its agents to be compensated on a salary basis without commission or provides for its agents to represent that company exclusively, the insurer may appoint the producer under this system; or

3. Buy out the producer by paying to him or her an amount equivalent to at least one year's commission based on the book of business at the end of the two year assignment period.

(c) If the insurer and the producer cannot reach an agreement under (b) above, the producer shall be deemed a terminated agent who is subject to the provisions of N.J.S.A. 17:22–6.14a(d) and (*l*), notwithstanding N.J.S.A. 17:22–6.14a(e) or the mode of appointment of the producer under this Program (that is, exclusive agent or independent agent).

Administrative Correction.
See: 25 N.J.R. 5930(a).

Case Notes

Regulation allowing producers to place new business complied with statute. Matter of Producer Assignment Program, 261 N.J.Super. 292, 618 A.2d 894 (A.D.1993), certification denied 133 N.J. 438, 627 A.2d 1144, certification denied 133 N.J. 439, 627 A.2d 1144.

11:3–42.18 Exclusion from program

(a) Any producer who refuses an assignment under this Program, that provides for his or her appointment as the assigned company's agent on fair and equitable terms, shall be excluded from further participation in this Program.

(b) Any producer who is terminated within the two year period set forth in N.J.A.C. 11:3–42.17(a) above shall be excluded from further participation in this Program.

(c) Insurers shall immediately provide notice of any refusal of assignment as provided in (b) above, respectively, in writing, to the Department in the format set forth in Appendix C to this subchapter, incorporated herein by reference. A copy of the notice shall be simultaneously delivered to the affected producer.

(d) A producer who has received a notice of termination for cause or a Notice of Refusal of Appointment may file a written response with the Department. Such response shall be made within 10 days of the insurer's notice. The Commissioner shall issue a written decision with reasons within 30 days.

Amended by R.1992 d.482, effective December 7, 1992.
See: 24 N.J.R. 3421(a), 24 N.J.R. 4397(a).
Citation corrected.

11:3–42.19 Initial implementation of program

For the initial implementation of this Program, in-force voluntary agreements that are established by insurers with eligible Association producers and Category B producers located in inadequately serviced territories between October 1, 1990 and February 29, 1992 shall be used to determine any credits under N.J.A.C. 11:3–42.10.

11:3–42.20 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of penalties as authorized by law.

Date Stamp

Application Number

PRODUCER ASSIGNMENT PROGRAM (PAP)
Producer Application

Producer License Reference #

Name of Applicant (must be same as on license)

Contact Person if Applicant is Corp. or Partnership

(_____) Telephone Number

Main Business Address of Applicant—No. & Street (no Post Office Box #)

City NJ Zip

Rating Territory of Main Business Address _____

SS or Tax ID#_____

Does the applicant have a valid New Jersey producer license? Yes _____ No _____

Did the applicant have a valid Association producer contract on 9/30/90? Yes _____ No _____

Does the applicant have a current appointment with a voluntary market insurer for the placement of automobile insurance? Yes _____ No _____

Did the applicant have an appointment with a voluntary insurer for the placement of automobile insurance that was terminated by the insurer after 12/31/80? Yes _____ No _____ If yes, list the insurers with the date and reason for termination below.

Insurer	Date	Reason for Termination
Insurer	Date	Reason for Termination
Insurer	Date	Reason for Termination

Total commission income earned by applicant from JUA/MTF business in 1990? $_____

Total commission earned on voluntary market auto insurance policies, if any? $_____
Attach copies of IRS 1099 forms.

If the answer to any of the questions below is YES, attach copies of relevant documents and explain in the Remarks section below. Add additional sheets if necessary.

