

PART 65

(Regulation 68)

REGULATIONS IMPLEMENTING THE COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT

Editor's Note: The former No-Fault regulation was repealed effective April 5, 2002. It is therefore no longer included in the official New York Codes, Rules and Regulations. However, because there may still be claims or claim procedures which remain covered by the old regulation, the New York State Insurance Department is making a copy of this regulation available for historical reference at the Insurance Department's website at http://www.dfs.ny.gov/insurance/r68_old.htm. Questions as to whether specific claims and claims procedures are subject to the old or new No-Fault regulations are clarified under the FAQ section for No-Fault at <http://www.dfs.ny.gov/insurance/faqs1.htm>.

(Statutory authority: Insurance Law, §§ 201, 301, 2307, 2601, 5103, 5106, 5109, 5221, arts. 4, 51; Vehicle and Traffic Law, § 2407; Financial Services Law, § 202, arts. 3, 4)

Historical Note

Part (§§ 65.1-65.9) filed Oct. 3, 1973; amd. filed Aug. 30, 1985 eff. Sept. 1, 1985. Amended Part title and statutory authority. Part 65 filed Oct. 18, 1999, declared invalid, null and void on June 9, 2000 in *Medical Society of New York v. Neil D. Levin as Superintendent of Insurance*, 712 NY2d 745 (Supreme Court, New York County). Amendments to such Part filed Jan. 31, 2000 as emergency measure eff. Jan. 31, 2000; filed April 26, 2000 as emergency measure eff. Jan. 31, 2000; filed July 24, 2000 as emergency measure eff. July 24, 2000; filed Oct. 19, 2000 as emergency measure eff. Oct. 19, 2000; amd. filed Jan. 8, 2001 as emergency measure eff. Jan. 8, 2001, invalid, null and void by operation of *Medical Society of New York*, Id. Former Part 65 as extant prior to Nov. 1, 1999, continued effective from Oct. 31, 1999; Part (*Regulations Implementing the Comprehensive Motor Vehicle Insurance Reparations Act*, §§ 65.1-65.19) repealed, new (Subparts 65-1—65-4) filed Aug. 2, 2001 eff. Sept. 1, 2001. Effectiveness stayed Aug. 29, 2001; stay overruled April 4, 2002, Part effective April 5, 2002.

SUBPART 65-1

(Regulation 68-A)

PRESCRIBED POLICY ENDORSEMENTS

Historical Note

Subpart (§§ 65-1.1—65-1.8) filed Aug. 2, 2001 eff. Sept. 1, 2001.

§ 65-1.1 Requirements for minimum benefit insurance policies for personal injuries.

(a) Every owner's policy of liability insurance issued in satisfaction of the minimum requirements of article 6 or 8 of the Vehicle and Traffic Law and article 51 of the Insurance Law and every policy issued in satisfaction of the minimum requirements of article 44-B of the Vehicle and Traffic Law shall contain provisions providing minimum first-party benefits equal to those set out below in the mandatory personal injury protection endorsement (New York), or mandatory personal injury protection endorsement - motorcycles (New York), respectively.

(b) An insurer shall provide the appropriate endorsement to be used with a policy. The Mandatory Personal Injury Protection Endorsement (New York) and the Mandatory Personal Injury Protection Endorsement - Motorcycles (New York) set out below are approved and promulgated for use by an insurer. Except as provided in subdivision (c) of this section and section 65-1.7 of this Subpart, an insurer shall provide:

(1) the Mandatory Personal Injury Protection Endorsement (New York) to every insured with respect to a policy issued, renewed, modified, altered or amended on or after January 26, 2011; or

(2) the Mandatory Personal Injury Protection Endorsement - Motorcycles (New York) to every insured with respect to a motorcycle policy issued or renewed.

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(c) The mandatory personal injury protection endorsement - all-terrain vehicles (New York), set out below is approved and promulgated for use by an insurer and, except as provided in section 65-1.7 of this Subpart, must be issued with every liability policy covering an all-terrain vehicle as required by section 2407 of article 48-C of the New York Vehicle and Traffic Law and Subpart 64-2 of this Title and must be:

- (1) furnished to all new insureds with policies effective on and after September 1, 2001; and
 - (2) enclosed with the first renewal policies renewed on and after September 1, 2001.
- (d) *Mandatory personal injury protection endorsement.*

MANDATORY PERSONAL INJURY PROTECTION ENDORSEMENT

(New York)

The Company agrees with the named insured, as follows:

Section I

Mandatory Personal Injury Protection

The company will pay first-party benefits to reimburse for basic economic loss sustained by an eligible injured person on account of personal injuries caused by an accident arising out of the use or operation of a motor vehicle or a motorcycle during the policy period and within the United States of America, its territories or possessions, or Canada.¹

First-Party Benefits

First-party benefits, other than death benefits, are payments equal to basic economic loss, reduced by the following:

- (a) 20 percent of the eligible injured person's loss of earnings from work to the extent that an eligible injured person's basic economic loss consists of such loss of earnings;
- (b) amounts recovered or recoverable on account of personal injury to an eligible injured person under State or Federal laws providing social security disability or workers' compensation benefits, or disability benefits under article 9 of the New York Workers' Compensation Law;
- (c) the amount of any applicable deductible, provided that such deductible shall apply to each accident, but only to the total of first-party benefits otherwise payable to the named insured and any relative as a result of that accident.

Basic Economic Loss

Basic economic loss shall consist of medical expense, work loss, other expense and, when death occurs, a death benefit as herein provided. Except for such death benefit, basic economic loss shall not include any loss sustained on account of death. Basic economic loss of each eligible injured person on account of any single accident shall not exceed \$50,000, except that any death benefit hereunder shall be in addition thereto.

Medical Expense

Medical expense shall consist of necessary expenses for:

- (a) medical, hospital (including services rendered in compliance with Article 41 of the Public Health Law, whether or not such services are rendered directly by a hospital), surgical, nursing, dental, ambulance, X-ray, prescription drug and prosthetic services;
- (b) psychiatric, physical and occupational therapy and rehabilitation;
- (c) any nonmedical remedial care and treatment rendered in accordance with a religious method of healing recognized by the laws of New York; and

¹If the policy is being used to satisfy the financial responsibility requirements of article 44-B of the Vehicle and Traffic Law, then the Company may substitute the following language:

The company will pay first-party benefits to reimburse for basic economic loss sustained by an eligible injured person on account of personal injuries caused by an accident arising out of the use or operation of a motor vehicle, pursuant to article 44-B of the Vehicle and Traffic Law, by a transportation network company driver during the policy period and within the United States of America, its territories or possessions, or Canada.

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- (d) any other professional health services.

These medical expenses will not be subject to a time limitation, provided that, within one year after the date of the accident, it is ascertainable that further medical expenses may be sustained as a result of the injury. Payments hereunder for necessary medical expenses shall be subject to the limitations and requirements of section 5108 of the New York Insurance Law.

Work Loss

Work loss shall consist of the sum of the following losses and expenses, up to a maximum payment of \$2,000 per month for a maximum period of three years from the date of the accident:

- (a) loss of earnings from work which the eligible injured person would have performed had such person not been injured, except that an employee who is entitled to receive monetary payments, pursuant to statute or contract with the employer, or who receives voluntary monetary benefits paid for by the employer, by reason of such employee's inability to work because of personal injury arising out of the use or operation of a motor vehicle or a motorcycle, shall not be entitled to receive first-party benefits for loss of earnings from work to the extent that such monetary payments or benefits from the employer do not result in the employee suffering a reduction in income or a reduction in such employee's level of future benefits arising from a subsequent illness or injury; and
- (b) reasonable and necessary expenses sustained by the eligible injured person in obtaining services in lieu of those which such person would have performed for income.

Other Expenses

Other expenses shall consist of all reasonable and necessary expenses, other than medical expense and work loss, up to \$25 per day for a period of one year from the date of the accident causing injury.

Death Benefit

Upon the death of any eligible injured person, caused by an accident to which this coverage applies, the Company will pay to the estate of such person a death benefit of \$2,000.

Eligible Injured Person

Subject to the exclusions and conditions set forth below, an eligible injured person is:

- (a) the named insured and any relative who sustains personal injury arising out of the use or operation of any motor vehicle;
- (b) the named insured and any relative who sustains personal injury arising out of the use or operation of any motorcycle, while not occupying a motorcycle;
- (c) any other person who sustains personal injury arising out of the use or operation of the insured motor vehicle in the State of New York while not occupying another motor vehicle; or
- (d) any New York State resident who sustains personal injury arising out of the use or operation of the insured motor vehicle outside of New York while not occupying another motor vehicle.

Exclusions

This coverage does not apply to personal injury sustained by:

- (a) the named insured while occupying, or while a pedestrian through being struck by, any motor vehicle owned by the named insured with respect to which the coverage required by the New York Comprehensive Motor Vehicle Insurance Reparations Act is not in effect;
- (b) any relative while occupying, or while a pedestrian through being struck by, any motor vehicle owned by the relative with respect to which the coverage required by the New York Comprehensive Motor Vehicle Insurance Reparations Act is not in effect;
- (c) the named insured or relative while occupying, or while a pedestrian through being struck by, a motor vehicle in New York State, other than the insured motor vehicle, with respect to which the coverage required by the New York Comprehensive Motor Vehicle Insurance Reparations Act is in effect; however, this exclusion does not apply to personal injury sustained in New York State by the named insured or relative while occupying a bus or school bus, as defined in sections 104 and 142 of the New York Vehicle and Traffic Law, unless that person is the operator, an owner, or an employee of the owner or operator, of such bus or school bus;

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- [(d) any person in New York State while occupying the insured motor vehicle which is a bus or school bus, as defined in sections 104 and 142 of the New York Vehicle and Traffic Law, but only if such person is a named insured or relative under any other policy providing the coverage required by the New York Comprehensive Motor Vehicle Insurance Reparations Act; however, this exclusion does not apply to the operator, an owner, or an employee of the owner or operator, of such bus or school bus;]²
- (e) any person while occupying a motorcycle;
- (f) any person who intentionally causes his or her own personal injury;³
- (g) any person as a result of operating a motor vehicle while in an intoxicated condition or while his or her ability to operate the vehicle is impaired by the use of a drug (within the meaning of section 1192 of the New York Vehicle and Traffic Law), except that coverage shall apply to necessary emergency health services rendered in a general hospital, as defined in section 2801(10) of the New York Public Health Law, including ambulance services attendant thereto and related medical screening. However, where the person has been convicted of violating section 1192 of the New York Vehicle and Traffic Law while operating a motor vehicle in an intoxicated condition or while his or her ability to operate such vehicle is impaired by the use of a drug, and the conviction is a final determination, the company has a cause of action against such person for the amount of first party benefits that are paid or payable;⁴
- (h) any person while:
 - (1) committing an act which would constitute a felony, or seeking to avoid lawful apprehension or arrest by a law enforcement officer;³
 - (2) operating a motor vehicle in a race or speed test;³
 - (3) operating or occupying a motor vehicle known to that person to be stolen;³ or
 - (4) repairing, servicing or otherwise maintaining a motor vehicle if the conduct is within the course of a business of repairing, servicing or otherwise maintaining a motor vehicle and the injury occurs on the business premises;³
- (i) the named insured or relative while not occupying a motor vehicle or a motorcycle when struck by a motorcycle in New York State with respect to which the coverage required by the New York Comprehensive Motor Vehicle Insurance Reparations Act is in effect;
- (j) any New York State resident other than the named insured or relative injured through the use or operation of the insured motor vehicle outside of New York State if such resident is the owner or a relative of the owner of a motor vehicle insured under another policy providing the coverage required by the New York Comprehensive Motor Vehicle Insurance Reparations Act;
- (k) any New York State resident other than the named insured or relative injured through the use or operation of the insured motor vehicle outside of New York State if such resident is the owner of a motor vehicle for which the coverage required by the New York Comprehensive Motor Vehicle Insurance Reparations Act is not in effect; or

²Language in brackets may be deleted if the insured motor vehicle is not a bus or school bus.

³These exclusions may be deleted, in the event the Company wishes to provide coverage under the indicated circumstances.

⁴This exclusion may be deleted, in the event the company wishes to provide coverage under the indicated circumstance. Alternatively, the company may delete the cause of action language only, provided, however, that, in either case, if the company deletes this language, then the company will be deemed to have waived its right to bring a cause of action against the person.

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- (l) any person who is injured while, pursuant to article 44-B of the Vehicle and Traffic Law, the insured motor vehicle is being used or operated by a transportation network company driver.⁵

Other Definitions

When used in reference to this coverage:

- (a) the *insured motor vehicle* means a motor vehicle owned by the named insured and to which the bodily injury liability insurance of this policy applies and for which a specific premium is charged;
- (b) *motorcycle* means a vehicle as defined in section 123 of the New York Vehicle and Traffic Law and which is required to carry financial security pursuant to article 6, 8 or 48-A of the Vehicle and Traffic Law;
- (c) *motor vehicle* means a motor vehicle, as defined in section 311 of the New York Vehicle and Traffic Law, and also includes fire and police vehicles, but shall not include any motor vehicle not required to carry financial security pursuant to article 6, 8 or 48-A of the Vehicle and Traffic Law, or a motorcycle as defined above;
- (d) *named insured* means the person or organization named [in the declarations];⁶
- (e) *occupying* means in or upon or entering into or alighting from;
- (f) *personal injury* means bodily injury, sickness or disease;
- (g) *relative* means a spouse, child, or other person related to the named insured by blood, marriage, or adoption (including a ward or foster child), who regularly resides in the insured's household, including any such person who regularly resides in the household, but is temporarily living elsewhere; and
- (h) *use or operation* of a motor vehicle or a motorcycle includes the loading or unloading of such vehicle.

Conditions

Action Against Company. No action shall lie against the Company unless, as a condition precedent thereto, there shall have been full compliance with the terms of this coverage.

Notice. In the event of an accident, written notice setting forth details sufficient to identify the eligible injured person, along with reasonably obtainable information regarding the time, place and circumstances of the accident, shall be given by, or on behalf of, each eligible injured person, to the Company, or any of the Company's authorized agents, as soon as reasonably practicable, but in no event more than 30 days after the date of the accident, unless the eligible injured person submits written proof providing clear and reasonable justification for the failure to comply with such time limitation. If an eligible injured person or that person's legal representative institutes a proceeding to recover damages for personal injury under section 5104(b) of the New York Insurance Law, a copy of the summons and complaint or other process served in connection with such action shall be forwarded as soon as practicable to the Company or any of the Company's authorized agents by such eligible injured person or that person's legal representative.

Proof of Claim. Medical, Work Loss, and Other Necessary Expenses. In the case of a claim for health service expenses, the eligible injured person or that person's assignee or representative shall

⁵An insurer may not include this exclusion in a policy used to satisfy the requirements under article 44-B of the Vehicle and Traffic Law. An insurer may use one of the following exclusions:

If the policy provides liability coverage while, pursuant to article 44-B of the Vehicle and Traffic Law, the insured motor vehicle is being used or operated by a transportation network company driver while providing a transportation network company prearranged trip:

any person who is injured while, pursuant to article 44-B of the Vehicle and Traffic Law, the insured motor vehicle is being used or operated by a transportation network company driver while the driver is logged onto a transportation network company's digital network but is not engaged in a transportation network company prearranged trip.

If the policy provides liability coverage while, pursuant to article 44-B of the Vehicle and Traffic Law, the insured motor vehicle is being used or operated by a transportation network company driver while logged onto a transportation network company's digital network but who is not engaged in a transportation network company prearranged trip:

any person who is injured while, pursuant to article 44-B of the Vehicle and Traffic Law, the insured motor vehicle is being used or operated by a transportation network company driver, while the driver provides a transportation network company prearranged trip.

⁶Companies may substitute the appropriate term, reference or language for the matter set out in brackets. With respect to a group policy issued pursuant to Insurance Law section 3455, the named insured includes transportation network driver to whom a certificate of insurance is issued under the group policy.

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submit written proof of claim to the Company, including full particulars of the nature and extent of the injuries and treatment received and contemplated, as soon as reasonably practicable but, in no event later than 45 days after the date services are rendered. The eligible injured person or that person's representative shall submit written proof of claim for work loss benefits and for other necessary expenses to the Company as soon as reasonably practicable but, in no event, later than 90 days after the work loss is incurred or the other necessary services are rendered. The foregoing time limitations for the submission of proof of claim shall apply unless the eligible injured person or that person's representative submits written proof providing clear and reasonable justification for the failure to comply with such time limitation. Upon request by the Company, the eligible injured person or that person's assignee or representative shall:

- (a) execute a written proof of claim under oath;
- (b) as may reasonably be required submit to examinations under oath by any person named by the Company and subscribe the same;
- (c) provide authorization that will enable the Company to obtain medical records; and
- (d) provide any other pertinent information that may assist the Company in determining the amount due and payable.

The eligible injured person shall submit to medical examination by physicians selected by, or acceptable to, the Company, when, and as often as, the Company may reasonably require.

Arbitration. In the event any person making a claim for first-party benefits and the Company do not agree regarding any matter relating to the claim, such person shall have the option of submitting such disagreement to arbitration pursuant to procedures promulgated or approved by the Superintendent of Financial Services.

Reimbursement and Trust Agreement. To the extent that the Company pays first-party benefits, the Company is entitled to the proceeds of any settlement or judgment resulting from the exercise of any right of recovery for damages for personal injury under section 5104(b) of the New York Insurance Law. The Company shall have a lien upon any such settlement or judgment to the extent that the Company has paid first-party benefits. An eligible injured person shall:

- (a) hold in trust, for the benefit of the Company, all rights of recovery which that person shall have for personal injury under section 5104(b) of the New York Insurance Law;
- (b) do whatever is proper to secure, and shall do nothing to prejudice, such rights; and
- (c) execute, and deliver to the Company, instruments and papers as may be appropriate to secure the rights and obligations of such person and the Company established by this provision.

An eligible injured person shall not compromise an action to recover damages brought under section 5104(b) of the New York Insurance Law, except:

- (a) with the written consent of the Company;
- (b) with approval of the court; or
- (c) where the amount of the settlement exceeds \$50,000.

Other Coverage. Where more than one source of first-party benefits required by article 51 of the New York Insurance Law and article 6, 8, or 44-B of the New York Vehicle and Traffic Law is available and applicable to an eligible injured person in any one accident, this Company is liable to an eligible injured person only for an amount equal to the maximum amount that the eligible injured person is entitled to recover under this coverage, divided by the number of available and applicable sources of required first-party benefits. An eligible injured person shall not recover duplicate benefits for the same elements of loss under this coverage or any other mandatory first-party motor vehicle or no-fault motor vehicle insurance coverage issued in compliance with the laws of another state.

If the eligible injured person is entitled to benefits under any such mandatory first-party motor vehicle or no-fault motor vehicle insurance for the same elements of loss under this coverage, this Company shall be liable only for an amount equal to the proportion that the total amount available under this coverage bears to the sum of the amount available under this coverage and the amount available under such other mandatory insurance for the common elements of loss. However, where another state's mandatory first-party or no-fault motor vehicle insurance law provides unlimited coverage available to an eligible injured person for an element of loss under this coverage, the obligation of this Company is to share equally for that element of loss with such other mandatory

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insurance until the \$50,000, or \$75,000 if Optional Basic Economic Loss (OBEL) coverage is purchased, limit of this coverage is exhausted by the payment of that element of loss and any other elements of loss.

Section II

Excess Coverage

If motor vehicle medical payments coverage or any disability coverages or uninsured motorists coverage are afforded under this policy, such coverages shall be excess insurance over any Mandatory PIP, OBEL or Additional PIP benefits paid or payable, or which would be paid or payable but for the application of a deductible, under this or any other motor vehicle No-Fault insurance policy.

Section III

Constitutionality

If it is conclusively determined by a court of competent jurisdiction that the New York Comprehensive Motor Vehicle Insurance Reparations Act, or any amendment thereto, is invalid or unenforceable in whole or in part, then, subject to the approval of the Superintendent of Financial Services, the Company may amend this policy and may also recompute the premium for the existing or amended policy.

These amendments and recomputations will be effective retroactively to the date that such act or any amendment is deemed to be invalid or unenforceable in whole or in part.

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(e) *Mandatory personal injury protection endorsement - motorcycles.*

MANDATORY PERSONAL INJURY PROTECTION ENDORSEMENT

MOTORCYCLES - (New York)⁷

The company agrees with the named insured as follows:

Section I

Mandatory Personal Injury Protection

The Company will pay first-party benefits to reimburse for basic economic loss sustained by an eligible injured person on account of personal injuries caused by an accident arising out of the use or operation of the insured motorcycle. This coverage applies only to motorcycle accidents which occur during the policy period and within the State of New York.

Eligible Injured Person

An eligible injured person is any person who sustains a personal injury arising out of the use or operation of the insured motorcycle while not occupying the insured motorcycle, any other motorcycle or a motor vehicle.

First-Party Benefits

First-party benefits, other than death benefits, are payments equal to basic economic loss, reduced by the following:

- (a) 20 percent of the eligible injured person's loss of earnings from work to the extent that an eligible injured person's basic economic loss consists of such loss of earnings;
- (b) amounts recovered or recoverable on account of personal injury to an eligible injured person under State or Federal laws providing social security disability or workers' compensation benefits, or disability benefits under article 9 of the New York Workers' Compensation Law.

Basic Economic Loss

Basic economic loss shall consist of medical expense, work loss, other expense and, when death occurs, a death benefit as herein provided. Except for such death benefit, basic economic loss shall not include any loss sustained on account of death. Basic economic loss of each eligible injured person on account of any single accident shall not exceed \$50,000, except that any death benefit hereunder shall be in addition thereto.

⁷This endorsement shall be issued only for insured motorcycles.

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Medical Expense

Medical expense shall consist of necessary expenses for:

- (a) medical, hospital (including services rendered in compliance with article 41 of the Public Health Law, whether or not such services are rendered directly by a hospital), surgical, nursing, dental, ambulance, X-ray, prescription drug and prosthetic services;
- (b) psychiatric, physical and occupational therapy and rehabilitation;
- (c) any nonmedical remedial care and treatment rendered in accordance with a religious method of healing recognized by the laws of New York; and
- (d) any other professional health services.

These medical expenses will not be subject to a time limitation, provided that within one year after the date of the accident it is ascertainable that further medical expenses may be sustained as a result of the injury. Payments hereunder for necessary medical expenses shall be subject to the limitations and requirements of section 5108 of the New York Insurance Law.

Work Loss

Work loss shall consist of the sum of the following losses and expenses, up to a maximum payment of \$2,000 per month for a maximum period of three years from the date of the accident:

- (a) loss of earnings from work which the eligible injured person would have performed had such person not been injured, except that an employee who is entitled to receive monetary payments, pursuant to statute or contract with the employer, or who receives voluntary monetary benefits paid for by the employer, by reason of such employee's inability to work because of personal injury arising out of the use or operation of a motorcycle, shall not be entitled to receive first- party benefits for loss of earnings from work to the extent that such monetary payments or benefits from the employer do not result in the employee suffering a reduction in income or a reduction in such employee's level of future benefits arising from a subsequent illness or injury; and
- (b) reasonable and necessary expenses sustained by the eligible injured person in obtaining services in lieu of those which such person would have performed for income.

Other Expenses

Other expenses shall consist of all reasonable and necessary expenses, other than medical expense and work loss, up to \$25 per day for a period of one year from the date of the accident causing injury.

Death Benefit

Upon the death of any eligible injured person, caused by an accident to which this coverage applies, the Company will pay to the estate of such person a death benefit of \$2,000.

*Exclusions*⁸

This coverage does not apply:

- (a) to a personal injury sustained by any person who intentionally causes his own personal injury;
- (b) to a personal injury sustained by any person while committing an act which would constitute a felony, or seeking to avoid lawful apprehension or arrest by a law enforcement officer; or
- (c) to a personal injury sustained by a person while repairing, servicing, or otherwise maintaining a motor vehicle or motorcycle, if such conduct is within the course of a business of repairing, servicing, or otherwise maintaining a motor vehicle or motorcycle and the injury occurs on the business premises.

Other Definitions

When used in reference to this coverage:

- (a) *insured motorcycle* means a motorcycle owned by the named insured and to which the bodily injury liability insurance of this policy applies and for which a specific premium is charged;

⁸These exclusions may be deleted, in the event the Company wishes to provide coverage under the indicated circumstances.

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- (b) *motorcycle* means a vehicle as defined in section 123 of the New York Vehicle and Traffic Law, and which is required to carry financial security pursuant to article 6, 8 or 48-A of the Vehicle and Traffic Law;
- (c) *motor vehicle* means a motor vehicle, as defined in section 311 of the New York Vehicle and Traffic Law, and also includes fire and police vehicles, but shall not include any motor vehicle not required to carry financial security pursuant to article 6, 8 or 48-A of the Vehicle and Traffic Law, or a motorcycle as defined above;
- (d) *named insured* means the person or organization named [in the declaration];⁹
- (e) *occupying* means in or upon or entering into or alighting from;
- (f) *personal injury* means bodily injury, sickness or disease;
- (g) *use or operation* of a motor vehicle or motorcycle includes the loading or unloading of such vehicle.

Conditions

Action Against Company. No action shall lie against the Company unless, as a condition precedent thereto, there shall have been full compliance with the terms of this coverage.

Notice. In the event of an accident, written notice setting forth details sufficient to identify the eligible injured person, along with reasonably obtainable information regarding the time, place and circumstances of the accident, shall be given by, or on behalf of, each eligible injured person, to the Company, or any of the Company's authorized agents, as soon as reasonably practicable, but in no event more than 30 days after the date of the accident, unless the eligible injured person submits written proof providing clear and reasonable justification for the failure to comply with such time limitation. If an eligible injured person or that person's legal representative institutes a proceeding to recover damages for personal injury under section 5104(b) of the New York Insurance Law, a copy of the summons and complaint or other process served in connection with such action shall be forwarded as soon as practicable to the Company or any of the Company's authorized agents by such eligible injured person or that person's legal representative.

Proof of Claim; Medical, Work Loss, and Other Necessary Expenses. In the case of a claim for health service expenses, the eligible injured person or that person's assignee or representative shall submit written proof of claim to the Company, including full particulars of the nature and extent of the injuries and treatment received and contemplated, as soon as reasonably practicable but, in no event later than 45 days after the date services are rendered. The eligible injured person or that person's representative shall submit written proof of claim for work loss benefits and for other necessary expenses to the Company as soon as reasonably practicable but, in no event, later than 90 days after the work loss is incurred or the other necessary services are rendered. The foregoing time limitations for the submission of proof of claim shall apply unless the eligible injured person submits written proof providing clear and reasonable justification for the failure to comply with such time limitation. Upon request by the Company, the eligible injured person or that person's assignee or representative shall:

- (a) execute a written proof of claim under oath;
- (b) as may reasonably be required submit to examinations under oath by any person named by the Company and subscribe the same;
- (c) provide authorization that will enable the Company to obtain medical records; and
- (d) provide any other pertinent information that may assist the Company in determining the amount due and payable.

