PENNSYLVANIA MOTOR VEHICLE FINANCIAL RESPONSIBILITY LAW

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MOTOR VEHICLE FINANCIAL RESPONSIBILITY LAW

I. GENERAL PROVISIONS

A. Title (§ 1701)

Motor Vehicle Financial Responsibility Law, 75 Pa. C.S. §§ 1701, *et seq.*

B. Effective Dates

1. The MVFRL applies to all policies issued or renewed on or after 10/1/84. Effective 7/1/86, "Certain Nonexcludable Conditions" § 1724 was added. Effective 12/12/88, §§ 1761 to 1769 "Catastrophic Loss Trust Fund" were repealed. Effective 6/1/89, § 1715 "Availability of Adequate Limits" was amended to provide for extraordinary medical benefit coverage.

2. Act 6 Amendments, signed into law on 2/7/90, have varying effective dates:

(a) § 1702 "Definitions" amended effective 2/7/90.

(b) § 1705 "Election of Tort Options" and § 1791.1 "Disclosure of Premium Charges and Tort Options" amended effective 2/7/90 for policies issued or renewed on and after 7/1/90.

(c) § 1799.7 "Rates" amended effective 2/7/90 but freezes private passenger motor vehicle rates at 12/1/89 levels.

(d) § 1799.4 "Examination of Vehicle Repairs," § 1799.5 "Conduct of Market Study," and § 1799.6 "Conduct of Random Field Surveys" all amended effective in 60 days. (i.e., 4/8/90).

(e) § 1797 "Customary Charges for Treatment" amended effective 4/15/90.

(f) All remaining Amendments to MVFRL are effective 7/1/90 for policies issued or renewed on or after that date.

3. Workers' Compensation Amendments, effective 7/2/93, affect the MVFRL as follows:

(a) §§ 1735 and 1737 dealing with workers' compensation immunity in UM/UIM claims are repealed.

(b) §§ 1720 and 1722 dealing with subrogation and admissibility of evidence, respectively, are modified effective 8/31/93 to delete references to workers compensation.

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NOTE: These workers compensation amendments are substantive, not procedural, and will not be given retroactive effect, *Brogan v. WCAB*, 637 A.2d 689 (Pa. Cmwlth. 1994), *Carrick v. Zurich American Ins. Co*., 14 F.3d 907 (3d Cir., 1994). The compensation carrier's right to subrogation is governed by date of accident, not by date of compensation payments, *Schraeder v. Schroeder*, 682 A.2d 1305 (Pa. Super. 1996).

C. Definitions (§ 1702)

Definitions include:

1. **"Financial Responsibility"** as the ability to respond in damages for liability for accidents arising out of the maintenance or use of a motor vehicle for at least $15,000/$30,000 bodily injury and $5,000 property damage per accident.

NOTE: Guiding or directing a vehicle operated by another is not "maintenance or use of a motor vehicle," *Belser v. Rockwood Ins. Co.,* 791 A.2d 1216 (Pa Super. 2002).

2. **"Injury"** as accidentally sustained bodily harm to an individual and that individual's illness, disease or death resulting therefrom.

NOTE: "Injury" does not include mental injury which is not the result of bodily injury, *Zerr v. Erie*, 667 A.2d 237 (Pa Super. 1995), and thus does *not* include mental or emotional distress from witnessing injury to family members, *Jackson v. Travelers Ins. Co.*, 606 A.2d 1384 (Pa. Super. 1992), though a policy defining "injury" to include disease or illness without prerequisite bodily injury does cover such mental or emotional distress, *Glikman v. Progressive*, 917 A.2d 872 (Pa Super. 2007).

3. **"Insured"** as

(a) an individual identified by name as an insured in a policy of motor vehicle liability insurance;

NOTE: Listing as a "named driver" does not create "named insured" status, *Stump v. State Farm*, 564 A.2d 194 (Pa. Super. 1989), *Caron v. Reliance Ins. Co.,* 703 A.2d 63 (Pa. Super. 1997).

NOTE: "First named insured" literally means the first name listed on the policy, *Jones v. Prudential*, 856 A.2d 838 (Pa. Super. 2004).

NOTE: If the Named Insured is a partnership, individual partners also qualify as Named Insureds when acting as partners, *Continental Casualty v. PRO Machine*, 916 A.2d 1111 (Pa. Super. 2007).

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NOTE: A policy may limit coverages to “named insureds” or “named drivers” only, *Byoung v. Victoria Fire Ins. Co.*, 113 A.3d 1285 (Pa. Super. 2015), *Safe Auto v. Oriental-Guillermo,* 214 A.3d 1257 (Pa. 2017).

(b) a spouse or other relative if resident in the household with the named insured;

NOTE: Effective January 1, 2005, Pennsylvania does not recognize new common law marriages, *Costello v. WCAB,* 916 A.2d 1242 (Pa. Cmwlth. 2007).

NOTE: A spouse is not an "insured" under her husband’s employer’s commercial auto policy where the husband is not identified as a named insured under the policy, *Hunyady v. Aetna*, 578 A.2d 1312 (Pa. Super. 1990), *Northern Ins. Co. v. Resinski*, 827 A.2d 1240 (Pa. Super. 2003).

NOTE: In a homeowner's coverage context, relatives who from time to time visit or stay at the residence do not through such temporary arrangements qualify as "residents in the household," *McNally v. Republic Ins. Co*., 718 A.2d 301 (Pa. Super. 1998), *Wall Rose Mutual v. Manross,* 939 A.2d 958 (Pa. Super. 2007).

NOTE: Policy language may not restrict “resident of the household” status to those occupying an insured auto, *Prudential v. Colbert*, 813 A.2d 747 (Pa. 2002).

NOTE: A child of separated parents is not necessarily a resident of both households. The usual tests to determine “resident of the household” of any relative apply, *Erie v. Weryha*, 931 A.2d 739 (Pa. Super. 2007).

NOTE: The statutory definition of "insured" applies to individuals, not corporations (which do not have spouses or relatives). Using the same policy language for individuals and corporations does not render the policy ambiguous and does not create coverage that would otherwise not exist, *Insurance Company of Evanston v. Bowers*, 758 A.2d 213 (Pa. Super. 2000).

(c) A minor in the custody of the named insured or a relative of the named insured if the minor is a resident in the household of the named insured.

NOTE: “In the custody” may arise even in the absence of a court order or government placement in foster care, *Donegal Mutual v. Raymond*, 899 A.2d 357 (Pa. Super. 2006).

NOTE: If the policy defines "insured" to include "foster child or ward" without reference to age, a former court-placed foster child, if still resident in the household, can still be a "ward" entitled to coverage after aging out

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of the foster care program, *Rourke v. Pennsylvania National*, 116 A.3d 87 (Pa. Super. 2015).

4. **"Necessary Medical Treatment and Rehabilitative Services"** as treatment, accommodations, products, or services which are determined to be necessary by a licensed health care provider unless they shall have been found or determined to be unnecessary by a State-approved Peer Review Organization (PRO).

NOTE: Thermograms qualify as "medical treatment," *Tagliati v. Nationwide*, 720 A.2d 1051 (Pa. Super. 1998).

NOTE: "Monitoring" a patient is neither a necessary rehabilitative service (since it does not assist or increase the patient's ability for self-care) nor necessary medical treatment (because treatment requires overt action which simple monitoring is not*), Bickerton v. Insurance Commissioner*, 808 A.2d 971 (Pa. Cmwlth. 2002).

NOTE: Services performed by unlicensed personnel under the supervision of an on-premises chiropractor are covered where the procedures (e.g., turning equipment on and off, applying hot or cold packs, etc.) require no formal chiropractic education or training, *State Farm v. Cavuto*, 34 A.3d 123 (Pa. Super. 2011).

5. **"Noneconomic Loss"** as pain and suffering and other nonmonetary detriment.

6. **"Private Passenger Motor Vehicle"** as a four-wheel motor vehicle, except recreational motor vehicles not intended for highway use, which is insured by a natural person and either is a passenger car neither used as a public or livery conveyance nor rented to others, or has a gross weight not exceeding 9,000 pounds and is not principally used for commercial purposes other than farming.

NOTE: The MVFRL does not distinguish between "Personal Automobile Liability Policy" and "Commercial Automobile Liability Policy," instead focusing on whether a vehicle is insured by a natural person (as opposed to a corporation or partnership), thus a passenger car used for personal purposes will not qualify as a "Private Passenger Motor Vehicle" if insurance is obtained by a corporation, partnership, or other non-natural person.

7. **"Serious Injury"** as personal injury resulting in death, serious impairment of a body function, or permanent serious disfigurement.

NOTE: In all but the clearest cases, a jury determines whether a "serious injury" exists by evaluating what body function, if any, was impaired and whether any impairment was serious. The focus of inquiry is not injuries but rather how injuries affect body functions, which generally requires

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medical evidence. To determine whether any impairment is serious, a jury should consider extent of impairment, duration of impairment, treatment required to correct impairment, and "any other relevant factors." An impairment need not be permanent to be serious, *Washington v. Baxter*, 719 A.2d 733 (Pa. 1998)

8. **"Underinsured Motor Vehicle"** as a motor vehicle for which the limits of available liability insurance and self-insurance are insufficient to pay losses and damages.

NOTE: Policy language excluding family cars from the definition of "underinsured motor vehicle" is enforceable to prevent conversion of UIM coverage into additional liability coverage, *Paylor v. Hartford Ins. Co.*, 640 A.2d 1234 (Pa. 1994).

NOTE: The MVFRL excludes federal government vehicles from the definition of "underinsured motor vehicle" but policy language seeking to exclude all other government vehicles is void, *Kmonk-Sullivan v. State Farm*, 788 A.2d 955 (Pa. 2001).

9. **"Uninsured Motor Vehicle"** as

(a) a motor vehicle without liability insurance or self-insurance at the time of the accident;

NOTE: Policy language defining UM vehicle to not include any vehicle owned by the insured is valid, *Progressive Northern v. Gondi*, 165 Fed. App. 217 (3rd Cir., 2006) (where the insured, seeking to prevent theft of his insured car, was run over by his own car).

NOTE: In *Federal Kemper Ins. Co. v. Wales*, 633 A.2d 1212 (Pa. Super. 1993), the tortfeasor, though insured, was a co-employee, thus immune from suit. The absence of a tort remedy does not create a UM claim since the statutory definition of "uninsured motor vehicle" has not been met. Accord, *Erie v. Conley*, 29 A.3d 389 (Pa. Super. 2011).

NOTE: A policy may define "uninsured motor vehicle" to exclude "any equipment or vehicle designed for use mainly off public roads, except while on public roads," thus excluding, for instance, ATVs and similar vehicles covered under the Snowmobile All-Terrain Vehicle Law, 75 P.S. §§ 1701 et seq., *Nationwide v. Yungwirth*, 940 A.2d 523 (Pa. Super. 2008). Dirt bikes, however, are covered under the Vehicle Code and qualify as UM or UIM vehicles, *Burdick v. Erie*, 946 A.2d 1106 (Pa. Super. 2008).

(b) a motor vehicle for which the liability insurance company has denied coverage;

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NOTE: Where wrongful coverage denial by the tortfeasor's liability carrier causes UM payments, the UM carrier may pursue recovery against the liability carrier for the wrongful denial, *General Accident v. Federal Kemper*, 682 A.2d 819 (Pa. Super. 1996).

(c) an unidentified motor vehicle provided the accident is reported to the police or proper governmental authority and the claimant notifies the insurance carrier within thirty days of the accident or as soon as practicable thereafter.

NOTE: Reporting requirements also apply to passengers, *Jackson v. Assigned Claims Plan*, 575 A.2d 626 (Pa. Super. 1990). Claimant, having reported the accident to the police, is not required to produce an actual written police report, *Hatcher v. Travelers Ins. Co.*, 617 A.2d 808 (Pa. Super. 1992). Claimant can justifiably rely on an EMT employed by the city that the EMT would notify the police, *Gunter v. Constitution State Service Co*., 638 A.2d 233 (Pa. Super. 1994). Report of a work-related injury to the Department of Labor and Industry does not qualify as report to "proper governmental authority," *Owens v. Travelers Ins. Co.*, Pa. Super., 675 A.2d 751 (Pa. Super. 1996). A direct report to the Department of Transportation (but not to the police) is not a report to a "proper governmental authority," *Blazquez v. Pennsylvania Assigned Claims Plan*, 757 A.2d 384 (Pa. Super. 2000).

NOTE: Denial based on a late report of a “phantom vehicle” requires prejudice caused by late reporting, such as rendering usual investigation techniques (e.g., site inspection, canvassing for witnesses, etc.) useless. The carrier need not demonstrate what an investigation would have revealed but rather just that ability to investigate was impaired, *Vanderhoff v. Harleysville*, 78 A.3d 1060 (Pa. 2013).

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II. FIRST PARTY BENEFITS

A. Required Benefits (§ 1711)

MVFRL coverage requirements apply to liability insurance policies covering motor vehicles (except certain recreational vehicles and motorcycle type vehicles) registered and operated in the Commonwealth.

> NOTE: Unlike the No-Fault Statute, the MVFRL does not impose coverage requirements on vehicles not registered in PA, *Pugh v. GEICO*, Pa. Super., 552 A.2d 708 (Pa. Super. 1989), *Boone v. Stonewall Ins. Co.*, 554 A.2d 968 (Pa. Super. 1989), *Jarrett v. Pennsylvania National*, 584 A.2d 327 (Pa. Super. 1990), *Peters v. National Interstate*, 108 A.3d 38 (Pa. Super. 2015).
>
> NOTE: New Jersey requires NJ licensed insurers to provide NJ PIP limits if their out of state insureds are injured in NJ. An MVFRL minimum benefits policy, therefore, must provide NJ unlimited medical benefits if the insurer is licensed in NJ and if the accident occurs in NJ, *Smith v. Fireman's Ins. Co. of Newark*, 590 A.2d 24 (Pa. Super. 1991). MVFRL procedural remedies (e.g., medical examinations) are still available even if original MVFRL limits are exhausted and payments fall within extended New Jersey coverage, *Allstate Insurance Company v. McNichol*, 617 A.2d 333 (Pa. Super. 1992).
>
> NOTE: Though occupants of motorcycles do not qualify for First Party Benefits, policies covering motorcycles must still provide first party coverage to otherwise uninsured pedestrians involved in accidents with motorcycles, *Green v. K&K Ins. Agency*, 566 A.2d 622 (Pa Super. 1989).

B. Minimum Benefits

Minimum Benefits on MVFRL policies are $5,000 in medical benefits for payment of reasonable and necessary medical treatment without limitation as to time, provided that within eighteen (18) months from the accident it is ascertainable with reasonable medical probability that further expenses might be incurred, §§ 1711, 1712(1).

C. Optional Benefits

Optional Benefits on MVFRL policies, which must be offered for purchase, include:

1. Income loss benefits up to $50,000 ($2,500 per month maximum), §§ 1715(a)(2), 1712(2), which cover:

   (a) 80% of actual loss of gross income,

   (b) reasonable expenses incurred to hire replacements to perform self-employment services.

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(c) reasonable expenses incurred for "special help" enabling the claimant to work.

Income loss benefit does not cover postmortem work loss.

A five (5) day deductible applies to any work loss claim.

> NOTE: Lack of employment at the time of the accident does not bar recovery since "actual loss of gross income" can be proved by showing the victim would have worked and earned income but for the accident, *Persik v. Nationwide Ins. Co*., 554 A.2d 930 (Pa. Super. 1989).
>
> NOTE: Where claimant received workers' compensation benefits, MVFRL wage benefit is 80% of wage loss after reduction by workers' compensation payments, *Danko v. Erie Ins. Exchange*, 630 A.2d 1219 (Pa. Super. 1993)
>
> NOTE: "Actual loss of gross income" is not reduced by sick pay or social security, *Panichelli v. Liberty Mutual Ins. Co*., 669 A.2d 930 (Pa. 1996), *Browne v. Nationwide*, 674 A.2d 1127 (Pa. Super. 1996).
>
> NOTE: "Month" when calculating the maximum benefit for wage loss means the period beginning with a date in one calendar month and ending with the corresponding date in the next calendar month (e.g. April 15 to May 15), *Tyler v. Motorists Mutual*, 779 A.2d 528 (Pa. Super. 2001).

2. Funeral benefits up to $2,500 provided death due to the accident occurs within twenty-four months of the accident, § 1715 (a)(4), § 1712(4).

3. Accidental death benefits up to $25,000, §§ 1712(3), 1715(a)(3), with the benefit payable to the personal representative of estate. Death must occur within twenty-four months of accident. No dependency required.

> NOTE: Policy language may restrict this coverage to named insureds and relatives resident in the household, *Duffy v. Nationwide Ins. Co*., 542 144 (Pa. Super. 1988).
>
> NOTE: Policy language may restrict stacking of this coverage based on number of vehicles on a policy or number of policies. Despite the "appearance of unfairness" of collecting premiums for duplicative benefits that cannot be collected, anti-stacking language is enforceable, *Fay v. Erie Insurance Group*, 723 A.2d 712 (Pa. Super. 1999).

4. Additional medical benefits up to at least $100,000, § 1715(a)(1).

> NOTE: Unlike requests for lower limits under UM/UIM, the MVFRL provides no special procedure or forms for selecting first party benefit coverage levels. Where the carrier reduced medical limits from $100,000 to $5,000 in response to an ambiguous request from the insured, the policy

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would not be reformed to provide the higher coverage, especially where the insured paid premiums only for the lower coverage, *Bubis v. Prudential*, 718 A.2d 1270 (Pa. Super. 1998).

5. Extraordinary medical benefits from $100,000 to $1,100,000 which may be offered in increments of $100,000. Except for the first 18 months after an accident (when no annual limit applies), this coverage is subject to a $50,000 per year cap, §§ 1712(6), 1715(a)(1.1), 1715(d).

6. A combination benefit package with a $177,500 limit, with individual limits of $25,000 on accidental death and $2,500 on funeral, subject to a three-year limitation period, § 1715(a)(5).

NOTE: The three-year limitation is enforceable and is not against public policy, *Toner v. Nationwide*, Pa. Super., 610 A.2d 53 (Pa. Super. 1992).

7. The carrier may offer higher limits than the "optional benefits" listed above, § 1715(b).

D. Source of Benefits

The sources of benefits in order of priority are:

1. The policy under which claimant is a named insured, §1713(a)(1).

2. The policy under which the claimant is an insured, §1713(a)(2).

3. The policy covering the motor vehicle occupied by claimant, §1713(a)(3).

NOTE: In *Frain v. Keystone Ins. Co.*, 640 A.2d 1352 (Pa. Super. 1994), the court in an MVFRL benefit claim applied the "occupant of a motor vehicle" test announced for UM claims in *Utica Mutual Ins. Co. v. Contrisciane*, 473 A.2d 1005 (Pa. 1984), that a claimant not physically in or upon a motor vehicle may still qualify as an "occupant of the motor vehicle" by showing:

(a) causal relation between injury and use of the insured vehicle,

(b) close proximity of claimant to the vehicle,

(c) claimant as vehicle, not highway, oriented, and

(d) claimant engaged in a transaction essential to use of the vehicle.

NOTE: See *Curry v. Huron Ins. Co.*, 781 A.2d 1255 (Pa. Super. 2001) for analysis of "essential to the use of the vehicle" under the *Frain* test and for an example of activity which does not meet the standard. See *Petika v.*

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Transcontinental, 855 A.2d 85 (Pa. Super. 2004) for discussion of "oriented" under the *Frain* test.

NOTE: A SEPTA passenger hit while crossing the street to transfer from a bus to a trolley is "highway oriented," thus not an occupant of a SEPTA vehicle, *Jones-Molina v. SEPTA*, 29A.3d 73 (Pa. Cmwlth. 2011)

4. For claimants other than occupants of motor vehicles, the policy covering any vehicle involved in the accident, (§ 1713(a)(4)), but a parked, unoccupied motor vehicle is not a "motor vehicle involved in the accident" unless it was parked so as to cause unreasonable risk of injury.

NOTE: Benefit claims in this priority level are brought against the carrier for the involved vehicle, not against the owner or driver of the involved vehicle, *Glover v. State Farm*, 950 A.2d 335 (Pa. Super. 2008).

NOTE: Occupants of a trolley car on tracks are not occupants of a motor vehicle but, instead, are treated as pedestrians for first party benefit purposes, *Ellis v. SEPTA*, 573 A.2d 216 (Pa. 1990).

5. The Assigned Claims Plan, §§ 1751-1757.

NOTE: First party benefit coverages cannot be stacked between priority levels. Once coverage under the first applicable priority is exhausted, claimant may not seek additional benefits from other policies at lower levels, *Wheeler v. Nationwide*, 905 A.2d 504 (Pa. Super. 2006).

E. Ineligible/Excluded Claimants

The following individuals are ineligible to receive first party benefits:

1. The owner of a currently registered motor vehicle which does not have "financial responsibility" as required by the Statute, § 1714.

NOTE: Such an owner is ineligible for first party benefits from any MVFRL policy, *Swords v. Harleysville*, 883 A.2d 562 (Pa. 2005).

NOTE: This exclusion applies even if the uninsured vehicle is registered outside Pennsylvania, *Santorella v. Donegal*, 905 A.2d 534 (Pa. Super. 2006).

NOTE: The spouse of an uninsured owner may also be considered an ineligible claimant, *Ibarra v. Prudential Ins. Co.*, 585 A.2d 1119 (Pa. Super. 1991) (spouse eligible for benefits since she was separated from the titled owner spouse and there was no evidence of ownership, control, or use of the vehicle on a regular basis), accord, *Ickes v. Burkes*, 713 A.2d 653 (Pa. Super. 1998), *Bethea v. Assigned Claims Plan*, 595 A.2d 122 (Pa. Super. 1991) (marital property rights under the Divorce Code, together

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with evidence of regular use of the vehicle, may be sufficient to exclude benefits for spouse of uninsured owner), accord, *Allen v. Merriweather*, 605 A.2d 424 (Pa. Super. 1992).

2. Operators or occupants of certain recreational vehicles or motorcycle type vehicles, § 1714.

NOTE: An occupant of a snowmobile struck by a car is not entitled to first party benefits, *Gallo v. Nationwide*, 791 A.2d 1193 (Pa. Super. 2002).

3. Claimants who intentionally injure themselves, § 1718(a)(l).

4. Claimants injured while committing a felony, provided the felonious activity contributes to the cause of injury, § 1718(a)(2).

5. Claimants injured while seeking to elude lawful apprehension or arrest, § 1718(a)(3).

6. Claimants who knowingly convert motor vehicles (this exclusion does not apply to claimants who are named insureds or insureds under a policy), § 1718(b).

7. Claimants excluded from coverage by endorsement as permitted by law, § 1718(c).

NOTE: A "named driver exclusion" based on DUI conviction is valid for all subsequent policy renewals and excludes all policy coverages, not just first party benefit coverage, *Donegal Mutual v. Fackler*, 835 A.2d 712 (Pa. Super. 2003).

NOTE: Benefits may not be denied solely because the driver is under the influence of drugs or alcohol at the time of the accident. Any such contractual exclusion is void under § 1724, *Atlantic States v. Northeast Networking*, 893 A.2d 741 (Pa. Super. 2006).

NOTE: In general, exclusions based on "loading and unloading" vehicles are void, *Omodio v. Aetna*, 559 A.2d 570 (Pa. Super. 1989), *Callahan v. Federal Kemper Ins. Co*., 568 A.2d 264 (Pa. Super. 1989), though exclusions limiting application to those not occupying a vehicle are enforceable, *Huber v. Erie Ins. Exchange*, 587 A.2d 333 (Pa. Super. 1991). With "loading and unloading" claims, the issue is whether there is a causal relationship between injuries and maintenance or use of a motor vehicle.

NOTE: A "garageman exclusion" seeking to exclude coverage for "any person engaged in the business of repairing, servicing, or otherwise maintaining a motor vehicle" is void, *Rimpa v. Erie Ins. Exchange*, 590 A.2d 784 (Pa. Super. 1991).

NOTE: A policy exclusion denying first party benefits when the insured vehicle is used to carry persons or properties for a fee, i.e., a livery

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exclusion, is valid, *Brosovic v. Nationwide*, 841 A.2d 1071 (Pa. Super. 2004). For a similar result regarding UM/UIM benefits, see *Marino v. General Accident*, 610 A.2d 477 (Pa. Super. 1990) and *Nationwide v. Easley*, 960 A.2d 843 (Pa. Super. 2008). For a discussion involving liability coverage, see *Prudential v. Sartno*, 903 A.2d 1170 (Pa. 2006) (the "for a fee" language is ambiguous where neither the driver nor the employer charged a fee for pizza delivery).

F. Payment of Benefits

1. Payments of first party benefits are due within thirty (30) days of receipt of the proof of loss. Overdue payments bear 12% interest, § 1716.

NOTE: The MVFRL permits a private cause of action for interest on bills paid late, *Schappell v. Motorists Mutual*, 934 A.2d 1184 (Pa. 2007).

2. Medical benefit payments cover only "customary charges" as calculated under the MVFRL. The medical service supplier may not request or accept payment other than the lesser of:

(a) 110% of the Medicare prevailing charge at the 75th percentile,

(b) 110% of the applicable fee schedule, recommended fee, or the inflation index charge,

(c) 110% of the diagnostic related groups (DRG) payment, or

(d) The provider's usual and customary charge.

If Medicare has not calculated a charge under (a), (b) and (c) as above, for the specific treatment involved, then the medical service supplier can charge no more than 80% of its usual and customary charge, § 1797(a).

NOTE: In the absence of a Medicare fee, an insurer may use market data, charges of other providers, and other sources to determine "usual and customary charge," *Freedom Medical Supply v. State Farm*, 131 A.3d 977 (Pa. 2016).

NOTE: Cost containment applies to payment from liability, UM/UIM, or first party benefit coverages of an auto policy. As a result, insured tort defendants owe cost containment amounts, rather than the face amount of bills, *Pittsburgh Neurosurgery v. Danner*, 733 A.2d 1279 (Pa. Super. 1999).

NOTE: Medical cost containment under § 1797(a) is constitutional, *Pa. Medical Society v. Foster*, 624 A.2d 274 (Pa. Cmwlth. 1993). Medical cost containment regulations at 31 Pa. Code § 69.1 et seq. are also

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constitutional, *Pa. Assoc. of Rehabilitation Facilities v. Foster*, 633 A.2d 1248 (Pa. Cmwlth. 1993).

NOTE: The medical cost containment provisions of § 1797(a) apply to claims under MVFRL policies for treatment rendered on and after 4/15/90, regardless of date of accident or inception date of the policy, *Lynn v. Prudential*, 619 A.2d 779 (Pa. Super. 1993), *Frey v. State Farm Ins. Co*., 632 A.2d 930 (Pa. Super. 1993), *Schmidt v. State Farm Ins. Co*., 635 A.2d 638 (Pa. Super. 1993).

NOTE: Medical cost containment applies to self-insureds as well as insurance carriers, *Houston v. SEPTA*, 19 A.3d 6 (Pa. Cmwlth. 2011).

3. A medical service supplier may not charge the patient for any excess amounts not covered under the MVFRL/Medicare formula.

4. A carrier may challenge the necessity of medical treatment by submitting bills within ninety days of receipt to a Peer Review Organization. Within thirty days of any PRO decision, the insurer, insured, or medical service supplier may seek reconsideration. On reconsideration, the PRO must include as a member an individual in the same specialty as the medical service supplier. To stay the MVFRL requirement that payment be made within thirty days of receipt of a bill, a carrier must submit the bill to the PRO within thirty days, § 1797(b).

NOTE: §1797(b) does not reference determination of causal relationship as a function of the PRO. The Insurance Department has taken the position that causation determinations are inherent in the PRO process and come within the "medically necessary" language of the MVFRL. *Bodtke v. State Farm Ins. Co*., 637 A.2d 648 (Pa. Super. 1994), reversed other grounds, 659 A.2d 541 (Pa. 1995), adopts the Insurance Department position.

NOTE: If bills are not submitted to a PRO within 30 days, the carrier must pay the bills, even if the carrier ultimately submits the claim to a PRO between the 31st day and the 90th day, *Harcourt v. General Accident*, 615 A.2d 71 (Pa. Super. 1992).

NOTE: A PRO during the initial review must include a member of the same profession as the service supplier. On reconsideration, a PRO must include representation from the specialty within the profession of the medical service supplier. The initial review, for instance, might require a podiatrist while the reconsideration might require a podiatric surgeon, *Harcourt v. General Accident*, 615 A.2d 71 (Pa. Super. 1992).

NOTE: When a PRO fails to apply national or regional norms or established written criteria based upon typical patterns of practice in the

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PRO's geographic area (as required by 31 Pa. Code 69.53(e)), the PRO is not valid, but attorney fees may not be awarded, *Doctor's Choice v. Travelers*, 128 A.3d 1183 (Pa. 2015).

5. If the PRO ultimately determines that the medical service was necessary, the carrier must pay the properly calculated "customary charge" and must also pay 12% annual interest, §1797(5).

6. Where a carrier refuses to pay bills for past or future medical treatment, a medical service supplier may challenge the refusal. If a court determines that the medical treatment was medically necessary, the carrier must pay the properly calculated charge, interest at 12%, cost of litigation, and all attorney fees, §§1797(4) and (6).

NOTE: Administrative remedies (i.e. PRO reconsideration) need not be exhausted before resort to court, and regulations to the contrary at 31 Pa. Code §69.52(m) are void, *Terminato v. Pennsylvania National Ins. Co.* 645 A.2d 1287 (Pa. 1994).

NOTE: Both medical providers and patients have standing to sue following PRO determinations, *Kuropatwa v. State Farm*, 721 A.2d 1067 (Pa. 1998).

NOTE: If a court determines that treatment was medically necessary, attorney fees may not be awarded if the carrier submitted the bills for PRO review, *Herd Chiropractic v. State Farm*, 64 A.3d 1058 (Pa. 2013), *Doctor's Choice v. Travelers*, 128 A.3d 1183 (Pa. 2015).

NOTE: Any vagueness or due process deficiencies in § 1797(b) were corrected by the Insurance Department Regulations which provide detailed procedures, *Pennsylvania Medical Providers Association v. Foster*, 613 A.2d 51 (Pa. Cmwlth. 1992), *Lynn v. Prudential*, 619 A.2d 779 (Pa. Super. 1993).

7. If the carrier prevails in either the PRO or the proceeding, the carrier is not required to pay the submitted bills. In addition, if any previously paid bills are found to cover medically unnecessary treatment, the medical service supplier must reimburse the carrier for the prior payments, § 1797(7).

G. Stacking of Benefits (§ 1717)

Stacking first party benefits (i.e. cumulation of limits) based either on the number of vehicles or the number of available policies is not permitted.

NOTE: When there is more than one policy at the same priority level, claimant may collect from more than one policy but may not collect in toto more than the highest coverage limit on any one policy, *Neilson v. Nationwide*, 738 A.2d 490 (Pa. Super. 1999).

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NOTE: An insured at a higher priority level cannot drop down to a lower priority level to collect benefits either exhausted or not available on the higher priority policy, *Wheeler v. Nationwide*, 905 A.2d 504 (Pa. Super. 2006).

H. Coordination of Benefits (§ 1719)

1. Policies providing for first party benefits are deemed primary over all other available accident and health policies, work loss programs, etc., except workmen's compensation.

2. Accident and health policies, programs, etc., are deemed amended to insert a clause making benefits under these policies and programs excess above any first party policy or workmen's compensation coverage.

I. Subrogation (§ 1720)

For actions arising out of the maintenance or use of a motor vehicle, as a general rule no subrogation is permitted for workers' compensation, first party benefit, or any other payments made under group contracts, programs, or A&H type coverages, but see below for exceptions and amendments.

NOTE: The general bar on subrogation is constitutional and applies in all auto accident cases, regardless of theory of liability, *Walters v. Kamppi*, 545 A.2d 975 (Pa. Super. 1988).

NOTE: HMO subrogation rights granted by the HMO Act are not preempted by the MVFRL ban on subrogation, *Wirth v. Aetna U.S. Healthcare*, 137 Fed. Appx. 455 (3d Cir. 2005), *Wirth v. Aetna U.S. Healthcare*, 904 A.2d 858 (Pa. 2006).

NOTE: Payments under a self-insured ERISA plan, governed by federal law, are not subject to the MVFRL bar on subrogation, *FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

NOTE: The bar on subrogation applies to Heart and Lung Act benefits, *Fulmer v. Cmwlth. of Pennsylvania*, 647 A.2d 616 (Pa. Cmwlth. 1994), *City of Phila. V. Zampogna*, A.3d 1027 (Pa. Cmwlth. 2017).

NOTE: As part of a workers' compensation reform statute effective 8/31/93, the MVFRL bar on workers' compensation subrogation is repealed. The amendments are substantive, not procedural, and will not be given retroactive effect, *Brogan v. WCAB*, 637 A.2d 689 (Pa. Cmwlth. 1994), *Carrick v. Zurich American Ins. Co*., 14 F.3d 907 (3d Cir., 1994). The compensation carrier's right to subrogation is governed by date of

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accident, not date of the compensation payments. *Schraeder v. Schroeder*, 682 A.2d 1305 (Pa. Super. 1996), *DePaul Concrete v. WCAB,* 734 A.2d 481 (Pa. Cmwlth. 1999). When Pennsylvania workers' compensation benefits have been paid, subrogation is permitted even though the accident occurred in a different jurisdiction. *Young v. WCAB (Chubb*), 88 A.3d 295 (Pa. Cmwlth 2014).

J. Statute of Limitations (§ 1721)

1. In cases where no first party benefits have been paid, suit must be filed within four years of the date of the accident, § 1721(a).

2. If first party benefits were previously paid, any suit for further benefits must be filed:

(a) Within four years of the last payment;

(b) Within four years of the date the expense or loss in dispute was incurred.

3. The Statute of Limitations does not run on a minor but, unlike prior no-fault law, does run on other claimants under a legal disability, § 1721(b).

K. Preclusion of Evidence (§ 1722)

In general, plaintiffs are precluded from recovering in tort or UM/UIM actions for benefits paid or payable under MVFRL, auto policy, workers' compensation, or A&H type coverages, in effect removing the "collateral source" rule from automobile accident claims, but see below for exceptions and amendments.

NOTE: Effective 8/31/93, § 1722 is amended to delete reference workers' compensation benefits, consistent with a simultaneous restoration of workers' compensation subrogation rights. Claims arising out of pre-8/31/93 accidents will be governed by the original § 1722 preclusion rule.

NOTE: For accidents occurring prior to 7/1/90, plaintiffs are not precluded from collecting again for medical or wage losses covered by workers' compensation or any other coverage in excess of the then $10,000 medical and $5,000 wage minimums, *Palmosina v. Laidlaw Transit Co.*, 664 A.2d 1038 (Pa. Super. 1995) (workers' compensation), *Stroback v. Camaioni*, 674 A.2d 257 (Pa. Super. 1995) (coverage above minimum).

NOTE: Social Security disability benefits do not qualify as § 1722 benefits and do not create an offset or credit against wage losses, *Browne v. Nationwide*, 674 A.2d 1127 (Pa. Super. 1996). The same is true for benefits payable under an ERISA plan, *Orndoff v. Wilson*, 760 A.2d 1 (Pa. Super. 2000).

