APPENDIX A - STATUTES

UNSATISFIED CLAIM AND JUDGMENT FUND LAW

39:6-61. Title. This act shall be known and may be cited as the "unsatisfied claim and judgment fund law."

Adopted. L. 1952, c. 174, §1.

39:6-62. Definitions. As used in this act:

"Association" means the New Jersey Property-Liability Insurance Guaranty Association created pursuant to P.L.1974, c.17 (C.17:30A-1 et seq.).

"Commissioner" means the Commissioner of Banking and Insurance.

"Unsatisfied Claim and Judgment Fund" or "Fund" means the fund derived from the sources specified in this act.

"Qualified person" means a resident of this State or the owner of a motor vehicle registered in this State or a resident of another state, territory, or federal district of the United States or province of Canada or of a foreign country, in which recourse is afforded, to residents of this State, of substantially similar character to that provided for by this act; provided, however, that no person shall be a qualified person where such person is an insured under a policy provision providing coverage for damages sustained by the insured as a result of the operation of an uninsured motor vehicle in a form authorized to be included in automobile liability policies of insurance delivered or issued for delivery in this State, pursuant to the provisions of, or any supplement to, chapter 28 of Title 17 of the Revised Statutes or in a form substantially similar thereto.

"Uninsured motor vehicle" means a motor vehicle as to which there is not in force a liability policy meeting the requirements of section 3 or 26 of the "Motor Vehicle Security-Responsibility Law," P.L. 1952, c. 173 (C. 39:6-25 or C. 39:6-48), and which is not owned by a holder of a certificate of self-insurance under said law, but shall not include a motor vehicle with a policy in force which is insured pursuant to section 4 of P.L. 1998, c. 21 (C.39:6A-3.1).

"Person" includes natural persons, firms, copartnerships, associations and corporations.

"Insurer" means any insurer authorized in this State to write the kinds of insurance specified in paragraphs d. and e. of R.S. 17:17-1.

"Net direct written premiums" means direct gross premiums written on policies, insuring against legal liability for bodily injury or death and for damage to property arising out of the ownership, operation or maintenance of motor vehicles, which are principally garaged in this State, less return premiums thereon and dividends paid to policyholders on such direct business.

Adopted. L. 1952, c. 174, §2. **Amended.** L. 1955, c. 1, §1; L. 1956, c. 22, §1; L. 1968, c. 323, §1; L. 1968, c. 385, §4; L. 1985, c. 148, §3; L. 1998, c. 21, §21, approved May 19, 1998, to take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later; L. 2003, c. 89, §8, effective June 9, 2003.

39:6-63. Fund created. For the purpose of creating and maintaining the fund:

(a) (Deleted by amendment, P.L. 1968, c. 323, §3.)

(b) (Deleted by amendment, P.L. 1968, c. 323, §3.)

(c) (Deleted by amendment, P.L. 1968, c. 323, §3.)

(d) Commencing on or before December 30, 2003, and on or before December 30 in each year thereafter, the association shall calculate the probable amount which will be needed to carry out its responsibilities under section 35 of P.L.2003, c.89 (C.39:6-86.7), section 9 of P.L.1952, c.174 (C.39:6-69) and section 7 of P.L.1972, c.198 (C.39:6-86.1) during the ensuing year. In that calculation, the association shall take into consideration the amount presently reserved for pending claims, anticipated payments from the fund during that year and during the two years after that year, anticipated amounts to be reserved for claims pending during that year, and the desirability of maintaining a surplus over and above those anticipated payments and present and anticipated reserves, which surplus shall not exceed the amount actually paid from the fund during the 12 full calendar months immediately preceding the date of calculation. The probable amount needed to carry out the provisions of this section shall be assessed against insurers for that year's contribution to the fund.

(e) Whenever any of the provisions concerning the method and sources of assessments on insurers, the maximum amounts payable from the fund, eligibility or qualifications of claimants, or amounts to be deducted from payments made from the fund are amended by law, the association may, if the association deems it

necessary, rescind any assessment on insurers. The association shall then, within 30 days of the adoption of such amendment, recalculate the probable amount which will be needed to carry out the provisions of P.L.2003, c.89 (C.17:30A-2.1 et al.) during the ensuing fiscal year, in accordance with the provisions of subsection (d) of this section. If, in the judgment of the association, the estimated balance of the fund at the beginning of the next year will be sufficient to meet those needs, the association shall determine the contributions of insurers, if any, in accordance with the provisions of subsection (d) of this section.

Adopted. L. 1952, c. 174, §3. **Amended.** L. 1955, c. 1, §2; L. 1956, c. 22, §2; L. 1965, c. 72, §1; L. 1968, c. 323, §2; L. 1972, c. 198, §1; L. 1977, c. 310, §3; L. 1983, c. 125, §1; L. 1985, c. 148, §4; L. 1988, c. 119, §2; L. 1990, c. 8, §85, effective March 12, 1990; L. 2003, c. 89, §9, effective June 9, 2003.

39:6-63.1. Assessment rescinded; fee. Any assessment made under the provisions of subparagraph (2), of paragraph (d) of section 3 [39:6-63] of the act of which this act is amendatory which has not been collected prior to the effective date of this act, is hereby rescinded and shall not be collected. Every person registering an uninsured motor vehicle in this state, during the period commencing June 1, 1956 and ending May 31, 1957, shall pay at the time of registering the same, in addition to any other fee prescribed by any other law, a fee of $8.00.

Amended. L. 1956, c. 22, §3.

39:6-63.2. Repealed.

Repealed. L. 1969, c. 113, §1.

39:6-64 through 39:6-64b. Repealed.

Repealed. L. 2003, c. 89, §85, effective June 9, 2003.

39:6-64c. Unsatisfied Claim and Judgment Fund abolished, transfer to PLIGA. The Unsatisfied Claim and Judgment Fund Board in the Department of Banking and Insurance, established pursuant to P.L.1952, c.174 (C.39:6-61 et seq.), is hereby abolished and all its functions, powers and duties, along with the Unsatisfied Claim and Judgment Fund, including all its assets, liabilities and balances, are transferred from the Department of Banking and Insurance to the New Jersey Property-Liability Insurance Guaranty Association, established pursuant to P.L.1974, c.17 (C.17:30A-1 et seq.). Wherever in any law, rule or regulation, reference is made to the Unsatisfied Claim and Judgment Fund Board, the same shall mean and refer to the New Jersey Property-Liability Insurance Guaranty Association.

Adopted. L. 2003, c. 89, §7, effective June 9, 2003.

39:6-64.1. Rules and regulations; services of attorneys, others; payment. a. The association may from time to time, adopt and amend a plan of operation, subject to the approval of the commissioner, necessary or desirable in connection with its functions, duties and responsibilities in administering this act [R.S. Cum. Supp. 39:6-62 et seq.].

The plan of operation shall provide that the Unsatisfied Claim and Judgment Fund may (1) borrow and separately account for moneys from any source, including, but not limited to, the New Jersey Property-Liability Insurance Guaranty Association and the New Jersey Surplus Lines Insurance Guaranty Fund, in such amounts and on such terms as the board of directors may determine, are necessary or appropriate and (2) make loans, in such amounts and on such terms as the board of directors may determine are necessary or appropriate, to the New Jersey Property-Liability Insurance Guaranty Association and the New Jersey Surplus Lines Insurance Guaranty Fund.

b. There shall be no liability on the part of and no cause of action of any nature shall arise against the association, its agents, employees, or the commissioner or his designees for any action taken by them in the performance of their powers and duties under P.L.2003, c.89 (C.17:30A-2.1 et al.).

Adopted. L. 1955, c. 1, §18. **Amended.** L. 1961, c. 69, §1; L. 1985, c. 148, §6; L. 2003, c. 89, §10, effective June 9, 2003.

39:6-65. Notice of accident and intention to file claim. Any qualified person, or the personal representative of such person, who suffers damages resulting from bodily injury or death or damage to property arising out of the ownership, maintenance or use of a motor vehicle in this State on or after April 1, 1955, and whose damages may be satisfied in whole or in part from the fund, shall, except in cases in which the claim is asserted by actions brought under section 18 [39:6-78] of this act pursuant to section 19 [39:6-79] of this act, within 180 days after the accident, as a condition precedent to the right thereafter to apply for payment from the fund, give notice to the association, the form and contents of which shall be prescribed by the association, of his intention to make a claim thereon for such damages if otherwise uncollectible; provided, any such qualified person may, in lieu of giving said notice within said time, make proof to the court on the hearing of the application for the payment of a judgment (a) that he was physically incapable of giving said notice within said period and that he gave said notice within 180 days after he became physically capable to do so or in the event he did not become so capable, that a notice was given on his behalf within a reasonable period, or (b) that he gave notice to the association within 15 days of receiving notice that an insurer had disclaimed on a policy of insurance so as to remove or withdraw liability insurance coverage for his claim against a person or persons who allegedly caused him to suffer damages. A copy of the complaint shall be furnished to the association if an action has theretofore been brought for the enforcement of such claim. Such person shall also notify the association of any action thereafter instituted for the enforcement of such claim within 15 days after the institution thereof and such notice shall be accompanied by a copy of the complaint.

The Director of the Division of Motor Vehicles is hereby authorized and empowered, the provisions of any other law relating to the confidential nature of any reports or information furnished to or filed with the division notwithstanding, to furnish to the association upon its request, for such use, utilization and purposes as the association may deem reasonably appropriate to administer this act [R.S. Cum. Supp. 39:6-61 et seq.] and discharge its functions hereunder, any reports or information filed by any person or persons claiming benefits under the provisions of this act, that the director has with regard to any accident, and any operator or owner of a motor vehicle involved in any accident, and as to any automobile or motor vehicle liability insurance or bond carried by an operator or owner of any motor vehicle.

Adopted. L. 1952, c. 174, §5. **Amended.** L. 1955, c. 1, §4; L. 1956, c. 200, §1; L. 1958, c. 99, §2; L. 1963, c. 81, §10; L. 1985, c. 148, §7; L. 2003, c. 89, §11, effective June 9, 2003.

39:6-66. Repealed.

Repealed. L. 2003, c. 89, §85, effective June 9, 2003.

39:6-67. Defense of actions against motorists. The association may through counsel enter an appearance on behalf of the defendant, file a defense, appear at the trial or take such other steps as it may deem appropriate on the behalf and in the name of the defendant, and may thereupon, on the behalf and in the name of the defendant, conduct his defense, take recourse to any appropriate method of review on behalf of, and in the name of, the defendant, and all such acts shall be deemed to be the acts of such defendant; provided, however, that nothing contained herein shall deprive the defendant of the right to also employ his own counsel and defend the action. All expense incurred by the association in connection with any review prosecuted or defended by it from a judgment rendered in such action, including its attorneys' fees in connection therewith, shall be borne by the fund.

Adopted. L. 1952, c. 174, §7. **Amended.** L. 1968, c. 323, §4; L. 2003, c. 89, §12, effective June 9, 2003.

39:6-68. Co-operation of defendant. In any case in which the association has assumed under this act, the defense of any action, the defendant shall co-operate

with the association in the defense of such action. In the event of his failure to do so, the association may apply to the court for an order directing such co-operation.
Adopted. L. 1952, c. 174, §8. **Amended.** L. 2003, c. 89, §13, effective June 9, 2003.

39:6-69. Application for payment of judgment. When any qualified person recovers a valid judgment in any court of competent jurisdiction in this State against any other person, who was the operator or owner of a motor vehicle, for injury to, death of, any person or persons, or a similar valid judgment in such court against such a defendant for an amount in excess of $500.00, exclusive of interest and costs, for damage to property, except property of others in charge of such operator or owner or such operator's or owner's employees, arising out of the ownership, maintenance or use of the motor vehicle in this State on or after April 1, 1955, and any amount remains unpaid thereon in the case of a judgment for bodily injury or death, or any amount in excess of $500.00 remains unpaid thereon in case of a judgment for damage to property, such judgment creditor may, upon the termination of all proceedings, including reviews and appeals in connection with such judgment, file a verified claim in the court in which the judgment was entered, and upon 10 days' written notice to the association may apply to the court for an order directing payment out of the fund, of the amount unpaid upon such judgment for bodily injury or death, which does not exceed, or upon such judgment for damage to propert, which exceeds the sum of $500.00 and does not exceed—

(a) The maximum amount or limit of $15,000.00, exclusive of interest and costs, on account of injury to, or death of, one person, in any one accident, and

(b) The maximum amount or limit, subject to such limit for any one person so injured or killed, of $30,000.00, exclusive of interest and costs, on account of injury to, or death of, more than one person, in any one accident, and

(c) The maximum amount or limit of $5,000.00 exclusive of interest and costs, for damage to property in any one accident.
Adopted. L. 1952, c. 174, §9. **Amended.** L. 1958, c. 99, §3; L. 1972, c. 198, §3; L. 1983, c. 362, §21; L. 1988, c. 119, §15; L. 2003, c. 89, §14, effective June 9, 2003.

39:6-70. Hearing on application for payment of judgment. The court shall proceed upon such application, in a summary manner, and, upon the hearing thereof, the applicant shall be required to show:

(a) He is not a person covered with respect to such injury or death by any workers' compensation law, or the personal representative of such a person,

(b) He is not a spouse, parent or child of the judgment debtor, or the personal representative of such spouse, parent or child,

(c) He was not at the time of the accident a person (1) operating or riding in a motor vehicle which he had stolen or participated in stealing or (2) operating or riding in a motor vehicle without the permission of the owner, and is not the personal representative of such a person,

(d) He was not at the time of the accident, the owner or registrant of an uninsured motor vehicle, or was not operating a motor vehicle in violation of an order of suspension or revocation,

(e) He has complied with all of the requirements of section 5 [39:6-65],

(f) The judgment debtor at the time of the accident was not insured under a policy of automobile liability insurance under the terms of which the insurer is liable to pay in whole or in part the amount of the judgment,

(g) He has obtained a judgment as set out in section 9 [39:6-69] of this act, stating the amount thereof and the amount owing thereon at the date of the application,

(h) He has caused to be issued a writ of execution upon said judgment and the sheriff or officer executing the same has made a return showing that no personal or real property of the judgment debtor, liable to be levied upon in satisfaction of the judgment, could be found or that the amount realized on the sale of them or of such of them as were found, under said execution, was insufficient to satisfy the

judgment, stating the amount so realized and the balance remaining due on the judgment after application thereon of the amount realized,

(i) He has caused the judgment debtor to make discovery under oath, pursuant to law, concerning his personal property and as to whether such judgment debtor was at the time of the accident insured under any policy or policies of insurance described in subsection (f) of this section,

(j) He has made all reasonable searches and inquiries to ascertain whether the judgment debtor is possessed of personal or real property or other assets, liable to be sold or applied in satisfaction of the judgment,

(k) By such search he has discovered no personal or real property or other assets, liable to be sold or applied or that he has discovered certain of them, describing them, owned by the judgment debtor and liable to be so sold and applied and that he has taken all necessary action and proceedings for the realization thereof and that the amount thereby realized was insufficient to satisfy the judgment, stating the amount so realized and the balance remaining due on the judgment after application of the amount realized,

(l) The application is not made by or on behalf of any insurer by reason of the existence of a policy of insurance, whereby the insurer is liable to pay, in whole or in part, the amount of the judgment and that no part of the amount to be paid out of the fund is sought in lieu of making a claim or receiving a payment which is payable by reason of the existence of such a policy of insurance and that no part of the amount so sought will be paid to an insurer to reimburse or otherwise indemnify the insurer in respect of any amount paid or payable by the insurer by reason of the existence of such a policy of insurance,

(m) Whether or not he has recovered a judgment in an action against any other person against whom he has a cause of action in respect of his damages for bodily injury or death or damage to property arising out of the accident and what amounts, if any, he has received by way of payments upon the judgment, or by way of settlement of such cause of action, in whole or in part, from or on behalf of such other person,

(n) In order to recover for noneconomic loss, as defined in section 2 of P.L. 1972, c. 70 (C. 39:6A-2) for accidents to which the benefits of sections 7 and 10 of P.L. 1972, c. 198 (C. 39:6-86.1 and C. 39:6-86.4) apply, the injured person shall have sustained an injury described in subsection a. of section 8 of P.L. 1972, c. 70 (C. 39:6A-8).

Whenever the applicant satisfies the court that it is not possible to comply with one or more of the requirements enumerated in subsections (h) and (I) of this section and that the applicant has taken all reasonable steps to collect the amount of the judgment or the unsatisfied part thereof and has been unable to collect the same, the court may dispense with the necessity for complying with such requirements.

The association may appear and be heard on application and show cause why the order should not be made.

Adopted. L. 1952, c. 174, §10. **Amended.** L. 1958, c. 98, §1; L. 1961, c. 19, §1; L. 1983, c. 362, §2; L. 1988, c. 119, §19; L. 2003, c. 89, §15, effective June 9, 2003.

39:6-71. Order for payment of judgment. The court shall make an order directed to the association requiring the association to make payment from the fund of such sum, if any, as it shall find to be payable upon said claim, pursuant to the provisions of and in accordance with the limitations contained in this act, if the court is satisfied, upon the hearing:

(a) Of the truth of all matters required to be shown by the applicant by section 10 [39:6-70],

(b) That the applicant has fully pursued and exhausted all remedies available to him for recovering damages against all persons mentioned in subparagraph (m) of section 10 by

(1) Commencing action against all such persons against whom the applicant might reasonably be considered as having a cause of action in respect of such damages and prosecuting every such action in good faith to judgment and

(2) Taking all reasonable steps available to him to collect on every judgment so obtained and by applying the proceeds of any judgment or recovery so obtained towards satisfaction of the amount due upon the judgment for payment of which the claim is made.

Any amount which the plaintiff has received or can collect by way of payments upon the judgment or by way of settlement of the cause of action, in whole or in part, from or on behalf of any person other than the judgment debtor, described in subparagraph (m) of section 10, shall be deducted from the amount due upon the judgment for payment of which claim is made.

Adopted. L. 1952, c. 174, §11. **Amended.** L. 1955, c. 1, §5; L. 1958, c. 98, §2; L. 2003, c. 89, §16, effective June 9, 2003.

39:6-72. Settlement of actions against motorists. (a) In any action against an operator or owner of a motor vehicle for injury to or death of any person or for damage to property arising out of the ownership, maintenance or use of said vehicle in this State on or after April 1, 1955, pending in any court of competent jurisdiction in this State, the plaintiff may upon notice to the association file a verified petition with the court alleging:

(1) the matters set forth in subparagraphs (a), (b), (c), (d), (e) and (f) of section 10 [39:6-70];

(2) that the petition is not presented on behalf of an insurer under circumstances set forth in subparagraph (1) of section 10;

(3) that he has entered into an agreement with the defendant to settle all claims set forth in the complaint in said action and the amount proposed to be paid to him pursuant thereto;

(4) that the said proposed settlement has been entered into with and by the consent of the Superior Court and approved by the association;

(5) that the defendant has executed and delivered to the association a verified statement of his financial condition;

(6) that a judgment against the defendant would be uncollectible;

(7) that the defendant has undertaken in writing to repay to the association the sum that he would be required to pay under such settlement, and has executed a confession of judgment in connection therewith.

If the court be satisfied of the truth of the allegations in said petition and of the fairness of such proposed settlement, it may enter an order approving the same and directing the association, upon receipt of the undertaking and confession of judgment mentioned in subparagraph (7) of this section, to make payment to the plaintiff of the amount agreed to be accepted.

(b) The association may settle any claim, without court approval, if satisfied:

(1) that the claimant is not a person of the character described in subparagraphs (a), (b), (c), (d), (e) and (f) of section 10;

(2) that the settlement is not made on behalf of an insurer under circumstances set forth in subparagraph (e) of section 10; and

(3) that a judgment against the owner or operator of the motor vehicle involved in the accident would be uncollectible, and that such owner or operator has consented to such settlement, executed and delivered to the association a verified statement of his financial condition and undertaken in writing to repay to the association the sum to be paid under the settlement, and executed a confession of judgment in connection therewith.

Adopted. L. 1952, c. 174, §12. **Amended.** L. 1955, c. 1, §6; L. 1958, c. 99, §4; L. 1968, c. 323, §5; L. 1985, c. 148, §8; L. 2003, c. 89, §17, effective June 9, 2003.

39:6-73. Limiting amounts payable from fund. Except with respect to medical expense benefits paid pursuant to section 2 of P.L. 1977, c. 310 (C. 39:6-

73.1), no order shall be made for the payment and the association shall make no payment, out of the fund, of

(a) Any claim for damage to property for less than $500.00,

(b) The first $500.00 of any judgment for damage to property or of the unsatisfied portion thereof, or

(c) The unsatisfied portion of any judgment which, after deducting $500.00 therefrom if the judgment is for damage to property, exceeds

(1) the maximum or limit of $15,000.00, exclusive of interest and costs, on account of injury to, or death of, one person in any one accident, and

(2) the maximum amount or limit, subject to such limit for any one person so injured or killed, of $30,000.00, exclusive of interest and costs, on account of injury to, or death of, more than one person, in any one accident, and

(3) the maximum amount or limit of $5,000.00, exclusive of interest and costs, for damage to property in any one accident; provided, that such maximum amounts shall be reduced by any amount received or recovered as specified in subsection (m) of section 10 [39:6-70].

(d) Any claim for damage to property which includes any sum greater than the difference between said maximum amounts and the sum of $500.00, and any amount paid out of the fund in excess of the amount so authorized may be recovered by the association in an action brought to it against the person receiving the same.

Adopted. L. 1952, c. 174, §13. **Amended.** L. 1958, c. 99, §5; L. 1972, c. 198, §4; L. 1977, c. 310, §4; L. 1983, c. 362, §22; L. 1988, c. 119, §16; L. 2003, c. 89, §18, effective June 9, 2003.

39:6-73.1. Assumption of excess payment by fund; exceptions. In the event medical expense benefits paid by an insurer, in accordance with subsection a. of section 4 of P.L. 1972, c. 70 (C. 39:6A-4) or section 4 of P.L. 1998, c. 21 (C.39:6A-3.1), are in excess of $75,000.00 on account of personal injury to any one person in any one accident covered under a policy issued prior to January 1, 2004, the Unsatisfied Claim and Judgment Fund shall assume the following: a. the entire excess for a medical expense benefits claim covered under a policy issued before January 1, 1991; and b. such excess up to $250,000 for a medical expense benefits claim covered under a policy issued on or after January 1, 1991 and the Unsatisfied Claim and Judgment Fund shall reimburse the insurer therefor in accordance with rules and regulations promulgated by the commissioner; provided, however, that this provision is not intended to broaden the coverage available to accidents involving uninsured or hit-and-run automobiles, to provide extraterritorial coverage, or to pay excess medical expenses.

The Unsatisfied Claim and Judgment Fund shall cease to reimburse an insurer for medical expense benefits under this section for injuries covered under a policy issued on or after January 1, 2004.

Adopted. L. 1977, c. 310, §2. **Amended.** L. 1985, c. 148, §9; L. 1990, c. 8, §14, effective March 12, 1990; L. 1998, c. 21, §69, approved May 19, 1998, to take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later; L. 2003, c. 89, §19, effective June 9, 2003.