The eligible injured person shall submit to medical examination by physicians selected by, or acceptable to, the Company when, and as often as, the Company may reasonably require.

Arbitration. In the event any person making a claim for first-party benefits and the Company do not agree regarding any matter relating to the claim, such person shall have the option of submitting such disagreement to arbitration pursuant to procedures promulgated or approved by the Superintendent of Financial Services.

Reimbursement and Trust Agreement. To the extent that the Company pays first-party benefits, the Company is entitled to the proceeds of any settlement or judgment resulting from the exercise of any

⁹Companies may substitute the appropriate term, reference or language for the matter set out in brackets.

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right of recovery for damages for personal injury under section 5104(b) of the New York Insurance Law. The Company shall have a lien upon any such settlement or judgment to the extent that the Company has paid first-party benefits. An eligible injured person shall:

- (a) hold in trust, for the benefit of the Company, all rights of recovery which that person shall have for personal injury under section 5104(b) of the New York Insurance Law;
- (b) do whatever is proper to secure, and shall do nothing to prejudice, such rights; and
- (c) execute, and deliver to the Company, instruments and papers as may be appropriate to secure the rights and obligations of such person and the Company established by this provision.

An eligible injured person shall not compromise an action to recover damages brought under section 5104(b) of the New York Insurance Law, except:

- (a) with the written consent of the Company;
- (b) with approval of the court; or
- (c) where the amount of the settlement exceeds \$50,000.

Other Coverage. Where more than one source of first-party benefits required by article 51 of the New York Insurance Law and article 6 or 8 of the New York Vehicle and Traffic Law is available and applicable to an eligible injured person in any one accident, this Company is liable to an eligible injured person only for an amount equal to the maximum amount that the eligible injured person is entitled to recover under this coverage, divided by the number of available and applicable sources of required first-party benefits. An eligible injured person shall not recover duplicate benefits for the same elements of loss under this coverage or any other mandatory first-party motor vehicle or no-fault motor vehicle insurance coverage issued in compliance with the laws of another state.

If the eligible injured person is entitled to benefits under any such mandatory first-party motor vehicle or no-fault motor vehicle insurance for the same elements of loss under this coverage, this Company shall be liable only for an amount equal to the proportion that the total amount available under this coverage bears to the sum of the amount available under this coverage and the amount available under such other mandatory insurance for the common elements of loss. However, where another state’s mandatory first-party or no-fault motor vehicle insurance law provides unlimited coverage available to an eligible injured person for an element of loss under this coverage, the obligation of this Company is to share equally for that element of loss with such other mandatory insurance until the \$50,000, or \$75,000 if Optional Basic Economic Loss (OBEL) coverage is purchased, limit of this coverage is exhausted by the payment of that element of loss and any other elements of loss.

Section II

Excess Coverage

If medical payments coverage or any disability coverages or uninsured motorists coverage are afforded under this policy, such coverages shall be excess insurance over any Mandatory PIP, OBEL or Additional PIP benefits paid or payable, or which would be paid or payable but for the application of a deductible under this or any other motor vehicle No-Fault insurance policy.

Section III

Constitutionality

If it is conclusively determined by a court of competent jurisdiction that the New York Comprehensive Motor Vehicle Insurance Reparations Act, or any amendment thereto, is invalid or unenforceable in whole or in part, then, subject to the approval of the Superintendent of Financial Services, the Company may amend this policy and may also recompute the premium for the existing or amended policy.

These amendments and recomputations will be effective retroactively to the date that such Act or any amendment is deemed to be invalid or unenforceable in whole or in part.

* * *

- (f) *Mandatory personal injury protection endorsement - all-terrain vehicles (ATV).*

MANDATORY PERSONAL INJURY PROTECTION ENDORSEMENT

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ALL-TERRAIN VEHICLES (ATV) ¹⁰ (New York)

The Company agrees with the named insured as follows:

Section I

Mandatory Personal Injury Protection

The company will pay first-party benefits to reimburse for basic economic loss sustained by an eligible injured person on account of personal injuries caused by an accident arising out of the use or operation of the insured ATV. This coverage applies only to ATV accidents which occur during the policy period and on or after January 1, 1987 and within the State of New York.

Eligible Injured Person

An eligible injured person is any person who sustains a personal injury arising out of the use or operation of the insured ATV while not occupying the insured ATV, any other ATV, any motorcycle or a motor vehicle.

First-Party Benefits

First-party benefits, other than death benefits, are payments equal to basic economic loss, reduced by the following:

- (a) 20 percent of the eligible injured person's loss of earnings from work to the extent that an eligible injured person's basic economic loss consists of such loss of earnings;
- (b) amounts recovered or recoverable on account of personal injury to an eligible injured person under State or Federal laws providing social security disability or workers' compensation benefits, or disability benefits under article 9 of the New York Workers' Compensation Law.

Basic Economic Loss

Basic economic loss shall consist of medical expense, work loss, other expense and, when death occurs, a death benefit as herein provided. Except for such death benefit, basic economic loss shall not include any loss sustained on account of death. Basic economic loss of each eligible injured person on account of any single accident shall not exceed \$50,000 except that any death benefit hereunder shall be in addition thereto.

Medical Expense

Medical expense shall consist of necessary expenses for:

- (a) medical, hospital, surgical, nursing, dental, ambulance, X-ray, prescription drug and prosthetic services;
- (b) psychiatric, physical and occupational therapy and rehabilitation;
- (c) any nonmedical remedial care and treatment rendered in accordance with a religious method of healing recognized by the laws of New York; and
- (d) any other professional health services.

These medical expenses will not be subject to a time limitation, provided that within one year after the date of the accident it is ascertainable that further medical expenses may be sustained as a result of the injury. Payments hereunder for necessary medical expenses shall be subject to the limitations and requirements of section 5108 of the New York Insurance Law.

Work Loss

Work loss shall consist of the sum of the following losses and expenses, up to a maximum payment of \$2,000 per month for a period of three years from the date of the accident:

- (a) loss of earnings from work which the eligible injured person would have performed had such person not been injured, except that an employee who is entitled to receive monetary payments, pursuant to statute or contract with the employer, or who receives voluntary monetary benefits paid for by the employer, by reason of such employee's inability to work because of personal injury arising out of the use or operation of an ATV shall not be entitled

¹⁰This endorsement shall be issued only for all-terrain vehicles.

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to receive first-party benefits for loss of earnings from work to the extent that such monetary payments or benefits from the employer do not result in the employee suffering a reduction in income or a reduction in such employee's level of future benefits arising from a subsequent illness or injury; and

- (b) reasonable and necessary expenses sustained by the eligible injured person in obtaining services in lieu of those which such person would have performed for income.

Other Expenses

Other expenses shall consist of all reasonable and necessary expenses, other than medical expense and work loss, up to \$25 per day for a period of one year from the date of the accident causing injury.

Death Benefit

Upon the death of any eligible injured person, caused by an accident to which this coverage applies, the Company will pay to the estate of such person a death benefit of \$2,000.

*Exclusions*¹¹

This coverage does not apply:

- (a) to a personal injury sustained by any person who intentionally causes his own personal injury;
- (b) to a personal injury sustained by any person while committing an act which would constitute a felony, or seeking to avoid lawful apprehension or arrest by a law enforcement officer; or
- (c) to a personal injury sustained by a person while repairing, servicing, or otherwise maintaining a motor vehicle, motorcycle or ATV, if such conduct is within the course of a business of repairing, servicing, or otherwise maintaining a motor vehicle, motorcycle or ATV, and the injury occurs on the business premises.

Other Definitions

When used in reference to this coverage:

- (a) the *insured ATV* means an ATV owned by the named insured and to which the bodily injury liability insurance of this policy applies and for which a specific premium is charged;
- (b) *motorcycle* means a vehicle as defined in section 123 of the New York Vehicle and Traffic Law, and which is required to carry financial security pursuant to article 6, 8 or 48-A of the Vehicle and Traffic Law;
- (c) *all-terrain vehicle (ATV)* means a vehicle defined in section 2281 of the New York Vehicle and Traffic Law, which is required to carry financial security pursuant to articles 48-A and 48-C of the Vehicle and Traffic Law;
- (d) *motor vehicle* means a motor vehicle, as defined in section 311 of the New York Vehicle and Traffic Law, and also includes fire and police vehicles, but shall not include any motor vehicle not required to carry financial security pursuant to article 6, 8 or 48-A of the Vehicle and Traffic Law, or a motorcycle or ATV, as defined above;
- (e) *named insured* means the person or organization named [in the declaration];¹²
- (f) *occupying* means in or upon or entering into or alighting from;
- (g) *personal injury* means bodily injury, sickness or disease;
- (h) *use or operation* of a motor vehicle, motorcycle or ATV includes the loading or unloading of such vehicle.

Conditions

Action Against Company. No action shall lie against the Company, unless, as a condition precedent thereto, there shall have been full compliance with the terms of this coverage.

Notice. In the event of an accident, written notice setting forth details sufficient to identify the eligible injured person, along with reasonably obtainable information regarding the time, place and

¹¹These exclusions may be deleted, in the event the Company wishes to provide coverage under the indicated circumstances.

¹²Companies may substitute the appropriate term, reference or language for the matter set out in brackets.

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circumstances of the accident, shall be given by, or on behalf of, each eligible injured person, to the Company, or any of the Company's authorized agents, as soon as reasonably practicable, but in no event more than 30 days after the date of the accident, unless the eligible injured person submits written proof providing clear and reasonable justification for the failure to comply with such time limitation. If an eligible injured person or his legal representative institutes a proceeding to recover damages for personal injury under section 5104(b) of the New York Insurance Law, a copy of the summons and complaint or other process served in connection with such action shall be forwarded as soon as practicable to the Company or any of the Company's authorized agents by such eligible injured person or his legal representative.

Proof of Claim; Medical, Work Loss, and Other Necessary Expenses. In the case of a claim for health service expenses, the eligible injured person or that person's assignee or representative shall submit written proof of claim to the Company, including full particulars of the nature and extent of the injuries and treatment received and contemplated, as soon as reasonably practicable but, in no event later than 45 days after the date services are rendered. The eligible injured person or that person's representative shall submit written proof of claim for work loss benefits and for other necessary expenses to the Company as soon as reasonably practicable but, in no event, later than 90 days after the work loss is incurred or the other necessary services are rendered. The foregoing time limitations for the submission of proof of claim shall apply unless the eligible injured person submits written proof providing clear and reasonable justification for the failure to comply with such time limitation. Upon request by the Company, the eligible injured person or that person's assignee or representative shall:

- (a) execute a written proof of claim under oath;
- (b) as may reasonably be required submit to examinations under oath by any person named by the Company and subscribe the same;
- (c) provide authorization that will enable the Company to obtain medical records; and
- (d) provide any other pertinent information that may assist the Company in determining the amount due and payable.

The eligible injured person shall submit to medical examination by physicians selected by, or acceptable to, the Company, when, and as often as, the Company may reasonably require.

Arbitration. In the event any person making a claim for first-party benefits and the Company do not agree regarding any matter relating to the claim, such person shall have the option of submitting such disagreement to arbitration pursuant to procedures promulgated or approved by the Superintendent of Financial Services.

Reimbursement and Trust Agreement. To the extent that the Company pays first-party benefits, the Company is entitled to the proceeds of any settlement or judgment resulting from the exercise of any right of recovery for damages for personal injury under section 5104(b) of the New York Insurance Law. The Company shall have a lien upon any such settlement or judgment to the extent that the Company has paid first-party benefits. An eligible injured person shall:

- (a) hold in trust, for the benefit of the Company, all rights of recovery which he shall have for personal injury under section 5104(b) of the New York Insurance Law;
- (b) do whatever is proper to secure, and shall do nothing to prejudice, such rights; and
- (c) execute, and deliver to the Company, instruments and papers as may be appropriate to secure the rights and obligations of such person and the Company established by this provision.

An eligible injured person shall not compromise an action to recover damages brought under section 5104(b) of the New York Insurance Law except:

- (a) with the written consent of the Company;
- (b) with approval of the court; or
- (c) where the amount of the settlement exceeds \$50,000.

Other Coverage. Where more than one source of first-party benefits required by article 51 of the New York Insurance Law and article 6 or 8 of the New York Vehicle and Traffic Law is available and applicable to an eligible injured person in any one accident, this Company is liable to an eligible injured person only for an amount equal to the maximum amount that the eligible injured person is entitled to recover under this coverage, divided by the number of available and applicable sources of

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required first-party benefits. An eligible injured person shall not recover duplicate benefits for the same elements of loss under this coverage or any other mandatory first-party automobile or no-fault automobile insurance coverage issued in compliance with the laws of another state.

If the eligible injured person is entitled to benefits under any such mandatory first-party automobile or no-fault automobile insurance for the same elements of loss under this coverage, this Company shall be liable only for an amount equal to the proportion that the total amount available under this coverage bears to the sum of the amount available under this coverage and the amount available under such other mandatory insurance of the common elements of loss. However, where another state's mandatory first-party or no-fault automobile insurance law provides unlimited coverage available to an eligible injured person for an element of loss under this coverage, the obligation of this Company is to share equally for that element of loss with such other mandatory insurance until the \$50,000 limit of this coverage is exhausted by the payment of that element of loss and any other elements of loss.

Section II

Excess Coverage

If medical payments coverage or any disability coverages or uninsured motorists coverage are afforded under this policy, such coverages shall be excess insurance over any mandatory or additional personal injury protection benefits paid or payable, or which would be paid or payable but for the application of a deductible under this or any other automobile no-fault insurance policy.

Section III

Constitutionality

If it is conclusively determined by a court of competent jurisdiction that the New York Comprehensive Motor Vehicle Insurance Reparations Act, or any amendment thereto, is invalid or unenforceable in whole or in part, then, subject to the approval of the Superintendent of Financial Services, the Company may amend this policy and may also recompute the premium for the existing or amended policy.

These amendments and recomputations will be effective retroactively to the date that such Act or any amendment is deemed to be invalid or unenforceable in whole or in part.

* * *

(g) Notwithstanding any of the provisions of these endorsements, the Company shall provide at least for the payment of first-party benefits pursuant to section 5103 of the Insurance Law, and these endorsements shall be construed as if such coverage were embodied therein.

Historical Note

Sec. filed Aug. 2, 2001; amds. filed: Dec. 20, 2010 as emergency measure, expired 90 days after filing; March 21, 2011 as emergency measure; April 26, 2011; April 9, 2013 eff. June 1, 2013; amended adoption filed May 16, 2013; June 6, 2017 as emergency measure; Sept. 1, 2017 as emergency measure; Oct. 10, 2017 eff. Oct. 25, 2017. Amended (a), (d), (e), (f).

§ 65-1.2 Requirements for optional basic economic loss coverage.

(a) The Optional Basic Economic Loss Coverage Endorsement (New York), set out below is approved and promulgated for use by an insurer and, except as provided in section 65-1.7 of this Subpart, must be furnished to all insureds who purchase Optional Basic Economic Loss (OBEL) coverage.

OPTIONAL BASIC ECONOMIC LOSS COVERAGE ENDORSEMENT (New York)

The Company agrees with the named insured, subject to all of the provisions, exclusions and conditions of the MANDATORY PERSONAL INJURY PROTECTION ENDORSEMENT (New York) not expressly modified in this Endorsement, as follows:

The definition of Basic Economic Loss contained in the MANDATORY PERSONAL INJURY PROTECTION ENDORSEMENT (New York) or the MANDATORY PERSONAL INJURY PROTECTION ENDORSEMENT-MOTORCYCLES (New York) is replaced by the following:

Basic Economic Loss:

Basic economic loss shall consist of medical expense, work loss, other expense and, when death occurs, a death benefit as herein provided. Except for such death benefit, basic economic loss shall not

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include any loss sustained on account of death. Basic economic loss of each eligible injured person on account of any single accident shall not exceed \$75,000, the last \$25,000 of which represents optional basic economic loss coverage, payable after the first \$50,000 of basic economic loss has been exhausted, that the eligible injured person or that person's legal representative may specify will be applied to one of the following four options:

- (a) basic economic loss;
- (b) loss of earnings from work;
- (c) Psychiatric, physical or occupational therapy and rehabilitation; or
- (d) a combination of options (b) and (c).

Any death benefit hereunder shall be in addition thereto.

Exclusion (c) set forth in the MANDATORY PERSONAL INJURY PROTECTION ENDORSEMENT (New York) is replaced by the following:

- (c) the named insured or relative while occupying, or while a pedestrian through being struck by, a motor vehicle in New York State, other than the insured motor vehicle, with respect to which the coverage required by the New York Comprehensive Motor Vehicle Insurance Reparations Act is in effect; however, this exclusion does not apply to:
 - (1) the Optional Basic Economic Loss coverage provided under this endorsement, unless OBEL coverage is provided by the policy covering the other motor vehicle; or
 - (2) to personal injury sustained in New York State by the named insured or relative while occupying a bus or school bus, as defined in sections 104 and 142 of the New York Vehicle and Traffic Law, unless that person is the operator, an owner, or an employee of the owner or operator, of such bus or school bus.

Election

Election of the OBEL option shall be made by the eligible injured person or that person's legal representative after such person has incurred expense aggregating \$30,000 in basic economic loss and after receiving the required notices from the Company that an OBEL election may be made. Failure of the eligible injured person or that person's legal representative to respond to the second notice within 15 calendar days after its mailing shall be considered an election by the eligible injured person to apply OBEL coverage to all elements of basic economic loss. Once made by the eligible injured person or that person's legal representative, an OBEL election cannot be changed. However, if claims payable under OBEL coverage have not yet been received by the Company, an eligible injured person who has failed to respond to the second notice in a timely manner may make an election.

Notice

If OBEL coverage is payable under this policy, but Mandatory PIP is being paid under a policy covering another motor vehicle, then the named insured or relative shall notify the Company no later than 90 days after Mandatory PIP benefits under that other policy have been exhausted. The Company shall then send its OBEL election notice.

- (b) The insurer shall in connection with new policy applications offer applicants OBEL coverage by sending the applicant the following letter:

Dear Applicant:

Optional Basic Economic Loss (OBEL) coverage is being offered to you as an enhancement of the Basic No-Fault coverage you are presently required to purchase. But before we describe this coverage, we would like to advise you what benefits Basic No-Fault coverage does and does not provide.

No-Fault coverage, otherwise known as Personal Injury Protection or "PIP" coverage, pays for expenses incurred by persons injured in a motor vehicle accident. This coverage does not pay to repair damage to your automobile.

Basic No-Fault, which you are required by law to purchase, provides coverage of up to \$50,000 per person in benefits for:

1. all necessary doctor and hospital bills and other health service expenses, payable in accordance with fee schedules established or adopted by the New York State Department of Financial Services; and

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2. 80% of lost earnings up to a maximum monthly payment of \$2,000 for up to three years following the date of accident; and
3. up to \$25 per day for a period of one year from the date of the accident for other reasonable and necessary expenses the injured person may have incurred because of an injury resulting from the accident, such as the cost of hiring a housekeeper or necessary transportation expenses to and from a health service provider; and
4. a \$2,000 death benefit, payable to the estate of a covered person, in addition to the \$50,000 coverage for economic loss described above.

No-Fault benefits will be reduced by other benefits that are payable under Workers' Compensation, Social Security Disability, New York State Disability, and certain employer "wage continuation" plans where an employee does not lose any future sick leave benefits. [In addition to the basic No-Fault coverage described, higher limits of up to _____, including payments of up to _____ for loss of earnings and up to _____ for other reasonable and necessary expenses, are available for purchase upon request.]¹³

OPTIONAL COVERAGE AVAILABLE

In addition to Basic No-Fault Coverage, you may also purchase OBEL coverage that will pay certain expenses, up to \$25,000, above the Basic No-Fault limit of \$50,000. OBEL coverage is different from other coverages in that a claimant can select the kinds of benefits to be paid under OBEL.

If you purchase OBEL coverage and if it appears likely that a claimant will use up the Basic No-Fault coverage, your insurer will send the claimant a form for the claimant to choose what expenses the \$25,000 in OBEL coverage will be used to pay. Under No-Fault, a claimant could include you, family members, passengers in your car, or pedestrians, if injured in an auto accident.

The claimant will be able to choose one of the following four OBEL options and thereby direct the insurer to pay expenses for:

1. basic economic loss, whether health care expenses, loss of earnings from work, or other reasonable and necessary expenses;
2. loss of earnings from work;
3. psychiatric, physical or occupational therapy and rehabilitation; or
4. a combination of options 2 and 3.

The additional \$25,000 of OBEL coverage will be used only for costs incurred under the chosen option, which, once selected, the claimant cannot change.

If you have any questions, please contact your Company or agent.

Historical Note

Sec. filed Aug. 2, 2001; amds. filed: April 9, 2013; amended adoption filed May 16, 2013; June 6, 2017 as emergency measure; Sept. 1, 2017 as emergency measure; Oct. 10, 2017 eff. Oct. 25, 2017. Amended (b).

§ 65-1.3 Requirements for additional personal injury protection coverage.

(a) The additional personal injury protection endorsement (New York), set out in this section, is approved and promulgated and all of the provisions thereof shall, in accordance with section 2307(b) of the Insurance Law, be deemed to be included in all additional personal injury protection endorsements in force. This endorsement contains nonsubstantive changes from the previously prescribed additional personal injury protection endorsement (New York) and may be substituted for that endorsement when supplies of that endorsement are exhausted. This endorsement may be combined with the Mandatory Personal Injury Protection Endorsement (New York) and other coverages, with appropriate language.

(b) The endorsement set forth in this section may include the following provision, together with appropriate schedule(s) of named individuals: "It is agreed that the individual(s) named in this endorsement shall be deemed to be a named insured under the Mandatory Personal Injury Protection Endorsement (New York) and, to the extent applicable, this endorsement."

¹³This Additional PIP language may be deleted at the insurer's option.

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(c) *Additional personal injury protection endorsement.*

ADDITIONAL PERSONAL INJURY PROTECTION ENDORSEMENT
(New York)

The Company agrees with the named insured subject to all of the provisions, exclusions and conditions of the Mandatory Personal Injury Protection (Endorsement)¹⁴ (New York), not expressly modified in this (Endorsement)¹⁴ as follows:

Additional Personal Injury Protection

The Company will pay additional first-party benefits to reimburse for extended economic loss on account of personal injuries sustained by an eligible injured person and caused by an accident arising out of the use or operation of a motor vehicle or motorcycle during the policy period. This coverage only applies to motor vehicle accidents within the United States of America, its territories or possessions, or Canada.¹⁵

Eligible Injured Person

Subject to the exclusions and conditions set forth below, an eligible injured person is:

- (a) the named insured and any relative who sustains personal injury arising out of the use or operation of any motor vehicle;
- (b) the named insured and any relative who sustains personal injury arising out of the use or operation of any motorcycle while not occupying a motorcycle;
- (c) any other person who sustains personal injury arising out of the use or operation of the insured motor vehicle while occupying the insured motor vehicle; or
- (d) any other person who sustains personal injury arising out of the use or operation of any other motor vehicle (other than a public or livery conveyance) while occupying such other motor vehicle, if such other motor vehicle is being operated by the named insured or any relative.

Exclusions

This coverage does not apply to personal injury sustained by:

- (a) any person while occupying a motor vehicle owned by such person with respect to which the coverage required by the New York Comprehensive Motor Vehicle Insurance Reparations Act is not in effect;
- (b) any person while occupying, or while a pedestrian through being struck by, a motor vehicle owned by the named insured with respect to which additional personal injury protection coverage is not provided under this policy;
- (c) any relative while occupying, or while a pedestrian through being struck by, a motor vehicle owned by such relative with respect to which additional personal injury protection coverage is not provided under this policy;
- (d) any New York State resident other than the named insured or relative injured through the use or operation of a motor vehicle outside of New York State if such resident is the owner of a motor vehicle for which the coverage required by the New York Comprehensive Motor Vehicle Insurance Reparations Act is not in effect;
- (e) any person while occupying a motorcycle;
- (f) any person who intentionally causes his own personal injury;¹⁶
- (g) any person as a result of operating a motor vehicle while in an intoxicated condition or while his or her ability to operate the vehicle is impaired by the use of a drug (within the meaning

¹⁴Companies may substitute the appropriate term, reference or language for the matter set out in parenthesis.

¹⁵If the policy is being used to satisfy the financial responsibility requirements of article 44-B of the Vehicle and Traffic Law, then the Company may substitute the following language:

The company will pay first-party benefits to reimburse for basic economic loss sustained by an eligible injured person on account of personal injuries caused by an accident arising out of the use or operation of a motor vehicle, pursuant to article 44-B of the Vehicle and Traffic Law, by a transportation network company driver during the policy period and within the United States of America, its territories or possessions, or Canada.

¹⁶These exclusions may be deleted, in the event the Company wishes to provide coverage under the indicated circumstances.

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of section 1192 of the New York Vehicle and Traffic Law) except that coverage shall apply to necessary emergency health services rendered in a general hospital, as defined in section 2801(10) of the New York Public Health Law, including ambulance services attendant thereto and related medical screening. However, where the person has been convicted of violating section 1192 of the New York Vehicle and Traffic Law while operating a motor vehicle in an intoxicated condition or while his or her ability to operate such vehicle is impaired by the use of a drug, and the conviction is a final determination, the company has a cause of action against such person for the amount of first party benefits that are paid or payable;¹⁷ or

- (h) any person while:
 - (i) committing an act which would constitute a felony, or seeking to avoid lawful apprehension or arrest by a law enforcement officer;¹⁶
 - (ii) operating a motor vehicle in a race or speed test;¹⁶
 - (iii) operating or occupying a motor vehicle known to him to be stolen; or¹⁶
 - (iv) repairing, servicing, or otherwise maintaining a motor vehicle if such conduct is within the course of a business of repairing, servicing or otherwise maintaining a motor vehicle and the injury occurs on the business premises;¹⁶ or
- (i) any person who is injured while, pursuant to article 44-B of the Vehicle and Traffic Law, the insured motor vehicle is being used or operated by a transportation network company driver.¹⁸

Additional First-Party Benefits

Additional first-party benefits are payments equal to extended economic loss reduced by:

- (a) 20 percent of the eligible injured person's loss of earnings from work, to the extent that the extended economic loss covered by this [Endorsement]¹⁹ includes such loss of earnings;
- (b) amounts recovered or recoverable on account of personal injury to an eligible injured person under State or Federal laws providing social security disability or workers' compensation benefits or disability benefits under article 9 of the New York Workers' Compensation law, which amounts have not been applied to reduce first-party benefits recovered or recoverable under basic economic loss;
- (c) amounts recovered or recoverable by the eligible injured person for any element of extended economic loss covered by this [Endorsement]¹⁹ under any mandatory source of first-party automobile no-fault benefits required by the laws of any state (other than the State of New York) of the United States of America, its possessions or territories, or by the laws of any province of Canada.