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NOTE: Personal disability policies paid for in whole or in part by the claimant either directly, or through payroll deductions, qualify as § 1722 benefits and thus offset any claimed wage losses, *Tannenbaum v. Nationwide*, 992 A.2d 859 (Pa. 2010).

NOTE: Language prohibiting pleading and proving "special damages" has been deleted from the MVFRL, but "special damages" should nevertheless still be precluded from pleading and evidence since they are not probative of the degree and extent of pain and suffering, *Martin v. Soblotney*, 466 A.2d 1022 (Pa. 1983), *Carlson v. Bubash*, 639 A.2d 458 (Pa. Super. 1994).

NOTE: While MVFRL "ineligible claimant" rules are constitutional, *Mowery v. Prudential Ins. Co.*, 535 A.2d 658 (Pa. Super. 1987), an "ineligible claimant" is barred only from first party benefits and may collect economic losses in a tort case, *Corbin v. Khosla*, 42 A.3d 254 (Pa. 2012).

NOTE: The preclusion rules apply only when coverage is in effect which is paid or payable. Where wage coverage has not been purchased on the policy, wage claims in tort are not restricted, reduced, or precluded simply because wage coverage could have been purchased, *Carroll v. Kephart*, 717 A.2d 554 (Pa. Super. 1998).

L. Medical Examinations (§ 1796)

Carriers are permitted to obtain medical examinations on Court application upon good cause shown. The MVFRL does not define "good cause." Claimants are entitled to copies of written reports generated from examinations. Failure to comply with a Court Order for examination may result in forfeiture of first party benefits pending compliance. Forfeiture is not automatic and must be sought by further Court application.

NOTE: IME reports are conditionally privileged, thus barring defamation claims against carriers and IME physicians, *Elia v. Erie Ins. Exchange*, 634 A.2d 657 (Pa. Super. 1993).

NOTE: *Keystone Insurance Company v. Caputo*, 529 A.2d 1134 (Pa. Super. 1987*), State Farm Insurance Company v. Zachary*, 536 A.2d 800 (Pa. Super. 1987*), State Farm Insurance Company v. Allen*, 544 A.2d 491 (Pa. Super. 1988), *State Farm Insurance Company v. Hunt*, 569 A.2d 365 (Pa. Super. 1990*), State Farm Insurance Company v. Swantner*, 594 A.2d 316 (Pa. Super. 1991), and *Allstate Insurance Company v. McNichol*, 617 A.2d 333 (Pa. Super. 1992), all discuss the "good cause" requirement, but the definition of "good cause" varies depending upon composition of the

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Superior Court panel. In general, the Superior Court will not disturb trial court decisions absent an abuse of discretion or other gross impropriety.

NOTE: In *Horne v. Century Insurance Company*, 588 A.2d 546 (Pa. Super. 1991), the Superior Court in a footnote suggests that the carrier could have (but failed to) argue that an IME is required by the insurance policy, without reference to § 1796. *In Fleming v. CNA*, 597 A.2d 1206 (Pa. Super. 1991), the Superior Court agrees with *Horne* that the policy requires submission to an IME without any showing of "good cause." Fleming, though, failed to argue that the policy language was illegal as contrary to the MVFRL or to public policy, issues that remain unresolved.

M. Attorney Fees

The Statute makes the following provisions for attorney's fees:

1. Under § 1716, the carrier must pay reasonable attorney's fees if it acted in an unreasonable manner in refusing to pay first party benefits when due.

NOTE: The report of a defense medical expert may not be sufficient to insulate a carrier from attorney fee claims if the Court finds "overwhelming contrary evidence" concerning the need for medical treatment, *Hill v. Nationwide Ins. Co.*, 570 A.2d 574 (Pa. Super. 1990)

2. Under §1798(b), the carrier is required to pay reasonable attorney's fees if the carrier is found to have acted with no reasonable foundation in refusing to pay first party benefits.

3. Contingent fees are not permitted on first party benefit claims, § 1798(a).

4. The carrier is entitled to attorney's fees from a claimant where the claimant has presented a fraudulent or excessive claim for first party benefits, § 1798(d).

5. Where a carrier has refused payment for medical treatment or rehabilitative services, the carrier must pay attorney fees and costs if a court ultimately determines that the treatment and services were medically necessary, § 1797(b)(6), *Herd Chiropractic v. State Farm*, 64 A.3d 1058 (Pa. 2013).

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III. UNINSURED/UNDERINSURED MOTORIST COVERAGE

A. Required Coverage

1. While UM/UIM coverages are no longer mandatory, carriers are required to offer such coverages on all policies issued or renewed on and after 7/1/90, § 1731.

NOTE: Effective 12/28/94, § 1731(b.1) through (b.3) were added to the MVFRL concerning rejection of UM coverage on rented or leased vehicles. The new provisions do not apply to common carriers by motor vehicle. Under the amendments, UM coverage on rental or leased vehicles may be rejected only if the specific statutory rejection form is signed by the person renting or leasing the motor vehicle.

NOTE: A signature on the reverse side of such a waiver in a rental form is valid, *Smith v. Enterprise*, 833 A.2d 751 (Pa. Super. 2003).

NOTE: UM/UIM coverage must be offered on any "motor vehicle liability insurance policy" which is "delivered or issued for delivery in the Commonwealth with respect to any motor vehicle registered or principally garaged in the Commonwealth." In *Kromer v. Reliance Ins. Co*., 677 A.2d 1224 (Pa. Super. 1996), the court ruled that excess or umbrella policies are not "motor vehicle liability insurance policies" for purposes of the MVFRL and thus need not offer UM/UIM coverages. In accord, *Been v. Empire Fire and Marine*, 751 A.2d 238 (Pa. Super. 2000). In addition, UM/UIM coverages need not be offered on a policy offering comprehensive coverage only, *Nationwide Ins. Co. v. Calhoun*, 635 A.2d 643 (Pa. Super. 1993). The MVFRL does not apply to a policy issued and delivered in another state for a vehicle registered in that state, even though the vehicle may be principally garaged in Pennsylvania, *Insurance Company of the State of Pennsylvania v. Hampton*, 657 A.2d 976 (Pa. Super. 1995) (Delaware vehicle and policy), *Bamber v. Lumbermen's Mutual Ins. Co.*, 680 A.2d 901 (Pa. Super. 1996) (Washington D.C. vehicle and policy), *Nationwide v. West*, 807 A.2d 916 (Pa. Super. 2002) (Ohio policy re: priority of recovery issues).

2. Unless coverage is waived by the first named insured on the policy by signing and dating an approved form, the insured is deemed to have elected UM/UIM coverage in amounts equal to the BI coverage, § 1731(c.1).

NOTE: "First named insured" literally means the first name listed on the policy even if the insurer by error fails to list the applicant (i.e. the person who requested coverage and filled out the application) first, *Jones v. Prudential*, 856 A.2d 838 (Pa. Super. 2004).

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NOTE: Where the UIM coverage rejection form changes the "all underinsured losses and damages" language in the form to simply "underinsured losses and damages," the change creates ambiguity rather than clarity and the form is void, resulting in UIM coverage, *American International Ins. Co. v. Vaxmonsky*, 916 A.2d 1106 (Pa. Super. 2006).

NOTE: Where the UIM coverage rejection form adds "by rejecting this coverage, I am also signing the waiver on Page 13 rejecting stacked limits of UIM coverage," the form is void, *Jones v. Unitrin Auto*, 40 A.3d 125 (Pa. Super. 2012).

NOTE: Under § 1731, UM/UIM waiver forms must each be on a separate sheet. The "separate sheet" requirement means only that UM and UIM forms must be separate from each other. UM or UIM rejection forms may on the same sheet address other options (e.g. stacking) for that same coverage, *Winslow-Quattlebaum v. Maryland Casualty Company*, 752 A.2d 878 (Pa. 2000).

NOTE: Hyper-technical or *de minimis* deviations from statutory language do not void otherwise valid waivers since the "specifically comply" statutory requirement is not the same as "verbatim," *Petty v. Federated Mutual*, 152 A.3d 120 (Pa. Super. 2016), *Ford v. American States*, 154 A.3d 237 (Pa. 2017).

NOTE: A § 1731 waiver of UM/UIM is valid even if the carrier fails to provide a § 1791.1 invoice and notice at renewal, *Salazar v. Allstate Ins. Co.*, 702 A.2d 1038 (Pa. 1997*), Kline v. Old Guard*, 820 A.2d 783 (Pa. Super. 2003).

NOTE: Where UM/UIM coverages have been waived, policy renewals must so state in prominent type. Failure to include this notice on the renewal form, however, does not void the waiver, *Franks v. Allstate Ins. Co.*, 897 F. Supp. 77 (M.D. Pa. 1995).

NOTE: The named insured executing the waiver is precluded from claiming against any person based upon inadequate information. The Statute does not, however, specifically extend that preclusion to other named insureds or insureds affected by the election.

NOTE: The election form "may" be witnessed by an agent or broker. The effect of any failure to so witness is not addressed in the MVFRL.

NOTE: A waiver of UM/UIM coverage is effective not only against the insured and relatives in the household, but also against any party claiming under the insurance policy, *General Accident Insurance Co. v. Parker*, 665 A.2d 502 (Pa. Super. 1995*), Blakney v. Gay,* Pa. Super., 657 A.2d 1302

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(1995), *Salazar v. Allstate Ins. Co*., Pa. 702 A.2d 1038 (1997). A corporate insured, though not having "relatives," can reject UM/UIM coverage, thereby waiving such coverage for any occupants of its vehicles, *Travelers Indemnity Co. v. DiBartolo,* 171 F.3d 168 (3d Cir. 1999).

NOTE: Where UM/UIM coverages have been waived, a subsequent request to increase BI limits on the policy does not require new UM/UIM rejection forms, *Smith v. Hartford*, 849 A.2d 277 (Pa. Super. 2004), appeal denied, 867 A.2d 524 (Pa. 2005).

NOTE: Where the carrier receives a rejection form which purports to be signed by the first named insured, the first name insured has the burden of proving any forgery, including that the signature is a forgery, that it was placed on the rejection form without her knowledge or consent, and that she did not willingly waive UIM coverage, *Toth v. Donegal Companies*, 964 A.2d 413 (Pa. Super. 2009).

B. Amount of Coverage

1. With the repeal of § 1732, the MVFRL no longer requires that UM and UIM coverages always be in equal amounts.

2. UM/UIM coverages may be equal to, less than, but never more than BI limits on the policy, §§ 1734, 1736. An insured may in writing request UM or UIM limits lower than the BI limits.

NOTE: Only a request in writing is required to reduce the UM or UIM limits. The more restrictive forms and procedures of § 1731 (concerning rejection of coverages) are not applicable to requests for lower limits, *Lewis v. Erie Ins. Co.*, 793 A.2d 143 (Pa. 2002), *Nationwide v. Heintz*, 804 A.2d 1209 (Pa. Super. 2002), *Hartford v. O'Mara,* 907 A.2d 589 (Pa. Super. 2006), *Orsag v. Farmers New Century*, 15 A.3d 896 (Pa. 2011).

NOTE: A reference only to "statutory" limits does not reduce limits but rather requires that UM/UIM limits equal BI limits on the policy, *Peele v. Atlantic Express,* 840 A.2d 1008 (Pa. Super. 2003).

3. When the first named insured fails to submit a properly completed election form, UM/UIM limits, absent written request for lower limits, will equal BI limits, §§ 1731(C.1), 1734.

NOTE: When the original named insured has properly requested lower limits, subsequently added named insureds, absent any request to increase limits, are bound by the original election, *Kimball v. CIGNA*, 660 A.2d 1386 (Pa. Super. 1995). Where the named insured husband, following a divorce, is dropped from the policy and replaced as named insured by the

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wife, the original request for lower limits remains in effect despite the change in named insureds, *Nationwide v. Buffetta*, 230 F.3d 634 (3rd Cir. 2000).

NOTE: When liability limits are changed, prior proper requests for lower limits remain in effect until the insured requests otherwise, *Blood v. Old Guard*, Pa. 934 A.2d 1218 (Pa. 2007), *Nationwide v. Catalini*, 18 A.3d 1206 (Pa. Super. 2011).

NOTE: In the absence of a written request for lower limits, repeated payment of a reduced premium for lower limits will not justify the lower limits, *Breuninger v. Pennland Ins. Co.*, 675 A.2d 353 (Pa. Super. 1996), *Erie Ins. Exchange v. Larrimore*, 987 A.2d 732 (Pa. Super. 2009).

NOTE: Where the insurance application provides a section, with the signature line left blank, to request lower UM/UIM limits, the insured's signature at the end of the application form (but not in the lower limits selection section) will not constitute written request for lower limits, *Motorists Ins. Co. v. Emig*, 664 A.2d 559 (Pa. Super. 1995).

NOTE: Where UM/UIM limits are retroactively increased to BI limits due to an improper § 1734 request, the carrier can retroactively bill the insured for the increased coverage, *Niemiec v. Allstate*, 33 Phila. 131 (1997).

4. UIM coverage is "excess" rather than "gap" (i.e. tort recovery is a credit against damages, not against policy limits), *Bateman v. Motorists Mutual Ins. Co.*, 590 A.2d 281 (Pa. 1991).

NOTE: Although the Insurance Department approved UIM endorsements with "gap" coverage, *Allwein v. Donegal Mutual*, 671 A.2d 744 (Pa. Super. 1996) held such forms invalid since the MVFRL requires "excess" UIM coverage.

NOTE: The UIM credit against damages includes recoveries from any tortfeasors, not just the UIM tortfeasor, *AAA Mid-Atlantic v. Ryan*, 84 A.3d 626 (Pa. 2014).

5. With split limits coverage, a bystander claim for negligent infliction of emotional distress triggers a separate limit of coverage, *Erie v. Shue*, 741 A.2d 803 (Pa. Super. 1999).

6. Interest at the legal rate is owed on UM/UIM awards starting on the date the arbitrators agree on the award (even if it is not communicated to the parties at that time) and ending when claimant receives payment of the award (not when the check is mailed), *Perel v. Liberty Mutual*, 839 A.2d 426 (Pa. Super. 2003).

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7. In an action (as opposed to arbitration) for UM/UIM benefits, delay damages may be recovered but only on the amount up to policy limits, not on any amount above policy limits awarded by the jury, *Marlette v. State Farm*, 57 A.3d 1224 (Pa. 2012).

C. Priority of Recovery (§ 1733)

Where multiple policies are applicable, the priority of recovery is:

1. The policy covering the motor vehicle occupied by the claimant.

> NOTE: The MVFRL does not impose its priority of recovery provisions on out of state policies, *Nationwide v. West*, 807 A.2d 916 (Pa. Super. 2002).
>
> NOTE: See "occupant of a motor vehicle" discussion under FIRST PARTY BENEFITS. In addition, see *L.S. v. Eschbach L.S. v. Eschbach,* Pa., 874 A.2d 1150 (2005),) (re: "essential to the use") and *Petika v. Transcontinental,* 855 A.2d 85 (Pa. Super. 2004) (re: "oriented").

2. The policy under which the claimant is an insured.

> NOTE: Although the MVFRL for first party benefit priority purposes distinguishes between named insured coverage and member of the household coverage, no such distinction exists regarding UM/UIM priority. Named insured coverage and household coverage are treated equally as excess to vehicle coverage and will prorate based on policy limits.
>
> NOTE: Contrary to prior No Fault era rulings, the MVFRL will not provide an uninsured pedestrian with UM benefits from the policy covering a stolen vehicle since the uninsured pedestrian is neither an occupant of the stolen vehicle nor an "insured" under the policy or the MVFRL, *Frazier v. State Farm Ins. Co.*, 665 A.2d 1 (Pa. Super. 1995).

3. Where multiple sources of equal priority exist (typically arising under §1733(a)(2)), the carrier against which claim is first asserted processes the claim and seeks contribution pro rata (including costs of adjustment) from any other carriers.

D. Immunity

1. Sovereign immunity does not bar UM claims against a self-insured Commonwealth agency, *Lowery v. Port Authority of Allegheny County,* 914 A.2d 953 (Pa. Cmwlth. 2006), *Paravati v. Port Authority of Allegheny County*, 914 A.2d 946 (Pa. Cmwlth. 2006).

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2. Self-insureds are immune from UM claims by employees injured in the course of employment, *Hackenberg v. SEPTA*, 586 A.2d 879 (Pa. 1991).

3. For accidents occurring between 10/1/84 and 7/1/90, immunity for the insurance carrier is precluded by *Chatham v. Aetna Ins. Co*., 605 A.2d 329 (Pa. 1992).

4. For accidents occurring between 7/1/90 and 7/2/93, immunity for the insurance carrier is precluded not only by *Chatham* but also by § 1735 as clarified by § 1737.

5. Effective 7/2/93, §§1735 and 1737 are repealed as part of a workers' compensation reform statute. Although the repeal appeared to restore immunity to employers' carriers from UM/UIM claims, immunity defenses have been contested. Decisions interpreting pre-MVFRL immunity gave immunity to self-insured employers, *Lewis v. School District of Philadelphia*, 538 A.2d 862 (Pa. 1988). The question of pre-MVFRL immunity to an employer's carrier, however, was never fully resolved. *In Boris v. Liberty Mutual*, 515 A.2d 21 (Pa. Super. 1986), immunity was denied. In *Roux Laboratories v. Turner*, 843 F.2d 205 (3d Cir., 1988), immunity was granted. In *Selected Risks v. Thompson*, 552 A.2d 1382 (Pa. 1989), the Supreme Court discussed the issue and denied immunity on the technical ground that the policy in question was not issued to the employer. After repeal of §§1735 and 1737, federal and state intermediate appellate courts have disagreed on immunity. In *Electric Ins. Co. v. Wilkins*, 85 F.3d 611 (3rd Cir. 1996), the court, citing *dicta* from *Ducjai v. Dennis*, 656 A.2d 102 (Pa. 1995), granted immunity in a post 7/2/93 accident. In *Warner v. Continental Ins. Co.*, 688 A.2d 177 (Pa. Super. 1996), the court denied immunity. Accord, *Travelers v. DiBartolo*, 171 F.3d 168 (3d Cir. 1999). Immunity was also denied to the carrier for the co-employee/owner of the vehicle involved in the accident. *Gardner v. Erie Ins. Co.*, 722 A.2d 1041 (Pa. 1999).

> NOTE: Policy exclusions may not eliminate UM/UIM coverage for injuries covered by workers' compensation, *Heller v. PA League of Cities*, 32 A.3d 1213 (Pa. 2011).
>
> NOTE: Under *Brennan v. General Accident*, 574 A.2d 580 (Pa. 1990) and *Azpell v. Old Republic Insurance Company*, 584 A.2d 950 (Pa. 1991), virtually all UM/UIM issues (including immunity) in policies with arbitration clauses are decided by arbitrators with only limited scope of appellate review thereafter.

E. Stacking/Coordination of Benefits

1. Recovery of both UM and UIM motorist benefits for the same accident is expressly prohibited, § 1731(d).

> NOTE: Prohibition upheld in *Erie Ins. Co. v. Danielson*, 621 A.2d 656 (Pa. Super. 1993).

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2. Stacking of BI and UIM coverages in a single policy, while not expressly prohibited by statute, is precluded by court decisions.

NOTE: Policy provisions allowing a setoff between Part A (i.e. liability coverage) and Part C (i.e. UM/UIM coverages) are enforceable, *Pennsylvania National v. Black*, 916 A.2d 569 (Pa. 2007).

NOTE: The *Wolgemuth* restriction on combined BI/UIM recovery applies only to claims brought under a single policy. UIM benefits may not be denied a claimant because of a BI recovery from a family member under a different policy, *Marroquin v. Mutual Benefit Ins. Co*, 591 A.2d 290 (Pa. Super. 1991).

3. Stacking of BI and UM coverages in a single policy may be defeated by policy language which sets off one coverage against the other, *Pennsylvania National v. Black*, 916 A.2d 569 (Pa. 2007), *Jeffrey v. Erie Ins. Exchange*, 621 A.2d 635 (Pa. Super. 1993), *State Farm Ins. Co. v. Broughton*, 621 A.2d 654 (Pa. Super. 1993), and *Pempkowski v. State Farm*,693 A.2d 201 (Pa. 1997).

4. Stacking of UM limits is not permitted against self-insureds, § 1731(d).

5. Absent a waiver of stacking in return for a reduced premium, "insureds" may stack in UM/UIM claims based on the sum of the limits of coverage on vehicles on applicable policies.

NOTE: The MVFRL definition of "insured" may vary from policy definitions of "insured", "covered person" or "eligible person", etc. The apparent statutory intent is to permit Class I stacking. Class II stacking is not addressed in the MVFRL.

NOTE: The statute contemplates both inter-policy and intra-policy stacking, both of which are waived by use of the statutory waiver form. “Stacking” involves “insureds” seeking to cumulate coverages per vehicle and thus “stacking” or “waiver of stacking” do not apply to guest passengers who are covered for UM/UIM as occupants but who are not MVFRL “insureds,” *Generette v. Donegal*, 957 A.2d 1180 (Pa. 2008).

NOTE: Waiver of stacking is available even to named insureds who purchase coverage for only one vehicle, *Craley v. State Farm*, 895 A.2d 530 (Pa. 2006).

NOTE: Insurers are not required to offer stacking/non-stacking options on commercial fleet policies, since the MVFRL did not replace prior law that UM/UIM coverages on such policies are not stacked, *Everhart v. PMA*, 938 A.2d 301 (Pa. 2007).

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6. The option to waive stacking may be exercised only by the first named insured and only by signing and dating an approved waiver form. The election to waive stacking is binding on all "insureds."

NOTE: "First named insured" literally means the first name listed on the policy even if the insurer by error failed to list the applicant (i.e. the person who requested coverage and filled out the application) first, *Jones v. Prudential*, 856 A.2d 838 (Pa. Super.2004).

NOTE: Unlike the tort remedy election and the UM/UIM coverage rejection option, the stacking waiver option does not include a statutory bar to claims based on inadequate information.

NOTE: Although the stacking waiver is not statutorily binding on Class II claimants, such claimants are generally not permitted to stack under Pennsylvania law, *Utica Mutual Ins. Co. v. Contrisciane*, 473 A.2d 1005 (Pa. 1984).

NOTE: Where the title on the waiver form varies slightly from the statutory language, the waiver of stacking is valid despite the slight deviation, *Allstate v. Seelye*, 846 A.2d 1286 (Pa. Super. 2004), *Vosk v. Encompass*, 851 A.2d 162 (Pa. Super. 2004).

7. When additional vehicles are added to a policy (as opposed to replacement of existing vehicles), no new waiver of stacking form is needed if coverage is automatically extended, assuming notice and premium payment conditions are met, *Shipp v. Phoenix Ins. Co.*, 51 A.3d 219 (Pa. Super. 2012). If, however, coverage is extended only for a finite period, new stacking waiver forms are required, *Sackett v. Nationwide (I)*, 919 A.2d 194 (Pa. 2007), *Sackett v. Nationwide (II)*, 940 A.2d 329 (Pa. 2007), *State Auto v. Pro Design*, 566 F.3rd 86 (3rd Cir., 2009).

8. When new, non-replacement vehicles are added by endorsement, new waivers of stacking are required, *Bumbarger v. Peerless Indemnity*, 93 A.3d 872 (Pa. Super. 2014), *Pergolese v. Standard Fire*, 162 A.3d 481 (Pa. Super. 2017), except if such vehicles are added by standard "Newly Acquired Vehicle" clauses, no new waivers are required, *Toner v. Travelers Ins. Co.*, 137 A.3d 583 (Pa. Super. 2016), appeal granted 158 A.3d 64 (Pa 2016).

9. When UM/UIM limits are changed, an insurer must obtain new waivers of stacking, *Barnard v. Travelers Home & Marine,* -- A.3d – (Pa. 2019).

F. Consent/Exhaustion Clauses

1. The "consent to settle" clause in the UIM endorsement is limited by *Daley-Sand v. West American Ins. Co.*, 564 A.2d 965 (Pa. Super. 1989), which adopts the Minnesota approach requiring UIM carriers to "purchase" subrogation rights by matching BI policy

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limit offers. Under *Baith v. CNA Ins. Co*., 593 A.2d 881 (Pa. Super. 1991), claimant does not need to file a Petition with the court to enforce *Daley-Sand* rights. Written notice to the UIM carrier of the policy limit offer together with a reasonable time in which to match the offer suffices before the claimant can accept the BI offer and give the tortfeasor a general release. *Nationwide v. Lehman*, 743 A.2d 933 (Pa. Super. 1999), without referencing earlier contrary opinions, holds that carriers must demonstrate actual prejudice before any unauthorized settlement bars UM/UIM claims. In accord, *Cerankowski v. State Farm*, 783 A.2d 343 (Pa. Super. 2001). A carrier may by wrongful denial of UM/UIM coverage waive any right to rely upon a "consent to settle" clause, *Kolbe v. Aegis Ins. Co.*, 537 A.2d 7 (Pa. Super. 1987).

NOTE: The "consent to settle" and "exhaustion" rules applicable in the BI/primary UIM context apply similarly in the primary UIM/excess UIM context, *Nationwide v. Schneider*, 960 A.2d 442 (Pa. 2008).

2. The "consent to be bound" clause in a UM endorsement (which provides that the carrier is not bound by a judgment against the tortfeasor without its prior written consent) is enforceable, *Sands v. Andino*, Pa. Super., 590 A.2d 761 (Pa. super. 1991).

3. The "exhaustion" clause in the UIM endorsement requires exhaustion only as to any one motor vehicle tortfeasor, not as to all potential tortfeasors (*Werntz v. General Accident*, 1 D&C 4th 386 (1988)) and not as to any non-motor vehicle tortfeasors (*Kester v. Erie Ins. Exchange*, 582 A.2d 17 (Pa. Super. 1990)). Exhaustion as to any one motor vehicle tortfeasor, however, applies to both primary and excess policies (*USF&G v. Lombardi*, 14 D&C 4th 276 (1992)).

NOTE: A carrier's ten month delay in responding to a request for consent to settle estopped the carrier from raising either consent to settle or failure to exhaust as defenses, *Boyle v. Erie*, 656 A.2d 941 (Pa. Super. 1995)

NOTE: Only a credit for (not an exhaustion of) liability limits is necessary before seeking UIM benefits, *Chambers v. Aetna*, 658 A.2d 1346 (Pa. Super. 1995), *Kelly v. State Farm*, 668 A.2d 1154 (Pa. Super. 1996), *Sorber v. American Motorist Ins. Co.*, 680 A.2d 881 (Pa. Super. 1996). A UIM hearing may precede settlement or trial of the underlying tort claim (*Harper v. Providence Washington Ins. Co.*, 753 A.2d 282 (Pa. Super. 2000)) even though a jury may later determine that the UIM driver was not at fault (*Krakower v. Nationwide*, 790 A.2d 1039 (Pa. Super. 2002)).

NOTE: The "consent to settle" and "exhaustion" rules applicable in the BI/primary UIM context apply similarly in the primary UIM/excess UIM context, *Nationwide v. Schneider*, 960 A.2d 442 (Pa. 2008).

G. Exclusions

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1. Territorial limitations in a policy are enforceable to bar UM/UIM claims, *Hall v. Amica Mutual Ins. Co.*, 648 A.2d 755 (Pa. 1994).

2. "Regular use," "family use," or "household use" vehicle exclusions/definitions are not against public policy, *State Farm v. Craley*, 844 A.2d 573 (Pa. Super. 2004), *Estate of Demutis v. Erie*, 851 A.2d 172 (Pa. Super. 2004).

> NOTE: A "regular use" exclusion is still applicable even if the use is subject to restrictions or the use has been occurring for only a short period before the accident. *Rother v. Erie Ins. Exchange*, 57 A.3d 116 (Pa. Super. 2012).
>
> NOTE: "Regular use" exclusions apply to use of an employer's fleet vehicle, *Williams v. GEICO*, 32 A.3d 1195 (Pa. 2011), *Adamitis v. Erie Ins. Exchange*, 54 A.3d 371 (Pa. Super. 2012), *Hand v. City of Philadelphia*, 65 A.3d 916 (Pa. Super. 2013), *Erie v. Catania*, 95 A.3d 320 (Pa. Super. 2014).

3. The owner of a registered uninsured motor vehicle is not automatically barred from collecting UM/UIM benefits from other coverage in the household, provided he is not occupying his owned UM vehicle at the time of the accident, *Henrich v. Harleysville Ins. Co*., 620 A.2d 1122 (Pa.1993) as clarified in *Swords v. Harleysville Ins. Co.*, 883 A.2d 562 (Pa. 2005). If the household policy has an exclusion avoiding coverage in such a case, the exclusion will be enforced, *Hart v. Nationwide*, 663 A.2d 682 (Pa. 1995), *Old Guard Ins. Co. v. Houck*, 801 A.2d 559 (Pa. Super. 2002), *Rudloff v. Nationwide*, 806 A.2d 1270 (Pa. Super. 2002).

4. If the claimant is occupying an owned UM vehicle at the time of the accident, policy language prohibiting coverage will be enforced, *Windrim v. Nationwide Ins. Co*., 641 A.2d 1154 (Pa. 1994), *Eichelman v. Nationwide*, 711 A.2d 1006 (Pa. 1998).

5. Where claimant seeks UIM coverage from a household policy other than the policy paying BI, benefits are provided if the named insured on the two policies are different, *Marroquin v. Mutual Benefit Ins. Co.*, 591 A.2d 290 (Pa. Super. 1991) but are denied if the named insureds on the policies are the same, *Paylor v. Hartford Ins. Co.*, 640 A.2d 1234 (Pa. 1994), *Ridley v. State Farm Ins. Co.*, 745 A.2d 7 (Pa. Super. 1999).

6. An exclusion of UM/UIM coverage where the insured is occupying a "regularly used non-owned car" not insured on that policy is valid, *Williams v. GEICO*, 32 A.3d 1195 (Pa. 2011). Where the exclusion is triggered by "using," not by "occupying" such a vehicle, mere passenger status is not "using" the vehicle, *Erie v. E.L.*, 941 A.2d 1270 (Pa. Super. 2008).

7. "Household vehicle" exclusions barring UM/UIM coverage when the insured is occupying a household vehicle not covered on the policy are void, since exclusions are not valid substitutes for proper waivers of stacking, *Gallagher v. GEICO*, 201 A.3d 131

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(Pa. 2019), overturning or distinguishing *Prudential v. Colbert*, 813 A.2d 747 (Pa. 2002) and *Erie Ins. Exchange v. Baker*, 972 A.2d 507 (Pa. 2009).

8. Policy language seeking to restrict UM/UIM coverage to insureds occupying cars (as opposed to trucks, buses, two or three wheel vehicles, etc.) is void, *Prudential v. Ziatyk*, 793 A.2d 965 (Pa. Super. 2002), *Richmond v. Prudential (I)*, 789 A.2d 271 (Pa. Super. 2001), *Prudential v. McAninley*, 801 A.2d 1268 (Pa. Super. 2002), *Richmond v. Prudential (II)*, 856 A.2d 1260 (Pa. Super. 2004).

9. Language in an antique auto policy restricting UM/UIM coverage to occupants of the antique auto is valid, *St. Paul Mercury Ins. Co. v. Corbett*, 630 A.2d 28 (Pa. Super. 1993).

10. An exclusion of UM/UIM coverage when the vehicle is used to carry persons or property for a fee is valid, *Marino v. General Accident Ins. Co.*, 610 A.2d 477 (Pa. Super. 1990), *Nationwide v. Easley*, 960 A.2d 843 (Pa. Super. 2008). For a similar result regarding First Party Benefits, see *Brosovic v. Nationwide*, 841 A.2d 1071 (Pa. Super. 2004).

11. UM/UIM exclusions which deny coverage for "use of any vehicle by an insured without permission" are valid, even when the claimant is an innocent passenger in a stolen vehicle, *Nationwide Ins. Co. v. Cummings*, 652 A.2d 1338 (Pa. Super. 1994). The same is true when the vehicle is operated by a specifically excluded driver, *Progressive Ins. Co. v. Schneck*, 813 A.2d 828 (Pa. 2002). But see *Erie v. E.L.*, 941 A.2d 1270 (Pa. Super. 2008) where the court refuses to equate “use” with “occupying” in a “household vehicle” exclusion context.

12. UM/UIM exclusions for punitive damages are not only enforceable, such damages are not, in any event, recoverable in UM/UIM, *Robson v. EMC Ins. Co.*, 785 A. 2d 507 (Pa. Super. 2001).

H. Subrogation/Preclusion of Evidence

1. For accidents occurring between 10/1/84 and 6/30/90, claimant may not plead, prove, or collect amounts covered by the then basic first party benefits of $10,000 medical, $5,000 wage, and $1,500 funeral, (§ 1722). Subrogation is not permitted, (§ 1720).

2. For accidents occurring between 7/1/90 and 8/30/93, claimant may not collect in UM/UIM for any amounts covered by any first party benefits, any workers' compensation, or any other health/disability benefits paid or payable, (§ 1722 as amended by Act 6). Subrogation is not permitted (§ 1720).

3. For accidents occurring on and after 8/31/93, claimant may not collect for amounts covered by any first party benefits or any other health/disability benefits paid or payable (§ 1722 as further amended). Amounts paid or payable by workers' compensation can be collected again in UM/UIM claims. Subrogation is not permitted for first party benefits

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or other health/disability benefits but the prohibition on workers' compensation subrogation is repealed.

NOTE: Workers' compensation carriers may not subrogate against UM/UIM payments from personal auto carriers, *Standish v. American Manufacturers*, 698 A.2d 599 (Pa. Super. 1997), *American Red Cross v. WCAB*, 745 A.2d 78 (Pa. Cmwlth. 2000), *Entertainment Partners v. WCAB*, 749 A.2d 551 (Pa. Cmwlth. 2000). In such cases, the claimant "double dips" by recovering and keeping payments from the workers' compensation carrier and the UM/UIM personal auto carrier for the same losses, *Ricks v. Nationwide*, 879 A.2d 796 (Pa. Super. 2005). Workers' compensation carriers may subrogate against UM/UIM payments from employers' carriers, *Harper v. Providence Washington Ins. Co.*, 753 A.2d 282 (Pa. Super. 2000) and *City of Meadville v. WCAB*, 810 A.2d 703 (Pa. Cmwlth. 2002) or a co-employee's carrier, *Davis v. WCAB (PA Social Services Union)*, 131 A.3d 537 (Pa. Cmwlth. 2015).

NOTE: Where the workers' compensation carrier waives its subrogation rights in settlement of the workers' compensation claim, claimants may not prove damages covered by workers' compensation in UM/UIM claims against the employer's carrier, *Burke v. Erie*, 940 A.2d 472 (Pa. Super. 2007).

NOTE: Where the UIM claim settles before trial of the tort case, the tort defendant is not entitled to a credit for the UIM payment against any damage verdict even when the UIM carrier has waived subrogation, *Smith v. Rohrbaugh*, 54 A.3d 892 (Pa. Super. 2012), reversing *Pusl v. Means*, 982 A.2d 550 (Pa. Super. 2009).

4. An insurer paying UIM (and, by analogy, UM) benefits has subrogation rights not only against the UIM (or UM) tortfeasor, but also against any tortfeasor, *American States Ins. Co. v. Estate of Braheem*, 918 A.2d 750 (Pa. Super. 2007).