39:6-74. Default and consent judgments. No claim shall be allowed and ordered to be paid out of the fund if the court shall find, upon the hearing for the allowance of the claim, that it is founded upon a judgment which was entered by default unless (1) the claimant shall have complied with the requirements of section 5 [39:6-65], and (2) prior to the entry of such judgment the association shall have been given notice of intention to enter the judgment and file a claim thereon against the fund and shall have been afforded an opportunity to take such action as it shall deem advisable [39:6-75].

If the court, upon a hearing for the allowance of any claim against the fund, finds that it was a claim which was not assigned by the association for defense[39:6-66], or that the action upon such claim was not fully and fairly defended, or that the

judgment thereon was entered upon the consent or with the agreement of the defendant, the court shall allow such claim but shall order it to be paid only in such sum as the court shall determine to be justly due and payable out of the fund, on the basis of the actual amount of damages for which the defendant was liable to the plaintiff under the cause of action, upon which the judgment was rendered and reduced by any amount received from any person mentioned in subparagraph (m) of section 10 [39:6-70], notwithstanding that the judgment is for a greater amount.
Adopted. L. 1952, c. 174, §14. **Amended.** L. 1955, c. 1, §7; L. 2003, c. 89, §20, effective June 9, 2003.

39:6-75. Repealed.
Repealed. L. 2003, c. 89, §85, effective June 9, 2003.

39:6-76. Collusive judgments. No claim against the fund shall be allowed in any case in which the court shall find, upon hearing for the allowance of the claim, that the judgment upon which the claim is founded was obtained by fraud, or by collusion of the plaintiff and of any defendant in the action, relating to any matter affecting the cause of action upon which such judgment is founded or the amount of damages assessed therein.
Adopted. L. 1952, c. 174, §16.

39:6-77. Assignment of judgments to association. The association shall not pay any sum from the fund, in compliance with an order made for that purpose, in any case in which the claim is founded upon a judgment, except a judgment obtained against the association under this act [R.S. Cum. Supp. 39:6-61 et seq.], until the applicant assigns the judgment to the association and, thereupon, the association shall be deemed to have all the rights of the judgment creditor under the judgment and shall enforce and collect the same for the full amount thereof with interest and costs and if more money is collected upon any such judgment than the amount paid out of the fund, the association shall pay the balance, after reimbursing the fund, to the judgment creditor. Upon assignment of a judgment to the association the association may enter into agreement with the defendant for reimbursement of the fund by lump sum or installment payments, including waiver of interest and subordination of the lien of the judgment where the same is determined to be advantageous in obtaining reimbursement of payments made by the fund. Any such agreement may be annexed to an application for a court order made pursuant to section 27(b) [39:6-87(b)].
Adopted. L. 1952, c. 174, §17. **Amended.** L. 1955, c. 1, §8; L. 1968, c. 323, §6; L. 1985, c. 148, §10; L. 2003, c. 89, §21, effective June 9, 2003.

39:6-78. "Hit-and-run" cases. When the death of, or personal injury to, any person arises out of ownership, maintenance or use of a motor vehicle in this State on or after April 1, 1955, but the identity of the motor vehicle and of the operator and owner thereof cannot be ascertained or it is established that the motor vehicle was, at the time said accident occurred, in the possession of some person other than the owner without the owner's consent and that the identity of such person cannot be ascertained, any qualified person who would have a cause of action against the operator or owner or both in respect to such death or personal injury may bring an action therefor against the association in any court of competent jurisdiction, but no judgment against the association shall be entered in such an action unless the court is satisfied, upon the hearing of the action, that—

(a) The claimant has complied with the requirements of section 5 [39:6-65],

(b) The claimant is not a person covered with respect to such injury or death by any workers' compensation law, or the personal representative of such a person,

(c) The claimant was not at the time of the accident the owner or registrant of an uninsured motor vehicle, or was not operating a motor vehicle in violation of an order of suspension or revocation,

(d) The claimant has a cause of action against the operator or owner of such motor vehicle or against the operator who was operating the motor vehicle without the consent of the owner of the motor vehicle,

(e) All reasonable efforts have been made to ascertain the identity of the motor vehicle and of the owner and operator thereof and either that the identity of the motor vehicle and the owner and operator thereof cannot be established, or that the identity of the operator, who was operating the motor vehicle without the owner's consent, cannot be established,

(f) The action is not brought by or on behalf of an insurer under circumstances set forth in paragraph (1) of section 10 [39:6-70].

Adopted. L. 1952, c. 174, §18. **Amended.** L. 1955, c. 1, §9; L. 1956, c. 150, §1; L. 1958, c. 99, §6; L. 1983, c. 362, §2.1; L. 1985, c. 148, §11; L. 2003, c. 89, §22, effective June 9, 2003.

39:6-79. Other "hit-and-run" cases. When in an action in respect to the death of, or personal injury to, any person, arising out of the ownership, maintenance or use of a motor vehicle in this State on or after April 1, 1955, judgment is rendered for the defendant on the sole ground that such death or personal injury was occasioned by a motor vehicle—

(a) The identity of which, and of the owner and operator of which, has not been established, or

(b) Which was in the possession of some person other than the owner or his agent without the consent of the owner and the identity of the operator has not been established, such cause shall be stated in the judgment and the plaintiff in such action may within 180 days from the date of the entry of such judgment bring an action upon said cause of action against the association in the manner provided in section 18 [39:6-78].

Adopted. L. 1952, c. 174, §19. **Amended.** L. 1955, c. 1, §10; L. 1958, c. 99, §7; L. 1963, c. 81, §11; L. 1985, c. 148, §12; L. 2003, c. 89, §23, effective June 9, 2003.

39:6-80. Impleading association in "hit-and-run" cases. When an action has been commenced in respect of the death or injury of any person arising out of the ownership, maintenance or use of a motor vehicle in this State on or after April 1, 1955, the plaintiff shall be entitled to make the association a party thereto if the provisions of section 18 or 19 [39:6-78, 39:6-79] shall apply in any such case, and the plaintiff has made the application and the court has entered the order provided for in section 18.

Adopted. L. 1952, c. 174, §20. **Amended.** L. 1955, c. 1, §11; L. 1985, c. 148, §13; L. 2003, c. 89, §24, effective June 9, 2003.

39:6-81. Defense of such actions by association. In any action brought under sections 18 and 19 [39:6-78, 39:6-79] of this act, the association may appear. The association shall for all purposes of the action be deemed to be the defendant. The association shall have available to it any and all defenses which would have been available to said operator or owner or both if the action had been brought against them or either of them and process upon them or either of them had been duly served within this State, but the association shall be entitled to defend in all cases without asserting any specific facts.

Adopted. L. 1952, c. 174, §21. **Amended.** L. 1955, c. 1, §12; L. 1985, c. 148, §14; L. 2003, c. 89, §25, effective June 9, 2003.

39:6-82. Settlement of actions against the association. In any action brought against the association pursuant to an order by the court entered in accordance with the provisions of section 18 [39:6-78], the plaintiff may file a verified petition alleging that he has entered into an agreement with the association to settle all claims set forth in the complaint in said action and the amount proposed to be paid to him pursuant thereto. If the court be satisfied of the fairness of such proposed settlement, it may enter an order approving such settlement and enter a judgment against the association for the amount so agreed to be paid thereunder.

Adopted. L. 1952, c. 174, §22. **Amended.** L. 1955, c. 1, §13; L. 1985, c. 148, §15; L. 2003, c. 89, §26, effective June 9, 2003.

39:6-83. Credits against judgment. A judgment against the association shall be reduced by any amounts which such plaintiff has received from any person mentioned in subparagraph (m) of section 10 [39:6-70].

Adopted. L. 1952, c. 174, §23. **Amended.** L. 1955, c. 1, §14; L. 1985, c. 148, §16; L. 2003, c. 89, §27, effective June 9, 2003.

39:6-84. Judgment against commissioner. When a judgment is obtained against the association, in an action brought under this act, upon the determination of all proceedings including appeals and reviews, the court shall make an order directed to the association directing it to pay out of the fund to the plaintiff in the action the amount thereof which does not exceed $15,000.00, exclusive of interest and costs, on account of injury to, or death of, one person and, subject to such limits for the death of, or injury to, any one person, does not exceed $30,000.00, exclusive of interest and costs, on account of the injury to, or death of, more than one person, in any one accident, provided that such maximum amount shall be reduced by any amount received or recovered by the plaintiff as specified in subparagraph (m) of section 10 [39:6-70].

Adopted. L. 1952, c. 174, §24. **Amended.** L. 1955, c. 1, §15; L. 1958, c. 99, §8; L. 1972, c. 198, §5; L. 1985, c. 148, §17; L. 2003, c. 89, §28, effective June 9, 2003.

39:6-84.1. Applicability of increased amounts. The provisions of sections 9, 13 and 24 of the act of which this act is supplementary (C. 39:6-69, 39:6-73 and 39:6-84) as amended by sections 3, 4 and 5 of P.L. 1972, c. 198 which increase the maximum amounts payable from the fund shall be applicable only to claims made by qualified persons, or the personal representatives of such persons, who suffered damages resulting from bodily injury or death or damage to property arising out of the ownership, maintenance or use of a motor vehicle in this state on or after January 1, 1973, and whose damages may be satisfied in whole or in part from the fund.

Adopted. L. 1974, c. 6, §1.

39:6-85. Subrogation. When judgment has been obtained against the association in an action brought under this act [R.S. Cum. Supp. 39:6-61 et seq.], the association shall, upon payment from the fund of the amount of the judgment to the extent provided in this act, be subrogated to the cause of action of the judgment creditor against the operator and owner of the motor vehicle by which the accident was occasioned and shall bring an action against either or both of such persons for the amount of the damage sustained by the judgment creditor when and in the event that the identity of either or both of such persons shall be established, and shall recover the same out of any funds which would be payable in respect to the death or injury under any policy of insurance, which was in force at the time of the accident and in event that more is recovered and collected in any such action than the amount paid out of the fund by reason of the judgment, the association shall pay the balance, after reimbursing the fund, to the judgment creditor.

Adopted. L. 1952, c. 174, §25. **Amended.** L. 1955, c. 1, §16; L. 1968, c. 323, §7; L. 1985, c. 148, §18; L. 2003, c. 89, §29, effective June 9, 2003.

39:6-86. Repealed.

Repealed. L. 1955, c. 1, §17.

39:6-86.1. Personal injury coverage. When any person qualified to receive payments under the provisions of the "Unsatisfied Claim and Judgment Fund Law" suffers bodily injury or death as a pedestrian, as defined in section 2 of P.L. 1972, c. 70 (C. 39:6A-2), caused by a motor vehicle, including an automobile as defined in section 2 of P.L. 1972, c. 70 (C. 39:6A-2), and a motorcycle, or by an object propelled therefrom, or arising out of an accident while occupying, entering into, alighting from, or using an automobile, registered or principally garaged in this State for which personal injury protection benefits under the "New Jersey Automobile Reparation Reform Act," P.L. 1972, c. 70 (C. 39:6A-1 et seq.), or section 19 of P.L. 1983, c. 362 (C. 17:28-1.3), would be payable to such person if personal injury protection coverage were in force and the damages resulting from

such accident or death are not satisfied due to the personal injury protection coverage not being in effect with respect to such accident, or when a pedestrian suffers bodily injury as provided by section 35 of P.L.2003, c.89 (C.39:6-86.7) then in such event the Unsatisfied Claim and Judgment Fund shall provide, under the following conditions, the following benefits:

a. Medical expense benefits. Payment of all medical expense benefits in accordance with a benefits plan, subject to the approval of the commissioner, for reasonable, necessary and appropriate treatment and provision of services in an amount not exceeding $250,000 per person per accident. In the event of death, payment shall be made to the estate of the decedent. The benefits plan shall set forth the benefits provided by the Unsatisfied Claim and Judgment Fund, including eligible medical treatments, diagnostic tests and services as well as such other benefits as the Unsatisfied Claim and Judgment Fund may provide.

Medical expense benefit payments shall be subject to a deductible of $250.00 on account of injury in any one accident and a copayment of 20% of any benefits payable between $250.00 and $5,000.00.

b. Income continuation benefits. The payment of the loss of income of an income producer as a result of bodily injury disability, subject to a maximum weekly payment of $100.00. Such sums shall be payable during the life of the injured person and shall be subject to an amount or limit of $5,200.00, on account of injury to any one person in any one accident, except that in no case shall income continuation benefits exceed the net income normally earned during the period in which the benefits are payable.

c. Essential services benefits. Payment of essential services benefits to an injured person shall be made in reimbursement of necessary and reasonable expenses incurred for such substitute essential services ordinarily performed by the injured person for himself, his family and members of the family residing in the household, subject to an amount or limit of $12.00 per day. Such benefits shall be payable during the life of the injured person and shall be subject to an amount or limit of $4,380.00, on account of injury to any one person in any one accident.

d. Death benefits. In the event of the death of an income producer as a result of injuries sustained in an accident entitling such person to benefits under this section, the maximum amount of benefits which could have been paid to the income producer, but for his death, under subsection b. of this section shall be paid to the surviving spouse, or in the event there is no surviving spouse, then to the surviving children, and in the event there are no surviving spouse or surviving children, then to the estate of the income producer.

In the event of the death of one performing essential services as a result of injuries sustained in an accident entitling such person to benefits under subsection c. of this section, the maximum amount of benefits which could have been paid such person, under subsection c., shall be paid to the person incurring the expense of providing such essential services.

e. Funeral expenses benefits. All reasonable funeral, burial and cremation expenses, subject to a maximum benefit of $1,000.00, on account of the death to any one person in any one accident shall be payable to decedent’s estate.

Provided, however, that no benefits shall be paid under this section unless the person applying for benefits has demonstrated that he is not disqualified by reason of the provisions of subsection (a), (c), (d) or (l) of section 10 of P.L. 1952, c. 174 (C. 39:6-70), or any other provision of law.

Adopted. L. 1972, c. 198, §7. **Amended.** L. 1983, c. 362, §3; L. 1988, c. 119, §5; L. 1990, c. 8, §101, effective March 12, 1990; L. 2003, c. 89, §30, effective June 9, 2003.

39:6-86.2. Payment of benefits; notice and proof of loss; deductions. The benefits provided in sections 7 [39:6-86.1] and 10 [39:6-86.4], shall be payable as loss accrues, upon written notice of such loss including reasonable proof of such loss, except that benefits collectible under:

a. Employees' temporary disability benefit statutes and medicare provided under Federal law shall be deducted from the benefits collectible under sections 7 and 10 [39:6-86.1 and 39:6-86.4]; and

b. Any hospital, medical or dental benefit plan or policy coverage with benefits similar to those provided under section 7, in an amount not to exceed in the aggregate $2,500.00 for any one accident; shall be deducted from the benefits collectible under sections 7 and 10.

Evidence of benefit payments collectible under subsections a. and b. of this section shall not be admissible in a civil action by the claimant for recovery of damages for bodily injury from the fund.

The amount of $2,500.00 shall be deemed to have been exceeded whether the amount is paid or benefits in that amount are provided to one or more persons eligible for benefits under the hospital, medical or dental plan or policy, for injuries sustained in any one accident.

Adopted. L. 1972, c. 198, §8. **Amended.** L. 1983, c. 362, §4; L. 1984, c. 40, §2.

39:6-86.3. Conduct precluding benefits. Any qualified person entitled to receive benefits as provided in section 7 [39:6-86.1] of this act shall be precluded from receiving such benefits where such person's conduct contributed to his personal injuries or death in any of the following ways:

a. While committing a high misdemeanor or felony or seeking to avoid lawful apprehension or arrest by a police officer; or

b. While acting with specific intent of causing injury or damage to himself or others.

Adopted. L. 1972, c. 198, §9.

39:6-86.4. Conditions where payments made by unsatisfied claim and judgment fund. When the death of or personal injury to any person arises out of the ownership, maintenance or use of an automobile in this state on or after the effective date of this act, but the identity of the automobile and of the operator and owner thereof cannot be ascertained or it is established that the automobile was at the time said accident occurred, in the possession of some person other than the owner without the owner's consent and that the identity of such person cannot be ascertained, any person qualified to receive payments under the provisions of the "Unsatisfied Claim and Judgment Fund Law" shall be entitled to receive payment under sections [39:6-86.1] and 10 [39:6-86.4] of this act, provided that:

a. The claimant is not a person covered with respect to such injury or death by any worker's compensation law, or the personal representative of such a person,

b. The claimant was not at the time of the accident the owner or registrant of an uninsured motor vehicle, or was not operating a motor vehicle in violation of an order of suspension or revocation,

c. The claimant was not at the time of the accident:

(1) a person operating or riding in a motor vehicle which he had stolen or participated in stealing, or

(2) operating a motor vehicle without the permission of the owner, and is not the personal representative of such a person,

d. All reasonable efforts have been made to ascertain the identity of the motor vehicle and of the owner and operator thereof and either that the identity of the motor vehicle and the owner and operator thereof cannot be established, or that the identity of the operator, who was operating the motor vehicle without the owner's consent, cannot be established, or

e. Deleted by amendment, P.L. 1983, c. 362, §5.

f. The action or claim is not brought by or on behalf of an insurer.
Adopted. L. 1972, c. 198, §10. **Amended.** L. 1983, c. 362, §5.

39:6-86.5. Payments to qualified persons. Any qualified person seeking to receive benefits as provided in sections 7 [39:6-86.1] and 10 [39:6-86.4] of this act shall comply with the provisions of section 5 of P.L. 1952, c. 174 (C. 39:6-65) and payment under these sections shall be payable to the qualified person entitled to receive such benefits, as the loss accrues, upon receipt of reasonable proof of such loss and without the need of a judgment as to damages, or a hearing as provided in section 10 of P.L. 1954, c. 174 (C. 39:6-70) or an order for payment as provided in section 11 of P.L. 1954, c. 174 (C. 39:6-71).
Adopted. L. 1972, c. 198, §11.

39:6-86.6. Recovery by commissioner of fund. The association shall be entitled to recover on behalf of the Unsatisfied Claim and Judgment Fund for all payments made by it pursuant to sections 7 [39:6- 86.1] and 10 [39:6-86.4] of this act, regardless of fault, from any person who owned or operated the automobile involved in the accident and whose failure to have the required insurance coverage in effect at the time of the accident resulted in the payment of personal injury protection benefits. If the identity of the owner and operator is not ascertained until after personal injury protection benefits have been paid then the association shall be entitled to recover for such payments, regardless of fault, from the operator if he was driving without the owner's permission or from the operator and the owner if he was driving with the owner's permission or, in either case, from the insurer if there is an insurance policy providing personal injury protection benefits that was in effect at the time of the accident with respect to such automobile.

The association is authorized to bring an action, which shall be a summary proceeding, in the Superior Court to reduce the right provided by this section to judgment.
Adopted. L. 1972, c. 198, §12. **Amended.** L. 1985, c. 148, §19; L. 2003, c. 89, §31, effective June 9, 2003.

39:6-86.7. Provision of personal injury protection benefits, certain pedestrians. The Unsatisfied Claim and Judgment Fund created pursuant to P.L.1952, c.174 (C.39:6-61 et seq.) shall provide personal injury protection benefits pursuant to section 7 of P.L.1972, c.198 (C.39:6-86.1) to a pedestrian sustaining bodily injury in this State caused by an automobile, other than to a named insured or a member of the named insured's family residing in his household, if that pedestrian is entitled to personal injury protection coverage under an automobile insurance policy.
Adopted. L. 2003, c. 89, §35, effective June 9, 2003.

39:6-87. Registration, etc. not restored until fund is reimbursed. Where the license or privileges of any person, or the registration of a motor vehicle registered in the person's name, has been suspended or cancelled under the Motor Vehicle Security-Responsibility Law of this State, and the association has paid from the fund any amount in settlement of a claim or towards satisfaction of a judgment against that person, or for the payment of personal injury protection benefits as provided in section 7 [39:6-86.1] and section 10 [39:6-86.4] of this act, the cancellation or suspension shall not be removed, nor the license, privileges, or registration restored, nor shall any new license or privilege be issued or granted to, or registration be permitted to be made by, that person until the person has:

(a) Repaid in full to the association the amount so paid by the person together with interest thereon at eight percent per annum from the date of the payment; and

(b) Satisfied all requirements of the Motor Vehicle Security-Responsibility Law in respect of giving proof of ability to respond in damages for future accidents, provided, that the court in which the judgment was rendered may, upon 10 days' notice to the association, make an order permitting payment of the amount of the person's indebtedness to the fund, to be made in installments, or in the event the

fund makes personal injury protection benefit payments, the person and the fund by agreement may provide for repayment to the fund to be made in installments, and in such case, the person's driver's license, or driving privileges, or registration certificate, if the same have been suspended or revoked, or have expired, may be restored or renewed and shall remain in effect unless and until the person defaults in making any installment payment specified in the order. In the event of a default, the Director of the Division of Motor Vehicles may upon notice of the default suspend the person's driver's license, or driving privileges or registration certificate until the amount of the person's indebtedness to the fund has been paid in full.
Adopted. L. 1952, c. 174, §27. **Amended.** L. 1968, c. 323, §8; L. 1972, c. 198, §6; L. 1981, c. 175, §1; L. 1985, c. 148, §20; L. 2003, c. 89, §32, effective June 9, 2003; L. 2019, c. 276, §15, effective January 1, 2021.

39:6-88. Fund to be held in trust. All sums received by the association pursuant to any of the provisions of this act shall become part of the fund, and shall be held by the association in trust for the carrying out of the purposes of this act and for the payment of the cost of administering this act.
Adopted. L. 1952, c. 174, §28. **Amended.** L. 1975, c. 174, §1; L. 1977, c. 310, §5; L. 1983, c. 125, §2; L. 1985, c. 148, §21; L. 2003, c. 89, §33, effective June 9, 2003.

39:6-89. Repealed.
Repealed. L. 2003, c. 89, §85, effective June 9, 2003.

39:6-90. Penalty for false statements. Any person and any agent or servant of such person, who knowingly files with the fund or the association or either of them, any notice, statement or other document required under this act, which is false or untrue or contains any material misstatement of fact shall be subject to a penalty as provided in section 5 of P.L.1983, c.320 (C.17:33A-5) and damages as provided in section 7 of P.L.1983, c.320 (C.17:33A-7).
Adopted. L. 1952, c. 174, §30. **Amended.** L. 2003, c. 89, §34, effective June 9, 2003.

39:6-90.1. Effect of partial invalidity. In the event any section, term or provision of this act or of the act to which this act is amendatory and supplementary [R.S. Cum. Supp. 39:6-61 et seq.] shall be adjudged invalid for any reason, such judgment shall not affect, impair or invalidate any other section, term or provision of said acts, but the remaining sections, terms and provisions shall be and remain in full force and effect.
Adopted. L. 1955, c. 1, §19.

39:6-91. Repealed.
Repealed. L. 2003, c. 89, §85, effective June 9, 2003.

39:6-92 through 39:6-104. Repealed.
Repealed. L. 1975, c. 175, §1.