Extended Economic Loss

Extended economic loss shall consist of the following:

- (a) basic economic loss sustained on account of an accident occurring within the United States of America, its possessions or territories, or Canada, which is not recovered or recoverable under a policy issued in satisfaction of the requirements of article 6 or 8 of the New York Vehicle and Traffic law and article 51 of the New York Insurance Law;

¹⁷This exclusion may be deleted, in the event the company wishes to provide coverage under the indicated circumstance. Alternatively, the company may delete the cause of action language only, provided, however, that, in either case, if the company deletes this language, then the company will be deemed to have waived its right to bring a cause of action against the person.

¹⁸An insurer may not include this exclusion in a policy used to satisfy the requirements under article 44-B of the Vehicle and Traffic Law. An insurer may use one of the following exclusions: If the policy provides liability coverage while, pursuant to article 44-B of the Vehicle and Traffic Law, the insured motor vehicle is being used or operated by a transportation network company driver while providing a transportation network company prearranged trip: any person who is injured while, pursuant to article 44-B of the Vehicle and Traffic Law, the insured motor vehicle is being used or operated by a transportation network company driver while the driver is logged onto a transportation network company's digital network but is not engaged in a transportation network company prearranged trip. If the policy provides liability coverage while, pursuant to article 44-B of the Vehicle and Traffic Law, the insured motor vehicle is being used or operated by a transportation network company driver while logged onto a transportation network company's digital network but who is not engaged in a transportation network company prearranged trip: any person who is injured while, pursuant to article 44-B of the Vehicle and Traffic Law, the insured motor vehicle is being used or operated by a transportation network company driver while the driver provides a transportation network company prearranged trip.

¹⁹Companies may substitute the appropriate term, reference or language for the matter set out in brackets.

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- (b) the difference between
 - (i) basic economic loss; and
 - (ii) basic economic loss recomputed in accordance with the time and dollar limits;¹⁹ and
- [(c) an additional death benefit in the amount set out in the declarations]²⁰

Two or More Motor Vehicles Insured Under This Policy

The limit of liability under this [Endorsement]¹⁹ applicable to injuries sustained by an eligible injured person while occupying, or while a pedestrian through being struck by, the insured motor vehicle shall be as stated [in the declarations]¹⁹ for that insured motor vehicle. The limit of liability for injuries covered by this [Endorsement]²¹ and sustained by an eligible injured person while occupying, or while a pedestrian through being struck by, a motor vehicle, other than the insured motor vehicle, shall be the highest limit stated for this coverage in the declarations for any insured motor vehicle under this policy.

Arbitration

In the event any person making a claim for additional first-party benefits and the Company do not agree regarding any matter relating to the claim, such person shall have the option of submitting such disagreement to arbitration pursuant to procedures promulgated or approved by the Superintendent of Financial Services.

Subrogation

In the event of any payment for extended economic loss, the Company is subrogated to the extent of such payments to the rights of the person to whom, or for whose benefit, such payments were made. Such person must execute and deliver instruments and papers and do whatever else is necessary to secure such rights. Such person shall do nothing to prejudice such rights.

Other Coverage; Nonduplication

The eligible injured person shall not recover duplicate benefits for the same elements of loss covered by this [Endorsement]²² or any other optional first-party automobile or no-fault automobile insurance coverage.

If an eligible injured person is entitled to New York mandatory and additional personal injury protection benefits under any other policy, and if such eligible injured person is not entitled to New York mandatory personal injury protection benefits under this policy, then the coverage provided under this Additional Personal Injury Protection Endorsement (New York) shall be excess over such other New York mandatory and additional personal injury protection benefits.

When coverage provided under this [Endorsement]²² applies on an excess basis, it shall apply only in the amount by which the total limit of liability of New York mandatory and additional personal injury protection coverage available under this policy exceeds the total limit of liability for any other applicable New York mandatory and additional personal injury protection coverage.

Subject to the provisions of the preceding three paragraphs, if the eligible injured person is entitled to benefits under any other optional first-party automobile or no-fault automobile insurance for the same elements of loss covered by this [Endorsement]²² this Company shall be liable only for an amount equal to the proportion that the total amount available under this [Endorsement]²² bears to the sum of the amounts available under this [Endorsement]²³ and such other optional insurance, for the same element of loss.

Historical Note

Sec. filed Aug. 2, 2001; amds. filed: Dec. 20, 2010 as emergency measure, expired 90 days after filing; March 21, 2011 as emergency measure; April 26, 2011; April 9, 2013; amended adoption filed May 16, 2013; June 6, 2017 as emergency measure; Sept. 1, 2017 as emergency measure; Oct. 10, 2017 eff. Oct. 25, 2017. Amended (c).

²⁰Language in brackets may be deleted if additional death benefits are not offered.

²¹Companies may substitute the appropriate term, reference or language for the matter set out in brackets.

²²Companies may substitute the appropriate term, reference or language for the matter set out in brackets.

²³Companies may substitute the appropriate term, reference or language for the matter set out in brackets.

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§ 65-1.4 Medical expense exclusion.

The Exclusion of Medical Expense from Mandatory Personal Injury Protection Endorsement (New York), set out below is approved and promulgated for use in accordance with the provisions of section 5103(g) of the Insurance Law. This endorsement may be used as a separate endorsement or appropriately added to the mandatory endorsement.

EXCLUSION OF MEDICAL EXPENSE FROM MANDATORY
PERSONAL INJURY PROTECTION ENDORSEMENT
(New York)

In consideration of a reduction in premium, it is agreed that:

If the Medical Expense element of Basic Economic Loss is identified as not applicable [in the declarations] ¹⁹ the Company shall not be liable for any items of such loss which would otherwise be covered under the Mandatory Personal Injury Protection Endorsement (New York) with respect to the named insured or named insured and any relative as specified [in the declarations] ¹⁹ Coverage for any such medical expense element of basic economic loss provided to such named insured, or such relative, by a Company or corporation in accordance with the provisions of section 5103(g) of the New York Insurance Law shall reduce the \$50,000 aggregate limit of liability for basic economic loss to such person under this policy. This endorsement shall be effective during the term of this policy so long as the medical expense coverage provided by such Company or corporation remains in effect, notwithstanding any provisions [in the declarations] ¹⁹ of this policy to the contrary, and in the event this endorsement shall no longer be in effect the premium may be adjusted accordingly.

Historical Note

Sec. filed Aug. 2, 2001; ams. filed: Dec. 20, 2010 as emergency measure, expired 90 days after filing; March 21, 2011 as emergency measure; April 26, 2011 eff. May 11, 2011.

§ 65-1.5 Declarations page requirements for policies insuring a motor vehicle.

(a) The declarations page of each policy must specify the dollar amount of basic economic loss coverage under the policy and, if the insured has purchased OBEL coverage, OBEL coverage shall be separately identified on the declarations page of the policy.

(b) If additional PIP coverage is purchased by the policyholder, the declarations page shall state:

- (1) the basic economic loss limits (mandatory PIP coverage and, if purchased, OBEL coverage);
- (2) the maximum amount payable under additional PIP coverage; and
- (3) the aggregate amount payable as PIP benefits, including the maximum amounts payable as work loss benefits, other expenses and the death benefit.

Historical Note

Sec. filed Aug. 2, 2001 eff. Sept. 1, 2001.

§ 65-1.6 Deductibles.

Each insurance company which offers insurance policies to satisfy the minimum requirements of article 51 shall offer the policy prescribed in this Subpart with a family deductible of \$200 and without any deductible. Each insurance company may also offer the above policy with a family deductible of \$100. Any family deductible shall apply to the "named insured" and any "relative", as these terms are defined in the Mandatory Personal Injury Protection Endorsement set forth in this Subpart.

Historical Note

Sec. filed Aug. 2, 2001 eff. Sept. 1, 2001.

§ 65-1.7 Deviations.

Deviations from these endorsements prescribed by this Subpart may be submitted for prior approval, but approval will not be granted for any reduction in first-party benefits payable to eligible

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injured persons, or any changes in form alone, or nonsubstantive or editorial deviations or minor deviations in first-party benefits or other provisions.

Historical Note

Sec. filed Aug. 2, 2001 eff. Sept. 1, 2001.

§ 65-1.8 Coverage for nonresident motorists driving in this State.

(a) The automobile liability insurance policies of every authorized insurer which are sold in any other state or Canadian province shall be deemed to satisfy the financial security requirements of article 6 or 8 of the New York Vehicle and Traffic Law, and shall be deemed to provide for the payment of first-party benefits pursuant to section 5103 of the New York Insurance Law when the insured motor vehicle is used or operated in this State.

(b) The automobile liability insurance policies which are sold in any other state or Canadian province by an unauthorized insurer which is controlled by, or controlling, or under common control of, an authorized insurer shall be deemed to satisfy the financial security requirements of article 6 or 8 of the New York Vehicle and Traffic Law, and shall be deemed to provide for the payment of first-party benefits pursuant to section 5103 of the New York Insurance Law when the insured motor vehicle is used or operated in this State.

(c) Any other unauthorized insurer may file with the Superintendent of Financial Services a statement that its automobile insurance policies sold in any other state or Canadian province will be deemed to satisfy the financial security requirements of article 6 or 8 of the New York Vehicle and Traffic Law, and will be deemed to provide for the payment of first-party benefits pursuant to section 5103 of the New York Insurance Law when the insured motor vehicle is used or operated in this State.

Historical Note

Sec. filed Aug. 2, 2001; amd. filed April 9, 2013 eff. June 1, 2013; amended adoption filed May 16, 2013 eff. Aug. 1, 2013. Amended (c).

SUBPART 65-2
(Regulation 68-B)
RIGHTS AND LIABILITIES OF SELF-INSURERS

Historical Note

Subpart (§§ 65-2.1—65-2.6) filed Aug. 2, 2001 eff. Sept. 1, 2001.

§ 65-2.1 Rights and liabilities of self-insurers.

Definitions. For the purpose of this Part:

(a) A *self-insurer* is any person, firm, association or corporation that:

(1) maintains a form of financial security other than an owner's automobile insurance policy in satisfaction of article 6 or 8 of the New York Vehicle and Traffic Law; or

(2) is subject to article 51 of the New York Insurance Law as provided for in section 321 of the New York Vehicle and Traffic Law.

(b) *Motorcycle* means a vehicle as defined in section 123 of the New York Vehicle and Traffic Law, and which is required to carry financial security pursuant to article 6, 8 or 48-A of the Vehicle and Traffic Law.

(c) *Motor vehicle* means a motor vehicle, as defined in section 311 of the New York Vehicle and Traffic Law, and also includes fire and police vehicles, but shall not include any motor vehicle not required to carry financial security pursuant to article 6, 8 or 48-A of the Vehicle and Traffic Law, or a motorcycle as defined in subdivision (b) of this section.

(d) *Occupying* means in or upon or entering into or alighting from.

(e) *Personal injury* means bodily injury, sickness or disease.

(f) *Relative* means a spouse, child or other person related to the self-insurer (who is a natural person), by blood, marriage or adoption (including a ward or foster child), who regularly resides in the self-insurer's household, including any such person who regularly resides in the household but is temporarily residing elsewhere.

(g) *Use or operation* of a motor vehicle or a motorcycle includes the loading or unloading of such vehicle.

Historical Note

Sec. filed Aug. 2, 2001 eff. Sept. 1, 2001.

§ 65-2.2 Obligations of self-insurers.

(a) In accordance with the provisions of article 51 of the New York Insurance Law and this Part, a self-insurer shall pay first-party benefits to reimburse for basic economic loss sustained by an eligible injured person on account of personal injuries caused by an accident arising out of the use or operation of a motor vehicle within the United States of America, its territories or possessions, or Canada.

(b) *First-party benefits.* First-party benefits, other than death benefits, are payments equal to basic economic loss, reduced by the following:

(1) 20 percent of the eligible injured person's loss of earnings from work to the extent that an eligible injured person's basic economic loss consists of such loss of earnings; and

(2) amounts recovered or recoverable on account of personal injury to an eligible injured person under State or Federal laws providing social security disability or workers' compensation benefits, or disability benefits under article 9 of the New York Workers' Compensation Law.

(c) *Basic economic loss.* Basic economic loss shall consist of medical expense, work loss, other expense and, when death occurs, a death benefit as provided in this section. Except for such death benefit, basic economic loss shall not include any loss sustained on account of death. Basic economic loss of each eligible injured person on account of any single accident shall not exceed \$50,000, or \$75,000 if the self-insurer elects to provide optional basic economic loss coverage, except that any death benefit shall be in addition thereto.

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(d) If the self-insurer has elected to provide Optional Basic Economic Loss (OBEL) coverage, the eligible injured person or that person's legal representative may specify that the OBEL coverage will be applied to one of the following four options:

- (1) basic economic loss;
- (2) loss of earnings from work;
- (3) psychiatric, physical or occupational therapy and rehabilitation; or
- (4) a combination of paragraphs (2) and (3) of this subdivision.

(e) OBEL coverage shall apply after the initial \$50,000 of basic economic loss has been exhausted.

(f) *Medical expense.* Medical expense shall consist of necessary expenses for:

- (1) medical, hospital, surgical, nursing, dental, ambulance, X-ray, prescription drug and prosthetic services;
- (2) psychiatric, physical and occupational therapy and rehabilitation;
- (3) any nonmedical remedial care and treatment rendered in accordance with a religious method of healing recognized by the laws of New York; and
- (4) any other professional health services.

These medical expenses will not be subject to a time limitation, provided that within one year after the date of the accident it is ascertainable that further medical expenses may be sustained as a result of the injury. Payments pursuant to this section for necessary medical expenses shall be subject to the limitations and requirements of section 5108 of the New York Insurance Law.

(g) *Work loss.* Work loss shall consist of the sum of the following losses and expenses, up to a maximum payment of \$2,000 per month for a maximum period of three years from the date of the accident:

- (1) loss of earnings from work which the eligible injured person would have performed had such person not been injured, except that an employee who is entitled to receive monetary payments, pursuant to statute or contract with the employer, or who receives voluntary monetary benefits paid for by the employer, by reason of such employee's inability to work because of personal injury arising out of the use or operation of a motor vehicle, shall not be entitled to receive first-party benefits for loss of earnings from work to the extent that such monetary payments or benefits from the employer do not result in the employee suffering a reduction in income or a reduction in such employee's level of future benefits arising from a subsequent illness or injury; and
- (2) reasonable and necessary expenses sustained by the eligible injured person in obtaining services in lieu of those which such person would have performed for income.

(h) *Other expenses.* Other expenses shall consist of all reasonable and necessary expenses, other than medical expense and work loss, up to \$25 per day for a period of one year from the date of accident causing injury.

(i) *Death benefit.* Upon the death of any eligible injured person, caused by an accident for which the self-insurer is required to provide first-party benefits pursuant to this section, the self-insurer will pay to the estate of such person a death benefit of \$2,000.

(j) *Eligible injured person.* Subject to the exclusions and conditions set forth below, an eligible injured person is:

- (1) the self-insurer (who is a natural person) and any relative who sustains personal injury arising out of the use or operation of any motor vehicle;
- (2) the self-insurer (who is a natural person) and any relative who, on or after July 22, 1982, sustains personal injury arising out of the use or operation of any motorcycle while not occupying a motorcycle;
- (3) any other person who sustains personal injury arising out of the use or operation of the self-insured motor vehicle in the State of New York while not occupying another motor vehicle; or

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(4) any New York State resident who, on or after January 1, 1983, sustains personal injury arising out of the use or operation of the self-insured motor vehicle outside of New York State while not occupying another motor vehicle.

Historical Note

Sec. filed Aug. 2, 2001 eff. Sept. 1, 2001.

§ 65-2.3 Exclusions.

The requirement for payment by a self-insurer of first-party benefits does not apply to personal injury sustained by:

(a) the self-insurer (who is a natural person) or relative while occupying, or while a pedestrian through being struck by, any motor vehicle owned by the self-insurer with respect to which the coverage required by the New York Comprehensive Motor Vehicle Insurance Reparations Act is not in effect;

(b) any relative while occupying, or while a pedestrian through being struck by, any motor vehicle owned by the relative with respect to which the coverage required by the New York Comprehensive Motor Vehicle Insurance Reparations Act is not in effect;

(c) the self-insurer (who is a natural person) or relative while occupying, or while a pedestrian through being struck by, a motor vehicle in New York State, other than the self-insured motor vehicle, with respect to which the coverage required by the New York Comprehensive Motor Vehicle Insurance Reparations Act is in effect;

(d) the self-insurer (who is a natural person) or relative while not occupying a motor vehicle or a motorcycle when struck by a motorcycle in New York State with respect to which the coverage required by the New York Comprehensive Motor Vehicle Insurance Reparations Act is in effect;

(e) any New York State resident other than the self-insurer or relative injured through the use or operation of the self-insured motor vehicle outside of New York State if such resident is the owner or a relative of the owner of a motor vehicle insured under another policy providing the coverage required by the New York Comprehensive Motor Vehicle Insurance Reparations Act;

(f) any New York State resident other than the self-insurer or relative injured through the use or operation of the self-insured motor vehicle outside of New York State if such resident is the owner of a motor vehicle for which the coverage required by the New York Comprehensive Motor Vehicle Insurance Reparations Act is not in effect;

(g) any person in New York State while occupying the self-insured motor vehicle which is a bus or school bus, as defined in sections 104 and 142 of the New York Vehicle and Traffic Law, but only if such person is a named insured or relative under any policy providing the coverage required by the New York Comprehensive Motor Vehicle Insurance Reparations Act; however, this exclusion does not apply to the operator, an owner, or an employee of the owner or operator, of such bus or school bus;

(h) any person while occupying a motorcycle;

(i) any person who intentionally causes his own personal injury;

(j) any person as a result of operating a motor vehicle while in an intoxicated condition or while his or her ability to operate such vehicle is impaired by the use of a drug (within the meaning of section 1192 of the New York Vehicle and Traffic Law) except that coverage shall apply to necessary emergency health services rendered in a general hospital, as defined in section 2801(10) of the New York Public Health Law, including ambulance services attendant thereto and related medical screening. However, where the person has been convicted of violating section 1192 of the New York Vehicle and Traffic Law while operating a motor vehicle in an intoxicated condition or while his or her ability to operate such vehicle is impaired by the use of a drug, and the conviction is a final determination, the self-insurer has a cause of action against such person for the amount of first party benefits that are paid or payable; or

(k) any person while:

(1) committing an act which would constitute a felony, or seeking to avoid lawful apprehension or arrest by a law enforcement officer;

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- (2) operating a motor vehicle in a race or speed test;
- (3) operating or occupying a motor vehicle known to him to be stolen; or
- (4) repairing, servicing or otherwise maintaining a motor vehicle if such conduct is within the course of a business of repairing, servicing or otherwise maintaining a motor vehicle and the injury occurs on the business premises.

Historical Note

Sec. filed Aug. 2, 2001; amds. filed: Dec. 20, 2010 as emergency measure, expired 90 days after filing; March 21, 2011 as emergency measure; April 26, 2011 eff. May 11, 2011. Amended (j).

§ 65-2.4 Conditions.

(a) *Action against self-insurer.* No action shall lie against the self-insurer unless, as a condition precedent thereto, there shall have been full compliance with the terms of this section.

(b) *Notice.* In the event of an accident, written notice setting forth details sufficient to identify the eligible injured person, along with reasonably obtainable information regarding the time, place and circumstances of the accident, shall be given by or on behalf of each eligible injured person to the self-insurer or any of the self-insurer's authorized agents, as soon as reasonably practicable, but in no event more than 30 days after the date of the accident, unless the eligible injured person submits written proof providing clear and reasonable justification for the failure to comply with such time limitation. If an eligible injured person or that person's legal representative institutes a proceeding to recover damages for personal injury under section 5104(b) of the New York Insurance Law, a copy of the summons and complaint or other process served in connection with such action shall be forwarded as soon as practicable to the self-insurer or any of the self-insurer's authorized agents by such eligible injured person or that person's legal representative.

(c) *Proof of claim; medical, work loss, and other necessary expenses.* In the case of a claim for health service expenses, the eligible injured person or that person's assignee or legal representative shall submit written proof of claim to the self-insurer, including full particulars of the nature and extent of the injuries and treatment received and contemplated, as soon as reasonably practicable but, in no event later than 45 days after the date services are rendered. The eligible injured person or that person's legal representative shall submit written proof of claim for work loss benefits and for other necessary expenses to the self-insurer as soon as reasonably practicable but, in no event, later than 90 days after the work loss is incurred or the other necessary services are rendered. The foregoing time limitations for the submission of proof of claim shall apply unless the eligible injured person submits written proof providing clear and reasonable justification for the failure to comply with such time limitation. Upon request by the self-insurer, the eligible injured person or that person's assignee or representative shall:

- (1) execute a written proof of claim under oath;
- (2) as may reasonably be required submit to examinations under oath by any person named by the self-insurer and subscribe the same;
- (3) provide authorization that will enable the self-insurer to obtain medical records; and
- (4) provide any other pertinent information that may assist the self-insurer in determining the amount due and payable.

The eligible injured person shall submit to medical examination by physicians selected by, or acceptable to, the self-insurer, when, and as often as, the self-insurer may reasonably require.

(d) *Arbitration.* In the event any person making a claim for first-party benefits and the self-insurer do not agree regarding any matter relating to the claim, such person shall have the option of submitting such disagreement to arbitration pursuant to Subpart 64-5 of this Title.

Historical Note

Sec. filed Aug. 2, 2001 eff. Sept. 1, 2001.

§ 65-2.5 Reimbursement and trust agreement.

(a) To the extent that the self-insurer pays first-party benefits, the self-insurer is entitled to the proceeds of any settlement or judgment resulting from the exercise of any right of recovery for

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damages for personal injury under section 5104(b) of the New York Insurance Law. The self-insurer shall have a lien upon any such settlement or judgment to the extent that the self-insurer has paid first-party benefits. An eligible injured person shall:

- (1) hold in trust, for the benefit of the self-insurer, all rights of recovery which he shall have for personal injury under section 5104(b) of the New York Insurance Law;
- (2) do whatever is proper to secure, and shall do nothing to prejudice, such rights; and
- (3) execute, and deliver to the self-insurer, instruments and papers as may be appropriate to secure the rights and obligations of such person and the self-insurer, established by this Part.

(b) An eligible injured person shall not compromise an action to recover damages brought under section 5104(b) of the New York Insurance Law except:

- (1) with the written consent of the self-insurer;
- (2) with approval of the court; or
- (3) where the amount of the settlement exceeds \$50,000.

Historical Note

Sec. filed Aug. 2, 2001 eff. Sept. 1, 2001.

§ 65-2.6 Other sources of first-party benefits.

(a) Where more than one source of first-party benefits required by article 51 of the New York Insurance Law and article 6 or 8 of the New York Vehicle and Traffic Law is available and applicable to an eligible injured person in any one accident, the self-insurer is liable to an eligible injured person only for an amount equal to the maximum amount that the eligible injured person is entitled to recover from the self-insurer, divided by the number of available and applicable sources of required first-party benefits.

(b) An eligible injured person shall not recover duplicate benefits for the same elements of loss required to be recovered by the self-insurer or any mandatory first-party automobile or no-fault automobile insurance coverage issued in compliance with the laws of another state. If the eligible injured person is entitled to benefits under any such mandatory first-party automobile or no-fault automobile insurance for the same elements of loss required to be covered by the self-insurer, the self-insurer shall be liable only for an amount equal to the proportion that the total amount available from the self-insurer bears to the sum of the amount available from the self-insurer and the amount available under such mandatory insurance for the common elements of loss. However, where another state's mandatory first-party or no-fault automobile insurance law provides unlimited coverage available to an eligible injured person for an element of loss required to be covered by the self-insurer, the obligation of the self-insurer is to share equally for that element of loss with such other mandatory insurance until the \$50,000, or \$75,000 if provided, limit available from the self-insurer is exhausted by the payment of that element of loss and any other elements of loss.

Historical Note

Sec. filed Aug. 2, 2001 eff. Sept. 1, 2001.

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SUBPART 65-3

(Regulation 68-C)

CLAIMS FOR PERSONAL INJURY PROTECTION BENEFITS

Historical Note

Subpart (§§ 65-3.1—65-3.20) filed Aug. 2, 2001 eff. Sept. 1, 2001.

§ 65-3.1 Applicability.

The following are rules for the settlement of claims for first-party and additional first-party benefits on account of injuries arising out of the use or operation of a motor vehicle, a motorcycle or an all-terrain vehicle. These rules shall apply to insurers and self-insurers, and the term insurer, as used in this section, shall include both insurers and self-insurers as those terms are defined in this Part and article 51 of the Insurance Law, the Motor Vehicle Accident Indemnification Corporation (MVAIC), pursuant to section 5221(b) of the Insurance Law and any company or corporation providing insurance pursuant to section 5103(g) of the Insurance Law, for the items of basic economic loss specified in section 5102(a) of the Insurance Law.

Historical Note

Sec. filed Aug. 2, 2001 eff. Sept. 1, 2001.

§ 65-3.2 Claim practice principles to be followed by all insurers.

- (a) Have as your basic goal the prompt and fair payment to all automobile accident victims.
- (b) Assist the applicant in the processing of a claim. Do not treat the applicant as an adversary.
- (c) Do not demand verification of facts unless there are good reasons to do so. When verification of facts is necessary, it should be done as expeditiously as possible.
- (d) Hasten the processing of a claim through the use of a telephone whenever it is possible to do so.
- (e) Clearly inform the applicant of the insurer's position regarding any disputed matter.
- (f) Respond promptly, when a response is indicated, to all communications from insureds, applicants, attorneys and any other interested persons.
- (g) Every insurer shall distribute copies of this regulation to every person directly responsible to it for the handling and settlement of claims for first-party benefits, and every insurer shall satisfy itself that all such personnel are thoroughly conversant with this regulation.

Historical Note

Sec. filed Aug. 2, 2001 eff. Sept. 1, 2001.

§ 65-3.3 Notice.

