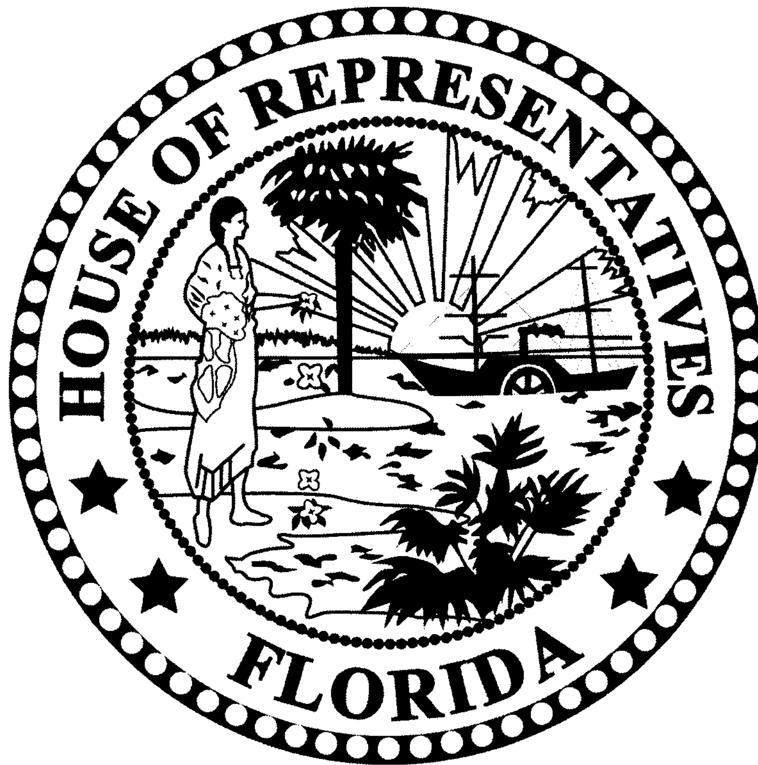

Jobs & Entrepreneurship Council

Tuesday, October 2, 2007
4:15 pm – 6:00 pm
212 Knott

(This is a joint meeting with the Committee on Insurance)

Marco Rubio
Speaker

Ron Reagan
Chair

Council Meeting Notice

HOUSE OF REPRESENTATIVES

Speaker Marco Rubio

Jobs & Entrepreneurship Council

Start Date and Time: Tuesday, October 02, 2007 04:15 pm

End Date and Time: Tuesday, October 02, 2007 06:00 pm

Location: 212 Knott Building
Duration: 1.75 hrs

The Jobs & Entrepreneurship Council will be meeting jointly with the Committee on Insurance to workshop the Florida Motor Vehicle No-Fault Law

NOTICE FINALIZED on 09/25/2007 16:15 by SJG

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Speaker Marco Rubio

Committee on Insurance

Start Date and Time: Tuesday, October 02, 2007 04:15 pm

End Date and Time: Tuesday, October 02, 2007 06:00 pm

Location: 212 Knott Building
Duration: 1.75 hrs

The Committee on Insurance will be meeting jointly with the Jobs & Entrepreneurship Council to workshop the Florida Motor Vehicle No-Fault Law

NOTICE FINALIZED on 09/25/2007 16:12 by SJG

Summary of Legislation

HB 13C by Representative Bogdanoff
Reenacting and Revising
The Florida Motor Vehicle No-Fault Law

Reenacts No-Fault Law

- Reenacts the No-Fault Law upon becoming law, for policies issued on or after that date. (No-Fault was repealed on Oct. 1, 2007.)
- Insurers must send revised premium and coverage change notices to persons who have been issued a policy or renewal notice without Personal Injury Protection (PIP) coverage.
- Persons who obtain a policy between October 1 and the effective date of the bill have until December 1, 2007, to add PIP and are not subject to penalties or no-fault tort restrictions until such time.
- Insurers must use the forms and rates that were in effect on September 30, 2007, for policies containing PIP, unless a new rate filing is made.
- The PIP reforms contained in the bill only apply to policies issued or renewed on or after January 15, 2008.

Medical Benefits - PIP continues to pay 80% of medical expenses up to $10,000, but the benefits are limited to services and care provided, ordered, or prescribed by a physician, osteopath, or dentist **or** provided by:

- Hospital or ambulatory surgical center
- Emergency transportation and treatment by an ambulance or emergency medical technician
- Chiropractic physician
- Entities wholly owned by physicians, osteopaths, chiropractors, dentists, or such practitioners and their spouse, parent, child, or sibling
- Entities wholly owned by a hospital or hospitals
- Licensed health care clinics that are accredited by a specified accrediting organization **or** the health care clinic:
    - Has a medical director that is a Florida licensed physician, osteopath, or chiropractor;
    - Has either been continuously licensed for more than 3 years or is a publicly traded corporation; and
    - Provides at least four of the following medical specialties: 1) general medicine; 2) radiography; 3) orthopedic medicine; 4) physical medicine; 5) physical therapy; 6) physical rehabilitation; 7) prescribing or dispensing outpatient prescription medication; 8) laboratory services.

Medical Fee Limits for PIP - Allows PIP insurers to limit reimbursement to 80% of the following schedule of maximum charges:

- For emergency transport and treatment (ambulance, emergency medical technicians), 200% of Medicare;
- For emergency services and care provided by a hospital, 75% of the hospital's usual and customary charge;
- For emergency services and care and related hospital inpatient services rendered by a physician, the usual and customary charges in the community;
- For hospital inpatient services, 200% of Medicare Part A;
- For hospital outpatient services, 200% of Medicare Part A;
- For all other medical services, 200% of Medicare Part B;
- If medical care is not reimbursable under Medicare, the insurer may limit reimbursement to 80% of the workers' compensation fee schedule. If the medical care is not reimbursable under either Medicare or workers' compensation, the insurer is not required to pay.
- The insurer may not apply any utilization limits that apply under Medicare or workers' compensation.
- The insurer must reimburse any health care provider rendering services under the scope of their license, regardless of any restriction under Medicare that restricts payments to certain types of health care providers for specified procedures.
- If an insurer limits payment as authorized, the medical provider may not bill the insured for any excess amount, except for amounts that are not covered due to the coinsurance amount or maximum policy limits.