Chapter 6A. COMPULSORY AUTOMOBILE LIABILITY INSURANCE—NO FAULT PROVISIONS.

Section

39:6A-1. Short title. This act [chapter] may be cited and known as the "New Jersey Automobile Reparation Reform Act."

Adopted. L. 1972, c. 70, §1.

39:6A-1.1. Short title; findings, declarations. a. This act shall be known and may be cited as the "Automobile Insurance Cost Reduction Act."

b. The Legislature finds and declares:

Whereas, While New Jersey's automobile insurance no-fault law, enacted twenty-six years ago, has provided valuable benefits in the form of medical benefits

and wage replacement benefits, without regard to fault, to New Jersey residents who have been injured in an automobile accident; and

Whereas, Medical benefits paid by no-fault policies over those years amount to billions of dollars, which would otherwise have been paid by health insurance, thus raising the cost of health insurance for everyone; and

Whereas, While medical benefits under no-fault insurance were unlimited under the law enacted in 1972, the rapidly escalating cost of those benefits made it necessary for the Legislature to reduce those benefits to a limit of $250,000 in 1990; and

Whereas, Since the enactment of the verbal threshold in 1988, the substantial increase in the cost of medical expense benefits indicates that the benefits are being overutilized for the purpose of gaining standing to sue for pain and suffering, thus undermining the limitations imposed by the threshold and necessitating the imposition of further controls on the use of those benefits, including the establishment of a basis for determining whether treatments or diagnostic tests are medically necessary; and

Whereas, The present arbitration system has not sufficiently addressed the Legislature's goal of eliminating payment for treatments and diagnostic tests which are not medically necessary, leading to the belief that a revised dispute resolution mechanism needs to be established which will accomplish this goal; and

Whereas, The principle underlying the philosophical basis of the no-fault system is that of a trade-off of one benefit for another; in this case, providing medical benefits in return for a limitation on the right to sue for non-serious injuries; and

Whereas, While the Legislature believes that it is good public policy to provide medical benefits on a first party basis, without regard to fault, to persons injured in automobile accidents, it recognizes that in order to keep premium costs down, the cost of the benefit must be offset by a reduction in the cost of other coverages, most notably a restriction on the right of persons who have non-permanent or non-serious injuries to sue for pain and suffering; and

Whereas, The high cost of automobile insurance in New Jersey has presented a significant problem for many-lower income residents of the state, many of whom have been forced to drop or lapse their coverage in violation of the State's mandatory motor vehicle insurance laws, making it necessary to provide a lower-cost option to protect people by providing coverage to pay their medical expenses if they are injured; and

Whereas, To meet these goals, this legislation provides for the creation of two insurance coverage options, a basic policy and a standard policy, provides for cost containment of medical expense benefits through a revised dispute resolution proceeding, provides for a revised lawsuit threshold for suits for pain and suffering which will eliminate suits for injuries which are not serious or permanent, including those for soft tissue injuries, would more precisely define the benefits available under the medical expense benefits coverage, and establishes standard treatment and diagnostic procedures against which the medical necessity of treatments reimbursable under medical expense benefits coverage would be judged; and

Whereas, It is generally recognized that fraud, whether in the form of inappropriate medical treatments, inflated claims, staged accidents, falsification of records, or in any other form, has increased premiums, and must be uncovered and vigorously prosecuted, and while the pursuit of those who defraud the automobile insurance system has heretofore been addressed by the State through various agencies, it has been without sufficient coordination to aggressively combat fraud, leading to the conclusion that greater consolidation of agencies which were created to combat fraud is necessary to accomplish this purpose; and

Whereas, With these many objectives, the Legislature nevertheless recognizes that to provide a healthy and competitive automobile insurance market, insurers are entitled to earn an adequate rate of return through the ratemaking process, which

shall reflect the impact of the cost-saving provisions of this act and other recent legislative insurance reforms; and

Whereas, The Legislature has thus addressed these and other issues in this comprehensive legislation designed to preserve the no-fault system, while at the same time reducing unnecessary costs which drive premiums higher.

Adopted. L. 1998, c. 21, §1, effective May 19, 1998.

39:6A-1.2. Rules, regulations. The commissioner may promulgate any rules and regulations pursuant to P.L.1968, c.410 (C.52:14B-1 et seq.) deemed necessary in order to effectuate the provisions of this amendatory and supplementary act.

Adopted. L. 1998, c. 21, §73, approved May 19, 1998, to take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later.

39:6A-2. Definitions. As used in this act:

a. "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.

b. "Essential services" means those services performed not for income which are ordinarily performed by an individual for the care and maintenance of such individual's family or family household.

c. "Income" means salary, wages, tips, commissions, fees and other earnings derived from work or employment.

d. "Income producer" means a person who, at the time of the accident causing personal injury or death, was in an occupational status, earning or producing income.

e. "Medical expenses" means reasonable and necessary expenses for treatment or services as provided by the policy, including medical, surgical, rehabilitative and diagnostic services and hospital expenses, provided by a health care provider licensed or certified by the State or by another state or nation, and reasonable and necessary expenses for ambulance services or other transportation, medication and other services as may be provided for, and subject to such limitations as provided for, in the policy, as approved by the commissioner. "Medical expenses" shall also include any nonmedical remedial treatment rendered in accordance with a recognized religious method of healing.

f. "Hospital expenses" means the cost of treatment and services, as provided in the policy approved by the commissioner, by a licensed and accredited acute care facility which engages primarily in providing diagnosis, treatment and care of sick and injured persons on an inpatient or outpatient basis; the cost of covered treatment and services provided by an extended care facility which provides room and board and skilled nursing care 24 hours a day and which is recognized by the administrators of the federal Medicare program as an extended care facility; and the cost of covered services at an ambulatory surgical facility supervised by a physician licensed in this State or in another jurisdiction and recognized by the Commissioner of Health and Senior Services, or any other facility licensed, certified or recognized by the Commissioner of Health and Senior Services or the Commissioner of Human Services or a nationally recognized system such as the Commission on

Accreditation of Rehabilitation Facilities, or by another jurisdiction in which it is located.

g. “Named insured” means the person or persons identified as the insured in the policy and, if an individual, his or her spouse, if the spouse is named as a resident of the same household, except that if the spouse ceases to be a resident of the household of the named insured, coverage shall be extended to the spouse for the full term of any policy period in effect at the time of the cessation of residency.

h. “Pedestrian” means any person who is not occupying, entering into, or alighting from a vehicle propelled by other than muscular power and designed primarily for use on highways, rails and tracks.

i. “Noneconomic loss” means pain, suffering and inconvenience.

j. “Motor vehicle” means a motor vehicle as defined in R.S. 39:1-1, exclusive of an automobile as defined in subsection a. of this section.

k. “Economic loss” means uncompensated loss of income or property, or other uncompensated expenses, including, but not limited to, medical expenses.

l. “Health care provider” or “provider” means those persons licensed or certified to perform health care treatment or services compensable as medical expenses and shall include, but not be limited to, (1) a hospital or health care facility which is maintained by a state or any of its political subdivisions, (2) a hospital or health care facility licensed by the Department of Health and Senior Services, (3) other hospitals or health care facilities designated by the Department of Health and Senior Services to provide health care services, or other facilities, including facilities for radiology and diagnostic testing, freestanding emergency clinics or offices, and private treatment centers, (4) a nonprofit voluntary visiting nurse organization providing health care services other than in a hospital, (5) hospitals or other health care facilities or treatment centers located in other states or nations, (6) physicians licensed to practice medicine and surgery, (7) licensed chiropractors, (8) licensed dentists, (9) licensed optometrists, (10) licensed pharmacists, (11) licensed podiatrists, (12) registered bio-analytical laboratories, (13) licensed psychologists, (14) licensed physical therapists, (16) certified nurse-midwives, (17) certified nurse-practitioners/clinical nurse-specialists, (18) licensed health maintenance organizations, (19) licensed orthotists and prosthetists, (20) licensed professional nurses, and (21) providers of other health care services or supplies, including durable medical goods.

m. “Medically necessary” means that the treatment is consistent with the symptoms or diagnosis, and treatment of the injury (1) is not primarily for the convenience of the injured person or provider, (2) is the most appropriate standard or level of service which is in accordance with standards of good practice and standard professional treatment protocols, as such protocols may be recognized or designated by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services or with a professional licensing or certifying board in the Division of Consumer Affairs in the Department of Law and Public Safety, or by a nationally recognized professional organization, and (3) does not involve unnecessary diagnostic testing.

n. “Standard automobile insurance policy” means an automobile insurance policy with at least the coverage required pursuant to sections 3 and 4 of P.L.1972, c.70 (C.39:6A-3 and 39:6A-4).

o. “Basic automobile insurance policy” means an automobile insurance policy pursuant to section of 4 of P.L. 1998, c. 21 (C.39:6A-3.1).

Adopted. L. 1972, c. 70, §2. **Amended.** L. 1972, c. 203, §1; L. 1983, c. 362, §6; L. 1998, c. 21, §2, approved May 19, 1998, and shall take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later.

39:6A-3. Compulsory automobile insurance coverage; limits. Except as provided by section 4 of P.L.1998, c.21 (C.39:6A-3.1), every owner or registered owner of an automobile registered or principally garaged in this State shall maintain automobile liability insurance coverage, under provisions approved by the Commissioner of Banking and Insurance, 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, maintenance, operation or use of an automobile wherein such coverage shall be at least in:

a. an amount or limit of $15,000.00 for plans issued or renewed prior to January 1, 2023, $25,000 for plans issued or renewed on or after January 1, 2023 but prior to January 1, 2026, and $35,000 for plans issued or renewed on or after January 1, 2026, exclusive of interest and costs, on account of injury to, or death of, one person, in any one accident; and

b. an amount or limit, subject to such limit for any one person so injured or killed, of $30,000.00 for plans issued or renewed prior to January 1, 2023, $50,000 for plans issued or renewed on or after January 1, 2023 but prior to January 1, 2026, and $70,000 for plans issued or renewed on or after January 1, 2026, exclusive of interest and costs, on account of injury to or death of, more than one person, in any one accident; and

c. an amount or limit of $25,000 for plans issued or renewed on or after January 1, 2023, exclusive of interest and costs, for damage to property in any one accident.

No licensed insurance carrier shall refuse to renew the required coverage stipulated by this act of an eligible person as defined in section 25 of P.L.1990, c.8 (C.17:33B-13) except in accordance with the provisions of section 26 of P.L.1988, c.119 (C.17:29C-7.1) or with the consent of the Commissioner of Banking and Insurance.

Adopted. L. 1972, c. 70, §3. **Amended.** L. 1972, c. 203, §2; L. 1988, c. 119, §9; L. 1990, c. 8, §3, effective March 12, 1990; L. 1998, c. 21, §3, approved May 19, 1998, to take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later; L. 2022, c. 87, §3, effective August 5, 2022.

39:6A-3.1. Election of basic automobile insurance policy; coverage provided. As an alternative to the mandatory coverages provided in sections 3 and 4 of P.L.1972, c.70 (C.39:6A-3 and 39:6A-4), any owner or registered owner of an automobile registered or principally garaged in this State may elect a basic automobile insurance policy providing the following coverage:

a. Personal injury protection coverage, for the payment of benefits without regard to negligence, liability or fault of any kind, to the named insured and members of his family residing in his household, who sustained bodily injury 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, and to other persons sustaining bodily injury while occupying, entering into, alighting from or using the automobile of the named insured, with the permission of the named insured. “Personal injury protection coverage” issued pursuant to this section means and includes payment of medical expense benefits, as provided in the policy and approved by the commissioner, for the reasonable and necessary treatment of bodily injury in an amount not to exceed $15,000 per person per accident; except that, medical expense benefits shall be paid in an amount not to exceed $250,000: (1) for all medically necessary treatment of permanent or significant brain injury, spinal cord injury or disfigurement or (2) for medically necessary treatment of other permanent or significant injuries rendered at a trauma center or acute care hospital immediately following the accident and until the patient is stable, no longer requires critical care and can be safely discharged or transferred to another facility in the judgment of the attending physician. In the event benefits paid by an insurer pursuant to this subsection are in excess of $75,000 on account of

personal injury to any one person in any one accident covered by a policy issued or renewed prior to January 1, 2004, such excess shall be paid by the insurer and shall be reimbursable to the insurer from the Unsatisfied Claim and Judgment Fund pursuant to section 2 of P.L.1977, c.310 (C.39:6-73.1). Benefits provided under basic coverage shall be in accordance with a benefit plan provided in the policy and approved by the commissioner. The policy form, which shall be subject to the approval of the commissioner, shall set forth the benefits provided under the policy, including eligible medical treatments, diagnostic tests and services as well as such other benefits as the policy may provide. The commissioner shall set forth by regulation a statement of the basic benefits which shall be included in the policy. Medical treatments, diagnostic tests, and services provided by the policy shall be rendered in accordance with commonly accepted protocols and professional standards and practices which are commonly accepted as being beneficial for the treatment of the covered injury. Protocols and professional standards and practices which are deemed to be commonly accepted pursuant to this section shall be those recognized by national standard setting organizations, national or state professional organizations of the same discipline as the treating provider, or those designated or approved by the commissioner in consultation with the professional licensing boards in the Division of Consumer Affairs in the Department of Law and Public Safety. The commissioner, in consultation with the Commissioner of the Department of Health and Senior Services and the applicable licensing boards, may reject the use of protocols, standards and practices or lists of diagnostic tests set by any organization deemed not to have standing or general recognition by the provider community or the applicable licensing boards. Protocols shall be deemed to establish guidelines as to standard appropriate treatment and diagnostic tests for injuries sustained in automobile accidents, but the establishment of standard treatment protocols or protocols for the administration of diagnostic tests shall not be interpreted in such a manner as to preclude variance from the standard when warranted by reason of medical necessity. The policy form may provide for the precertification of certain procedures, treatments, diagnostic tests, or other services or for the purchase of durable medical goods, as approved by the commissioner, provided that the requirement for precertification shall not be unreasonable, and no precertification requirement shall apply within ten days of the insured event. The policy may provide that certain benefits provided by the policy which are in excess of the basic benefits required by the commissioner to be included in the policy may be subject to reasonable copayments in addition to the copayments provided for herein, provided that the copayments shall not be unreasonable and shall be established in such a manner as not to serve to encourage underutilization of benefits subject to the copayments, nor encourage overutilization of benefits. The policy form shall clearly set forth any limitations on benefits or exclusions, which may include, but need not be limited to, benefits which are otherwise compensable under workers' compensation, or benefits for treatments deemed to be experimental or investigational, or benefits deducted pursuant to section 6 of P.L.1972, c.70 (C.39:6A-6). The commissioner may enlist the services of a benefit consultant in establishing the basic benefits level provided in this subsection, which shall be set forth by regulation no later than 120 days following the enactment date of this amendatory and supplementary act. The commissioner shall not advertise for the consultant as provided in sections 3 and 4 of P.L.1954, c.48 (C.52:34-8 and 52:34-9).

Medical expense benefits payable under this subsection shall not be assignable, except to a provider of service benefits, in accordance with policy terms approved by the commissioner, nor shall they be subject to levy, execution, attachment or other process for satisfaction of debts. Medical expense benefits payable in accordance with this subsection may be subject to a deductible and copayments as provided for in the policy, if any. No insurer or provider providing service benefits to an insured shall have a right of subrogation for the amount of benefits paid pursuant to any deductible or copayment under this section.

Notwithstanding the provisions of P.L.2003, c.18, physical therapy treatment shall not be reimbursable as medical expense benefits pursuant to this subsection unless rendered by a licensed physical therapist pursuant to a referral from a licensed physician, dentist, podiatrist or chiropractor within the scope of their respective practices.

Notwithstanding the provisions of P.L. 2009, c. (C. 56), acupuncture treatment shall not be reimbursable as medical expense benefits pursuant to this subsection unless rendered by a licensed acupuncturist pursuant to a referral from a licensed physician within the scope of the physician's practice.

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

c. In addition to the aforesaid coverages required to be provided in a basic automobile insurance policy, optional liability insurance coverage insuring against loss resulting from liability imposed by law for bodily injury or death in an amount or limit of $10,000, exclusive of interests and costs, on account of injury to, or death of, one or more persons in any one accident.

If a named insured has elected the basic automobile insurance policy option and an immediate family member or members or relatives resident in his household have one or more policies with the coverages provided for in sections 3 and 4 of P.L.1972, c.70 (C.39:6A-3 and 39:6A-4), the provisions of section 12 of P.L.1983, c.362 (C.39:6A-4.2) shall apply.

Every named insured and any other person to whom the basic automobile insurance policy, with or without the optional $10,000 liability coverage insuring against loss resulting from liability imposed by law for bodily injury or death provided for in subsection c. of this section, applies shall be subject to the tort option provided in subsection a. of section 8 of P.L.1972, c.70 (C.39:6A-8).

No licensed insurance carrier shall refuse to renew the coverage stipulated by this section of an eligible person as defined in section 25 of P.L.1990, c.8 (C.17:33B-13) except in accordance with the provisions of section 26 of P.L.1988, c.119 (C.17:29C-7.1) or with the consent of the Commissioner of Banking and Insurance.

Adopted. L. 1998, c. 21, §4, approved May 19, 1998, to take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later. **Amended.** L. 1998, c. 22, §1, effective May 19, 1998, but shall remain inoperative until the 90th day following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later; L. 2003, c. 18, §26, effective February 13, 2003; L. 2003, c. 89, §36, effective June 9, 2003; L. 2009, c. 56, §17, effective November 2, 2009.

39:6A-3.2. Issuance, renewal of automobile insurance policies; required coverage; exception for basic policy. a. All automobile insurance policies issued or renewed on or after the effective date of P.L. 1998, c. 21 (C.39:6A-1.1 et al.) shall be issued or renewed including at least the coverages required pursuant to sections 3 and 4 of P.L.1972, c.70 (C.39:6A-3 and 39:6A-4), unless the named insured elects a basic automobile insurance policy pursuant to section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) or, after the effective date of P.L.2003, c.89 (C.17:30A-2.1 et al.), a special automobile insurance policy pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3). Election of a basic automobile insurance policy or a special automobile insurance policy shall be in writing and signed by the named insured on the coverage selection form required by section 17 of P.L.1983, c.362 (C.39:6A-23). The coverage selection form shall contain a statement, clearly readable and in 12-point bold type, in a form approved by the commissioner, that: (1) election of a basic automobile insurance policy will result in less coverage than the $250,000 medical expense

benefits coverage mandated prior to the effective date of P.L.1998, c.21 (C.39:6A-1.1 et al.); or (2) election of a special automobile insurance policy will result in coverage only for emergency care. Furthermore, the coverage election form shall contain a statement, clearly readable and in 12-point bold type, in a form approved by the commissioner, that election of a special automobile insurance policy, or a basic automobile insurance policy without the optional $10,000 liability coverage provided for in section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) may subject the named insured to a claim or judgment for noneconomic loss which is not covered by the basic or special automobile insurance policy, and which may place his assets at risk, and in the event the named insured is sued, the insurer shall not provide legal counsel.

b. The insurance coverages provided for in section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) shall be offered by every insurer which writes insurance coverages pursuant to sections 3 and 4 of P.L.1972, c.70 (C.39:6A-3 and 39:6A-4) for a period of five years after the effective date of P.L. 1998, c. 21 (C.39:6A-1.1 et al.). The commissioner shall require every company writing such insurance coverage to report to him annually during that five-year period as to the number of policies written pursuant to this subsection in the previous year, the number of policies with the coverage offered pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) which have been converted to policies with the coverage offered pursuant to section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) and any other information the commissioner may require such as, but not limited to, the age of the policyholders and the territories in which the policyholders reside. The commissioner shall then report to the Governor and the Legislature regarding the acceptance of the basic automobile insurance policy by the automobile insurance consumers of this State annually for the first four years the basic policy is sold. On or before January 1, 2003, the commissioner shall make a final, cumulative report which shall include recommendations as to the continuation of the basic policy to the Governor and the Legislature.

c. The insurance coverages provided for in section 45 of P.L.2003, c.89 (C.39:6A-3.3) shall be offered or provided pursuant to subsection f. of that section for a period of five years after the effective date of P.L.2003, c.89 (C.17:30A-2.1 et al.). On or before January 1, 2008, the commissioner shall make a final report which shall include recommendations as to the continuation of the special policy to the Governor and the Legislature.

Adopted. L. 1998, c. 21, §5, approved May 19, 1998, to take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later. **Amended.** L. 2003, c. 89, §46, effective June 9, 2003.

39:6A-3.3. Establishment of special automobile insurance policy. a. In order to assist certain low income individuals in this State and encourage their greater compliance in satisfying the mandatory private passenger automobile insurance requirements, the Legislature intends to establish a special automobile insurance policy. The special automobile insurance policy shall be offered only to individuals who qualify for and are actively covered by designated government subsidized programs in the State. For the purpose of this section, "eligible low income individual" means an individual who meets the income criteria established by the commissioner by regulation. In setting the low income criteria, the commissioner shall limit availability to those persons eligible and enrolled in the federal Medicaid program.

b. As an additional option to the mandatory coverage provided in sections 3 and 4 of P.L.1972, c.70 (C.39:6A-3 and 39:6A-4) or the alternative covered provided in section 4 of P.L.1998, c.21 (C.39:6A-3.1), an owner or registered owner of an automobile registered or principally garaged in this State, who is an eligible low income individual, may elect a special automobile insurance policy providing the following coverage:

(1) Emergency personal injury protection coverage, for the payment of benefits without regard to negligence, liability or fault of any kind, only to the named insured

and dependent members of his family, as defined by the federal Medicaid program, residing in his household, who sustain bodily injury 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, and to other persons sustaining bodily injury while occupying, entering into, alighting from or using the automobile of the named insured, with the permission of the named insured. "Emergency personal injury protection coverage" issued pursuant to this section means and includes only payment of treatment for emergency care in an amount not to exceed $250,000 per person per accident. "Emergency care" means all medically necessary treatment of a traumatic injury or a medical condition manifesting itself by acute symptoms of sufficient severity such that absence of immediate attention could reasonably be expected to result in: death; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. Such emergency care shall include all medically necessary care immediately following an automobile accident, including, but not limited to, immediate pre-hospitalization care, transportation to a hospital or trauma center, emergency room care, surgery, critical and acute care. Emergency care extends during the period of initial hospitalization until the patient is discharged from acute care by the attending physician. Emergency care shall be presumed when medical care is initiated at a hospital within 120 hours of the accident. "Emergency personal injury protection coverage" shall also include all medically necessary treatment of permanent or significant brain injury, spinal cord injury or disfigurement after the patient is discharged from acute care. In the event benefits paid by an insurer pursuant to this subsection are in excess of $75,000 on account of bodily injury to any one person in any one accident covered by a policy issued or renewed prior to January 1, 2004, that excess shall be paid by the insurer and shall be reimbursable to the insurer from the Unsatisfied Claim and Judgment Fund pursuant to section 2 of P.L.1977, c.310 (C.39:6-73.1);

(2) Death benefit in the amount of $10,000;

(3) The tort option provided in subsection a. of section 8 of P.L.1972, c.70 (C.39:6A-8) shall apply to every named insured and any other person to whom the special automobile insurance policy applies.

c. A special automobile insurance policy shall not provide liability, collision, comprehensive, uninsured or underinsured motorist coverage.

d. The policy form for special automobile insurance policies shall be subject to the approval of the Commissioner of Banking and Insurance and shall clearly and conspicuously set forth the limitations on benefits provided under the policy.

e. The commissioner shall approve the rating system to be used for a special automobile insurance policy, which shall be administered by the plan created pursuant to section 1 of P.L.1970, c.215 (C.17:29D-1), to provide a uniform Statewide rate to be utilized by all insurers providing coverage through a special automobile insurance policy. The rate established by the commissioner shall be sufficient to reimburse the insurer for the cost of writing the policy and an amount set by the commissioner to be forwarded to the Unsatisfied Claim and Judgment Fund to offset claims paid by the Unsatisfied Claim and Judgment Fund. The commissioner may adjust the rate annually.

f. Special automobile insurance policies shall be assigned to insurers pursuant to the apportionment methodology of the plan created pursuant to section 1 of P.L.1970, c.215 (C.17:29D-1). The number of policies assigned pursuant to this subsection shall not be included in the determination of a competitive market pursuant to subsection d. of section 27 of P.L.1990, c.8 (C.17:33B-15).