- (a) If the applicant's written notice of a claim, required by section 65-2.4 of this Part and the mandatory and additional personal injury protection endorsements, is given to a designated agent of an insurer or to a person authorized to receive service of summons, the insurer is deemed to have received the notice; provided, however, that unless otherwise provided by law or contract, notice to the agent shall not be notice to the insurer if the agent promptly notifies the applicant that the agent is not authorized to receive notice of a claim.
- (b) If the agent is permitted to receive a notice of a claim, the agent may acknowledge receipt of such notice in the manner set forth in this section.
- (c) Receipt of a Department of Motor Vehicles Accident Report 104 (MV 104), or other accident report indicating injuries to eligible injured persons, shall be deemed written notice of a claim.
- (d) The written notice required by section 65-2.4 of this Part and the mandatory and additional personal injury protection endorsement(s) shall be deemed to be satisfied by the insurer's receipt of a completed prescribed application for motor vehicle no-fault benefits (NYS form N-F 2) forwarded to the applicant pursuant to section 65-3.4(b) of this Subpart or by the insurer's receipt of a completed hospital facility form (NYS form N-F 5).

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(e) When an insurer denies a claim based upon the failure to provide timely written notice of claim or timely submission of proof of claim by the applicant, such denial must advise the applicant that late notice will be excused where the applicant can provide reasonable justification of the failure to give timely notice.

Historical Note

Sec. filed Aug. 2, 2001 eff. Sept. 1, 2001.

§ 65-3.4 Acknowledgment of claim.

(a) Whenever the insurer receives notice of claim by telephone, the party receiving such notice on behalf of the insurer shall be identified to the caller by name and title and shall request the name, address and telephone number of the applicant and the name of the policyholder or the policy number or both, if available, along with reasonably obtainable information regarding the time, place and circumstances of the accident which will enable the insurer to begin processing the claim.

(b) Unless the insurer will pay the claim as submitted within 30 calendar days, then, within five business days after notice is received by the insurer at the address of its proper claim processing office, either orally pursuant to subdivision (a) of this section or in any other manner, the insurer shall forward to the applicant the prescribed application for motor vehicle no-fault benefits (NYS form N-F 2) accompanied by the prescribed cover letter (NYS form N-F 1). If notice is initially received by the insurer at an address other than the proper claims processing office, the five-day period for forwarding of the prescribed forms shall commence on the day such notice is received at the proper claims processing office, but in no event shall the prescribed forms be forwarded later than 10 business days after receipt of the original notice.

(c) Attached is an appendix (Appendix 13, *infra*), which includes the following prescribed claim forms that must be used by all insurers, and shall not be altered unless approved by the superintendent:

- (1) Cover letter (NYS form N-F 1A)—to be used with policies effective on or after September 1, 2001.
- (2) Cover letter (NYS form NF-1B)—to be used with policies effective prior to September 1, 2001.
- (3) Application for motor vehicle no-fault benefits (NYS form NF-2).
- (4) Verification of treatment by attending physician or other provider of health service (NYS form NF-3).
- (5) Verification of hospital treatment (NYS form NF-4).
- (6) Hospital facility form (NYS form NF-5).
- (7) Employer's wage verification report (NYS form NF-6).
- (8) Verification of self-employment income (NYS form NF-7).
- (9) Agreement to pursue social security disability benefits (NYS form NF-8).
- (10) Agreement to pursue workers' compensation or New York State disability benefits (NYS form NF-9).
- (11) Denial of claim form (NYS form NF-10).
- (12) Subrogation agreement (NYS form NF-11).
- (13) Lump-sum settlement agreement (NYS form NF-12).
- (14) Election-optional basic economic loss (NYS form NF-13).

Historical Note

Sec. filed Aug. 2, 2001 eff. Sept. 1, 2001.

§ 65-3.5 Claim procedure.

(a) Within 10 business days after receipt of the completed application for motor vehicle no-fault benefits (NYS form NF-2) or other substantially equivalent written notice, the insurer shall

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forward, to the parties required to complete them, those prescribed verification forms it will require prior to payment of the initial claim.

(b) Subsequent to the receipt of one or more of the completed verification forms, any additional verification required by the insurer to establish proof of claim shall be requested within 15 business days of receipt of the prescribed verification forms. Any requests by an insurer for additional verification need not be made on any prescribed or particular form. If a claim is received by an insurer at an address other than the proper claims processing office, the 15 business day period for requesting additional verification shall commence on the date the claim is received at the proper claims processing office. In such event, the date deemed to constitute receipt of claim at the proper claim processing office shall not exceed 10 business days after receipt at the incorrect office.

(c) The insurer is entitled to receive all items necessary to verify the claim directly from the parties from whom such verification was requested.

(d) If the additional verification required by the insurer is a medical examination, the insurer shall schedule the examination to be held within 30 calendar days from the date of receipt of the prescribed verification forms.

(e) All examinations under oath and medical examinations requested by the insurer shall be held at a place and time reasonably convenient to the applicant and medical examinations shall be conducted in a facility properly equipped for the performance of the medical examination. The insurer shall inform the applicant at the time the examination is scheduled that the applicant will be reimbursed for any loss of earnings and reasonable transportation expenses incurred in complying with the request. When an insurer requires an examination under oath of an applicant to establish proof of claim, such requirement must be based upon the application of objective standards so that there is specific objective justification supporting the use of such examination. Insurer standards shall be available for review by department examiners.

(f) An insurer must accept proof of claim submitted on a form other than a prescribed form if it contains substantially the same information as the prescribed form. An insurer, however, may require the submission of the prescribed application for motor vehicle no-fault benefits, the prescribed verification of treatment by attending physician or other provider of health service, and the prescribed hospital facility form.

(g) In lieu of a prescribed application for motor vehicle no-fault benefits submitted by an applicant and a verification of hospital treatment (NYS form NF-4), an insurer shall accept a completed hospital facility form (NYS form NF-5) (or an NF-5 and uniform billing form [UBF-1] which together supply all the information requested by the NF-5) submitted by a provider of health services with respect to the claim of such provider.

(h) When benefits are claimed under an additional personal injury protection endorsement, the insurer may require that the applicant execute a prescribed subrogation agreement (NYS form NF-11) prior to the payment of any benefits. If the insurer shall impose the above requirement, it shall deliver the prescribed agreement to the applicant as soon as it is known that the claim is payable under an additional personal injury protection endorsement.

(i) If the insurer has knowledge that the applicant for benefits under a mandatory or additional personal injury protection endorsement is entitled to benefits under any other mandatory or optional first-party automobile or no-fault automobile insurance for the same elements of loss, the insurer should give written notice of claim to all other such sources of benefits in order to protect its right under the endorsement to recover from such other sources their proportionate share of the costs of the claim and the allocated expenses of processing the claim.

(j) Every insurer who does not staff and maintain a claims office in this State shall establish a communications system, by means of a direct toll-free telephone line, to conveniently process all claims made pursuant to article 51 of the Insurance Law. Such toll-free number shall appear on all correspondence relating to claims.

(k) Every insurer, which writes more than 1,000 motor vehicle liability policies in this State, shall establish procedures for the receipt of all claims, notices and verification, subject to this Part, by facsimile and/or electronic data transmittal.

(l) The insurer shall establish standards for review of its determinations that applicants have provided late notice of claim or late proof of claim. In the case of notice of claim, such standards

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shall include, but not be limited to, appropriate consideration for pedestrians and nonrelated occupants of motor vehicles who may have difficulty ascertaining the identify of the insurer. In the case of proof of claim, such standards shall include, but not be limited to, appropriate consideration for emergency care providers, demonstrated difficulty in ascertaining the identity of the insurer and inadvertent submission to the incorrect insurer. The insurer shall establish procedures, based upon objective criteria, to ensure due consideration of denial of claims based upon late notice or late submission of proof of claim, including supervisory review of all such determinations. Insurer standards shall be available for review by department examiners.

(m) The failure of an employer, or other third party, to provide information necessary to establish proof of claim for lost wages on behalf of an applicant shall not be utilized as a basis for denial of claim based upon late submission of proof of claim.

(n) The timely submission of a proof of claim by a hospital that is based upon Diagnostic Related Group (DRG) codes which may be adjusted prospectively shall be deemed to be timely notice for the submission of a subsequent claim which is adjusted in accordance with the promulgation of DRG codes which were not implemented at the time of the original submission of claim.

(o) An applicant from whom verification is requested shall, within 120 calendar days from the date of the initial request for verification, submit all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply. The insurer shall advise the applicant in the verification request that the insurer may deny the claim if the applicant does not provide within 120 calendar days from the date of the initial request either all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply. This subdivision shall not apply to a prescribed form (NF-form) as set forth in Appendix 13 of this Title, medical examination request, or examination under oath request. This subdivision shall apply, with respect to claims for medical services, to any treatment or service rendered on or after April 1, 2013 and with respect to claims for lost earnings and reasonable and necessary expenses, to any accident occurring on or after April 1, 2013.

(p) With respect to a verification request and notice, an insurer's non-substantive technical or immaterial defect or omission, as well as an insurer's failure to comply with a prescribed time frame, shall not negate an applicant's obligation to comply with the request or notice. This subdivision shall apply to medical services rendered, and to lost earnings and other reasonable and necessary expenses incurred, on or after April 1, 2013.

Historical Note

Sec. filed Aug. 2, 2001; amds. filed: July 9, 2002 as emergency measure; Oct. 4, 2002 as emergency measure; Nov. 27, 2002 as emergency measure; Jan. 17, 2003 as emergency measure; Jan. 17, 2003; Jan. 30, 2013 eff. April 1, 2013. Added (o), (p).

§ 65-3.6 Follow-up requirements.

(a) *Application for motor vehicle no-fault benefits.* At a minimum, the insurer shall, within 10 calendar days, mail a second application for motor vehicle no-fault benefits, with the prescribed cover letter, to the eligible injured person or such person's attorney if, 30 calendar days after the original mailing, a prescribed application has not been completed and returned to the insurer. If the follow-up is sent to the applicant's attorney, a copy of the prescribed cover letter, marked "second notice," shall be forwarded to the applicant.

(b) *Verification requests.* At a minimum, if any requested verifications has not been supplied to the insurer 30 calendar days after the original request, the insurer shall, within 10 calendar days, follow up with the party from whom the verification was requested, either by telephone call, properly documented in the file, or by mail. At the same time the insurer shall inform the applicant and such person's attorney of the reason(s) why the claim is delayed by identifying in writing the missing verification and the party from whom it was requested.

Historical Note

Sec. filed Aug. 2, 2001 eff. Sept. 1, 2001.

§ 65-3.7 Election.

(a) If an insured has purchased optional basic economic loss (OBEL) coverage pursuant to section 5102(a)(5) of the Insurance Law, the insurer shall notify each eligible injured person (or

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that person's legal representative) making a claim under such policy that such person may elect how OBEL coverage will be applied.

(b) The insurer shall mail form NYS form NF-13 to the eligible injured person or that person's legal representative as soon as, and in no event later than 15 calendar days after, the insurer has received claims aggregating \$30,000 in basic economic loss.

(c) If the eligible injured person or that person's legal representative does not return the election form (NYS form NF-13) within 15 calendar days after the initial mailing, then within five calendar days after such time has elapsed the insurer shall mail to the eligible injured person or that person's legal representative a second election notice, clearly marked "SECOND NOTICE."

(d) Failure of the eligible injured person or that person's legal representative to respond to the second notice within 15 calendar days after its mailing shall be considered an election by the eligible injured person to apply OBEL coverage to all elements of basic economic loss.

(e) Once made by the eligible injured person or that person's legal representative, an OBEL election cannot be changed, except that, if claims payable under OBEL coverage have not yet been received by the company, an eligible injured person who has failed to respond to the second notice in a timely manner may make an election.

Historical Note

Sec. filed Aug. 2, 2001 eff. Sept. 1, 2001.

§ 65-3.8 Payment or denial of claim (30-day rule).

(a) (1) No-fault benefits are overdue if not paid within 30 calendar days after the insurer receives proof of claim, which shall include verification of all of the relevant information requested pursuant to section 65-3.5 of this Subpart. In the case of an examination under oath or a medical examination, the verification is deemed to have been received by the insurer on the day the examination was performed.

(2) An insurer shall defer payment of OBEL benefits for claims submitted by or on behalf of the eligible injured person until an OBEL option has been elected in accordance with section 65-3.7 of this Subpart. An insurer shall pay or deny such claims under OBEL coverage within 30 calendar days of the date that an election has been made.

(b) (1) An insurer may not interrupt the payment of benefits for any element of basic or extended economic loss pending the administering of a medical examination, unless the applicant or the applicant's attorney is responsible for the delay or inability to schedule the examination, in which case any denial of payment shall be made only in accordance with policy provisions on a prescribed denial of claim form (NYS form NF-10).

(2) Notwithstanding paragraph (1) of this subdivision, if the insurer has information which clearly demonstrates that the applicant is no longer disabled, the insurer may discontinue the payment of benefits by forwarding to the applicant a prescribed denial of claim form.

(3) Except as provided in subdivision (e) of this section, an insurer shall not issue a denial of claim form (NYS form NF-10) prior to its receipt of verification of all of the relevant information requested pursuant to sections 65-3.5 and 65-3.6 of this Subpart (*e.g.*, medical reports, wage verification, etc.). However, an insurer may issue a denial if, more than 120 calendar days after the initial request for verification, the applicant has not submitted all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply, provided that the verification request so advised the applicant as required in section 65-3.5(o) of this Subpart. This subdivision shall not apply to a prescribed form (NF-form) as set forth in Appendix 13 of this Title, medical examination request, or examination under oath request. This paragraph shall apply, with respect to claims for medical services, to any treatment or service rendered on or after April 1, 2013, and with respect to claims for lost earnings and reasonable and necessary expenses, to any accident occurring on or after April 1, 2013.

(4) If the specific reason for a denial of a no-fault claim, or any element thereof, is a medical examination or peer review report requested by the insurer, the insurer shall release a copy of that report to the applicant for benefits, the applicant's attorney, or the applicant's treating physician, upon the written request of any of these parties.

(c) Within 30 calendar days after proof of claim is received, the insurer shall either pay or deny the claim in whole or in part.

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(1) If the insurer denies a claim in whole or in part involving elements of basic economic loss or extended economic loss, the insurer shall notify the applicant or the authorized representative on the prescribed denial of claim form, in duplicate, and shall furnish, if requested by the applicant, one copy of all prescribed claim forms submitted by or on behalf of the applicant thereto. However, where a denial involves a portion of a health provider's bill, the insurer may make such a denial on a form or letter approved by the department which is issued in duplicate. No form or letter shall be approved unless it contains substantially the same information as the prescribed form which is relevant to the claim denied.

(2) Notwithstanding paragraph (1) of this subdivision, where there is a denial in part of a medical bill as a result of charges not conforming to section 5108 of the Insurance Law, an insurer may effect compliance with paragraph (1) of this subdivision for those overcharges of \$50 or less by telephone agreement with the provider or provider's representative, with proper documentation of such agreement in the claim file. The provider must have been entitled to direct payment pursuant to section 65-3.11 of this Subpart.

(d) Where an insurer denies part of a claim, it shall pay benefits for the undisputed elements of the claim. Such payments shall be made without prejudice to either party.

(e) If an insurer has determined that benefits are not payable for any of the following reasons:

- (1) no coverage on the date of accident;
- (2) circumstances of the accident not covered by no-fault; or

(3) statutory exclusions pursuant to section 5103(b) of the Insurance Law; it shall notify the applicant within 10 business days after such determination on a prescribed denial of claim form, specifying the reasons for the denial. Failure by an insurer to notify the applicant of its denial of the claim within the 10-business-day period after its determination shall not preclude the insurer from asserting a defense to the claim which is based upon the reasons for such denial.

(f) An insurer shall be entitled to receive proper proof of claim and a failure to observe any of the time frames specified in this section shall not prevent an insurer from requiring proper proof of claim.

(g) (1) Proof of the fact and amount of loss sustained pursuant to Insurance Law section 5106(a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for such claimed medical services under any circumstances:

- (i) when the claimed medical services were not provided to an injured party; or
- (ii) for those claimed medical service fees that exceed the charges permissible pursuant to Insurance Law section 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers.

(2) This subdivision shall apply to medical services rendered on or after April 1, 2013.

(h) With respect to a denial of claim (NYS form NF-10), an insurer's non-substantive technical or immaterial defect or omission shall not affect the validity of a denial of claim. This subdivision shall apply to medical services rendered, and to lost earnings and other reasonable and necessary expenses incurred, on or after April 1, 2013.

(i) Notwithstanding subdivision (e) of this section, if an insurer has reason to believe that the applicant was operating a motor vehicle while intoxicated or impaired by the use of a drug, and such intoxication or impairment was a contributing cause of the automobile accident, the insurer shall be entitled to all available information relating to the applicant's condition at the time of the accident. Proof of a claim shall not be complete until the information which has been requested, pursuant to section 65-3.5(a) or (b) of this Subpart, has been furnished to the insurer by the applicant or the authorized representative.

(j) Where the insurer has determined that a self-employed applicant's disability arose from the claimed accident, the insurer shall be deemed to have proof of claim for loss of earnings or substitute services, subject to receipt of medical proof of disability for the period claimed, when it has received a completed prescribed verification of self-employment income form (NYS form NF-7) and the proof requested thereon. The insurer shall determine therefrom the amount of loss of earnings benefits, if any, due the applicant. Notwithstanding the above, if an insurer requires

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verification in addition to the proof supplied, it may request such additional verification pursuant to section 65-3.5(b) of this Subpart.

(k) A death benefit claim will be deemed to have been proven when the insurer receives a copy of the decedent's death certificate and proof that the personal representative of the decedent's estate was duly appointed in this State or any other jurisdiction.

(l) For the purposes of counting the 30 calendar days after proof of claim, wherein the claim becomes overdue pursuant to section 5106 of the Insurance Law, with the exception of section 65-3.6 of this Subpart, any deviation from the rules set out in this section shall reduce the 30 calendar days allowed.

Example: Where an insurer sends an application for motor vehicle no-fault benefits 15 business days after notice is received at the address of the insurer's proper claim processing office instead of five business days, the 30 calendar days permitted by subdivision (a) of this section are reduced to 20 calendar days.

Historical Note

Sec. filed Aug. 2, 2001; amds. filed: Jan. 17, 2003; Jan. 30, 2013 eff. April 1, 2013. Amended (b)(3), relettered (g)-(j) to (i)-(l), added new (g), (h).

§ 65-3.9 Interest on overdue payments.

(a) All overdue mandatory and additional personal injury protection benefits due an applicant or assignee shall bear interest at a rate of two percent per month, calculated on a pro-rata basis using a 30-day month. When payment is made on an overdue claim, any interest calculated to be due in an amount exceeding \$5 shall be paid to the applicant or the applicant's assignee without demand therefor.

(b) The insurer shall not suggest or require, as a condition to settlement of a claim, that the interest due be waived.

(c) If an applicant does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Department of Financial Services regulations, interest shall not accumulate on the disputed claim or element of claim until such action is taken. If any applicant is a member of a class in a class action brought for payment of benefits, but is not a named party, interest shall not accumulate on the disputed claim or element of claim until a class that includes such applicant is certified by court order, or such benefits are authorized in that action by Appellate Court decision, whichever is earlier.

(d) If an applicant has submitted a dispute to arbitration or the courts, interest shall accumulate, unless the applicant unreasonably delays the arbitration or court proceeding.

(e) The insurer shall separately identify any interest payment on an overdue claim from benefit payments. This may be done by issuing separate drafts for each amount or by an accompanying statement that clearly and separately identifies the components of the draft.

(f) An insurer may not include in its rate making calculations any interest paid on an overdue claim.

Historical Note

Sec. filed Aug. 2, 2001; amd. filed April 9, 2013 eff. June 1, 2013; amended adoption filed May 16, 2013 eff. Aug. 1, 2013. Amended (c).

§ 65-3.10 Attorneys.

(a) An applicant or an assignee shall be entitled to recover their attorney's fees, for services necessarily performed in connection with securing payment, if a valid claim or portion thereof was denied or overdue. If such a claim was initially denied and subsequently paid by the insurer, the attorney's fee shall be \$80. If such a claim was overdue but not denied, the attorney's fee shall be equal to 20 percent of the amount of the first-party benefits and any additional first-party benefits plus interest payable pursuant to section 65-3.9 of this Subpart, subject to a maximum fee of \$60.

(b) If a dispute is resolved in accordance with any of the optional arbitration procedures contained in this Part, either during the initial review by the Department of Financial Services or

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by an arbitration award, and if payment is not made by the insurer in accordance with the terms specified in the conciliation letter or arbitration award within 45 days following such resolution, an additional attorney's fee shall be paid by the insurer when the attorney writes to the insurer in order to receive such overdue payment. The additional attorney's fee shall be \$60 and shall become payable only after written request from the attorney to the insurer, received by the insurer more than 45 days after mailing of the conciliation letter or arbitration award. Such fee shall not be payable if payment was made by the insurer prior to the attorney's request for such payment or if an arbitration award is appealed in accordance with the provisions of this Part.

(c) The insurer shall segregate any attorney's fee on an overdue claim from the loss and interest payments, either through issuance of separate drafts or through an accompanying statement which clearly and separately identifies the components of the draft.

(d) No attorney's fee payable by an insurer on account of an overdue claim may be included by the insurer in any rate making calculations.

Historical Note

Sec. filed Aug. 2, 2001; amds. filed: Jan. 17, 2003; April 9, 2013 eff. June 1, 2013; amended adoption filed May 16, 2013 eff. Aug. 1, 2013. Amended (b).

§ 65-3.11 Direct payments.

(a) An insurer shall pay benefits for any element of loss other than death benefits, directly to the applicant or, when appropriate, to the applicant's parent or legal guardian or to any person legally responsible for necessities, or, upon assignment by the applicant or any of the aforementioned persons, shall pay benefits directly to providers of health care services as covered under section 5102(a)(1) of the Insurance Law, or to the applicant's employer for loss of earnings from work as authorized under section 5102(a)(2) of the Insurance Law. Death benefits shall be paid to the estate of the eligible injured person.

(b) In order for a health care provider/hospital to receive direct payment from the insurer, the health care provider or hospital must submit to the insurer:

(1) a properly executed authorization to pay benefits as contained on NYS form NF-3, NF-4 or NF-5 or other claim form acceptable to the insurer. Execution of an authorization to pay benefits shall not constitute or operate as a transfer of all rights from the eligible injured person to the provider; or

(2) a properly executed assignment on:

(i) the prescribed verification of treatment by attending physician or other provider of service form (NYS form NF-3); or

(ii) the prescribed verification of hospital treatment form (NYS form NF-4), or the prescribed hospital facility form (NYS form NF-5); or

(iii) the prescribed no-fault assignment of benefits form (NYS form NF-AOB) contained in Appendix 13, *infra*, or an equivalent form containing nonsubstantive enhancements, but no changes may be made to the assignment language itself.

With respect to health care providers, other than hospitals, the use of revised form NF-3 is applicable to all claims arising from motor vehicle accidents, which occur on and after March 1, 2002. With respect to hospitals, the use of revised forms NF-4 and NF-5 is applicable to all claims arising from motor vehicle accidents, which occur on and after September 1, 2002.

(c) The insurer may request, in writing, the original assignment or authorization to pay benefits form to establish proof of claim in accordance with the procedures contained in subdivision (d) of this section. The insurer must maintain the original form in its claim file.

(d) If an assignment has been furnished an insurer, the assignor or legal representative of the assignor shall not unilaterally revoke the assignment after the services for which the assignment was originally executed were rendered. If the assignment is revoked for services not yet rendered, the assignor or legal representative shall provide written notification to the insurer that the assignee has been notified of the revocation.

(e) The draft or check in payment of benefits shall include information sufficient to identify the element(s) of covered expense(s) being reimbursed, or must be accompanied by an explanation containing such identifying information.

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Example: Payment of loss of earnings shall indicate that the payment is for loss of earnings, and shall identify the period of lost time from work being reimbursed and the rate at which reimbursement is being made.

Historical Note

Sec. filed Aug. 2, 2001; amds. filed: April 11, 2002 as emergency measure; July 9, 2002 as emergency measure; Oct. 4, 2002 as emergency measure; Nov. 27, 2002 as emergency measure; Jan. 17, 2003 as emergency measure; Jan. 17, 2003 eff. Feb. 5, 2003. Relettered (b)-(c) to (d)-(e), added new (b)-(c).

§ 65-3.12 Sources of mandatory personal injury protection benefits.

(a) *Institution of claims for first-party benefits-priority.* (1) Subject to paragraph (9) of this subdivision, an applicant who is an operator or occupant of an insured motor vehicle, or any other person, not occupying another motor vehicle or a motorcycle, who sustains a personal injury arising out of the use or operation in New York State of such motor vehicle, shall institute the claim against the insurer of such motor vehicle.

(2) An applicant who is neither an operator nor an occupant of a motor vehicle or a motorcycle, and who sustains a personal injury arising out of the use or operation in New York State of more than one insured motor vehicle or insured motorcycle shall institute the claim against the insurer of any one of such motor vehicles or motorcycles unless the insurers agree among themselves that one of them will accept and pay the claim initially.

(3) An applicant who is a named insured or a relative of a named insured, other than the occupant of a motorcycle, and who sustains a personal injury arising out of the use or operation of a motor vehicle outside of New York State, shall institute the claim against the insurer of the named insured or the insurer of the relative. Where there is more than one insurer which would be the source of benefits, the insurers may agree among themselves, if there is a valid basis therefor, that one of them will accept and pay the claim initially. If there is no such agreement, the provisions of subdivisions (b) and (e) of this section shall apply.

(4) An applicant who is a named insured or a relative of a named insured, other than the occupant of a motorcycle, and who sustains a personal injury arising out of the use or operation of an uninsured motor vehicle in New York State, shall institute the claim against the insurer of the named insured or the insurer of the relative. Where there is more than one insurer which would be the source of benefits, the insurers may agree among themselves, if there is a valid basis therefor, that one of them will accept and pay the claim initially. If there is no such agreement, the provisions of subdivisions (b) and (e) of this section shall apply. If there is no such insurer and the accident occurs in New York State, then an applicant who is a qualified person as defined in article 52 of the Insurance Law shall institute the claim against the MVAIC.

(5) An applicant who is neither an operator nor an occupant of a motor vehicle or a motorcycle, and who sustains a personal injury arising out of the use or operation in New York State of an insured motorcycle, shall institute the claim against the insurer of the motorcycle.

(6) An applicant who is a named insured or a relative of a named insured, other than the occupant of a motor vehicle or a motorcycle, and who sustains a personal injury arising out of the use or operation of an uninsured motorcycle in New York State shall institute the claim against the insurer of the named insured or the insurer of the relative. Where there is more than one insurer which would be the source of benefits, the insurers may agree among themselves, if there is a valid basis therefor, that one of them will accept and pay the claim initially. If there is no such agreement, the provisions of subdivisions (b) and (e) of this section shall apply. If there is no such insurer and the accident occurs in New York State, then an applicant who is a qualified person as defined in article 52 of the Insurance Law shall institute the claim against the MVAIC.