5. Where a wrongful denial of coverage by the liability carrier results in payment of UM benefits, the UM carrier may pursue recovery against the liability carrier based on the wrongful denial, *General Accident v. Federal Kemper*, 682 A.2d 819 (Pa. Super. 1996).

6. The insured's failure to protect subrogation rights by suing the tortfeasor within the statute of limitations bars any UM/UIM claim, *Zourelias v. Erie*, 691 A.2d 963 (Pa. Super. 1997).

I. Statute of Limitations

1. Contract, rather than tort, statute of limitations will apply to UM/UIM claims, *Boyle v. State Farm Ins. Co.*, 456 A.2d 156 (Pa. Super. 1983), *Clark v. State Farm Ins. Co.*, 599 A.2d 1001 (Pa. Super. 1991). For causes of action accruing on and after 2/18/83, the

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contract statute of limitations in Pennsylvania is four years, not six years (42 P.S. § 5525(8)).

2. UM (and presumably UIM) statute of limitations starts to run when the insurance contract is breached, i.e., denial of a claim or refusal to arbitrate, *Erie Insurance v. Bristol*, 174 A.3d 578 (Pa.2017), reversing *Boyle v. State Farm Ins. Co.*, 456 A.2d 156 (Pa. Super. 1993). Once the statute starts to run, the statute is tolled by commencement of an action, *Hopkins v. Erie*, 65 A.3d 452 (Pa. Super. 2013).

3. If the policy provides for arbitration, statute of limitations defenses must be presented to arbitrators, not the court, *Messa v. State Farm Ins. Co*., 641 A.2d 1167 (Pa. Super. 1994).

J. Arbitration or Trial

1. The MVFRL does not control the type, timing, or method of UM/UIM arbitration and the Insurance Commissioner does not even have authority to mandate arbitration clauses in UM/UIM endorsements, *Insurance Federation v. Koken*, 899 A.2d 550 (Pa. 2005).

2. Where a policy without an arbitration clause requires that any suit for UM/UIM benefits be filed in the state and county of domicile of the claimant, the venue provision is enforceable, *O'Hara v. First Liberty*, 984 A.2d 938 (Pa. Super. 2009).

> NOTE: Where tort and UIM claims are joined in a single suit, proper venue as to the carrier does not create proper venue for the tortfeasor since P.R.C.P. 1006(c)(1) applies only in cases where the defendants can be jointly and severally liable, *Sehl v. Neff*, 26 A.3d 1130 (Pa. Super. 2011).
>
> NOTE: Where tort and UIM claims are joined in a single suit, the UIM carrier, though not identified as such to the jury, may participate in the defense (e.g., by examining witnesses), *Stepanovich v. McGraw*, 78 A.3d 1147 (Pa. Super. 2013).

3. Policy provisions can specify the type of arbitration, e.g., the Uniform Arbitration Act of 1980, the Arbitration Act of 1927, or common law arbitration.

> NOTE: Class II claimants, though not parties to the insurance contract, are still bound by any arbitration provision in the policy. *Johnson v. Pennsylvania National Ins. Co.*, 594 A.2d 296 (Pa. 1991). If the policy contains no arbitration clause, UM/UIM claimants may not compel arbitration or selection of arbitrators, *McFarley v. AIIC*, 663 A.2d 738 (Pa. Super. 1995).
>
> NOTE: Orders requiring arbitration are interlocutory and not immediately appealable, *Erie Ins. Exchange v. Midili*, 675 A.2d 1267 (Pa. Super. 1996), *Rosy v. National Grange*, 771 A.2d 60 (Pa. Super. 2001).

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NOTE: Arbitration clauses which permit appeals for trials *de novo* when awards are greater than $15,000 are void as against public policy, *Zak v. Prudential*, 713 A.2d 681 (Pa. Super. 1998).

NOTE: Arbitration clauses which provide for arbitration only if both parties agree are valid, *Amber-Messick v. Progressive*, 2005 U.S. Dist. LEXIS 13100.

4. The Uniform Arbitration Act of 1980 (42 P.S. § 7301 et seq.) applies when specifically referenced or when "statutory arbitration" is referenced. The Uniform Act allows very limited appellate review, generally based on fraud, denial of due process, or improper conduct by arbitrators.

5. The Arbitration Act of 1927, though repealed in 1980, may still be used if specifically referenced in the arbitration agreement, *CIGNA v. Squires*, 628 A.2d 899 (Pa. Super. 1993). The Act of 1927 allows appellate review of errors of law, *Nationwide Ins. Co. v. Calhoun*, 635 A.2d 643 (Pa. Super. 1993).

NOTE: Since courts under the Act of 1927 have ultimate jurisdiction over legal issues, arbitration and Declaratory Judgment litigation may proceed simultaneously with the court having the final say on legal issues, *Bottomer v. Progressive Ins. Co.*, 816 A.2d 1172 (Pa. Super. 2003).

6. Common law arbitration applies when no other statutory arbitration system is specified in the policy. Virtually no appellate review is permitted at common law other than for fraudulent conduct of the arbitrators.

7. Under all the above arbitration systems, arbitrators must be impartial. Where the policy calls for "disinterested arbitrators," arbitrators may not have at any time represented one of the parties, *Donegal v. Longo*, 610 A.2d 466 (Pa. Super. 1992), *Bole v. Nationwide*, 379 A.2d 1346 (Pa. 1977). Prior service as an arbitrator for a party, however, does not require disqualification, *Land v. State Farm*, 600 A.2d 605 (Pa. Super. 1991). Where the policy calls for "competent arbitrators," prior representation of a party does not automatically disqualify an arbitrator absent evidence of that arbitrator's inability to act impartially, *Sheehan v. Nationwide*, 779 A.2d 582 (Pa. Super. 2001).

8. Arbitrators, once the existence of an arbitration agreement is established, decide all fact, legal, and coverage issues, *Brennan v. General Accident*, 574 A.2d 580 (Pa. 1990*), Nationwide v. Patterson*, 953 F.2d 44 (3d Cir. 1991). Arbitrators also decide where the arbitration will take place, *Santiago v. State Farm*, 683 A.2d 1216 (Pa. Super. 1996). Where the arbitration agreement provides that "covered person"/carrier disputes on "policy coverages" go to arbitration, arbitrators also decide who qualifies as a "covered person," *Borgia v. Prudential*, 750 A.2d 843 (Pa. 2000). If, however, the policy provides that arbitrators may not decide coverage issues or that arbitrators decide only tort liability and damage issues, then coverage disputes do not fall within the arbitration agreement

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and must be decided by a court, *State Farm v. Coviello*, 233 F.3d 710 (3rd Cir., 2000), *Nationwide v. Cosenza*, 258 F. 3d 197 (3rd Cir., 2001), *Henning v. State Farm*, 795 A.2d 994 (Pa. Super. 2002).

> NOTE: Objections to the venue of a petition to compel arbitration should be raised in answer to the petition rather than by preliminary objections, *CID v. Erie*, 63 A.3d 787 (Pa. Super. 2013).

9. Arbitrators do not have jurisdiction over statutory "bad faith" claims, *Nealy v. State Farm*, 695 A.2d 790 (Pa. Super. 1997).

10. Arbitrators do not have jurisdiction over disputes concerning or enforcement of UM/UIM settlements, *Nationwide v. Moustakidis*, 830 A.2d 1288 (Pa. Super. 2003).

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IV. ASSIGNED CLAIMS PLAN (§§ 1751-1757)

A. Eligible Claimant

To be eligible for Assigned Claims Plan benefits, the claimant must:

1. Be a resident of the Commonwealth of Pennsylvania;

2. Be injured in a motor vehicle accident in the Commonwealth of Pennsylvania;

3. Not be the owner of a motor vehicle of the type required to be registered under Pennsylvania law;

4. Not be an operator/occupant of a motor vehicle owned by the Federal government;

5. Not be an operator/occupant of a motor vehicle owned by a self-insurer or entity immune from liability for benefits or for uninsured motorist or underinsured motorist benefits.

> NOTE: Since vehicles (whether registered or unregistered) owned by non-Pennsylvania residents are not required to provide MVFRL benefits, an occupant of such a vehicle is not an eligible claimant under the Assigned Claim Plan, *Rosado v. Constitution State Service Co.*, 625 A.2d 1239 (Pa. Super. 1993), *Bridges v. Gary*, 633 A.2d 170 (Pa. Super. 1993), *Zeigler v. Constitution State Service Co.*, 634 A.2d 261 (Pa. Super. 1993). Where, on the other hand, the unregistered vehicle is owned by a Pennsylvania resident, the vehicle is then of the type required to be registered and innocent occupants of such a vehicle qualify for MVFRL benefits, *Ortiz v. Gamble*, 759 A.2d 408 (Pa. Super. 2000), *Parnell v. Constitution State Service Company*, 764 A.2d 1136 (2000).

6. Not be otherwise barred from first party benefits under other MVFRL provisions;

7. Not be an operator/occupant of certain recreational vehicles or motorcycle type vehicles, § 1752(a).

B. Ineligible Claimants (§ 1752(b))

Even if a claimant meets the eligibility requirements as above, coverage will still be excluded if the claimant contributes to the injury:

1. While intentionally injuring himself or another;

2. While committing a felony;

3. While seeking to elude lawful arrest;

4. While knowingly converting a motor vehicle.

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C. Benefits. (§ 1753)

1. Medical benefits are provided up to a dollar limitation of $5,000;

2. No income loss benefits are provided;

3. No accidental death benefits are provided;

> NOTE: The $1,500 funeral benefit previously provided through the Assigned Claims Plan has been eliminated.

4. Uninsured motorist benefits are provided up to $15,000 (with a $30,000 cap for all claims arising out of any one accident) but the amount of available uninsured motorist coverage is reduced by any medical payments provided through the Assigned Claims Plan, § 1754. There is no provision for underinsured motorist coverage through the Assigned Claims Plan.

> NOTE: Where claimant has received first party benefits (but, due to a UM waiver, no UM payments) from an insurance policy, UM benefits are not provided by the Assigned Claims Plan, *Walker v. Fennell*, 627 A.2d 771 (Pa. Super. 1993).

> NOTE: The Plan must make UM benefits available to occupants of uninsured motor vehicles (other than the uninsured owner), *Assigned Claims Plan v. English*, 664 A.2d 84 (Pa. 1995).

D. Coordination of Benefits (§ 1755)

1. The Assigned Claims Plan receives a credit for all workmen's compensation or similar payments.

2. The Assigned Claims Plan receives a credit for all available accident and health benefits.

E. Subrogation (§ 1756)

The Assigned Claims Plan has subrogation rights against the tortfeasor in accordance with Pennsylvania tort law.

> NOTE: Where the claimant gives a release of all claims to the tortfeasor, that release also extinguishes all claims by the Assigned Claims Plan against the tortfeasor. Any such unauthorized release results in forfeiture of claimant's right to recover benefits from the Plan, *Melendez v. Pa. Assigned Claims Plan*, 557 A.2d 767 (Pa. Super. 1989). In addition, the Plan, under *Brikaljik v. Paxton National Ins. Co.*, 522 A.2d 531 (Pa. 1987) likely has the right to recover from claimant any amounts previously paid in first party benefits.

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F. Statute of Limitations. (§ 1757)

1. The Statute of Limitations is four years from the date of the accident.

2. For minors, the Statute of Limitations starts to run when they reach eighteen.

3. There is no sixty-day grace period as under the No Fault system (i.e., a claimant was permitted to file against the Assigned Claims Plan sixty days after he received a final determination that the carrier to whom he had originally made application would not cover the loss).

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V. PROOF OF FINANCIAL RESPONSIBILITY (§ 178l-1787)

A. General Rules

Proof of financial responsibility through insurance or qualifying self-insurance must be provided:

1. Before restoration of a suspended or revoked license.

2. When a defendant is convicted of a traffic offense (other than a parking violation) that requires a Court appearance.

3. After any accident that must be reported to the police (i.e., an accident causing death or injury or causing property damage to the extent that the vehicle is disabled or constitutes a safety hazard).

4. After notice of failure to satisfy a judgment arising from an accident covered by the MVFRL.

5. At the registration or renewal of registration of a motor vehicle.

6. At the annual inspection of the vehicle.

NOTE: This provision is not in the MVFRL but in Vehicle Code at 75 P.S. 4727.

B. Self-Insurance. (§ 1787)

1. The applicant must provide evidence of reliable financial arrangements, deposits, reserves, resources, or commitments sufficient to pay the minimum first party benefits, liability coverages, and uninsured motorist coverage required by the Statute.

NOTE: UM must be provided by a self-insured and is not subject to waiver or rejection as with insurance policies, *Gutman v. Worldwide Ins. Co.*, 630 A.2d 1263 (Pa. Super. 1993).

NOTE: UM coverage required from a self-insured entity cannot be avoided by sovereign immunity, *Lowery v. Port Authority of Allegheny Co.*, 914 A.2d 953 (Pa. Cmwlth. 2006), *Paravati v. Port Authority of Allegheny Co*., 914 A.2d 946 (Pa. Cmwlth. 2006).

NOTE: UIM is not required from a self-insurer. If UIM is voluntarily offered (e.g. through a car rental contract), MVFRL requirements on waivers, rejection, or limits are not applicable, *Ingals v. Hertz*, 683 A.2d 1252 (Pa. Super. 1996).

NOTE: Self-insureds providing liability protection with car rentals need not provide § 1791 and § 1791.1 notices concerning availability of coverage, *Saunders v. Hertz*, 717 A.2d 561 (Pa. Super. 1998).

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2. Stacking of uninsured motorist benefits against a self-insured is specifically prohibited.

3. Self-insureds are not required to participate in the Assigned Claims or Assigned Risk Plans.

4. The cost containment provisions of § 1797(a) apply to self-insureds, *Houston v. SEPTA*, 19 A.3d 6 (Pa. Cmwlth 2011).

C. Penalties for Failure to Maintain Financial Responsibility.

1. Suspension of motor vehicle registration, § 1786(d).

2. Revocation of driver's license, § 1786(d).

NOTE: A driver may defend against suspension proceedings by demonstrating that coverage was improperly cancelled, *Eckenrode v. Cmwlth. of Pa*., 853 A.2d 1141 (Pa. Cmwlth. 2004).

NOTE: These penalties do not apply to a judgment against a parent based only on the Parental Liability Act, *Franklin v. Pa. Department of Transportation*, 39 A.3d 453 (Pa. Cmwlth. 2012).

3. $300 fine, § 1786(f).

D. Mandatory Offer of Liability and UM/UIM Coverages (§ 1792)

1. Carriers must make available for purchase liability and UM/UIM coverages of up to $100,000/$300,000 or, in the alternative, a $300,000 single limit. A property damage coverage of $5,000 must be offered.

NOTE: Policy provisions which seek to reduce available coverage to minimum limits where the victim is a family member are void as against public policy and as violative of § 1792. The so called "intrafamily reduction" is not enforceable and any higher policy limits will apply to family members as well as strangers to the policy, *Lambert v. McClure*, 595 A.2d 629 (Pa. Super. 1991). A similar exclusion or reduction in homeowner's policies, however, is permissible since no statute mandates the offer of higher coverages *Neil v. Allstate*, 549 A.2d 1304 (Pa. Super. 1988).

NOTE: An auto dealership which sells and delivers an auto to an unlicensed driver without confirming the existence of coverage or a valid driver's license is liable under 75 P.S. § 1574 for damages caused by the unlicensed/uninsured driver/owner, *Pizzonia v. Colonial Motors*, 639 A.2d 1185 (Pa. Super. 1994). Where an auto is leased to a corporation, however, the lessor is not required to identify possible driver employees of

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lessee to confirm valid licenses, *Burkholder v. Genway Corp*., 637 A.2d 650 (Pa. Super. 1994).

NOTE: Where the WHO IS AN INSURED clause extends coverage to permissive users only when "required by law," coverage is extended since §1786(f) prohibits an owner from operating or permitting operation of a motor vehicle without financial responsibility. *Progressive Ins. Co. v. Universal Underwriters,* 898 A.2d 1116 (Pa. Super. 2006).

2. Private passenger automobile policies will automatically have a $500 collision deductible absent a written request by the named insured for a lower deductible. The minimum allowable deductible is $100.

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VI. TORT OPTIONS

A. Notice of Options

1. For all policies issued or renewed on or after 7/1/90, carriers must advise each named insured of the two tort options available under the MVFRL, § 1705(a)(1).

NOTE: Failure by a carrier to give premium differential between limited tort and full tort options neither voids otherwise valid limited tort elections (*Donnelly v. Bauer*, 720 A.2d 447 (Pa. 1998)), nor gives rise to Consumer Protection Law, Unfair Insurance Practices Act, or bad faith claims (*Booze v. Allstate Ins. Co*., 750 A.2d 877 (Pa. Super. 2000)).

2. Any named insured may make the tort election. Such election will bind all other named insureds and insureds, § 1705(a)(2).

NOTE: When any named insured makes the tort election in writing, all named insureds and all insureds are barred from claiming liability based on being inadequately informed. Compare:

(a) UM/UIM coverage waiver where only the named insured signing the form is so barred;

(b) UM/UIM stacking waiver where no statutory bar is imposed.

NOTE: "Insureds" bound by this election are as defined in the MVFRL (e.g., relatives resident in the household, etc.), not as defined in the policy (e.g., any permissive users). *McWeeney v. Estate of Strickler*, 61 A.3d 1023 (Pa. Super. 2013).

3. If no named insured responds after the two required notices of the available tort elections, there will be a presumption that the "full tort" alternative was elected. That election will apply to all named insureds and insureds under the policy, § 1705(a)(3).

B. Application of Options

1. An owner of a currently registered private passenger motor vehicle who does not have financial responsibility is deemed to have selected the "limited tort" option, § 1705(a)(5).

NOTE: If the owner of the currently registered UM vehicle qualifies for full tort status as an "insured" under a policy and if the owner is not occupying the UM vehicle at the time of the accident, the owner is full tort, *Berger v. Rinaldi*, 651 A.2d 553 (Pa. Super. 1994).

NOTE: Under *Schwartzberg v. Greco*, 793 A.2d 945 (Pa. Super. 2002), the owner, not the vehicle, must have financial responsibility. Schwartzberg owned the vehicle and, since his license was suspended, had

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it insured by his girlfriend but with himself listed as an excluded driver. Since Schwartzberg had no financial responsibility, he was bound by limited tort.

2. A person who neither owns a currently registered private passenger motor vehicle nor qualifies as an "insured" as defined in the MVFRL has "full tort" rights, § 1705(b)(3).

NOTE: Qualifying as an "insured" under policy language (e.g., as a permissive user) does not impose limited tort status. Only status as an MVFRL defined "insured" (e.g., named insured, spouse, or resident family members) controls, *McWeeney v. Estate of Strickler*, 61 A.3d 1023 (Pa. Super. 2013).

NOTE: While a parent/owner of a currently registered uninsured motor vehicle is deemed to have selected limited tort, the children of the parent/owner have full tort rights, *Holland v. Marcy*, 883 A.2d 449 (Pa. 2005), reversing *Hames v. PHA*, 696 A.2d 880 (Pa. Cmwlth. 1997).

3. Pedestrians are not subject to limited tort regardless of their status as named insureds or insureds on limited tort policies, *L.S. v. Eschbach*, Pa., 874 A.2d 1150 (2005).

4. Once an election of tort option has been made (or is deemed to have been made), the election remains in effect until the carrier receives a properly executed option form changing the election, § 1705(b)(1).

5. If a person qualifies as an insured under two or more policies with conflicting tort option elections, the tort option election on the policy covering the motor vehicle involved in the accident controls. If no vehicle insured under the conflicting policies is involved in the accident, the "full tort" option applies, § 1705(b)(2).

NOTE: If a person is a "named insured" on a limited tort policy but qualifies as an "insured" on the full tort policy covering the vehicle occupied in the accident, full tort applies, *Hoffman v. Troncelliti*, 839 A.2d 1013 (Pa. 2003). If the person owns a registered, uninsured auto (and is thus "deemed" limited tort), but is occupying his insured full tort auto at the time of the accident, full tort applies, *Progressive Halcyon Ins. Co. v. Kennedy*, 908 A.2d 911 (Pa. Super. 2006).

C. Full Tort Option

Plaintiff can seek recovery for all unreimbursed economic and non-economic loss arising out of an automobile accident, § 1705(c).

NOTE: If an accident occurs in NJ and claimant's MVFRL carrier does business in NJ, then the NJ "verbal threshold" (similar to the MVFRL "limited tort" option) applies, regardless of any full tort selection on the MVFRL policy, *Dyszel v. Marks*, 6 F.3d 116 (3d Cir., 1993).

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D. Limited Tort Option

1. Unless plaintiff falls within one or more of seven exceptions, plaintiff can seek recovery only for unreimbursed economic loss arising out of an automobile accident, (§ 1705(d)).

> NOTE: The court should not instruct the jury that plaintiff selected limited tort for a lower premium but should state only that plaintiff must prove a "serious injury," *Price v. Guy*, 735 A.2 668 (Pa. 1999).
>
> NOTE: The exceptions to limited tort status in (a) through (d) below are available only on claims against third parties, not on UM/UIM claims, *Rump v. Aetna*, 710 A.2d 1093 (Pa. 1998).

2. Exceptions:

(a) If the tortfeasor is a convicted or ARD drunk driver, § 1705(d)(l)(i).

(b) If the tortfeasor is operating a motor vehicle registered out of state, § 1705(d)(l)(ii).

(c) If the tortfeasor intended to injure himself or another, § 1705(d)(1)(iii).

(d) If the tortfeasor is uninsured (except for any resulting UM claim), § 1705(d)(1)(iv).

(e) If recovery is sought against a person in the business of designing, manufacturing, repairing, servicing, or maintaining vehicles for acts or omissions arising out of such a business, § 1705(d)(2).

(f) If plaintiff is an occupant of a motor vehicle other than a private passenger motor vehicle, § 1705(d)(3).

(g) If plaintiff suffers a personal injury resulting in death, serious impairment of a body function, or permanent serious disfigurement, § 1705(d).

> NOTE: Under *Washington v. Baxter*, 719 A.2d 733 (Pa. 1998), whether a "serious injury" exists should be determined in all but the clearest cases by a jury which should evaluate two issues:
>
> 1. What body function, if any, was impaired; and
> 2. Was the impairment of the body function serious?
>
> The focus is not on injuries but rather on how injuries affect body functions, a topic generally requiring medical evidence. In determining whether any impairment is serious, the fact finder should consider the extent of the impairment, the length of time the impairment lasted, the

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treatment required to correct the impairment, and "any other relevant factors." An impairment need not be permanent to be serious. In accord, *Long v. Mejia*, 896 A.2d 596 (Pa. Super. 2006), *Brown v. Trinidad,* 111 A.3d 765 (Pa. Super. 2015)(where claimant could no longer ice skate, bowl, run, jump, play basketball, or play with his daughter as before).

NOTE: Summary judgment for defendants is still possible and, in fact, was affirmed in *Washington*. In accord, *McGee v. Muldowney*, 750 A.2d 912 (Pa. Super. 2000) (no treatment in five years prior to the motion for summary judgment, no absence from employment, albeit with a change in professions from plumber to electrician).

NOTE: The jury is not to be told that plaintiff elected limited tort and that, by so doing, paid a lower premium, *Price v. Guy*, 735 A.2d 668 (Pa. 1999).

NOTE: A limited tort plaintiff who proves liability but is awarded no damages is not a "prevailing party" for purposes of assessing costs, *Oliver v. Irvello,* 165 A.3d 981 (Pa. Super. 2017)

NOTE: Soft tissue injuries can constitute "serious injury*," Chanthavong v. Tran*, 682 A.2d 334 (Pa. Super. 1996). With proper proof, mental disorders or psychiatric problems can constitute a "serious injury," *Hames v. PHA*, 696 A.2d 880 (Pa. Cmwlth. 1997).

E. Tort Statute of Limitations

1. The statute of limitations on claims for noneconomic detriment by limited tort claimants does not start to run until the claimant knows or has reason to know that any injuries from the accident constitute a "serious injury," *Walls v. Scheckler*, 700 A.2d 532 (Pa. Super. 1997*), Varner-Mort v. Kapfhammer,* 109 A.3d 244 (Pa. Super., 2015) (follows Walls, but notes "it is just plain wrong.")

2. The statute of limitations on claims for economic detriment by limited tort claimants begins to run on the day of accident even if medical and wage losses initially fall within available insurance coverage. To protect against future economic detriment that may eventually exceed available coverage, plaintiff must file a suit within two years of the accident and support the claim for potential future uninsured losses through expert testimony, *Haines v. Jones*, 830 A.2d 579 (Pa. Super. 2003).

F. New Jersey Tort Issues.

1. Courts have split on whether New Jersey insureds subject to the New Jersey verbal threshold will be subject to either "verbal threshold" or "limited tort" when the accident occurs in Pennsylvania, *Perkins v. Cheung*, 1996 WL 37767 (E.D. Pa. 1996) (limited tort not applicable), *Roghanchi v. Rorick*, 1992 WL 279530 (E.D. Pa. 1992) (limited tort not

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applicable) *Petitte v. Panteli*, CP Carbon County (6/30/99) (limited tort not applicable); *Koch v. Venezia Transportation*, 2001 U.S. Dist. LEXIS 8664 (2001) (limited tort not applicable), *Dalessio v. Nicosie*, Phila. CCP 6/93, No. 1234 (1996) (limited tort applicable).

2. Under the New Jersey "deemer" statute, a Pennsylvania plaintiff insured by a carrier licensed in New Jersey is subject to the New Jersey verbal threshold when the accident occurs in New Jersey, regardless of plaintiff's tort selection under the MVFRL policy, *Dyszel v. Marks*, 6 F.3d 116 (3rd Cir. 1993), *Whitaker v. DeVilla*, NJ, 687 A.2d 738 (1997).

3. New Jersey insureds involved in New Jersey accidents with Pennsylvania insureds will be subject to the verbal threshold, or not, depending on whether the carrier for the Pennsylvania insured is licensed to conduct business in New Jersey, thus subject to the "deemer" statute. In such cases, the New Jersey insured is subject to the tort option on the New Jersey policy. Where the Pennsylvania insured is covered by a carrier not subject to the "deemer" statute, the New Jersey insured is entitled to full tort recovery.

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VII. ACTIONS ON INSURANCE POLICIES (42 P.S. 8371)

A. Statutory Cause of Action

1. In an action arising under an insurance policy, if the court finds that the insurer has acted in bad faith toward the insured, the court may take all the following actions:

(a) Award interest on the amount of the claim from the date the claim was made by the insured in an amount equal to the prime rate of interest plus 3%

(b) Award punitive damages against the insurer.

(c) Assess court costs and attorney fees against the insurer.

B. Effective Date

Effective date of the statute is 7/1/90.

NOTE: If the allegedly wrongful denial of coverage occurs before 7/1/90, then the statute will not apply absent additional acts of bad faith after 7/1/90, *Adamski v. Allstate Insurance Company*, 738 A.2d 1033 (Pa. Super. 1999).

C. Policies Affected

1. Policies issued under and subject to jurisdiction of ERISA are not governed by the Actions on Insurance Policies statute. Any remedies against carriers on such policies must be under the terms of ERISA, *Smith v. Hartford Insurance Group*, 1990 U.S. Dist. LEXIS (M.D. Pa.), *Cannon v. Vanguard*,1998 U.S. Dist. LEXIS 18077 (M.D. Pa.), *Norris v. Continental Casualty Co*., 2000 U.S. Dist. LEXIS 13993 (E.D. Pa.).

2. Policies issued under and subject to the jurisdiction of the HMO Act are not governed by the Actions on Insurance Policies statute, *DiGregorio v. Keystone Health Plan*, 840 A.2d 361 (Pa. Super. 2003).

3. Trial courts split on whether the statute applied to MVFRL first party claims. *In Barnum v. State Farm Ins. Co.*, 635 A.2d 155 (Pa. Super. 1993), the Superior Court ruled that only MVFRL remedies were available on MVFRL benefit claims, but *Barnum* was reversed on other grounds, 652 A.2d 1319 (Pa. 1995).

4. SEPTA is not an insurance carrier and thus not subject to bad faith causes of action under the Actions on Insurance Policies statute. *SEPTA v. Holmes*, 835 A.2d 851 (Pa. Cmwlth. 2003).

D. Statute of Limitations

The statute itself makes no reference to any limitation period. Since the statute creates a tort cause of action with tort-type remedies, the two-year tort statute of limitations applies, *Haugh v. Allstate*, 322 F. 3d 227 (3rd Cir., 2003), *Ash v. Continental*, 932 A. 2d 877 (Pa. 2007).

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E. Procedural Issues

1. A claim for bad faith damages under this statute is not subject to garnishment. Absent an assignment of the bad faith claim by the insured to a tort plaintiff, the tort plaintiff cannot through garnishment seek to recover a verdict in above policy limits or any other type of "bad faith" damages, *Brown v. Candelora*, 708 A.2d 104 (Pa. Super. 1998).

2. Parties to a statutory bad faith suit in state court are not entitled to a trial by jury, *Mishoe v. Erie*, 824 A.2d 1153 (Pa. 2003).

3. The statutory cause of action does not apply to a carrier's failure to timely pay a judgment in a bad faith suit, *Ridgeway v. U.S. Life*, 793 A.2d 972 (Pa. Super. 2002).

4. The statutory cause of action does not apply to alleged unfair or deceptive practices in soliciting the purchase of a policy, *Toy v. Metropolitan Life*, 928 A.2d 186 (Pa. 2007).

> NOTE: In *Haslip v. Pacific Mutual Life Insurance Company*, 499 U.S. 1 (1991), the U.S. Supreme Court, although affirming an award of punitive damages in an Alabama case, noted that the absence of certain procedural safeguards could render a given punitive damage system unconstitutional under the Due Process Clause of the Constitution. Despite *Haslip*, trial level decisions have upheld the constitutionality of the PA statute, *Coyne v. Allstate Insurance Company*, 771 F. Supp. 673 (E.D. Pa. 1991), *W.W. Development Company v. Scottsdale Insurance Company*, 769 F. Supp. 178 (E.D. Pa. 1991).

F. Application of Statute

1. Coupling payment of clearly owed policy benefits with a demand for a release of bad faith claims is itself bad faith, *Hayes v. Harleysville*, 841 A.2d 121 (Pa. Super. 2003).

2. Attorney fee awards may include fees for prosecuting the bad faith claim as well as any fees for litigating underlying claims, *Polselli v. Nationwide*, 126 F.3d 524 (3d Cir. 1997*), Bonenberger v. Nationwide,* Pa. Super., 791 A.2d 378 (Pa. Super. 2002).

3. Insurers are not, prior to an actual settlement, required to pay reserves or offers to UM/UIM claimants as "undisputed amounts." Failure to so pay is not "bad faith," *Williams v. Nationwide,* 750 A.2d 881 (Pa. Super. 2000).

4. Once a settlement has been reached or a judgment has been entered against a carrier, the carrier's fiduciary duty as an insurer is extinguished and the Actions on Insurance Policies statute no longer applies, *Ridgeway v. U.S. Life,* 793 A.2d 972 (Pa. Super. 2002).

5. A carrier may in UM/UIM cases dispute medical causation even if the carrier earlier paid medical first party benefits for the same treatment. Such a denial is not bad faith since different analyses apply for the different coverages, *Pantelis v. Erie Insurance Exchange*, 890 A.2d 1063 (Pa. Super. 2006).

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6. Bad faith exists where "the insurer did not have a reasonable basis for denying benefits under the policy and knew or recklessly disregarded its lack of reasonable basis," *O'Donnell v. Allstate*, 734 A.2d 901 (Pa. Super. 1999).

7. Bad faith is a frivolous or unfounded refusal to pay the proceeds of a policy done with dishonest purpose, motivated by self-interest or ill will, *Terletsky v. Prudential*, 649 A.2d 680 (Pa. Super. 1994).

8. In a third-party context, a carrier may be found guilty of bad faith where it intransigently refuses to settle a claim that could have been settled within policy limits where the insurer lacked a bona fide belief that it had a good possibility of winning at trial, thus causing a large damage award against the insured, *The Birth Center v. St. Paul Ins. Co.*, 787 A.2d 376 (Pa. 2001).

9. A carrier may be found guilty of bad faith where it misrepresented the amount of coverage, arbitrarily refused to accept evidence of causation, secretly placed the insured under surveillance, acted in a dilatory manner, and forced the insured into arbitration by presenting an arbitrary low offer bearing no reasonable relationship to the insured's reasonable medical expenses and where the eventual award proved to be 29 times higher than the offer, *Hollock v. Erie Insurance Exchange*, 842 A.2d 409 (Pa. Super. 2004).

10. Any facts giving rise to a bad faith claim must be proved by clear and convincing evidence, a standard higher than a mere preponderance of evidence, *Terletsky v. Prudential*, 649 A.2d 680 (Pa. Super. 1999). Plaintiff must prove that the insurer did not have a reasonable basis for denying benefits and knew of or recklessly disregarded its lack of a reasonable basis. Proof of an insurer's self-interest or ill will, while probative, is not a prerequisite to recovery of bad faith damages, *Rancosky v. Washington National*, 170 A.3d 364 (Pa. 2017)

11. There is no heightened duty of good faith in first party or UM/UIM cases. A carrier always owes a duty of good faith and fair dealing. UM/UIM cases, however, are inherently adversarial and a carrier may legitimately protect its interests through discovery and litigation, *Condio v. Erie Insurance Exchange*, 899 A.2d 1136 (Pa. Super. 2005), *Zappile v. AMEX*, 928 A.2d 251 (Pa. Super. 2007).

12. An insured may not collect as compensatory damages in a bad faith suit the punitive damages awarded in the underlying tort litigation, nor is the insurer under any duty to consider its insured's potential exposure to punitive damages when negotiating settlement of the underlying litigation, *Wolfe v. Allstate*, 790 F.3d 487 (3rd Cir. 2015).

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VIII. RELATED STATUTORY PROVISIONS

A. Motor Vehicle Insurance Fraud (Criminal Provision at 18 P.S. 4117)

1. Effective 4/8/90.

2. Criminal offense to submit a claim, or to aid in or solicit a claim, supported by a statement containing false, incomplete, or misleading information if:

(a) The statement is material to the claim, and

(b) The statement is intended to defraud.

3. Criminal offense for a lawyer to compensate non-lawyers for referral of a client. Advertising specifically excepted.

4. Carriers are immune from liability for supplying information to Federal or state authorities where the carrier has reason to believe that the information relates to insurance fraud under the statute.

5. Carriers have a civil remedy against a criminal defendant for conduct constituting a crime but only if the court finds that the "Defendant has engaged in a pattern of violating" the statute.

6. State RICO law (18 P.S. 911(h)) amended to include insurance fraud under the definition of "racketeering activity."

B. Motor Vehicle Insurance Fraud (Civil Provisions at 75 P.S. 1801 et seq.)

1. Effective 2/7/90.

2. Carriers required to establish anti-fraud plans on or before 12/31/90.

3. Carriers required to report suspected fraud to Federal, state or local authorities and to Index Bureau.

4. Civil penalty of up to $10,000 for failure to establish or follow anti-fraud plan.

5. Carriers immune from civil liability for making required reports of suspected fraud.

6. Pa. Insurance Department to create Motor Vehicle Insurance Fraud Index Bureau to receive and store information on suspected fraud.