Adopted. L. 2003, c. 89, §45, effective October 7, 2003, or upon the adoption of regulations by the Commissioner of Banking and Insurance to implement this section, whichever is earlier.

39:6A-4. Personal injury protection coverage; regardless of fault. Except as provided by section 45 of P.L.2003, c.89 (C.39:6A-3.3) and section 4 of P.L. 1998, c. 21 (C.39:6A-3.1), every standard automobile liability insurance policy issued or

renewed on or after the effective date of P.L. 1998, c. 21 (C.39:6A-1.1 et al.) shall contain personal injury protection benefits for the payment of benefits without regard to negligence, liability or fault of any kind, to the named insured and members of his family residing in his household who sustain bodily injury 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, and to other persons sustaining bodily injury while occupying, entering into, alighting from or using the automobile of the named insured, with permission of the named insured.

"Personal injury protection coverage" means and includes:

a. [Medical expense benefits.] Payment of medical expense benefits in accordance with a benefit plan provided in the policy and approved by the commissioner, for reasonable, necessary, and appropriate treatment and provision of services to persons sustaining bodily injury, in an amount not to exceed $250,000 per person per accident. In the event benefits paid by an insurer pursuant to this subsection are in excess of $75,000 on account of bodily injury to any one person in any one accident, that excess shall be paid by the insurer and shall be reimbursable to the insurer from the Unsatisfied Claim and Judgment Fund pursuant to section 2 of P.L.1977, c.310 (C.39:6-73.1). The policy form, which shall be subject to the approval of the commissioner, shall set forth the benefits provided under the policy, including eligible medical treatments, diagnostic tests and services as well as such other benefits as the policy may provide. The commissioner shall set forth by regulation a statement of the basic benefits which shall be included in the policy. Medical treatments, diagnostic tests, and services provided by the policy shall be rendered in accordance with commonly accepted protocols and professional standards and practices which are commonly accepted as being beneficial for the treatment of the covered injury. Protocols and professional standards and practices and lists of valid diagnostic tests which are deemed to be commonly accepted pursuant to this section shall be those recognized by national standard setting organizations, national or state professional organizations of the same discipline as the treating provider, or those designated or approved by the commissioner in consultation with the professional licensing boards in the Division of Consumer Affairs in the Department of Law and Public Safety. The commissioner, in consultation with the Commissioner of the Department of Health and Senior Services and the applicable licensing boards, may reject the use of protocols, standards and practices or lists of diagnostic tests set by any organization deemed not to have standing or general recognition by the provider community or the applicable licensing boards. Protocols shall be deemed to establish guidelines as to standard appropriate treatment and diagnostic tests for injuries sustained in automobile accidents, but the establishment of standard treatment protocols or protocols for the administration of diagnostic tests shall not be interpreted in such a manner as to preclude variance from the standard when warranted by reason of medical necessity. The policy form may provide for the precertification of certain procedures, treatments, diagnostic tests, or other services or for the purchase of durable medical goods, as approved by the commissioner, provided that the requirement for precertification shall not be unreasonable, and no precertification requirement shall apply within ten days of the insured event. The policy may provide that certain benefits provided by the policy which are in excess of the basic benefits required by the commissioner to be included in the policy may be subject to reasonable copayments in addition to the copayments provided for pursuant to subsection e. of this section, provided that the copayments shall not be unreasonable and shall be established in such a manner as not to serve to encourage underutilization of benefits subject to the copayments, nor encourage

overutilization of benefits. The policy form shall clearly set forth any limitations on benefits or exclusions, which may include, but need not be limited to, benefits which are otherwise compensable under workers' compensation, or benefits for treatments deemed to be experimental or investigational, or benefits deducted pursuant to section 6 of P.L.1972, c.70 (C.39:6A-6). The commissioner may enlist the services of a benefit consultant in establishing the basic benefits level provided in this subsection, which shall be set forth by regulation no later than 120 days following the enactment date of P.L. 1998, c. 21 (C.39:6A-1.1 et al.). The commissioner shall not advertise for bids for the consultant as provided in sections 3 and 4 of P.L.1954, c.48 (C.52:34-8 and 52:34-9).

Notwithstanding the provisions of P.L.2003, c.18, physical therapy treatment shall not be reimbursable as medical expense benefits pursuant to this subsection unless rendered by a licensed physical therapist pursuant to a referral from a licensed physician, dentist, podiatrist or chiropractor within the scope of their respective practices.

Notwithstanding the provisions of P.L. 2009, c. (C. 56), acupuncture treatment shall not be reimbursable as medical expense benefits pursuant to this subsection unless rendered by a licensed acupuncturist pursuant to a referral from a licensed physician within the scope of the physician's practice.

b. Income continuation benefits. The payment of the loss of income of an income producer as a result of bodily injury disability, subject to a maximum weekly payment of $100. Such sum shall be payable during the life of the injured person and shall be subject to an amount or limit of $5,200, on account of injury to any one person in any one accident, except that in no case shall income continuation benefits exceed the net income normally earned during the period in which the benefits are payable.

c. Essential services benefits. Payment of essential services benefits to an injured person shall be made in reimbursement of necessary and reasonable expenses incurred for such substitute essential services ordinarily performed by the injured person for himself, his family and members of the family residing in the household, subject to an amount or limit of $12 per day. Such benefits shall be payable during the life of the injured person and shall be subject to an amount or limit of $4,380, on account of injury to any one person in any one accident.

d. Death benefits. In the event of the death of an income producer as a result of injuries sustained in an accident entitling such person to benefits under this section, the maximum amount of benefits which could have been paid to the income producer, but for his death, under subsection b. of this section shall be paid to the surviving spouse, or in the event there is no surviving spouse, then to the surviving children, and in the event there are no surviving spouse or surviving children, then to the estate of the income producer.

In the event of the death of one performing essential services as a result of injuries sustained in an accident entitling such person to benefits under subsection c. of this section, the maximum amount of benefits which could have been paid to such person, under subsection c., shall be paid to the person incurring the expense of providing such essential services.

e. Funeral expenses benefits. All reasonable funeral, burial and cremation expenses, subject to a maximum benefit of $1,000, on account of the death of any one person in any one accident shall be payable to the decedent's estate.

Benefits payable under this section shall:

(1) Be subject to any option elected by the policyholder pursuant to section 13 of P.L.1983, c.362 (C.39:6A-4.3);

(2) Not be assignable, except to a provider of service benefits under this section in accordance with policy terms approved by the commissioner, nor subject to levy, execution, attachment or other process for satisfaction of debts.

Medical expense benefit payments shall be subject to any deductible and any copayment which may be established as provided in the policy. Upon the request of the commissioner or any party to a claim for benefits or payment for services rendered, a provider shall present adequate proof that any deductible or copayment related to that claim has not been waived or discharged by the provider.

No insurer or health provider providing benefits to an insured shall have a right of subrogation for the amount of benefits paid pursuant to any deductible or copayment under this section.

Adopted. L. 1972, c. 70, §4. **Amended.** L. 1972, c. 203, §3; L. 1977, c. 310, §1; L. 1981, c. 562, §1; L. 1983, c. 362, §7; L. 1984, c. 40, §3; L. 1988, c. 119, §3; L. 1990, c. 8, §4, effective March 12, 1990; L. 1997, c. 151, §31, effective January 1, 1998; L. 1998, c. 21, §6, approved May 19, 1998, to take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later; L. 1998, c. 22, §2, effective May 19, 1998, but shall remain inoperative until the 90th day following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later; L. 2003, c. 18, §27, effective February 13, 2003; L. 2003, c. 89, §37, effective June 9, 2003; L. 2009, c. 56, §17, effective November 2, 2009.

39:6A-4.1. Reduced premiums for additional vehicles. When a named insured is the owner and only designated operator of two or more automobiles and the only licensed driver residing in the household, he shall be charged a reduced personal injury protection premium for each automobile listed in addition to the principal automobile on the policy in an amount determined by the commissioner for the benefits provided in section 4 of P.L. 1972, c. 70 (C. 39:6A-4). Three years after the initial reduction in such premiums the personal injury protection premium for such additional automobiles shall be determined by the loss experience of the rate filer with respect to the payment of personal injury protection benefits which are attributable to such additional automobiles.

Adopted. L. 1983, c. 212, §1.

39:6A-4.2. Primacy of coverages. Except as provided in subsection d. of section 13 of P.L. 1983, c. 362 (C. 39:6A-4.3), the personal injury protection coverage of the named insured shall be the primary coverage for the named insured and any resident relative in the named insured's household who is not a named insured under an automobile insurance policy of his own. No person shall recover personal injury protection benefits under more than one automobile insurance policy for injuries sustained in any one accident.

Adopted. L. 1983, c. 362, §12. **Amended.** L. 1990, c. 8, §5, effective March 12, 1990.

39:6A-4.3. Personal injury protection coverage options. With respect to personal injury protection coverage provided on an automobile in accordance with section 4 of P.L. 1972, c. 70 (C. 39:6A-4), the automobile insurer shall provide the following coverage options:

a. Medical expense benefit deductibles in amounts of $500.00, $1,000.00, $2,000.00 and $2,500.00 for any one accident;

b. The option to exclude all benefits offered under subsections b., c., d., and e. of section 4;

c. (Deleted by amendment, P.L. 1988, c. 119.)

d. For policies issued or renewed on or after January 1, 1991, 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 in regard to medical expense benefits pursuant to section 4 of P.L. 1972, c. 70 (C.

39:6A-4). If health insurance coverage or benefits are primary, an automobile insurer providing medical expense benefits under personal injury protection coverage shall be liable for reasonable medical expenses not covered by the health insurance coverage or benefits up to the limit of the medical expense benefits coverage. The principles of coordination of benefits shall apply to personal injury protection medical expense benefits coverage pursuant to this subsection.

e. Medical expense benefits in amounts of $150,000, $75,000, $50,000 or $15,000 per person per accident; except that, medical expense benefits shall be paid in an amount not to exceed $250,000 for all medically necessary treatment of permanent or significant brain injury, spinal cord injury or disfigurement or for medically necessary treatment of other permanent or significant injuries rendered at a trauma center or acute care hospital immediately following the accident and until the patient is stable, no longer requires critical care and can be safely discharged or transferred to another facility in the judgment of the attending physician. The coverage election form shall contain a statement, clearly readable and in 12-point bold type, in a form approved by the commissioner, that election of any of the aforesaid medical expense benefits options results in less coverage than the $250,000 medical expense benefits coverage mandated prior to the effective date of P.L., c. (now before the Legislature as Senate Bill No. 3 (2R) of 1998).

If none of the aforesaid medical expense benefits options is affirmatively chosen in writing, the policy shall provide $250,000 medical expense benefits coverage.

f. The insurer shall provide an appropriate reduction from the territorial base rate for personal injury protection coverage for those electing any of the options in subsections a., b., d. and e. of this section.

Any named insured who chooses the option provided by subsection d. of this section shall provide proof that he and members of his family residing in his household are covered by health insurance coverage or benefits in a manner and to an extent approved by the commissioner. Nothing in this section shall be construed to require a health insurer, health maintenance organization or governmental agency to cover individuals or treatment which is not normally covered under the applicable benefit contract or plan. If it is determined that an insured who selected or is otherwise covered by the option provided in subsection d. of this section did not have such health coverage in effect at the time of an accident, medical expense benefits shall be payable by the person's automobile insurer and shall be subject to any deductible required by law or otherwise selected as an option pursuant to subsection a. of this section, any copayment required by law and an additional deductible in the amount of $750.

An option elected by the named insured in accordance with this section 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, and not to any other person eligible for personal injury protection benefits required to be provided in accordance with section 4 of P.L. 1972, c. 70 (C. 39:6A-4).

Medical expense benefits payable in any amount between the deductible selected pursuant to subsection a. of this section and $5,000.00 shall be subject to the copayment provided in the policy, if any.

No insurer or health provider providing benefits to an insured who has elected a deductible pursuant to subsection a. of this section shall have a right of subrogation for the amount of benefits paid pursuant to a deductible elected thereunder or any applicable copayment.

The Commissioner of Banking and Insurance shall adopt rules and regulations to effectuate the purposes of this section and may promulgate standards applicable to the coordination of personal injury protection medical expense benefits coverage.

Adopted. L. 1983, c. 362, §13. **Amended.** L. 1984, c. 40, §1; L. 1988, c. 119, §38; L. 1990, c. 8, §6, effective March 12, 1990; L. 1997, c. 151, §32, effective January 1, 1998; L. 1998, c. 21, §7, approved May 19, 1998, to take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-

4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later; L. 1998, c. 22, §3, effective May 19, 1998, but shall remain inoperative until the 90th day following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later.

39:6A-4.4. Application of 39:6A-4.3 amendments. The amendments to section 13 of P.L. 1983, c. 362 (C. 39:6A-4.3) contained in section 1 of this amendatory and supplementary act shall apply to any accident occurring on or after the effective date of this amendatory and supplementary act involving an automobile insurance policy in force on, or issued on or after that date, under which the named insured has elected a medical expense deductible in accordance with subsection a. of section 13 of P.L. 1983, c. 362 (C. 39:6A-4.3). Any additional premium that may be owing on an existing policy by reason of the application of those amendments shall be debited to the account of the named insured and shall be payable at the time of payment of the next policy premium.

Adopted. L. 1984, c. 40, §4.

39:6A-4.5. Loss limitations for those who fail to maintain medical expense benefits coverage. a. Any person who, at the time of an automobile accident resulting in injuries to that person, is required but fails to maintain medical expense benefits coverage mandated by section 4 of P.L. 1972, c. 70 (C. 39:6A-4), section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) or section 45 of P.L.2003, c.89 (C.39:6A-3.3) shall have no cause of action for recovery of economic or noneconomic loss sustained as a result of an accident while operating an uninsured automobile.

b. Any person who is convicted of, or pleads guilty to, operating a motor vehicle in violation of R.S.39:4-50, section 2 of P.L.1981, c.512 (C.39:4-50.4a), or a similar statute from any other jurisdiction, in connection with an accident, shall have no cause of action for recovery of economic or noneconomic loss sustained as a result of the accident.

c. Any person acting with specific intent of causing injury to himself or others in the operation or use of an automobile shall have no cause of action for recovery of economic or noneconomic loss sustained as a result of an accident arising from such conduct.

Adopted. L. 1985, c. 520, §14. **Amended.** L. 1988, c. 119, §4; L. 1997, c. 151, §13, effective June 30, 1997; L. 1998, c. 21, §8, approved May 19, 1998, to take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later; L. 2003, c. 89, §47, effective June 9, 2003.

39:6A-4.6. Medical fee schedules. a. The Commissioner of Banking and Insurance shall, within 90 days after the effective date of P.L.1990, c.8 (C.17:33B-1 et al.), promulgate medical fee schedules on a regional basis for the reimbursement of health care providers providing services or equipment for medical expense benefits for which payment is to be made by an automobile insurer under personal injury protection coverage pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), by an insurer under medical expense benefits coverage pursuant to section 2 of P.L.1991, c.154 (C.17:28-1.6), or for payment of unreimbursed medical expenses that are admissible as uncompensated economic loss pursuant to section 12 of P.L. 1972, c. 70 (C39:6A-12). These fee schedules shall be promulgated on the basis of the type of service provided, and shall incorporate the reasonable and prevailing fees of 75% of the practitioners within the region. If, in the case of a specialist provider, there are fewer than 50 specialists within a region, the fee schedule shall incorporate the reasonable and prevailing fees of the specialist providers on a Statewide basis. The commissioner may contract with a proprietary purveyor of fee schedules for the maintenance of the fee schedule, which shall be adjusted biennially for inflation and for the addition of new medical procedures.

b. The fee schedule may provide for reimbursement for appropriate services on the basis of a diagnostic-related (DRG) payment by diagnostic code where appropriate, and may establish the use of a single fee, rather than an unbundled fee, for a group of services if those services are commonly provided together. In the case of multiple procedures performed simultaneously, the fee schedule and regulations promulgated pursuant thereto may also provide for a standard fee for a primary procedure, and proportional reductions in the cost of the additional procedures.

c. No health care provider may demand or request any payment from any person in excess of those permitted by the medical fee schedules established pursuant to this section, 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 established pursuant to this section. This subsection shall apply to unreimbursed medical expenses that are subject to the medical fee schedules and admissible as uncompensated economic loss pursuant to section 12 of P.L.1972, c.70 (C.39:6A-12).

Adopted. L. 1988, c. 119, §10. **Amended.** L. 1988, c. 156, §4; L. 1990, c. 8, §7, effective March 12, 1990; L. 1991, c. 154, §6, effective October 5, 1991; L. 1997, c. 151, §33, effective June 30, 1997; L. 2019, c. 245, §1, effective August 1, 2019, and shall apply to automobile accidents occurring on or after that date.

39:6A-4.7. Compilation of list of valid diagnostic tests used in treatment of persons sustaining bodily injury. The professional licensing boards governing health care providers in the Division of Consumer Affairs shall promulgate, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), a list of valid diagnostic tests to be used in conjunction with the appropriate health care protocols in the treatment of persons sustaining bodily injury and subject to subsection a. of section 8 of P.L.1972, c.70 (C.39:6A-8). Inclusion of a test on the list of valid diagnostic tests shall be based on demonstrated medical value, and a level of general acceptance by the relevant provider community and shall not be dependent for results entirely upon subjective patient response. The initial lists shall be promulgated within 180 days of the effective date of this section and shall be revised from time to time as determined by the respective boards to reflect new testing procedures and emerging technologies enjoying a level of general acceptance within the appropriate provider community. In updating its list, a board may take action at a regularly scheduled meeting, notwithstanding the provisions of P.L.1968, c.410 (C.52:14B-1 et seq.) to the contrary, after notice as provided herein. The professional boards, individually or collectively, may enlist the services of a consulting firm to assist in compiling and updating the list. The Commissioner of Banking and Insurance may reimburse the boards for the cost of the services of the consultant. The list of valid diagnostic tests, once approved by the commissioner shall apply only to benefits under section 4 of P.L.1972, c.70 (C.39:6A-4) and section 4 of P.L. 1998, c. 21 (C.39:6A-3.1). The board or boards hiring a consultant shall not advertise for bids, as provided in sections 3 and 4 of P.L.1954, c.48 (C.52:34-8 and 52:34-9). Notwithstanding any of the provisions of this section to the contrary, a diagnostic test performed in an acute care facility, or extended care facility recognized by Medicare, shall not be excluded from a list of valid diagnostic tests promulgated pursuant to this section.

a. For the purposes of this section, "action" includes, but is not limited to:

(1) the addition or deletion of a test to the list; or

(2) procedures and standards for the performance of a test.

"Action" shall not include the hearing and resolution of contested cases, licensing matters, personnel matters or any other duties of a professional licensing board.

b. Prior to the adoption of an action by the board, the board shall forward the notice of intended action and a detailed description of the intended action to the Office of Administrative Law for publication in the New Jersey Register.

A copy of the text of the intended action shall be available in the Division of Consumer Affairs in accordance with the provisions of P.L.1963, c.73 (C.47:1A-1 et seq.).

c. The board may hold a public hearing on any intended action.

d. Whether or not a public hearing is held, the board shall afford all interested persons an opportunity to comment in writing on the intended action. Written comments shall be submitted to the board within the time established by the board in the notice of intended action, which time shall not be less than 10 calendar days from the date of notice. The board shall give due consideration to all comments received. A copy of the submissions shall be filed with the Office of Administrative Law for publication in the New Jersey Register.

e. The board may adopt the intended action immediately following the expiration of the public comment period provided in subsection d. of this section, or the hearing provided for in subsection c. of this section, whichever date is later. The final action adopted by the board shall be submitted for publication in the New Jersey Register to the Office of Administrative Law, and shall be effective on the date of the submission or such later date as the board may establish.

f. Actions filed with the Office of Administrative Law pursuant to this section shall be filed subject to the provisions of subsections (a), (c), (d) and (e) of section 5 of P.L.1968, c.410 (C.52:14B-5).

g. Nothing in this section shall be construed to prohibit the board from adopting any action pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

h. Nothing in this section shall be construed to prohibit the Director of the Division of Consumer Affairs from adopting any rule or regulation pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

Adopted. L. 1998, c. 21, §12, effective May 19, 1998.