(7) An applicant who is a named insured or a relative of a named insured, other than the occupant of a motor vehicle or a motorcycle, and who sustains a personal injury arising out of the use or operation of a motorcycle outside of New York State shall institute the claim against the insurer of the named insured or relative. Where there is more than one insurer which would be the source of benefits, the insurers may agree among themselves, if there is a valid basis

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therefor, that one of them will accept and pay the claim initially. If there is no such agreement, the provisions of subdivisions (b) and (e) of this section shall apply.

(8) An applicant who is a New York State resident and who is neither a named insured or relative under any mandatory personal injury protection endorsement nor the owner of an uninsured motor vehicle and who sustains a personal injury arising out of the use or operation of a New York insured motor vehicle outside of New York State shall institute the claim against the insurer of such motor vehicle. Where there is more than one insurer that would be the source of benefits, the insurers may agree among themselves, if there is a valid basis therefor, that one of them will accept and pay the claim initially. If there is no such agreement, the provisions of subdivisions (b) and (e) of this section shall apply.

(9) An applicant, other than an operator, owner, or employee of the owner or operator of a bus or school bus, who, while an occupant of such bus or school bus, sustains a personal injury arising out of the use or operation in New York State of such bus or school bus, shall institute the claim against the applicant's own insurer. If the applicant does not have an insurer, the applicant shall institute the claim against the insurer of the bus or school bus.

(10) An applicant who is an operator, owner, or employee of the operator or owner of a bus or school bus, and who, while an occupant of such bus or school bus, sustains a personal injury arising out of the use or operation of such bus or school bus, shall institute the claim against the insurer of such bus or school bus.

(b) (1) If a dispute regarding priority of payment arises among insurers who otherwise are liable for the payment of first-party benefits, or if a dispute arises among insurers who are liable for the payment of first-party benefits and have the same priority of payment, then the first insurer to whom notice of claim is given pursuant to section 65-3.3 or 65-3.4(a) of this Subpart, by or on behalf of an eligible injured person, shall be responsible for payment to such person. Any such dispute shall be resolved in accordance with the arbitration procedures established pursuant to section 5105 of the Insurance Law and section 65-4.11 of this Part. Each insurer that concludes that it was not the first insurer contacted to provide first party benefits shall issue a denial of claim form (NF-10) that includes the following statement in box 33:

If, after contacting the insurer that we advised you has primary responsibility for the payment of first party benefits, that insurer denies coverage for your claim, you have the option to submit this dispute for expedited arbitration by providing a copy of the denial form and a written request along with a \$40 filing fee to the organization listed under option two on the back of this form. Your \$40 filing fee will be refunded to you by the insurer determined to be responsible for processing your claim. This arbitration is limited solely to determining the insurer to process your claim, and it will not resolve issues regarding pending bills or consider any other defense to payment. You do not need to submit bills for this arbitration.

(2) (i) Under section 5106(d)(2) of the Insurance Law, a group policy issued pursuant to section 3455 of the Insurance Law shall provide first party benefits when a dispute exists as to whether a driver was using or operating a motor vehicle in connection with a transportation network company when loss, damage, injury, or death occurs. Section 5106(d)(2) of the Insurance Law requires a transportation network company to notify the insurer that issued the owner's policy of liability insurance of the dispute within 10 business days of becoming aware that the dispute exists. When there is a dispute, the group insurer liable for the payment of first party benefits under a group policy shall have the right to recover the amount paid from the driver's insurer to the extent that the driver would have been liable to pay damages in an action at law.

(ii) Any such dispute shall be resolved in accordance with the arbitration procedures established pursuant to section 65-4.11 of this Part.

(iii) Each insurer that is not the insurer that issued the group policy shall issue a denial of claim form (NF-10) that includes in box 33 the statement set forth in paragraph (1) of this subdivision.

(3) With respect to any accident, insured event, or occurrence prior to January 1, 2019, where the driver was using or operating a motor vehicle in connection with a transportation network company when loss, damage, injury, or death occurs:

(i) an insurer that issued a group policy pursuant to section 3455 of the Insurance Law shall not seek to recover any amount that it pays pursuant to article 51 of the Insurance Law

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from the insurer that issued the owner's policy of liability insurance issued in satisfaction of the minimum requirements of article 6 of the Vehicle and Traffic Law; and

(ii) if an insurer that issued the owner's policy of liability insurance issued in satisfaction of the minimum requirements of article 6 of the Vehicle and Traffic Law receives the claim first, the insurer that issued a group policy pursuant to section 3455 of the Insurance Law shall fully indemnify the insurer that issued the owner's policy of liability insurance for amounts that it pays pursuant to article 51 of the Insurance Law.

(c) If the source of first-party benefits is at issue because the status of the injured person as a pedestrian or an occupant of a motor vehicle is in dispute, the insurer to whom notice of claim was given or if such notice was given to more than one insurer, the first insurer to whom notice was given shall, within 15 calendar days after receipt of notice, obtain an agreement with the other insurer or insurers as to which insurer will furnish no-fault benefits. If such an agreement is not reached within the aforementioned 15 days, then the insurer to whom such notice was first given shall process the claim and pay first-party benefits and resolve the dispute in accordance with the arbitration procedures established pursuant to section 5105 of the Insurance Law and section 65-4.11 of this Part. Each insurer that concludes that it was not the first insurer contacted to provide first party benefits shall issue a denial of claim form (NF-10) that includes the following statement in box 33:

If, after contacting the insurer that we advised you has primary responsibility for the payment of first party benefits, that insurer denies coverage for your claim, you have the option to submit this dispute for expedited arbitration by providing a copy of the denial form and a written request along with a \$40 filing fee to the organization listed under option two on the back of this form. Your \$40 filing fee will be refunded to you by the insurer determined to be responsible for processing your claim. This arbitration is limited solely to determining the insurer to process your claim, and it will not resolve issues regarding pending bills or consider any other defense to payment. You do not need to submit bills for this arbitration.

(d) The insurer of the named insured or relative shall be responsible for the payment of first-party benefits to such person when he/she is injured through the use or operation of another motor vehicle, the alleged insurer of which has denied coverage claiming it did not have a policy in force on such vehicle on the accident date; provided, however, that the named insured or relative injured in the accident was not the owner of the alleged uninsured motor vehicle. Payment by the insurer of the named insured or relative shall not affect any legal right of such insurer to challenge the validity of the denial by the other insurer.

(e) Any insurer paying first-party benefits shall be reimbursed by other insurers for their proportionate share of the costs of the claim and the allocated expenses of processing the claim, in accordance with the provisions entitled "other coverage" contained in section 65-1.1 of this Part and provisions entitled "other sources of first-party benefits" contained in Subpart 65-2 of this Part.

(f) For the purposes of this section, *insurer of such motor vehicle* means any insurer that is providing first party benefits at the time the personal injury is sustained.

Historical Note

Sec. filed Aug. 2, 2001; amds. filed: Oct. 4, 2005 as emergency measure; Dec. 29, 2005 as emergency measure; March 27, 2006 as emergency measure; June 23, 2006 as emergency measure; Sept. 1, 2006 as emergency measure; Nov. 28, 2006 as emergency measure; Feb. 23, 2007 as emergency measure eff. Feb. 23, 2007; Feb. 23, 2007; June 6, 2017 as emergency measure; Sept. 1, 2017 as emergency measure; Oct. 10, 2017 eff. Oct. 25, 2017. Amended (a)(8), (b); added (f).

§ 65-3.13 Sources of additional personal injury protection benefits.

(a) *Institution of claims-priority.* Generally, an applicant's initial source of additional personal injury protection benefits will be the same source which provides the mandatory personal injury protection benefits, until the total available limits under that source's mandatory and additional personal injury protection coverages are exhausted. Specifically:

(1) An applicant who is an operator or occupant of an insured motor vehicle covered for additional personal injury protection benefits, and who sustains a personal injury arising out of the use or operation in New York State of such motor vehicle, shall institute the claim against the insurer of such motor vehicle.

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(2) An applicant who is a named insured or a relative of a named insured covered by additional personal injury protection benefits, and who, while an operator or occupant of a motor vehicle, sustains a personal injury arising out of the use or operation of such motor vehicle outside of New York State, shall institute the claim against the insurer of the named insured or the relative. Where there is more than one insurer which would be the source of benefits, the first such insurer applied to shall process the claim, unless the insurers agree among themselves that another such insurer will accept and pay the claim initially. (See subdivision [b] of this section.) If the insurers do not reach an agreement, then each insurer that concludes it was not the first insurer contacted to provide first party benefits shall issue a denial of claim form (NF-10) that includes the following statement in box 33:

If, after contacting the insurer that we advised you has primary responsibility for the payment of first party benefits, that insurer denies coverage for your claim, you have the option to submit this dispute for expedited arbitration by providing a copy of the denial form and a written request along with a \$40 filing fee to the organization listed under option two on the back of this form. Your \$40 filing fee will be refunded to you by the insurer determined to be responsible for processing your claim. This arbitration is limited solely to determining the insurer to process your claim, and it will not resolve issues regarding pending bills or consider any other defense to payment. You do not need to submit bills for this arbitration.

(3) An applicant who is a named insured or a relative of a named insured covered for additional personal injury protection benefits, and who is neither an operator nor an occupant of a motor vehicle or a motorcycle, and who sustains a personal injury through the use or operation of a motor vehicle or a motorcycle shall institute the claim against the insurer of the named insured or the relative. Where there is more than one insurer which would be the source of benefits, the first such insurer applied to shall process the claim, unless the insurers agree among themselves that another such insurer will accept and pay the claim initially. (See subdivision [b] of this section.) If the insurers do not reach an agreement, then each insurer that concludes it was not the first insurer contacted to provide first party benefits shall issue a denial of claim form (NF-10) that includes the following statement in box 33:

If, after contacting the insurer that we advised you has primary responsibility for the payment of first party benefits, that insurer denies coverage for your claim, you have the option to submit this dispute for expedited arbitration by providing a copy of the denial form and a written request along with a \$40 filing fee to the organization listed under option two on the back of this form. Your \$40 filing fee will be refunded to you by the insurer determined to be responsible for processing your claim. This arbitration is limited solely to determining the insurer to process your claim, and it will not resolve issues regarding pending bills or consider any other defense to payment. You do not need to submit bills for this arbitration.

(4) An applicant who is not a named insured or a relative of a named insured covered for additional personal injury protection benefits, and who is an occupant of an insured motor vehicle covered for additional personal injury protection benefits or a motor vehicle operated by a person covered for additional personal injury protection benefits, and who sustains a personal injury through the use or operation of the insured motor vehicle outside of New York State, shall institute the claim against the insurer of the owner or operator of the insured motor vehicle. Where there is more than one insurer which would be the source of benefits, the first such insurer applied to shall process the claim unless the insurers agree among themselves that another such insurer will accept and pay the claim initially. (See subdivision [b] of this section.) If the insurers do not reach an agreement, then each insurer that concludes it was not the first insurer contacted to provide first party benefits shall issue a denial of claim form (NF-10) that includes the following statement in box 33:

If, after contacting the insurer that we advised you has primary responsibility for the payment of first party benefits, that insurer denies coverage for your claim, you have the option to submit this dispute for expedited arbitration by providing a copy of the denial form and a written request along with a \$40 filing fee to the organization listed under option two on the back of this form. Your \$40 filing fee will be refunded to you by the insurer determined to be responsible for processing your claim. This arbitration is limited solely to determining the insurer to process your claim, and it will not resolve issues regarding pending bills or consider any other defense to payment. You do not need to submit bills for this arbitration.

(5) An applicant who has exhausted the additional personal injury protection benefits available under the initial sources as set forth in this section, shall then apply for benefits from

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the next available source providing a higher level of additional personal injury protection benefits. This latter source shall provide benefits to the extent that the total limit available under such latter source exceeds the amount available under the initial sources as set forth in this section. This process will repeat until all available additional personal injury protection benefit sources have been exhausted.

(6) If a dispute arises among insurers who are liable for the payment of additional personal injury protection benefits and have the same priority of payment, then the first insurer to whom notice of claim is given pursuant to section 65-3.3 or 65-3.4(a) of this Subpart, by or on behalf of an eligible injured person, shall be responsible for payment to such person. Any such dispute shall be resolved in accordance with the arbitration procedures established pursuant to section 5105 of the Insurance Law and section 65-4.11 of this Part. Each insurer that concludes that it was not the first insurer contacted to provide additional personal injury protection benefits shall issue a denial of claim form (NF-10) that includes the following statement in box 33:

If, after contacting the insurer that we advised you has primary responsibility for the payment of additional personal injury protection benefits, that insurer denies coverage for your claim, you have the option to submit this dispute for expedited arbitration by providing a copy of the denial form and a written request along with a \$40 filing fee to the organization listed under option two on the back of this form. Your \$40 filing fee will be refunded to you by the insurer determined to be responsible for processing your claim. This arbitration is limited solely to determining the insurer to process your claim, and it will not resolve issues regarding pending bills or consider any other defense to payment. You do not need to submit bills for this arbitration.

(b) Any insurer paying additional personal injury protection benefits as provided in this section shall be reimbursed by the other insurers for their proportionate share of the costs of the claim and the allocated expenses of processing the claim, in accordance with the other coverage; nonduplication paragraph of the additional personal injury protection endorsement contained in section 65-1.3 of this Part.

(c) For the purposes of this section, *insurer of such motor vehicle* means any insurer that is providing additional personal injury protection benefits at the time the personal injury is sustained.

Historical Note

Sec. filed Aug. 2, 2001; amds. filed: Oct. 4, 2005 as emergency measure; Dec. 29, 2005 as emergency measure; March 27, 2006 as emergency measure; June 23, 2006 as emergency measure; Sept. 1, 2006 as emergency measure; Nov. 28, 2006 as emergency measure; Feb. 23, 2007 as emergency measure; Feb. 23, 2007; June 6, 2017 as emergency measure; Sept. 1, 2017 as emergency measure; Oct. 10, 2017 eff. Oct. 25, 2017. Added (a)(6), (c).

§ 65-3.14 Scope of coverage.

(a) An insurer shall be liable only for the payment of benefits for losses caused by the accident, including those caused by the aggravation of preexisting conditions.

(b) An insurer shall pay benefits to an applicant for losses arising out of an accident in the following situations:

(1) where coverage has been excluded for an applicant operating a vehicle while in an intoxicated condition or while the applicant's ability is impaired by the use of a drug, if such intoxicated or drugged condition was not a contributing cause of the accident causing the injuries;

(2) where coverage has been excluded for an applicant operating or occupying a motor vehicle known to the applicant to be stolen, and the applicant is an involuntary operator or occupant of said vehicle;

(3) where there is no physical contact between the applicant and a motor vehicle or motorcycle which is the proximate cause of the injury;

(4) where the motor vehicle or motorcycle is used without the specific permission of the owner, but is not a stolen vehicle; or

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(5) where the accident arises out of repairing, servicing or otherwise maintaining a motor vehicle or a motorcycle, other than in the course of a business, and for which no charge or fee is contemplated.

Historical Note

Sec. filed Aug. 2, 2001 eff. Sept. 1, 2001.

§ 65-3.15 Computation of basic economic loss.

When claims aggregate to more than \$50,000, payments for basic economic loss shall be made to the applicant and/or an assignee in the order in which each service was rendered or each expense was incurred, provided claims therefor were made to the insurer prior to the exhaustion of the \$50,000. If the insurer pays the \$50,000 before receiving claims for services rendered prior in time to those which were paid, the insurer will not be liable to pay such late claims. If the insurer receives claims of a number of providers of services, at the same time, the payments shall be made in the order of rendition of services.

Historical Note

Sec. filed Aug. 2, 2001 eff. Sept. 1, 2001.

§ 65-3.16 Measurement of no-fault benefits.

(a) *Medical expenses.* (1) Payment for medical expenses shall be in accordance with fee schedules promulgated under section 5108 of the Insurance Law and contained in Part 68 of this Title (Regulation 83).

(2) Where an applicant receives treatment from a health maintenance organization, an Insurance Law article 43 corporation, a veterans administration hospital or provider, or any other provider which does not render specific charges for services, or where any such charges are indeterminate, the applicant shall be entitled to payment of benefits equal to the value for equivalent services rendered by a provider as limited by section 5108 of the Insurance Law and Part 68 of this Title (Regulation 83).

(3) Pursuant to section 5102(a)(1) of the Insurance Law, an insurer shall not be liable for the payment of medical and other benefits enumerated in section 5102(a)(1) of the Insurance Law if, during a period of one year from the date of the accident, no such expenses have been incurred by the applicant.

(4) The term *nursing*, as used in section 5102(a)(1)(i) of the Insurance Law, shall include but not be limited to all necessary services rendered to the eligible injured person by a licensed practical nurse.

(5) If the applicant's injuries warrant occupational therapy or rehabilitation based on an attending physician's recommendation, or if the injuries have rendered the applicant unable to resume the applicant's occupation, the insurer shall inform the applicant of the coverage for occupational therapy or rehabilitation required by section 5102(a)(1)(ii) of the Insurance Law, and the insurer shall assist the applicant in obtaining such occupational therapy and rehabilitation.

(6) The term *any other professional health services*, as used in section 5102(a)(1)(iv) of the Insurance Law, this Part and approved endorsements, shall be limited to those services that are required or would be required to be licensed by the State of New York if performed within the State of New York. Such professional health services should be necessary for the treatment of the injuries sustained and within the lawful scope of the licensee's practice. Charges for the services shall be covered pursuant to schedules promulgated under section 5108 of the Insurance Law and Part 68 of this Title (Regulation 83). The services need not be initiated through referral by a treating or practicing physician.

(7) The scope of the term *religious methods of healing recognized by the laws of this State*, as used in section 5102(a)(1)(iii) of the Insurance Law, this Part and approved endorsements, is a method recognized under article 131 of the Education Law. Charges for such services shall be covered pursuant to schedules promulgated under section 5108 of the Insurance Law.

(8) Services rendered to the eligible injured person by a certified or licensed home health care agency shall be considered a medical expense payable under section 5102(a)(1) of the Insurance Law.

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(9) Pursuant to section 5102(b)(2) of the Insurance Law, when the applicant is entitled to workers' compensation benefits due to the same accident, the workers' compensation carrier shall be the sole source of reimbursement for medical expenses.

(10) If a provider of health service requires proof of the applicant's ability to pay for the services to be rendered as a result of the accident, the insurer shall provide the applicant or the provider (if the applicant is entitled to benefits) with a letter stating that the applicant has coverage under its policy and that the necessary medical expenses incurred as a result of the accident are covered expenses subject to the policy limits and conditions and applicable fee schedules.

(11) Within 30 calendar days of a submission by a dentist or plastic surgeon of a proposal for a course of treatment and charges, an insurer shall review such proposal and notify the provider as to whether or not payment will be made in accordance with the proposal. The foregoing shall apply to nonemergency situations and when the course of treatment is expected to involve covered expenses of \$250 or more.

(12) A provider of health care services is not eligible for reimbursement under section 5102(a)(1) of the Insurance Law if the provider fails to meet any applicable New York State or local licensing requirement necessary to perform such service in New York or meet any applicable licensing requirement necessary to perform such service in any other state in which such service is performed.

(b) *Loss of earnings.* In determining loss of earnings from work:

(1) benefits from other sources shall not be considered as an offset against or a deduction from loss of earnings, unless article 51 of the Insurance Law expressly provides for such offset or deduction;

(i) within the meaning of section 5102(a)(2) of the Insurance Law, insurers shall not take a deduction for statutory or contractual wage continuation plans which are diminished or exhausted as payments are made or when accumulated sick leave time is used. In order for an insurer to be entitled to offset or deduct payments received by a claimant under a particular wage continuation plan, the plan must meet all of the following conditions:

(a) the applicant must be entitled to receive the same level of wage continuation benefits for a subsequent unrelated accident or illness when he or she returns to work after recovering from the injuries sustained in the motor vehicle accident;

(b) benefits for a subsequent unrelated accident or illness must be equal in both time and amount to the wage continuation benefits to which the applicant was entitled as a result of the injuries suffered in the motor vehicle accident; and

(c) wage continuation benefits for a subsequent disability must be immediately available, without any requirement that the applicant work a stated period of time before full benefits are restored;

(ii) within the meaning of section 5102(a)(2) of the Insurance Law, insurers shall take a deduction for any payments made by an employer on a voluntary basis;

(iii) within the meaning of section 5102(a)(2) of the Insurance Law, insurers shall not take a deduction for contractual or voluntary long-term disability plans, which generally become effective six months after the date disability begins;

(2) insureds covered by wage continuation plans which meet the criteria for deduction set forth in subparagraph (1)(i) of this subdivision, are entitled to a premium reduction to reflect the insurer's reduced exposure to loss, pursuant to section 2330 of the Insurance Law. Insurers shall grant the premium reduction upon receipt of information that indicates the insured is covered by such wage continuation plan;

(3) loss of earnings from work shall not necessarily be limited to the applicant's actual level of earnings at the time of the accident, but may also include demonstrated future earnings reasonably projected;

(4) an applicant, whose unemployment was the result of the seasonal nature of the work which the applicant usually performed, shall be entitled to receive payments for loss of earnings from work during the claimed period of disability arising from the accident which coincides with the seasonal period of employment;

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(5) where the injury renders an unemployed applicant ineligible to receive unemployment benefits, the applicant shall be entitled to receive payments for loss of earnings from work equivalent in value to the unemployment benefits which the applicant would otherwise have received. If an unemployed applicant is eligible for disability benefits pursuant to Workers' Compensation Law, section 207 (sick unemployed fund), the no-fault insurer shall supplement such benefits to bring them up to the level of the lost unemployment benefits. If the unemployed applicant is not eligible for such disability benefits, the insurer shall pay an amount equal to the lost unemployment benefits. Such loss of earnings is eligible basic economic loss, but is not subject to the 20-percent offset from loss of earnings provided for in section 5102(b)(1) of the Insurance Law;

(6) if the applicant, while disabled, is discharged from employment solely because of inability to work due to the injury, benefits for basic economic loss shall continue at the same level while the disability continues;

(7) if an applicant, while disabled, is discharged from employment, benefits shall cease if the position would have been lost had the accident not occurred (*e.g.*, plant shutdown, strike, etc.). However, the insurer shall reimburse the applicant for benefits lost which would have been received had the applicant not been disabled (*e.g.*, union strike benefits, unemployment, etc.);

(8) during the continuance of a disability arising from a covered accident, loss of earnings benefits due and payable must be paid periodically, at least once in every 30 calendar days;

(9) refusal by an eligible injured person to accept reasonable rehabilitative treatment may be the basis for denial of future payment of benefits for loss of earnings from work and may be used as evidence to dispute the reasonableness or necessity of any further expense or loss;

(10) substitute services:

(i) where an applicant sustains expenses in obtaining services in lieu of those such person would have performed for income, but still suffers a net loss of earnings from work which the applicant would have performed, such loss of earnings is eligible basic economic loss and shall be subject to the offsets provided for in section 5102(b) of the Insurance Law; and the cost of substitute services reasonably sustained is also eligible basic economic loss, but shall not be subject to such offsets;

(ii) where an applicant has a claim for both substitute services and loss of earnings from work, the claim for substitute services shall be primary in computing the loss of earnings benefit payable;

(11) monthly work loss limit. The monthly limitation on the aggregate of work loss and substitute services shall not be prorated in the event that one is unable to work or is required to obtain substitute services for a period less than one month. A month shall be each consecutive period of 30 days beginning with the date of the accident unless the injury extends for more than one year, in which case there shall be 12 monthly payment periods for the period from the date of accident to each annual anniversary of the accident date;

(12) the maximum first-party benefit payable for loss of earnings from work under the mandatory coverage is \$1,000 per month for claims arising from accidents occurring prior to November 12, 1991 and \$2,000 per month for claims arising from accidents occurring on and after November 12, 1991;

(13) lump-sum settlement for loss of earnings:

(i) an insurer may at its option enter into a lump-sum settlement agreement for the payment of first-party benefits, provided that competent medical testimony establishes that:

(a) the period of disability will extend for at least three years beyond the date of the accident; and

(b) the settlement would be of material benefit to the applicant, occupationally and from a rehabilitative standpoint;

(ii) lump-sum settlements shall be permitted only for the payment of loss of earnings from work and may be reduced to the present value of net benefit payments computed on the basis of a six percent annual interest factor and any other applicable offsets; and

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(iii) no lump-sum settlement shall be permitted unless the form for lump-sum settlement agreement, Appendix 13-A, *infra*, is executed by the parties specified thereon and approved by an arbitrator or a court of competent jurisdiction in accordance with the provisions of this Subpart.

(c) *Other reasonable and necessary expenses sustained.* Where the applicant sustains other reasonable and necessary expenses, such services must be actually performed for a charge by a person who is not legally obligated to render them and would not ordinarily perform such services as part of a family relationship; provided, however, that if a member of a family or relative suffers pecuniary loss in order to render such services, such person shall be reimbursed to the extent of the reasonable value of such services.

Historical Note

Sec. filed Aug. 2, 2001 eff. Sept. 1, 2001.

§ 65-3.17 Explanation of benefits.

At least for every six month period during which any benefits are paid, the insurer shall forward an explanation of benefits (EOB) to the eligible injured person and such person's attorney. The first six month period shall commence on the date of the accident and the EOB shall be mailed within 60 days of the conclusion of the period selected by the insurer. Such EOB shall include, at a minimum, the name of the payee, a description of the service or benefit claimed and the amount paid. It shall also include the fraud warning statement prescribed on the application for motor vehicle no-fault benefits (NYS form NF-2) contained in Appendix 13, *infra*, and the name, address and telephone number of the insurer representative to whom questions should be directed.

Historical Note

Sec. filed Aug. 2, 2001 eff. Sept. 1, 2001.

§ 65-3.18 Releases.

Except as provided in section 65-3.16(b)(13) of this Subpart (lump-sum settlements), there shall be no settlement nor any release, express or implied, for mandatory or optional personal injury protection benefits (mandatory PIP or additional PIP benefits).

Historical Note

Sec. filed Aug. 2, 2001; amd. filed Jan. 17, 2003 eff. Feb. 5, 2003.

§ 65-3.19 Offsets.

(a) State or Federal Workers' Compensation Law benefits that are to be deducted from first-party benefits or additional first-party benefits in accordance with this Part shall not include payments made under any Workers' Compensation Law of the Dominion of Canada or any of its provinces.