Priority of Payment for Physicians Rendering Care in a Hospital

- If the PIP insurer receives notice of an accident, the insurer must reserve $5,000 of PIP benefits for payment to physicians rendering emergency care or inpatient care in the hospital.
- Thirty days after the insurer receives notice of an accident, the unclaimed amount of the reserve may be used to pay claims from other providers.
- The required time to pay claims to other providers is tolled for the time period the insurer is required to hold such claims due to this requirement.

Eliminates PIP Deductibles - Deductibles would no longer be allowed for PIP. (Currently, insurers must offer $250, $500, and $1,000 PIP deductibles.)

Mandatory Consolidation of PIP Claims - Requires that all PIP claims against an insurer related to the same health care provider for the same injured person must be brought together in a single lawsuit, unless good cause is shown why such claims should not be brought separately.

PIP Death Benefits - Clarifies current law that the death benefit is $5,000, or the remainder of unused PIP benefits, whichever is less.

Unfair Trade Practices; Attorney General Powers

- An insurer that fails to pay valid PIP claims with such frequency as to indicate a general business practice violates the unfair and deceptive practice provisions of the Insurance Code.
- The Dept. of Legal Affairs (Attorney General) may investigate and initiate actions for such violations, as specified in part II of ch. 501 (Deceptive and Unfair Practices)

Clarification of Property Damage Liability Mandate: Clarifies that property damage liability is mandatory and remains effective during any period that PIP is not required.

HB 13C
Bogdanoff

1 A bill to be entitled
2 An act relating to motor vehicle insurance; amending s.
3 316.646, F.S.; requiring each person operating a motor
4 vehicle to have in his or her possession proof of property
5 damage liability coverage; conforming a cross-reference to
6 changes made by the act; amending s. 320.02, F.S.;
7 clarifying the requirements concerning insurance and
8 liability coverage for certain motor vehicles registered
9 in this state; amending s. 321.245, F.S., relating to the
10 disposition of certain funds in the Highway Safety
11 Operating Trust Fund; conforming a cross-reference;
12 amending s. 324.022, F.S.; revising provisions requiring
13 the owner or operator of a motor vehicle to maintain
14 property damage liability coverage; specifying the
15 requirements that apply to such a policy; providing
16 definitions; requiring that a nonresident owner or
17 registrant of a motor vehicle maintain property damage
18 liability coverage if the motor vehicle is in the state
19 longer than a specified period; providing an exception for
20 a member of the United States Armed Forces who is on
21 active duty outside the United States; creating s.
22 324.0221, F.S.; requiring insurers to report to the
23 Department of Highway Safety and Motor Vehicles the
24 renewal, cancellation, or nonrenewal of a policy providing
25 personal injury protection coverage or motor vehicle
26 property damage liability coverage; authorizing the
27 department to adopt rules for the reports; providing that
28 failure to report as required is a violation of the

29 Florida Insurance Code; requiring that an insurer notify
30 the named insured that a cancelled or nonrenewed policy
31 will be reported to the department; requiring that the
32 department suspend the registration and driver's license
33 of an owner or registrant of a motor vehicle who fails to
34 maintain the required liability coverage; providing for
35 the reinstatement of a registration or driver's license
36 upon payment of certain fees; requiring that a person
37 obtain noncancelable coverage following such
38 reinstatement; providing for the deposit and use of
39 reinstatement fees; amending ss. 627.7275 and 627.7295,
40 F.S., relating to motor vehicle insurance policies and
41 contracts; conforming provisions to changes made by the
42 act; reviving and reenacting ss. 627.730, 627.731,
43 627.732, 627.734, 627.737, 627.739, 627.7401, 627.7403,
44 and 627.7405, F.S., and reviving, reenacting, and amending
45 ss. 627.733 and 627.736, the Florida Motor Vehicle No-
46 Fault Law, notwithstanding the repeal of such law provided
47 in s. 19, chapter 2003-411, Laws of Florida; deleting
48 certain provisions relating to the suspension and
49 reinstatement of a driver's license and registration and
50 notice to the Department of Highway Safety and Motor
51 Vehicles; conforming provisions to changes made by the
52 act; providing legislative intent with respect to the
53 reenactment and codification of the Florida Motor Vehicle
54 No-Fault Law, notwithstanding its prior repeal; amending
55 s. 627.736, F.S., as reenacted and amended; revising
56 provisions governing the medical benefits provided as

57 required personal injury protection benefits; providing
58 medical benefits for services and care ordered or
59 prescribed by a physician or provided by certain persons
60 or entities that meet certain requirements; requiring the
61 Financial services Commission to adopt rules; revising a
62 limitation on the amount of death benefits payable;
63 requiring personal injury protection insurers to reserve
64 benefits for certain providers for a specified period;
65 tolling the time period for the insurer to pay claims from
66 other providers; authorizing an insurer to limit
67 reimbursement for personal injury protection benefits to a
68 specified percentage of a schedule of maximum charges;
69 prohibiting provider from billing or attempting to collect
70 amounts in excess of such limits, except for amounts that
71 are not covered by personal injury protection coverage;
72 deleting provisions specifying allowable amounts for
73 certain tests and services; providing for electronic
74 transmission of certain statements; extending the period
75 during which an insurer may pay an overdue claim following
76 receipt of a demand letter without incurring a penalty;
77 providing for penalties to be imposed against certain
78 insurers for failing to pay claims for personal injury
79 protection; authorizing the Department of Legal Affairs to
80 investigate violations and initiate enforcement action;
81 requiring that all claims related to the same health care
82 provider for the same injured person be brought in one act
83 unless good cause is shown; requiring that the
84 transmission of electronic notices and communications