39:6A-5. Payment of personal injury protection coverage benefits. a. An insurer may require written notice to be given as soon as practicable after an accident involving an automobile with respect to which the policy affords personal injury protection coverage benefits payable under a standard automobile insurance policy pursuant to section 4 of P.L.1972, c.70 (C.34:6A-4), medical expense benefits payable under a basic automobile insurance policy pursuant to section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) or emergency care medical expense benefits payable under a special automobile insurance policy pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3). In the case of claims for medical expense benefits under any of those policies, written notice shall be provided to the insurer by the treating health care provider no later than 21 days following the commencement of treatment. Notification required under this section shall be made in accordance with regulations adopted by the Commissioner of Banking and Insurance and on a form prescribed by the Commissioner of Banking and Insurance. Within a reasonable time after receiving notification required pursuant to this act, the insurer shall confirm to the treating health care provider that its policy affords the claimant personal injury protection coverage benefits as required by section 4 of P.L.1972, c.70 (C.39:6A-4), medical expense benefits pursuant to section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) or emergency care medical expense benefits payable under a special automobile insurance policy pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3).

b. For the purposes of this section, notification shall be deemed to be met if a treating health care provider submits a bill or invoice to the insurer for reimbursement of services within 21 days of the commencement of treatment.

c. In the event that notification is not made by the treating health care provider within 21 days following the commencement of treatment, the insurer shall reserve the right to deny, in accordance with regulations established by the Commissioner

of Banking and Insurance, payment of the claim and the treating health care provider shall be prohibited from seeking any payment directly from the insured. In establishing the standards for denial of payment, the Commissioner of Banking and Insurance shall consider the length of delay in notification, the severity of the treating health care provider's failure to comply with the notification provisions of this act based upon the potential adverse impact to the public and whether or not the provider has engaged in a pattern of noncompliance with the notification provisions of this act. In establishing the regulations necessary to effectuate the purposes of this subsection, the Commissioner of Banking and Insurance shall define specific instances where the sanctions permitted pursuant to this subsection shall not apply. Such instances may include, but not be limited to, a treating medical provider's failure to provide notification to the insurer as required by this act due to the insured's medical condition during the time period within which notification is required.

d. A health care provider who fails to notify the insurer within 21 days and whose claim for payment has been denied by the insurer pursuant to the standards established by the Commissioner of Banking and Insurance may, in the discretion of a judge of the Superior Court, be permitted to refile such claim provided that the insurer has not been substantially prejudiced thereby. Application to the court for permission to refile a claim shall be made within 14 days of notification of denial of payment and shall be made upon motion based upon affidavits showing sufficient reasons for the failure to notify the insurer within the period of time prescribed by this act.

e. (Deleted by amendment, P.L. 1998, c. 21.)

f. In instances when multiple treating health care providers render services in connection with emergency care, the Commissioner of Banking and Insurance shall designate, through regulation, a process whereby notification by one treating health care provider to the insurer shall be deemed to meet the notification requirements of all the treating health care providers who render services in connection with emergency care.

g. Personal injury protection coverage benefits pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) and medical expense benefits pursuant to section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) or emergency care medical expense benefits payable under a special automobile insurance policy pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3) shall be overdue if not paid within 60 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same. If such written notice is not furnished to the insurer as to the entire claim, any partial amount supported by written notice is overdue if not paid within 60 days after such written notice is furnished to the insurer. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within 60 days after such written notice is furnished to the insurer; provided, however, that any payment shall not be deemed overdue where, within 60 days of receipt of notice of the claim, the insurer notifies the claimant or his representative in writing of the denial of the claim or the need for additional time, not to exceed 45 days, to investigate the claim, and states the reasons therefor. The written notice stating the need for additional time to investigate the claim shall set forth the number of the insurance policy against which the claim is made, the claim number, the address of the office handling the claim and a telephone number, which is toll free or can be called collect, or is within the claimant's area code. Written notice to the organization administering dispute resolution pursuant to sections 24 and 25 of P.L. 1998, c. 21 (C.39:6A-5.1 and C.39:6A-5.2) shall satisfy the notice request for additional time to investigate a claim pursuant to this subsection. For the purpose of determining interest charges in the event the injured party prevails in a subsequent proceeding where an insurer has elected a 45-day extension pursuant to this subsection, payment shall be considered overdue at the expiration of the 45-day

period or, if the injured person was required to provide additional information to the insurer, within 10 business days following receipt by the insurer of all the information requested by it, whichever is later.

For the purpose of calculating the extent to which any benefits are overdue, payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery.

h. All overdue payments shall bear interest at the percentage of interest prescribed in the Rules Governing the Courts of the State of New Jersey for judgments, awards and orders for the payment of money.

i. All automobile insurers and the Unsatisfied Claim and Judgment Fund shall provide any claimant with the option of submitting a dispute under this section to dispute resolution pursuant to sections 24 and 25 of P.L. 1998, c. 21 (C.39:6A-5.1 and C.39:6A-5.2).

Adopted. L. 1972, c. 70, §5. **Amended.** L. 1983, c. 362, §8; L. 1990, c. 8, §8, effective March 12, 1990; L. 1995, c. 407, §1, effective January 10, 1996, but it shall remain inoperative for 180 days and shall apply to accidents occurring after that date; L. 1998, c. 21, §23, approved May 19, 1998, to take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later; L. 2003, c. 89, §48, effective June 9, 2003.

39:6A-5.1. Dispute resolution provided regarding recovery of personal injury protection benefits. a. Any dispute regarding the recovery of medical expense benefits or other benefits provided under personal injury protection coverage pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4), section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) or section 45 of P.L.2003, c.89 (C.39:6A-3.3) arising out of the operation, ownership, maintenance or use of an automobile may be submitted to dispute resolution on the initiative of any party to the dispute, as hereinafter provided.

b. The Commissioner of Banking and Insurance shall designate an organization, and for that purpose may, at his discretion, advertise for proposals, for the purpose of administering dispute resolution proceedings regarding medical expense benefits and other benefits provided under personal injury protection pursuant to section 4 of P.L. 1972, c.70 (C.39:6A-4), medical expense benefits coverage pursuant to section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) or emergency care medical expense benefits pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3). The commissioner shall promulgate rules and regulations with respect to the conduct of the dispute resolution proceedings. The organization administering dispute resolution shall utilize qualified professionals who serve on a full-time basis and who meet standards of competency established by the commissioner. The commissioner shall establish standards of performance for the organization to ensure the independence and fairness of the review process, including, but not limited to, standards relative to the professional qualifications of the professionals presiding over the dispute resolution process, and standards to ensure that no conflict of interest exists which would prevent the professional from performing his duties in an impartial manner. The standards of performance shall include a requirement that the organization establish an advisory council composed of parties who are users of the dispute resolution mechanism established herein. The commissioner may contract with a consulting firm for the formulation of the standards of performance of the organization and establishment of qualifications for the persons who are to conduct the dispute resolution proceedings. The commissioner shall not advertise for bids for the consulting firm, as provided in sections 3 and 4 of P.L.1954, c.48 (C.52:34-8 and 52:34-9). Compensation to the dispute resolution professionals shall be established by the commissioner and adjusted from time to time as appropriate, with the approval of the commissioner. In no case shall compensation be paid on a contingency basis. The organization shall establish a dispute resolution plan, which

shall include procedures and rules governing the dispute resolution process and provisions for monitoring the dispute resolution process to ensure adherence to the standards of performance established by the commissioner. The plan, and any amendments thereto, shall be subject to the approval of the commissioner.

c. Dispute resolution proceedings under this section 24 and section 25 of this amendatory and supplementary act shall include disputes arising regarding medical expense benefits provided under subsection a. of section 4 of P.L.1972, c.70 (C.39:6A-4), section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) or section 45 of P.L.2003, c.89 (C.39:6A-3.3), benefits provided pursuant to subsection b., c., d. or e. of section 4 of P.L.1972, c.70 (C.39:6A-4), subsection b., c., d. or e. of section 7 of P.L.1972, c.198 (C.39:6-86.1), and disputes as to additional first party coverage benefits required to be offered pursuant to section 10 of P.L.1972, c.70 (C.39:6A-10). Disputes involving medical expense benefits may include, but not necessarily be limited to, matters concerning: (1) interpretation of the insurance contract; (2) whether the treatment or health care service which is the subject of the dispute resolution proceeding is in accordance with the provisions of section 4 of P.L.1972, c.70 (C.39:6A-4), section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) or section 45 of P.L.2003, c.89 (C.39:6A-3.3) or the terms of the policy; (3) the eligibility of the treatment or service for compensation; (4) the eligibility of the provider performing the treatment or service to be compensated under the terms of the policy or under regulations promulgated by the commissioner, including whether the person is licensed or certified to perform such treatment; (5) whether the disputed medical treatment was actually performed; (6) whether diagnostic tests performed in connection with the treatment are those recognized by the commissioner; (7) the necessity or appropriateness of consultations by other health care providers; (8) disputes involving application of and adherence to fee schedules promulgated by the commissioner; and (9) whether the treatment performed is reasonable, necessary, and compatible with the protocols provided for pursuant to P.L. 1998, c. 21 (C.39:6A-1.1 et al.). The dispute resolution professionals may review the entire claims file of the insurer, subject to any confidentiality requirement established pursuant to State or federal law. All decisions of the dispute resolution professional shall be in writing, in a form prescribed by the commissioner, shall state the issues in dispute, the findings and conclusions on which the decision is based, and shall be signed by the dispute resolution professional. All decisions of a dispute resolution professional shall be binding. The dispute resolution organization shall provide for the retention of all documents used in dispute resolution proceedings under this section and section 25 of this amendatory and supplementary act, including the written decision, for a period of at least five years, in a form approved by the commissioner, or for such additional time as may be established by the commissioner. The written decisions of the dispute resolution professional shall be forwarded to the commissioner, who shall establish a record of the proceedings conducted under the dispute resolution procedure, which shall be accessible to the public and may be used as guidance in subsequent dispute resolution proceedings.

d. With respect to disputes as to the diagnosis, the medical necessity of the treatment or diagnostic test administered to the injured person, whether the injury is causally related to the insured event or is the product of a preexisting condition, or disputes as to the appropriateness of the protocols utilized by the provider, the dispute resolution professional shall, either at his option or at the request of any party to the dispute, refer the matter to a medical review organization for a determination. The determination of the medical review organization on the dispute referred shall be presumed to be correct by the dispute resolution professional, which presumption may be rebutted by a preponderance of the evidence. Should the dispute resolution professional find that the decision of the medical review organization is not correct, the reasons supporting that finding shall be set forth in the dispute resolution professional’s written decision.

e. Any person submitting a matter to the dispute resolution process established herein may submit for review all or a portion of a disputed treatment or treatments or a dispute regarding a diagnostic test or tests or a dispute regarding the providing of services or durable medical goods. Any portion of a treatment or diagnostic test or service which is not under review shall be reimbursed in accordance with the provisions of section 5 of P.L.1972, c.70 (C.39:6A-5). If the dispute resolution proceeding results in a determination that all or part of a treatment or treatments, diagnostic test or tests or service performed, or durable medical goods provided are medically necessary and appropriate, reimbursement shall be made with interest payable in accordance with the provisions of section 5 of P.L.1972, c.70 (C.39:6A-5).

Adopted. L. 1998, c. 21, §24, approved May 19, 1998, to take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later. **Amended.** L. 1998, c. 22, §4, effective May 19, 1998, but shall remain inoperative until the 90th day following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later; L. 2003, c. 89, §49, effective June 9, 2003.

39:6A-5.2. Establishment of standards for certification of medical review organizations. a. The commissioner shall establish standards for the certification of medical review organizations, which shall include standards of performance formulated by the commissioner in consultation with the Commissioner of Health and Senior Services. The standards of performance shall set forth procedures to ensure a timely and impartial review of the medical records of the injured person by a medical review organization, including, but not limited to, a review of the necessity or appropriateness of treatments for injuries, including diagnostic tests, sustained in an automobile accident. The commissioner shall establish standards for persons conducting the medical review, including standards with respect to credentials, experience, licensure, fees, and confidentiality. The standards shall include a requirement that all persons performing reviews are New Jersey licensed or certified health care providers, and a requirement that any medical review panel contain a health care provider licensed or certified in the same profession as the treating health care provider and that it contain a sufficient representation of reviewers to judge the appropriateness of treatment or treatments in dispute, including, but not limited to, the medical necessity of such treatments, appropriateness of the protocols used by the treating provider, issues regarding causality and preexisting conditions, the appropriateness and efficacy of diagnostic tests performed in connection with the diagnosis, and whether the diagnostic tests meet the requirements established by the commissioner. The commissioner may contract with a consultant for the formulation of the standards governing the certification of the persons conducting the medical reviews. The commissioner shall not advertise for bids for the consultant, as provided in sections 3 and 4 of P.L.1954, c.48 (C.52:34-8 and 52:34-9).

b. Before certifying a medical review organization to receive referrals from dispute resolution proceedings, the commissioner shall determine that the organization has a sufficient number of qualified health care providers, by specialty, to perform the reviews, has a satisfactory procedure for maintaining the confidentiality of medical records, is not owned or controlled by an insurer, and has met any other requirements established by the commissioner.

c. The medical review organization shall establish and utilize written review procedures, which shall be filed with the commissioner. Every determination made by a medical review organization shall be in writing and shall be retained by the organization for a period of no less than five years.

d. The medical review organization may review the medical treatment or treatments in dispute to determine whether: (1) the treatment or diagnostic test being given for the injury or the services provided in connection with the injury is medically necessary; (2) the treatment is in accordance with or compatible with medically recognized standard protocols, professional standards, and commonly accepted medical practice in the same health care discipline as the treating provider; (3) the treatment is consistent with the symptoms or diagnosis of the injury; (4) the treatment or health care service is related to the injury sustained in the insured event, or is required for the diagnosis, evaluation or confirmation of the injury; (5) the treatment is of a palliative, rather than restorative, nature; and (6) medical procedures, treatment, or testing which have been repeated are medically necessary and consistent with standard practice.

e. Cases referred by a dispute resolution professional for medical review shall be referred to appropriate certified medical reviewers affiliated with the certified medical review organization by a dispute resolution organization. The dispute resolution organization shall forward the referrals to certified medical reviewers on a random basis, so that there is a relatively equal apportionment among all medical reviewers. Referrals shall be made in such a manner so as not to disclose to the medical reviewers the identity of the insurer, nor shall the identity of the reviewer be disclosed to the insurer.

f. When appropriate in the context of its review of services or treatments under dispute, a medical reviewer may request and shall receive a written report or copy of the provider's records regarding the case history, treatment dates, or the dates diagnostic tests or other services were performed, and the provider's projected treatment plan. The injured person or provider, as applicable, shall provide or make available to the medical reviewer any pertinent medical records or medical history which the medical reviewer may request. The medical reviewer shall complete its review and make a determination within 20 business days of receipt of all of the requested information from the dispute resolution professional or provider, as the case may be. The medical reviewer shall submit its determination in writing to the referring dispute resolution organization, which shall forward it to the dispute resolution professional.

g. The cost of the proceedings shall be apportioned by the dispute resolution professional. Fees shall be determined to be reasonable if they are consonant with the amount of the award, in accordance with a schedule established by the New Jersey Supreme Court. If the treatment, diagnostic test, or service performed is not determined to be medically necessary or appropriate, the injured person shall not be liable to pay the provider the disputed amount.

Adopted. L. 1998, c. 21, §25, approved May 19, 1998, to take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later.

39:6A-5.3. Definitions relative to electronic submission of certain automobile insurance claims. As used in this act:

"Complete electronic medical bill" means a medical bill that meets all of the following criteria: (1) it is submitted in the correct uniform billing format, with the correct uniform billing code sets, transmitted in compliance with the guidelines; (2) the bill and electronic attachments provide all information required under the guidelines established by this act; and (3) the health care provider or its billing representative has provided all information that the insurance carrier or its third party administrator requested.

"Electronic bill" means a communication between computerized data exchange systems that complies with the guidelines enumerated; or a mutually agreed upon electronic data exchange plan established between health care providers or their billing representatives and insurance companies or their third party administrators.

"Guidelines" means the current version of the ASC X12 005010 format.

"Insurance carrier" means any company underwriting personal injury protection coverage benefits payable under a standard automobile insurance policy pursuant to section 4 of P.L.1972, c.70 (C.34:6A-4); a basic automobile insurance policy pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1); or emergency care medical expense benefits payable under a special automobile insurance policy pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3), and shall include any managed care organization associated with the carrier.

Adopted. L. 2017, c. 369, §1, effective January 16, 2018, except that insurance carriers and third party administrators shall not be required to adopt electronic bill transmission before the first day of the 20th month next following the date of enactment; nothing in this act shall prevent insurance carriers or their third-party administrators from earlier adoption of electronic bills transmission.

39:6A-5.4. Electronic bills. a. All healthcare providers or their billing representative shall submit electronic bills for payment which shall be completed on standardized forms following the guidelines established pursuant to this act.

b. Insurance carriers, medical management companies, or their third-party administrators shall accept electronic bills and shall comply with the guidelines.

c. Confidentiality of medical information submitted on electronic bills for payment of medical services pursuant to this act shallbe maintained.

d. Insurance carriers or their third-party administrators shall acknowledge receipt of a complete electronic medical bill to the party that sent the complete electronic medical bill in compliance with the guidelines.

e. Payment for a complete electronic medical bill deemed compensable by the insurance carrier shall be made in accordance with subsection g. of section 5 of P.L.1972, c.70 (C.39:6A-5), provided, however, that insurance carriers or their third party administrators may establish shorter payment deadlines through contracts or agreements with health care providers or their billing representatives in a non-prescribed format or timeline.

Adopted. L. 2017, c. 369, §2, effective January 16, 2018, except that insurance carriers and third party administrators shall not be required to adopt electronic bill transmission before the first day of the 20th month next following the date of enactment; nothing in this act shall prevent insurance carriers or their third-party administrators from earlier adoption of electronic bills transmission.

39:6A-5.5. Inapplicability. This act shall not apply to any provider that:

a. submits less than 25 medical bills per month to insurance carriers or third-party administrators;

b. furnishes services only outside of the United States;

c. experiences a disruption in electricity and communication connections that are beyond its control; or

d. demonstrates that a specific and unusual circumstance exists that precludes submission of electronic bills.

Adopted. L. 2017, c. 369, §3, effective January 16, 2018, except that insurance carriers and third party administrators shall not be required to adopt electronic bill transmission before the first day of the 20th month next following the date of enactment; nothing in this act shall prevent insurance carriers or their third-party administrators from earlier adoption of electronic bills transmission.

39:6A-6. Collateral source. The benefits provided in sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10), the medical expense benefits provided in section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) and the benefits provided in section 45 of P.L.2003, c.89 (C.39:6A-3.3) shall be payable as loss accrues, upon written notice of such loss and without regard to collateral sources, except that benefits, collectible under workers' compensation insurance, employees' temporary disability benefit statutes, Medicare provided under federal law, and benefits, in fact collected, that are provided under federal law to active and retired military personnel shall be deducted from the benefits collectible under sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10), the medical expense benefits provided in section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) and the benefits provided in section 45 of P.L.2003, c.89 (C.39:6A-3.3).

If an insurer has paid those benefits and the insured is entitled to, but has failed to apply for, workers' compensation benefits or employees' temporary disability benefits, the insurer may immediately apply to the provider of workers' compensation benefits or of employees' temporary disability benefits for a reimbursement of any benefits pursuant to sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10), medical expense benefits pursuant to section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) or benefits pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3) it has paid.

Adopted. L. 1972, c. 70, §6. **Amended.** L. 1972, c. 203, §4; L. 1981, c. 95, §1; L. 1983, c. 362, §9; L. 1998, c. 21, §9, approved May 19, 1998, to take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later; L. 2003, c. 89, §50, effective June 9, 2003.

39:6A-7. Exclusions. a. Insurers may exclude a person from benefits under sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10), medical expense benefits provided in section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) and benefits provided in section 45 of P.L.2003, c.89 (C.39:6A-3.3) if that person's conduct contributed to his personal injuries or death occurred in any of the following ways:

(1) while committing a high misdemeanor or felony or seeking to avoid lawful apprehension or arrest by a police officer; or

(2) while acting with specific intent of causing injury or damage to himself or others.

b. An insurer may also exclude from the benefits provided in sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10), the medical expense benefits provided in section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) and benefits provided in section 45 of P.L.2003, c.89 (C.39:6A-3.3) any person having incurred injuries or death, who, at the time of the accident:

(1) was the owner or registrant of an automobile registered or principally garaged in this State that was being operated without personal injury protection coverage;

(2) was occupying or operating an automobile without the permission of the owner or other named insured;

(3) was a person other than the named insured or a member of the named insured's family residing in his household, if that person is entitled to coverage under section 4 or section 10 of P.L.1972, c.70 (C.39:6A-4 or 39:6A-10), or both, section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) or section 45 of P.L.2003, c.89 (C.39:6A-3.3), as a named insured or member of the named insured's family residing in his household under the terms of another policy; or

(4) was a member of the named insured's family residing in the named insured's household, if that person is entitled to coverage under section 4 or section 10 of P.L.1972, c.70 (C.39:6A-4 or 39:6A-10), or both, section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) or section 45 of P.L.2003, c.89 (C.39:6A-3.3) as a named insured under the terms of another policy.

Adopted. L. 1972, c. 70, §7. **Amended.** L. 1972, c. 203, §5; L. 1983, c. 362, §10; L. 1997, c. 270, §1, effective December 22, 1997; L. 1998, c. 21, §10, approved May 19, 1998, to take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later; L. 2003, c. 89, §51, effective June 9, 2003.

39:6A-8. Tort exemption; limitation on the right to non-economic loss. One of the following two tort options shall be elected, in accordance with section 14.1 of P.L. 1983, c. 362 (C. 39:6A-8.1), by any named insured required to maintain personal injury protection coverage pursuant to section 4 of P.L. 1972, c. 70 (C. 39:6A-4):

a. Limitation on lawsuit option. Every owner, registrant, operator or occupant of an automobile to which section 4 of P.L.1972, c.70 (C.39:6A-4), personal injury protection coverage, section 4 of P.L. 1998, c. 21 (C.39:6A-3.1), medical expense benefits coverage, or section 45 of P.L.2003, c.89 (C.39:6A-3.3) regardless of fault, applies, and every person or organization legally responsible for his acts or omissions,

is hereby exempted from tort liability for noneconomic loss to a person who is subject to this subsection and who is either a person who is required to maintain personal injury protection coverage pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4), medical expense benefits pursuant to section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) or benefits pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3), or is a person who has a right to receive benefits under section 4 of P.L.1972, c.70 (C.39:6A-4), section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) or section 45 of P.L.2003, c.89 (C.39:6A-3.3), as a result of bodily injury, arising out of the ownership, operation, maintenance or use of such automobile in this State, unless that person has sustained a bodily injury which results in death; dismemberment; significant disfigurement or significant scarring; displaced fractures; loss of a fetus; or a permanent injury within a reasonable degree of medical probability, other than scarring or disfigurement. An injury shall be considered permanent when the body part or organ, or both, has not healed to function normally and will not heal to function normally with further medical treatment. For the purposes of this subsection, "physician" means a physician as defined in section 5 of P.L.1939, c.115 (C.45:9-5.1).

In order to satisfy the tort option provisions of this subsection, the plaintiff shall, within 60 days following the date of the answer to the complaint by the defendant, provide the defendant with a certification from the licensed treating physician or a board-certified licensed physician to whom the plaintiff was referred by the treating physician. The certification shall state, under penalty of perjury, that the plaintiff has sustained an injury described above. The certification shall be based on and refer to objective clinical evidence, which may include medical testing, except that any such testing shall be performed in accordance with medical protocols pursuant to subsection a. of section 4 of P.L.1972, c.70 (C.39:6A-4) and the use of valid diagnostic tests administered in accordance with section 12 of P.L. 1998, c. 21 (C.39:6A-4.7). Such testing may not be experimental in nature or dependent entirely upon subjective patient response. The court may grant no more than one additional period not to exceed 60 days to file the certification pursuant to this subsection upon a finding of good cause.