NOTE: § 1822 is unconstitutional since it requires report of attorneys to the Fraud Index Bureau without notice to the attorney and without any requirement that the attorney actually be suspected of fraudulent conduct, *Pennsylvania Bar Association v. Commonwealth of Pennsylvania*, 607 A.2d 850 (Pa. Cmwlth. 1992),

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C. Driving Under the Influence for Commercial Vehicles (75 P.S. 3731.1)

1. Blood alcohol content necessary for conviction reduced from .10 to .04 effective 4/1/92

2. Applies to operators of commercial vehicles where the vehicle

(a) has a gross weight rating greater than 26001 lbs.

(b) is designed for 16 or more occupants, or

(c) carries certain hazardous materials.

D. Certification of Pleadings and Motions

1. Effective 7/1/02, P.R.C.P. 1023.1 adopts the substantial equivalent of F.R.C.P. 11.

2. All pleadings must be signed by an attorney of record.

3. By signing, the attorney certifies:

(a) That he has read the pleading;

(b) That he has a good faith belief that the pleading is well grounded in fact and under existing law (or under a reasonable attempt to create or change existing law);

(c) That the pleading is not filed for any improper purpose (e.g., to delay, to harass, to increase cost of litigation, etc.);

(d) That the factual allegations have or, after discovery, are likely to have evidentiary support; and

(e) That denials of factual allegations are based on evidence or on the lack of information or belief.

4. A motion for sanctions may be filed if, at least 28 days after demand, the offending allegation or denial has not been withdrawn or corrected.

5. Sanctions can include striking pleadings, fines payable into court, and attorney fee awards to the moving party.

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APPENDIX A

Motor Vehicle Financial Responsibility Law

CHAPTER 17
FINANCIAL RESPONSIBILITY

Subchapter
A. General Provisions
B. Motor Vehicle Liability Insurance First Party Benefits
C. Uninsured and Underinsured Motorist Coverage
D. Assigned Risk Plan
E. Assigned Claims Plan
F. Catastrophic Loss Trust Fund (Repealed 12/12/88)
G. Nonpayment of Judgments
H. Proof of Financial Responsibility
I. Miscellaneous Provisions

SUBCHAPTER A
GENERAL PROVISIONS

Sec.
1701. Short title of chapter.
1702. Definitions.
1703. Application of chapter.
1704. Administration of chapter.
1705. Election of tort options.

Sec. 1701. Short title of chapter.

This chapter shall be known and may be cited as the Motor Vehicle Financial Responsibility Law.

Sec. 1702. Definitions.

The following words and phrases when used in this chapter shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Assigned Risk Plan." A program for the equitable apportionment of assigned risks and clean risks among insurers.

"Automobile Insurance Policy Act." The act of June 5, 1968 (P.L. 140, No. 78), entitled "An act regulating the writing, cancellation of or refusal to renew policies of automobile insurance; and imposing powers and duties on the Insurance Commissioner therefor."

"Benefits" or "first party benefits." Medical benefits, income loss benefits, accidental death benefits and funeral benefits.

"Clean risk." An insured or an applicant for insurance, who for the 36-month period immediately preceding the date of application or renewal date of the policy:

(1) has not been involved in an accident as a driver, provided, that for purposes of this paragraph, an "accident" shall not include accidents described in section 3 of the Automobile Insurance Policy Act or section 1799.3 (relating to limit on cancellations, refusals to renew, refusals to write, surcharges, rate penalties and point assignments);

(2) has not received more than three points for violations as set forth in Chapter 15 (relating to licensing of drivers); and

(3) whose operator's license has not been suspended or revoked except under section 1533 (relating to suspension of operating privilege for failure to respond to citation) and the insured is able to produce proof that he or she has responded to all citations and paid all fines and penalties imposed under that section and provided further that the named insured has been a licensed operator in Pennsylvania or another state for the immediately preceding three years.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Department." The Department of Transportation or Insurance Department, as applicable.

"Financial Responsibility." The ability to respond in damages for liability on account of accidents arising out of the maintenance or use of a motor vehicle in the amount of $15,000.00 because of injury to one person in any one accident, in the amount of $30,000.00 because of injury to two or more persons in any one accident and in the amount of $5,000.00 because of damage to property of others in any one accident. The financial responsibility shall be in a form acceptable to the Department of Transportation.

"Injury." Accidentally sustained bodily harm to an individual and that individual's illness, disease or death resulting therefrom.

"Insured." Any of the following:

(1) An individual identified by name as an insured in a policy of motor vehicle liability insurance.

(2) If residing in the household of the named insured:

(i) a spouse or other relative of the named insured; or

(ii) a minor in the custody of either the named insured or a relative of the named insured.

"Insurer" or **"insurance company."** A motor vehicle liability insurer subject to the requirements of this chapter.

"Necessary medical treatment and rehabilitative services." Treatment, accommodations, products or services which are determined to be necessary by a licensed health care provider unless they shall have been found or determined to be unnecessary by a State-approved Peer Review Organization (PRO).

"Noneconomic loss." Pain and suffering and other nonmonetary detriment.

"Peer Review Organization" or **"PRO."** Any Peer Review Organization with which the Federal Health Care Financing Administration or the Commonwealth contracts for medical review of Medicare or medical assistance services, or any health care review company, approved by the commissioner, that engages in peer review for the purposes of determining that medical and rehabilitation services are medically necessary and economically provided. The membership of any PRO utilized in connection with this chapter shall include representation from the profession whose services are subject to the review.

"Private passenger motor vehicle." A four-wheel motor vehicle, except recreational vehicles not intended for highway use, which is insured by a natural person and:

(1) is a passenger car neither used as a public or livery conveyance nor rented to others; or

(2) has a gross weight not exceeding 9,000 pounds and is not principally used for commercial purposes other than farming.

The term does not include any motor vehicle insured exclusively under a policy covering garage, automobile sales agency repair shop, service station or public parking operation hazards.

"Self-insurer." An entity providing benefits and qualified in the manner set forth in section 1787 (relating to self-insurance).

"Serious injury." A personal injury resulting in death, serious impairment of body function or permanent serious disfigurement.

"Underinsured motor vehicle." A motor vehicle for which the limits of available liability insurance and self-insurance are insufficient to pay losses and damages.

"Uninsured motor vehicle." Any of the following:

(1) A motor vehicle for which there is no liability insurance or self-insurance applicable at the time of the accident.

(2) A motor vehicle for which the insurance company denies coverage or the insurance company is or becomes involved in insolvency proceedings in any jurisdiction.

(3) An unidentified motor vehicle that causes an accident resulting in injury provided the accident is reported to the police or proper governmental authority and the claimant notifies his insurer within 30 days, or as soon as practicable thereafter, that the claimant or his legal representative has a legal action arising out of the accident.

"Voluntary rate." An insurer's rating plan approved by the commissioner. In the case of an insurer with multiple rating plans, the voluntary rate shall be that rating plan applicable to the risk.

Sec. 1703. Application of chapter.

This chapter does not apply with respect to any motor vehicle owned by the United States.

Sec. 1704. Administration of chapter.

(a) General rule. -- Except as provided in subsection (b), the Department of Transportation shall administer and enforce this chapter and may make rules and regulations necessary for the administration and enforcement of this chapter.

(b) Insurance matters. --The Insurance Department shall administer and enforce those provisions of this Chapter as to matters under its jurisdiction as determined by this chapter or other statute and may make rules and regulations necessary for the administration and enforcement of those provisions.

Sec. 1705. Election of tort options.

(a) Financial responsibility requirements.

(1) Each insurer, not less than 45 days prior to the first renewal of a private passenger motor vehicle liability insurance policy on and after July 1, 1990, shall notify, in writing, each named insured of the availability of two alternatives of full tort insurance and limited tort insurance described in subsections (c) and (d). The notice shall be a standardized form adopted by the commissioner and shall include the following language:

NOTICE TO NAMED INSUREDS

A. "Limited Tort" Option--The laws of the Commonwealth of Pennsylvania give you the right to choose a form of insurance that limits your right and the rights of members of your household to seek financial compensation for injuries caused by other drivers. Under this form of insurance, you and other household members covered under this policy may seek recovery for all medical and other out-of-pocket expenses, but not for pain and suffering or other nonmonetary damages unless the injuries suffered fall within the definition of "serious injury" as set forth in the policy, or unless one of several other exceptions noted in the policy applies. The annual premium for basic coverage as required by law under this "limited tort" option is $.
Additional coverages under this option are available at additional cost.

B. "Full Tort" Option--The laws of the Commonwealth of Pennsylvania also give you the right to choose a form of insurance under which you maintain an unrestricted right for you and the members of your household to seek financial compensation for injuries caused by other drivers. Under this form of insurance, you and other household members covered under this policy may seek recovery for all medical and other out-of-pocket expenses and may also seek financial compensation for pain and suffering and other nonmonetary damages as a result of injuries caused by other drivers. The annual premium for basic coverage as required by law under this "full tort" option is $.
Additional coverages under this option are available at additional cost.

C. You may contact your insurance agent, broker or company to discuss the cost of other coverages.

D. If you wish to choose the **"limited tort"** option described in paragraph A, you must sign this notice where indicated below and return it. If you do not sign and return this notice, you will be considered to have chosen the **"full tort"** coverage as described in paragraph B and you will be charged the **"full tort"** premium.

I wish to choose the **"limited tort"** option described in Paragraph A:

_____ _____
Named Insured Date

E. If you wish to choose the **"full tort"** option described in paragraph B, you may sign this notice where indicated below and return it. However, if you do not sign and return this notice, you will be considered to have chosen the **"full tort"** coverage as described in paragraph B and you will be charged the **"full tort"** premium.

I wish to choose the **"full tort"** option described in paragraph B:

_____ _____
Named Insured Date

(2) Insurers shall print the above notice containing both options on one sheet in prominent type and place in a prominent location. Any person signing, or otherwise bound by, a document containing such terms is bound by such election and is precluded from claiming liability of any person based upon being inadequately informed in making the election between full tort or limited tort alternatives. Where there are two or more named insureds on a policy, any named insured may make the full or limited tort election provided for in this section for all named insureds on the policy.

(3) If a named insured who receives a notice under paragraph (l) does not indicate a choice within 20 days, the insurer shall send a second notice. The second notice shall be in a form identical to the first notice, except that it shall be identified as a second and final notice. If a named insured has not responded to either notice, ten days prior to the renewal date, the named insured and those he is empowered by this section to bind by his choice are conclusively presumed to have chosen the full tort alternative. All notices required by this section shall advise that if no tort election is made, the named insured and those he is empowered to bind by his choice are conclusively presumed to have chosen the full tort alternative. Any person subject to the limited tort option

by virtue of this section shall be precluded from claiming liability of any person based upon being inadequately informed.

(4) Each insurer, prior to the first issuance of a private passenger motor vehicle liability insurance policy on and after July 1, 1990, shall provide each applicant with the notice required by paragraph (1). A policy may not be issued until the applicant has been provided an opportunity to elect a tort option.

(5) An owner of a currently registered private passenger motor vehicle who does not have financial responsibility shall be deemed to have chosen the limited tort alternative.

(6) Nothing in this section changes or modifies the existing requirement that owners of registered vehicles maintain bodily injury and property damage liability insurance arising out of the ownership, maintenance or use of a motor vehicle.

(b) Application of tort options.--

(1) The tort option elected by a named insured shall apply to all private passenger motor vehicle policies of the named insured issued by the same insurer and shall continue in force as to all subsequent renewal policies, replacement policies and any other private passenger motor vehicle policies under which the individual is a named insured, until the insurer, or its authorized representative, receives a properly executed form electing the other tort option.

(2) The tort option elected by a named insured shall apply to all insureds under the private passenger motor vehicle policy who are not named insureds under another private passenger motor vehicle policy. In the case where more than one private passenger motor vehicle policy is applicable to an insured, and the policies have conflicting tort options, the insured is bound by the tort option of the policy associated with the private passenger motor vehicle in which the insured is an occupant at the time of the accident if he is an insured on that policy, and bound by the full tort option otherwise.

(3) An individual who is not an owner of a currently registered private passenger motor vehicle and who is not a named insured or insured under any private passenger motor vehicle policy, shall not be precluded from maintaining an action for noneconomic loss or economic loss sustained in a motor vehicle accident as the consequence of

the fault of another person pursuant to applicable tort law.

(c) **Full tort alternative.**--Each person who is bound by the full tort election remains eligible to seek compensation for noneconomic loss claimed and economic loss sustained in a motor vehicle accident as the consequence of the fault of another person pursuant to applicable tort law.

(d) **Limited tort alternative.**--Each person who elects the limited tort alternative remains eligible to seek compensation for economic loss sustained in a motor vehicle accident as the consequence of the fault of another person pursuant to applicable tort law. Unless the injury sustained is a serious injury, each person who is bound by the limited tort election shall be precluded from maintaining an action for any noneconomic loss, except that:

(1) An individual otherwise bound by the limited tort election who sustains damages in a motor vehicle accident as the consequence of the fault of another person may recover damages as if the individual damaged had elected the full tort alternative whenever the person at fault:

(i) is convicted, or accepts Accelerated Rehabilitative Disposition (ARD) for driving under the influence of alcohol or a controlled substance in that accident;

(ii) is operating a motor vehicle registered in another state;

(iii) intends to injure himself or another person, provided that an individual does not intentionally injure himself or another person merely because his act or failure to act is intentional or done with his realization that it creates a grave risk of causing injury if the act or omission causing the injury is for the purpose of averting bodily harm to himself or another person; or

(iv) has not maintained financial responsibility as required by this chapter, provided that, nothing in this paragraph shall affect the limitation of section 1731(d)(2) (relating to availability, scope and amount of coverage).

(2) An individual otherwise bound by the limited tort election shall retain full tort rights with respect to claims against a person in the business of designing, manufacturing, repairing, servicing or otherwise maintaining motor vehicles arising out of a defect in such motor vehicle

which is caused by or not corrected by an act or omission in the course of such business, other than a defect in a motor vehicle which is operated by such business.

(3) An individual otherwise bound by the limited tort election shall retain full tort rights if injured while an occupant of a motor vehicle other than a private passenger motor vehicle.

(e) **Nondiscrimination.**--No insurer shall cancel, refuse to write, or refuse to renew a motor vehicle insurance policy based on the tort option election of the named insured. Any violation of this subsection shall be deemed a violation of the Automobile Insurance Policy Act.

(f) **Definitions.**--As used in this section, the following words and phrases when used in this section shall have the meanings given to them in this subsection unless the context clearly indicates otherwise:

"Insured." Any individual residing in the household of the named insured who is:

(1) a spouse or other relative of the named insured;or

(2) a minor in the custody of either the named insured or relative of the named insured.

"Named insured." Any individual identified by name as an insured in a policy of private passenger motor vehicle insurance.

SUBCHAPTER B
MOTOR VEHICLE LIABILITY INSURANCE
FIRST PARTY BENEFITS

Sec.
1711. Required benefits
1712. Availability of benefits.
1713. Source of benefits
1714. Ineligible claimants.
1715. Availability of adequate limits.
1716. Payment of benefits.
1717. Stacking of benefits.
1718. Exclusion from benefits.
1719. Coordination of benefits.
1720. Subrogation.
1721. Statute of limitations.
1722. Preclusion of recovering required benefits.
1723. Reporting requirements.
1724. Certain nonexcludable conditions.

Sec. 1711. Required benefits.

(a) **Medical benefit.** - An insurer issuing or delivering liability insurance policies covering any motor vehicle of the type required to be registered under this title, except recreational vehicles not intended for highway use, motorcycles, motor-driven cycles or motorized pedalcycles or like type vehicles, registered and operated in this Commonwealth, shall include coverage providing a medical benefit in the amount of $5,000.

(b) **Minimum policy.** - All insurers subject to this chapter shall make available for purchase a motor vehicle insurance policy which contains only the minimum requirements of financial responsibility and medical benefits as provided for in this chapter.

Sec. 1712. Availability of benefits.

An insurer issuing or delivering liability insurance policies covering any motor vehicle of the type required to be registered under this title, except recreational vehicles not intended for highway use, motorcycles, motor-driven cycles or motorized pedalcycles or like type vehicles, registered and operated in this Commonwealth, shall make available for purchase first party benefits with respect to injury arising out of the maintenance or use of a motor vehicle as follows:

(1) **Medical benefit.--** Subject to the limitations of section 1797 (relating to customary charges for treatment), coverage to provide for reasonable and necessary medical treatment and rehabilitative services, including but not limited to, hospital, dental, surgical, psychiatric, psychological, osteopathic, ambulance, chiropractic, licensed physical therapy, nursing services, vocational rehabilitation and occupational therapy, speech pathology and audiology, optometric services, medications, medical supplies and prosthetic devices, all without limitation as to time, provided that, within 18 months from the date of the accident causing injury, it is ascertainable with reasonable medical probability that further expenses may be incurred as a result of the injury. Benefits under this paragraph may include any nonmedical remedial care and treatment rendered in accordance with a recognized religious method of healing.

(2) Income loss benefit.--Includes the following:

(i) Eighty percent of actual loss of gross income.

(ii) Reasonable expenses actually incurred for hiring a substitute to perform self-employment

services thereby mitigating loss of gross income or for hiring special help thereby enabling a person to work and mitigate loss of gross income. Income loss does not include loss of expected income for any period following the death of an individual or expenses incurred for services performed following the death of an individual. Income loss shall not commence until five working days have been lost after the date of the accident.

(3) **Accidental death benefit.**--A death benefit paid to the personal representative of the insured, should injury resulting from a motor vehicle accident cause death within 24 months from the date of the accident.

(4) **Funeral benefit.**--Expenses directly related to the funeral, burial, cremation or other form of disposition of the remains of a deceased individual, incurred as a result of the death of the individual as a result of the accident and within 24 months from the date of the accident.

(5) **Combination benefit.**--A combination of benefits described in paragraphs (1) through (4) as an alternative to the separate purchase of those benefits.

(6) **Extraordinary medical benefits.**--Medical benefits, as defined in paragraph (1), which exceed $100,000.

Sec. 1713. Source of benefits.

(a) **General rule.** Except as provided in Section 1714 (relating to ineligible claimants), a person who suffers injury arising out of the maintenance or use of a motor vehicle shall recover first party benefits against applicable insurance coverage in the following order or priority:

(1) For a named insured, the policy on which he is the named insured.

(2) For an insured, the policy covering the insured.

(3) For the occupants of an insured motor vehicle, the policy on that motor vehicle.

(4) For a person who is not the occupant of a motor vehicle, the policy on any motor vehicle involved in the accident. For the purpose of this paragraph, a parked and unoccupied motor vehicle is not a motor vehicle involved in an accident unless it was parked so as to cause unreasonable risk of injury.

(b) **Multiple sources of equal priority.** The insurer against whom a claim is asserted first under the priorities set forth in subsection (a) shall process and pay the claim as if wholly responsible. The insurer is thereafter entitled to recover contribution pro rata from any other insurer for the benefits paid and the costs of processing the claim. If contribution is sought among insurers responsible under subsection (a)(4), proration shall be based on the number of involved motor vehicles.

Sec. 1714. Ineligible claimants.

An owner of a currently registered motor vehicle who does not have financial responsibility or an operator or occupant of a recreational vehicle not intended for highway use, motorcycle, motor-driven cycle, motorized pedalcycle or like type vehicle required to be registered under this title cannot recover first party benefits.

Sec. 1715. Availability of adequate limits.

(a) General rule.-- An insurer shall make available for purchase first party benefits as follows:

(1) For medical benefits, up to at least $100,000.

(1.1) For extraordinary medical benefits, from $100,000 to $1,100,000., which may be offered in increments of $100,000, as limited by subsection (d).

(2) For income loss benefits, up to at least $2,500 per month up to a maximum benefit of at least $50,000.

(3) For accidental death benefits, up to at least $25,000.

(4) For funeral benefits, $2,500.

(5) For combination of benefits enumerated in paragraphs (1), (2),(3) and (4) and subject to a limit on the accidental death benefit of up to $25,000 and a limit on the funeral benefit of $2,500, up to at least $177,500 of benefits in the aggregate or benefits payable up to three years from the date of the accident, whichever occurs first, provided that nothing contained in this subsection shall be construed to limit, reduce, modify or change the provisions of subsection (d).

(b) **Higher or lower limits and additional benefits.**--Insurers may make available higher or lower limits or benefits in addition to those enumerated in subsection (a).

(c) **Restriction on providing first party benefits.**--An insurer shall not issue or deliver a policy providing first party benefits in accordance with this subchapter unless the policy also contains coverage for liability in amounts at least equal to the limits required for financial responsibility.

(d) **Limitations.** The maximum medical benefit which shall be paid on behalf of any one eligible claimant under subsection (a)(1.1.) shall be $50,000 per year and $1,000,000 lifetime aggregate of reasonable and necessary expenses only for medical treatment and rehabilitative services which, as described in section 1712(1) (relating to availability of benefits), exceed $100,000. During the first 18 months of eligibility, the insurer shall approve payments on behalf of a claimant without regard to the $50,000 per year limit but subject to the $1,000,000 lifetime aggregate.

(e) **Other extraordinary medical benefits.**--Notwithstanding the requirement of subsection (a)(1.1), an insured may obtain the extraordinary medical benefits described in that subsection through any insurance contract, program or group arrangement.

(f) **Determining adverse experience of an agent.**--For purposes of determining adverse experience of an agent, experience generated from extraordinary medical benefit coverage described in subsection (a)(1.1) shall be excluded.

(g) **Voluntary pooling.**--Notwithstanding any other provisions of this act or the act of June 11, 1947 (L.538, No. 246), known as The Casualty and Surety Rate Regulatory Act, two or more insurers may enter into an arrangement or agreement to provide for the availability of an extraordinary medical benefit pursuant to the provisions of this chapter. All such arrangements or agreements entered into by an insurer shall be subject to the prior approval of the Insurance Commissioner. (As amended by Section 3 of Act of February 12, 1984, P.L. 53, No. 12, effective October 1, 1984; amended by Section 4 of Act of April 26, 1989, P.L. 13, No. 4, effective June 1, 1989.)

Sec. 1716. Payment of benefits.

Benefits are overdue if not paid within 30 days after the insurer receives reasonable proof of the amount of the benefits. If reasonable proof is not supplied as to all benefits, the portion supported by reasonable proof is overdue if not paid within 30 days after the proof is received by the insurer. Overdue benefits shall bear interest at the rate of 12% per annum from the date the

benefits become due. In the event that the insurer is found to have acted in an unreasonable manner in refusing to pay the benefits when due, the insurer shall pay, in addition to the benefits owed and the interest thereon, a reasonable attorney fee based upon actual time expended.

Sec. 1717. Stacking of benefits.

First party benefits shall not be increased by stacking the limits of coverage of:

(1) multiple motor vehicles covered under the same policy of insurance; or

(2) multiple motor vehicle policies covering the individual for the same loss.

Sec. 1718. Exclusion from benefits.

(a) **General rule.**--An insurer shall exclude from benefits any insured, or his personal representative, under a policy enumerated in section 1711 (relating to required benefits) or 1712 (relating to availability of benefits), when the conduct of the insured contributed to the injury sustained by the insured in any of the following ways:

(1) While intentionally injuring himself or another or attempting to intentionally injure himself or another.

(2) While committing a felony.

(3) While seeking to elude lawful apprehension or arrest by a law enforcement official.

(b) **Conversion of a vehicle.**--A person who knowingly converts a motor vehicle is ineligible to receive first party benefits from any source other than a policy of insurance under which he is an insured for any injury arising out of the maintenance or use of the converted vehicle.

(c) **Named driver exclusion.**--An insurer or the first named insured may exclude any person or his personal representative from benefits under a policy enumerated in section 1711 or 1712 when any of the following apply:

(1) The person is excluded from coverage while operating a motor vehicle in accordance with the act of June

5, 1968 (P.L. 140, No.78), relating to the writing, cancellation of or refusal to renew policies of automobile insurance.

(2) The first named insured has requested that the person be excluded from coverage while operating a motor vehicle. This paragraph shall only apply if the excluded person is insured on another policy of motor vehicle liability insurance.

Sec. 1719. Coordination of benefits.

(a) **General rule.**--Except for workers' compensation, a policy of insurance issued or delivered pursuant to this subchapter shall be primary. Any program, group contract or other arrangement for payment of benefits such as described in section 1711 (relating to required benefits), 1712(1) and (2) (relating to availability of benefits), or 1715 (relating to availability of adequate limits), shall be construed to contain a provision that all benefits provided therein shall be in excess of and not in duplication of any valid and collectible first party benefits provided in section 1711, 1712, or 1715 or workers' compensation.

(b) **Definition.**--As used in this section, the term "Program, group contract, or other arrangement" includes, but is not limited to, benefits payable by a hospital plan corporation or a professional health service corporation subject to 40 Pa. C.S. Chapter 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

Sec. 1720. Subrogation.

In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits, benefits available under section 1711 (relating to required benefits), 1712 (relating to availability of benefits) or 1715 (relating to availability of adequate limits) or benefits paid or payable by a program, group contract or other arrangement whether primary or excess under section 1719 (relating to coordination of benefits).

EFFECTIVE 8/31/93, REFERENCE TO WORKERS' COMPENSATION BENEFITS IS DELETED.

Sec. 1721. Statute of limitations.

(a) **General rule.**--If benefits have not been paid, an action for first party benefits shall be commenced within four years from the date of the accident giving rise to the claim. If first party benefits have been paid, an action for further benefits shall be commenced within four years from the date of the last payment.

(b) **Minors.**--For minors entitled to benefits described in section 1711 (relating to required benefits) or 1712 (relating to availability of benefits), an action for benefits shall be commenced within four years from the date on which the injured minor attains 18 years of age.

(c) **Definition.**--As used in this section, the term "further benefits" means expenses incurred not earlier than four years preceding the date an action is commenced.

Sec. 1722. Preclusion of recovering required benefits.

In any action for damages against a tortfeasor, or in any uninsured or underinsured motorist proceeding, arising out of the maintenance or use of a motor vehicle, a person who is eligible to receive benefits under the coverages set forth in this subchapter, or workers' compensation, or any program, group contract or other arrangement for payment of benefits as defined in section 1719 (relating to coordination of benefits) shall be precluded from recovering the amount of benefits paid or payable under this subchapter, or workers' compensation or any program, group contract or other arrangement for payment of benefits as defined in section 1719.

EFFECTIVE 8/31/93, REFERENCE TO WORKERS' COMPENSATION IS DELETED.

Sec. 1723. Reporting requirements.

Beginning December 31, 1986, and each year thereafter, each insurance company writing automobile insurance in this Commonwealth shall file with the Insurance Department the number of its insureds, the number of its insureds who have purchased first party medical benefits in excess of the minimum required by section 1711 (relating to required benefits) and the number of insureds who have purchased first party medical benefits in the amount of $100,000. The Insurance Department shall furnish this information to the General Assembly annually.

Sec. 1724. Certain nonexcludable conditions.

(a) **General rule.**--Insurance benefits may not be denied solely because the driver of the insured motor vehicle is determined to be under the influence of drugs or intoxicating beverages at the time of the accident for which benefits are sought.

(b) **Contract exclusions.**--Provisions of an insurance policy which exclude insurance benefits if the insured causes a vehicular accident while under the influence of drugs or intoxicating beverages at the time of the accident are void.

SUBCHAPTER C
UNINSURED AND UNDERINSURED MOTORIST COVERAGE

Sec.
1731. Availability, Scope and amount of coverage.
1732. Limits of coverage. (Repealed)
1733. Priority of recovery.
1734. Request for lower limits of coverage.
1735. Coverages unaffected by workers' compensation.
1736. Coverages in excess of required amounts.
1737. Workers' compensation benefits not a bar to uninsured and underinsured motorist benefits.
1738. Stacking of uninsured and underinsured benefits and option to waive.

Sec. 1731. Availability, scope and amount of coverage.

(a) **Mandatory offering.**--No motor vehicle liability insurance policy shall be delivered or issued for delivery in this Commonwealth, with respect to any motor vehicle registered or principally garaged in this Commonwealth, unless uninsured motorist and underinsured motorist coverages are offered therein or supplemental thereto in amounts as provided in section 1734 (relating to request for lower limits of coverage). Purchase of uninsured motorist and underinsured motorist coverages is optional.

(b) **Uninsured motorist coverage.**--Uninsured motorist coverage shall provide protection for persons who suffer injury arising out of the maintenance or use of a motor vehicle and are legally entitled to recover damages therefor from owners or operators of uninsured motor vehicles. The named insured shall be informed that he may reject uninsured motorist coverage by signing the following written rejection form.

REJECTION OF UNINSURED MOTORIST PROTECTION

By signing this waiver I am rejecting uninsured motorist coverage under this policy, for myself and all relatives residing in my household. Uninsured coverage protects me and relatives living in my household for losses and damages suffered if injury is caused by the negligence of a driver who does not have any insurance to pay for losses and damages. I knowingly and voluntarily reject this coverage.

_____
SIGNATURE OF FIRST NAMED INSURED

_____
DATE

(b.1) **Limitation of rejection.**--Uninsured motorist protection may be rejected for the driver and passengers for rental or lease vehicles which are not otherwise common carriers by motor vehicle, but such coverage may only be rejected if the rental or lease agreement is signed by the person renting or leasing the vehicle and contains the following rejection language:

REJECTION OF UNINSURED MOTORIST PROTECTION

> I am rejecting uninsured motorist coverage under this rental or lease agreement, and any policy of insurance or self-insurance issued under this agreement, for myself and all other passengers of this vehicle. Uninsured coverage protects me and other passengers in this vehicle for losses and damages suffered if injury is caused by the negligence of a driver who does not have any insurance to pay for losses and damages.

(b.2) **Rejection language change.**--The rejection language of subsection (b.1) may only be changed grammatically to reflect a difference in tense in the rental agreement or lease agreement.

(b.3) **Vehicle rental services.**--The requirements of subsection (b.1) may be met in connection with an expedited vehicle rental service, which service by agreement of the renter does not require the renter's signature for each rental, if a master enrollment or rental agreement contains the rejection language of subsection (b.1) and such agreement is signed by the renter.

(c) **Underinsured motorist coverage.**--Underinsured motorist coverage shall provide protection for persons who suffer injury arising out of the maintenance or use of a motor vehicle and are legally entitled to recover damages therefor from owners or operators of underinsured motor vehicles. The named insured shall be informed that he may reject underinsured motorist coverage by signing the following written rejection form.

REJECTION OF UNDERINSURED MOTORIST PROTECTION

By signing this waiver I am rejecting underinsured motorist coverage under this policy, for myself and all relatives residing in my household. Underinsured coverage protects me and relatives living in my household for losses and damages suffered if injury is caused by the negligence of a driver who does not have enough insurance to pay for all losses and damages. I knowingly and voluntarily reject this coverage.

_____
SIGNATURE OF FIRST NAMED INSURED

_____
DATE

(c.1) **Form of waiver.**--Insurers shall print the rejection forms required by subsections (b) and (c) on separate sheets in prominent type and location. The forms must be signed by the first named insured and dated to be valid. The signatures on the forms may be witnessed by an insurance agent or broker. Any rejection form that does not specifically comply with this section is void. If the insurer fails to produce a valid rejection form, uninsured or underinsured coverage, or both, as the case may be, under that policy shall be equal to the bodily injury liability limits. On policies in which either uninsured or underinsured coverage has been rejected, the policy renewals must contain notice in prominent type that the policy does not provide protection against damages caused by uninsured or underinsured motorists. Any person who executes a waiver under subsection (b) or (c) shall be precluded from claiming liability of any person based upon inadequate information.

(d) **Limitation on recovery.**--

(1) A person who recovers damages under uninsured motorist coverage or coverages cannot recover damages under underinsured motorist coverage or coverages for the same accident.

(2) A person precluded from maintaining an action for noneconomic damages under section 1705 (relating to election of tort options) may not recover from uninsured motorist coverage or underinsured motorist coverage for noneconomic damages.

Sec. 1732. Limits of coverage (Repealed effective 7/1/90).

Sec. 1733. Priority of recovery.

(a) **General rule.**-- Where multiple policies apply, payment shall be made in the following order or priority:

(1) A policy covering a motor vehicle occupied by the injured person at the time of the accident.

(2) A policy covering a motor vehicle not involved in the accident with respect to which the injured person is an insured.

(b) **Multiple sources of equal priority.**--The insurer against whom a claim is asserted first under the priorities set forth in subsection (a) shall process and pay the claim as if wholly responsible. The insurer is thereafter entitled to recover contribution pro rata from any other insurer for the benefits paid and the costs of processing the claim.

Sec. 1734. Request for lower limits of coverage.

A named insured may request in writing the issuance of coverages under section 1731 (relating to availability, scope and amount of coverage) in amounts equal to or less than the limits of liability for bodily injury.

Sec. 1735. Coverages unaffected by workers' compensation benefits. (Repealed effective 7/2/93)

Sec. 1736. Coverages in excess of required amounts.

The coverages provided under this subchapter may be offered by insurers in amounts higher than those required by this chapter, but may not be greater than the limits of liability specified in the bodily injury liability provisions of the insured's policy.

Sec. 1737. Workers' compensation benefits not a bar to uninsured and underinsured motorist benefits. (Repealed effective 7/2/93)

Sec. 1738. Stacking of uninsured and underinsured benefits and option to waive.

(a) **Limit for each vehicle.**--When more than one vehicle is insured under one or more policies providing uninsured or underinsured motorist coverage, the stated limit for uninsured or underinsured motorist coverage shall apply separately to each vehicle so insured. The limits of coverages available under this subchapter for an insured shall be the sum of the limits for each motor vehicle as to which the injured person is an insured.

(b) **Waiver.**--Notwithstanding the provisions of subsection (a), a named insured may waive coverage providing stacking of uninsured or underinsured coverages in which case the limits of coverage available under the policy for an insured shall be the stated limits for the motor vehicle as to which the injured person is an insured.

(c) **More than one vehicle.**--Each named insured purchasing uninsured or underinsured motorist coverage for more than one vehicle under a policy shall be provided the opportunity to waive the stacked limits of coverage and instead purchase coverage as described in subsection (b). The premiums for an insured who exercises such waiver shall be reduced to reflect the different cost of such coverage.

(d) **Forms.**--

(1) The named insured shall be informed that he may exercise the waiver of the stacked limits of uninsured motorist coverage by signing the following written rejection form:

UNINSURED COVERAGE LIMITS

By signing this waiver, I am rejecting stacked limits of uninsured motorist coverage under the policy for myself and members of my household under which the limits of coverage available would be the sum of limits for each motor vehicle insured under the policy. Instead the limits of coverage that I am purchasing shall be reduced to the limits stated in the policy. I knowingly and voluntarily reject the stacked limits of coverage. I understand that my premiums will be reduced if I reject this coverage.

_____
SIGNATURE OF FIRST NAMED INSURED

_____
DATE

(2) The named insured shall be informed that he may exercise the waiver of the stacked limits of underinsured

motorist coverage by signing the following written rejection form:

UNDERINSURED COVERAGE LIMITS

By signing this waiver, I am rejecting stacked limits of underinsured motorist coverage under the policy for myself and members of my household under which the limits of coverage available would be the sum of limits for each motor vehicle insured under the policy. Instead the limits of coverage that I am purchasing shall be reduced to the limits stated in the policy. I knowingly and voluntarily reject the stacked limits of coverage. I understand that my premiums will be reduced if I reject this coverage.