(b) Federal social security disability benefits that are to be deducted from first-party or additional first-party benefits shall include, but not be limited to, disability benefits provided for under the Railroad Retirement Act.

(c) (1) If any source of workers' compensation benefits, or disability benefits under article 9 of the Workers' Compensation Law, denies liability for payment of benefits, in whole or in part, the insurer responsible for the payment of first-party or additional first-party benefits shall pay benefits without deducting the withheld workers' compensation or disability benefits; provided, however, that the applicant executes a prescribed agreement to pursue workers' compensation or New York State disability benefits (NYS form NF-9), which shall obligate the applicant to diligently pursue the claim and to repay first-party benefits equal to the withheld amounts in the event such amounts are eventually paid to the applicant. The insurer is entitled to independent verification of the claim in accordance with this Subpart. If the applicant paid an attorney's fee out of the proceeds of the award, pursuant thereto, the amount of the attorney's fee shall be deducted from the repayment.

(2) The insurer should send a copy of the completed agreement to the local district office of the Workers' Compensation Board nearest the applicant's residence. Thereafter, the Workers' Compensation Board will give the insurer notice of the applicant's hearing, so that the insurer may be present. Although the insurer may not be a party to such hearing, it may submit evidence to the referee and may request that the referee put specific questions to the parties.

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(3) If the applicant will not execute the agreement and the automobile insurer is held ultimately liable, such insurer shall not on that account be responsible for the payment of an attorney's fee or interest on the late payment. To the extent that any reimbursement due the insurer is not made by the applicant, the insurer may thereafter deduct such amounts from any future first-party benefits due on the claim.

(d) When it becomes apparent that an applicant, who is receiving no-fault first-party benefits, will be disabled for more than one year, the insurer shall proceed as follows:

(1) forward to the applicant, in triplicate, the prescribed agreement to pursue social security disability benefits (NYS form NF-8) and a self-addressed, stamped return envelope. The applicant shall bring this form to the Social Security Administration (SSA) and, when completed, one copy will be retained by the SSA, one will be retained by the applicant and one will be returned by the applicant to the insurer in the self-addressed, return envelope;

(2) pursuant to the agreement, the insurer shall continue to pay first-party benefits until the applicant begins receiving social security disability benefits.

(3) the insurer, when notified by the Social Security Administration of the amount of the award and the effective date thereof, shall, as of the effective date, reduce the applicant's first-party benefits in an amount equal to the monthly social security disability benefits awarded on account of the applicant's injury, inclusive of awards made to the applicant's spouse and dependents on account of the injury. However, if the applicant paid an attorney's fee out of the proceeds of the award, pursuant thereto, the insurer shall not take credit for that portion of the award in computing the amount of the reduction.

(4) in the event that the applicant fails to execute the agreement, the insurer may, beginning the 27th week after the accident, or 35 calendar days after the agreement was forwarded to the applicant (the extra five calendar days allowed are for mailing) in the event the 27th week has passed, estimate the social security disability benefit it believes the applicant is entitled to on account of the automobile accident and begin reducing the applicant's first-party benefits accordingly. If it is later determined that no such social security disability benefits were due the applicant or that the estimate made by the automobile insurer was too high, the insurer shall pay the applicant for benefits due but shall not on that account be responsible for an attorney's fee or interest on the late payment; and

(5) to the extent that any reimbursement due the insurer pursuant to the agreement is not made by the applicant, the insurer may thereafter deduct such amounts from any future no-fault benefits due on the claim.

(e) *Workers' compensation or disability benefits liens reimbursement of section 5102(b)(2) offset.* (1) Whenever a lien is asserted against the proceeds of any tort recovery made pursuant to section 5104(a) of the Insurance Law for workers' compensation benefits paid pursuant to any other State or Federal law, the no-fault insurer shall make the claimant whole in a manner consistent with the following examples:

(i) Pursuant to section 5102(b)(2), the no-fault insurer takes an offset of \$15,000 from first-party benefits due claimant. Claimant recovers \$25,000 in an action brought pursuant to section 5104(a). Workers' compensation lien of \$15,000, less the workers' compensation provider's share of expenses and attorney's fees, in the amount of \$5,000 is satisfied out of the \$25,000 recovery. In order to make the claimant whole, the no-fault insurer shall pay the claimant \$10,000 in first-party benefits. The amount owed to the claimant is the net amount of the satisfied lien.

(ii) Pursuant to section 5102(b)(2), the no-fault insurer takes an offset of \$15,000 from first-party benefits due claimant. Claimant recovers \$10,000 in an action brought pursuant to section 5104(a), which is the total amount available to satisfy the judgment or settlement. Workers' compensation lien of \$15,000 is compromised to \$5,000, less the provider's share of expenses and attorney's fees, in the amount of \$2,000 and is satisfied out of the \$10,000 recovery. In order to make the claimant whole, the no-fault insurer shall pay the claimant \$3,000 in first-party benefits. The amount owed to the claimant by the no-fault insurer is the net amount of the compromised lien, not the full amount of the no-fault insurer's offset.

(iii) Pursuant to section 5102(b)(2), the no-fault insurer takes an offset of \$40,000 from first-party benefits due claimant. The workers' compensation provider pays an additional

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\$20,000 in benefits pursuant to the State's Workers' Compensation Law. Claimant recovers \$200,000 in an action brought pursuant to section 5104(a). The workers' compensation lien of \$60,000 less the provider's share of expenses and attorney's fees is satisfied out of the \$200,000 recovery. In order to make the claimant whole, the automobile insurer shall pay the claimant \$40,000 in first-party benefits. The amount owed the claimant by the no-fault insurer can never exceed the amount of the section 5102(b)(2) offset taken by the no-fault insurer.

(2) In lieu of the procedure set forth in paragraph (1) of this subdivision, subject to acceptance by the workers' compensation or disability benefits provider, the claimant may assign the payment right to the workers' compensation or disability benefits provider having the lien, as an alternative to the workers' compensation or disability benefits provider obtaining satisfaction of its lien directly from claimant's recovery. The assignment shall be effective only if there has been a recovery made pursuant to section 5104(a) of the Insurance Law. The maximum obligation of the no-fault insurer shall be limited to the amount of the lien which would have been satisfied out of the recovery, but for the assignment and shall, in no event, exceed the amount of the offset taken by the no-fault insurer under section 5102(b)(2) of the Insurance Law. The no fault insurer shall honor such assignment by paying first-party benefits directly to the workers' compensation or disability benefits provider for appropriate credit toward satisfaction of its lien.

(3) Under paragraph (2) of this subdivision, the no-fault insurer shall either pay or deny in whole or in part on the prescribed denial of claim form (NYS form NF-10) within 30 days after submission of proof that the workers' compensation or disability benefits lien has been satisfied or that the provider, as assignee, has effected such recovery.

(4) Under paragraph (3) of this subdivision, the no-fault insurer shall, provided proof of assignment has been received, either pay the workers' compensation or disability benefits provider or deny payment in whole or in part on the prescribed denial of claim form (NYS form NF-10) within 30 days after receipt of proof of recovery by the claimant in an action brought pursuant to section 5104(a) of the Insurance Law.

(5) Failure to make timely payment, as provided for in paragraph (3) or (4) of this subdivision, shall subject the no-fault insurer to the interest, attorney's fees and arbitration provisions of sections 65-3.9 and 65-3.10 of this Subpart and Subpart 65-4 of this Part.

(f) (1) Whenever an eligible injured person is entitled to disability benefits under article 9 of the Workers' Compensation Law, the insurer shall be entitled to an offset equal to the lesser of:

(i) 50 percent of the applicant's average weekly wage loss not to exceed \$170 per week; or

(ii) the actual dollar amount of the disability benefits being received where the employer's plan provides a maximum payment of less than \$170 per week. The \$170 per week previously referred to shall be adjusted whenever section 204 of the Workers' Compensation Law is amended to provide a higher statutory dollar maximum. The offset shall be applicable during the statutory 26-week benefit period beginning seven days after the accident date except in the case where lower benefits are paid in exchange for a longer benefit period. In no event shall the offset for New York State disability benefits exceed the weekly statutory dollar maximum multiplied by the maximum statutory benefit period (currently $\$170 \times 26 \text{ weeks} = \$4,420$).

(2) The insurer shall provide the applicant with a notice and proof of claim for disability benefits (DB 450), which has been printed on buff-colored paper and, in addition, shall notify the applicant's employer that such employer is required to process the applicant's disability benefits claim if its employees are covered for such benefits by the Workers' Compensation Law. The notification to the employer should be sent along with the employer's wage verification report (NYS form NF-6). Unless the insurer has complied with the above, it shall not take an offset for New York State disability benefits until it verifies that the applicant is actually receiving statutory disability benefits.

(3) For all qualified wage continuation plans, (referred to in section 65-3.16[b][1][i] of this Subpart) which provide benefits equal to less than 100 percent of the employee's salary, the insurer should reduce the amount paid under the plan by the amount required to be paid in satisfaction of the New York State Disability Law. Only the excess over the New York State disability benefits is a qualified wage continuation plan benefit.

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Example:

	A	B
Gross Monthly Earnings	\$6,000	\$4,000
Monthly Qualified Wage Continuation Plan Benefit		
Benefit	\$3,000	
NYS Disability offset		
offset	<u>-680</u>	
Insurer's Qualified Wage Continuation Plan Offset	<u>-\$2,320</u>	<u>-\$2,320</u>
Gross Lost Earnings	\$3,680	\$1,680
First-party Benefit for Loss of Earnings Limited to Maximum of \$2,500	\$2,500	\$1,680
Less NYS Disability Offset ¹	<u>680</u>	<u>680</u>
	\$1,820	\$1,000
Less 20% Offset	<u>\$ 364</u>	<u>\$ 200</u>
Net Loss of Earnings Benefit	<u>\$1,456</u>	<u>\$ 800</u>

(4) The insurer, when making its first payment for loss of earnings, shall include a written explanation of the computation of the New York State disability offset taken.

Historical Note

Sec. filed Aug. 2, 2001; amd. filed Jan. 17, 2003 eff. Feb. 5, 2003. Amended (e)(5), (f)(3).

§ 65-3.20 Reimbursement and trust agreement.

An insurer may request that an applicant assign to the insurer such applicant's right to commence an action, pursuant to section 5104(b) of the Insurance Law, before two years after the accrual thereof; provided, however, that such request must be accompanied by a clear, detailed explanation that the applicant has the right to refuse such request and that such refusal will not prejudice the applicant's eligibility for the payment of any first-party benefits to which the applicant is entitled. If, as a result of such assignment, the insurer recovers an amount in excess of the amount paid or payable to the applicant in first-party benefits, such excess amount shall be remitted to the applicant less a pro rata share of collection costs.

Historical Note

Sec. filed Aug. 2, 2001 eff. Sept. 1, 2001.

¹If NYS disability benefits are taxable, the offset should be deducted from the lesser of gross lost earnings or \$2,500, prior to the 20 percent offset.

SUBPART 65-4

(Regulation 68-D)

ARBITRATION

Historical Note

Subpart (§§ 65-4.1—65-4.11) filed Aug. 2, 2001 eff. Sept. 1, 2001.

§ 65-4.1 Applicability of arbitration procedures under article 51 of the Insurance Law.

This Subpart shall apply to insurers, and the term *insurer*, as used in this Subpart, shall include both insurers and self-insurers, as those terms are defined in this Part and article 51 of the Insurance Law, and shall also include the Motor Vehicle Accident Indemnification Corporation (MVAIC) created pursuant to article 52 of the Insurance Law and any company or corporation providing insurance pursuant to section 5103(g) of the Insurance Law.

Historical Note

Sec. filed Aug. 2, 2001 eff. Sept. 1, 2001.

§ 65-4.2 Initiation of optional arbitration procedures under section 5106(b) of the Insurance Law for arbitrations filed with an organization designated by the superintendent on and after December 1, 1999.

(a) *Administration by an organization designated by the superintendent.* (1) Section 5106 of the Insurance Law requires that the Superintendent of Financial Services promulgate simplified procedures for the resolution by arbitration of no-fault disputes.

(2) Chapter 892 of the Laws of 1977 provides for the establishment of revised optional arbitration systems for the resolution of no-fault disputes. These changed procedures for the administration of the arbitration system provide for initial review of all arbitration requests by an organization designated by the superintendent. The designated organization, acting on behalf of the superintendent, is authorized to receive, attempt to conciliate and forward to arbitration all requests for arbitration that it cannot conciliate.

(3) All optional arbitrations pursuant to section 5106(b) of the Insurance Law will be administered by an organization designated by the superintendent.

(4) No-fault optional arbitration advisory committee. The superintendent shall select an advisory committee composed of 12 members to review the operations and the actual costs of the optional arbitration procedures set forth in this Subpart. Not more than four of the members of the advisory committee shall be representatives of self-insurers.

(5) Oversight. The superintendent shall oversee the operation procedures of the designated organization with respect to the administration of the optional arbitration process. Such oversight shall include, but not be limited to, access to all systems, databases, and records related to the optional arbitration process. In addition, the designated organization shall make reports to the superintendent in whatever form the superintendent shall prescribe.

(b) *Procedures.* (1) Initiation of arbitration.

(i) An applicant for benefits may initiate arbitration proceedings by mailing a copy of the denial of claim form prescribed by section 65-3.4(c)(11) of this Part, upon which the applicant has entered the reason(s) for contesting the denial, together with a detailed listing and calculation of all incurred expenses in dispute, indicating the dates upon which the claims for incurred expenses were submitted to the insurer, to the address designated on the denial of claim form.

(ii) If there is a dispute with respect to any matter which is arbitrable pursuant to section 5106 of the Insurance Law and a denial of claim form has not been issued, the applicant may initiate arbitration by completing a no-fault arbitration request form and forwarding the original and one copy to the designated organization at the address designated on the form, and one copy to the insurer against which arbitration is being requested. The no-fault arbitration request form shall be prescribed by the designated organization and approved by the superintendent.

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(iii) The denial of claim form or the arbitration request form shall be accompanied by a check or money order for \$40 payable to the designated organization. This filing fee shall be returned to the applicant directly by the insurer, if the applicant prevails in whole or in part.

(iv) As a condition precedent to arbitration where there is no denial of claim by an insurer, evidence of attempts to settle the dispute must be detailed on the arbitration request form.

(v) In the absence of a denial of claim form, a dispute shall be considered arbitrable if the claim is overdue as described in section 65-3.8(a)(1) of this Part and a demonstrable attempt was made by the applicant to obtain payment or an explanation from the insurer of the continued nonpayment of the claim.

(vi) All items on the no-fault arbitration request form must be completed in full. An explanation must be provided for any omitted spaces on the form, which may be obtained, upon request, from the designated organization by writing to the address designated on the denial of claim form (NYS form NF-10), which is included in Appendix 13 of this Title.

(2) Initial review by the conciliation center. (i) The designated organization shall establish a conciliation center, which shall review all requests for arbitration and assign file numbers thereto, which shall be used by the designated organization and the parties to identify the case.

(ii) Each insurer shall designate, for each claims office used by the insurer to handle New York no-fault claims, a responsible staff member whom the conciliation center can contact to determine whether the no-fault dispute for which arbitration has been requested can be resolved without the need for arbitration. Since conciliation staff will attempt to resolve the dispute by telephone, facsimile, e-mail, or other appropriate means, the insurer's designated representative shall have the authority to bind the insurer to any agreement reached. The insurer shall notify the conciliation center of the designated representative in writing and immediately notify the conciliation center of any change in such designation.

(iii) If it appears, after review, that the dispute may be resolved without arbitration, the conciliation center will communicate with the parties and attempt through conciliation to resolve the dispute.

(a) If all the issues in dispute are resolved through the designated organization's conciliation, by the insurer agreeing to pay and the applicant agreeing to accept all or a portion of the amount in dispute, the insurer shall, in addition, return the filing fee to the applicant. If the claim was overdue, the insurer shall also pay the applicable interest.

(b) If the arbitration was initiated by use of a no-fault arbitration request form and it is subsequently established that the claim and any applicable interest and attorney fees were paid at least 20 calendar days prior to the submission of the completed arbitration request form, the filing fee shall not be returned to the applicant. In such instance, an additional \$100 service and processing fee shall be payable by the applicant to the designated organization.

(iv) If it appears to the conciliation center that the dispute cannot be resolved through conciliation within 60 calendar days, the conciliation center will refer the request for arbitration as prescribed in this section and the parties shall be so advised. The conciliation center may, however, withhold such referral pending receipt from the applicant of pertinent and available information that has been requested.

(3) Submission of documents. (i) The applicant shall submit all documents supporting the applicant's position along with their request for arbitration. All such documents shall also be simultaneously submitted to the respondent. Following this original submission of documents, no additional documents may be submitted by the applicant other than bills or claims for ongoing benefits.

(ii) The designated organization shall, no later than five business days after receipt of the arbitration request, advise the respondent of such receipt. The respondent shall, within 30 calendar days after the mailing of such advice, provide all documents supporting its position on the disputed matter. Such documents shall be submitted to the applicant at the same time. The respondent may, in writing, request that the designated organization provide an additional 30 calendar days to respond based upon reasonable circumstances that prevent it from complying.

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(iii) The written record shall be closed upon receipt of the respondent's submission or the expiration of the period for receipt of the respondent's submission. Documents submitted by either party after the record is closed shall be marked "Late."

(iv) Any additional written submissions may be made only at the request or with the approval of the arbitrator.

(v) The provisions of this paragraph shall take effect with all arbitrations filed on and after March 1, 2002.

(4) Prior to transmittal to arbitration, the insurer may make a non-binding written offer to resolve the dispute. Such offer, if not accepted by the applicant, shall be transmitted to the arbitration forum, but shall not be disclosed to the arbitrator. The parties to the dispute shall also not disclose the offer to the arbitrator.

(5) All disputes remaining after expiration of the conciliation period shall be forwarded for arbitration.

(c) *Financing.* (1) The cost of administering the conciliation function, reduced by any fees collected, shall be paid annually by insurers (including self-insurers and MVAIC) to the designated organization upon receipt of a statement therefrom. This cost shall be distributed among insurers in an equitable manner approved by the Superintendent of Financial Services. This distribution shall, to the extent practicable, be a function of the degree to which an insurer is named as a respondent in conciliation proceedings of the designated organization.

(2) Semiannually, commencing December 1, 1999 and continuing every six months thereafter, the designated organization shall prepare an estimate of the expenses expected to be incurred for the operation of the conciliation function during the subsequent six-month period. The projected cost of the conciliation function shall be assessed on a proportionate basis to those insurers named as respondents in the preceding calendar year and shall be subject to the approval of the superintendent. The designated organization shall send to each applicable insurer a bill for the amount due and any payment due shall be made to the designated organization within 30 days after billing date.

(3) On an annual basis, as of December 31st of each year, the designated organization shall prepare a detailed analysis of the actual costs incurred for the operation of the conciliation function. This analysis shall be forwarded to the no-fault optional arbitration advisory committee and the superintendent on or before April 30th of each year. The no-fault optional arbitration advisory committee shall notify the designated organization and the superintendent whether it accepts or rejects the designated organization's cost analysis in whole or in part. In the event that the designated organization and the no-fault optional arbitration advisory committee cannot resolve any differences that may exist, such differences will be referred to the superintendent for resolution. The superintendent's decision shall be binding on the designated organization and insurers.

(4) Once the designated organization submits a final cost analysis that has either been approved by the no-fault optional arbitration advisory committee or resolved by the superintendent in the event of a dispute, the designated organization shall send to each applicable insurer an accounting of the actual assessment. Any adjustment shall be made to the bill for the subsequent estimated assessment, as illustrated by the following example:

<i>Example:</i> (1) Total conciliation cases closed during year	30,000
(2) Cases in which insurer A was named as a respondent in the conciliation proceeding	1,250
(3) Insurer A's assessment percentage = (2)/(1)	4.167%
(4) Actual expenses of the conciliation function reduced by amounts received through fees collected	\$2,500,000
(5) Insurer A's actual expense = (3)*(4)	\$104,175
(6) Insurer A's estimated assessment	\$102,000

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(7) Insurer A's debit or (credit) = (5)-(6) \$2,175

Historical Note

Sec. filed Aug. 2, 2001; amds. filed: April 11, 2002 as emergency measure; July 9, 2002 as emergency measure; Oct. 4, 2002 as emergency measure; Nov. 27, 2002 as emergency measure; Jan. 17, 2003 as emergency measure; Jan. 17, 2003; April 9, 2013 eff. June 1, 2013; amended adoption filed May 16, 2013 eff. Aug. 1, 2013. Amended (a)(1), (c)(1).

§ 65-4.3 Jurisdiction of arbitration forums.

(a) *Insurance Department Arbitration (IDA) forum.* IDA jurisdiction shall be limited to requests for no-fault arbitration filed prior to December 1, 1999 and shall include only those disputes where the remaining issues after expiration of the conciliation period involve:

- (1) correct computation of health service provider fees, whether or not such fees are specifically covered by the fee schedules promulgated in Part 68 of this Title (Regulation 83);
- (2) where the amount in dispute is less than \$400 and such dispute does not involve a coverage question or affect the outcome of any other portion of the applicant's claim; or
- (3) whether the claim was overdue at the time it was paid, how long the claim was overdue, or whether the correct amount of interest or attorney's fee on an overdue claim was paid.

(b) *No-fault arbitration forum.* All disputes remaining after expiration of the conciliation period, involving issues other than those to be resolved pursuant to subdivision (a) of this section, shall be forwarded to the no-fault arbitration forum which shall be the forum for their resolution.

(c) Where a request for arbitration involves issues which fall within the jurisdiction of both of the forums specified in this section, the dispute shall be resolved by the no-fault arbitration forum, except disputes specified in paragraph (a)(1) of this section and filed prior to December 1, 1999 shall be resolved by IDA arbitration.

Historical Note

Sec. filed Aug. 2, 2001 eff. Sept. 1, 2001.

§ 65-4.4 Insurance Department Arbitration (IDA) forum procedure.

(a) *Notice.* If the dispute is subject to IDA arbitration, the parties will be notified by the IDA, in writing, that the dispute will be resolved by arbitration on the basis of written submissions of the parties. All such submissions shall be received by the IDA within 30 calendar days of the date of mailing of the notice. No oral arguments will be permitted. In order to facilitate receipt of evidence by IDA, the parties may forward their submissions prior to receipt of the above notification.

(b) *Consolidation.* The IDA may consolidate disputes if the claims arose out of the same accident and involve common issues of fact.

(c) *Designation of arbitrators.* The arbitrator shall be a senior member of the Insurance Department staff designated by the superintendent to serve as an IDA arbitrator and shall not be the same person who attempted to conciliate the dispute.

(d) *Qualifications of the arbitrator.* Every IDA arbitrator shall be an examiner who regularly administers article 51 of the Insurance Law or an attorney. If the issue in dispute includes a request for an additional attorney's fee pursuant to section 65-4.6 of this Subpart, the IDA arbitrator shall be an attorney. No person shall serve as an arbitrator in any arbitration in which such person has any financial or personal interest. An arbitrator shall disclose to the IDA any circumstance which is likely to create an appearance of bias or which might disqualify such arbitrator. Upon receipt of such information, the IDA shall immediately disclose it to the parties. If a party challenges an arbitrator, the specific grounds for the challenge shall be submitted in writing to the superintendent. The superintendent shall determine whether the arbitrator should be disqualified and shall inform the parties of that determination, which shall be conclusive. If an arbitrator should resign, be disqualified or be otherwise unable to perform necessary duties, the superintendent shall designate another arbitrator to resolve the dispute.

(e) *Evidence.* The arbitrator shall be the judge of the relevancy and materiality of the evidence offered and strict conformity to legal rules of evidence shall not be necessary. The arbitra-

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tor may subpoena documents upon the arbitrator's own initiative or upon the request of any party when the issues to be resolved require such documents. Copies of all documents submitted to the arbitrator shall be simultaneously transmitted to the other parties. The arbitrator may raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and department regulations.

(f) *Form and scope of award.* The award, which shall be in writing and signed by the arbitrator, shall state the issues in dispute and contain the arbitrator's findings, conclusions and decision based on the Insurance Law and Insurance Department regulations. In the event that the applicant prevails in whole or in part on the claim, the arbitrator shall also direct the insurer to:

(1) reimburse the applicant for the amount of the filing fee paid, unless the filing fee had already been returned to the applicant;

(2) if due under section 5106 of the Insurance Law, pay a reasonable attorney's fee in accordance with the limitations set forth in section 65-4.6 of this Subpart; and

(3) in an award of interest, the arbitrator shall compute the amount due for each element of first-party benefits in dispute, commencing 30 days after proof of claim therefor was received by the insurer and ending with the day of payment of the award, subject to the provisions of section 65-3.9(c) and (d) of this Part (stay of interest).

(g) *Time of award.* The award shall be issued no later than 30 calendar days from the final date submissions must be received. Failure to adhere to the prescribed time limit shall not nullify the award.

(h) *Delivery of award to parties.* The award shall be transmitted to the parties, which shall accept as delivery of the award the placing of the award or a true copy thereof, in the mail, addressed to the parties and their designated representatives at their last known addresses, or by any other form of service permitted by law. The IDA shall note on such award or transmittal letter thereof the date of mailing, and keep a record of same.

(i) *Interpretation and application of procedures.* The arbitrator shall interpret and apply these procedures insofar as they relate to the arbitrator's powers and duties. All other procedures shall be administered by the Insurance Department.

(j) *Payment of award.* Insurers shall, within 30 calendar days of the date of mailing of the award, either pay the amounts set forth in the award or, where grounds exist, appeal to the master arbitrator as provided for in this Part, which appeal shall stay payment of the award. The award need not be confirmed into judgment.

(k) *Financing.* The Insurance Department shall bill the insurer the sum of \$100 whenever the applicant prevails in whole or in part on the disputed claim. Such fee shall be payable within 30 days after the billing date and shall be utilized to defray the operating expenses of the department.

Historical Note

Sec. filed Aug. 2, 2001; amd. filed Feb. 17, 2003 eff. Feb. 5, 2003. Amended (f).

§ 65-4.5 No-fault arbitration forum procedure.

(a) *Notice.* If a dispute has been transmitted for arbitration by the Department of Financial Services or the conciliation center, the parties will be notified by the designated organization, in writing, that the dispute will be resolved by arbitration. At the arbitrator's discretion, if the dispute involves an amount less than \$2,000, the parties shall be notified that the dispute shall be resolved on the basis of written submissions of the parties. All such submissions shall be received by the designated organization within 30 calendar days of the date of mailing of the notice. No oral arguments will be permitted, unless the arbitrator determines that additional evidence or testimony is necessary. In order to facilitate receipt of evidence by the designated organization, the parties may forward their submissions prior to receipt of the above notification.