A person is guilty of a crime of the fourth degree if that person purposefully or knowingly makes, or causes to be made, a false, fictitious, fraudulent, or misleading statement of material fact in, or omits a material fact from, or causes a material fact to be omitted from, any certification filed pursuant to this subsection. Notwithstanding the provisions of subsection e. of N.J.S. 2C:44-1, the court shall deal with a person who has been convicted of a violation of this subsection by imposing a sentence of imprisonment unless, having regard to the character and condition of the person, the court is of the opinion that imprisonment would be a serious injustice which overrides the need to deter such conduct by others. If the court imposes a noncustodial or probationary sentence, such sentence shall not become final for 10 days in order to permit the appeal of such sentence by the prosecution. Nothing in this subsection a. shall preclude an indictment and conviction for any other offense defined by the laws of this State. In addition, any professional license held by the person shall be forfeited according to the procedures established by section 4 of P.L.1997, c.353 (C.2C:51-5); or

b. No limitation on lawsuit option. As an alternative to the basic tort option specified in subsection a. of this section, every owner, registrant, operator, or occupant of an automobile to which section 4 of P.L. 1972, c. 70 (C. 39:6A-4), personal injury protection coverage, section 4 of P.L. 1998, c. 21 (C.39:6A-3.1), medical expense benefits coverage, or section 45 of P.L.2003, c.89 (C.39:6A-3.3), regardless of fault, applies, and every person or organization legally responsible for his acts or omissions, shall be liable for noneconomic loss to a person who is subject to this subsection and who is either a person who is required to maintain the coverage mandated by P.L. 1972, c. 70 (C. 39:6A-1 et seq.) or is a person who has a right to receive benefits under section 4 of that act (C. 39:6A-4), as a result of bodily injury, arising out of the ownership, operation, maintenance or use of such automobile in this State.

The tort option provisions of subsection b. of this section shall also apply to the right to recover for noneconomic loss of any person eligible for benefits pursuant to section 4 of P.L. 1972, c. 70 (C. 39:6A-4), section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) or section 45 of P.L.2003, c.89 (C.39:6A-3.3) but who is not required to maintain personal injury protection coverage pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4), medical expense benefits coverage pursuant to section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) or benefits pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3) and is not an immediate family member, as defined in section 14.1 of P.L. 1983, c. 362 (C. 39:6A-8.1), under a standard automobile insurance policy or basic automobile insurance policy.

The tort option provisions of subsection a. of this section shall also apply to any person subject to section 14 of P.L. 1985, c. 520 (C. 39:6A-4.5) and to every named insured and any other person to whom the benefits of the special automobile insurance policy provided in section 45 of P.L.2003, c.89 (C.39:6A-3.3) or the medical expense benefits of the basic automobile insurance policy pursuant to section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) apply whether or not the person has elected the optional $10,000 liability coverage insuring against loss resulting from liability imposed by law for bodily injury or death provided for in subsection c. of section 4 of P.L. 1998, c. 21 (C.39:6A-3.1).

The tort option provisions of subsections a. and b. of this section as provided in this 1998 amendatory and supplementary act shall apply to automobile insurance policies issued or renewed on or after the effective date of P.L. 1998, c. 21 (C.39:6A-1.1 et al.) and as otherwise provided by law.

Adopted. L. 1972, c. 70, §8. **Amended.** L. 1972, c. 203, §6; L. 1983, c. 362, §14; L. 1985, c. 520, §15; L. 1988, c. 119, §6; L. 1990, c. 8, §9, effective March 12, 1990; L. 1998, c. 21, §11, approved May 19, 1998, to take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later; L. 2003, c. 89, §52, effective June 9, 2003.

39:6A-8.1. Election of tort option. a. Election of a tort option pursuant to section 8 of P.L. 1972, c. 70 (C. 39:6A-8) shall be in writing and signed by the named insured on the coverage selection form required by section 17 of P.L. 1983, c. 362 (C. 39:6A-23). The form shall state the percentage difference in the premium rates or the dollar savings between the two tort options. The tort option elected shall apply to the named insured and any immediate family member residing in the named insured's household. "Immediate family member" means the spouse of the named insured and any child of the named insured or spouse residing in the named insured's household who is not a named insured under another automobile insurance policy.

b. If the named insured fails to elect, in writing, any of the tort options offered pursuant to section 8 of P.L. 1972, c. 70 (C. 39:6A-8), the named insured shall be deemed to elect the tort option of subsection a. of that section 8.

c. The tort option elected by a named insured for an automobile policy issued or renewed on or after January 1, 1989 shall continue in force as to subsequent renewal or replacement policies until the insurer or its authorized representative receives a properly executed form electing the other tort option.

d. The tort option elected by the named insured shall apply to all automobiles owned by the named insured and to any immediate family member who is not a named insured under another automobile insurance policy, except that in the case where more than one policy is applicable to the named insured or immediate family member, and the policies have different tort options, the tort option elected by the injured named insured shall apply or, in the case of an immediate family member who is not a named insured and is injured in an accident involving an automobile to which a policy issued to a named insured in the household of the injured immediate family member applies, the tort option elected by that named insured shall apply.

e. Notwithstanding any other provision of law to the contrary, no person, including, but not limited to, an insurer, an insurance producer as defined in section 2 of P.L. 1987, c. 293 (C. 17:22A-2), a servicing carrier or non-insurer servicing carrier acting in that capacity pursuant to P.L. 1983, c. 65 (C. 17:30E-1 et seq.), and the New Jersey Automobile Full Insurance Underwriting Association created pursuant to P.L. 1983, c. 65 (C. 17:30E-1 et seq.), shall be liable in an action for damages on account of the election of a tort option by a named insured or on account of the tort option imposed pursuant to subsection b. of this section or otherwise imposed by law. Nothing in this subsection shall be deemed to grant immunity to any person causing damage as the result of his willful, wanton or grossly negligent act of commission or omission.

In the case of automobile insurance policies in force on January 1, 1989, notice of the tort options available pursuant to the aforesaid section 8 shall be given in accordance with section 17 of P.L. 1983, c. 362 (C. 39:6A-23).

Adopted. L. 1983, c. 362, §14.1. **Amended.** L. 1988, c. 119, §7.

39:6A-9. Subrogation. Any insurer paying benefits in accordance with the provisions of section 4 [39:6A-4] and section 10 [39:6A-10], personal injury protection coverage, regardless of fault, shall be subrogated to the rights of any party to whom it makes such payments to the extent of such payments. Such subrogated insurer may only by intercompany arbitration or by intercompany agreement exercise its subrogation rights against only the insurer of any person liable for such damages in tort provided, however, that such insurer may exercise its subrogation rights directly against any person required to have in effect the coverage required by this act and who failed to have such coverage in effect at the time of the accident. The exemption from tort liability provided in section 8 [39:6A-8] does not apply to the insurers' subrogation rights. On and after 2 years from the effective date of this act the provisions of this section shall be inoperative.

Adopted. L. 1972, c. 70, §9. **Amended.** L. 1972, c. 203, §7.

39:6A-9.1. Insurer recovery. a. An insurer, health maintenance organization or governmental agency paying benefits pursuant to subsection a., b. or d. of section 13 of P.L.1983, c.362 (C.39:6A-4.3), personal injury protection benefits in accordance with section 4 or section 10 of P.L.1972, c.70 (C.39:6A-4 or 39:6A-10), medical expense benefits pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1) or benefits pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3), as a result of an accident occurring within this State, shall, within two years of the filing of the claim, have the right to recover the amount of payments from any tortfeasor who was not, at the time of the accident, required to maintain personal injury protection or medical expense benefits coverage, other than for pedestrians, under the laws of this State, including personal injury protection coverage required to be provided in accordance with section 18 of P.L.1985, c.520 (C.17:28-1.4), or although required did not maintain personal injury protection or medical expense benefits coverage at the time of the accident.

b. In the case of an accident occurring in this State involving an insured tortfeasor, the determination as to whether an insurer, health maintenance organization or governmental agency is legally entitled to recover the amount of payments and the amount of recovery, including the costs of processing benefit claims and enforcing rights granted under this section, shall be made against the insurer of the tortfeasor, and shall be by agreement of the involved parties or, upon failing to agree, by arbitration. Any recovery by an insurer, health maintenance organization or governmental agency pursuant to this subsection shall be subject to any claim against the insured tortfeasor's insurer by the injured party and shall be paid only after satisfaction of that claim, up to the limits of the insured tortfeasor's motor vehicle or other liability insurance policy.

Adopted. L. 1983, c. 362, §20. **Amended.** L. 1985, c. 520, §17; L. 1990, c. 8, §10, effective March 12, 1990; L. 1998, c. 21, §13, approved May 19, 1998, to take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided

pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later; L. 2003, c. 89, §53, effective June 9, 2003; L. 2011, c. 11, §1, effective January 28, 2011

39:6A-10. Additional personal injury protection coverage. Insurers shall make available to the named insured electing the standard automobile insurance policy and covered under section 4 of P.L. 1972, c. 70 (C. 39:6A-4), and, at his option, to resident relatives in the household of the named insured, suitable additional first party coverage for income continuation benefits, essential services benefits, death benefits and funeral expense benefits, but the income continuation and essential services benefits shall cease upon the death of the claimant, and shall not operate to increase the amount of any death benefits payable under section 4 of P.L. 1972, c. 70 (C. 39:6A-4) and such additional first party coverage shall be payable only to the extent that the claimant establishes that the amount of loss sustained exceeds the coverage specified in section 4 of P.L. 1972, c. 70 (C. 39:6A-4). Insurers may also make available to named insureds electing a standard automobile insurance policy and covered under section 4 of P.L. 1972, c. 70 (C. 39:6A-4), and, at their option, to resident relatives in the household of the named insured or to other persons provided medical expense benefits coverage pursuant to section 4 of P.L. 1972, c. 70 (C. 39:6A-4), or both, additional first party medical expense benefits coverage. The additional coverage shall be offered by the insurer at least annually as part of the coverage selection form applicable to the standard automobile insurance policy and required by section 17 of P.L. 1983, c. 362 (C. 39:6A-23). Income continuation in excess of that provided for in section 4 of P.L.1972, c.70 (C.39:6A-4) shall be provided as an option by insurers for disabilities, as long as the disability persists, up to an income level of $35,000.00 per year, provided that a. the excess between $5,200.00 and the amount of coverage contracted for shall be written on the basis of 75% of said difference, and b. regardless of the duration of the disability, the benefits payable shall not exceed the total maximum amount of income continuation benefits contracted for. Death benefits provided pursuant to this section shall be payable without regard to the period of time elapsing between the date of the accident and the date of death, if death occurs within two years of the accident and results from bodily injury from that accident to which coverage under this section applies. The Commissioner of Insurance is hereby authorized and empowered to establish, by rule or regulation, the amounts and terms of income continuation insurance to be provided pursuant to this section.

Adopted. L. 1972, c. 70, §10. **Amended.** L. 1972, c. 203, §8; L. 1981, c. 533, §1; L. 1985, c. 520, §16; L. 1990, c. 8, §11, effective March 12, 1990; L. 1998, c. 21, §14, approved May 19, 1998, to take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later.

39:6A-11. Contribution among insurers. If two or more insurers are liable to pay benefits under sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10) under a standard automobile insurance policy for the same bodily injury, or death, of any one person, the maximum amount payable shall be as specified in those sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10), section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) and section 45 of P.L.2003, c.89 (C.39:6A-3.3), respectively, if additional first party coverage applies and any insurer paying the benefits shall be entitled to recover from each of the other insurers, only by inter-company arbitration or inter-company agreement, an equitable pro-rata share of the benefits paid.

Adopted. L. 1972, c. 70, §11. **Amended.** L. 1998, c. 21, §15, approved May 19, 1998, to take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later; L. 2003, c. 89, §54, effective June 9, 2003.

39:6A-12. Inadmissibility of evidence of losses collectible under personal injury protection coverage. Except as may be required in an action brought pursuant to section 20 of P.L. 1983, c. 362 (C. 39:6A-9.1), evidence of the amounts collectible or paid under a standard automobile insurance policy pursuant to sections 4 and 10 of P.L. 1972, c. 70 (C.39:6A-4 and 39:6A-10), amounts collectible or paid for medical expense benefits under a basic automobile insurance policy pursuant to section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) and amounts collectible or paid for benefits under a special automobile insurance policy pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3), to an injured person, including the amounts of any deductibles, copayments or exclusions, including exclusions pursuant to subsection d. of section 13 of P.L. 1983, c. 362 (C. 39:6A-4.3), otherwise compensated is inadmissible in a civil action for recovery of damages for bodily injury by such injured person.

The court shall instruct the jury that, in arriving at a verdict as to the amount of the damages for noneconomic loss to be recovered by the injured person, the jury shall not speculate as to the amount of the medical expense benefits paid or payable by an automobile insurer under personal injury protection coverage payable under a standard automobile insurance policy pursuant to sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10), medical expense benefits under a basic automobile insurance policy pursuant to section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) or benefits under a special automobile insurance policy pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3) to the injured person, nor shall they speculate as to the amount of benefits paid or payable by a health insurer, health maintenance organization or governmental agency under subsection d. of section 13 of P.L. 1983, c. 362 (C. 39:6A-4.3).

[Publisher's Note: The following paragraph is effective for causes of action pending on August 15, 2019 or filed on or after that date. L. 2019, c. 244]

Nothing in this section shall be construed to limit the right of recovery, against the tortfeasor, of uncompensated economic loss as defined by subsection k. of section 2 of P.L. 1972, c. 70 (C. 39:6A-2), including all uncompensated medical expenses not covered by the personal injury protection limits applicable to the injured party and sustained by the injured party. All medical expenses that exceed, or are unpaid or uncovered by any injured party's medical expense benefits personal injury protection limits, regardless of any health insurance coverage, are claimable by any injured party as against all liable parties, including any self-funded health care plans that assert valid liens.

[Publisher's Note: The following paragraph is effective for all automobile accidents occurring on or after August 1, 2019. L. 2019, c. 245]

Nothing in this section shall be construed to limit the right of recovery, against the tortfeasor, of uncompensated economic loss as defined by subsection k. of section 2 of P.L.1972, c.70 (C.39:6A-2), including all unreimbursed medical expenses not covered by the personal injury protection limits applicable to the injured party and sustained by the injured party, including the value of any deductibles and copayments incurred through a driver's secondary insurance coverage and medical liens asserted by a health insurance company related to the treatment of injuries sustained in the accident. Medical expenses shall be subject to the current automobile medical fee schedules established pursuant to section 10 of P.L.1988, c.119 (C.39:6A-4.6). In any case in which the recovery is for medical expenses only, a prevailing claimant shall be entitled to reasonable and necessary attorneys' fees incurred by the prevailing claimant in the collection of such medical expenses.

Adopted. L. 1972, c. 70, §12. **Amended.** L. 1983, c. 362, §11; L. 1988, c. 119, §44; L. 1990, c. 8, §12, effective March 12, 1990; L. 1998, c. 21, §16, approved May 19, 1998, to take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12

of this act[39:6A-4.7], whichever is later; L. 2003, c. 89, §55, effective June 9, 2003; L. 2019, c. 244, §1, effective August 15, 2019, and shall apply to causes of action pending on that date or filed on or after that date; L. 2019, c. 245, §2, effective August 1, 2019, and shall apply to automobile accidents occurring on or after that date.

39:6A-13. Discovery of facts as to personal injury protection coverage. The following apply to personal injury protection coverage benefits payable under a standard automobile insurance policy pursuant to sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10), medical expense benefits payable under a basic automobile insurance policy pursuant to section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) and benefits payable under a special automobile insurance policy pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3):

a. Every employer shall, if a request is made by an insurer or the Unsatisfied Claim and Judgment Fund providing personal injury protection benefits under a standard automobile insurance policy or medical expense benefits payable under a basic automobile insurance policy against whom a claim has been made, furnish forthwith, in a form approved by the Commissioner of Banking and Insurance, a signed statement of the lost earnings since the date of the bodily injury and for a reasonable period before the injury, of the person upon whose injury the claim is based.

b. Every physician, hospital, or other health care provider providing, before and after the bodily injury upon which a claim for personal injury protection benefits or medical expense benefits is based, any products, services or accommodations in relation to such bodily injury or any other injury, or in relation to a condition claimed to be connected with such bodily injury or any other injury, shall, if requested to do so by the insurer or the Unsatisfied Claim and Judgment Fund against whom the claim has been made, furnish forthwith a written report of the history, condition, treatment, dates and costs of such treatment of the injured person, and produce forthwith and permit the inspection and copying of his or its records regarding such history, condition, treatment dates and costs of treatment. The person requesting such records shall pay all reasonable costs connected therewith.

c. The injured person shall be furnished upon demand a copy of all information obtained by the insurer or the Unsatisfied Claim and Judgment Fund under the provisions of this section, and shall pay a reasonable charge, if required by the insurer and the Unsatisfied Claim and Judgment Fund.

d. Whenever the mental or physical condition of an injured person covered by personal injury protection under a standard automobile insurance policy or medical expense benefits under a basic automobile insurance policy is material to any claim that has been or may be made for such past or future personal injury protection benefits or medical expense benefits, such person shall, upon request of an insurer or the Unsatisfied Claim and Judgment Fund submit to mental or physical examination conducted by a health care provider licensed in this State in the same profession or specialty as the health care provider whose services are subject to review under this section and who is located within a reasonable proximity to the injured person’s residence. The injured person shall provide or make available to the provider any pertinent medical records or medical history that the provider deems necessary to the examination. The costs of any examinations requested by an insurer or the Unsatisfied Claim and Judgment Fund shall be borne entirely by whomever makes such request. Such examination shall be conducted within the municipality of residence of the injured person. If there is no qualified health care provider to conduct the examination within the municipality of residence of the injured person, then such examination shall be conducted in an area of the closest proximity to the injured person’s residence. Insurers providing personal injury protection coverage under a standard automobile insurance policy or medical expense benefits under a basic automobile insurance policy are authorized to include reasonable provisions requiring those claiming personal injury protection

coverage benefits or medical expense benefits to submit to mental or physical examination as requested by an insurer or the Unsatisfied Claim and Judgment Fund pursuant to the provisions of this section. Failure to submit to a mental or physical examination requested by an insurer or the Unsatisfied Claim and Judgment Fund pursuant to the provisions of this section shall subject the injured person to certain limitations in coverage as specified in regulations promulgated by the commissioner.

e. If requested by the person examined, a party causing an examination to be made, shall deliver to him a copy of every written report concerning the examination rendered by an examining health care provider, at least one of which reports must set out his findings and conclusions in detail. After such request and delivery, the party causing the examination to be made is entitled upon request to receive from the person examined every written report available to him, or his representative, concerning any examination, previously or thereafter made of the same mental or physical condition.

f. The injured person, upon reasonable request by the insurer or the Unsatisfied Claim and Judgment Fund, shall sign all forms, authorizations or releases for information, approved by the Commissioner of Banking and Insurance, which may be necessary to the discovery of the above facts, in order to reasonably prove the injured person's losses.

g. In the event of any dispute regarding an insurer's or the Unsatisfied Claim and Judgment Fund's or an injured person's right as to the discovery of facts about the injured person's earnings or about his history, condition, treatment, dates and costs of such treatment, or the submission of such injured person to a mental or physical examination subject to the provisions of this section, the insurer, Unsatisfied Claim and Judgment Fund or the injured person may petition a court of competent jurisdiction for an order resolving the dispute and protecting the rights of all parties. The order may be entered on motion for good cause shown giving notice to all persons having an interest therein. Such court may protect against annoyance, embarrassment or oppression and may as justice requires, enter an order compelling or refusing discovery, or specifying conditions of such discovery; the court may further order the payment of costs and expenses of the proceeding, as justice requires.

Adopted. L. 1972, c. 70, §13. **Amended.** L. 1993, c. 186, §1, effective July 16, 1993; L. 1998, c. 21, §17, approved May 19, 1998, to take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later; L. 2003, c. 89, §56, effective June 9, 2003.

39:6A-13.1. Statute of limitations. a. Every action for the payment of benefits payable under a standard automobile insurance policy pursuant to sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10), medical expense benefits payable under a basic automobile insurance policy pursuant to section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) or benefits payable under a special automobile insurance policy pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3), except an action by a decedent's estate, shall be commenced not later than two years after the injured person or survivor suffers a loss or incurs an expense and either knows or in the exercise of reasonable diligence should know that the loss or expense was caused by the accident, or not later than four years after the accident whichever is earlier, provided, however, that if benefits have been paid before then an action for further benefits may be commenced not later than two years after the last payment of benefits.

b. Every action by a decedent's estate for the payment of benefits provided under a standard automobile insurance policy pursuant to sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10), medical expense benefits provided under a basic automobile insurance policy pursuant to section 4 of P.L. 1998, c. 21 (C.39:6A-3.1)

or benefits payable under a special automobile insurance policy pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3), shall be commenced not later than two years after death or four years after the accident from which death results, whichever is earlier, provided, however, that if benefits had been paid to the decedent prior to his death then an action may be commenced not later than two years after his death or four years after the last payment of benefits, whichever is earlier, provided, further, that if the decedent's estate has received benefits before then an action for further benefits shall be commenced not later than two years from the last payment of benefits.
Adopted. L. 1972, c. 203, §11. **Amended.** L. 1998, c. 21, §18, approved May 19, 1998, to take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later; L. 2003, c. 89, §57, effective June 9, 2003.

39:6A-13.2. Disclosure of policy limits. a. An insurer who receives a request, from an attorney admitted to the practice of law in this State, for disclosure of the policy limits under a private passenger automobile insurance policy issued by the insurer to an insured, shall provide written disclosure of the policy limits to the attorney no later than 30 days from receipt of the request. The disclosure shall indicate the limits of all private passenger automobile insurance policies and any applicable umbrella or excess liability insurance policies issued by the insurer to the insured.

b. A request for disclosure of policy limits shall be in writing and shall include:

(1) a statement that the attorney represents an individual who has suffered bodily injury or death alleged to be caused by a motor vehicle accident with an insured under a private passenger automobile insurance policy issued by the insurer;

(2) the name and last known address of the insured;

(3) the date and approximate time of the motor vehicle accident;

(4) a copy of the accident report, if available, relating to the motor vehicle accident; and

(5) a statement from the claimant, or an attorney representing the claimant, providing insurance information, which shall include the claimant's:

(a) insurer, policy number, and policyholder name;

(b) tort threshold selection; and

(c) personal injury protection coverage limit.

c. Disclosure of policy limits under this section shall not constitute an admission that the alleged injury or damage is subject to the policy.

d. Information concerning the insurance policy shall not be admissible as evidence at trial by reason of disclosure pursuant to this section. The disclosure shall be confidential and available only to the individual injured and the attorney representing the injured person and personnel in the office of the attorney.

e. The Department of Banking and Insurance shall publish on its website the email address of each insurer, which shall be supplied by each insurer issuing private passenger automobile policies in this State, for the purpose of receiving requests for policy limit disclosures pursuant to this section.
Adopted. L. 2021, c. 177, §1, effective July 22, 2021, except subsection e. shall take effect September 20, 2021

. **39:6A-14. Compulsory uninsured motorist protection.** Every owner or registrant of an automobile registered or principally garaged in this state shall maintain uninsured motorist coverage as provided in P.L. 1968, c. 385 (C. 17:28-1.1).
Adopted. L. 1972, c. 70, §14.