_____
SIGNATURE OF FIRST NAMED INSURED

_____
DATE

(e) **Signature and date.**--The forms described in subsection (d) must be signed by the first named insured and dated to be valid. Any rejection form that does not comply with this section is void.

SUBCHAPTER D
ASSIGNED RISK PLAN

Sec.
1741. Establishment.
1742. Scope of Plan.
1743. Rates.
1744. Termination of policies.

Sec. 1741. Establishment.

The Insurance Department shall, after consultation with the insurers licensed to write motor vehicle liability insurance in this Commonwealth, adopt a reasonable Assigned Risk Plan for the equitable apportionment among those insurers of applicants for motor vehicle liability insurance who are entitled to, but are unable to, procure insurance through ordinary methods. When the plan has been adopted, all motor vehicle liability insurers shall subscribe thereto and shall participate in the plan. The plan may provide reasonable means for the transfer of individuals insured thereunder into the ordinary market, at the same or lower rates, pursuant to regulations established by the department.

Sec. 1742. Scope of plan.

The Assigned Risk Plan shall:

(1) Include rules for the classification of risks and rates therefor.

(2) Provide for the installment payment of premiums subject to customary terms and conditions.

(3) Provide rules for the equitable apportionment among participating insurers of clean risks who shall be eligible to receive the insurer's voluntary rate.

(4) Provide rules to specify the effective date and time of coverage, provided that applicants may only obtain coverage effective as of the date and time of the application if the agent or broker of record uses electronic mail binding procedures specified in the rules.

Sec. 1743. Rates.

All rates for the Assigned Risk Plan shall be subject to the act of June 11, 1947 (P.L.538, No. 246), known as The Casualty and Surety Rate Regulatory Act, and shall not be inadequate, excessive or unfairly discriminatory.

Sec. 1744. Termination of policies.

Cancellation, refusal to renew and other termination of policies issued under the Assigned Risk Plan shall be in accordance with the rules of the plan.

SUBCHAPTER B
ASSIGNED CLAIMS PLAN

Sec.
1751. Organization
1752. Eligible claimants.
1753. Benefits available.
1754. Additional coverage.
1755. Coordination of benefits.
1756. Subrogation.
1757. Statute of limitations.

Sec. 1751. Organization.

Insurers providing financial responsibility as required by law shall organize and maintain, subject to the approval and regulation of the Insurance Department, an Assigned Claims Plan and adopt rules for the operation and for the assessment of costs on a fair and equitable basis.

Sec. 1752. Eligible claimants.

(a) **General rule.**--A person is eligible to recover benefits from the Assigned Claims Plan if the person meets the following requirements:

(1) Is a resident of this Commonwealth.

(2) Is injured as the result of a motor vehicle accident occurring in this Commonwealth.

(3) Is not an owner of a motor vehicle required to be registered under Chapter 13 (relating to registration of vehicles).

(4) Is not the operator or occupant of a motor vehicle owned by the Federal Government or any of its agencies, departments or authorities.

(5) Is not the operator or occupant of a motor vehicle owned by a self-insurer or by an individual or entity who or which is immune from liability for, or is not required to provide, benefits or uninsured and under-insured motorist coverage.

(6) Is otherwise not entitled to receive any first party benefits under Section 1711 (relating to required benefits) or 1712 (relating to availability of benefits) applicable to the injury arising from the accident.

(7) Is not the operator or occupant of a recreational vehicle not intended for highway use, motorcycle, motor-driven cycle or motorized pedalcycle or other like type vehicle required to be registered under this title and involved in the accident.

(b) **Grounds for ineligibility.**--A person otherwise qualifying as an eligible claimant under subsection (a) shall nevertheless be ineligible to recover benefits from the Assigned Claims Plan if that person contributed to his own injury in any of the following ways:

(1) While intentionally injuring himself or another or attempting to intentionally injure himself or another.

(2) While committing a felony.

(3) While seeking to elude lawful apprehension or arrest by a law enforcement official.

(4) While knowingly converting a motor vehicle.

Sec. 1753. Benefits available.

An eligible claimant may recover medical benefits, as described in section 1712(1) (relating to availability of benefits), up to a maximum of $5,000. No income loss benefit or accidental death benefit shall be payable under this subchapter.

Sec. 1754. Additional coverage.

An eligible claimant who has no other source of applicable uninsured motorist coverage and is otherwise entitled to recover in an action in tort against a party who has failed to comply with this chapter may recover for losses or damages suffered as a result of the injury up to $15,000. subject to an aggregate limit for all claims arising out of any one motor vehicle accident of $30,000. If a claimant recovers medical benefits under section 1753 (relating to benefits available), the amount of medical benefits recovered or recoverable up to $5,000. shall be set off against any amounts recoverable in this section.

Sec. 1755. Coordination of benefits.

(a) **Workers' compensation.**--All benefits (less reasonably incurred collection costs) that an eligible claimant receives or is entitled to receive from workers' compensation and from any other like source under local, state, or Federal law shall be subtracted from any benefits available in section 1753 (relating to benefits available) unless the law authorizing or providing for those benefits makes them excess or secondary to the benefits in accordance with this subchapter.

(b) **Accident and health benefits.**--All benefits an eligible claimant receives or is entitled to receive as a result of injury from any available source of accident and health benefits shall be subtracted from those benefits available in section 1753.

Sec. 1756. Subrogation.

The Assigned Claims Plan or its assignee is entitled to recover, in accordance with the tort liability law of this Commonwealth, reimbursement for benefits or coverages paid, loss adjustment costs and any other sums paid to an eligible claimant under this subchapter.

Sec. 1757. Statute of limitations.

(a) **General rule.**--An action by an eligible claimant to recover benefits or coverages from the Assigned Claims Plan shall be commenced within four years from the date of the accident.

(b) **Minors.**--For minors entitled to benefits described in section 1753 (relating to benefits available) or 1754 (relating to additional coverage), an action to recover these benefits or coverages shall be commenced within four years from the date on which the injured minor attains 18 years of age.

SUBCHAPTER F
CATASTROPHIC LOSS FUND

(Repealed effective 12/12/88)

SUBCHAPTER G
NONPAYMENT OF JUDGMENTS

Sec.
1771. Court reports on nonpayment of judgments.
1772. Suspension for nonpayment of judgments.
1773. Continuation of suspension until judgments paid and proof given.
1774. Payments sufficient to satisfy judgments.
1775. Installment payment of judgments.

Sec. 1771. Court reports on nonpayment of judgments.

(a) **General rule.**-- Whenever any person fails within 60 days to satisfy any judgment arising from a motor vehicle accident, the judgment creditor may forward to the department a certified copy of the judgment.

(b) **Notice to state of nonresident defendant.**--If the defendant named in any certified copy of a judgment reported to the Department is a nonresident, the department shall transmit a certified copy of the judgment to the official in charge of the issuance of licenses and registration certificates of the state of which the defendant is a resident.

Sec. 1772. Suspension for nonpayment of judgments.

(a) **General rule.**--The department, upon receipt of a certified copy of a judgment, shall suspend the operating privilege of each person against whom the judgment was rendered except as otherwise provided in this section and in section 1775 (relating to installment payment of judgments).

(b) **Nonsuspension with consent of judgment creditor.**--If the judgment creditor consents in writing, in such form as the department may prescribe that the judgment debtor's operating privilege be retained or restored, the department shall not suspend or shall restore until the consent is revoked in writing, notwithstanding default in the payment of the judgment, or of any installment thereof prescribed in section 1775, provided the judgment debtor furnishes proof of financial responsibility.

(c) **Financial responsibility in effect at time of accident.**--Any person whose operating privilege has been suspended, or is about to be suspended or become subject to suspension under this chapter shall be relieved from the effect of the judgment as prescribed in this chapter if the person files evidence satisfactory to the department that financial responsibility was in force and effect at the time of the accident resulting in the judgment and is or should be available for the satisfaction of the judgment. If insurance already obtained is not available because the insurance company has gone into receivership or bankruptcy, the person shall only be required to present to or file with the department proper evidence that an insurance policy was in force and effect at the time of the accident.

Sec. 1773. Continuation of suspension until judgments paid and proof given.

A person's operating privilege shall remain suspended and shall not be renewed in the name of that person unless and until every judgment is stayed, satisfied in full or to the extent provided in this subchapter, and until the person furnishes proof of financial responsibility as required.

Sec. 1774. Payments sufficient to satisfy judgments.

(a) **General rule.**--For the purpose of this chapter only, judgments shall be deemed satisfied upon the occurrence of one of the following:

(1) When $15,000. has been credited upon any judgment or judgments rendered in excess of that amount because of injury to one person as the result of any one accident.

(2) When $30,000. has been credited upon any judgment or judgments rendered in excess of that amount because of injury to two or more persons as the result of any one accident.

(3) When $5,000. has been credited upon any judgment or judgments rendered in excess of that amount because of damage to property of others as the result of any one accident.

(b) **Credit for payment under settlement.**--Payments made in settlement of any claims because of bodily injury or property damage arising from a motor vehicle accident shall be credited in reduction of the amounts provided for in this section.

(c) **Escrow deposit by judgment debtor.**--When the judgment creditor can not be found, the judgment debtor may deposit in escrow with the prothonotary of the court where the judgment was entered in an amount equal to the amount of the judgment, subject to the limits set forth in subsection (a), interest to date and record costs, whereupon the prothonotary shall notify the department and the judgment shall be deemed satisfied. The amount deposited shall be retained by the prothonotary for a period of five years from the date of the deposit, after which, if it has not been claimed by the judgment creditor, it shall be returned to the judgment debtor. When the deposit is made, the prothonotary shall notify the judgment creditor and his counsel, if any, by certified or registered mail at his last known address. No interest shall run on any judgment with respect to the amount deposited with the prothonotary under the terms of this subsection.

Sec. 1775. Installment payment of judgments.

(a) **Order authorizing installment payment.**--A judgment debtor, upon due notice to the judgment creditor, may apply to the court in which the judgment was rendered for the privilege of paying the judgment in installments and the court, in its discretion and without prejudice to any other legal remedies which the judgment creditor may have, may so order and fix the amounts and times of payment of the installments.

(b) **Suspension prohibited during compliance with order.**--The department shall not suspend a driver's operating privilege and shall restore any operating privilege suspended following nonpayment of a judgment when the judgment debtor obtains an order permitting payment of the judgment in installments and while the payment of any installment is not in default, provided that the judgment debtor furnishes proof of financial responsibility.

(c) **Suspension for default in payment.**--In the event the judgment debtor fails to pay any installment as specified by the order, then, upon notice of the default, the department shall suspend the operating privilege of the judgment debtor until the judgment is satisfied as provided in this chapter.

SUBCHAPTER H
PROOF OF FINANCIAL RESPONSIBILITY

Sec.

1781. Notice of sanction for not evidencing financial responsibility.
1782. Manner of providing proof of financial responsibility.
1783. Proof of financial responsibility before restoring operating privilege or registration.
1784. Proof of financial responsibility following violation.
1785. Proof of financial responsibility following accident.
1786. Required financial responsibility.
1787. Self-insurance.

Sec. 1781. Notice of sanction for not evidencing financial responsibility.

An applicant for registration of a vehicle shall acknowledge on a form developed by the Department of Transportation that the applicant knows he may lose his operating privilege or vehicle registrations if he fails to maintain financial responsibility on the currently registered vehicle for the period of registration.

Sec. 1782. Manner of providing proof of financial responsibility.

(a) **General rule.**--Proof of financial responsibility may be furnished by filing evidence satisfactory to the department that all motor vehicles registered in a person's name are covered by motor vehicle liability insurance or by a program of self-insurance as provided by section 1787 (relating to self-insurance) or other reliable financial arrangements, deposits, resources or commitments acceptable to the department.

(b) **Nonresident.**--The nonresident owner of a motor vehicle not registered in this Commonwealth may give proof of financial responsibility by filing with the department a written certificate or certificates of an insurance company authorized to transact business in the state in which the motor vehicle or motor vehicles described in the certificate are registered or, if the nonresident does not own a motor vehicle, then evidence satisfactory to the department that the person does not own a motor vehicle. The department shall accept the certificate upon condition that the insurance company complies with the following provisions with respect to the policies so certified:

(1) The insurance company shall execute a power of attorney authorizing the department to accept service on its behalf or process in any action arising out of a motor vehicle accident in this Commonwealth.

(2) The insurance company shall agree in writing that the policy shall be deemed to conform with the laws of this Commonwealth relating to the terms of motor vehicle liability policies issued in this Commonwealth.

(c) **Default by foreign insurance company.**--If any insurance company not authorized to transact business in this Commonwealth, which has qualified to furnish proof of financial responsibility, defaults in any undertakings or agreements, the department shall not thereafter accept as proof any certificate of the company whether theretofore filed or thereafter tendered as proof as long as the default continues.

(d) **Financial responsibility identification cards.**--Insurers shall provide financial responsibility identification cards to insureds which shall be valid only for the period for which coverage has been paid by the insured. Financial responsibility identification cards shall disclose the period for which coverage has been paid by the insured and shall contain such other information as required by the Insurance Department. In such instance where the insured has financed premiums through a premium finance company or where the insured is on an insurer-sponsored or agency-sponsored payment plan, financial responsibility identification cards may be issued for periods of six months even though such payment by the insured may be for a period of less than six months. Nothing in this paragraph shall be construed to require the immediate issuance of financial responsibility identification cards where an insured replaces an insured vehicle, adds a vehicle or increases coverages under an existing policy for which a premium adjustment is required.

Sec. 1783. Proof of financial responsibility before restoring operating privilege or registration.

Whenever the department suspends or revokes the operating privilege of any person or the registration of any vehicle pursuant to section 1532 (relating to revocation or suspension of operating privilege), 1542 (relating to revocation of habitual offender's license) 1772 (relating to suspension for nonpayment of judgments), 1784 (relating to proof of financial responsibility following violation) or 1785 (relating to proof of financial responsibility following accident), or upon receiving the record of conviction or forfeiture of bail, the department shall not restore the operating privilege or the applicable registration until the person furnishes proof of financial responsibility.

Sec. 1784. Proof of financial responsibility following violation.

A defendant who is convicted of a traffic offense, other than a parking offense, that requires a court appearance shall be required to show proof of financial responsibility covering the operation of the vehicle at the time of the offense. If the defendant fails to show proof of financial responsibility, the court shall notify the department of that fact. Upon receipt of the notice, the department shall revoke the registration of the vehicle. If the defendant is the owner of the vehicle, the department shall also suspend the operating privilege of the defendant.

Sec. 1785. Proof of financial responsibility following accident.

If the department determines that the owner of a motor vehicle involved in an accident requiring notice to a police department pursuant to section 3746 (relating to immediate notice of accident to police department) did not maintain financial responsibility on the motor vehicle at the time of the accident, the department shall suspend the operating privilege of the owner, where applicable, and the department shall revoke the registration of the vehicle.

Sec. 1786. Required financial responsibility.

(a) **General rule.**--Every motor vehicle of the type required to be registered under this title which is operated or currently registered shall be covered by financial responsibility.

(b) **Self-certification.**--The Department of Transportation shall require that each motor vehicle registrant certify that the registrant is financially responsible at the time of registration or renewal thereof. The department shall refuse to register or renew the registration of a vehicle for failure to comply with this requirement or falsification of self-certification.

(c) **Consent to produce proof of financial responsibility.**--Upon registering a motor vehicle or renewing a motor vehicle registration, the owner of the motor vehicle shall be deemed to have given consent to produce proof, upon request, to the Department of Transportation or a police officer that the vehicle registrant has the financial responsibility required by this chapter.

(d) **Suspension of registration and operating privilege.--**

(1) The Department of Transportation shall suspend the registration of a vehicle for a period of three months if it determines the required financial responsibility was not secured as required by this chapter and shall suspend the operating privilege of the owner or registrant for a period of three months if the department determines that the owner or registrant has operated or permitted the operation of the vehicle without the required financial responsibility. The operating privilege shall not be restored until the restoration fee for operating privilege provided by section 1960 (relating to reinstatement of operating privilege or vehicle registration) is paid.

(2) Whenever the department revokes or suspends the registration of any vehicle under this chapter, the department shall not restore the registration until the vehicle owner furnishes proof of financial responsibility in a manner determined by the department and submits an application for registration to the department, accompanied by the fee for restoration of registration provided by section 1960. This subsection shall not apply in the following circumstances:

(i) The owner or registrant proves to the satisfaction of the department that the lapse in financial responsibility coverage was for a period of less than 31 days and that the owner or registrant did not operate or permit the operation of the vehicle during the period of lapse in financial responsibility.

(ii) The owner or registrant is a member of the armed services of the United States, the owner or registrant has previously had the financial responsibility required by this chapter, financial responsibility had lapsed while the owner or registrant was on temporary, emergency duty and the vehicle was not operated during the period of lapse in financial responsibility. The exemption granted by this paragraph shall continue for 30 days after the owner or registrant returns from duty as long as the vehicle is not operated until the required financial responsibility has been established.

(iii) The insurance coverage has terminated or financial responsibility has lapsed simultaneously with or subsequent to expiration of a seasonal registration, as provided in section 1307(a.1) (relating to period of registration).

(3) An owner whose vehicle registration has been suspended under this subsection shall have the same right of appeal under section 1377 (relating to judicial review) as provided for in cases of the suspension fo vehicle registration for other purposes. The filing of the appeal shall act as a supersedeas, and the suspension shall not be imposed until determination of the matter as provided in section 1377. The court's scope of review in an appeal from a vehicle registration suspension shall be limited to determining whether:

(i) the vehicle is registered or of a type that is required to be registered under this title; and

(ii) there has been either notice to the department of a lapse, termination or cancellation in the financial responsibility coverage as required by law for that vehicle or that the owner, registrant or driver was requested to provide proof of financial responsibility to the department, a police officer or another driver and failed to do so. Notice to the department of the lapse, termination or cancellation or the failure to provide the requested proof of financial responsibility shall create a presumption that the vehicle lacked the requisite financial responsibility. This presumption may be overcome by producing clear and convincing evidence that the vehicle was insured at all relevant times.

(4) Where an owner or registrant's operating privilege has been suspended under this subsection, the owner or registrant shall have the same right of appeal under section 1550 (relating to judicial review) as provided for in cases of suspension for other reason. The court's scope of review in an appeal from an operating privilege suspension shall be limited to determining whether:

(i) the vehicle was registered or of a type required to be registered under this title; and

(ii) the owner or registrant operated or permitted the operation of the same vehicle when it was not covered by financial responsibility. The fact that an owner, registrant or operator of the motor vehicle failed to provide competent evidence of insurance or the fat that the department received notice of a lapse, termination or cancellation of insurance for the vehicle shall create a presumption that the vehicle lacked the requisite financial responsibility. This presumption may be overcome by producing clear and convincing evidence that the vehicle was insured at the time that it was driven.

(5) An alleged lapse, cancellation or termination of a policy of insurance by an insurer may only be challenged by requesting review by the Insurance Commissioner pursuant to Article XX of the act of May 17, 1921 (P.L. 682, No. 284), known as The Insurance Company Law of 1921. Proof that a timely request has been made to the Insurance Commissioner for such a review shall act as a supersedeas, staying the suspension of registration or operating privilege under this section pending a determination pursuant to section 2009(a) of The Insurance Company Law of 1921 or, in the event that further review at a hearing is requested by either party, a final order pursuant to section 2009(i) of The Insurance Company Law of 1921.

(e) **Obligations upon lapse, termination or cancellation of financial responsibility.--**

(1) An owner of a motor vehicle who ceases to maintain financial responsibility on a registered vehicle shall not operate or permit operation of the vehicle in this Commonwealth until proof of the required financial responsibility has been provided to the Department of Transportation.

(2) An insurer who has issued a contract of motor vehicle liability insurance, or any approved self-insurance entity, shall notify the department in a timely manner and in a method prescribed by the department's regulations. Upon request of an owner or registrant in the case of an appeal brought by an owner or registrant for suspension under this section, an insurer shall provide a copy of the notice of cancellation or a copy of the insurer's filing procedures with proof that the notice was written in the normal course of business and placed in the normal course of mailing. The department shall not be required to produce such copy or any other proof that notice of termination, lapse or cancellation was provided to the owner or registrant in order to satisfy the burden of proof in a proceeding under this section.

(3) An insurer who has issued a contract of motor vehicle liability insurance and knows or has reason to believe that the contract is only for the purpose of providing proof of financial responsibility shall notify the department if the insurance has been canceled or terminated by the insured or by the insurer. The insurer shall notify the department not later than ten days following the effective date of the cancellation or termination.

(4) A person who, after maintaining financial responsibility on the vehicle of another person, ceases to maintain such financial responsibility shall immediately notify the vehicle's owner who shall not operate, permit operation of, the vehicle in this Commonwealth.

(5) In the case of a person who leases any motor vehicle from a person engaged in the business of leasing motor vehicles, the lessee shall sign a statement indicating that the required financial responsibility has been provided through the lessor or through the lessee's motor vehicle liability insurance policy coverage. The lessee shall submit the statement to the lessor.

(f) **Operation of a motor vehicle without required financial responsibility.**--Any owner of a motor vehicle for which the existence of financial responsibility is a requirement for its legal operation shall not operate the motor vehicle or permit it to be operated upon a highway of this Commonwealth without the

financial responsibility required by this chapter. In addition to the penalties provided by subsection (d), any person who fails to comply with this subsection commits a summary offense and shall, upon conviction, be sentenced to pay a fine of $300.

(g) **Defenses.**--

(1) No person shall be convicted of failing to produce proof of financial responsibility under this subchapter or section 3743 (relating to accidents involving damage to attended vehicle or property) or 6308 (relating to investigation by police officers), if the person produces, at the office of the issuing authority within five days of the date of the violation, proof that he possessed the required financial responsibility at the time of the violation.

(2) No person shall be penalized for maintaining a registered motor vehicle without financial responsibility under subsection (d) if, at the time insurance coverage terminated or financial responsibility lapsed, the registration plate and card were voluntarily surrendered to the department, a full agent designated by the department to accept voluntarily surrendered registration plates and cards pursuant to regulations promulgated by the department or a decentralized service agent appointed by the department. If a seasonal registration, as provided in section 1307(a.1), has been issued for the vehicle, return of the registration plate and card shall be required only if the insurance coverage terminates or financial responsibility lapses prior to the expiration of the seasonal registration. The department, a full agent or the decentralized service agent, as the case may be, shall issue a receipt showing the date that the registration plate and card were received. The designated full agent or the decentralized service agent shall return the registration plate and card to the department accompanied by a copy of the receipt.

(h) **Reinstatement of voluntarily surrendered registration plate and card.**--

(1) Except as provided in paragraph (2), the original registration plate and card shall be canceled by the department and destroyed. Any person who voluntarily surrendered a registration plate and card pursuant to the provisions of subsection (g)(2) may obtain a substitute registration plate and card bearing a registration number other than that originally issued from the department, a designated full agent or a decentralized service agent, as the case may be. Proof of financial responsibility in a form approved by the department shall be submitted

together with the receipt showing the registration plate and card were voluntarily surrendered.

(2) Any registration plate issued under sections 1340 (relating to antique and classic plates) and 1341 (relating to personal plate) shall be returned by the department to the owner of the motor vehicle upon receipt of proof of financial responsibility.

(3) A full agent designated by the department to issue substitute temporary registration cards and plates following a voluntary surrender of registration cards and plates pursuant to regulations promulgated by the department or a decentralized service agent appointed by the department may be authorized to issue substitute temporary registration plates provided proof of financial responsibility and a copy of the receipt showing the original registration plate and card were voluntarily surrendered are furnished. The fees provided pursuant to sections 1929 (relating to replacement registration plates) and 1932 (relating to duplicate registration cards) shall not be charged if the original registration plate and card were canceled pursuant to paragraph (1).

Sec. 1787. Self-insurance.

(a) **General rule.**--Self-insurance is effected by filing with the Department of Transportation, in satisfactory form, evidence that reliable financial arrangements, deposits, resources or commitments exist such as will satisfy the department that the self-insurer will:

(1) Provide the benefits required by section 1711 (relating to required benefits), subject to the provisions of Subchapter B (relating to motor vehicle liability insurance first party benefits), except the additional benefits and limits provided in sections 1712 (relating to availability of benefits) and 1715 (relating to availability of adequate limits).

(2) Make payments sufficient to satisfy judgments as required by section 1774 (relating to payments sufficient to satisfy judgments).

(3) Provide uninsured motorist coverage up to the limits set forth in section 1774.

(b) **Stacking limits prohibited.**--Any recovery of uninsured motorist benefits under this section only shall not be increased by

stacking the limits provided in section 1774, in consideration of the ownership or operation of multiple vehicles or otherwise.

(c) **Assigned Risk and Assigned Claims Plans.**--Self-insurers shall not be required to accept Assigned Risks pursuant to Subchapter D (relating to Assigned Risk Plan) or contribute to the Assigned Claims Plan pursuant to Subchapter E (relating to Assigned Claims Plan).

(d) **Catastrophic Loss Trust Fund.**-- Self-insurers shall contribute to the Catastrophic Loss Trust Fund in the manner provided in Subchapter F (relating to Catastrophic Loss Trust Fund).

(e) **Promulgation of regulations, etc.**--The Department of Transportation may, jointly with the Insurance Department, promulgate rules, regulations, guidelines, procedures or standards for reviewing and establishing the financial eligibility of self-insurers.

SUBCHAPTER I
MISCELLANEOUS PROVISIONS

Sec.
1791. Notice of available benefits and limits.
1791.1 Disclosure of premium charges and tort options.
1792. Availability of uninsured, underinsured, bodily injury liability and property damage coverages and mandatory deductibles.
1793. Special provisions relating to premiums.
1794. Compulsory judicial arbitration jurisdiction.
1795. Insurance fraud reporting immunity.
1796. Mental or physical examination of person.
1797. Customary charges for treatment.
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1798.1 Extraordinary medical benefit rate.
1798.2 Transition
1798.3 Unfunded liability report.
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1799. Restraint system.
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1799.4 Examination of vehicle repairs.
1799.5 Conduct of market study.
1799.6 Conduct of random field surveys.
1799.7 Rates

Sec. 1791. Notice of available benefits and limits.

It shall be presumed that the insured has been advised of the benefits and limits available under this chapter provided the following notice in bold print of at least ten-point type is given to the applicant at the time of application for original coverage and no other notice or rejection shall be required:

IMPORTANT NOTICE

Insurance companies operating in the Commonwealth of Pennsylvania are required by law to make available for purchase the following benefits for you, your spouse or other relatives or minors in your custody or in the custody of your relatives, residing in your household, occupants of your motor vehicle or persons struck by your motor vehicle:

(1) Medical benefits, up to at least $100,000.

(1.1) Extraordinary medical benefits, from $100,000. to $1,100,000. which may be offered in increments of $100,000.

(2) Income loss benefits, up to at least $2,500. per month up to a maximum benefit of at least $50,000.

(3) Accidental death benefits, up to at least $25,000.

(4) Funeral benefits, $2,500.

(5) As an alternative to paragraphs (1),(2), (3) and (4), a combination benefit, up to at least $177,500. of benefits in the aggregate or benefits payable up to three years from the date of the accident, whichever occurs first, subject to a limit on accidental death benefit of up to $25,000. and a limit on funeral benefit of $2,500., provided that nothing contained in this subsection shall be construed to limit, reduce, modify or change the provisions of section 1715 (d) (relating to availability of adequate limits).

(6) Uninsured, underinsured and bodily injury liability coverage up to at least $100,000 because of injury to one person in any one accident and up to at least $300,000 because of injury of two or more persons in any one accident or, at the option of the insurer, up to at least $300,000 in a single limit for these coverages, except for policies issued under the Assigned Risk Plan. Also, at least $5,000 for damage to property of others in any one accident.
Additionally, insurers may offer higher benefit levels

than those enumerated above as well as additional benefits. However, an insured may elect to purchase lower benefit levels than those enumerated above. Your signature on this notice or your payment of any renewal premium evidences your actual knowledge and understanding of the availability of these benefits and limits as well as the benefits and limits you have selected.
If you have any questions or you do not understand all of the various options available to you, contact your agent or company.
If you do not understand any of the provisions contained in this notice, contact your agent or company before you sign.

Sec. 1791.1. Disclosure of premium charges and tort options.

(a) **Invoice.**--At the time of application for original coverage and every renewal thereafter, an insurer must provide to an insured an itemized invoice listing the minimum motor vehicle insurance coverage levels mandated by the Commonwealth and the premium charge for the insured to purchase the minimum mandated coverages. The invoice must contain the following notice in print of no less than ten-point type:

> The laws of the Commonwealth of Pennsylvania, as enacted by the General Assembly, only require that you purchase liability and first-party medical benefit coverages. Any additional coverages or coverages in excess of the limits required by law are provided only at your request as enhancements to basic coverages.

The insurer shall provide the itemized invoice to the insured in conjunction with the declaration of coverage limits and premiums for the insured's existing coverages.

(b) **Notice of tort options.**--In addition to the invoice required under subsection (a), an insurer must, at the time of application for original coverage for private passenger motor vehicle insurance and every renewal thereafter, provide to an insured the following notice of the availability of two alternatives of full tort insurance and limited tort insurance described in section 1705(c) and (d) (relating to election of tort options):

> The laws of the Commonwealth of Pennsylvania give you the right to choose either of the following two tort options:

A. "Limited Tort" Option--This form of insurance limits your right and the rights of members of your household to seek financial compensation for injuries caused by other drivers. Under this form of insurance, you and other household members covered under this policy may seek recovery for all medical and other out-of-pocket expenses, but not for pain and suffering or other nonmonetary damages unless the injuries suffered fall within the definition of "serious injury," as set forth in the policy, or unless one of several other exceptions noted in the policy applies.

B. "Full Tort" Option--This form of insurance allows you to maintain an unrestricted right for yourself and other members of your household to seek financial compensation for injuries caused by other drivers. Under this form of insurance, you and other household members covered under this policy may seek recovery for all medical and other out-of-pocket expenses and may also seek financial compensation for pain and suffering or other monetary damages as a result of injuries caused by other drivers.

If you wish to change the tort option that currently applies to your policy, you must notify your agent, broker or company and request and complete the appropriate form.

(c) **Notice of premium discounts.** Except where the commissioner has determined that an insurer may omit a discount because the discount is duplicative of other discounts or is specifically reflected in the insurer's experience, at the time of application for original coverage and every renewal thereafter, an insurer must provide to an insured a notice stating that discounts are available for drivers who meet the requirements of section 1799 (relating to restraint system), 1799.1 (relating to antitheft devices) and 1799.2 (relating to driver improvement course discounts).

(d) **Additional information.**--Upon an oral or written request, an insurer subject to this chapter shall provide to the requestor information on the requestor's cost to purchase from the insurer the minimum requested automobile insurance coverages under either of the two tort options described in subsection (b). These requirements shall include the request for and provision of information by telephone.

Sec. 1792. Availability of uninsured, underinsured, bodily injury liability and property damage coverages and mandatory deductibles.

(a) **Availability of coverages.**--Except for policies issued under Subchapter D (relating to Assigned Risk Plan), an insurer issuing a policy of bodily injury liability coverage pursuant to this chapter shall make available for purchase higher limits of uninsured, underinsured and bodily injury liability coverages up to at least $100,000 because of injury to one person in any one accident and up to at least $300,000 because of a injury to two or more persons in any one accident or, at the option of the insurer, up to at least $300,000 in a single limit for these coverages. Additionally, an insurer shall make available for purchase at least $5,000 because of damage to property of others in any one accident. However, the exclusion of availability relating to the Assigned Risk Plan shall not apply to damage to property of others in any one accident.

(b) **Mandatory deductibles.**--

(1) Every private passenger automobile insurance policy providing collision coverage issued or renewed on and after the effective date of this subsection shall provide a deductible in an amount of $500 for collision coverage, unless the named insured signs a statement indicating the insured is aware that the purchase of a lower deductible is permissible and that there is an additional cost of purchasing a lower deductible, and the insured agrees to accept it.

(2) Under no circumstances may a private passenger automobile insurance policy provide a collision deductible in an amount less than $100.

(3) Any person or entity providing financing to the purchaser of a motor vehicle or otherwise holding a security interest in a motor vehicle shall not be permitted to require the purchase of a deductible for less than $500 for collision and comprehensive coverages. Any financial institution, insurer, agent or other person or entity found to have violated this provision shall be required to reimburse the policyholder in an amount equal to the difference in premium and, in addition, shall be required to pay a civil penalty of $500 to the Department of Transportation for each violation.

(4) With the purchase of a $500 or greater deductible, there shall be an immediate commensurate reduction in rate for collision and comprehensive coverages. The reduction in rate shall be based on the insured's existing deductible level.

Sec. 1793. Special provisions relating to premiums.

(a) **Limitation on premium increases.**--

(1) An insurer shall not increase the premium rate of an owner of a policy of insurance subject to this chapter solely because one or more of the insureds under the policy made a claim under the policy and was paid thereon unless it is determined that the insured was at fault in contributing to the accident giving rise to the claim.

(2) No insurer shall charge an insured who has been convicted of a violation of an offense enumerated in section 1535 (relating to schedule of conviction and points) a higher rate for a policy of insurance solely on account of the conviction. An insurer may charge an insured a higher rate for a policy of insurance if a claim is made under paragraph (1).

(b) **Surcharge disclosure plan.**--All insurers shall provide to the insured a surcharge disclosure plan. The insurer providing the surcharge disclosure plan shall detail the provisions of the plan including, but not limited to:

(1) A description of conditions that would assess a premium surcharge to an insured along with the estimated increase of the surcharge per policy period per policyholder.

(2) The number of years any surcharge will be in effect. The surcharge disclosure plan shall be delivered to each insured by the insurer at least once annually. Additionally, the surcharge information plan shall be given to each prospective insured at the time application is made for motor vehicle insurance coverage.

(c) **Return of premiums of cancelled policies.**--When an insurer cancels a motor vehicle insurance policy which is subject to section 6(3) of the Act of June 5, 1968 (P.L. 140, No. 78), relating to writing, cancellation of or refusal to renew policies of automobile insurance, the insurer shall within 30 days of cancelling the policy return to the insured all premiums paid under the policy less any proration for the period the policy was in effect. Premiums are overdue if not paid to the insured within 30 days after cancelling the policy. Overdue return premiums shall bear interest at the rate of 12% per annum from the date the return premium became due.

(d) **Rules and regulations.**--The Insurance Department shall promulgate rules and regulations establishing guidelines and procedures for determining fault of an insured for the purpose of

subsection (a) and guidelines for the content and format of the surcharge disclosure plan.

Sec. 1794. Compulsory judicial arbitration jurisdiction.

Beginning January 1, 1987, the monetary limit in 42 Pa.C.S. Section 7361(b)(2)(i) (relating to compulsory arbitration) for the submission of matters to judicial arbitration in judicial districts embracing first and second class counties shall be $25,000 for actions arising from the maintenance or use of a motor vehicle.