85 required or authorized under the Florida Motor Vehicle No-
86 Fault Law be consistent with state and federal privacy and
87 security laws; amending s. 627.739, F.S., as reenacted;
88 deleting provisions authorizing an insurer to offer
89 certain deductibles with respect to a policy of personal
90 injury protection; providing legislative intent concerning
91 the application of the act; requiring insurers to deliver
92 revised notices of premium and policy changes to certain
93 policyholders; requiring an insurer to cancel the policy
94 and return any unearned premium if the insured fails to
95 timely respond to the notice; providing for calculating
96 the amount of unearned premium; requiring that insurers
97 continue to use certain forms and rates until a specified
98 date unless the Office of Insurance Regulation approves
99 new forms or rates or are otherwise legally allowed;
100 providing that a person purchasing a motor vehicle
101 insurance policy without personal injury protection
102 coverage is exempt from the requirement for such coverage
103 and is not subject to certain liability provisions for a
104 specified period; requiring that insurers provide notice
105 of the requirement for personal injury protection coverage
106 or add an endorsement to the policy providing such
107 coverage; providing effective dates.
108
109 Be It Enacted by the Legislature of the State of Florida:
110
111 Section 1. Subsections (1) and (3) of section 316.646,
112 Florida Statutes, are amended to read:

113 316.646 Security required; proof of security and display
114 thereof; dismissal of cases.--
115 (1) Any person required by s. 324.022 to maintain property
116 damage liability security, required by s. 324.023 to maintain
117 liability security for bodily injury or death, or ~~any person~~
118 required by s. 627.733 to maintain personal injury protection
119 security on a motor vehicle shall have in his or her immediate
120 possession at all times while operating such motor vehicle
121 proper proof of maintenance of the required security. Such proof
122 shall be ~~either~~ a uniform proof-of-insurance card in a form
123 prescribed by the department, a valid insurance policy, an
124 insurance policy binder, a certificate of insurance, or such
125 other proof as may be prescribed by the department.
126 (3) Any person who violates this section commits a
127 nonmoving traffic infraction subject to the penalty provided in
128 chapter 318 and shall be required to furnish proof of security
129 as provided in this section. If any person charged with a
130 violation of this section fails to furnish proof, at or before
131 the scheduled court appearance date, that security was in effect
132 at the time of the violation, the court may immediately suspend
133 the registration and driver's license of such person. Such
134 license and registration may ~~only~~ be reinstated only as provided
135 in s. 324.0221 ~~627.733~~.
136 Section 2. Paragraphs (a) and (d) of subsection (5) of
137 section 320.02, Florida Statutes, are amended to read:
138 320.02 Registration required; application for
139 registration; forms.--
140 (5)(a) Proof that personal injury protection benefits have

141 been purchased when required under s. 627.733, that property
142 damage liability coverage has been purchased as required under
143 s. 324.022, that bodily injury or death coverage has been
144 purchased if required under s. 324.023, and that combined bodily
145 liability insurance and property damage liability insurance have
146 been purchased when required under s. 627.7415 shall be provided
147 in the manner prescribed by law by the applicant at the time of
148 application for registration of any motor vehicle that is
149 subject to such requirements ~~owned as defined in s. 627.732~~. The
150 issuing agent shall refuse to issue registration if such proof
151 of purchase is not provided. Insurers shall furnish uniform
152 proof-of-purchase cards in a form prescribed by the department
153 and shall include the name of the insured's insurance company,
154 the coverage identification number, and the make, year, and
155 vehicle identification number of the vehicle insured. The card
156 shall contain a statement notifying the applicant of the penalty
157 specified in s. 316.646(4). The card or insurance policy,
158 insurance policy binder, or certificate of insurance or a
159 photocopy of any of these; an affidavit containing the name of
160 the insured's insurance company, the insured's policy number,
161 and the make and year of the vehicle insured; or such other
162 proof as may be prescribed by the department shall constitute
163 sufficient proof of purchase. If an affidavit is provided as
164 proof, it shall be in substantially the following form:
165
166 Under penalty of perjury, I (Name of insured) do hereby
167 certify that I have (Personal Injury Protection, Property
168 Damage Liability, and, when required, Bodily Injury Liability)

169 Insurance currently in effect with (Name of insurance company)
170 under (policy number) covering (make, year, and vehicle
171 identification number of vehicle) . (Signature of Insured)
172
173 Such affidavit shall include the following warning:
174
175 WARNING: GIVING FALSE INFORMATION IN ORDER TO OBTAIN A VEHICLE
176 REGISTRATION CERTIFICATE IS A CRIMINAL OFFENSE UNDER FLORIDA
177 LAW. ANYONE GIVING FALSE INFORMATION ON THIS AFFIDAVIT IS
178 SUBJECT TO PROSECUTION.
179
180 When an application is made through a licensed motor vehicle
181 dealer as required in s. 319.23, the original or a photostatic
182 copy of such card, insurance policy, insurance policy binder, or
183 certificate of insurance or the original affidavit from the
184 insured shall be forwarded by the dealer to the tax collector of
185 the county or the Department of Highway Safety and Motor
186 Vehicles for processing. By executing the aforesaid affidavit,
187 no licensed motor vehicle dealer will be liable in damages for
188 any inadequacy, insufficiency, or falsification of any statement
189 contained therein. A card shall also indicate the existence of
190 any bodily injury liability insurance voluntarily purchased.
191 (d) The verifying of proof of personal injury protection
192 insurance, proof of property damage liability insurance, proof
193 of combined bodily liability insurance and property damage
194 liability insurance, or proof of financial responsibility
195 insurance and the issuance or failure to issue the motor vehicle
196 registration under the provisions of this chapter may not be