Has the applicant or any officer, partner, director or owner of 5% or more have any unsatisfied judgments against them? Yes _____ No _____

Has the applicant or any officer, partner, director or owner of 5% or more ever been indicted or convicted of a crime, misdemeanor or disorderly persons offense in this State, other state or by the federal government? Yes _____ No _____

Has the applicant or any officer, partner, director or owner of 5% or more ever been the subject of any administrative action initiated by the Department of Insurance of this State or any other licensing authority of this or any other state, that resulted in the revocation or suspension of license privileges? Yes _____ No _____

Certification—I/We hereby certify that:

1. I/We give the Department of Insurance permission to verify any information supplied with any federal, state or local government agency, insurance company, JUA or MTF.
2. All the information submitted on this application and all attachments are true and complete. I am/We are aware that submitting false information in connection with this application is grounds for exclusion from the Producer Assignment Program and may subject me/us to administrative including revocation of license.

_____ _____

Signature of Applicant or Officer of Corporation

_____

Print Name

Return to: NJ Department of Insurance
ARM Unit/PAP Applications
20 W. State Street CN 325
Trenton, NJ 08625

APPENDIX B

COVERAGE DETERMINATION EXAMPLES

The following examples are provided for illustration purposes only:

Example 1: The MTF policyholder presently has $25,000/$50,000/$10,000 split limits of liability coverage. However, the member company only writes combined single limit of liability coverage and only has rules and rates filed and approved by the Department for this type coverage. Therefore, the member company must offer the MTF policyholder a combined single limit of liability coverage which is equal to the bodily injury occurrences limit and the property damage occurrence limit added together or the next broadest available coverage (for example, $75,000, but in no event less than $60,000).

Example 2: The MTF policyholder presently has $25,000/$50,000/$10,000 split limits of liability coverage. The member company only writes combined single limit of liability coverage and offers $100,000 combined single limit of liability coverage as the minimum coverage to its voluntary insureds. However, the member company has rates and rules filed and approved by the Department for combined single limit of liability coverage for amounts less than $100,000. Therefore, the member company must offer the MTF policyholder a combined single limit of liability coverage which is equal to the bodily injury occurrence limit and the property damage occurrence limit added together or the next broadest available coverage, but less than $100,000 (for example, $75,000, but in no event less than $60,000).

Example 3: The MTF policyholder presently has $25,000/$50,000/$10,000 split limits of liability coverage. The member company only writes combined single limit of liability coverage and offers $100,000 combined single limit of liability of coverage as the minimum coverage to its voluntary insureds. The member company does not have any rates and rules filed and approved by the Department for amounts of combined single limit of liability coverage less than $100,000. Therefore, the member company must offer the MTF policyholder $100,000 combined single limit of liability coverage.

Example 4: The MTF policyholder presently has $75,000 combined single limits of liability coverage. The member company writes both split limits and combined single limit of liability coverage and has rates and rules filed and approved by the Department for both types of coverage. Therefore, the member company must offer the MTF policyholder $75,000 combined single limit of liability coverage and not a split limits policy.

Example 5: The MTF policyholder presently has $100,000 combined single limit of liability coverage. The member company only writes split limits of liability coverage and only has rates and rules filed and approved by the Department for this type of coverage. Therefore, the member company must offer the MTF policyholder split limits of liability coverage with a bodily injury per person limit equal to the combined single limit of liability coverage or the next broadest available coverage (for example, $100,000/$300,000/$50,000). (Note: All conversions of combined single limit of liability coverage should be handled in the same manner, except a $35,000 combined single limits policy. In this particular case, the member company shall offer $15,000/$30,000/$5,000 split limits of liability coverage.)

PRODUCER ASSIGNMENT PROGRAM—REFUSAL OF PRODUCER APPOINTMENT
(Please print or type)

---------- Company Information ----------

_____ _____
Name of Company or Group NAIC #

Address: _____

_____ _____
Company Contact Person Title

Phone No.: (_____)_____ FAX No.: (_____)_____

---------- Producer Information ----------

_____ _ _ _ _ _ _ _ _ _
Name of JEA/MIF Contractholder DOI Producer Reference No.

Contact Person: _____
Individual Licensee if above is Partnership or Corporation

_____
Main Business Address—No. and Street (P.O. Box not permitted)

_____ NJ _____ (_____)_____
City Zip Phone

SUBCHAPTER 43. (RESERVED)

SUBCHAPTER 44. SPECIAL RULES FOR EFFECTING COVERAGE FOR PRIVATE PASSENGER AUTOMOBILE INSURANCE

Source and Effective Date

Emergency Rule, R.1993 d.135, effective March 1, 1993, operative March 8, 1993 (expires April 30, 1993).
See: 25 N.J.R. 1290(a).
Adopted Concurrent Proposal, R.1993 d.238, effective April 30, 1993.
See: 25 N.J.R. 1290(a), 25 N.J.R. 2479(a).