Sec. 1795. Insurance fraud reporting immunity.

(a) **General rule.**--An insurance company, and any agent, servant or employee acting in the course and scope of his employment, shall be immune from civil or criminal liability arising from the supply or release of written or oral information to any duly authorized Federal or state law enforcement agency, including the Insurance Department, upon compliance with the following:

(1) The information is supplied to the agency in connection with an allegation of fraudulent conduct on the part of any person relating to the filing or maintenance of a motor vehicle insurance claim for bodily injury or property damage.

(2) The insurance company, agent, servant or employee has probable cause to believe that the information supplied is reasonably related to the allegation of fraud.

(b) **Notice to policyholder.**-- The insurance company shall send written notice to the policyholder or policyholders about whom the information pertains unless the insurance company receives notice that the authorized agency finds, based on specific facts, that there is reason to believe that the information will result in any of the following:

(1) Endangerment to the life or physical safety of any person.

(2) Flight from prosecution.

(3) Destruction of or tampering with evidence.

(4) Intimidation of any potential witness or witnesses.

(5) Obstruction of or serious jeopardy to an investigation.

The insurance company shall send written notice no sooner than 45 days nor more than 60 days from the time the information is furnished to an authorized agency except when the authorized agency specifies that a notice should not be sent in accordance with the exceptions enumerated in this subsection in which event the insurance company shall send written notice to the policyholder not sooner than 180 days nor more than 190 days following the date the information is furnished.

(c) **Immunity for sending notice.**--An insurance company or authorized agency and any person acting on behalf of an insurance company or authorized agency complying with or attempting in good faith to comply with subsection (b) shall be immune from civil liability arising out of any acts or omissions in so doing.

(d) **Applicability.**--Nothing in this section shall be construed to create any rights to privacy or causes of action on behalf of policyholders that are not in existence as of the effective date of this section.

Sec. 1796. Mental or physical examination of person.

(a) **General rule.**--Whenever the mental or physical condition of a person is material to any claim for medical, income loss or catastrophic loss benefits, a court of competent jurisdiction or the administrator of the Catastrophic Loss Trust Fund for catastrophic loss claims may order the person to submit to a mental or physical examination by a physician. The order may only be made upon motion for good cause shown. The order shall give the person to be examined adequate notice of the time and date of the examination and shall state the manner, conditions and scope of the examination and the physician by whom it is to be performed. If a person fails to comply with an order to be examined, the court or the administrator may order that the person be denied benefits until compliance.

(b) **Report of examination.**--If requested by the person examined, a party causing an examination to be made shall promptly deliver to the person examined a copy of every written report concerning the examination at least one of which must set forth the physician's findings and conclusions in detail. Upon failure to promptly provide copies of these reports, the court or the administrator shall prohibit the testimony of the examining physician in any proceedings to recover benefits.

Sec. 1797. Customary charges for treatment.

(a) **General rule.**--A person or institution providing treatment, accommodations, products or services to an injured person for an injury covered by liability or uninsured and underinsured benefits or first party medical benefits, including extraordinary medical benefits, for a motor vehicle described in Subchapter B (relating to motor vehicle liability insurance first party benefits), shall not require, request or accept payment for the treatment, accommodations, products or services in excess of 110% of the prevailing charge at the 75th percentile; 110% of the applicable fee schedule, the recommended fee or the inflation index charge; or 110% of the diagnostic-related groups (DRG) payment; whichever pertains to the specialty service involved, determined to be applicable in this Commonwealth under the Medicare program for comparable services at the time the services were rendered, or the provider's usual and customary charge, whichever is less. The General Assembly finds that the reimbursement allowances applicable in the Commonwealth under the Medicare program are an appropriate basis to calculate payment for treatments, accommodations, products or services for injuries covered by liability or uninsured and underinsured benefits or first party medical benefits insurance. Future changes or additions to Medicare allowances are applicable under this section. If the commissioner determines that an allowance under the Medicare program is not reasonable, he may adopt a different allowance by regulation, which allowance shall be applied against the percentage limitation in this subsection. If a prevailing charge, fee schedule, recommended fee, inflation index charge or DRG payment has not been calculated under the Medicare program for a particular treatment, accommodation, product or service, the amount of the payment may not exceed 80% of the provider's usual and customary charge. If acute care is provided in an acute care facility to a patient with an immediately life-threatening or urgent injury by a Level I or Level II trauma center accredited by the Pennsylvania Trauma Systems Foundation under the act of July 3, 1985 (P.L. 164, No. 45), known as the Emergency Medical Services Act, or to a major burn injury patient by a burn facility which meets all the service standards of the American Burn Association, the amount of payment may not exceed the usual and customary charge. Providers subject to this section may not bill the insured directly but must bill the insurer for a determination of the amount payable. The provider shall not bill or otherwise attempt to collect from the insured the difference between the provider's full charge and the amount paid by the insurer.

(b) **Peer review plan for challenges to reasonableness and necessity of treatment.**--

(1) Peer review plan.--Insurers shall contract jointly or separately with any peer review organization established for the purpose of evaluating treatment, health care services, products or accommodations provided to any

injured person. Such evaluation shall be for the purpose of confirming that such treatment, products, services or accommodations conform to the professional standards of performance and are medically necessary. An insurer's challenge must be made to a PRO within 90 days of the insurer's receipt of the provider's bill for treatment or services or may be made at any time for continuing treatment or services.

(2) PRO reconsideration.--An insurer, provider or insured may request a reconsideration by the PRO of the PRO's initial determination. Such a request for reconsideration must be made within 30 days of the PRO's initial determination. If reconsideration is requested for the services of a physician or other licensed health care professional, then the reviewing individual must be, or the reviewing panel must include, an individual in the same specialty as the individual subject to review.

(3) Pending determination by PRO.--If the insurer challenges within 30 days of receipt of a bill for medical treatment or rehabilitative services, the insurer need not pay the provider subject to the challenge until a determination has been made by the PRO. The insured may not be billed for any treatment, accommodations, products or services during the peer review process.

(4) Appeal to court.--A provider of medical treatment or rehabilitative services or merchandise or an insured may challenge before a court an insurer's refusal to pay for past or future medical treatment or rehabilitative services or merchandise, the reasonableness or necessity of which the insurer has not challenged before a PRO. Conduct considered to be wanton shall be subject to a payment of treble damages to the injured party.

(5) PRO determination in favor of provider or insured.--If a PRO determines that medical treatment or rehabilitative services or merchandise were medically necessary, the insurer must pay to the provider the outstanding amount plus interest at 12% per year on any amount withheld by the insurer pending PRO review.

(6) Court determination in favor of provider or insured.--If, pursuant to paragraph (4), a court determines that medical treatment or rehabilitative services or merchandise were medically necessary, the insurer must pay to the provider the outstanding amount plus interest at 12%, as well as the costs of the challenge and all attorney fees.

(7) Determination in favor of insurer.--If it is

determined by a PRO or court that a provider has provided unnecessary medical treatment or rehabilitative services or merchandise or that future provision of such treatment, services or merchandise will be unnecessary, or both, the provider may not collect payment for the medically unnecessary treatment, services or merchandise. If the provider has collected such payment, it must return the amount paid plus interest at 12% per year within 30 days. In no case does the failure of the provider to return the payment obligate the insured to assume responsibility for payment for the treatment, services or merchandise.

(c) **Review authorized.**--By December 1, 1991, the Legislative Budget and Finance Committee shall commence a review of the impact of this section. Such review may be conducted biennially.

Sec. 1798. Attorney fees and costs.

(a) **Basis for reasonable fee.**--No attorney's fee for representing a claimant in connection with a claim for first party benefits provided under Subchapter B (relating to motor vehicle liability insurance first party benefits) or a claim for catastrophic loss benefits under Subchapter F (relating to Catastrophic Loss Trust Fund) shall be calculated, determined or paid on a contingent fee basis, nor shall any attorney's fees be deducted from the benefits enumerated in this subsection which are otherwise due such claimant. An attorney may charge a claimant a reasonable fee based upon actual time expended.

(b) **Unreasonable refusal to pay benefits.**--In the event an insurer is found to have acted with no reasonable foundation in refusing to pay the benefits enumerated in subsection (a) when due, the insurer shall pay, in addition to the benefits owed and the interest thereon, a reasonable attorney fee based upon actual time expended.

(c) **Payment by fund.** The Catastrophic Loss Trust Fund may award the claimant's attorney a reasonable fee based upon actual time expended because a claimant is unable to otherwise pay the fees and costs.

(d) **Fraudulent or excessive claims.**--If, in any action by a claimant to recover benefits under this chapter, the court determines that the claim, or a significant part thereof, is fraudulent or so excessive as to have no reasonable foundation, the court may award the insurer's attorney a reasonable fee based upon actual time expended. The court, in such case, may direct that the fee shall be paid by the claimant or that the fee may be treated in whole or in part as an offset against any benefits due or to become due the claimant.

Sec. 1798.1. Extraordinary medical benefit rate.

(a) **Filing.**--Each insurer issuing or delivering liability insurance policies as described in section 1711 (relating to required benefits) shall file with the Insurance Commissioner for an extraordinary medical benefit rate for coverage under section 1715(a)(1.1) (relating to availability of adequate limits). The filing shall be subject to the act of June 11, 1947 (P.L. 538, No. 246), known as The Casualty and Surety Rate Regulatory Act, provided that no first time filing for extraordinary medical benefit coverage which is scheduled for a formal administrative hearing may be deemed effective until an adjudication is issued by the Insurance Commissioner. Insurers may provide for the discounting of extraordinary medical benefit loss reserves in annual financial statements. Unallocated extraordinary medical benefit loss expense payments my be treated in accordance with section 315 of the act of May 17, 1921 (P.L. 789, No. 285), known as The Insurance Department Act of one thousand nine hundred and twenty-one, and regulations promulgated pursuant thereto. The Insurance Commissioner may order the discounting of extraordinary medical benefit losses and allocated loss adjustment expenses in calculating rates for coverage under section 1715(a)(1.1) to the extent determined to be actuarially sound.

(b) **Rates.**--All rates established under this section shall be adequate to assure actuarial soundness. Under no circumstances shall rates for other coverages required under the provisions of this chapter be modified or otherwise established to subsidize, in whole or in part, the rate for the extraordinary medical benefit. In making a rate for the extraordinary medical benefit, due consideration shall be given to the current factors generally in use in making motor vehicle insurance rates.

(c) **Limitation.**--The extraordinary medical benefit rate for coverage under section 1715(a)(1.1) shall not be subject to any premium tax levied under State law.

Sec. 1798.2. Transition.

(a) **Savings provision.**--Notwithstanding the repeal of Subchapter F (relating to Catastrophic Loss Trust Fund) by the act of December 12, 1988 (P.L. 1120, No. 144), all natural persons who suffer or suffered a catastrophic loss prior to June 1, 1989, or who may suffer a catastrophic loss during the registration year for which payment was made in accordance with former section 1762 (relating to funding), respectively, shall continue to receive, or be eligible to receive, catastrophic loss benefits as if Subchapter F had not been repealed. To ensure the administration and delivery of catastrophic loss benefits to eligible claimants, all powers and duties previously imposed on the Catastrophic Loss Trust Fund Board

under Subchapter F are hereby transferred to the Insurance Commissioner.

(b) **Rate filing.**--All insurers shall, within 30 days of the effective date of this section, file for approval by the Insurance Commissioner an extraordinary medical benefit rate pursuant to section 1798.1(a) (relating to extraordinary medical benefit rate). Any insurer having an approved rate for catastrophic loss coverage on the effective date of this section shall utilize that approved rate.

(c) **Notice.**--For extraordinary medical benefit rate filings approved after the effective date of this section, the insurer shall provide the following notice to all policyholders no later than 30 days from the date of approval, which notice shall not be subject to any provision of any law or regulation requiring the approval of the Insurance Commissioner prior to its adoption or use:

IMPORTANT NOTICE
EXTRAORDINARY MEDICAL BENEFITS

> By virtue of recent amendment to the Motor Vehicle Financial Responsibility Law, as of June 1, 1989, the first party benefits coverage may be extended to provide an extraordinary medical benefit which will pay the medical and rehabilitation costs for you and your family members residing in your household which are more than $100,000 for each person injured as the result of an automobile accident, up to a lifetime benefit limit of $1,000,000 for each person. The cost of this extraordinary medical benefit coverage on an annual basis is $ per vehicle. If you wish to purchase the extraordinary medical benefit coverage, please notify your agent or insurance company for additional information. If you do not wish to purchase extraordinary medical benefit coverage, please disregard this notice.

Sec. 1798.3. Unfunded liability report.

By May 15, 1989, the Insurance Commissioner and the Budget Secretary shall jointly prepare and provide to the Governor and to the General Assembly a report on the actuarial soundness of the fund, including a projection of the additional revenues needed on a year-to-year basis and a comparison of the cost of providing additional revenues on a year-to-year, as-needed basis and the cost of providing adequate revenues to eliminate the unfunded liability within no more than five years. The report shall include recommendations as to how rapidly the unfunded liability should be

eliminated and what the source or sources of the additional revenues should be, which shall include, but not be limited to, the General Fund or other surcharges. If such report includes recommendations for collecting a surcharge to eliminate the unfunded liability, the report shall compare the consequences of imposing that surcharge on each motor vehicle required to be registered under Chapter 13 (relating to registration of vehicles) except trailers, recreational vehicles not intended for highway use, motorcycles, motor-driven cycles, motorized pedalcycles or like type vehicles; on each insured as defined in section 1702 (relating to definitions); and on each motor vehicle for which coverage is purchased under section 1715(a)(1) (relating to availability of adequate limits) and shall compare the consequences of eliminating the unfunded liability over a period of five years, a period of ten years, a period of 15 years and a period of 20 years.

Sec. 1798.4. Catastrophic Loss Benefits Continuation Fund.

(a) **Creation.**--The Catastrophic Loss Benefits Continuation Fund is hereby created to provide funds necessary to pay catastrophic loss benefits under section 1798.2 (relating to transition).

(b) **Composition.**--The Catastrophic Loss Benefits Continuation Fund shall be composed of funds transferred from the Catastrophic Loss Trust Fund, funds contributed pursuant to section 6506 (relating to surcharge) and funds earned by the investment and reinvestment of such funds. The funds shall be held in trust, be deposited in a separate account and be the sole and exclusive source of funds for the payment of catastrophic loss benefits under section 1798.2 and the administration of the Catastrophic Loss Benefits Continuation Fund.

(c) **Separation from General Fund and Motor License Fund.**--The fund and all income earned by it shall not become part of the General Fund or Motor License Fund. No obligations or expenses of or claim against the Catastrophic Loss Trust Fund or the Catastrophic Loss Benefits Continuation Fund shall constitute a debt of the Commonwealth or a charge against the General Fund or Motor License Fund. Upon the expiration of section 6506, excess money in the Catastrophic Loss Benefits Continuation Fund, beyond the money needed to cover the unfunded liability of the Catastrophic Loss Trust Fund in accordance with section 6506, shall be deposited in the Motor License Fund.

(d) **Borrowing from the Workers' Compensation Security Fund.**--Whenever the Governor shall ascertain that the cash balance and the current estimated receipts of the Catastrophic Loss Benefits Continuation Fund shall be insufficient at any time during any

fiscal period to meet promptly any expenses payable from the fund, the Governor shall authorize the transfer from the Workers' Compensation Security Fund to the Catastrophic Loss Benefits Continuation Fund such sums as are necessary. Any sum so transferred shall be available for the purpose for which the Catastrophic Loss Benefits Continuation Fund is created by law and shall be considered as a loan to that fund. Such transfers shall be made upon warrant of the State Treasurer upon requisition of the Governor. For purposes of determining whether contributions to the Workers' Compensation Security Fund pursuant to section 5 of the act of July 1, 1937 (P.L. 2532, No. 470), known as the Workers' Compensation Security Fund Act, are necessary, the Insurance Commissioner shall consider the amount of any loan made pursuant to this act as an asset of the Workers' Compensation Security Fund that does not reduce the fund below 5% of its loss reserves and does not trigger the resumption of contributions to the fund. The amounts transferred to the Catastrophic Loss Benefits Continuation Fund may carry over from fiscal year to fiscal year and shall be repaid together with an amount of interest equivalent to the average interest rate derived from investments of the Workers' Compensation Security Fund in the immediately preceding fiscal year as determined by the State Treasurer. An estimate of the actual and projected borrowings and loan repayments to be made from and to the Workers' Compensation Security Fund shall be included in the report required pursuant to section 7 of the act of July 1, 1989 (P.L. 115, No. 24), entitled "An act amending Title 75 (Vehicles) of the Pennsylvania Consolidated Statutes, creating the Catastrophic Loss Benefits Continuation Fund for payment of certain catastrophic loss benefits; providing for surcharges for certain offenses to provide moneys for the fund; and further providing for conditions of permits." The authorization to make transfers pursuant to this subsection shall expire on July 1, 1998, unless otherwise provided by the General Assembly.

Sec. 1799. Restraint system.

(a) **General rule.**--All insurance companies authorized to write private passenger automobile insurance within this Commonwealth shall provide premium discounts for motor vehicles equipped with passive restraint devices. These discounts shall apply to the first party benefits coverage and shall be approved by the commissioner as part of the insurer's rate filing, provided that such discounts shall not be less than 15% for passive seat belts, 20% for one airbag on the operator's side of the vehicle and 30% for two airbags. Some or all of the premium discounts required by this subsection may be omitted upon demonstration to the commissioner in an insurer's rate filing that the discounts are duplicative of other discounts provided by the insurer or specifically reflected in the insurer's experience.

(b) **Definitions.**--As used in this section, the following words and phrases shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Passive restraint." Any frontal automobile crash protection system which requires no action of the vehicle occupants and complies with standard 571.208 of the National Traffic Safety Administration or its successor.

Sec. 1799.1. Antitheft devices.

(a) **General rule.**--All insurance companies authorized to write private passenger automobile insurance within this Commonwealth shall provide premium discounts for motor vehicles with passive antitheft devices. These discounts shall apply to the comprehensive coverage and shall be approved by the commissioner as part of the insurer's rate filing, provided that such discounts shall not be less than 10%. Some or all of the premium discounts required by this subsection may be omitted upon demonstration to the commissioner in an insurer's rate filing that the discounts are duplicative of other discounts provided by the insurer.

(b) **Definitions.**--As used in this section, the following words and phrases shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Passive antitheft device." Any item or system installed in an automobile which is activated automatically when the operator turns the ignition key to the off position and which is designed to prevent unauthorized use, as prescribed by regulations of the commissioner. The term does not include an ignition interlock provided as a standard antitheft device by the original automobile manufacturer.

Sec. 1799.2. Driver improvement course discounts.

(a) **Motor vehicle driver improvement course.**--All insurance companies authorized to write private passenger automobile insurance within this Commonwealth shall provide a premium discount for each motor vehicle on a policy under which all named insureds are 55 years of age or older and have successfully completed a motor vehicle driver improvement course meeting the standards of the Department of Transportation. This discount shall apply to all coverages for all policy periods beginning within the three-year period immediately following the successful completion of the course, and shall be approved by the commissioner as part of the insurer's rate filing, provided that such discount shall not be less than 5%. The successful

completion of more than one course within a three-year period does not qualify the insured for additional discounts. The premium discount required by this subsection may be omitted upon demonstration to the commissioner in an insurer's rate filing that the discount is duplicative of a driver improvement course discount provided by the insurer.

(b) **Completion of course.**--Upon successfully completing the approved course, each participant shall be issued, by the course's sponsoring agency, a certificate which shall be the basis of qualification for the discount on insurance.

(c) **Continuing eligibility.**--Each participant shall take an approved course every three years to continue to be eligible for the discount on insurance. Each insurer may require, as a condition of providing and maintaining the discount, that the insured for a three-year period after course completion:

(1) not be involved in an accident for which the insured is chargeable;

(2) not be convicted of an offense enumerated in section 1535 (relating to schedule of convictions and points); and

(3) not be convicted, or have accepted Accelerated Rehabilitative Disposition (ARD) for driving under the influence of alcohol or a controlled substance.

(d) **Nonapplicability.**--This section shall not apply in the event the approved course is specified by a court or other governmental entity resulting from a conviction of an offense enumerated in section 1535.

Sec. 1799.3. Limit on cancellations, refusals to renew, refusals to write, surcharges, rate penalties and point assignments.

(a) **Damage claims.**--No insurer shall cancel or refuse to renew a policy or apply any surcharge, rate penalty or driver record point assignment where, during the preceding three-year period, the aggregate cost to the insurer for any person injured or property damaged is determined to be less than $650 in excess of any self-insured retention or deductible applicable to the named insured.

(b) **Reimbursements.**--A surcharge, rate penalty or driver record point assignment shall not be made if the insurer is reimbursed by or on behalf of the named insured or other resident operator for at least 60% of the total amount of the paid claim

received through subrogation or from a settlement or judgment against the individual responsible for the accident.

(c) **First party medical claims.**--No surcharge, rate penalty or driver record point assignment shall be made as a result of an insurer paying a first party medical claim.

(d) **Notice to insured.**--If an insurer makes a determination to impose a surcharge, rate penalty or driver record point assignment, the insurer shall inform the named insured of the determination and shall specify the manner in which the surcharge, rate penalty or driver record point assignment was made and clearly identify the amount of the surcharge or rate penalty on the premium notice for as long as the surcharge or rate penalty is in effect.

(e) **Adjustment of cap.**--The Insurance Department, at least once every three years, shall adjust the $650 cap or limit relative to changes in the components of the Consumer Price Index (Urban) to measure seasonally adjusted changes in medical care and automobile maintenance and repair costs and shall make such adjustments to the cap or limit as shall be necessary to maintain the same rate of change in the cap or limit as has occurred in the Consumer Price Index (Urban). Such adjustments may be rounded off to the nearest $50 figure.

(f) **Notice of refusal to write.**--If requested by the applicant, an agent for an insurer shall submit an application for automobile insurance to the insurer or provide the applicant written notice of the reasons for refusal to write on a form supplied by the insurer and approved by the commissioner. An applicant receiving a notice of reasons under this subsection may obtain review by the commissioner pursuant to the Automobile Insurance Policy Act. If either the applicant or insurer are aggrieved by the commissioner's review, the commissioner may in his discretion and for cause shown, hold a hearing pursuant to the Automobile Insurance Policy Act. No insurer shall take any action, overt or otherwise, against any agent or broker for complying with this subsection.

(g) **Conflict with other law.**--The limitations imposed on cancellations, refusals to renew, surcharges, rate penalties and point assignments by this section shall be in addition to any other limitations imposed by other laws. Where any conflict exists between this section and the provisions of any other law, this section shall be applied so as to supersede such other laws to the extent of the conflict.

Sec. 1799.4. Examination of vehicle repairs.

Upon request of the insurer, an insurance adjuster shall be afforded a reasonable opportunity to enter a repair facility and examine covered repairs being made to a specific insured's vehicle during regular business hours.

Sec. 1799.5. Conduct of market study.

(a) **Duty of Insurance Department.**--The Insurance Department may authorize a market conduct study of private passenger automobile insurers.

(b) **Purposes of study.**--The purposes of the study shall be to:

(1) Determine extent of insurer competition.

(2) Determine the number of uninsured motorists.

(3) Determine extent of insurer profits and losses.

(4) Determine that rates and premiums charged to residents are lawfully applied.

(5) Determine if the various policies for automobile insurance written in this Commonwealth are available equally to each resident.

(6) Determine the validity of existing rating territories and if rate differentials between or among rating territories is justified by the losses.

Sec. 1799.6. Conduct of random field surveys.

(a) **Authority.**--In furtherance of the purposes and goals of section 1799.5 (relating to conduct of market study), the Insurance Department may conduct field surveys of agents and brokers in this Commonwealth, which shall include but not be limited to:

(1) The determination of the geographical areas to be surveyed.

(2) The establishment of a list of insurance agents and brokers in the surveyed area or its immediate neighborhood.

(3) The interview of agents and brokers at their offices to obtain premium quotations from the agent for each

company represented by that agent.

(4) The sorting and categorizing of information.

(5) The construction of a table displaying quotations by insurer, area and risk.

(6) The writing of a report of the findings.

(b) **Conjunctive analysis of market study and field survey.**--The Department may analyze information collected from insurance companies under section 1799.5 in conjunction with information collected from field surveys. This analysis may be ongoing. The department's authority to undertake the conjunctive analysis is in addition to any other of its statutory investigative responsibilities. The conjunctive analysis may be used by the department for general regulatory purposes, including enforcement of the insurance laws.

Sec. 1799.7. Rates.

(a) **Rate filing.**--All insurers and the Assigned Risk Plan must file for new private passenger motor vehicle rates on or before May 1, 1990. These rates shall apply to all policies issued or renewed on and after July 1, 1990.

(b) Rate reductions.--The rates charged by insurers under the filing required by subsection (a) shall be reduced from current rates as follows:

(1) For an insured electing the limited tort option under section 1705 (relating to election of tort options), the total premium charged for any selections of coverages and coverage limits shall be reduced by at least 22% from the total premium for the same selection of coverages and coverage limits in effect on December 1, 1989.

(2) For an insured bound by the full tort option under section 1705, the total premium charged for any selection of coverages and coverage limits shall be reduced by at least 10% from the total premium for the same selection of coverages and coverage limits in effect on December 1, 1989.

(3) An insurer aggrieved by the rate reductions mandated by this subsection may seek relief from the commissioner which relief may be granted when the commissioner deems necessary in extraordinary circumstances.

(c) **Approval and disapproval of certain filings.**--Any initial filing submitted by an insurer pursuant to subsection (a), which reduces rates for all insureds from rates in effect December 1, 1989, in amounts specified in subsection (b), shall become effective immediately for policies issued or renewed on and after July 1, 1990, upon receipt by the department and shall be deemed to comply with the act of June 11, 1947 (P.L. 538, No. 246), known as The Casualty and Surety Rate Regulatory Act and with Chapter 20 (relating to motor vehicle insurance rate review procedures). Any filing so deemed may subsequently be disapproved, effective upon seven days written notice by the commissioner stating in what respect the filing or part thereof fails to meet the requirements of this chapter or other applicable law. If a deemed filing is so disapproved within 90 day after receipt by the commissioner, the commissioner may order the insurer to pay refunds to all insureds charged inappropriate rates under the filing. The ability to order refunds shall be in addition to other penalties authorized by law.

(d) **Immediate rate freeze.**--In order to provide stability during the period of transition leading up to the effective date of the amendments to 75 Pa. C.S. Ch. 17 (relating to financial responsibility) and to assure fair and equitable treatment of insurers and insureds, it is in the best interest of the Commonwealth to temporarily suspend the adoption of new private passenger motor vehicle rates. Notwithstanding any provisions of law to the contrary, all private passenger motor vehicle rates in effect on December 1, 1989, may not be changed so as to be effective prior to July 1, 1990. Any rate requests filed with the commissioner to be effective on or after December 1, 1989, whether or not such requests were approved by the commissioner or by operation of law, prior to, on or after December 1, 1989, are hereby disapproved as being in conflict with this chapter.

(e) **Rate freeze after implementation of tort option elections.**--No insurer nor the Assigned Risk Plan may increase any private passenger motor vehicle rates between July 1, 1990, and June 30, 1991.

(f) **Rate increase justification.**--All rates charged by an insurer during the period between July 1, 1991, and June 30, 1992, may not be increased over the rates in effect pursuant to subsections (b) and (e) by an amount greater than that indicated by an increase in the Consumer Price Index (Urban), the cost of medical care services, the cost of automobile repairs or other indices of cost increases affecting automobile insurance adopted by the commissioner by publication of notice in the Pennsylvania Bulletin.

(g) **Calculation of rates**--In all rate filings subsequent to the initial filing required by subsection (a), insurers shall allocate expenses, losses and income according to the coverages which generate such expenses, losses and income, provided that each

insurer shall provide its limited tort electors with premium savings that equal, in the aggregate, reductions in the insurer's losses created by limited tort electors under the system of tort options established in section 1705 (relating to election of tort options).

(h) **Coverage reductions.**--Insurers shall reduce the premium for insureds who elect to reduce or eliminate first party benefits, uninsured or underinsured motorist coverage required prior to the effective date of this section by the cost of such coverage.

APPENDIX B

Automobile Insurance
Medical Cost Containment
Regulations

CHAPTER 69. MOTOR VEHICLE FINANCIAL FINANCIAL RESPONSIBILITY LAW

Subchapter A. AUTOMOBILE INSURANCE MEDICAL COST CONTAINMENT

PRELIMINARY PROVISIONS

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PRELIMINARY PROVISIONS

§69.1 Purpose

This chapter implements section 18 of Act 6 relating to insurer payments for medical treatment provided to injured persons covered by automobile insurance policies.

§69.2 Applicability

This chapter applies to medical payments made by insurers under automobile insurance policies issued under the MVFRL. This chapter applies to insurer payments to providers for services rendered on and after November 30, 1991.

§69.3 Definitions

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

Act 6 - The act of February 7, 1990 (P.L. 11, No. 6)

Burn facility - A facility which meets the service standards of the American Burn Association.

Care or services - The treatment, accommodations, products or services provided by a person or institution.

Carrier - An organization with a contractual relationship with HCFA to process Medicare Part B claims.

Commissioner - The Insurance Commissioner of the Commonwealth.

DRG - Diagnostic-related group.

Department - The Insurance Department of the Commonwealth.

HCFA - The Health Care Financing Administration.

Insured - An injured person covered by an automobile insurance policy issued under the MVFRL.

Insurer - A property and casualty insurance company providing coverage under automobile insurance policies to residents of this Commonwealth.

Intermediary - An organization with a contractual relationship with HCFA to process Medicare Part A claims.

Life-threatening injury - The term shall be as defined by the American College of Surgeons' triage guidelines regarding the use of trauma centers for the region where the services are provided.

MVFRL - Motor Vehicle Financial Responsibility Law - Title 75 of the *Pennsylvania Consolidated Statutes* §§1701 - 1799.7 (relating to the Motor Vehicle Financial Responsibility Law).

Medicare Part A - Medicare hospital insurance benefits which reimburse providers for facility-based care, such as in-patient and out-patient hospital services and skilled nursing care.

Medicare Part B - Medicare supplementary medical insurance which reimburses providers for physician services, durable medical equipment, physical therapy and other services.

Medicare payment - Payment at 110% of the Medicare reimbursement allowance with includes the prevailing charge at the 75th percentile; the applicable fee schedule, the recommended fee or the inflation index charge; the DRG payment; or any other Medicare reimbursement mechanism; as applied in this Commonwealth under the Medicare Program.

Medicare prevailing charge - The lowest customary charge high enough to include 75% of the individual provider charges for

services as adjusted by all limitations mandated by HCFA and the carrier.

Medicare recommended fee - The fee for which a Medicare payment schedule does not exist, and which is developed based upon a solicited recommendation from a consulting specialist or group of specialists. This fee may vary depending upon the specifics of a particular case.

Pass-through costs - Medicare reimbursed costs to a hospital that "pass through" the prospective payment system and are not included in the DRG payments. The term includes medical education, capital expenditures, insurance and interest expense on fixed assets.

PRO - Peer Review Organization - A professional organization with which HCFA or the Commonwealth contracts for medical review of Medicare or Medical Assistance services, or a health care entity approved by the Commissioner, that engages in reviewing medical files for the purpose of determining that medical and rehabilitation services are medically necessary and economically provided.

Provider - A person or institution which provides treatment, accommodations, products or services.

Trauma center - A facility accredited by the Pennsylvania Trauma Systems Foundation under the Emergency Medical Services Act (35 P.S. §§6921-6938).

Urgent injury - The term shall be as defined by the American College of Surgeons' triage guidelines regarding use of trauma centers for the region where the services are provided.

Usual and customary charge - The charge most often made by providers of similar training, experience and licensure for a specific treatment, accommodation, product or service in the geographic area where the treatment, accommodation, product or service is provided.

COVERED SERVICES

§69.11 Payment limitation applicability

(a) The payment limitations of Act 6 apply to a provider rendering services to an injured person whose medical costs are covered by automobile insurance issued under the MVFRL. The payment limitations of Act 6 also apply to providers not currently participating in Medicare.

(b) The payment limitations of Act 6 apply in cases when care is rendered by a Pennsylvania licensed provider to a Pennsylvania resident covered by automobile insurance for injuries arising out of the maintenance or use of a motor vehicle, irrespective of where the injuries occurred or where the care is rendered.

§69.12 Exemption from payment limitations

(a) Acute care treatment and services for life-threatening or urgent injuries, and services for burn injury patients rendered by providers during transport to and while at a trauma center or a burn facility, shall be paid at the usual and customary charge when the insured's condition meets the definition of urgent or life-threatening injury, based upon information available at the time of the insured's assessment. When the initial assessment at the

trauma center determines that the insured's injuries are not urgent or life-threatening, the exemption shall apply only to the initial assessment and the transportation to the facility. A decision by ambulance personnel that an injury is urgent or life-threatening shall be presumptive of the reasonableness and necessity of the transport to a trauma center or burn facility unless there is clear evidence of a violation of the American College of Surgeons' Triage Guidelines.

(b) A provider may seek a determination that a Medicare reimbursement allowance under the Medicare Program is unreasonably by applying to the Department for a deviation from the Medicare reimbursement allowance. The application shall be provider specific and shall be for the specific Medicare reimbursement allowance that is believed to be unreasonable. The application for a different Medicare reimbursement allowance will be subject to a formal adjudicatory hearing in accordance with 2 Pa.C.S. §§501 - 508 and 701 - 704 (relating to the Administrative Agency Law).

PROVIDER BILLING

§69.21 Allowable payment amounts

The provider may not require payment in excess of the Medicare payment pertaining to the applicable specialty under Medicare for comparable services at the time services were rendered, or the provider's usual and customary charge, whichever is less. An insurer shall use the Medicare payment applicable in this Commonwealth to determine the appropriate payment. The applicable Medicare payment shall be utilized even when a service is not a reimbursed service under Medicare. If no Medicare payment has been calculated, payment shall be 80% of the provider's usual and customary charge.

§69.22 Billing procedures

(a) An insurer shall apply the Medicare payment limitations of Act 6 to provider services covered by bodily injury liability, uninsured and underinsured motorists, first-party medical and extraordinary medical benefits coverages under an automobile insurance policy.

(b) In an action for damages against a tortfeasor arising out of the maintenance or use of a motor vehicle 75 Pa.C.S. §1720 (relating to subrogation) applies.

(c) If an insured's first party limits have been exhausted, the insurer shall, within 30 days of the receipt of the provider's bill, provide notice to the provider and the insured that the first-party limits have been exhausted.

(d) Upon receipt of a provider's bill, the insurer shall make a determination of the appropriate Medicare payment and pay up to the first-party benefit limits of the policy. If the determined amount exceeds the benefit limits of the policy, or the determined amount plus previously paid benefits exceed the benefit limits of the policy, the provider may directly bill the insured or a secondary insurance carrier.

(e) If only a portion of the provider's services are paid by the automobile insurance policy, because benefit limits have been

exhausted, the provider may bill the insured for the remaining services not paid under the automobile insurance policy. The provider's bill to the insured shall be limited to the remaining services not paid under the automobile insurance policy.