197 construed in any court as a warranty of the reliability or
198 accuracy of the evidence of such proof. Neither the department
199 nor any tax collector is liable in damages for any inadequacy,
200 insufficiency, falsification, or unauthorized modification of
201 any item of the proof of personal injury protection insurance,
202 proof of property damage liability insurance, proof of combined
203 bodily liability insurance and property damage liability
204 insurance, or proof of financial responsibility insurance ~~either~~
205 prior to, during, or subsequent to the verification of the
206 proof. The issuance of a motor vehicle registration does not
207 constitute prima facie evidence or a presumption of insurance
208 coverage.
209 Section 3. Section 321.245, Florida Statutes, is amended
210 to read:
211 321.245 Disposition of certain funds in the Highway Safety
212 Operating Trust Fund.--The director of the Florida Highway
213 Patrol, after receiving recommendations from the commander of
214 the auxiliary, is authorized to purchase uniforms and equipment
215 for auxiliary law enforcement officers as defined in s. 321.24
216 from funds described in s. 324.0221(3) ~~627.733(7)~~. The amounts
217 expended under this section shall not exceed $50,000 in any one
218 fiscal year.
219 Section 4. Section 324.022, Florida Statutes, is amended
220 to read:
221 324.022 Financial responsibility for property damage.--
222 (1) Every owner or operator of a motor vehicle~~, which~~
223 ~~motor vehicle is subject to the requirements of ss. 627.730-~~
224 ~~627.7405 and~~ required to be registered in this state~~,~~ shall~~, by~~

225 ~~one of the methods established in s. 324.031 or by having a~~
226 ~~policy that complies with s. 627.7275,~~ establish and maintain
227 the ability to respond in damages for liability on account of
228 accidents arising out of the use of the motor vehicle in the
229 amount of $10,000 because of damage to, or destruction of,
230 property of others in any one crash. The requirements of this
231 section may be met by one of the methods established in s.
232 324.031; by self-insuring as authorized by s. 768.28(16); or by
233 maintaining an insurance policy providing coverage for property
234 damage liability in the amount of at least $10,000 because of
235 damage to, or destruction of, property of others in any one
236 accident arising out of the use of the motor vehicle. The
237 requirements of this section may also be met by having a policy
238 which provides coverage in the amount of at least $30,000 for
239 combined property damage liability and bodily injury liability
240 for any one crash arising out of the use of the motor vehicle.
241 The policy, with respect to coverage for property damage
242 liability, must meet the applicable requirements of s. 324.151,
243 subject to the usual policy exclusions that have been approved
244 in policy forms by the Office of Insurance Regulation. No
245 insurer shall have any duty to defend uncovered claims
246 irrespective of their joinder with covered claims.
247 (2) As used in this section, the term:
248 (a) "Motor vehicle" means any self-propelled vehicle that
249 has four or more wheels and that is of a type designed and
250 required to be licensed for use on the highways of this state,
251 and any trailer or semitrailer designed for use with such
252 vehicle. The term does not include:

253 1. A mobile home.
254 2. A motor vehicle that is used in mass transit and
255 designed to transport more than five passengers, exclusive of
256 the operator of the motor vehicle, and that is owned by a
257 municipality, transit authority, or political subdivision of the
258 state.
259 3. A school bus as defined in s. 1006.25.
260 4. A vehicle providing for-hire transportation that is
261 subject to the provisions of s. 324.031. A taxicab shall
262 maintain security as required under s. 324.032(1).
263 (b) "Owner" means the person who holds legal title to a
264 motor vehicle or the debtor or lessee who has the right to
265 possession of a motor vehicle that is the subject of a security
266 agreement or lease with an option to purchase.
267 (3) Each nonresident owner or registrant of a motor
268 vehicle that, whether operated or not, has been physically
269 present within this state for more than 90 days during the
270 preceding 365 days shall maintain security as required by
271 subsection (1) that is in effect continuously throughout the
272 period the motor vehicle remains within this state.
273 (4) The owner or registrant of a motor vehicle is exempt
274 from the requirements of this section if she or he is a member
275 of the United States Armed Forces and is called to or on active
276 duty outside the United States in an emergency situation. The
277 exemption provided by this subsection applies only as long as
278 the member of the Armed Forces is on such active duty outside
279 the United States and applies only while the vehicle is not
280 operated by any person. Upon receipt of a written request by the

281 insured to whom the exemption provided in this subsection
282 applies, the insurer shall cancel the coverages and return any
283 unearned premium or suspend the security required by this
284 section. Notwithstanding s. 324.0221(3), the department may not
285 suspend the registration or operator's license of any owner or
286 registrant of a motor vehicle during the time she or he
287 qualifies for an exemption under this subsection. Any owner or
288 registrant of a motor vehicle who qualifies for an exemption
289 under this subsection shall immediately notify the department
290 prior to and at the end of the expiration of the exemption.
291 Section 5. Section 324.0221, Florida Statutes, is created
292 to read:
293 324.0221 Reports by insurers to the department; suspension
294 of driver's license and vehicle registrations; reinstatement.--
295 (1)(a) Each insurer that has issued a policy providing
296 personal injury protection coverage or property damage liability
297 coverage shall report the renewal, cancellation, or nonrenewal
298 thereof to the department within 45 days after the effective
299 date of each renewal, cancellation, or nonrenewal. Upon the
300 issuance of a policy providing personal injury protection
301 coverage or property damage liability coverage to a named
302 insured not previously insured by the insurer during that
303 calendar year, the insurer shall report the issuance of the new
304 policy to the department within 30 days. The report shall be in
305 the form and format and contain any information required by the
306 department and must be provided in a format that is compatible
307 with the data-processing capabilities of the department. The
308 department may adopt rules regarding the form and documentation

309 required. Failure by an insurer to file proper reports with the
310 department as required by this subsection or rules adopted with
311 respect to the requirements of this subsection constitutes a
312 violation of the Florida Insurance Code. These records shall be
313 used by the department only for enforcement and regulatory
314 purposes, including the generation by the department of data
315 regarding compliance by owners of motor vehicles with the
316 requirements for financial responsibility coverage.
317 (b) With respect to an insurance policy providing personal
318 injury protection coverage or property damage liability
319 coverage, each insurer shall notify the named insured, or the
320 first-named insured in the case of a commercial fleet policy, in
321 writing that any cancellation or nonrenewal of the policy will
322 be reported by the insurer to the department. The notice must
323 also inform the named insured that failure to maintain personal
324 injury protection coverage and property damage liability
325 coverage on a motor vehicle when required by law may result in
326 the loss of registration and driving privileges in this state
327 and inform the named insured of the amount of the reinstatement
328 fees required by this section. This notice is for informational
329 purposes only, and an insurer is not civilly liable for failing
330 to provide this notice.
331 (2) The department shall suspend, after due notice and an
332 opportunity to be heard, the registration and driver's license
333 of any owner or registrant of a motor vehicle with respect to
334 which security is required under ss. 324.022 and 627.733 upon:
335 (a) The department's records showing that the owner or
336 registrant of such motor vehicle did not have in full force and