11:3–44.1 Purpose and scope

(a) This subchapter implements the provisions of N.J.S.A. 17:33B–15 and 18 which prohibit insurers, both individually and through their agents, from attempting to channel away eligible persons, with the effect of avoiding an insurer's obligation to provide private passenger automobile insurance coverage to eligible persons.

(b) This subchapter applies to all persons that are licensed and authorized to transact the business of personal private passenger automobile insurance in this State and all producers.

11:3–44.2 Definitions

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

"Affiliate" means an insurer that directly, or indirectly through one or more intermediaries, controls or is controlled by, or is under common ownership and management with, another insurer.

"Business days" means all days other than weekends and official New Jersey State and Federal holidays.

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

"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.

"Days" means calendar days.

"Eligible person" means a person as defined at N.J.S.A. 17:33B–13 and N.J.A.C. 11:3–34.4.

"Insurer" means a person authorized to transact the business of personal private passenger automobile insurance in this State including insurers organized pursuant to N.J.S.A. 17:50–1 et seq.

"Market Transition Facility" or "MTF" means the New Jersey Market Transition Facility established pursuant to N.J.S.A. 17:33B–11.

"Personal private passenger automobile insurance" means a policy of automobile insurance principally used to provide primary insurance on private passenger automobiles which are owned individually, or jointly by individuals who are residents of the same household, and used for personal, family, or household needs.

"Transmit" means to mail or deliver by any means including, but not limited to, third class mail, certified mail, overnight delivery or express delivery, hand delivery and any transmission by wire, including, but not limited to, facsimile transmission or computer modem.

11:3–44.3 Duty to provide coverage upon receipt of a completed written application

(a) The minimum information necessary to determine whether an applicant is an eligible person and to rate and underwrite the policy is as follows:

1. The desired effective date of policy;

2. Personal information, including the name, address, home telephone number, date of birth, sex and marital status of the applicant and principal driver of each automobile to be insured under the policy;

3. The number of vehicles to be insured and a description of each such vehicle including:

i. The model year;

ii. The cost of the vehicle, if new;

iii. The trade name;

iv. The model;

v. The body type;

vi. The vehicle identification number;

vii. An approximate odometer reading if the insurer rates by mileage;

viii. The estimated annual mileage if the insurer rates by mileage;

ix. The intended use of vehicle (for pleasure, for or to work, to school or to public transportation);

4. Where the vehicle is garaged, if different from residence;

5. The month and year licensed for all drivers licensed less than three years;

6. Information regarding each resident licensed driver who is to be a named insurer under the policy, or who is the principal driver of a vehicle insured under the policy, or who is not otherwise a named insured under a separate policy of automobile insurance including:

i. The percentage use of each licensed driver;

ii. The motor vehicle record for the previous three years including:

(1) Convictions for traffic violations that result in the assessment of insurance eligibility points pursuant to N.J.A.C. 11:3–34.5;

(2) Motor vehicle accidents; and

(3) Drivers' license and registration suspensions and revocations;

iii. An insurer shall not require the applicant to submit a motor vehicle abstract;

iv. Automobile insurance claims history if needed to determine placement into a preferred company in a group of insurers;

v. Insurance fraud and other violations or crimes enumerated at N.J.S.A. 17:33B–13 or set forth at N.J.A.C. 11:3–34.4(a)1, 2 or 4; and

vi. Criminal convictions for offenses in the course of which a motor vehicle was used pursuant to N.J.S.A. 2C:43–2b(7);

7. The drivers' license number of the applicant;

8. Information relating to types of coverage, limits of liability and driver discounts;

9. A coverage selection form; and

10. No information shall be requested based on whether the insured is impaired by physical or mental disabilities except those disabilities that impair the ability to operate an automobile safely.