> *Example:* Assume an insured $5,000 of first-party benefits from the insured's automobile insurance policy and no health insurance. Further assume the provider's bill totals $10,000 and the Medicare payment for the $10,000 total bill would be $6,000. The actual worth of the $5,000 of first-party benefits applied at the appropriate Medicare payment is $8,333 worth of services of the $10,000 bill ($5,000 is to $6,000 as x is to $10,000; x is $8,333). The provider may bill the insured $1,677, or $10,000 less $8,333, for the remaining services not paid under the automobile insurance policy.

(f) If another insurance policy exists and a provider bills that insurer for the actual worth of remaining services not paid (such as $1,667 in the Example in subsection (e)) that insurer shall determine the appropriate amount of payment to the provider under the terms of the insured's health or other insurance policy, without regard to the medical cost containment provisions of the act.

(g) When multiple providers seek reimbursement and when their bills for services collectively exceed the policy limits, providers shall be paid by the insurer in the order the insurer receives a provider's bill. If bills are received simultaneously, the bill with the lowest payment amount in accordance with §69.43 (relating to insurer payment requirements) shall be paid first.

(h) If no portion of the provider's bill is payable under automobile insurance coverage, the Medicare payment limitations no longer apply. A provider may directly bill the insured or other insurance carrier as it has prior to passage of Act 6.

§69.23 Applicable Medicare payment and codes

(a) The applicable Medicare fee schedule shall include fees associated with all permissible procedure codes. If the Medicare fee schedule also includes a larger grouping of procedure codes and corresponding charges than are specifically reimbursed by Medicare, a provider may use these codes, and corresponding charges shall be paid by insurers. If a Medicare code exists for application to a specific provider specialty, that code shall be used.

(b) Medicare payments are updated periodically by HCFA and the carrier and intermediaries. Insurers and providers shall utilize the latest Medicare payments as updated and provided by HCFA. Medicare payments shall be utilized by insurers and providers within 30 days of their effective date or date of official publication by HCFA, whichever occurs later.

(c) Medicare procedure codes are updated periodically by HCFA and the carrier and the intermediaries. The updated Medicare procedure codes shall be utilized by insurers and providers within 30 days of

their effective date or date of official publication by HCFA, whichever occurs later.

§69.24 Unbundling

A provider may not fragment or unbundle charges imposed for specific care except as consistent with the Medicare Program. Changes to a provider's codes by an insurer shall be made only as consistent with the Medicare Program and when the insurer has sufficient information to make the changes and following consultation with the provider. An insurer shall substantiate the reasons for coding changes to the provider in writing.

§69.25 Required billing information

(a) In submitting a request for payment to an insurer, a provider may state the full charge for services rendered. To the extent possible, a Part A provider shall submit DRG payment information including estimated pass-throughs and outliers as calculated by the intermediary and shall utilize Form UB82 or the form currently in use by Medicare. If Form UB82 is used, the intermediary assigned provider number shall be shown on the form. To the extent possible, a Part B provider shall utilize Medicare procedure codes for the service rendered and shall utilize Form HCFA-1500 or the form currently in use by Medicare. Provider specialty codes shall be provided, if known. Failure to use Forms UB82 and HCFA-1500 or Medicare procedure codes does not preclude payment by an insurer if the provider submits a complete narrative describing the services rendered for which payment is requested, including complete information on the insured and provider. When applicable, complete information on the primary or secondary diagnosis shall also be submitted.

(b) Insurer processing of provider bills under this section is subject to the Unfair Insurance Practices Act (40 P.S. §§1171.1 - 1171.15).

§69.26 Complaint submissions to the Department by providers

(a) Before submitting a complaint to the Department, a provider shall first attempt to resolve the complaint in writing with the affected insurer and show evidence that the attempt at resolution failed. An insurer shall respond to complaint correspondence from a provider within 30 days of receipt.

(b) In submitting an unresolved complaint to the Department, a provider shall include the following information for each insured person:

(1) The name of the insured.
(2) The name of the provider.
(3) The name of the insurer.

(c) The following documentation shall be attached:

(1) A copy of the claim filed with the insurer.
(2) A copy of the explanation of benefits paid or denied by the insurer.
(3) A copy of the provider's complaint correspondence sent to the insurer.
(4) A copy of the insurer's response to the provider's complaint.

(5) A written explanation of why the provider disagrees with the insurer's decision.
(6) The name, address and telephone number of the insurer's representative answering the provider's complaint.
(7) The name and telephone number of a contact person in the provider's office.

(d) Questions or disputes regarding whether care conforms to professional standards of performance and is medically necessary shall be resolved in accordance with the peer review provisions of Act 6 and this chapter.

(e) The submission of a complaint to the Department will not alter the provider's obligation to adhere to the 30-day time line for requesting a reconsideration of a PRO determination.

(f) This section does not limit or restrict any person with an interest in a medical claim payment from making a complaint to the department or another governmental unit having jurisdiction over any party to a medical claim.

INSURER CLAIMS PROCESSING

§69.41 Medicare data

An insurer may obtain data on Medicare procedure codes and Medicare payments from the carrier and intermediaries at a cost for preparation and distribution of the data. A request for services beyond providing this data from the carrier and intermediaries is a matter of private negotiation.

§69.42 Payments under the act

An insurer shall make payments to providers in accordance with the Medicare Program as applied in this Commonwealth by the carrier and intermediaries. Care covered under the Medicare Program shall be reimbursed at 110% of the Medicare payment or a different allowance as may be determined under §69.12(b) (relating to exemption from payment limitations). Medicare coinsurance and deductibles may not be excluded in payments made by the insurer.

§69.43 Insurer payment requirements

(a) For part A providers, the payment shall be 110% of the Medicare reimbursement allowance plus, when applicable, the estimated pass-through costs and applicable cost or day outliers which are facility specific as calculated by the intermediaries. An insurer is not required to maintain an open claim file until final settlement of the pass-through costs and outliers. A claim file may be closed upon payment of the estimated pass-through costs and outliers. The estimated pass-through costs should be submitted by the provider at the time of billing. Neither a provider nor an insurer may seek to reopen closed claims or bill upon final settlement of the pass-through costs and outliers. A provider may seek payment for these amounts if an insurer has not paid for the estimated pass-through costs and outliers.

(b) If a Medicare fee schedule exists for out-patient, rehabilitation and physician services, insurers shall pay Part A and Part B providers at 110%. If the Medicare reimbursement allowance is the Medicare aggregate payment, in areas such as out-

patient services, rehabilitation services, and home health care services, payment shall be 110% of the actual cost based upon the cost-to-charge rations for each ancillary, out-patient, or other reimbursable cost center service utilized by the insured. When an ancillary cost center's services consist of a combined fee schedule and a blended payment, insurers shall pay 110% of the fee schedule amount plus 110% of the actual cost based upon the cost-to-charge ratio payment for the ancillary cost center. Payment for in-patient rehabilitation services shall consist of the routine cost per diem (room and board) plus the actual cost based upon the cost-to-charge ratio of each ancillary cost center service times 110%. Payment for out-patient rehabilitation services shall be the actual cost based upon the cost-to-charge ratio for each ancillary cost center service times 110%. The costs used to develop these payments shall be based upon the latest audited Medicare cost report for that facility.

(c) An insurer shall pay the provider's usual and customary charge for services rendered when the charge is less than 110% of the Medicare payment or a different allowance as may be determined under §69.12(b) (relating to exemption from payment limitations). An insurer shall pay 80% of the provider's usual and customary charge for services rendered if no Medicare payment exists. In calculating the usual and customary charge, an insurer may utilize the requested payment amount on the provider's bill for services or the data collected by the carrier or intermediaries to the extent that the data is made available.

(d) An insurer shall provide a complete explanation of the calculations made in computing its determination of the amount payable including whether the calculation is based on 110% of the Medicare payment, 80% of the usual and customary charge or at a different allowance determined by the Commissioner under §69.12(b). A bill submitted by the provider delineating the services rendered and the information from which a determination could be made by the insurer as to the appropriate payment amount will not be construed as a demand for payment in excess of the permissible payment amount.

PEER REVIEW

§69.51 Authority

A PRO has the authority to evaluate the reasonableness and medical necessity of care, and the professional standards of performance including the appropriateness of the setting where the care is rendered, and the appropriateness of the delivery of the care rendered.

§69.52 Peer review procedures

(a) A provider's bill shall be referred to a PRO only when circumstances or conditions relating to medical and rehabilitative services provided cause a prudent person, familiar with the PRO procedures, standards and practices, to believe it necessary that a PRO determine the reasonableness and necessity of care, the appropriateness of the setting where the care is rendered, and the

appropriateness of the delivery of the care. An insurer shall notify a provider, in writing, when referring bills for PRO review at the time of the referral.
(b) An insurer shall make a referral to a PRO within 90 days of the insurer's receipt of sufficient documentation supporting the bill. An insurer shall pay bills for care that are not referred to a PRO within 30 days after the insurer receives sufficient documentation supporting the bill. If an insurer makes its referral after the 30th day and on or before the 90th day, the provider's bill for care shall be paid.
(c) During an initial determination, a PRO shall request in writing from the provider the records and documents necessary to undertake its review. The PRO shall afford the provider an opportunity to discuss the case with the reviewer and to submit information to the reviewer prior to a final determination.
(d) A PRO's initial determination shall be completed within 30 days after the receipt of requested information. When a provider fails to respond to the PRO's inquiry or provide requested information, a PRO may commence its review 30 days after the request for information is postmarked. If additional information critical for the outcome of the determination is submitted by a provider or requested by a PRO, the 30-day review period may be tolled up to 20 days for the information to be received and taken into consideration.
(e) A PRO shall provide a written analysis, including specific reasons for its decision, to insurers, which shall within 5 days of receipt, provide copies to providers and insureds. Without the written analysis, the review may not be considered an initial determination and unpaid provider bills subject to review shall be paid by the insurer. An insurer may request another initial determination if the request is made within 90 days of its receipt of the bill and supporting documentation in accordance with §69.52(b) (relating to peer review procedures). The written analysis of the initial determination shall notify all parties that they have 30 days from the day the initial determination is effected to request a reconsideration and the process and location for filing a request for reconsideration.
(f) A PRO's initial determination resulting in the denial of a provider's claim, in whole or in part, shall be effected by a licensed practitioner of like specialty or a licensed practitioner with experience providing and prescribing the care subject to the review.
(g) Absent a change of condition, a decision of not medically necessary by the PRO is basis for an insurer to deny payment for similar services to the same insured resulting from the same accident. The insured or subsequent provider has the right to request a reconsideration of the initial determination for subsequent treatment or services received or provided.
(h) An insurer, provider or insured may request, in writing, reconsideration of the initial PRO determination within 30 days from the date the initial determination is effected. A PRO may set a reasonable charge for a reconsideration but the charge for a reconsideration may not exceed the charge for the initial review. An insurer shall make full payment of the charge for

reconsideration to the PRO, but the amount paid for the reconsideration shall be ultimately borne by the party against whom a reconsideration determination is made.
(i) A reconsideration shall be effected by a licensed practitioner of like specialty as the provider subject to the reconsideration review. The licensed practitioner effecting the reconsideration review may not be the same licensed practitioner who rendered the PRO's initial determination.
(j) A PRO shall afford the party requesting reconsideration an opportunity to discuss the case with the reviewer and to submit additional information identified by the reviewer before making a final determination of the reconsideration.
(k) A reconsideration shall be based upon the information that led to the initial determination, new information found in medical records or additional evidence submitted by the requesting party.
(l) A PRO shall complete a reconsideration within 30 days after receipt of the information submitted under subsection (k). If additional information critical for the outcome of the determination is submitted by a provider or requested by a PRO, the 30-day review period may be tolled up to 20 days for the information to be received and taken into consideration. A PRO shall send written notification of the reconsideration determination to the insurer, which shall within 5 days of receipt provide copies to providers and insureds. The written notice shall contain the basis and rationale for the reconsideration determination.
(m) Upon determination of a reconsideration by a PRO, an insurer, provider or insured may appeal the determination to the courts.
(n) The insured may not be billed during the peer review process.

§69.53 PRO standards for operation
(a) A PRO shall contract, in writing, jointly or separately with an insurer for the provision of peer review services as authorized by Act 6 and this chapter.
(b) A PRO may not mediate disputes over appropriate charges, costs or payments, and may not engage in administration of claims for insurers. A PRO engaging in claims administration shall establish a separate company to perform peer review services.
(c) A PRO shall reimburse providers the cost for copying of records at the current rate HCFA reimburses its contracted PRO.
(d) Written notice of determinations shall be mailed to the insurer within 3 working days of conclusion of a PRO's review.
(e) A PRO shall apply National, or when appropriate, regional norms in conducting determinations. If National and regional norms do not exist, a PRO shall establish written criteria to be used in conducting its reviews based upon typical patterns of practice in the PRO's geographic area of operation.
(f) A PRO shall maintain reasonable security and confidentiality practices to prevent unauthorized access to PRO records and information including training of employees in procedures to protect the confidentiality of information.

§69.54 PRO reporting responsibility

(a) A PRO shall submit an annual report to the Commissioner. The report shall include, at a minimum:

(1) The number of determinations performed.
(2) The results of initial determinations delineated by the provider and insurer.
(3) The number of reconsiderations requested.
(4) The number of initial determinations overturned.
(5) The number of determinations where the review period was tolled under §69.52(d) and (l) (relating to peer review procedures).

(b) A PRO shall file this report with the Commissioner by March 1 of each year with the information for the preceding calendar year.
(c) The initial annual report is due by March 1, 1992 and shall cover the period from June 1, 1990 through December 31, 1991.

§69.55 Criteria for Department approval of a PRO

(a) A PRO shall apply in writing to the Commissioner for approval to contract with an insurer to provide peer review services in accordance with the act and this chapter. If the application is disapproved, the PRO may appeal the disapproval to the Commissioner. If the Commissioner determines that reasonable grounds exist to review the disapproval, the Commissioner may schedule a hearing to review the determination. The hearing shall be conducted in accordance with 2 Pa.C.S. §§501-508 and 701-704 (relating to the Administrative Agency Law).
(b) A PRO applicant shall include in its written application the following information:

(1) A Certification of Independence. A PRO may not be owned by a Pennsylvania-licensed insurer. While a PRO may be organized by one or more insurers, that PRO may not review the claims of those insurers, may not be a subsidiary or affiliate of those insurers' corporate structure and none of the PRO's officers or directors may have a direct financial interest in the insurers. PRO personnel may not review services provided to an insured by an institution or agency in which they have financial interest.
(2) A description of previous experience as a PRO and the length of time in operation.
(3) A certification that reviews are conducted by medical personnel licensed in this Commonwealth.
(4) A compensation policy. A PRO shall charge for its service on a flat fee or hourly rate basis. A PRO may not charge for services on a percentage or contingency fee basis.

(5) A quality assessment of the PRO's review services, including examples of the PRO's review procedures.
(6) A policy statement on the preservation of the confidentiality of medical records.
(7) A certification that the PRO will operate and provide services in accordance with §§69.51-69.54 and this section.

APPENDIX C

Insurance Department Statements of Policy

Subchapter B -	Forms
Subchapter C -	Rate and Rule Filings
Subchapter D -	Insurance Availability and Consumer Protections
Subchapter E -	Anti-Fraud Provisions
Subchapter F -	1992 Rates

CHAPTER 68. MOTOR VEHICLE FINANCIAL RESPONSIBILITY LAW AMENDMENTS - STATEMENTS OF POLICY

Subchap.

B. FORMS

C. RATE AND RULE FILINGS

D. INSURANCE AVAILABILITY AND CONSUMER PROTECTIONS

E. ANTI-FRAUD PROVISIONS

F. FILING GUIDELINES FOR JULY 1, 1991 THROUGH JUNE 30, 1992 RATES; DISCLOSURE OF PREMIUM CHARGES AND TORT OPTIONS

SUBCHAPTER B. FORMS

Sec.

68.101 Identification of forms.
68.102 Section 1705 - notice to insureds to advise of the full tort and limited tort options.
68.103 Section 1731-notice to insureds to reject UM or UIM coverage.
68.104 Section 1738-rejection of stacking for UM/UIM.
68.105 Section 1782-financial responsibility identification cards.
68.106 Section 1791.1(a)-invoice.
68.107 Section 1791.1(b)-notice of tort options.
68.108 Section 1791.1(c)-notice of premium discounts.
68.109 Section 1792(b)-mandatory deductibles.
68.110 Section 1799.3(f).
68.111 Section 1702-definition of private passenger motor vehicle.
68.112 Policy endorsements.
68.113 Scope of UM and UIM coverage available to a limited tort elector.

§68.101. Identification of forms.

(a) The Motor Vehicle Financial Responsibility Law, 75 Pa.C.S. Chapter 17 (MVFRL), as amended by the act of February 7, 1990 (P.L. 11, No. 6) (Act 6), requires the following forms and notices to be sent to insureds:

Section of the MVFRL	*Description of Form or Notice*
1705(a)(1)	Notice advising of the limited tort option and the comparative cost savings.
	Notice advising of the full tort option and the comparative cost savings.
1705(a)(3)	Second notice of both the full tort and limited tort options.
1731(b)	Notice to reject uninsured motorist coverage.
1731(c)	Notice to reject underinsured motorist coverage.
1738(d)(1)	Option form to reject stacking of uninsured motorist coverage.
1738(d)(2)	Option form to reject stacking of underinsured motorist coverage.
1782(d)	Insurance identification cards (no change in the card format)
1791.1(a)	Notice informing insured of the ability to limit coverage to liability and medical, and the premium needed to purchase these coverages.
1791.1(b)	Limited tort option form to be used after the first renewal under Act 6 and for new business.
1791.1(b)	Full tort option form to be used after the first renewal under Act 6 and for new business.
1791.1(c)	Notice of premium discounts for passive restraints, air bags, anti-theft devices and driver training.

1792(b)(1) Statement requesting deductible of less than $500 for collision coverage.

(b) The forms which are identified in 75 Pa.C.S. §§1705(a)(1) and (3), 1791.1(b) and (c) and 1792(b)(1) are not applicable to commercial automobile insureds.

(c) To make the forms listed in subsection (a) understandable to consumers, instructions to assist insureds and applicants in choosing appropriate coverage options and in properly completing the forms shall be provided by insurers and the Assigned Risk Plan. A company return envelope shall accompany these instructions. To enable insurers to meet their statutory deadline, the Insurance Department (Department) has provided a model instruction sheet, color coded printed forms and an explanatory booklet. The forms in Appendix A shall be sent in the initial mailing to insureds. Insurers may use company-unique documents for this purpose subject to prior approval by the Department. The Department urges companies to use these preapproved documents which are in Appendix A.

(d) Forms shall meet the printing and legibility requirements in §64.9 (relating to legibility) for private passenger automobile forms.

(e) Forms produced in compliance with this subchapter, including those in Appendix A, may be filed with the Department on a file and use basis, and should be filed together as a package.

(f) The instructions and forms described in subsection (c) shall be sent to insureds at least 45 days prior to renewal, and shall be sent as a separate and unique mailing from other correspondence to the insured, such as the renewal policy or billing notice. Mailing compliance is achieved by sending these forms and notices to the person and address shown as item number 1 on the policy declaration sheet.

(g) On or before May 15, 1990, the first forms and notices required under the amended MVFRL shall be sent to insureds whose policies have a renewal effective date of July 1, 1990. If the forms and notices are returned by the insured and received by the company within 15 days of the initial mailing, the company shall reflect the insured's choices on the renewal policy billing.

§68.102. Section 1705-notice to insureds to advise of the full tort and limited tort options.

(a) The Insurance Commissioner has adopted the model form in Appendix A. The tort option form shall be signed by a named insured, and is binding on other named insureds.

(b) Both the full tort and limited tort options shall be printed on the same sheet of paper. The form requires an indication of the dollar amount of savings that will be realized by the choice of the full tort or limited tort option. The dollar savings notification will offer an insured a way to compare the price of his current in-force policy with the same policy enjoying either the minimum 10% full tort or 22% limited tort cost savings mandated by the act of February 7, 1990 (P.L. 11, No. 6) (Act 6). The term "basic coverage," as used in this notice, means the coverages that the insured has in force at the time the notice is sent.

(c) A premium comparison based on a semiannual rather than an

annual premium may be explicitly designated in an explanatory note in the premium comparison at the top of the cover sheet in Appendix A, in lieu of showing it on the limited tort or full tort notice.

(d) A second notice shall be sent to the insured if the insured does not respond within 20 days from the initial mailing date. The insurer may allow for a combined mailing time of 10 days for a total of 30 days before the second and final notice must be sent. The second notice shall have the words, "Second and Final Notice" displayed on it.

(e) If a company sends out two notices concerning the tort options, and the form is returned twice with different options, the company shall provide the full tort option to the policyholder and send correspondence to the agent or to the insured asking for clarification.

(f) The laws prohibits insurers or agents from discriminating in any manner between insureds who select either the full tort or limited tort option.

§68.103. Section 1731-notice to insureds to reject UM or UIM coverage.

(a) The use of the statutory language for these notices is required. Copies of these notices are included in Appendix A.

(b) Uninsured and underinsured motorist coverage shall be sold separately. insureds are free to buy or reject either coverage. Companies and agents may not engage in a practice to link the purchase of one of these coverages with the other, or require the same limits.

(c) To be valid, the rejection forms shall be signed by the "first named insured." The first named insured is the first name that appears in item 1 of the policy declarations page and on the recommended instruction sheet.

(d) If the first named insured makes no selection regarding uninsured or underinsured motorist coverage, then the coverage defaults to the same levels of coverage as previously provided to the insured. If the insured made a prior selection under 75 Pa.C.S. §1734 (relating to request for lower limits of coverage) for an amount less than the limits of liability for bodily injury, the Department regards this prior selection by the named insured as a waiver sufficient to comply with 75 Pa.C.S. §1731(c.1) (relating to availability, scope and amount of coverage).

(e) 75 Pa.C.S. §1731(c.1) requires the insurer to disclose the rejection of UM/UIM coverage. The declarations sheet can be used for this purpose.

§68.104. Section 1738 - rejection of stacking for UM/UIM.

The act of February 7, 1990 (P.L. 11, No. 6) (Act 6) requires new forms for the rejection of the stacking of uninsured and underinsured motorist coverage. Forms for each waiver shall follow the statutory language. A copy of this form is also included in Appendix A. This form shall also be signed by the first named insured.

§68.105. Section 1782 - financial responsibility identification cards.

(a) The act of February 7, 1990 (P.L. 11, No. 6) (Act 6) requires a change in the processing of insurance identification cards. Amended 75 Pa.C.S. §1782 (relating to manner of providing proof of financial responsibility) requires that ID cards be issued only upon the actual receipt of premium and reflect the period for which premium has been paid. If the premium has been financed by the agent, a premium finance company or an insurer-sponsored payment plan, a 6-month period may be reflected on the card.

(b) Companies who issue and mail a separate and unique notice of cancellation for nonpayment of renewal premium may issue the ID card at the same time that the renewal is processed since coverage remains in effect until otherwise canceled. Companies who use a combination cancellation/renewal notice may not issue an ID card with the renewal.

§68.106. Section 1791.1(2) - invoice.

(a) The act of February 7, 1990 (P.L. 11, No. 6) (Act 6) requires a new form giving an itemized comparison of minimum motor vehicle coverage levels with the insured's current coverages. The invoice shall contain the statutory language. Insurers may satisfy this requirement by printing another declarations page that includes the required information, or by providing that information on a billing notice. If a company uses either of these methods, the Insurance Department will not require the invoice to be filed. This comparison is required for renewals subsequent to the first renewal under Act 6, and for new business applied for on or after July 1, 1990. The annual renewal occurs at the annual anniversary date of the issuance of the original policy.

(b) The declarations page or billing notice shall contain the statutory language in 75 Pa.C.S. §1791.1(a) (relating to notice of available benefits and limits).

(c) The Insurance Department interprets Act 6 as granting insureds the right to purchase the minimum legal limits of coverage if they choose. Minimum limits for liability and medical coverages shall be available in all company programs and through the Assigned Risk Plan.

§68.107. Section 1791.1(b)-notice of tort options.

Notices for limited and full tort options are mandated for insureds. These forms are required for new business on or after July 1, 1990, and for renewal policies issued after the first renewal cycle following the initial notices required in 75 Pa.C.S. §1705 (relating to election of tort options). The use of statutory language is required. These notices shall be sent with the annual renewal forms. As previously indicated, the annual renewal occurs at the annual anniversary date of the issuance of the original policy.

§68.108. Section 1791.1(c)-notice of premium discounts.

Insureds shall be sent a notice informing them of other types of discounts for which they may qualify. The Insurance Department has included this information in Appendix A.

§68.109. Section 1792(b)-mandatory deductibles.

Insurers shall issue or renew policies with a $500 collision deductible unless the insured signs a statement indicating that the insured is aware of the additional cost of purchasing a lower deductible and opts for the lower deductible. The Insurance Department has included this information in Appendix A.

§68.110. Section 1799.3(f).

The act of February 7, 1990 (P.L. 11, No. 6) (Act 6), requires that agents provide a written notice of refusal to write to an insured who is refused automobile insurance coverage. The Department has included a model form as Appendix B which may be filed and used. The company shall include the company name prominently on the form. Companies will be responsible to furnish this form to their agents and properly instruct them on its use.

§68.111. Section 1702-definition of private passenger motor vehicle.

A "private passenger motor vehicle" includes all vehicles written under a private passenger automobile policy, and excludes a vehicle written on a commercial automobile policy, regardless of ownership.

§68.112. Policy endorsements.

Policy endorsements shall be filed with the Insurance Department (Department) on a file and use basis by May 1, 1990. The statutory language should be used in these forms when possible. In the Department's opinion, the changes to policy endorsements are self-evident, and detailed explanations are not necessary except for guidance with respect to availability of coverage under 75 Pa.C.S. §1705(d)(1) (relating to election of tort options) and limitation on recovery under 75 Pa.C.S. §1731(d)(2) (relating to availability, scope and amount of coverage). This explanation is provided in §68.113 (relating to scope of UM and UIM coverage available to a limited tort elector).

§68.113. **Scope of UM and UIM coverage available to a limited tort elector.**

It is the Insurance Department's position that a person who selects a limited tort option is not precluded from suing for noneconomic loss or making a claim under his uninsured or underinsured motorist coverage when the conditions of 75 Pa.C.S. §1705(d)(1)(i)-(iii) (relating to election of tort options) are met. When a person who selects a limited tort option has been injured by an uninsured motorist as described in 75 Pa.C.S. §1705(d)(1)(iv), the injured person may maintain an action for noneconomic loss, but is precluded by 75 Pa.C.S. §1731(d)(2) (relating to availability, scope and amount of coverage) from making a claim under his uninsured or underinsured motorist coverage for pain and suffering unless at least one of the conditions of 75 Pa.C.S. §1705(d)(1)(i), (ii) or (iii) is satisfied.

SUBCHAPTER C. RATE AND RULE FILINGS

Sec.

68.201	**Private passenger motor vehicle rate and rule filings.**
68.202	**Rate freeze.**
68.203	**Components of the rate filing.**
68.204	**Calculation of rates for subsequent filings.**
68.205	**Commercial motor vehicle risks.**
68.206	**Other Pennsylvania registered or principally garaged motor vehicle risks.**

§68.201. Private passenger motor vehicle rate and rule filings.

(a) Mandatory rate filing. Private passenger motor vehicle insurance companies are required under 75 Pa.C.S. §1799.7(a) (relating to rates) to file a mandatory rate and rule filing, including a complete revised manual, with the Insurance Department (Department) on or before May 1, 1990. These filings shall contain the mandated reductions in the total premium charged for any selection of coverages from the total premium charged for the same selection of coverages under rates in effect December 1, 1989. These premium reductions shall be at least 10% for insureds electing the full tort option and at least 22% for insureds electing the limited tort option under 75 Pa.C.S. §1799.7(b). The rate and rule filings are applicable to private passenger motor vehicle insurance policies issued or renewed to be effective on or after July 1, 1990.

(b) Rate service organization. The Insurance Services Office (ISO) may file the mandatory May 1, 1990 rate and ruling filing on behalf of all insurance company members of ISO. Companies planning to implement the ISO filing effective July 1, 1990 shall notify the Department of their intention on or before May 1, 1990.

(c) Approval of mandatory filing. The rate and rule filings described in subsection (a) are approved immediately upon receipt by the Department to be effective July 1, 1990. These file and use filings will be reviewed by the Department under 75 Pa.C.S. §1799.7(c).

(d) Option of prior approval. The Department will offer the option of prior approval, if so requested by a company, for those rate and rule filings that satisfy the requirements of the act of February 7, 1990 (P.L. 11, No. 6) (Act 6). The Department is committed to reviewing the requests for prior approval within 30 days of receipt of the rate and rule filing; however, the Department's first priority will be to review those filings requesting rate relief due to extraordinary circumstances. While a company may receive prior approval for its filing prior to July 1, 1990, the filing will only take effect July 1, 1990.

(e) Rate reductions. To achieve the minimum 10% and 22% reductions in premium from rates in effect on December 1, 1989 as required by 75 Pa.C.S. §1799.7(b), a company may use one of the following methods:

(1) The company may reduce rates by a certain fixed level for each coverage separately. Then, to ensure that insureds receive the mandatory premium reductions, the company will be required to

demonstrate that the overall effect of the various rate reductions applied separately by coverage will produce premium reductions of at least 10% for full tort electors and at least 22% for limited tort electors, regardless of driver class, rating territory and selection of coverages and coverage limits.

(2) Within each rating territory, the company may reduce premiums by fixed levels of at least 10% and 22%, depending upon the tort option selected, for all risks on a coverage by coverage, limit by limit basis. To use this approach, the company will be required to justify the overall premium reduction levels applicable for each territory, separately for full tort and limited tort electors. While these reductions can be applied across-the-board to all risks, coverages and limits within a given rating territory, the reduction levels will vary by rating territory in direct relation to the personal injury component-bodily injury, first party benefits and uninsured and underinsured motorist coverages-of the total limits premium within the territory.

(f) Physical damage only policies. In determining the appropriate rates for physical damage only policies, a motor vehicle insurance company shall consider the various cost savings provisions of Act 6, but need not satisfy the mandatory minimum 10% and 22% premium reductions mandated by 75 Pa.C.S. §1799.7(b).

(g) Extraordinary circumstances filings.

(1) Procedures.

(i) As stated in subsection (a), private passenger motor vehicle insurance companies shall submit the mandatory May 1, 1990 rate filing that satisfies the minimum 10% and 22% premium reductions required by law to be effective July 1, 1990. However, under 75 Pa.C.S. §1779.7(b)(3), a company may also, under extraordinary circumstances, file for relief from the mandated rate reductions. This additional filing may be made at the same time that the company makes the mandatory May 1, 1990 filing, or subsequent to the mandatory filing.

(ii) Extraordinary circumstances filings, as discussed in sub-paragraph (i), shall be separate and additional rate filings. Unlike the mandatory May 1, 1990 filings, these filings are not approved upon receipt by the Department. Extraordinary circumstances filings are subject to the motor vehicle insurance rate review procedures of 75 Pa.C.S. Chapter 20 (relating to motor vehicle insurance rate review procedures). The Department will provide priority review to extraordinary circumstances filings, in order of receipt.

(2) Rate relief.

(i) The Department interprets the provisions of 75 Pa.C.S. §1799.7(b)(3) providing for rate relief upon a showing of extraordinary circumstances to indicate a legislative intention that these rate filings were to be considered out of the ordinary and thus relief was not to be granted on a routine basis. The Department will consider extraordinary circumstances filings on a case by case basis.

(ii) If an insurance company is able to demonstrate extraordinary circumstances, this impact can be used to calculate the rates to be effective July 1, 1990.

(3) Definition. The Department interprets extraordinary

circumstances to mean that an insurance company's rates as filed in the mandatory May 1, 1990 filing would be constitutionally confiscatory. In using this standard, the Department will take the following factors into consideration:

(i) The insurance company's financial solvency.

(ii) The adequacy of the rates that were frozen at the December 1, 1989 level.

(iii) Other special circumstances unique to the insurance company and its particular book of business caused by Act 6.

§68.202. Rate freeze.

(a) Interim rate freeze.

(1) The act of February 7, 1990 (P.L. 11, No. 6) (Act 6) provides for rate stability during the period of transition by freezing rates in effect December 1, 1989, and disapproving rates filed to be effective on or after December 1, 1989, whether or not these rates were ever approved. The rates disapproved by Act 6 include filings approved to be effective after December 1, 1989 by operation of law so-called "deemed" filings.

(2) It is the position of the Insurance Department (Department) that symbol filings which are either rate neutral or simply add new motor vehicle models to a company's data base are not disapproved by Act 6 and may continue to be filed for approval with the Department. These filings will be subject to the Department's scrutiny to confirm that they meet the requirements in paragraph (1).

(b) Disapproval of certain filings. Rate filings that were filed to be effective on or after December 1, 1989, and approved by the Department or by operation of law, shall revert to December 1, 1989 rates effective February 7, 1990. A new or renewal policy written at the new rates prior to February 7, 1990 may remain in effect. However, a new or renewal policy written at the new rates on or after February 7, 1990 shall be corrected to December 1, 1989 rates, and appropriate refunds given.

(c) Further rate freezes. Rates are further frozen under Act 6 following implementation of the mandatory May 1, 1990 filings to be effective on July 1, 1990. Under 75 Pa.C.S. §1799.7(e) (relating to rates), no insurance company may increase private passenger motor vehicle insurance rates between July 1, 1990 and June 30, 1991. Rates charged by insurance companies for voluntary risks during the period of July 1, 1991 through June 30, 1992 may not be increased over the reduced rates in effect by an amount greater than what is justified by increases in the Consumer Price Index (URBAN), the cost of medical care services, the cost of automobile repairs or other indices of cost increases affecting automobile insurance as adopted by the Insurance Commissioner.

§68.203. Components of the rate filing.

(a) Consideration of cost savings. In submitting the mandatory May 1, 1990 rate and rule filing to the Insurance Department (Department), private passenger motor vehicle insurance companies shall demonstrate consideration of all of the cost savings resulting

from implementation of the act of February 7, 1990 (P.L. 11, No. 6) (Act 6) including:

(1) Optional verbal threshold.
(2) Capped reimbursement levels for medical care.
(3) Utilization of peer review organizations.
(4) Elimination of duplicate recoveries.
(5) Measures to combat insurance fraud.
(6) Anticipated reduction in the uninsured motorist population.

(b) Minimum medical payment coverage. Private passenger motor vehicle insurance companies and the Assigned Risk Plan shall provide rates for a minimum first party medical payment coverage in the amount of **$5,000** within the rate filing submitted to the Department, as required by 75 Pa.C.S. §1711(a) (relating to required benefits). Excluding this $5,000 medical payment coverage, other first party benefit coverages are now optional and shall be priced separately in the company's rate filing and rate and rule manual.

(c) Availability of minimum coverages. Private passenger motor vehicle insurance companies and the Assigned Risk Plan shall make available a motor vehicle insurance policy which contains only the minimum requirements of financial responsibility and medical benefits, as required by 75 Pa.C.S. §1711(b). As such, insurance companies are required to provide coverages including $15,000/$30,000 bodily injury liability limits, $5,000 property damage liability limits and $5,000 first party medical payment limits. A company is obligated to make provisions for the application of these coverages and limits in both its rate filing and rate and rule manual.