(b) *Special expedited arbitration.* (1) Special expedited arbitration shall be available for disputes involving:

(i) the failure to submit notice of claim within 30 calendar days after the accident and where it has been determined by the insurer that reasonable justification for late notice has not been established; and

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(ii) the proper application of sections 65-3.12(b) and (c) and 65-3.13(a)(2)-(4) and (8) of this Part.

(2) (i) An applicant may request special expedited arbitration for resolution of the dispute involving late notice within 30 calendar days after mailing of the denial of claim by the insurer stating that reasonable justification for late notice has not been established.

(ii) (a) In regard to disputes related to section 65-3.12(b) and (c) or 65-3.13(a)(2)-(4) and (8) of this Part, an applicant may request special expedited arbitration to designate an insurer that is responsible for processing first-party benefits and additional first party benefits, after each insurer has issued a denial of claim form (NF-10) stating that the insurer is not the insurer eligible to process the first-party benefits claimed.

(b) Special expedited arbitration required by clause (a) of this subparagraph shall only designate an insurer to commence processing the claim based upon the first insurer notified that is otherwise liable for the payment of first party benefits. The insurer designated by the arbitration shall retain all rights of investigation afforded under statute and regulation, and the ultimate liability for payment of benefits shall be resolved in accordance with section 65-4.11 of this Subpart.

(3) At the time of a request for special expedited arbitration, the applicant shall make a complete written submission supporting his or her position. Any further written submissions shall be accepted into evidence at the discretion of the arbitrator.

(4) Applications for special expedited arbitration shall be submitted to the conciliation center of the designated organization and shall comply with the requirements for initiation of arbitration contained in section 65-4.2(b)(1)(iii) of this Subpart.

(5) The applicant's submission shall be forwarded by the conciliation center to the insurer within three business days of receipt. The insurer may provide the center with reasonable special mailing or transmittal instructions to facilitate the processing of these arbitration requests.

(6) The insurer shall respond in writing to the applicant's submission within 10 business days after the mailing by the center. No further submissions shall be accepted unless requested by the arbitrator.

(7) The dispute shall be resolved solely upon the basis of written submissions unless the arbitrator concludes that the issues in dispute require an oral hearing.

(8) The arbitrator shall issue a written decision within 10 business days after receipt of all written submissions from the parties or at the conclusion of an oral hearing.

(9) For the purpose of special expedited arbitration, the superintendent may appoint arbitrators, qualified in accordance with the provisions of this section, to serve on a per diem basis. Such arbitrators shall contract with the designated organization. The rate of per diem compensation shall be determined by the designated organization, after consultation with the no-fault arbitrator screening committee subject to the approval of the superintendent. Such arbitrators shall be independent contractors, and shall not be employees or agents of the designated organization or the Department of Financial Services.

(c) *Consolidation.* The designated organization shall, except where impracticable, consolidate disputes for which a request for arbitration has been received, if the claims involved arose out of the same accident and involve common issues of fact.

(d) *Qualifications of arbitrators for a hearing held in New York State.* (1) No-fault arbitrator screening committee. The superintendent shall appoint an advisory committee composed of six members, who will review the qualifications of applicants for the position of no-fault arbitrator for hearings to be held in New York State and review the performance of the appointed arbitrators. The screening committee shall make recommendations to the superintendent pertaining to the appointment and dismissal of no-fault arbitrators. The committee shall consist of one representative of the New York State Bar Association, one representative of the New York State Trial Lawyer's Association, two representatives of the insurance industry selected by the no-fault optional arbitration advisory committee, a nonvoting representative of the designated organization and a nonvoting representative of the Department of Financial Services. Tie votes shall be reported as such to the superintendent.

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(2) A no-fault arbitrator shall be an attorney, licensed to practice law in New York State, with at least five years experience which the no-fault arbitrator screening committee has determined qualifies such attorney to review and resolve the issues involved in no-fault insurance disputes. Documentation of such experience shall be submitted to, and reviewed by, the superintendent prior to the appointment of an arbitrator.

(3) All no-fault arbitrators shall be appointed by, and serve at the pleasure of, the superintendent. An arbitrator candidate shall disclose to the superintendent any circumstance which is likely to create an appearance of bias or which might disqualify such person as an arbitrator, and the superintendent shall determine whether the candidate should be disqualified. The superintendent shall forward the name of all no-fault arbitrators to the designated organization, and promptly inform the designated organization of all additions to, and deletions from, the panel.

(4) No person shall, during the period of appointment as an arbitrator, have any practice or professional connection with any firm or insurer involved in any degree with automobile insurance or negligence law. The no-fault arbitrator screening committee, subject to the approval of the superintendent, shall establish any additional qualifications for appointment as a no-fault arbitrator.

(e) *Qualifications of arbitrators for a hearing held outside New York State.* For a hearing which will be held outside New York State, the arbitrator shall be a licensed attorney in the state or Canadian province where the hearing is held.

(f) *Designation of arbitrator.* The designated organization shall assign an arbitrator who will hear the case, and shall submit the name of the arbitrator to each party to the arbitration. The designated organization shall maintain a file containing the professional background of each of its no-fault arbitrators, and the information contained therein shall be available to any party to the arbitration upon written or oral request.

(g) *Conflict of interest and disqualification of arbitrator.* No person shall serve as an arbitrator in any arbitration in which such person has any financial or personal interest or bias. If a party challenges an arbitrator, the specific grounds for the challenge shall be submitted in writing to the designated organization, which shall determine, in consultation with the Department of Financial Services, within 15 calendar days after receipt of the challenge, whether the arbitrator shall be disqualified. Such written determination, in a format approved by the department, shall be final and binding. If an arbitrator should resign, be disqualified or be otherwise unable to perform necessary duties, the designated organization shall assign another arbitrator to the case.

(h) *Oaths.* Arbitrators shall take an annual oath of office. Arbitrators shall require all witnesses to testify under oath or affirm that their statements are true under the penalties of perjury.

(i) *Time and place of arbitration.* (1) The arbitration hearing shall be held in the arbitrator's office or any other appropriate place selected by the designated organization and, to the extent practicable, within the general locale of the applicant's residence but, in no event, more than 100 miles from such residence. The arbitrator shall fix the time and place for such hearing. At least 15 calendar days prior to the hearing, the designated organization shall mail a notice of hearing to each party. Unless otherwise agreed by the parties, the hearing shall be scheduled to be held within 30 calendar days of the date of the appointment of the arbitrator. The parties to the arbitration shall not directly contact the arbitrator at any time prior to or subsequent to the hearing, but shall direct all communications to the designated organization.

(2) Effective with arbitrations filed on and after March 1, 2002, if the applicant requests arbitration within 90 days after the claim became overdue or within 90 days after receipt of the denial of claim, the arbitration shall be scheduled for a hearing within 45 days after transmittal from the conciliation center, when requested by the applicant.

(j) *Postponements and adjournments.* The arbitrator may for good cause postpone or adjourn the hearing upon request of a party or upon the arbitrator's own initiative. Each party may cause one adjournment without the payment of an adjournment fee, if the adjournment request is received by the designated organization at least two business days prior to the scheduled arbitration. There shall be an adjournment fee of \$50 payable to the designated organization by the party requesting any subsequent adjournment. An adjournment fee of \$100 shall be payable to the designated organization by the party causing any adjournment within two business days

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prior to the scheduled hearing. Such fees shall be used to defray the cost of administration of the arbitration forum.

(k) *Representation at arbitration.* Any party shall either represent itself or be represented by an attorney.

(l) *Record of proceedings.* A stenographic record of the arbitration proceedings shall not be required. However, a party requesting such a record shall inform the other party or parties of such intent, make the necessary arrangements, and pay the cost thereof directly to the person or agency making such record. Any other party or parties to the arbitration shall be entitled to a copy of such record upon agreeing to share the cost of the total stenographic expense. Whether or not a stenographic record of the proceeding is made, the arbitrator shall, at a minimum, record the exhibits offered by each party and the names and addresses of all parties and witnesses.

(m) *Interpreters.* Any party wishing an interpreter shall make all arrangements directly with the interpreter and shall assume the costs of such services.

(n) *Attendance at hearings.* Persons having a direct interest in the arbitration are entitled to attend hearings. It shall be discretionary with the arbitrator to permit the attendance of any other persons.

(o) *Evidence.* (1) The arbitrator shall be the judge of the relevance and materiality of the evidence offered, and strict conformity to legal rules of evidence shall not be necessary. The arbitrator may question any witness or party and independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and department regulations.

(2) The arbitrator or an attorney of record in the arbitration may subpoena witnesses or documents upon the arbitrator's own initiative or upon the request of any party, when the issues to be resolved require such witnesses or documents.

(3) (i) For arbitrations filed prior to March 1, 2002, copies of all documents to be submitted to the arbitrator shall be simultaneously transmitted to the other parties at least seven calendar days prior to the hearing. The arbitrator shall determine if all parties received such documents prior to the commencement of the hearing.

(ii) For arbitrations filed on or after March 1, 2002, the arbitrator shall determine if the parties provided and exchanged documents in accordance with the requirements of section 65-4.2(b)(3) of this Subpart.

(4) If a party to an arbitration intends to introduce an expert witness at the hearing, the identity of the expert witness must be given to all parties at least seven calendar days prior to the hearing.

(p) *Arbitration in the absence of a party.* The arbitration may proceed in the absence of any party who, after due notice, fails to be present or fails to obtain a postponement or adjournment. An award shall not be made in favor of an appearing party solely on the default of another party. The arbitrator shall require the appearing party to submit such evidence as may be required for the making of an award. The arbitrator may require the appearance of a party at the hearing if the arbitrator determines that the party's appearance is necessary to realize a fair and just resolution of the dispute and to afford all parties due process.

(q) *Reopening of hearing.* The hearing may be reopened by the arbitrator, for good cause, at any time before the award is made.

(r) *Time of award.* The award shall be made and delivered no later than 30 calendar days from the date the hearing is completed or 30 days from the date of the designated organization's transmittal of the final documentary proofs to the arbitrator. Failure to adhere to this time limit shall not nullify the award.

(s) *Form and scope of award.* The award shall be in writing in a format approved by the superintendent. It shall state the issues in dispute and contain the arbitrator's findings and conclusions based on the Insurance Law and Department of Financial Services regulations. It shall be signed by the arbitrator and shall be transmitted to the parties by the designated organization with a copy to the Insurance Department. The award shall contain a decision on all issues submitted to

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the arbitrator by the parties. In the event that the applicant prevails in whole or in part on the claim, the arbitrator shall also direct the insurer to:

(1) reimburse the applicant for the amount of the filing fee paid, unless the filing fee had already been returned to the applicant;

(2) if due under section 5108 of the Insurance Law, pay a reasonable attorney's fee in accordance with the limitations set forth in section 65-4.6 of this Subpart; and

(3) in an award of interest, compute the amount due for each element of first-party benefits in dispute, commencing 30 days after proof of claim therefor was received by the insurer and ending with the date of payment of the award, subject to the provisions of section 65-3.9(c) of this Part (stay of interest).

(t) *Imposition of costs.* (1) Effective with arbitrations filed on and after March 1, 2002, the arbitrator may impose all administrative costs of arbitration to the applicant or apportion the administrative costs of arbitration between the parties if the arbitrator concludes that the applicant's arbitration request was frivolous, was without factual or legal merit, or was filed for the purpose of harassing the respondent. Cases in which arbitrators impose all administrative costs to the applicant shall be excluded from the assessment calculation contained in subdivision (aa) of this section.

(2) The amount of such administrative costs per case shall be established for each calendar year by the designated organization. The administrative cost shall be based upon the actual administrative costs per case in the prior calendar year. Such costs shall be paid to the designated organization and the receipt of such costs shall be used to reduce the actual expenses of the designated organization for the administration of the arbitration forum.

(u) *Award upon settlement.* (1) If the parties settle their dispute during the course of arbitration, the arbitrator shall set forth the terms of the agreed settlement in an award, which shall provide that the parties agree that the settlement is final and binding and shall not be subject to review by a master arbitrator or by a court. If an attorney's fee is due under section 5106 of the Insurance Law, such fee shall be awarded in accordance with the limitations set forth in section 65-4.6 of this Subpart. The award shall be signed by the arbitrator and shall be transmitted to the parties by the designated organization, with a copy to the Department of Financial Services.

(2) The insurer shall provide the designated organization with the terms of settlement for transmittal to the arbitrator no later than 30 calendar days following the scheduled date of the hearing.

(v) *Delivery of award to parties.* The parties shall accept as delivery of the award the placing of the award or a true copy thereof in the mail, addressed to the parties or their designated representatives at their last known addresses, or by any other form of service permitted by law. The designated organization shall note on such award or transmittal letter thereof the date of mailing and keep a record of same.

(w) *Interpretation and application of procedures.* The arbitrator shall interpret and apply these procedures insofar as they relate to the arbitrator's powers and duties. All other procedures shall be interpreted by the designated organization, subject to consultation with and approval by the superintendent.

(x) *Alternative legal remedies.* The designated organization shall not be made a party to a court proceeding relating to an arbitration award unless the designated organization's presence as a party is pertinent to the issues raised in the litigation. The participation of a party in an arbitration proceeding shall be a waiver of any claim against an arbitrator or the designated organization for any act or omission in connection with any arbitration conducted under these rules. The designated organization shall transmit to the superintendent copies of any legal papers served upon designated organization or an arbitrator, relating to any stay or appeal of an arbitration.

(y) *Payment of award.* Insurers shall, within 30 calendar days of the date of mailing of the award, either pay the amounts set forth in the award or, where grounds exist, appeal to the master arbitrator as provided for in this Part, which appeal shall stay payment of the award. The award need not be confirmed into judgment.

(z) *Arbitrator's compensation and expenses.* At the direction of the superintendent, arbitrators shall contract on an annual basis with the designated organization. The rate of annual

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compensation shall be determined by the designated organization, after consultation with the no-fault arbitrator screening committee subject to the approval of the superintendent. Arbitrators shall be independent contractors, and shall not be employees or agents of the designated organization or the Department of Financial Services.

(aa) *Financing.* (1) The cost of administering the no-fault arbitration forum shall be paid annually by insurers (including self-insurers and MVAIC) to the designated organization upon receipt of a statement therefrom. This cost shall be distributed among insurers in an equitable manner approved by the Superintendent of Financial Services. This distribution shall, to the extent practicable, be a function of the degree to which an insurer is named as a respondent in no-fault arbitration forum proceedings.

(2) Semiannually, the designated organization shall prepare a budget of the estimated fees to be incurred for the operation of the no-fault arbitration forum during the subsequent six-month period. The estimated fees of the no-fault arbitration forum shall be assessed on a proportionate basis to those insurers named as respondents on cases forwarded to no-fault arbitration in the preceding calendar year and shall be subject to the approval of the superintendent. The designated organization shall send to each applicable insurer a bill for the amount due and any payment due shall be made to the designated organization within 30 days after billing date.

(3) On an annual basis, as of December 31st of each year, the designated organization shall prepare a detailed analysis of the fees for the operation of the no-fault arbitration forum. This analysis shall be forwarded to the no-fault optional arbitration advisory committee and the superintendent on or before April 30th of each year. The no-fault optional arbitration advisory committee shall notify the designated organization and the superintendent whether it accepts or rejects the designated organization's fee analysis in whole or in part. In the event that the designated organization and the no-fault optional arbitration advisory committee cannot resolve any differences that may exist, such differences will be referred to the superintendent for resolution. The superintendent's decision shall be binding on the designated organization and insurers.

(4) Once the designated organization submits a final fee analysis that has either been approved by the no-fault optional arbitration advisory committee or resolved by the superintendent in the event of a dispute, the designated organization shall send to each applicable insurer an accounting of the designated organization's assessment. Any adjustment shall be made to the bill for the subsequent estimated assessment, as illustrated by the following example:

EXAMPLE

(1) Total no-fault arbitration forum cases closed during year	6,000
(2) Cases in which insurer A was named as a respondent in the no-fault arbitration forum proceeding	250
(3) Insurer A's assessment percentage = (2)/(1)	4.167%
(4) Actual expenses of the no-fault arbitration forum	\$2,500,000
(5) Insurer A's actual expense = (3) × (4)	\$104,175
(6) Insurer A's estimated assessment	\$102,000
(7) Insurer A's debit or (credit) = (5) – (6)	\$2,175

Historical Note

Sec. filed Aug. 2, 2001; amds. filed: April 11, 2002 as emergency measure; July 9, 2002 as emergency measure; Oct. 4, 2002 as emergency measure; Nov. 27, 2002 as emergency measure; Jan. 17, 2003 as emergency measure; Jan. 17, 2003; Jan. 14, 2004; Oct. 4, 2005 as emergency measure; Dec. 29, 2005 as emergency measure; March 27, 2006 as emergency measure; June 23, 2006 as emergency measure; Sept. 1, 2006 as emergency measure; Nov. 28, 2006 as emergency measure; Feb. 23, 2007 as emergency measure; Feb. 23, 2007; April 9, 2013; amended adoption filed May 16, 2013; June 6, 2017 as emergency measure; Sept. 1, 2017 as emergency measure; Oct. 10, 2017 eff. Oct. 25, 2017. Amended (b).

§ 65-4.6 Limitations on attorney's fees pursuant to section 5106 of the Insurance Law.

The following limitations shall apply to the payment by insurers of applicants' attorney's fees for services necessarily performed in the resolution of no-fault disputes:

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(a) If an arbitration was initiated or a court action was commenced by an attorney on behalf of an applicant and the claim or portion thereof was not denied or overdue at the time the arbitration proceeding was initiated or the action was commenced, no attorney's fees shall be granted.

(b) If the claim is resolved by the designated organization at any time prior to transmittal to an arbitrator and it was initially denied by the insurer or overdue, the payment of the applicant's attorney's fee by the insurer shall be limited to 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant with whom the respective parties have agreed and resolved disputes, subject to a maximum fee of \$1,360.

(c) For disputes subject to arbitration or court proceedings, where one of the issues involves a policy issue as enumerated on the prescribed denial of claim form (NYS form NF-10), subject to this section, the attorney's fee for the arbitration or litigation of all issues shall be limited to a fee of up to \$70 per hour, subject to a maximum fee of \$1,400. In addition, an attorney shall be entitled to receive a fee of up to \$80 per hour for each personal appearance before the arbitration forum or court.

(d) For all other disputes subject to arbitration or court proceedings, subject to the provisions of subdivision (a) of this section, the attorney's fee shall be limited as follows: 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon for each applicant per arbitration or court proceeding, subject to a maximum fee of \$1,360. If the nature of the dispute results in an attorney's fee that could be computed in accordance with the limitations prescribed in both subdivision (d) and this subdivision, the higher attorney's fee shall be payable.

(e) Notwithstanding the limitations specified in this section, if the arbitrator or a court determines that the issues in dispute were of such a novel or unique nature as to require extraordinary skills or services, the arbitrator or court may award an attorney's fee in excess of the limitations set forth in this section. An excess fee award shall detail the specific novel or unique nature of the dispute that justifies the award. An excess award of an attorney's fee by an arbitrator shall be appealable to a master arbitrator.

(f) If a dispute involving an overdue or denied claim is resolved by the parties after it has been forwarded to the conciliation center of the appropriate arbitration forum or after a court action has been commenced, the attorney for the applicant shall be entitled to a fee that shall be computed in accordance with the limitations set forth in this section.

(g) No attorney shall demand, request or receive from the insurer any payment of fees not permitted by this section.¹

(h) Notwithstanding any other provision of this section and with respect to billings on and after the effective date of this regulation, if the charges by a health care provider, who is an applicant for benefits, exceed the limitations contained in the schedules established pursuant to section 5108 of the Insurance Law, no attorney's fee shall be payable by the insurer. This provision shall not be applicable to charges that involve interpretation of such schedules or inadvertent miscalculation or error.

Historical Note

Sec. filed Aug. 2, 2001; amds. filed: April 11, 2002 as emergency measure; July 9, 2002 as emergency measure; Oct. 4, 2002 as emergency measure; Nov. 27, 2002 as emergency measure; Jan. 17, 2003 as emergency measure; Jan. 17, 2003; April 9, 2013; amended adoption filed May 16, 2013; amd. filed Jan. 20, 2015 eff. Feb. 4, 2015.

§ 65-4.7 Independent health consultant.

(a) The designated organization shall maintain a list of independent health consultants, who will review medical evidence or examine the eligible injured person upon the request of any arbitrator designated pursuant to this Subpart.

(b) The independent health consultant shall be selected by the designated organization from its list and, to the extent practicable, shall be a specialist in the field requested by the arbitrator. If a medical examination is requested by the arbitrator, such examination shall be conducted at the

¹Attorneys should be aware of the Appellate Division Rules prohibiting fees in connection with the collection of first-party no-fault benefits [22 NYCRR sections 603.7(e)(7), 691.20(e)(7), 806.13(f) and 1022.31(f)].

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health consultant's office, which shall be located in the general locale of the applicant's residence, or at a place agreed upon by the parties and the consultant.

(c) Within 15 calendar days after the review of medical evidence or examination of the eligible injured person, the health consultant shall submit to the designated organization a written report which shall contain the consultant's advisory opinion for consideration by the arbitrator. The designated organization shall submit such report to the arbitrator and the parties.

(d) The independent health consultant's fee shall include the written report and be paid by the designated organization, with the cost of such fee charged as an administrative expense of the no-fault arbitration forum.

(e) No person shall serve as an independent health consultant in any arbitration in which such person has any financial or personal interest or bias. An independent health consultant shall disclose to the designated organization any circumstance which is likely to create an appearance of bias or which might serve to disqualify such expert. Upon receipt of such information, the designated organization shall immediately disclose it to the parties. If a party challenges a health consultant, the specific grounds for the challenge shall be submitted in writing. The designated organization shall determine whether the health consultant should be disqualified and shall inform the parties of its decision, which shall be final and binding. If a health consultant should resign, be disqualified or be otherwise unable to perform necessary duties, the designated organization shall appoint another health consultant to the case.

Historical Note

Sec. filed Aug. 2, 2001 eff. Sept. 1, 2001.

§ 65-4.8 Witness fees.

(a) No witness fee shall be payable to a person who is a party to the arbitration.

(b) The arbitrator shall not approve the payment of a fee to a witness appearing on behalf of an applicant or an assignee, unless the witness was subpoenaed by the arbitrator or, prior to appearance, the witness's presence was determined by the arbitrator to be necessary for resolution of the dispute.

(c) Whenever a witness fee is determined by the arbitrator to be payable, the cost thereof shall be charged as an administrative expense of the arbitration forum.

(d) Any witness fee awarded pursuant to subdivisions (b) and (c) of this section shall be determined as follows:

(1) If the witness is testifying as an expert, the fee shall be calculated on the basis of such witness's documented usual and customary hourly charge for an appearance, plus necessary verified disbursements.

(2) Any other witness shall only be entitled to reimbursement for verified expenses and economic losses necessarily incurred in connection with an appearance before the arbitrator.

Historical Note

Sec. filed Aug. 2, 2001 eff. Sept. 1, 2001.

§ 65-4.9 Serving of notice.

The IDA, the designated organization and the parties may use facsimile transmission, telex, telegram or other written or electronic forms of communication to give the notices required by this Subpart.

Historical Note

Sec. filed Aug. 2, 2001 eff. Sept. 1, 2001.

§ 65-4.10 Master arbitration procedures under section 5106(b) of the Insurance Law.

(a) *Grounds for review.* An award by an arbitrator rendered pursuant to section 5106(b) of the Insurance Law and section 65-4.4 or 65-4.5 of this Subpart may be vacated or modified solely by appeal to a master arbitrator, and only upon one or more of the following grounds:

(1) any ground for vacating or modifying an award enumerated in article 75 of the Civil Practice Law and Rules (an article 75 proceeding), except the ground enumerated in CPLR subparagraph 7511(b)(1)(iv) (failure to follow article 75 procedure);

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(2) that the award required the insurer to pay amounts in excess of the policy limitations for any element of first-party benefits; provided that, as a condition precedent to review by a master arbitrator, the insurer shall pay all other amounts set forth in the award which will not be the subject of an appeal, as provided for in section 65-4.4 or 65-4.5 of this Subpart;

(3) that the award required the insurer to pay amounts in excess of the policy limitations for any element of additional first-party benefits (when the parties had agreed to arbitrate the dispute under the additional personal injury protection endorsement for an accident which occurred prior to January 1, 1982); provided that, as a condition precedent to review by a master arbitrator, the insurer shall pay all other amounts set forth in the award which will not be the subject of the appeal, as provided for in section 65-4.4 or 65-4.5 of this Subpart;

(4) that an award rendered in an arbitration under section 65-4.4 or 65-4.5 of this Subpart, was incorrect as a matter of law (procedural or factual errors committed in the arbitration below are not encompassed within this ground);

(5) that the attorney's fee awarded by an arbitrator below was not rendered in accordance with the limitations prescribed in section 65-4.6 of this Subpart; provided that, as a condition precedent to review by a master arbitrator, the insurer shall pay all other amounts set forth in the award which will not be the subject of the appeal, as provided for in section 65-4.4 or 65-4.5 of this Subpart.

(b) *Qualifications of master arbitrators.* (1) A master arbitrator shall be an attorney, licensed to practice law in New York State, who has at least 15 years' experience which the superintendent has determined qualifies such attorney to review and resolve the issues involved in no-fault insurance disputes. Documentation of such experience shall be submitted to, and reviewed by, the superintendent prior to appointment of a master arbitrator.

(2) All master arbitrators shall be appointed by, and serve at the pleasure of, the superintendent. A master arbitrator candidate shall disclose to the superintendent any circumstance which is likely to create an appearance of bias or which might disqualify such person as a master arbitrator, and the superintendent shall determine whether the candidate should be disqualified. The superintendent shall forward the names of all master arbitrators to the designated organization, and promptly inform it of all additions to, and deletions from, the panel.

(3) No person shall, during the period of appointment as a master arbitrator, also serve as an arbitrator under the optional arbitration systems prescribed in section 5106(b) of the Insurance Law and section 65-4.4 or 65-4.5 of this Subpart, nor serve as an attorney to a party to any such arbitration.

(4) All master arbitrators shall take an oath of office.

(5) No person shall serve as a master arbitrator in any master arbitration in which such person has any financial or personal interest or bias. If a party challenges a master arbitrator, the specific grounds for the challenge shall be submitted in writing to the designated organization which, in consultation with the superintendent, shall determine within 15 calendar days after receipt of the challenge whether the master arbitrator should be disqualified. Such determination shall be final and binding. If a master arbitrator should resign, be disqualified or be otherwise unable to perform necessary duties, the designated organization shall assign another master arbitrator to the case within seven calendar days after receipt of notice thereof.