39:6A-15. Penalties for false and fraudulent representation. In any claim or action arising for benefits payable under a standard automobile insurance policy under section 4 of P.L.1972, c.70 (C.39:6A-4), any claim or action arising for medical expense benefits payable under a basic automobile insurance policy under section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) or any claim or action arising for benefits payable under a special automobile insurance policy pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3) wherein any person obtains or attempts to obtain from any other person, insurance company or Unsatisfied Claim and Judgment Fund any money or other thing of value by (1) falsely or fraudulently representing

that the person is entitled to the benefits; (2) falsely and fraudulently making statements or presenting documentation in order to obtain or attempt to obtain the benefits; or (3) cooperates, conspires or otherwise acts in concert with any person seeking to falsely or fraudulently obtain, or attempt to obtain, the benefits may upon conviction be fined not more than $5,000, or imprisoned for not more than three years or both, or in the event the sum so obtained or attempted to be obtained is not more than $500, may upon conviction, be fined not more than $500, or imprisoned for not more than six months or both, as a disorderly person.

In addition to any penalties imposed by law, any person who is either found by a court of competent jurisdiction to have violated any provision of P.L.1983 c.320 (C.17:33A-1 et seq.) pertaining to automobile insurance or been convicted of any violation of Title 2C of the New Jersey Statutes arising out of automobile insurance fraud based on a claim for damages arising out of a motor vehicle accident shall not operate a motor vehicle over the highways of this State for a period of one year from the date of judgment or conviction.

Adopted. L. 1972, c. 70, §15. **Amended.** L. 1973, c. 298, §1; L. 1997, c. 151, §9, effective June 30, 1997; L. 1998, c. 21, §19, approved May 19, 1998, to take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later; L. 2003, c. 89, §58, effective June 9, 2003; L. 2019, c. 276, §16, effective January 1, 2021.

39:6A-16. Construction and severability. This act shall be liberally construed so as to effect the purpose thereof. The provisions of this act shall be severable and if any phrase, clause, sentence or provision of this act is declared to be contrary to the constitution of this state or of the United States or the applicability thereof to any person, government, agency or circumstance is held invalid, the validity of the remainder of this act and the applicability thereof to any person, government, agency or circumstance shall not be affected thereby.

Adopted. L. 1972, c. 70, §16.

39:6A-17. General repeal of inconsistent statutory provisions. All laws or parts of laws which are inconsistent with the provisions of this act are repealed and superseded to the extent of such inconsistency.

Adopted. L. 1972, c. 70, §17.

39:6A-18. Reduction of rates. Bodily injury insurance rates in effect on July 1, 1972 shall be reduced by at least 15% and shall become effective upon the effective date of this act.

Adopted. L. 1972, c. 70, §18.

39:6A-19. Rules and regulations by commissioner of insurance. The commissioner of insurance is hereby authorized and empowered to prescribe, adopt, promulgate, rescind and enforce such reasonable rules and regulations as may be required to effectuate the purposes of this act.

Adopted. L. 1972, c. 203, §9.

39:6A-20. Powers of commissioner of insurance. For the purpose of implementing and enforcing this act, the commissioner of insurance shall possess all of those general powers as enumerated in Title 17 of the Revised Statutes.

Adopted. L. 1972, c. 203, §10.

39:6A-21. The New Jersey Automobile Insurance Risk Exchange: membership, board of directors. There shall be created, within 45 days of the operative date of this act, an unincorporated association, to operate on a nonprofit-nonloss basis, to be known as the New Jersey Automobile Insurance Risk Exchange, with its headquarters to be located within the State of New Jersey. Every insurer licensed to transact private-passenger automobile insurance in this State shall be a member of the exchange and shall be bound by the rules of the exchange as a condition of the authority to transact insurance business in this State. Any insurer which ceases to transact automobile insurance business in this State shall remain liable for any

amounts due to the exchange for business transacted prior to the effective date of its cessation of business in the State.

The exchange shall adopt a plan of operation which shall become effective upon approval by the Commissioner of Banking and Insurance. The business affairs of the exchange shall be governed by a board of directors to be comprised of 12 members. Nine members shall be appointed, from a list of names submitted by the Commissioner of Banking and Insurance, by the Governor, with the advice and consent of the Senate, of whom two shall represent the Property Casualty Insurers Association of America, or its successor organization; two shall represent the American Insurance Association, or its successor organization; two shall represent the independent companies; two shall represent New Jersey domiciled insurance companies as nominated to the commissioner by the exchange; and one shall be a public member. If no name is submitted by an aforementioned association or company to serve as its representative on the board of the exchange, the exchange shall submit to the commissioner the name of an individual employed by an insurer transacting automobile insurance in this State. Additionally, the Governor, the Speaker of the General Assembly and the President of the Senate shall each appoint one public member. The board shall elect a chairman who shall be a representative of an insurer domiciled in New Jersey. No insurer shall represent more than one organization on the board of directors of the exchange.

All appointments made on or after the effective date of this amendatory act shall be for five-year terms. A director shall serve until his successor is appointed. Vacancies on the board of directors of the exchange shall be filled for the remainders of the terms in the same manner as the original appointments. Public members shall be compensated in an amount to be determined by the commissioner, and shall be reimbursed for necessary expenses actually incurred in the performance of their duties. All expenses incurred by the board shall be payable from moneys collected by the exchange.

Adopted. L. 1983, c. 362, §15. **Amended.** L. 1985, c. 520, §10; L. 2000, c. 66, §1, effective July 13, 2000; L. 2007, c. 72, §1, effective April 30, 2007.

39:6A-22. Powers of exchange. a. The exchange shall be empowered to raise sufficient monies to (1) pay its operating expenses, and (2) to compensate members of the exchange for claims paid for noneconomic loss, and associated claim adjustment expenses, which would not have been incurred had the tort limitation option provided in subsection b. of section 8 of P.L. 1972, c. 70 (C. 39:6A-8) or, in the case of policies issued or renewed on or after January 1, 1989, subsection a. of section 8 of P.L. 1972, c. 70 (C. 39:6A-8), been elected by the injured party filing the claim for noneconomic loss.

b. In order to enable the exchange to meet its obligations under subsection a. of this section, every member insurer or servicing carrier of the New Jersey Automobile Full Insurance Underwriting Association, shall forward on a monthly basis, within 15 days of the close of the member's accounting month, a charge, to be known as the AIRE charge, in an amount and manner to be prescribed by the board of directors.

AIRE charge amounts required to be paid to the exchange in accordance with this subsection shall, in the case of those amounts determined by the board of directors to be applicable during the period from July 1, 1984 to the effective date of P.L. 1985, c. 520, be paid to the exchange within 60 days of that date.

A 10% per annum penalty charge shall be assessed by the exchange on any overdue AIRE charges.

c. The board of directors shall establish guidelines by which members or servicing carriers and the exchange may verify the tort limitation options elected by claimants.

d. Moneys collected by or otherwise available to the exchange shall be invested as hereinafter provided in section 12 of P.L. 1985, c. 520 (C. 39:6A-22.1).

e. The exchange shall have such powers as may be necessary or appropriate to effectuate the purposes of the exchange.

Adopted. L. 1983, c. 362, §16. **Amended.** L. 1985, c. 520, §11; L. 1988, c. 119, §31.

39:6A-22.1. Investment; report. Moneys collected by or available to the exchange shall be invested by the board of directors in accordance with the liabilities of the fund and the statutory limitations on insurer investments in Title 17 of the Revised Statutes; except that the board shall invest moneys of the exchange in New Jersey or in equity securities or debt obligations of businesses incorporated in New Jersey for operations

in the State, if at least equivalent to any alternative investment opportunities outside New Jersey, with respect to risk exposure, rates of return and other investment objectives established by the board.

The exchange shall at least annually file a report with the Commissioner of Insurance and the chairmen of the Assembly Banking and Insurance Committee and the Senate Labor, Industry and Professions Committee, or the successors of those committees, setting forth, among other things, the income, claims and investment experience of the exchange. The commissioner shall prescribe, by regulation, the contents and form of the report.

Adopted. L. 1985, c. 520, §12.

39:6A-23. Written notice - buyer's guide and coverage selection form. a. No new automobile insurance policy shall be issued on or after the 180th day following the effective date of P.L. 1985, c. 520, unless the application for the policy is accompanied by a written notice identifying and containing a buyer's guide and coverage selection form. The buyer's guide shall contain a brief description of all available policy coverages and benefit limits, and shall identify which coverages are mandatory and which are optional under State law, as well as all options offered by the insurer.

The buyer's guide shall also contain a statement on the possible coordination of other health benefit coverages with the personal injury protection coverage options, the form and contents of which shall be prescribed by the Commissioner of Insurance.

The coverage selection form shall identify the range of premium rate credit or dollar savings, or both, and shall provide any other information required by the commissioner by regulation.

The applicant shall indicate the options elected on the coverage selection form which shall be signed and returned to the insurer.

b. (Deleted by amendment, P.L. 1985, c. 520).

c. Any notice of renewal of an automobile insurance policy with an effective date subsequent to July 1, 1984, shall be accompanied by a written notice of all policy coverage information required to be provided under subsection a. of this section.

The Commissioner of Insurance shall, within 45 days following the effective date of this act, promulgate standards for the written notice and buyer's guide required to be provided under this section.

d. Written notices provided by any insurer writing at least 2% of the New Jersey private passenger automobile market, including the New Jersey Automobile Full Insurance Underwriting Association established pursuant to section 16 of P.L. 1983, c. 65 (C. 17:30E-4), shall also contain a statement advising that if the insured or applicant has any questions concerning his automobile insurance policy, including questions as to coverage or premiums, he may contact his producer, or the company directly, by using a toll free number which shall be set forth in the notice. Written notice shall be given to all insureds of any change in the toll free number.

e. A properly completed and executed coverage selection form shall be prima facie evidence of the named insured's knowing election or rejection of any option.

f. Each named insured of an automobile insurance policy shall, at least annually or as otherwise ordered by the commissioner, receive a buyer's guide and coverage selection form.

g. On and after January 1, 1991, each buyer's guide and coverage selection form shall be written in plain language.

Adopted. L. 1983, c. 362, §17. **Amended.** L. 1985, c. 520, §5; L. 1988, c. 119, §35; L. 1990, c. 8, §13, effective March 12, 1990.

39:6A-23.1. Publication of representative sample of premiums charged in each territory. Within nine months of the effective date of this 1988 amendatory and supplementary act, the Commissioner of Insurance shall cause to have published a representative sample of the premiums being charged by insurers in each territory to facilitate price comparison by insureds or prospective insureds who are seeking new coverage. The commissioner may act to make comparative premium data available to all insureds and prospective insureds.

Adopted. L. 1988, c. 119, §36.

39:6A-24. Legislative purpose to establish settlement process for automobile tort claims. The purpose and intent of this act is to establish an informal system of settling tort claims arising out of automobile accidents in an expeditious, and least costly manner, and to ease the burdens and congestion of the State's courts.
Adopted. L. 1983, c. 358, §1.

39:6A-25. Arbitration of certain claims. a. Any cause of action filed in the Superior Court after the operative date of this act, for the recovery of noneconomic loss, as defined in section 2 of P.L. 1972, c. 70 (C. 39:6A-2), or the recovery of uncompensated economic loss, other than for damages to property, arising out of the operation, ownership, maintenance or use of an automobile, as defined in that section 2, shall be submitted, except as hereinafter provided, to arbitration by the assignment judge of the court in which the action is filed, if the court determines that the amount in controversy is $15,000.00 or less, exclusive of interest and costs; provided that if the action is for recovery for both noneconomic and economic loss, the controversy shall be submitted to arbitration if the court determines that the amount in controversy for noneconomic loss is $15,000.00 or less, exclusive of interest and costs.

b. Notwithstanding that the amount in controversy of an action for noneconomic loss is in excess of $15,000.00, the court may refer the matter to arbitration, if all of the parties to the action consent in writing to arbitration and the court determines that the controversy does not involve novel legal or unduly complex factual issues.

No cause of action determined by the court to be, upon proper motion of any party to the controversy, frivolous, insubstantial or without actionable cause shall be submitted to arbitration.

The provisions of this section shall not apply to any controversy on which an arbitration decision was rendered prior to the filing of the action.

The provisions of this section shall apply to any cause of action, subject to this section, filed prior to the operative date of this act, if a pretrial conference has not been concluded thereon.
Adopted. L. 1983, c. 358, §2.

39:6A-26. Statute of limitations tolled. Submission of a controversy to arbitration shall toll the statute of limitations for filing an action until the filing of the arbitration decision in accordance with section 7 [39:6A-30] of this act.
Adopted. L. 1983, c. 358, §3.

39:6A-27. Selection of arbitrators. a. The number or selection of arbitrators may be stipulated by mutual consent of all of the parties to the action, which stipulation shall be made in writing prior to or at the time notice is given that the controversy is to be submitted to arbitration. The assignment judge shall approve the arbitrators agreed to by the parties, whether or not the designated arbitrators satisfy the requirements of subsection b. of this section, upon a finding that the designees are qualified and their serving would not prejudice the interest of any of the parties.

b. If the parties fail to stipulate the number or names of the arbitrators, the arbitrators shall be selected, in accordance with the rules of court adopted by the Supreme Court of New Jersey, from a list of arbitrators compiled by the assignment judge, to be comprised of retired judges and qualified attorneys in this State with at least seven years negligence experience and recommended by the county or State bar association.
Adopted. L. 1983, c. 358, §4.

39:6A-28. Court rules to govern arbitrator compensation, attorney's fees, offers of judgment. Compensation for arbitrators shall be set by the rules of the Supreme Court of New Jersey. The Supreme Court may also establish a schedule of fees for attorneys representing the parties to the dispute and for witnesses in arbitration proceedings. Attorney's fees may exceed these limits upon application made to the assignment judge in accordance with the rules of the court for the purpose of determining a reasonable fee in the light of all the circumstances.

The Supreme Court may adopt rules governing offers of judgment by the claimant or defendant prior to the start of arbitration, including the assessment of the costs of arbitration proceedings and attorney's fees, where an offer is made but refused by the other party to the controversy.
Adopted. L. 1983, c. 358, §5.

39:6A-29. Subpoenas. The arbitrators may, at their initiative or at the request of any party to the arbitration, issue subpoenas for the attendance of witnesses and the production of books, records, documents and other evidence. Subpoenas shall be served and shall be enforceable in the manner provided by law.
Adopted. L. 1983, c. 358, §6.

39:6A-30. Award. Notwithstanding that a controversy was submitted pursuant to subsection a. of section 2 of this act [39:6A-25], the arbitration award for noneconomic loss may exceed $15,000.00. The arbitration decision shall be in writing, and shall set forth the issues in controversy, and the arbitrators' findings and conclusions of law and fact.
Adopted. L. 1983, c. 358, §7.

39:6A-31. Confirmation. Unless one of the parties to the arbitration petitions the court, within 30 days of the filing of the arbitration decision with the court, a. for a trial de novo, or b. for the modification or vacation of the arbitration decision for any of the reasons set forth in chapter 24 of Title 2A of the New Jersey Statutes, or an error of law or factual inconsistencies in the arbitration findings, the court shall, upon motion of any of the parties, confirm the arbitration decision, and the action of the court shall have the same effect and be enforceable as a judgment in any other action.
Adopted. L. 1983, c. 358, §8.

39:6A-32. Trial de novo, arbitrator fees. Except in the case of an arbitration decision vacated by the court or offers of judgment made pursuant to court rules, the party petitioning the court for a trial de novo shall pay to the court a trial de novo fee in an amount established pursuant to the Rules of Court, which shall be utilized by the judiciary to pay the costs of arbitration including the fees of the arbitrators.
Adopted. L. 1983, c. 358, §9. **Amended.** L. 1993, c. 88, §1, effective March 19, 1993.

39:6A-33. Trial de novo, use of prior proceedings. No statements, admissions or testimony made at the arbitration proceedings, nor the arbitration decision, as confirmed or modified by the court, shall be used or referred to at the trial de novo by any of the parties, except that the court may consider any of those matters in determining the amount of any reduction in assessments made pursuant to section 11 [39:6A-34] of this act.
Adopted. L. 1983, c. 358, §10.

39:6A-34. Trial de novo, costs. The party having filed for a trial de novo shall be assessed court costs and other reasonable costs of the other party to the judicial proceeding, including attorney's fees, investigation expenses and expenses for expert or other testimony or evidence, which amount shall be, if the party assessed the costs is the one to whom the award is made, offset against any damages awarded to that party by the court, and only to that extent; except that if the judgment is more favorable to the party having filed for a trial de novo, the court may reduce or eliminate the amount of the assessment in accordance with the extent to which the decision of the court is more favorable to that party than the arbitration decision, and as best serves the interest of justice. The court may waive an assessment of costs required by this section upon a finding that the imposition of costs would create a substantial economic hardship as not to be in the interest of justice.
Adopted. L. 1983, c. 358, §11.

39:6A-35. Duties of Supreme Court; Administrative Office of the Courts. The Supreme Court of New Jersey shall adopt rules of court appropriate or necessary to effectuate the purpose of this act. The Administrative Office of the Courts shall not later than March 1 of each year file with the Governor and

Legislature a report on the impact of the implementation of this act on automobile insurance settlement practices and costs, and on court calendars and workload.
Adopted. L. 1983, c. 358, §12.

Chapter 6B. COMPULSORY MOTOR VEHICLE INSURANCE.

Section

39:6B-1. Maintenance of motor vehicle liability insurance coverage. a. Every owner or registered owner of a motor vehicle registered or principally garaged in this State shall maintain motor vehicle liability insurance coverage, under provisions approved by the Commissioner of Banking and Insurance, 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, maintenance, operation or use of a motor vehicle wherein such coverage shall be at least in: (1) an amount or limit of $15,000 for plans issued or renewed prior to January 1, 2023, $25,000 for plans issued or renewed on or after January 1, 2023 but prior to January 1, 2026, and $35,000 for plans issued or renewed on or after January 1, 2026, exclusive of interest and costs, on account of injury to, or death of, one person, in any one accident; and (2) an amount or limit, subject to such limit for any one person so injured or killed, of $30,000 for plans issued or renewed prior to January 1, 2023, $50,000 for plans issued or renewed on or after January 1, 2023 but prior to January 1, 2026, and $70,000 for plans issued or renewed on or after January 1, 2026, exclusive of interest and costs, on account of injury to or death of, more than one person, in any one accident; and (3) an amount or limit of $25,000 for plans issued or renewed on or after January 1, 2023, exclusive of interest and costs, for damage to property in any one accident; and (4) for a commercial motor vehicle, an amount or limit of $1,500,000, exclusive of interest and costs, on account of injury to or death of, one or more persons in any one accident or for damage to property in any one accident; and (5) for a commercial motor vehicle with a gross vehicle weight rating of 10,001 or more pounds but less than 26,001 pounds, an amount or limit of $300,000, exclusive of interest and costs, on account of injury to or death of, one or more persons in any one accident or for damage to property in any one accident. The provisions of paragraphs (4) and (5) of this subsection may be satisfied by a commercial automobile insurance policy, fleet insurance policy, commercial umbrella insurance policy, commercial excess insurance policy, similar insurance policy, or any combination thereof.

b. Notwithstanding the provisions of subsection a. of this section, an owner or registered owner of an automobile, as defined in section 2 of P.L.1972, c.70 (C.39:6A-2), registered or primarily garaged in the State may satisfy the requirements of subsection a. of this section by maintaining a basic automobile insurance policy containing coverages provided pursuant to subsections a. and b. of section 4 of P.L.1998, c.21 (C.39:6A-3.1).

c. Notwithstanding the provisions of subsection a. of this section, an owner or registered owner of an automobile, as defined in section 2 of P.L.1972, c.70 (C.39:6A-2), registered or primarily garaged in the State may satisfy the requirements of subsection a. of this section by maintaining a special automobile insurance policy containing coverages provided pursuant to subsection b. of section 45 of P.L.2003, c.89 (C.39:6A-3.3).

d. Upon the renewal of a policy of insurance that, under its original policy limits, would no longer meet the minimum requirements established pursuant to this section, an insurer shall notify the named insured that the policy limits have been increased to meet the requirements established pursuant to this section. Notice provided pursuant to this subsection shall specify the limit or limits that have been increased to meet the requirements established pursuant to this section. Notwithstanding the provisions of any law, rule, or regulation to the contrary, an insurer shall not be required to receive a

signed coverage selection form pursuant to N.J.A.C.11:3-15.7, to increase a policy's limits pursuant to this section.

e. As used in this section, "commercial motor vehicle" means a commercial motor vehicle as defined pursuant to section 3 of P.L.1990, c.103 (C.39:3-10.11) and an autocab as defined pursuant to R.S.48:16-1, and shall include commercially registered vehicles. For purposes of paragraph (5) of subsection a. of this section, "commercial motor vehicle" shall also include commercially registered vehicles with a gross vehicle weight rating of 10,001 or more pounds but less than 26,001 pounds.

Adopted. L. 1972, c. 197, §1. **Amended.** L. 1998, c. 21, §20, approved May 19, 1998, to take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later; L. 2003, c. 89, §60, effective June 9, 2003; L. 2022, c. 87, §2, effective August 5, 2022; L. 2023, c. 276, §1, effective July 1, 2024, and shall apply to all automobile insurance policies initiated or renewed on or after that date.

39:6B-1.1. Insurer to provide written disclosure of policy limits, circumstances, certain; requirements for request. a. An insurer who receives a request, from an attorney admitted to the practice of law in this State, for disclosure of the policy limits under an insurance policy issued by the insurer to an insured, shall provide written disclosure of the policy limits to the attorney no later than 30 days from receipt of the request. The disclosure shall indicate the limits of all applicable insurance policies and any applicable umbrella or excess liability insurance policies issued by the insurer to the insured.

b. A request for disclosure of policy limits shall be in writing and shall include:

(1) a statement that the attorney represents an individual who has suffered bodily injury or death alleged to be caused by an accident with an insured under an insurance policy issued by the insurer, entity, or business;

(2) the name and last known address of the insured;

(3) the date and approximate time of the accident;

(4) a copy of the accident report, if available, relating to the accident; and

(5) in the case of a motor vehicle accident, a statement from the claimant, or an attorney representing the claimant, providing insurance information, which shall include the claimant's:

(a) insurer, policy number, and policyholder name;

(b) tort threshold selection; and

(c) personal injury protection coverage limit.

c. Disclosure of policy limits under this section shall not constitute an admission that the alleged injury or damage is subject to the policy.

d. Information concerning the insurance policy shall not be admissible as evidence at trial by reason of disclosure pursuant to this section. The disclosure shall be confidential and available only to the individual injured and the attorney representing the injured person and personnel in the office of the attorney.

e. The Department of Banking and Insurance shall publish on its website the email address of each insurer, which shall be supplied by each insurer issuing applicable policies in this State, for the purpose of receiving requests for policy limit disclosures pursuant to this section.

Adopted. L. 2022, c. 95, §1, effective August 5, 2022, except subsection e. shall take effect on the 60th day next following enactment.