(b) An insurer, by itself or through its producers with binding authority, shall provide coverage to an eligible person applicant who submits a completed written application that includes the information in (a) above.

1. Insurers shall have five business days from the date of receipt of a completed written application to either provide or decline insurance, or if requested to notify the applicant whether coverage will be provided or denied. An insurer shall obtain and retain documentation of the date of receipt of such application. When an application is transmitted to an insurer by first class mail, there is a rebuttable presumption that the application was received by the insurer two calendar days after mailing when the destination is in New Jersey or within a 300 mile radius of the place of mailing, or three calendar days when the destination is outside a 300 mile radius of the place of mailing, as evidenced by a proof of mailing or postmark.

2. Any document which an insurer requires to be submitted in connection with an application or renewal shall be prominently requested in the application or renewal form.

3. If physical damage coverages are requested by eligible person applicants, insurers shall bind liability coverages in accordance with these rules and may bind physical damage coverages subject to compliance with N.J.A.C. 11:3–36.

(c) If upon receipt of an application from a producer without immediate binding authority or directly from an applicant, an insurer finds that the application is incomplete and the insurer is unable to determine whether the applicant is an eligible person, the insurer shall, within five business days of the date the application was received by it, issue a notice which:

1. Clearly and specifically identifies the deficiencies;

2. Advises the applicant that if the deficiencies are cured within 15 days and the applicant is determined to be an eligible person, coverage shall be provided either immediately or as of the originally requested effective date if later; and

3. Advises the applicant that if the deficiencies are not cured within 15 days, the application shall be deemed to have been declined.

(d) Nothing in this rule shall be deemed to require an insurer to provide coverage prior to receipt by either the insurer or its producer of the premium deposit required based upon the premium quoted by the insurer or its producer.

Amended by R.1994 d.598, effective December 5, 1994.
See: 26 N.J.R. 3591(a), 26 N.J.R. 4777(a).

11:3–44.4 Immediate binding authority for insurers with MTF rates

Insurers which are approved by the Commissioner to use MTF rates in accordance with N.J.S.A. 17:33B–11c shall provide their producers with authority to immediately bind coverage on behalf of the insurer for all applicants to be charged MTF rates. Insurers shall amend their approved rating system, if necessary, either to incorporate MTF Manual Rule 5 which shall be deemed approved by the Commissioner; or to extend immediate binding authority to their producers in accordance with their own immediate binding procedures. This requirement shall not apply to insurers which transact personal private passenger automobile insurance directly with the public.

Amended by R.1994 d.598, effective December 5, 1994.
See: 26 N.J.R. 3591(a), 26 N.J.R. 4777(a).

11:3–44.5 New applicants previously insured in another state by the insurer or an affiliate

(a) An insurer shall immediately provide coverage, without lapse, to any eligible person applicant that:

1. Has moved to New Jersey from another state;

2. Submits a completed written application within 60 days of establishing residency in New Jersey; and

3. Applies to either the same insurer under which the applicant is currently insured or an affiliate of that insurer.

11:3–44.6 Underwriting rules

These new rules shall supersede any existing, conflicting underwriting rules previously filed and approved by the Department pursuant to N.J.A.C. 11:3–35.

11:3–44.7 Penalties

Any insurer that violates any provision of this subchapter shall be subject to the penalties provided by law, including but not limited to the suspension, revocation or termination of a certificate of authority and a civil penalty in an amount of up to $2,000 for the first violation and up to $5,000 for the second and each subsequent violation in accordance with N.J.S.A. 17:33B–15 and 17:33B–21.

SUBCHAPTER 45. INSURERS REQUIRED TO PROVIDE SURVEY INFORMATION

Authority

N.J.S.A. 17:1C–6(e), 17:29A–1 et seq., and 39:6A–23.1.

Source and Effective Date

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

11:3–45.1 Purpose and scope

(a) The purpose of the subchapter is to implement N.J.S.A. 39:6A–23.1 by setting forth those procedures by which insurers shall annually submit to the Department current premium information.