337 effect when required security that complies with the
338 requirements of ss. 324.022 and 627.733; or
339 (b) Notification by the insurer to the department, in a
340 form approved by the department, of cancellation or termination
341 of the required security.
342 (3) An operator or owner whose driver's license or
343 registration has been suspended under this section or s. 316.646
344 may effect its reinstatement upon compliance with the
345 requirements of this section and upon payment to the department
346 of a nonrefundable reinstatement fee of $150 for the first
347 reinstatement. The reinstatement fee is $250 for the second
348 reinstatement and $500 for each subsequent reinstatement during
349 the 3 years following the first reinstatement. A person
350 reinstating her or his insurance under this subsection must also
351 secure noncancelable coverage as described in ss. 324.021(8),
352 324.023, and 627.7275(2) and present to the appropriate person
353 proof that the coverage is in force on a form adopted by the
354 department, and such proof shall be maintained for 2 years. If
355 the person does not have a second reinstatement within 3 years
356 after her or his initial reinstatement, the reinstatement fee is
357 $150 for the first reinstatement after that 3-year period. If a
358 person's license and registration are suspended under this
359 section or s. 316.646, only one reinstatement fee must be paid
360 to reinstate the license and the registration. All fees shall be
361 collected by the department at the time of reinstatement. The
362 department shall issue proper receipts for such fees and shall
363 promptly deposit those fees in the Highway Safety Operating
364 Trust Fund. One-third of the fees collected under this

365 subsection shall be distributed from the Highway Safety
366 Operating Trust Fund to the local governmental entity or state
367 agency that employed the law enforcement officer seizing the
368 license plate pursuant to s. 324.201. The funds may be used by
369 the local governmental entity or state agency for any authorized
370 purpose.
371 Section 6. Section 627.7275, Florida Statutes, is amended
372 to read:
373 627.7275 Motor vehicle liability.--
374 (1) A motor vehicle insurance policy providing personal
375 injury protection as set forth in s. 627.736 may not be
376 delivered or issued for delivery in this state with respect to
377 any specifically insured or identified motor vehicle registered
378 or principally garaged in this state unless the policy also
379 provides coverage for property damage liability as required by
380 s. 324.022 ~~in the amount of at least $10,000 because of damage~~
381 ~~to, or destruction of, property of others in any one accident~~
382 ~~arising out of the use of the motor vehicle or unless the policy~~
383 ~~provides coverage in the amount of at least $30,000 for combined~~
384 ~~property damage liability and bodily injury liability in any one~~
385 ~~accident arising out of the use of the motor vehicle. The~~
386 ~~policy, as to coverage of property damage liability, must meet~~
387 ~~the applicable requirements of s. 324.151, subject to the usual~~
388 ~~policy exclusions that have been approved in policy forms by the~~
389 ~~office~~.
390 (2)(a) Insurers writing motor vehicle insurance in this
391 state shall make available, subject to the insurers' usual
392 underwriting restrictions:

393 1. Coverage under policies as described in subsection (1)
394 to any applicant for private passenger motor vehicle insurance
395 coverage who is seeking the coverage in order to reinstate the
396 applicant's driving privileges in this state when the driving
397 privileges were revoked or suspended pursuant to s. 316.646 or
398 s. 324.0221 ~~627.733~~ due to the failure of the applicant to
399 maintain required security.
400 2. Coverage under policies as described in subsection (1),
401 which also provides liability coverage for bodily injury, death,
402 and property damage arising out of the ownership, maintenance,
403 or use of the motor vehicle in an amount not less than the
404 limits described in s. 324.021(7) and conforms to the
405 requirements of s. 324.151, to any applicant for private
406 passenger motor vehicle insurance coverage who is seeking the
407 coverage in order to reinstate the applicant's driving
408 privileges in this state after such privileges were revoked or
409 suspended under s. 316.193 or s. 322.26(2) for driving under the
410 influence.
411 (b) The policies described in paragraph (a) shall be
412 issued for a period of at least 6 months and as to the minimum
413 coverages required under this section shall not be cancelable by
414 the insured for any reason or by the insurer after a period not
415 to exceed 30 days during which the insurer must complete
416 underwriting of the policy. After the insurer has completed
417 underwriting the policy within the 30-day period, the insurer
418 shall notify the Department of Highway Safety and Motor Vehicles
419 that the policy is in full force and effect and the policy shall
420 not be cancelable for the remainder of the policy period. A

421 premium shall be collected and coverage shall be in effect for
422 the 30-day period during which the insurer is completing the
423 underwriting of the policy whether or not the person's driver
424 license, motor vehicle tag, and motor vehicle registration are
425 in effect. Once the noncancelable provisions of the policy
426 become effective, the coverage or risk shall not be changed
427 during the policy period and the premium shall be nonrefundable.
428 If, during the pendency of the 2-year proof of insurance period
429 required under s. 324.0221 ~~627.733(7)~~ or during the 3-year proof
430 of financial responsibility required under s. 324.131, whichever
431 is applicable, the insured obtains additional coverage or
432 coverage for an additional risk or changes territories, the
433 insured must obtain a new 6-month noncancelable policy in
434 accordance with the provisions of this section. However, if the
435 insured must obtain a new 6-month policy and obtains the policy
436 from the same insurer, the policyholder shall receive credit on
437 the new policy for any premium paid on the previously issued
438 policy.
439 (c) This subsection controls to the extent of any conflict
440 with any other section.
441 (d) An insurer issuing a policy subject to this section
442 may cancel the policy if, during the policy term, the named
443 insured or any other operator, who resides in the same household
444 or customarily operates an automobile insured under the policy,
445 has his or her driver's license suspended or revoked.
446 (e) Nothing in this subsection requires an insurer to
447 offer a policy of insurance to an applicant if such offer would
448 be inconsistent with the insurer's underwriting guidelines and