39:6B-2. Penalties. a. An owner or registrant of a motor vehicle registered or principally garaged in this State who operates or causes to be operated a motor vehicle upon any public road or highway in this State without motor vehicle liability insurance coverage required by P.L.1972, c.197 (C.39:6B-1 et seq.), and an operator who operates or causes a motor vehicle to be operated and who knows or should know from the attendant circumstances that the motor vehicle is without motor vehicle liability insurance coverage required by P.L.1972, c.197[chapter] (C.39:6B-1 et seq.) shall be subject, for the first offense, to a fine of not less than $300 nor more than $1,000 and a period of community service to be determined by the court. The court, in its discretion, also may suspend the person's right to operate a motor vehicle over the highways of

this State for a period of up to one year from the date of conviction; provided, however, the period of license suspension may be reduced or eliminated if the person provides the court with satisfactory proof of motor vehicle liability insurance at the time of the hearing. Upon subsequent conviction, the person shall be subject to a fine of up to $5,000 and shall be subject to imprisonment for a term of 14 days and shall be ordered by the court to perform community service for a period of 30 days, which shall be of a form and on terms as the court shall deem appropriate under the circumstances, and the court, in its discretion, may suspend the person's right to operate a motor vehicle over the highways of this State for a period of up to two years from the date of the conviction. In deciding the duration of the any suspension of the person's right to operate a motor vehicle pursuant to this section, the court shall consider the circumstances of the violation and whether the loss of driving privileges will result in extreme hardship and alternative means of transportation are not readily available. After the expiration of the suspension, the person may make application to the Chief Administrator of the New Jersey Motor Vehicle Commission for a license to operate a motor vehicle, which application may be granted at the discretion of the chief administrator. The chief administrator's discretion shall be based upon an assessment of the likelihood that the individual will operate or cause a motor vehicle to be operated in the future without the insurance coverage required by this act [chapter]. A complaint for violation of this act [chapter] may be made to a municipal court at any time within six months after the date of the alleged offense.

Failure to produce at the time of trial an insurance identification card or an insurance policy which was in force for the time of operation for which the offense is charged creates a rebuttable presumption that the person was uninsured when charged with a violation of this section.

Adopted. L. 1972, c. 197, §2. **Amended.** L. 1983, c. 141, §1; L. 1987, c. 46, §1; L. 1988, c. 156, §15; L. 1990, c. 8, §49, effective March 12, 1990; L. 1997, c. 151, §12, effective June 30, 1997; L. 2013, c. 237, §1, effective January 17, 2014; L. 2019, c. 276, §17, effective January 1, 2021.

39:6B-3. The Uninsured Motorist Prevention Fund. The Uninsured Motorist Prevention Fund (hereinafter referred to as the "fund") is established as a nonlapsing, revolving fund into which shall be deposited all revenues from the fines imposed pursuant to section 2 of P.L. 1972, c. 197 (C. 39:6B-2) and $25 from each fine imposed pursuant to R.S.39:3-29. Interest received on moneys in the fund shall be credited to the fund. The fund shall be administered by the Division of Motor Vehicles in the Department of Transportation. Moneys in the fund shall be allocated and used for the purpose of the administrative expenses of the fund and enforcement of the compulsory motor vehicle insurance law, P.L. 1972, c. 197 (C. 39:6B-1 et seq.) by the Division of Motor Vehicles.

Adopted. L. 1983, c. 141, §2. **Amended.** L. 2003, c. 89, §80, effective June 9, 2003.

INSURANCE PROVISIONS

Section

17:28-1.1. Required coverage; exceptions. a. Except for a basic automobile insurance policy, no motor vehicle liability policy or renewal of such policy of insurance, including a standard liability policy for an automobile as defined in section 2 of P.L.1972, c.70 (C.39:6A-2), insuring against loss resulting from liability imposed by law for bodily injury or death, sustained by any person arising out of the ownership, maintenance or use of a motor vehicle, shall be issued in this State with respect to any

motor vehicle registered or principally garaged in this State unless it includes coverage in limits for bodily injury or death as follows:

(1) an amount or limit of $15,000 for plans issued or renewed prior to January 1, 2023, $25,000 for plans issued or renewed on or after January 1, 2023 but prior to January 1, 2026, and $35,000 for plans issued or renewed on or after January 1, 2026, exclusive of interest and costs, on account of injury to, or death of, one person, in any one accident, and

(2) an amount or limit, subject to such limit for any one person so injured or killed, of $30,000 for plans issued or renewed prior to January 1, 2023, $50,000 for plans issued or renewed on or after January 1, 2023 but prior to January 1, 2026, and $70,000 for plans issued or renewed on or after January 1, 2026, exclusive of interest and costs, on account of injury to or death of more than one person, in any one accident, under provisions approved by the Commissioner of Banking and Insurance, for payment of all or part of the sums which the insured or his legal representative shall be legally entitled to recover as damages from the operator or owner of an uninsured motor vehicle, underinsured motor vehicle, or hit and run motor vehicle, as defined in section 18 of P.L.1952, c.174 (C.39:6-78), because of bodily injury, sickness or disease, including death resulting therefrom, sustained by the insured, caused by accident and arising out of the ownership, maintenance, operation or use of such uninsured, underinsured or hit and run motor vehicle anywhere within the United States or Canada; except that uninsured motorist coverage shall provide that in order to recover for non-economic loss, as defined in section 2 of P.L.1972, c.70 (C.39:6A-2), for accidents to which the benefits of section 4 (C.39:6A-4) of that act apply, the tort option elected pursuant to section 8 (C.39:6A-8) of that act shall apply to that injured person.

All motor vehicle liability policies, except basic automobile insurance policies, shall also include coverage for the payment of all or part of the sums which persons insured thereunder shall be legally entitled to recover as damages from owners or operators of uninsured and underinsured motor vehicles, other than hit and run motor vehicles, because of injury to or destruction to the personal property of such insured, with a limit in the aggregate for all insurers involved in any one accident of $25,000 for plans issued or renewed on or after January 1, 2023, and subject, for each insured, to an exclusion of the first $500.00 of such damages.

b. Uninsured and underinsured motorist coverage shall be provided, as an option by an insurer to the named insured electing a standard automobile insurance policy, up to at least the following limits: $250,000.00 each person and $500,000.00 each accident for bodily injury; $100,000.00 each accident for property damage or $500,000.00 single limit, subject to an exclusion of the first $500.00 of such damage to property for each accident, except that 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.

Rates for uninsured and underinsured motorist coverage for the same limits shall, for each filer, be uniform on a Statewide basis without regard to classification or territory.

c. Uninsured and underinsured motorist coverage provided for in this section 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.

d. Uninsured and underinsured motorist coverage shall be subject to the policy terms, conditions and exclusions approved by the Commissioner of Banking and Insurance, including, but not limited to, unauthorized settlements, non-duplication of coverage, subrogation and arbitration.

e. For the purpose of this section, (1) "underinsured motorist coverage" means insurance for damages because of bodily injury and property damage resulting from an accident arising out of the ownership, maintenance, operation or use of an

underinsured motor vehicle. Underinsured motorist coverage shall not apply to an uninsured motor vehicle. A motor vehicle is underinsured when the sum of the limits of liability under all bodily injury and property damage liability bonds and insurance policies available to a person against whom recovery is sought for bodily injury or property damage is, at the time of the accident, less than the applicable limits for underinsured motorist coverage afforded under the motor vehicle insurance policy held by the person seeking that recovery. A motor vehicle shall not be considered an underinsured motor vehicle under this section unless the limits of all bodily injury liability insurance or bonds applicable at the time of the accident have been exhausted by payment of settlements or judgments. The limits of underinsured motorist coverage available to an injured person shall be reduced by the amount he has recovered under all bodily injury liability insurance or bonds;

(2) "uninsured motor vehicle" means:

(a) a motor vehicle with respect to the ownership, operation, maintenance, or use of which there is no bodily injury liability insurance or bond applicable at the time of the accident;

(b) a motor vehicle with respect to the ownership, operation, maintenance, or use of which there is bodily injury liability insurance in existence but the liability insurer denies coverage or is unable to make payment with respect to the legal liability of its insured because the insurer has become insolvent or bankrupt, or the Commissioner of Banking and Insurance has undertaken control of the insurer for the purpose of liquidation;

(c) a hit and run motor vehicle as described in section 18 of P.L.1952, c.174 (C.39:6-78); or

(d) an automobile covered by a special automobile insurance policy pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3).

"Uninsured motor vehicle" shall not include an automobile covered by a basic automobile insurance policy; an underinsured motor vehicle; a motor vehicle owned by or furnished for the regular use of the named insured or any resident of the same household; a self-insurer within the meaning of any financial responsibility or similar law of the state in which the motor vehicle is registered or principally garaged; a motor vehicle which is owned by the United States or Canada, or a state, political subdivision or agency of those governments or any of the foregoing; a land motor vehicle or trailer operated on rails or crawler treads; a motor vehicle used as a residence or stationary structure and not as a vehicle; or equipment or vehicles designed for use principally off public roads, except while actually upon public roads.

f. Notwithstanding the provisions of this section or any other law to the contrary, a motor vehicle liability policy or renewal of such policy of insurance, insuring against loss resulting from liability imposed by law for bodily injury or death, sustained by any person arising out of the ownership, maintenance or use of a motor vehicle, issued in this State to a corporate or business entity with respect to any motor vehicle registered or principally garaged in this State, shall not provide less uninsured or underinsured motorist coverage for an individual employed by the corporate or business entity than the coverage provided to the named insured under the policy. A policy that names a corporate or business entity as a named insured shall be deemed to provide the maximum uninsured or underinsured motorist coverage available under the policy to an individual employed by the corporate or business entity, regardless of whether the individual is an additional named insured under that policy or is a named insured or is covered under any other policy providing uninsured or underinsured motorist coverage.

Adopted. L. 1968, c. 385, §2. **Amended.** L. 1972, c. 204, §1; L. 1983, c. 65, §5; L. 1983, c. 362, §1; L. 1988, c. 119, §11; L. 1998, c. 21, §71, approved May 19, 1998, to take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later; L. 2003, c. 89, §59, effective June 9, 2003; L. 2007, c. 163, §1, effective September 10, 2007; L. 2022, c. 87, §1, effective August 5, 2022.

17:28-1.2. Repealed.
Repealed. L. 1972, c. 204, §2.

17:28-1.3. Coverage for pedestrians. Every liability insurance policy issued in this State on a motor vehicle, exclusive of an automobile as defined in section 2 of P.L. 1972, c. 70 (C. 39:6A-2), but including a motorcycle, or on a motorized bicycle, 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, maintenance, or use of a motor vehicle or motorized bicycle shall provide personal injury protection coverage benefits, in accordance with section 4 of P.L. 1972, c. 70 (C. 39:6A-4), to pedestrians who sustain bodily injury in the State caused by the named insured's motor vehicle or motorized bicycle or by being struck by an object propelled by or from the motor vehicle or motorized bicycle.
Adopted. L. 1983, c. 362, §19. **Amended.** L. 1985, c. 520, §19.

17:28-1.4. Mandatory coverage. Any insurer authorized to transact or transacting automobile or motor vehicle insurance business in this State, or controlling or controlled by, or under common control by, or with, an insurer authorized to transact or transacting insurance business in this State, which sells a policy providing automobile or motor vehicle liability insurance coverage, or any similar coverage, in any other state or in any province of Canada, shall include in each policy coverage to satisfy at least the personal injury protection benefits coverage pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or section 19 of P.L.1983, c.362 (C.17:28-1.3) for any New Jersey resident who is not required to maintain personal injury protection coverage pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or section 4 of P.L. 1998, c. 21 (C.39:6A-3.1) and who is not otherwise eligible for such benefits, whenever the automobile or motor vehicle insured under the policy is used or operated in this State. In addition, any insurer authorized to transact or transacting automobile or motor vehicle insurance business in this State, or controlling or controlled by, or under common control by, or with, an insurer authorized to transact or transacting automobile or motor vehicle insurance business in this State, which sells a policy providing automobile or motor vehicle liability insurance coverage, or any similar coverage, in any other state or in any province of Canada, shall include in each policy coverage to satisfy at least the liability insurance requirements of subsection a. of section 1 of P.L. 1972, c. 197 (C. 39:6B-1) or section 3 of P.L. 1972, c. 70 (C. 39:6A-3), the uninsured motorist insurance requirements of subsection a. of section 2 of P.L. 1968, c. 385 (C. 17:28-1.1), and personal injury protection benefits coverage pursuant to section 4 of P.L. 1972, c. 70 (C. 39:6A-4) or of section 19 of P.L. 1983, c. 362 (C. 17:28-1.3), whenever the automobile or motor vehicle insured under the policy is used or operated in this State.

Any liability insurance policy subject to this section shall be construed as providing the coverage required herein, and any named insured, and any immediate family member as defined in section 14.1 of P.L. 1983, c. 362 (C. 39:6A-8.1), under that policy, shall be subject to the tort option specified in subsection a. of section 8 of P.L. 1972, c. 70 (C. 39:6A-8).

Each insurer authorized to transact or transacting automobile or motor vehicle insurance business in this State and subject to the provisions of this section shall file and maintain with the Department of Banking and Insurance written certification of compliance with the provisions of this section.

"Automobile" means an automobile as defined in section 2 of P.L. 1972, c. 70 (C. 39:6A-2).
Adopted. L. 1985, c. 520, §18. **Amended.** L. 1988, c. 119, §1; L. 1997, c. 436, §1, effective January 19, 1998; L. 1998, c. 21, §72, approved May 19, 1998, to take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later.

17:28-1.5. Definitions. As used in this act:

"Commissioner" means the Commissioner of Insurance.

"Hospital expenses" means:

a. The cost of a semiprivate room, based on rates customarily charged by the institution in which the recipient of benefits is confined;

b. The cost of board, meals and dietary services;

c. The cost of other hospital services, such as operating room; medicines, drugs, anesthetics; treatments with X-ray, radium and other radioactive substances; laboratory tests, surgical dressings and supplies; and other medical care and treatment rendered by the hospital;

d. The cost of treatment by a physiotherapist;

e. The cost of medical supplies, such as prescribed drugs and medicines; blood and blood plasma; artificial limbs and eyes; surgical dressings, casts, splints, trusses, braces, crutches; rental of wheelchair, hospital bed or iron lung; oxygen and rental of equipment for its administration.

"Medical expenses" means expenses for medical treatment, surgical treatment, dental treatment, professional nursing services, hospital expenses, rehabilitation services, X-ray and other diagnostic services, prosthetic devices, ambulance services, medication and other reasonable and necessary expenses resulting from the treatment prescribed by persons licensed to practice medicine and surgery pursuant to R.S.45:9-1 et seq., dentistry pursuant to R.S.45:6-1 et seq., psychology pursuant to P.L.1966, c.282 (C.45:14B-1 et seq.) or chiropractic pursuant to P.L.1953, c.233 (C.45:9-41.4 et seq.) or by persons similarly licensed in other states and nations or any nonmedical remedial treatment rendered in accordance with a recognized religious method of healing.

"Motor bus" means an omnibus, as defined in R.S.39:1-1, except that "motor bus" shall not include:

a. Vehicles engaged in the transportation of passengers for hire in the manner and form commonly called taxicab service unless such service becomes or is held out to be regular service between stated termini;

b. Hotel buses used exclusively for the transportation of hotel patrons to or from local railroad or other common carrier stations including local airports;

c. Buses operated for the transportation of enrolled children and adults only when serving as chaperones to or from a school, school connected activity, day camp, summer day camp, nursery school, child care center, pre-school center or other similar places of education, including "School Vehicle Type I" and "School Vehicle Type II" as defined in R.S.39:1-1;

d. Any autobus with a carrying capacity of not more than 13 passengers operated under municipal consent upon a route established wholly within the limits of a single municipality or with a carrying capacity of not more than 20 passengers operated under municipal consent upon a route established wholly within the limits of not more than four contiguous municipalities within any county of the fifth or sixth class, which route in either case does not in whole or in part parallel upon the same street the line of any street railway or traction railway or any other autobus route;

e. Autocabs, limousines or livery services as defined in R.S.48:16-13, unless such service becomes or is held out to be regular service between stated termini;

f. Any vehicle used in a "ridesharing" arrangement, as defined by the "New Jersey Ridesharing Act of 1981," P.L.1981, c.413 (C.27:26-1 et al); or

g. Any motor bus owned and operated by the New Jersey Transit Corporation.

h. Any special paratransit vehicle as defined in R.S.48:4-1.

"Noneconomic loss" means pain, suffering and inconvenience.

"Passenger" means any person occupying, entering into or alighting from a motor bus, except employees of the owner or operator of the motor bus while they are on duty.

Adopted. L. 1991, c. 154, §1, effective October 5, 1991. **Amended.** L. 1992, c. 192, §1, effective December 21, 1992.

17:28-1.6. Owner, operator of motor bus to maintain medical expense benefits coverage. a. Every owner, registered owner or operator of a motor bus registered or principally garaged in this State shall maintain medical expense benefits coverage, under provisions approved by the commissioner, for the payment of benefits without regard to negligence, liability or fault of any kind, to any passenger who sustained bodily injury as a result of an accident while occupying, entering into or alighting from a motor bus.

b. Medical expense benefits coverage shall include the payment of reasonable medical expenses in an amount not to exceed $250,000 per person per accident. In event of death, payments shall be made to the estate of the decedent.

Adopted. L. 1991, c. 154, §2, effective October 5, 1991.

17:28-1.7. Exemption from tort liability for owner, registrant, operator of motor bus. Every owner, registrant or operator of a motor bus registered or principally garaged in this State and every person or organization legally responsible for his acts or omissions, is hereby exempted from tort liability for noneconomic loss to a passenger who has a right to receive benefits under section 2 of this act as a result of bodily injury arising out of the ownership, operation, maintenance or use of a motor bus in this State, unless that person has sustained a personal injury which results in death; dismemberment; significant disfigurement or significant scarring; displaced fractures; loss of a fetus; or a permanent injury within a reasonable degree of medical probability, other than scarring or disfigurement. An injury shall be considered permanent when the body part or organ, or both, has not healed to function normally and will not heal to function normally with further medical treatment. For the purposes of this subsection, "physician" means a physician as defined in section 5 of P.L.1939,c.115 (C.45:9-5.1).

In order to satisfy the provisions of this section, the plaintiff shall, within 60 days following the date of the answer to the complaint by the defendant, provide the defendant with a certification from the licensed treating physician or a board-certified licensed physician to whom the plaintiff was referred by the treating physician. The certification shall state, under penalty of perjury, that the plaintiff has sustained an injury described above. The certification shall be based on and refer to objective clinical evidence, which may include medical testing, except that any such testing shall be performed in accordance with medical protocols pursuant to subsection a. of section 4 of P.L.1972, c.70 (C.39:6A-4) and the use of valid diagnostic tests administered in accordance with section 12 of P.L. 1998, c. 21 (C.39:6A-4.7). Such testing may not be experimental in nature or dependent entirely upon subjective patient response. The court may grant no more than one additional period not to exceed 60 days to file the certification pursuant to this section upon a finding of good cause.

A person is guilty of a crime of the fourth degree if that person purposefully or knowingly makes, or causes to be made, a false, fictitious, fraudulent, or misleading statement of material fact in, or omits a material fact from, or causes a material fact to be omitted from, any certification filed pursuant to this section. Notwithstanding the provisions of subsection e. of N.J.S. 2C:44-1, the court shall deal with a person who has been convicted of a violation of this section by imposing a sentence of imprisonment unless, having regard to the character and condition of the person, the court is of the opinion that imprisonment would be a serious injustice which overrides the need to deter such conduct by others. If the court imposes a noncustodial or probationary sentence, such sentence shall not become final for 10 days in order to permit the appeal of such sentence by the prosecution. Nothing in this section shall preclude an indictment and conviction for any other offense defined by the laws of this State. In addition, any professional license held by the person shall be forfeited according to the procedures established by section 4 of P.L.1997, c.353 (C.2C:51-5).

Adopted. L. 1991, c. 154, §3, effective October 5, 1991. **Amended.** L. 1998, c. 21, §68, approved May 19, 1998, to take effect 90 days following the establishment by the Commissioner of Banking and

Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act[39:6A-4.7], whichever is later.

17:28-1.8. Evidence of amounts collectible, paid to injured passenger inadmissible in civil action. Evidence of the amounts collectible or paid to an injured passenger pursuant to section 2 of this act [17:28-1.6] is inadmissible in a civil action against an owner, registrant or operator of a motor bus for recovery of damages for bodily injury by such injured passenger.

The court shall instruct the jury that, in arriving at a verdict as to the amount of the damages for noneconomic loss to be recovered by the injured passenger, the jury shall not speculate as to the amount of the medical expense benefits paid or payable under section 2 to the injured passenger.

Nothing in this section shall be construed to limit the right of recovery, against the tortfeasor, of uncompensated economic loss sustained by the injured passenger.

Adopted. L. 1991, c. 154, §4, effective October 5, 1991.

17:28-1.9. Immunity from liability for certain auto insurance providers. a. Notwithstanding any other provision of law to the contrary, no person, including, but not limited to, an insurer, an insurance producer, as defined in section 2 of P.L.1987, c.293 (C.17:22A-2), a servicing carrier or non-insurer servicing carrier acting in that capacity pursuant to P.L.1983, c.65 (C.17:30E-1 et seq.) or section 88 of P.L.1990, c.8 (C.17:33B-11), the New Jersey Automobile Full Insurance Underwriting Association created pursuant to section 16 of P.L.1983, c.65 (C.17:30E-4), the Market Transition Facility created pursuant to section 88 of P.L.1990, c.8 (C.17:33B-11), and any plan established pursuant to section 1 of P.L.1970, c.215 (C.17:29D-1), shall be liable in an action for damages on account of the election of a given level of motor vehicle insurance coverage by a named insured as long as those limits provide at least the minimum coverage required by law or on account of a named insured not electing to purchase underinsured motorist coverage, collision coverage or comprehensive coverage. Nothing in this section shall be deemed to grant immunity to any person causing damage as the result of his willful, wanton or grossly negligent act of commission or omission.

b. The coverage selection form required pursuant to section 17 of P.L.1983, c.362 (C.39:6A-23) shall contain an acknowledgement by the named insured that the limits available to him for uninsured motorist coverage and underinsured motorist coverage have been explained to him and a statement that no person, including, but not limited to, an insurer, an insurance producer, as defined in section 2 of P.L.1987, c.293 (C.17:22A-2), a servicing carrier or non-insurer servicing carrier acting in that capacity pursuant to P.L.1983, c.65 (C.17:30E-1 et seq.) or section 88 of P.L.1990, c.8 (C.17:33B-11), the New Jersey Automobile Full Insurance Underwriting Association created pursuant to section 16 of P.L.1983, c.65 (C.17:30E-4), the Market Transition Facility created pursuant to section 88 of P.L.1990, c.8 (C.17:33B-11), and any plan established pursuant to section 1 of P.L.1970, c.215 (C.17:29D-1), shall be liable in an action for damages on account of the election of a given level of motor vehicle insurance coverage by a named insured as long as those limits provide at least the minimum coverage required by law or on account of a named insured not electing to purchase underinsured motorist coverage, collision coverage or comprehensive coverage, except for that person causing damage as the result of his willful, wanton or grossly negligent act of commission or omission.

Adopted. L. 1993, c. 156, §1, effective June 29, 1993.

APPENDIX A1 - PRE-AICRA STATUTES

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