(c) *Scope of master arbitration review.* (1) Review by a master arbitrator shall be based solely on submitted documents, including any record made of the arbitration below, unless a master arbitrator requires oral argument on specified issues.

(2) Legal briefs shall not be submitted, unless requested by the master arbitrator.

(3) The master arbitrator shall initially consider and determine whether the facts alleged in the submitted documents set forth a ground for review pursuant to subdivision (a) of this section.

(4) If the master arbitrator determines that subdivision (a) of this section has not been complied with, the master arbitrator shall, in lieu of rendering an award, deny the request for review. The procedural requirements contained in this section applicable to a master award, shall also be applicable to a denial of request for review, but such denial shall not form the basis of an action *de novo* within the meaning of section 5106(b) of the Insurance Law.

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(5) If the master arbitrator determines that subdivision (a) of this section has been complied with, the master arbitrator shall proceed to review the matter and render an award accordingly.

(6) The master arbitrator shall only consider those matters which were the subject of the arbitration below or which were included in the arbitration award appealed from.

(d) *Procedure for review.* (1) If grounds exist, pursuant to subdivision (a) of this section, any party to an arbitration may request that the arbitration award be vacated or modified by a master arbitrator.

(2) The request for review by a master arbitrator shall be in writing and shall be mailed or delivered to the designated organization's master arbitration administrative office within 21 calendar days of the mailing of the award. The request shall include a copy of the award in issue and shall state the nature of the dispute and the grounds for review. A request by an applicant for benefits shall be accompanied by a filing fee of \$75, payable by check or money order to the designated organization. A request by an insurer shall be accompanied by a filing fee of \$325, payable by check or money order to the designated organization. The failure of a party to enclose the appropriate filing fee with a timely request for review shall result in a denial of the request for review by a master arbitrator if such payment is not made within 28 calendar days of the mailing of the award.

(3) The applicant for master arbitration review shall send, by certified mail, a copy of its filing papers to the opposing party at the same time that it submits the request for review to the designated organization.

(4) Within seven calendar days of receipt of the request, the designated organization shall assign a master arbitrator, selected in sequence from a panel of master arbitrators appointed by the superintendent, and shall forward to the master arbitrator a copy of the request for review.

(5) The master arbitrator shall render an award no later than 90 calendar days after assignment.

(i) *Submission of materials.* Within 15 calendar days after assignment, the master arbitrator shall set a date (which date shall not be more than 45 calendar days after assignment) by which all evidence, documents and briefs, if any, must be submitted to the master arbitrator by the parties. The master arbitrator shall give the parties 30 calendar days' written notice of this date.

(ii) *Oral argument.* If after receipt of these materials, the master arbitrator determines that oral argument on specific issues is necessary, the master arbitrator shall give the parties 10 calendar days' notice of the place, time and date for oral argument and the issues to be argued. Oral argument shall be conducted at the office of the master arbitrator, the office of the designated organization or at a location agreeable to the parties and the master arbitrator.

(iii) The master arbitrator may postpone or adjourn the date for submission of materials or of oral argument to a date within the 90-day period for good cause shown. A postponement or adjournment shall also be granted when all the parties agree thereto. The postponement or adjournment shall not extend the 90-day period for rendering of an award.

(6) The failure of a master arbitrator to adhere to the procedural time frames, contained in paragraph (5) of this subdivision, shall not affect the validity of an award.

(7) Any party may be represented in a master arbitration by an attorney.

(8) A master arbitration shall proceed if any party, after due notice of the date to submit materials or date of oral arguments, fails to appear, to submit materials or to obtain a postponement or adjournment. However, an award shall not be made in favor of an appearing party solely on the default of another party. A master arbitrator shall direct the appearing party to submit such materials as may be required in order to render a decision in the matter.

(e) *Award by master arbitrator.* (1) Form and scope of award.

(i) The award shall be in writing in a format approved by the superintendent. It shall state the issues in dispute and contain the master arbitrator's findings and conclusions based on the materials submitted. It shall be signed by the master arbitrator and shall be transmitted to the parties by the designated organization, with a copy to the Department of Financial Services. The award shall be determinative of all issues submitted to the master arbitrator by the parties.

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(ii) If the applicant for benefits prevails in whole or part on the claim, the award shall also direct the insurer to:

(a) if the applicant requested review by a master arbitrator, pay to the applicant reimbursement of the amount of the master arbitration filing fee paid;

(b) pay to the applicant the amount previously paid by the applicant to reimburse for the filing fee in the arbitration below, unless the filing fee had already been returned to the applicant pursuant to an earlier award;

(c) if due under section 5106 of the Insurance Law, pay a reasonable attorney's fee in accordance with the limitations set forth in subdivision (j) of this section; and

(d) if due, compute and pay the amount of interest for each element of first-party benefits in dispute, commencing 30 days after proof of claim therefor was received by the insurer and ending with the date of payment of the award, subject to the provisions of section 65-3.9(c) and (d) of this Part (stay of interest).

(2) Award upon settlement. If the parties settle their dispute during the course of the master arbitration, the master arbitrator shall set forth the terms of the agreed settlement in an award which shall provide that the parties agree that the settlement is final and binding and shall not be subject to review by a court or the subject of a *de novo* court action. The award shall be signed by the master and shall be transmitted to the parties by the designated organization, with a copy to the Department of Financial Services.

(3) Delivery of award to parties. The parties shall accept as delivery of the award the placing of the award or a true copy thereof in the mail, addressed to the parties or their designated representatives at their last known addresses, or by any other form of service permitted by law. The designated organization shall note on such award or transmittal letter thereof the date of mailing and keep a record of same.

(4) Payment of award. Subject to subdivision (h) of this section, the insurer shall, within 21 calendar days of the date of mailing of the award, pay the amounts set forth in the award. The award need not be confirmed into judgment.

(f) *Interpretation and application of procedures.* The master arbitrator shall interpret and apply the procedures of this section insofar as they relate to the master arbitrator's powers and duties. All other procedures shall be administered by the designated organization, subject to consultation with and approval by the superintendent.

(g) *Alternative legal remedies.* The designated organization or the master arbitrator shall transmit to the superintendent copies of any legal papers served upon the designated organization, or the master arbitrator, relating to any stay or appeal of a master arbitration.

(h) *Appeal from master arbitrators award.* (1) A decision of a master arbitrator is final and binding, except for:

(i) court review pursuant to an article 75 proceeding; or

(ii) if the award of the master arbitrator is \$5,000 or greater, exclusive of interest and attorney's fees, either party may, in lieu of an article 75 proceeding, institute a court action to adjudicate the dispute *de novo*.

(2) A party who intends to commence an article 75 proceeding or an action to adjudicate a dispute *de novo* shall follow the applicable procedures as set forth in CPLR article 75. If the party initiating such action is an insurer, payment of all amounts set forth in the master arbitration award which will not be the subject of judicial action or review shall be made prior to the commencement of such action.

(i) *Master arbitrator's fee.* The master arbitrator shall be compensated in the amount of \$250 for each case. Such fee will be paid by the designated organization. The master arbitrator's fee shall be charged to the cost of administering the master arbitration system.

(j) *Limitations on attorney's fees pursuant to section 5106 of the Insurance Law.* The following limitations shall apply to the payment by insurers of applicant's attorney's fees for services rendered in a master arbitration to resolve a no-fault dispute:

(1) The minimum attorney's fee payable pursuant to this Subpart shall be \$60.

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(2) (i) For preparatory services necessarily rendered, the attorney shall be entitled to receive a fee of up to \$65 per hour, subject to a maximum fee of \$650.

(ii) An attorney shall be entitled to receive a fee of up to \$80 per hour for oral argument before the master arbitrator, made pursuant to paragraph (c)(1) of this section.

(iii) If an applicant is successful in obtaining a reversal of the arbitration(s) below, wherein no attorney's fee was awarded, the attorney in the arbitration below shall also be entitled to receive a fee, computed in accordance with the provisions of section 65-4.6 of this Subpart.

(3) Notwithstanding the above limitations, if the master arbitrator determines that the issues in dispute were of such a novel or unique nature as to require extraordinary skills or services, the master arbitrator may award an attorney's fee in excess of the limitations set forth above. An excess fee award shall detail the specific novel or unique nature of the dispute which justifies the award.

(4) The attorney's fee for services rendered in connection with a court adjudication of a dispute *de novo*, as provided in section 5106(c) of the Insurance Law, or in a court appeal from a master arbitration award and any further appeals, shall be fixed by the court adjudicating the matter.

(5) No attorney shall demand, request or receive from the insurer any payment or fee in excess of the fees permitted by this subdivision for services rendered with respect to a no-fault master arbitration dispute.

(k) *Financing.* (1) The cost of administering the master arbitration system over and above the amount of fees paid by applicants and insurers shall be paid annually by insurers to the designated organization upon receipt of a statement therefrom. This cost shall be distributed among insurers in an equitable manner approved by the superintendent. This distribution shall, to the extent practicable, be a function of the degree to which an insurer is a party to arbitration proceedings.

(2) Upon filing of a demand for master arbitration by an applicant, the designated organization shall bill the respondent insurer the sum of \$250, which shall be payable by the insurer within 30 days after billing.

(3) On an annual basis, as of December 31st of each year, the designated organization shall prepare a detailed accounting of the actual costs incurred for the implementation of the master arbitration system and the amount of fees received from applicants and insurers. The accounting will be forwarded to the No-Fault Optional Arbitration Advisory Committee (the committee) and the superintendent on or before April 30th of each year. The committee shall notify the designated organization and the superintendent whether it accepts the designated organization's accounting in whole or in part. In the event the designated organization and the committee cannot resolve any differences that may exist, the dispute will be referred to the superintendent for resolution. The superintendent's decision shall be binding on the designated organization and insurers.

(4) Once the designated organization submits a final accounting that has either been approved by the committee or resolved, in the event of a dispute, by the superintendent, the designated organization shall send to each insurer a bill for the amount due or a refund for the amount credited, based upon the number of master arbitrations to which the insurer was a party.

Historical Note

Sec. filed Aug. 2, 2001; amds. filed: Jan. 17, 2003; April 9, 2013 eff. June 1, 2013; amended adoption filed May 16, 2013 eff. Aug. 1, 2013. Amended (e)(1)-(2).

§ 65-4.11 Mandatory arbitration for insurers, self-insurers and compensation providers under section 5105 of the Insurance Law.

(a) *Applicability.* (1) This section shall apply to mandatory arbitration of controversies between insurers, pursuant to the provisions of sections 5105 and 5106(d) of the Insurance Law, and shall apply to insurers, self-insurers and compensation providers. The term *insurer* as used in this section (except as specified in paragraphs [c][2] and [f][1] of this section) shall include both *insurers* and *self-insurers* as those terms are defined in this Part and article 51 of the In-

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insurance Law; the Motor Vehicle Accident Indemnification Corporation (MVAIC); any company providing insurance pursuant to section 5103(g) of the Insurance Law; and compensation providers as defined in section 5102(l) of the Insurance Law.

(2) Except as provided in section 65-3.12(b)(3) of this Part, all insurers shall submit controversies arising out of accidents, insured events or occurrences within the jurisdiction of section 5105, 5106(d), or 5221(b) of the Insurance Law to mandatory arbitration, as prescribed in this section. Controversies arising from accidents, insured events or occurrences outside the jurisdiction of section 5105, 5106(d), or 5221(b) of the Insurance Law may be submitted with the consent of the controverting insurers.

(3) Any determination as to whether an insurer is legally entitled to recovery from another insurer shall be made by an arbitration panel (see paragraph [c][2] of this section) appointed pursuant to this section. The decision of a majority of an arbitration panel shall be final and binding upon the insurers to the controversy. There shall be no right of rehearing or appeal. However, this provision does not preclude correction of clerical or typographical errors.

(4) Where arbitrating insurers are signators to any insurer arbitration program under which a claim or companion claims would be otherwise subject to the compulsory jurisdiction of such agreements, the jurisdiction of this section shall be primary. Insurers shall waive their rights to proceed separately under such other arbitration programs and include all claims arising out of the same accident or insured event for disposition by an arbitration panel appointed pursuant to this section.

(5) This section is applicable only to controversies involving insurers.

(6) Other than claims asserted by MVAIC against an insurer, this section shall not apply to any claim for recovery rights to which an insurer in good faith asserts a defense of lack of coverage of an alleged covered person on any grounds, unless specific written consent of mandatory arbitration is obtained from the insurer asserting such defense. Where an insurer asserts a defense of lack of coverage of an alleged covered person on any grounds relating to claims asserted by MVAIC for recovery rights, same shall be subject to mandatory arbitration. However, any controversy between insurers involving the responsibility or the obligation to pay first-party benefits (*i.e.*, priority or payment or sources of payment as provided in section 65-3.12 of this Part) is not considered a coverage question and must be submitted to mandatory arbitration under this section.

(7) This section shall not be construed to create any causes of action or liabilities not existing in law or equity, nor shall this section be construed to abolish any causes of action or liabilities existing in law or equity.

(b) *Administration of arbitration.* (1) The arbitration prescribed in this section shall be administered by an inter-company arbitration administrator "administrator" designated by the superintendent. The administrator may:

- (i) make appropriate administrative rules for arbitrations;
- (ii) select places where arbitration facilities are to be available, and adopt a policy for the selection and appointment of arbitration panels; and
- (iii) make appropriate recommendations for equitable apportionment among arbitrating insurers of the operating expenses of this program.

(2) Local arbitration panels. (i) Members of local arbitration panels shall be appointed by the administrator from full-time salaried representative of insurers, on the basis of their experience and qualifications, and shall serve without compensation.

(ii) The administrator shall be responsible for the selection of arbitration panels to hear the particular cases.

(c) *Selection of arbitrators.* (1) Insurers shall furnish the administrator with a list of names, titles and local addresses of all employees who are qualified to act as arbitrators.

(2) The administrator shall designate one disinterested member of such panel to serve as an arbitrator in each case. However, an insurer may request a three-member arbitration panel in a specific case. If one or more of the controverting parties is a self-insurer which has requested a three-member panel, then the self-insurer may also request that at least one member of the

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panel be a disinterested representative of a self-insurer, where such representative is available to serve on the panel.

(3) No one shall serve as an arbitrator on a panel hearing a case in which the insurer represented by the arbitrator is directly or indirectly interested.

(d) All arbitrations under this Subpart shall be conducted in accordance with procedures established by the administrator and approved by the superintendent.

(e) *Filing assessments.* (1) The administrator, by resolution, will recommend the filing assessment for the use of local arbitration facilities. The expenses of the program shall be periodically reviewed by the loss transfer advisory committee (see subdivision [f] of this section), which shall consider the recommendations of the administrator and prescribe from time to time arbitration assessments.

(2) The obligation for the prescribed filing assessment is incurred upon filing by the applicant, by a respondent filing a counterclaim or by a party filing a deferment. There are no exceptions to an insurer's obligation to pay the filing assessment.

(3) The secretary of the administrator is the custodian of the assessment charges collected and shall make expenditures therefrom to defray such arbitration expenses as may be authorized by the administrator.

(4) The secretary of the administrator will submit reports on assessments collected and disbursed during such period as may be considered desirable by the administrator.

(f) *Loss transfer advisory committee.* (1) The superintendent shall select a loss transfer advisory committee composed of 14 members, of which eight shall represent motor vehicle insurers, three shall represent motor vehicle self-insurers, two shall represent compensation providers and one shall represent the Motor Vehicle Accident Indemnification Corporation.

(2) The loss transfer advisory committee shall:

(i) regularly review the operations, procedures, rules, expenditures, assessments and all other relevant matters involving settlements between insurers in accordance with the requirements of section 5105 or 5221(b) of the Insurance Law;

(ii) review the operations of the administrator insofar as they relate to the arbitration prescribed in this section; and

(iii) report its findings, conclusions and recommendations directly to the superintendent annually and at such other intervals as it deems appropriate.

Historical Note

Sec. filed Aug. 2, 2001; amds. filed: June 6, 2017 as emergency measure; Sept. 1, 2017 as emergency measure; Oct. 10, 2017 eff. Oct. 25, 2017. Amended (a).

SUBPART 65-5

(Regulation 68-E)

UNAUTHORIZED PROVIDERS OF HEALTH SERVICES

Historical Note

Subpart (§§ 65-5.0—65-5.5) filed: March 9, 2012 as emergency measure; June 6, 2012 as emergency measure; Aug. 31, 2012 as emergency measure; Nov. 28, 2012 as emergency measure; Feb. 25, 2013 as emergency measure; May 24, 2013 as emergency measure; July 22, 2013 as emergency measure; Sept. 19, 2013 as emergency measure; Oct. 24, 2013 eff. Nov. 13, 2013.

§ 65-5.0 Preamble.

(a) For years, certain owners and operators of professional service corporations or other similar business entities have abused the no-fault insurance system. These persons are involved in activities that include intentionally staging accidents and billing no-fault insurers for health services that were unnecessary or never in fact rendered. This fraud costs no-fault insurers tens if not hundreds of millions of dollars, which insurers ultimately pass on to New York consumers in the form of higher automobile insurance premiums. It also threatens the affordability of health care and the public's health, safety, and welfare.

(b) Insurance Law section 5109 requires the Superintendent of Financial Services, in consultation with the Commissioner of Health and the Commissioner of Education, to establish standards and procedures for the investigation and suspension or removal of a provider of health services' authorization to demand or request payment for health services provided under Insurance Law article 51. This Subpart implements Insurance Law section 5109.

Historical Note

Sec. filed: March 9, 2012 as emergency measure; June 6, 2012 as emergency measure; Aug. 31, 2012 as emergency measure; Nov. 28, 2012 as emergency measure; Feb. 25, 2013 as emergency measure; May 24, 2013 as emergency measure; July 22, 2013 as emergency measure; Sept. 19, 2013 as emergency measure; Oct. 24, 2013 eff. Nov. 13, 2013.

§ 65-5.1 Definitions.

As used in this Subpart, the following terms shall have the meaning ascribed to them:

(a) *Health services* or *medical services* means services, supplies, therapies, or other treatments as specified in Insurance Law section 5102(a)(1)(i), (ii), or (iv).

(b) *Insurer* shall have the meaning set forth in Insurance Law section 5102(g), and also shall include the motor vehicle accident indemnification corporation and any company or corporation providing coverage for basic economic loss, as defined in Insurance Law section 5102(a), pursuant to Insurance Law section 5103(g).

(c) *Noticing commissioner* means the Commissioner of Health or the Commissioner of Education, whomever sends a notice of hearing under this Subpart.

(d) *Provider of health services* or *provider* means a person or entity who or that renders or has rendered health services.

(e) *Superintendent* means the Superintendent of Financial Services.

Historical Note

Sec. filed: March 9, 2012 as emergency measure; June 6, 2012 as emergency measure; Aug. 31, 2012 as emergency measure; Nov. 28, 2012 as emergency measure; Feb. 25, 2013 as emergency measure; May 24, 2013 as emergency measure; July 22, 2013 as emergency measure; Sept. 19, 2013 as emergency measure; Oct. 24, 2013 eff. Nov. 13, 2013.

§ 65-5.2 Investigations.

(a) The superintendent may investigate any reports made pursuant to Insurance Law section 405, allegations, or other information in the superintendent's possession, regarding providers of health services engaging in any of the unlawful activities set forth in Insurance Law section 5109(b). After conducting an investigation, the superintendent will send to the Commissioner of

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Health or the Commissioner of Education, as appropriate, a list of any providers who or that the superintendent believes may have engaged in any of the unlawful activities set forth in Insurance Law section 5109(b), together with a description of the grounds for inclusion on the list. Within 45 days of receipt of the list, the Commissioner of Health or Commissioner of Education shall notify the superintendent in writing whether he or she confirms that the superintendent has a reasonable basis to proceed with notice and a hearing for determining whether any of the listed providers should be deauthorized from demanding or requesting any payment for medical services in connection with any claim under Insurance Law article 51.

(b) The Commissioner of Health and the Commissioner of Education also may investigate any reports, allegations, or other information in their possession, regarding providers engaging in any of the unlawful activities set forth in Insurance Law section 5109(b). If either commissioner conducts an investigation, then that commissioner, or the superintendent, if requested by the commissioner, shall be responsible for providing notice and an opportunity to be heard to the providers of health services that they are subject to deauthorization from demanding or requesting any payment for medical services in connection with any claim under Insurance Law article 51. Nothing in this section, however, shall preclude the superintendent, Commissioner of Health, or Commissioner of Education from conducting joint investigations and hearings, or the Commissioner of Health or Commissioner of Education from conducting professional misconduct proceedings against the providers of health services pursuant to the Public Health Law or title VIII of the Education Law.

Historical Note

Sec. filed: March 9, 2012 as emergency measure; June 6, 2012 as emergency measure; Aug. 31, 2012 as emergency measure; Nov. 28, 2012 as emergency measure; Feb. 25, 2013 as emergency measure; May 24, 2013 as emergency measure; July 22, 2013 as emergency measure; Sept. 19, 2013 as emergency measure; Oct. 24, 2013 eff. Nov. 13, 2013.

§ 65-5.3 Notice; how given.

(a) (1) The superintendent, Commissioner of Health, or Commissioner of Education shall give notice of any hearing to a provider at least 30 days prior to the hearing, in writing, either by delivering it to the provider or by depositing the same in the United States mail, postage prepaid, registered or certified, and addressed to the last known place of business of the provider or if no such address is known, then to the residence address of the provider.

(2) The notice shall refer to the applicable provisions of the law under which action is proposed to be taken and the grounds therefor, but failure to make such reference shall not render the notice ineffective if the provider to whom it is addressed is thereby or otherwise reasonably apprised of such grounds.

(3) It shall be sufficient for the superintendent or noticing commissioner to give to the provider:

(i) notice of the time and the place at which an opportunity for hearing will be afforded; and

(ii) if the person appears at the time and place specified in the notice or any adjourned date, a hearing.

(b) At least 10 days prior to the hearing date fixed in the notice, the provider may file an answer to any charges with the superintendent or noticing commissioner.

(c) Any hearing of which such notice is given may be adjourned from time to time without other notice than the announcement thereof at such hearing.

(d) The statement of any regular salaried employee of the Department of Financial Services, Department of Health, or Department of Education, subscribed and affirmed by such employee as true under the penalties of perjury, stating facts that show that any notice referred to in this

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section has been delivered or mailed as hereinbefore provided, shall be presumptive evidence that such notice has been duly delivered or mailed, as the case may be.

Historical Note

Sec. filed: March 9, 2012 as emergency measure; June 6, 2012 as emergency measure; Aug. 31, 2012 as emergency measure; Nov. 28, 2012 as emergency measure; Feb. 25, 2013 as emergency measure; May 24, 2013 as emergency measure; July 22, 2013 as emergency measure; Sept. 19, 2013 as emergency measure; Oct. 24, 2013 eff. Nov. 13, 2013.

§ 65-5.4 Hearings.

(a) Unless otherwise provided, any hearing may be held before the superintendent, Commissioner of Health or Commissioner of Education, any deputy, or any designated salaried employee of the Department of Financial Services, Department of Health, or Department of Education who is authorized by the superintendent or noticing commissioner for such purpose. The hearing shall be noticed, conducted, and administered in compliance with the State Administrative Procedure Act.

(b) The person conducting the hearing shall have the power to administer oaths, examine and cross-examine witnesses, and receive documentary evidence, and shall report his or her findings, in writing, to the superintendent or noticing commissioner with a recommendation. The report, if adopted by the superintendent or noticing commissioner, may be the basis of any determination made by the superintendent or noticing commissioner.

(c) Every such hearing shall be open to the public unless the superintendent or noticing commissioner, or the person authorized by the superintendent or noticing commissioner to conduct such hearing, shall determine that a private hearing would be in the public interest, in which case the hearing shall be private.

(d) Every provider affected shall be permitted to: be present during the giving of all the testimony; be represented by counsel; have a reasonable opportunity to inspect all adverse documentary proof; examine and cross-examine witnesses; and present proof in support of the provider's interest. A stenographic record of the hearing shall be made, and the witnesses shall testify under oath.

(e) Nothing herein contained shall require the observance at any such hearing of formal rules of pleading or evidence.

Historical Note

Sec. filed: March 9, 2012 as emergency measure; June 6, 2012 as emergency measure; Aug. 31, 2012 as emergency measure; Nov. 28, 2012 as emergency measure; Feb. 25, 2013 as emergency measure; May 24, 2013 as emergency measure; July 22, 2013 as emergency measure; Sept. 19, 2013 as emergency measure; Oct. 24, 2013 eff. Nov. 13, 2013.

§ 65-5.5 Report of hearing and findings.

(a) Pending a final determination by the superintendent, Commissioner of Health, or Commissioner of Education, if the superintendent or noticing commissioner believes that the provider has engaged in any activity set forth in Insurance Law section 5109(b), then the superintendent or noticing commissioner may temporarily prohibit the provider from demanding or requesting any payment for medical services under Insurance Law article 51 for up to 90 days from the date of the notice of such temporary prohibition pursuant to Insurance Law section 5109(e).

(b) The hearing officer shall issue to the superintendent or noticing commissioner the report described in section 65-5.4(b) of this Subpart, with a recommendation. The superintendent or noticing commissioner may adopt, modify, remand, or reject the hearing officer's report and recommendation.

(c) (1) Upon consideration of the hearing officer's report and recommendation, the superintendent or noticing commissioner may issue a final order prohibiting the provider from demanding or requesting any payment for medical services in connection with any claim under Insurance Law article 51 and requiring the provider to refrain from subsequently treating, for remuneration, as a private patient, any person seeking medical treatment under Insurance Law article 51, for a period specified by the superintendent or noticing commissioner.

(2) If the superintendent or noticing commissioner issues a final order prohibiting the provider from demanding or requesting any payment for medical services in connection with

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any claim under Insurance Law article 51 and requiring the provider to refrain from subsequently treating, for remuneration, as a private patient, any person seeking medical treatment under Insurance Law article 51, for a period longer than three years, then the provider may, after the expiration of three years, submit a written application to the superintendent or noticing commissioner requesting that the superintendent or noticing commissioner reconsider his or her order. The written application shall explain why revising the order would not jeopardize the health, safety, and welfare of the people of this State.

Historical Note

Sec. filed: March 9, 2012 as emergency measure; June 6, 2012 as emergency measure; Aug. 31, 2012 as emergency measure; Nov. 28, 2012 as emergency measure; Feb. 25, 2013 as emergency measure; May 24, 2013 as emergency measure; July 22, 2013 as emergency measure; Sept. 19, 2013 as emergency measure; Oct. 24, 2013 eff. Nov. 13, 2013.