449 procedures.
450 Section 7. Paragraph (a) of subsection (1) of section
451 627.7295, Florida Statutes, is amended to read:
452 627.7295 Motor vehicle insurance contracts.--
453 (1) As used in this section, the term:
454 (a) "Policy" means a motor vehicle insurance policy that
455 provides personal injury protection coverage, ~~and~~ property
456 damage liability coverage, or both.
457 Section 8. Notwithstanding the repeal of the Florida Motor
458 Vehicle No-Fault Law, which occurred on October 1, 2007, section
459 627.730, Florida Statutes, is revived and reenacted to read:
460 627.730 Florida Motor Vehicle No-Fault Law.--Sections
461 627.730-627.7405 may be cited and known as the "Florida Motor
462 Vehicle No-Fault Law."
463 Section 9. Notwithstanding the repeal of the Florida Motor
464 Vehicle No-Fault Law, which occurred on October 1, 2007, section
465 627.731, Florida Statutes, is revived and reenacted to read:
466 627.731 Purpose.--The purpose of ss. 627.730-627.7405 is
467 to provide for medical, surgical, funeral, and disability
468 insurance benefits without regard to fault, and to require motor
469 vehicle insurance securing such benefits, for motor vehicles
470 required to be registered in this state and, with respect to
471 motor vehicle accidents, a limitation on the right to claim
472 damages for pain, suffering, mental anguish, and inconvenience.
473 Section 10. Notwithstanding the repeal of the Florida
474 Motor Vehicle No-Fault Law, which occurred on October 1, 2007,
475 section 627.732, Florida Statutes, is revived and reenacted to
476 read:

477 627.732 Definitions.--As used in ss. 627.730-627.7405, the
478 term:
479 (1) "Broker" means any person not possessing a license
480 under chapter 395, chapter 400, chapter 429, chapter 458,
481 chapter 459, chapter 460, chapter 461, or chapter 641 who
482 charges or receives compensation for any use of medical
483 equipment and is not the 100-percent owner or the 100-percent
484 lessee of such equipment. For purposes of this section, such
485 owner or lessee may be an individual, a corporation, a
486 partnership, or any other entity and any of its 100-percent-
487 owned affiliates and subsidiaries. For purposes of this
488 subsection, the term "lessee" means a long-term lessee under a
489 capital or operating lease, but does not include a part-time
490 lessee. The term "broker" does not include a hospital or
491 physician management company whose medical equipment is
492 ancillary to the practices managed, a debt collection agency, or
493 an entity that has contracted with the insurer to obtain a
494 discounted rate for such services; nor does the term include a
495 management company that has contracted to provide general
496 management services for a licensed physician or health care
497 facility and whose compensation is not materially affected by
498 the usage or frequency of usage of medical equipment or an
499 entity that is 100-percent owned by one or more hospitals or
500 physicians. The term "broker" does not include a person or
501 entity that certifies, upon request of an insurer, that:
502 (a) It is a clinic licensed under ss. 400.990-400.995;
503 (b) It is a 100-percent owner of medical equipment; and
504 (c) The owner's only part-time lease of medical equipment

505 for personal injury protection patients is on a temporary basis
506 not to exceed 30 days in a 12-month period, and such lease is
507 solely for the purposes of necessary repair or maintenance of
508 the 100-percent-owned medical equipment or pending the arrival
509 and installation of the newly purchased or a replacement for the
510 100-percent-owned medical equipment, or for patients for whom,
511 because of physical size or claustrophobia, it is determined by
512 the medical director or clinical director to be medically
513 necessary that the test be performed in medical equipment that
514 is open-style. The leased medical equipment cannot be used by
515 patients who are not patients of the registered clinic for
516 medical treatment of services. Any person or entity making a
517 false certification under this subsection commits insurance
518 fraud as defined in s. 817.234. However, the 30-day period
519 provided in this paragraph may be extended for an additional 60
520 days as applicable to magnetic resonance imaging equipment if
521 the owner certifies that the extension otherwise complies with
522 this paragraph.

523 (2) "Medically necessary" refers to a medical service or
524 supply that a prudent physician would provide for the purpose of
525 preventing, diagnosing, or treating an illness, injury, disease,
526 or symptom in a manner that is:

527 (a) In accordance with generally accepted standards of
528 medical practice;

529 (b) Clinically appropriate in terms of type, frequency,
530 extent, site, and duration; and

531 (c) Not primarily for the convenience of the patient,
532 physician, or other health care provider.

533 (3) "Motor vehicle" means any self-propelled vehicle with
534 four or more wheels which is of a type both designed and
535 required to be licensed for use on the highways of this state
536 and any trailer or semitrailer designed for use with such
537 vehicle and includes:
538 (a) A "private passenger motor vehicle," which is any
539 motor vehicle which is a sedan, station wagon, or jeep-type
540 vehicle and, if not used primarily for occupational,
541 professional, or business purposes, a motor vehicle of the
542 pickup, panel, van, camper, or motor home type.
543 (b) A "commercial motor vehicle," which is any motor
544 vehicle which is not a private passenger motor vehicle.
545
546 The term "motor vehicle" does not include a mobile home or any
547 motor vehicle which is used in mass transit, other than public
548 school transportation, and designed to transport more than five
549 passengers exclusive of the operator of the motor vehicle and
550 which is owned by a municipality, a transit authority, or a
551 political subdivision of the state.
552 (4) "Named insured" means a person, usually the owner of a
553 vehicle, identified in a policy by name as the insured under the
554 policy.
555 (5) "Owner" means a person who holds the legal title to a
556 motor vehicle; or, in the event a motor vehicle is the subject
557 of a security agreement or lease with an option to purchase with
558 the debtor or lessee having the right to possession, then the
559 debtor or lessee shall be deemed the owner for the purposes of
560 ss. 627.730-627.7405.