(d) Combination of benefits limit. The mandatory combination of benefits limit has been reduced from up to at least $277,500 to $177,500 under 75 Pa.C.S. §1715 (relating to availability of adequate limits). Companies and the Assigned Risk Plan may satisfy this requirement by including a combination of benefits rate at a level of $177,500 or any amount above this level. Thus, a company retaining the limit of $277,500 would be in compliance with 75 Pa.C.S. §1715. If a company reduces the limit on the combination of benefits coverage, the rate shall be reduced accordingly.

(e) Uninsured and underinsured motorist coverages.

(1) The following principles will be used by the Department in reviewing the rates filed for the various types of uninsured and underinsured motorist coverage contemplated by Act 6:

(i) The uninsured and underinsured motorist coverages are now separate coverages that shall be priced separately.

(ii) An insured may select or reject both the uninsured and underinsured motorist coverages, independently of each other.

(iii) Following an insured's choice of uninsured or underinsured motorist coverage, the insured has the additional option of selecting or rejecting stacking of that coverage. The decision to select or reject stacking may be made for one coverage independently of the other.

(iv) Rates for uninsured and underinsured motorist coverages shall be priced separately for both full tort and limited tort electors.

(2) In short, companies and the Assigned Risk Plan shall make available the following coverages priced separately.

(i) Stacked uninsured motorist coverage for limited tort electors.

(ii) Unstacked uninsured motorist coverage for limited tort electors.

(iii) Stacked underinsured motorist coverage for limited tort electors.

(iv) Unstacked underinsured motorist coverage for limited tort electors.

(v) Stacked uninsured motorist coverage for full tort electors.

(vi) Unstacked uninsured motorist coverage for full tort electors.

(vii) Stacked underinsured motorist coverage for full tort electors.

(viii) Unstacked underinsured motorist coverage for full tort electors.

(f) Collision deductibles. Private passenger motor vehicle insurance companies providing collision coverage and the Assigned Risk Plan shall file a deductible in the amount of $500 for collision coverage, as required by 75 Pa.C.S. §1792(b) (relating to availability of uninsured, underinsured, bodily injury liability and property damage coverages and mandatory deductibles) and shall remove from its rate and rule manual rates for collision deductibles less than $100.

(g) Discounts. Private passenger motor vehicle insurance companies and the Assigned Risk Plan shall provide the following discounts:

(1) Restraint systems. Discounts for passive restraint devices provided under 75 Pa.C.S. §1799 (relating to restraint system) shall be applied to the rates for first party benefit coverages purchased. However, discounts should not duplicate other filed and approved discounts. If a vehicle is equipped with more than one safety device, only the highest discount can apply.

(2) Anti-theft devices. Discounts for anti-theft devices provided under 75 Pa.C.S. §1799.1 (relating to anti-theft devices) shall be applied to the rates for the comprehensive coverage. However, discounts should not duplicate other filed and approved discounts.

(3) Driver improvement courses. Discounts for driver improvement courses provided under 75 Pa.C.S. §1799.2 (relating to driver improvement course discounts) shall be applied to the rates for all coverages purchased. However, discounts should not duplicate other filed and approved discounts.

(h) Accident surcharges. Private passenger motor vehicle insurance companies shall file changes in their accident surcharge rules as part of their rate and rule manual.

(1) Insurance companies are prohibited under 75 Pa.C.S. §1799.3(a) (relating to limit on cancellations, refusals to renew, refusals to write, surcharges, rate penalties and point assignments) from applying a surcharge, rate penalty or driver record point assignment if, during the preceding 3 years, the aggregate amount paid by the named insured's insurance company for persons injured or

property damaged is determined to be less than $650 in excess of self-insured retention or deductible applicable to the named insured. This section applies separately to the initial surcharge amount and to subsequent surcharges. For each additional surcharge, rate penalty or driver record point assignment, there shall be an additional accumulation of $650 in aggregate payments, during the preceding 3 years, from incidents other than those generating the previous surcharge, rate penalty or driver record point assignment.

(2) A surcharge, rate penalty or driver record point assignment in effect prior to July 1, 1990 remains unchanged by 75 Pa.C.S. §1799.3(a).

(3) If the Department adjusts the $650 cap, as authorized by 75 Pa.C.S. §1799.3(e), the adjusted amount shall be used as the total accumulation in aggregate payments by the named insured's insurance company resulting from incidents separate from those considered for previous surcharges within the 3-year period.

(4) 75 Pa.C.S. §1799.3(b) prohibits a surcharge, rate penalty or driver record point assignment if the insurance company is reimbursed by or on behalf of the named insured or resident operator for at least 60% of the total amount of the paid claim through subrogation or from a settlement or judgment against the responsible party. If a surcharge is initially assessed, and reimbursement at a level of at least 60% is later obtained under this section, the insurance company shall refund the amount of the surcharge, rate penalty or driver record point assignment to the insured.

(5) 75 Pa.C.S. §1799.3(c) prohibits a surcharge, rate penalty or driver record point assignment if the only claim payment made by the insurance company is for the first party benefits medical coverage.

(i) Reduced premium for reduced coverage. Private passenger motor vehicle insurance companies shall further reduce the premium for insureds who elect to reduce or eliminate first party benefits or uninsured or underinsured motorist coverage required prior to July 1, 1990, by the cost of the coverage as required by 75 Pa.C.S. §1799.7(h) (relating to rates).

§68.204. Calculation of rates for subsequent filings.

(a) Method of calculation. Motor vehicle insurance companies are required under 75 Pa.C.S. §1799.7(g) (relating to rates), in filings made with the Insurance Department subsequent to the mandatory May 1, 1990 filing, to allocate expenses, losses and income according to the coverages which generate such expenses, losses and income, if each insurance company provides limited tort electors with premium savings that equal, in the aggregate, reductions in the company's losses created by the limited tort election. In each rate filing, the company shall forecast the total loss savings resulting from the proportion of insureds electing the limited tort option on a system-wide basis. This projection will depend on the number of exposures written by the insurance company and the system-wide proportion of limited tort electors, but it will not depend upon the proportion of limited tort electors written by the company. Loss dollars projected to be saved as a result of the

optional tort system shall be returned to the company's limited tort electors through appropriate premium reductions.

(b) Example.

(1) Consider two motor vehicle insurance companies, A and B, which have identical numbers of exposures and identical books of business in terms of the distribution of exposures over the various risk classifications and coverages purchased. Assume that 60% of Company A's insureds elect the limited tort option, whereas 90% of Company B's insureds elect the limited tort option. Suppose further that the system-wide proportion of limited tort electors is 85%. Then, the total loss savings achieved by both Company A and Company B as a result of the optional tort system should be identical, and based only upon the numbers of exposures written by the two companies and the 85% system-wide proportion of limited tort electors.

(2) The only difference in premiums between the two companies will be for limited tort electors. Specifically, limited tort electors in Company A will have their premiums reduced by an amount that is 1.5 times as great as the discount for limited tort electors in Company B, because the total amount saved by Company A will be divided up among only 2/3 as many limited tort electors

§68.205. Commercial motor vehicle risks.

Certain requirements of the act of February 7, 1990 (P.L. 11, No. 6) (Act 6) discussed for private passenger motor vehicles in §68.203 (relating to components of the rate filing), are also applicable to policies of insurance covering commercial motor vehicles risks in this Commonwealth. As such, commercial motor vehicle insurance companies and the Assigned Risk Plan shall make rate and rule filings, to be effective July 1, 1990, which reflect the following requirements:

(1) Minimum first party benefits medical payment coverage, as discussed in §68.203(b).

(2) Availability of minimum coverages, as discussed in §68.203(c).

(3) Combination of benefits limits, as discussed in §§68.203(d).

(4) Uninsured and underinsured motorist coverages, as discussed in §68.203(e).

(5) Accident surcharges, as discussed in §68.203(h).

§68.206. Other Pennsylvania registered or principally garaged motor vehicle risks.

Certain requirements of the act of February 7, 1990 (P.L. 11, No. 6) (Act 6) discussed for private passenger motor vehicles in §68.203 (relating to components of the rate filing), are also applicable to policies of insurance covering other Pennsylvania registered or principally garaged motor vehicle risks, including motorcycles. As such, motor vehicle insurance companies and the Assigned Risk Plan shall make rate and rule filings, to be effective

July 1, 1990, which reflect the following requirements:

(1) Uninsured and underinsured motorist coverages, as discussed in §68.203(c).

(2) Accident surcharges, as discussed in §68.203(h).

SUBCHAPTER D. INSURANCE AVAILABILITY AND CONSUMER PROTECTIONS

Sec.

68.301 New program ensuring clean risks access to a voluntary market rate.
68.302 Clean risks.
68.303 Limitations on terminations of policies for small accident experience.
68.304 Notice of refusals to write by agents and brokers.

§68.301. New program ensuring clean risks access to a voluntary market rate.

(a) Clean risk rating program. Provisions are in 75 Pa.C.S. §§1702 and 1742 (relating to definitions; and scope of plan) for a new insurance rating program, administered through the Assigned Risk Plan, whereby an eligible insured or applicant for insurance who meets the new statutorily established definition of "clean risk," will be written at a voluntary market rate level approved for the Assigned Risk Plan. Definitions of "Assigned Risk Plan," "clean risk" and "voluntary rate" are added in 75 Pa.C.S. §1702. To implement this new insurance rating program for applicants or insureds who meet the clean risk provisions of the statute, 75 Pa.C.S. §1742 expressly mandates that the Assigned Risk Plan include rules and rates for the equitable apportionment among participating insurers of clean risks.

(b) Adoption of Assigned Risk Plan and Rules.

(1) The Insurance Department (Department) is mandated by 75 Pa.C.S. §1741 (relating to establishment) to adopt a reasonable Assigned Risk Plan for the equitable apportionment among insurers of applicants who are unable to obtain insurance through ordinary methods. Assigned Risk Plan is defined in 75 Pa.C.S. §1742 as a program to apportion both assigned risks and clean risks among insurers. The scope of the plan shall include rules for the equitable apportionment of clean risks who shall receive a voluntary market rate under 75 Pa.C.S. §1742. Rules governing the effective date and time of coverage in situations where plan applicants seek immediate binding of coverage are also mandated by 75 Pa.C.S. §1742.

(2) Under 75 Pa.C.S. §1741, the Department has approved an Assigned Risk Plan which includes rating, rules and forms to govern the administration of the new clean risk rating program to be implemented by August 6, 1990, for new business and September 5, 1990 for renewal business and to otherwise comply with the Motor Vehicle Financial Responsibility Law, 75 Pa.C.S. §§1701 - 1799.7, as amended by the act of February 7, 1990 (P.L. 11, No. 6) (Act 6).

(c) Applicability and coverage of the clean risk rating program. The clean risk rating program applies only to private passenger automobile business; it does not affect the Assigned Risk Plan's current Commercial Automobile Insurance Program (CAIP).

(d) Implementation of clean risk application process.

(1) On and after August 6, 1990, insureds or applicants who meet the clean risk definition may seek a clean risk rate through the Assigned Risk Plan in accordance with the Plan rules governing clean risk placements. Insureds who have been assigned as

Assigned Risk Plan business but who meet the definition of a clean risk and renew on and after September 5, 1990 shall be converted by the assigned carrier at the first policy renewal date and receive the Plan's clean risk rate, or be offered the carrier's applicable voluntary rate, whichever is applicable under the Plan Rule 14A. Assigned Risk Plan business meeting the definition of clean risk and renewed with effective dates between July 1, 1990 and September 4, 1990 shall be converted to the clean risk program either upon receipt by the assigned insurer of the coverage option selection forms from the policyholder or October 6, 1990, whichever is earlier.

(2) Applications for clean risk placement shall be made in accordance with approved plan rules. Agents or brokers certified by the Assigned Risk Plan on and after August 6, 1990 are required to submit applications to the plan for assignment or provide the applicant with a written notice stating the reason for refusing to do so.

§68.302. Clean risks.

(a) Purpose of the definition. Clean risks, as defined in 75 Pa.C.S. §1702 (relating to definitions), are applicants or insureds who have been denied access to insurance at voluntary rates pursuant to the refusal to write provisions under the act of June 5, 1968 (P.L. 145, No. 78) (40 P.S. §§1008.1 - 1008.11) (Act 78), but who still may be eligible for rating as a clean risk through the Assigned Risk Plan on and after August 6, 1990. Therefore, clean risks, though potentially unable to secure coverage by conventional application directly to an insurer, may still secure a clean risk rate through the Assigned Risk Plan's clean risk rating program.

(b) Application of clean risk definition. The clean risk definition applies only to private passenger auto insurance policies as defined in Act 78. The definition shall be met by each insured (this includes all licensed drivers in the household whether or not they operate the insured's vehicle) or applicant covered under an insurance policy and for the policy to be rated as a clean risk the named insured has to have been a licensed operator in this Commonwealth or another state for the immediately preceding 3 years. The standards apply to insureds under the policy whether or not financial responsibility has been maintained during the preceding 3-year period. Clean risks may be surcharged as appropriate if the surcharge has been approved by the Insurance Department and is applied in accord with the limitations of 75 Pa.C.S. §§1793 and 1799.3 (relating to special provisions relating to premiums; and limit on cancellations, refusal to renew, refusal to write surcharges, rate penalties and point assignments).

§68.303. **Limitations on terminations of policies for small accident experience.**

(a) Small damage claims. 75 Pa.C.S. Chapter 17 (relating to the Motor Vehicle Financial Responsibility Law) effectively expands the existing consumer protection provisions of the act of June 5, 1968 (P.L. 140, No. 78) (40 P. S. §§1008.1-1008.11) (Act 78) by establishing a small damage claim threshold which shall be satisfied by an insured's aggregate paid loss experience before an insurer may

invoke policy terminations in accord with that statute. Specifically, 75 Pa.C.S. §1799.3(a) (relating to limit on cancellations, refusals to renew, refusals to write, surcharges, rate penalties and point assignments) in conjunction with Act 78 prohibits an insurer from canceling or refusing to renew an automobile policy unless during the preceding 36 months the insurer has paid out in the aggregate more than $650 for personal injuries or property damage claims for two or more accidents. Accidents may not be used for termination purposes until the named insured's insurer has actually paid out $650 or more above applicable deductibles or amounts paid by the insured. Only after the $650 aggregate requirement has been exceeded, may the accidents be used for termination purposes. Moreover, an accident excluded from consideration under Act 78 may not be used for termination purposes regardless of whether it resulted in a payment of $650 or more. Damage claims caused by an insured while previously an uninsured driver during the preceding 3-year period may not be applied toward the aggregate requirement. The new small damage claim threshold also applies to commercial policies that are not covered by Act 78.

(b) Adjustment of cap on small damage claims. 75 Pa.C.S. §1799.3(e) requires the $650 cap or limit to be adjusted at least every 3 years by the Insurance Department to maintain the same rate of change in the cap or limit as has occurred in the Consumer Price Index (URBAN), medical care and automobile maintenance and repair costs components.

§68.304. Notice of refusals to write by agents and brokers.

(a) Applicability of refusal to write notices. Agents and brokers are required by 75 Pa.C.S. §1799.3(f) (relating to limit on cancellations, refusals to renew, refusals to write surcharges, rate penalties and point assignments) to provide Insurance Department (Department) approved notices of refusals to write to applicants for automobile insurance if there is lawful reason for applicants to be denied an application for insurance. Consumers who request automobile insurance through an agent or broker shall either be afforded an application for insurance or be given a written notice which states clearly and specifically the reasons why the insurance cannot be provided. Insurers shall supply agents with Department approved notices. Agents and brokers licensed to sell automobile insurance in this Commonwealth are subject to this section. This requirement applies to private passenger motor vehicle insurance applications made directly to the voluntary market and applications to the Assigned Risk Plan.

(b) Procedure for agent and broker issuance of notices. Once an applicant requests automobile insurance from an agent or broker, the agent or broker is required to do the following in order:

(1) The agent or broker shall submit an application to any carrier with which the agent or broker has appointments and which has not formally restricted the agent from producing auto insurance business. If the applicant requests placement with a specific appointed carrier, an application to that carrier takes precedence over the applications made to the other appointed carriers. If there are lawful reasons under applicable statutes that an application cannot be made to any of the appointed carriers, the agent or broker

shall issue a refusal to write notice on behalf of the first carrier requested by the applicant or, in the absence of a request being made, the first carrier considered for placement by the agent or broker. In all instances, the refusal to write notice issued shall be on behalf of an insurer with whom the agent has an open line of business for private passenger motor vehicle insurance. If an agent has been formally restricted from producing business by all carriers with which he has appointments, the refusal to write notice issued shall state the name of the insurer and the nature of the formal restriction.

(2) If the agent or broker has lawful reason not to forward an application to his appointed insurer, he shall offer to make application to the Assigned Risk Plan. Application to the plan shall be done in accord with plan rules. If there is a lawful reason that the application to the plan cannot be made, the agent or broker shall provide the applicant in writing the specific reason for the refusal.

(3) An applicant for insurance through an agency is first entitled to access voluntary market coverage through the conventional insurance placement process. Only if this cannot occur for lawful reasons is the applicant then eligible for placement via the clean risk rating program. Only applicants for insurance whose risk characteristics preclude access to the voluntary insurance market under the act of June 5, 1968 (P.L. 140, No. 78) (40 P. S. §§1008.1-1008.11) (Act 78) may be written in the Assigned Risk Plan as an assigned risk at either clean risk or other than clean risk premiums, whichever is applicable.

(c) Records retention requirements. Agents shall forward copies of refusal to write notices involving appointed insurers to the respective insurers under §61.13 (relating to records; cancellation, refusal to write or renew). Agents and brokers shall maintain copies of refusals to write for the Assigned Risk Plan for 2 years from the date of issuance.

(d) Review by the Department. Upon receipt of a notice of a refusal to write an application, an applicant has 30 days in which to request review of the action by the Department under Act 78. If either the applicant or the insurer involved is aggrieved by the Department's review, the Insurance Commissioner may, for good cause shown, hold a formal administrative hearing under Act 78 and applicable regulations.

SUBCHAPTER E. ANTI-FRAUD PROVISIONS

Sec.
68.401 Anti-fraud plans.
68.402 Motor Vehicle Insurance Fraud Index Bureau.

§68.401 Anti-fraud plans.

(a) Filing of anti-fraud plans.

(1) 75 Pa.C.S. §1811 (relating to filing of plans) requires each insurance company licensed to write private passenger or commercial motor vehicle insurance in this Pennsylvania on July 1, 1990 to file an anti-fraud plan with the Insurance Department (Department) by December 31, 1990. An insurer licensed after July 1, 1990 shall file an anti-fraud plan with the Department within 6 months following the date of licensure. Newly licensed insurers will be notified by the Department's Division of Company Licensing of this requirement upon licensure. In addition, modifications to approved anti-fraud plans shall be filed with the Department within 30 calendar days of the modification. Modifications to the plan may be filed using insert pages. Extensive changes or additions to the plan require a completely revised plan to be filed with the Department. A comprehensive written explanation of modifications, including the nature and reason therefore, should accompany changes.

(2) Anti-fraud plans and modifications thereto should be sent to the attention of the Insurance Department, Gregory S. Martino, Director, Bureau of Enforcement, 1321 Strawberry Square, Harrisburg, Pennsylvania 17120. Filings shall identify a company contact person who is responsible for the anti-fraud plan.

(b) Anti-fraud plan contents.

(1) 75 Pa.C.S. §1812 (relating to content of plans) mandates that insurers establish plans containing specific anti-fraud procedures. Insurers are encouraged to file their anti-fraud plans in standard three ring binders divided into seven tabbed sections identified to include the following areas: prevention, detection/investigation, reporting, litigation/recovery, information sharing, cost control and other.

(2) In the respective areas, insurers are encouraged to include as much detail as possible about their procedures, including:

(i) Policies and procedures established by the insurer to prevent motor vehicle insurance fraud. The policies and procedures should cover all aspects of the insurer's operation and recognize the wide variety of potential fraudulent activity. Procedures should address internal fraud, fraud involving the integrity and security of company data including electronic data processed information, fraud involving employees or company representatives and fraud resulting from misrepresentation on applications and renewals for insurance coverage and claims fraud. Detailed information should be provided describing existing procedure manuals, internal policies, guidelines and employe training programs implemented by the insurer to prevent fraud. It is recommended that specific policies and procedures be either included

in the anti-fraud plan or, if the policies and procedures are voluminous, appropriately summarized.

(ii) Policies and procedures established by the insurer to detect and investigate possible motor vehicle insurance fraud in the claims and application review process. Reference should be made to specific procedure manuals, internal policies, guidelines and training initiatives designed to detect fraud in the claims and application review process.

(iii) Policies and procedures established by the insurer to report suspected or determined motor vehicle insurance fraud to appropriate law enforcement agencies including procedures to cooperate with and monitor progress of these agencies in their prosecution of fraud cases. The procedures shall ensure that suspected fraud cases, if there is a reasonable basis to believe that fraud has occurred, are reported to appropriate law enforcement authorities.

(iv) Policies and procedures established by the insurer to evaluate and undertake civil actions against persons who have engaged in fraudulent activities.

(v) Policies and procedures established by the insurer to report motor vehicle insurance fraud related activity on an ongoing basis to the designated fraud index bureau. To comply with this requirement, the insurer should describe reporting formats, frequency, method and other information deemed relevant by the insurer to report the activity to the index bureau.

(vi) Policies and procedures established by the insurer to ensure that the actual claim costs paid as a result of detected motor vehicle insurance fraud are not included in a rate base affecting the premiums of motor vehicle insurance to consumers.

(3) To facilitate the Department's understanding of the company's administration of its anti-fraud procedures, the company is encouraged to address the following elements in each section:

(i) Organizational components involved in or affected by the policies and procedures, including key positions involved.

(ii) Roles and interrelationships of components as they relate to the policies and procedures described.

(iii) Personnel resources involved and budget allocations to implement the anti-fraud policies and procedures.

(iv) Extra-company relationships with the index bureau and criminal authorities as they relate to the policies and procedures implemented for anti-fraud plans.

(4) Although the act of February 7, 1990 (P.L. 11, No. 6) (Act 6) addressed only motor vehicle insurance fraud, the Department encourages insurers to expand the scope of their anti-fraud plans to address fraud in other lines of insurance.

(c) Anti-fraud plan review disapproval. 75 Pa.C.S. §1813 (relating to review by commissioner) requires the Insurance Commissioner to review anti-fraud plans and receive subsequent modifications thereto. If the anti-fraud plan or modifications is disapproved, insurers will be notified by the Department of the specific reasons for disapproval. Plans disapproved by the Department shall be refiled within 60 days of the notification of disapproval. Refiled plans shall fully address the specific reasons for disapproval by the Department.

(d) Examination of insurer compliance with anti-fraud requirements. The Department will audit insurers to determine compliance with its anti-fraud plan and the anti-fraud provisions of Act 6 as part of financial and market conduct examinations performed under sections 213, 214 and 216 of The Insurance Department Act of one thousand nine hundred and twenty-one (40 P. S. §§51, 52 and 54).

(e) Insurer annual reports on anti-fraud activities.

(1) 75 Pa.C.S. §1814 (relating to report on anti-fraud activities) requires insurers to file reports with the Department each year on actions taken under their anti-fraud plans to prevent and combat motor vehicle insurance fraud during the preceding year. The first report is to be filed with the Department on or before March 31, 1992 covering the period July 1, 1990 through December 31, 1991. Thereafter, reports shall be filed by March 31 of each year and cover the previous calendar year's anti-fraud activities. The annual report should provide detailed information on the following:

(i) Specific actions taken by the insurer during the year to prevent and combat insurance fraud. The actions should be thoroughly described in the annual report and should contain statistical information relating to the number of cases of suspected and detected fraud, including the status of disposition of those cases, the number of personnel and other resources committed to detecting and combating fraud, and the total dollar cost or savings attributed to detected fraud.

(ii) Measures implemented throughout the year to provide for the integrity and security of data collected and maintained on fraud or suspected fraud. The measures apply to data collected and maintained in a manual or automated environment.

(iii) Originating sources of the information on the suspected fraudulent activity - for example, agent, adjustor, employee, policyholder and citizen.

(2) The annual reports should be submitted to the Department in a standard report format including a table of contents, summary, subdivisions of information in the report, including tables and graphs necessary to clearly illustrate the statistical information. Information and statistical data in the report should be broken down by application fraud, claim fraud and by private passenger and commercial motor vehicle insurance. Additionally, insurers should identify the person responsible for preparing and filing the annual report. The Department may require that the insurer clarify items addressed in the report or provide additional information relative to the annual report. Reports should be sent to the attention of the Insurance Department, Gregory S. Martino, Director, Bureau of Enforcement, 1321 Strawberry Square, Harrisburg, Pennsylvania 17120.

(f) Confidentiality of plans and reports. 75 Pa.C.S. §1816 (relating to confidentiality of plans and reports) requires that the anti-fraud plan, annual reports and information relating to the plan or report filed with the Department will be held as confidential, will not be subject to public inspection and will not become part of the public record.

(g) Obligation to report fraud to criminal authorities.

(1) 75 Pa.C.S. §1817 (relating to reporting of insurance fraud) requires that insurance companies and their employees,

agents, brokers, motor vehicle physical damage appraisers and public adjusters or public adjuster solicitors shall report incidents of suspected insurance fraud to Federal, State or local authorities. Licensed insurance agents and physical damage appraisers may report suspected fraud through the affected insurer with which they have a contractual relationship. Insurers shall report all instances where there is a reasonable basis to believe that fraud has occurred. Reports of suspected fraud should be made in writing with copies of the report sent to the index bureau by the individual filing the report. The report of suspected fraud should include the following:

(i) The person/entity suspected of the fraud.

(ii) The name, address and telephone number of the person filing the report of suspected fraud.

(iii) A description of the suspected fraud and the activity which led to the fraudulent act.

(iv) The evidence and information developed to support the activity and suspected fraud.

(2) If suspected insurance fraud specifically involves entities licensed by the Department, such as agents, brokers, physical damage appraisers and public adjusters, a copy of the report should also be filed with the Insurance Department, Bureau of Enforcement, Gregory S. Martino, Director, 1321 Strawberry Square, Harrisburg, Pennsylvania 17120.

§68.402. Motor Vehicle Insurance Fraud Index Bureau.

(a) Process for designation of a Motor Vehicle Insurance Fraud Index Bureau.

(1) 75 Pa.C.S. §1821 (relating to designation) provides for Insurance Department (Department) designation of an index bureau following consultation with insurers licensed to write motor vehicle insurance. The process will involve:

(i) Department consultation with the insurance industry, through its representative trade associations, for the purpose of developing basic qualifications and standards for an index bureau and its plan of operation.

(ii) Department publication of its intent to designate an index bureau and an invitation to interested entities to contact the Department for further information on how to be considered for designation.

(iii) Department designation of the index bureau.

(iv) Index bureau filing of its plan of operation with the Department.

(2) The Department in consultation with the insurance industry will prepare the qualifications and standards for the index bureau and its plan of operation. The Department invites written input and suggestions from insurers and plans to meet with representatives of the various industry trade associations during April and May of 1990 to receive input and suggestions on the necessary qualifications, specifications, standards and responsibilities of the index bureau. Written input or suggestions shall be provided to the Department's Bureau of Enforcement by May 31, 1990.

(3) The Department will provide by June 30, 1990 a public notification/announcement of its intent to designate a Motor Vehicle

Insurance Index Bureau. Interested parties who wish to be considered for designation as the index bureau will be invited to contact the Department to obtain details on the qualifications and standards developed by the Department prior to submitting a proposal for designation.

(4) The Department will review the proposals and make followup contacts necessary with the qualified candidates. Qualified candidates may be required to present oral presentations to the Department. Upon completion of the review and followup contacts, the Department will designate the entity which will serve as the motor vehicle insurance fraud index bureau. The designation will be made on or before October 1, 1990.

(b) Index bureau plan of operation.

(1) 75 Pa.C.S. §1821 requires that within 180 days after its designation, the index bureau will file with the Department a plan of operation. The plan will include the following:

(i) A description of the bureau's organizational makeup, staff complement, physical location and self-funding methodology.

(ii) Detailed procedures for a member to regularly report fraud related data to the bureau.

(iii) Policies and procedures governing insurer and law enforcement agency access to bureau data, information and reports, including appropriate fees charged.

(iv) A detailed accounting of how information on insurance fraud filed by insurers will be organized and maintained, including the bureau's use of electronic data processing.

(v) Other information, data, procedure or program relating to insurance fraud as required by the Department or determined necessary to facilitate the reporting and use of information and data.

(vi) Policies and procedures to ensure the preservation and confidentiality of the data, information and reports collected and maintained by the bureau.

(2) The Department will review the index bureau's plan of operation to ensure that it is consistent with the standards and qualifications developed for the bureau and reflects that the bureau will operate in accord with the statute. The index bureau will distribute its completed plan of operation to its membership.

(c) Requirements for insurer reporting to the index bureau.

(1) 75 Pa.C.S. §1822 (relating to reports) provides that as a condition of transacting insurance business in this Commonwealth, an insurer licensed to write private passenger and commercial motor vehicle insurance in this Commonwealth is required to become a member of the designated index bureau and report information about suspected fraudulent auto insurance applications and claims for benefits to the bureau. Insurers shall report relevant information about the suspected fraudulent act within 45 days of receipt of the claim or application.

(2) An insurer shall begin submitting information to the index bureau on suspected fraud by the date identified in the bureau's plan of operation. The information reported to the index bureau and format for the information shall be defined in the bureau's plan of operation, and at a minimum shall include:

(i) Identification of claimants, including name, address, date of birth, policy number and vehicle identification number (VIN).

(ii) Identification of medical providers, including name, address, licensure discipline, services provided and professional corporation title.

(iii) Identification of repair shop, including name, address, proprietor or employe names.

(iv) Identification of insurance adjusters, including names and addresses.

(v) Identification of attorneys representing claimants, including name, address, description of suits filed, and association or professional corporation title.

(vi) Narrative description of claims.

(vii) Other information deemed relevant by the submitting insurer or bureau.

(d) Membership reports to the Department and access to bureau data.

(1) Under 75 Pa.C.S. §1824 (relating to organization, reports and fees), the designated bureau is required to report annually to the Department a current listing of its member insurers. This report should be filed along with the bureau's annual report filed under 75 Pa.C.S. §1826 (relating to annual reports).

(2) Procedures for access to bureau information by member and nonmember insurers, other index bureaus, law enforcement authorities, including permissible charges therefore, should be incorporated in the bureau's plan of operation.

(e) Index bureau's annual report. 75 Pa.C.S. §1826 requires the index bureau to file an annual report with the Insurance Commissioner by July 1, 1991, and by July 1 of each year thereafter, on behalf of its members. The annual report should cover the immediately preceding annual period June I-May 31. The report shall cover the nature and effect of motor vehicle insurance fraud in this Commonwealth. It is anticipated that the report shall present summary and statistical data on fraud in this Commonwealth, including the total dollar amount of suspected fraud reported, the total number of individuals convicted of fraud and the total number of suspected fraudulent activities reported to the bureau under 75 Pa.C.S. §1822(b) and subsection (c). The annual report shall also be available to the membership of the bureau.

(f) Warning notice for motor vehicle insurance fraud.

(1) 75 Pa.C.S. §1827 (relating to warning notice on application for insurance and claim forms) requires that by May 1, 1990, applications, renewal notices and claim forms for automobile insurance contain the following statement established in the statute:

Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to 7 years and payment of a fine of up to $15,000.

(2) The statement in paragraph (1) in its statutorily established form shall appear on the relevant forms by printing or

be otherwise affixed by use of a stamp or preprinted pressure sensitive label. These forms are not subject to prior approval by the Department.

SUBCHAPTER F. FILING GUIDELINES FOR JULY 1, 1991 THROUGH JUNE 30,1992 RATES; DISCLOSURE OF PREMIUM CHARGES AND TORT OPTIONS

Sec.

68.101 File and use rate option.
68.602 Effective date of file and use rates.
68.603 Extraordinary circumstance relief; Act 6 experience.
68.694 Disclosure of premium charges and tort options on new and renewal business.

§68.601. File and use rate option.

Under 75 Pa.C.S. §1799.7(f) (relating to rates), the Insurance Commissioner has adopted by notice the maximum rate adjustment factors for rates charged by personal automobile insurers between July 1, 1991 and June 30, 1992. These factors may be used by an insurance company to increase personal automobile insurance rates on a file and use basis as outlined in this subchapter. Lower factors may also be used on a file and use basis. The changes may be taken separately by line of coverage for full and limited tort electors. A minimum 15.3% differential between the full tort rate and the limited tort rate shall be maintained for each insured. Only one file and use filing may be made. Other filings, including territorial relativity or classification relativity, or both, changes, shall continue to be made on a prior approval basis.

§68.602. Effective date of file and use rates.

(a) *A company not receiving rate adjustments between July 1, 1990 and June 30, 1991.* An insurance company that has not received rate adjustments effective between July 1, 1990 and June 30, 1991 may qualify to "file and use" the rate adjustments adopted by the Insurance Commissioner (Commissioner) under 75 Pa.C.S. §1799.7(f) (relating to rates) for new and renewal policies which become effective on or after July 1, 1991. To qualify, the insurance company shall submit notice of its intent to "file and use," including an updated manual, to the Insurance Department (Department) at least 30 days in advance of their proposed effective date.

(b) *A company receiving rate adjustments between July 1, 1990 and June 30, 1991.* An insurance company that has received rate adjustments effective between July 1, 1990 and June 30, 1991 may qualify to "file and use" the rate adjustments adopted by the Commissioner under 75 Pa.C.S. §1799(f) for new and renewal policies which become effective on the annual anniversary of the effective date of their rate adjustment. To qualify, the insurance company shall submit notice of the intent to "file and use," including an updated manual, to the Department at least 30 days in advance of its proposed effective date.

§68.603. Extraordinary circumstance relief; Act 6 experience.

An insurer aggrieved by the rate increase justification requirements of 75 Pa.C.S. §1799(f) (relating to rates) may seek relief by demonstrating extraordinary circumstances under 75 Pa.C.S. §1799.7(b)(3). Since the act of February 7, 1990 (P.L.11. No. 6)

(Act 6) has been in full effect since July 1, 1990, and in effect with regard to medical payments since April 15, 1990, the extraordinary circumstance filings shall include Act 6 experience. To facilitate the Department's actuarial review of extraordinary circumstance filings, Act 6 experience should be segregated from pre-Act 6 experience. Extraordinary circumstance filings will not be reviewed unless the Act 6 experience is segregated in the filing. Act 6 experience will be used to adjust rates for the purpose of determining extraordinary circumstances to the extent that it is actuarially credible.

§68.604. Disclosure of premium charges and tort options on new and renewal business.

Under 75 Pa.C.S. §1791.1(a) (relating to disclosure of premium charges and tort options), an insurer is required to provide an itemized invoice to an insured which displays the minimum limits and coverages required for the limited tort option. In implementing 75 Pa.C.S. §1791.1(b), an insurer should include up-to-date premium comparisons for the full and limited tort options in its notifications to customers. The Insurance Department encourages insurers to mail selection forms to those customers who did not complete forms during the initial implementation of the act of February 7, 1990 (P.L. 11, No. 6).