(b) This subchapter shall apply to all auto insurers that have on file with the Department a current personal lines rating system for automobile insurance and which are not exempted from the obligation to insure, renew, or provide automobile insurance to eligible persons. Exempted insurers are listed in N.J.A.C. 11:3–40.3(b), (c) and (d).

11:3–45.2 Definitions

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

"Automobile insurance" means insurance for private passenger automobile including one or more of the following coverages: bodily injury liability and property damage liability, comprehensive and collision coverages, uninsured and underinsured motorist coverage, personal injury protection, additional personal injury protection coverage and any other automobile insurance required by law.

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

"Department" means the New Jersey Department of Insurance.

"Auto insurer" means an entity authorized or admitted to write automobile insurance in New Jersey but does not include either any residual market mechanism implemented pursuant to N.J.S.A. 17:29D–1 et seq. or any other statute, or insurers which are exempted from the requirement to provide automobile insurance coverage to eligible persons in accordance with N.J.A.C. 11:3–40.3(b), (c) and (d).

"Survey information" means the data annually supplied by the Commissioner to the auto insurers from which they will then issue survey quotations. This information includes, but is not limited to, the prior driving experience of the insured, the nature and extent of coverages, the deductible, the composition of household, information regarding the proposed vehicle, and other pertinent information.

11:3–45.3 Annual premium survey filing

(a) Every auto insurer shall prepare and file on or before September 15 of each calendar year, with the Department, at the address set forth in (d) below, an annual premium survey reflecting premiums charged for specific automobile insurance coverage.

(b) The filing shall reflect the annual premiums by coverage as of October 1 of that calendar year and shall be predicated on survey information provided by the Commissioner to auto insurers by Bulletin on or before September 1 of each calendar year.

(c) Auto insurers shall prepare and file the information required by this subchapter in accordance with the forms contained in the Appendix and incorporated herein by reference.

(d) Completed annual premium survey forms shall be submitted to:

Department of Insurance
Division of Public Affairs
20 West State Street
CN 325
Trenton, NJ 08625
Attn. Automobile Premium Survey.

11:3–45.4 Penalties

Failure to comply with the provisions of this subsection shall result in the imposition of penalties as prescribed by law.

APPENDIX

New Jersey Automobile Insurance
Premium Comparison Survey

The sample premiums shall be calculated for each territory using the survey information provided by the Commissioner on or before September 1 each year. The premium information submitted in these forms must be effective October 1 of that year and must be calculated on an annual basis.

All of the forms in this Appendix shall be completed and filed with the New Jersey Department of Insurance, Division of Public Affairs NO LATER THAN SEPTEMBER 15 of the same year. Any questions regarding this survey may be directed to the Division of Public Affairs at (609) 292–5064.

If the data supplied herein is for more than one company, submit separate completed forms for each such company if different rates are on file with the Department.

1. Insurance Company Name: _____
2. NAIC Group #_____ NAIC Company #_____
3. Sample premiums must reflect split liability limits unless company only writes CSL. Choose one only:
   Combined Single Limits of Liability? yes____
   Split Liability Limits? yes____
4. Effective Date of Rates _____
5. Worksheets used to Calculate Rating Examples.
6. Individual collecting and submitting data:
   Name: _____
   Title: _____
   Phone #: _____
   (Include Area Code)

Insurance Co. Name: _____

NAIC Group #: _____ NAIC Company #: _____

COMPLETE A SEPARATE FORM FOR EACH COMPANY IN YOUR GROUP.

PREMIUM INFORMATION

Territory	Example 1	Example 2	Example 3	Example 4
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
19				

Footnote:
Companies should use the 27 territories set forth in the PAIP Manual.

Insurance Co. Name: _____
NAIC Group #: _____ NAIC Company #: _____
COMPLETE A SEPARATE FORM FOR EACH COMPANY IN YOUR GROUP.

Territory	Example 1	Example 2	Example 3	Example 4
22				
23				
24				
25				
26				
27				
31				
38				
39				
40				

Footnote:
Companies should use the 27 territories set forth in the PAIP Manual.

Comments and Footnotes

_____
_____
_____
_____