561 (6) "Relative residing in the same household" means a
562 relative of any degree by blood or by marriage who usually makes
563 her or his home in the same family unit, whether or not
564 temporarily living elsewhere.
565 (7) "Certify" means to swear or attest to being true or
566 represented in writing.
567 (8) "Immediate personal supervision," as it relates to the
568 performance of medical services by nonphysicians not in a
569 hospital, means that an individual licensed to perform the
570 medical service or provide the medical supplies must be present
571 within the confines of the physical structure where the medical
572 services are performed or where the medical supplies are
573 provided such that the licensed individual can respond
574 immediately to any emergencies if needed.
575 (9) "Incident," with respect to services considered as
576 incident to a physician's professional service, for a physician
577 licensed under chapter 458, chapter 459, chapter 460, or chapter
578 461, if not furnished in a hospital, means such services must be
579 an integral, even if incidental, part of a covered physician's
580 service.
581 (10) "Knowingly" means that a person, with respect to
582 information, has actual knowledge of the information; acts in
583 deliberate ignorance of the truth or falsity of the information;
584 or acts in reckless disregard of the information, and proof of
585 specific intent to defraud is not required.
586 (11) "Lawful" or "lawfully" means in substantial
587 compliance with all relevant applicable criminal, civil, and
588 administrative requirements of state and federal law related to

589 the provision of medical services or treatment.
590 (12) "Hospital" means a facility that, at the time
591 services or treatment were rendered, was licensed under chapter
592 395.
593 (13) "Properly completed" means providing truthful,
594 substantially complete, and substantially accurate responses as
595 to all material elements to each applicable request for
596 information or statement by a means that may lawfully be
597 provided and that complies with this section, or as agreed by
598 the parties.
599 (14) "Upcoding" means an action that submits a billing
600 code that would result in payment greater in amount than would
601 be paid using a billing code that accurately describes the
602 services performed. The term does not include an otherwise
603 lawful bill by a magnetic resonance imaging facility, which
604 globally combines both technical and professional components, if
605 the amount of the global bill is not more than the components if
606 billed separately; however, payment of such a bill constitutes
607 payment in full for all components of such service.
608 (15) "Unbundling" means an action that submits a billing
609 code that is properly billed under one billing code, but that
610 has been separated into two or more billing codes, and would
611 result in payment greater in amount than would be paid using one
612 billing code.
613 Section 11. Notwithstanding the repeal of the Florida
614 Motor Vehicle No-Fault Law, which occurred on October 1, 2007,
615 section 627.733, Florida Statutes, is revived, reenacted, and
616 amended to read:

617 627.733 Required security.--
618 (1)(a) Every owner or registrant of a motor vehicle, other
619 than a motor vehicle used as a school bus as defined in s.
620 1006.25 or limousine, required to be registered and licensed in
621 this state shall maintain security as required by subsection (3)
622 in effect continuously throughout the registration or licensing
623 period.
624 (b) Every owner or registrant of a motor vehicle used as a
625 taxicab shall not be governed by paragraph (1)(a) but shall
626 maintain security as required under s. 324.032(1), and s.
627 627.737 shall not apply to any motor vehicle used as a taxicab.
628 (2) Every nonresident owner or registrant of a motor
629 vehicle which, whether operated or not, has been physically
630 present within this state for more than 90 days during the
631 preceding 365 days shall thereafter maintain security as defined
632 by subsection (3) in effect continuously throughout the period
633 such motor vehicle remains within this state.
634 (3) Such security shall be provided:
635 (a) By an insurance policy delivered or issued for
636 delivery in this state by an authorized or eligible motor
637 vehicle liability insurer which provides the benefits and
638 exemptions contained in ss. 627.730-627.7405. Any policy of
639 insurance represented or sold as providing the security required
640 hereunder shall be deemed to provide insurance for the payment
641 of the required benefits; or
642 (b) By any other method authorized by s. 324.031(2), (3),
643 or (4) and approved by the Department of Highway Safety and
644 Motor Vehicles as affording security equivalent to that afforded

645 by a policy of insurance or by self-insuring as authorized by s.
646 768.28(16). The person filing such security shall have all of
647 the obligations and rights of an insurer under ss. 627.730-
648 627.7405.

649 (4) An owner of a motor vehicle with respect to which
650 security is required by this section who fails to have such
651 security in effect at the time of an accident shall have no
652 immunity from tort liability, but shall be personally liable for
653 the payment of benefits under s. 627.736. With respect to such
654 benefits, such an owner shall have all of the rights and
655 obligations of an insurer under ss. 627.730-627.7405.

656 (5) In addition to other persons who are not required to
657 provide required security as required under this section and s.
658 324.022, the owner or registrant of a motor vehicle is exempt
659 from such requirements if she or he is a member of the United
660 States Armed Forces and is called to or on active duty outside
661 the United States in an emergency situation. The exemption
662 provided by this subsection applies only as long as the member
663 of the armed forces is on such active duty outside the United
664 States and applies only while the vehicle covered by the
665 security required by this section and s. 324.022 is not operated
666 by any person. Upon receipt of a written request by the insured
667 to whom the exemption provided in this subsection applies, the
668 insurer shall cancel the coverages and return any unearned
669 premium or suspend the security required by this section and s.
670 324.022. Notwithstanding s. 324.0221(2) ~~subsection (6)~~, the
671 Department of Highway Safety and Motor Vehicles may not suspend
672 the registration or operator's license of any owner or

673 registrant of a motor vehicle during the time she or he
674 qualifies for an exemption under this subsection. Any owner or
675 registrant of a motor vehicle who qualifies for an exemption
676 under this subsection shall immediately notify the department
677 prior to and at the end of the expiration of the exemption.
678 ~~(6) The Department of Highway Safety and Motor Vehicles~~
679 ~~shall suspend, after due notice and an opportunity to be heard,~~
680 ~~the registration and driver's license of any owner or registrant~~
681 ~~of a motor vehicle with respect to which security is required~~
682 ~~under this section and s. 324.022:~~
683 ~~(a) Upon its records showing that the owner or registrant~~
684 ~~of such motor vehicle did not have in full force and effect when~~
685 ~~required security complying with the terms of this section; or~~
686 ~~(b) Upon notification by the insurer to the Department of~~
687 ~~Highway Safety and Motor Vehicles, in a form approved by the~~
688 ~~department, of cancellation or termination of the required~~
689 ~~security.~~
690 ~~(7) Any operator or owner whose driver's license or~~
691 ~~registration has been suspended pursuant to this section or s.~~
692 ~~316.646 may effect its reinstatement upon compliance with the~~
693 ~~requirements of this section and upon payment to the Department~~
694 ~~of Highway Safety and Motor Vehicles of a nonrefundable~~
695 ~~reinstatement fee of $150 for the first reinstatement. Such~~
696 ~~reinstatement fee shall be $250 for the second reinstatement and~~
697 ~~$500 for each subsequent reinstatement during the 3 years~~
698 ~~following the first reinstatement. Any person reinstating her or~~
699 ~~his insurance under this subsection must also secure~~
700 ~~noncancelable coverage as described in ss. 324.021(8), 324.023,~~

701 ~~and 627.7275(2) and present to the appropriate person proof that~~
702 ~~the coverage is in force on a form promulgated by the Department~~
703 ~~of Highway Safety and Motor Vehicles, such proof to be~~
704 ~~maintained for 2 years. If the person does not have a second~~
705 ~~reinstatement within 3 years after her or his initial~~
706 ~~reinstatement, the reinstatement fee shall be $150 for the first~~
707 ~~reinstatement after that 3-year period. In the event that a~~
708 ~~person's license and registration are suspended pursuant to this~~
709 ~~section or s. 316.646, only one reinstatement fee shall be paid~~
710 ~~to reinstate the license and the registration. All fees shall be~~
711 ~~collected by the Department of Highway Safety and Motor Vehicles~~
712 ~~at the time of reinstatement. The Department of Highway Safety~~
713 ~~and Motor Vehicles shall issue proper receipts for such fees and~~
714 ~~shall promptly deposit those fees in the Highway Safety~~
715 ~~Operating Trust Fund. One-third of the fee collected under this~~
716 ~~subsection shall be distributed from the Highway Safety~~
717 ~~Operating Trust Fund to the local government entity or state~~
718 ~~agency which employed the law enforcement officer who seizes a~~
719 ~~license plate pursuant to s. 324.201. Such funds may be used by~~
720 ~~the local government entity or state agency for any authorized~~
721 ~~purpose.~~
722 Section 12. Notwithstanding the repeal of the Florida
723 Motor Vehicle No-Fault Law, which occurred on October 1, 2007,
724 section 627.734, Florida Statutes, is revived and reenacted to
725 read:
726 627.734 Proof of security; security requirements;
727 penalties.--
728 (1) The provisions of chapter 324 which pertain to the

729 method of giving and maintaining proof of financial
730 responsibility and which govern and define a motor vehicle
731 liability policy shall apply to filing and maintaining proof of
732 security required by ss. 627.730-627.7405.
733 (2) Any person who:
734 (a) Gives information required in a report or otherwise as
735 provided for in ss. 627.730-627.7405, knowing or having reason
736 to believe that such information is false;
737 (b) Forges or, without authority, signs any evidence of
738 proof of security; or
739 (c) Files, or offers for filing, any such evidence of
740 proof, knowing or having reason to believe that it is forged or
741 signed without authority,
742
743 is guilty of a misdemeanor of the first degree, punishable as
744 provided in s. 775.082 or s. 775.083.
745 Section 13. Notwithstanding the repeal of the Florida
746 Motor Vehicle No-Fault Law, which occurred on October 1, 2007,
747 section 627.736, Florida Statutes, is revived, reenacted, and
748 amended to read:
749 627.736 Required personal injury protection benefits;
750 exclusions; priority; claims.--
751 (1) REQUIRED BENEFITS.--Every insurance policy complying
752 with the security requirements of s. 627.733 shall provide
753 personal injury protection to the named insured, relatives
754 residing in the same household, persons operating the insured
755 motor vehicle, passengers in such motor vehicle, and other
756 persons struck by such motor vehicle and suffering bodily injury

757 while not an occupant of a self-propelled vehicle, subject to
758 the provisions of subsection (2) and paragraph (4)(d), to a
759 limit of $10,000 for loss sustained by any such person as a
760 result of bodily injury, sickness, disease, or death arising out
761 of the ownership, maintenance, or use of a motor vehicle as
762 follows:
763 (a) Medical benefits.--Eighty percent of all reasonable
764 expenses for medically necessary medical, surgical, X-ray,
765 dental, and rehabilitative services, including prosthetic
766 devices, and medically necessary ambulance, hospital, and
767 nursing services. Such benefits shall also include necessary
768 remedial treatment and services recognized and permitted under
769 the laws of the state for an injured person who relies upon
770 spiritual means through prayer alone for healing, in accordance
771 with his or her religious beliefs; however, this sentence does
772 not affect the determination of what other services or
773 procedures are medically necessary.
774 (b) Disability benefits.--Sixty percent of any loss of
775 gross income and loss of earning capacity per individual from
776 inability to work proximately caused by the injury sustained by
777 the injured person, plus all expenses reasonably incurred in
778 obtaining from others ordinary and necessary services in lieu of
779 those that, but for the injury, the injured person would have
780 performed without income for the benefit of his or her
781 household. All disability benefits payable under this provision
782 shall be paid not less than every 2 weeks.
783 (c) Death benefits.--Death benefits of $5,000 per
784 individual. The insurer may pay such benefits to the executor

785 or administrator of the deceased, to any of the deceased's
786 relatives by blood or legal adoption or connection by marriage,
787 or to any person appearing to the insurer to be equitably
788 entitled thereto.
789
790 Only insurers writing motor vehicle liability insurance in this
791 state may provide the required benefits of this section, and no
792 such insurer shall require the purchase of any other motor
793 vehicle coverage other than the purchase of property damage
794 liability coverage as required by s. 627.7275 as a condition for
795 providing such required benefits. Insurers may not require that
796 property damage liability insurance in an amount greater than
797 $10,000 be purchased in conjunction with personal injury
798 protection. Such insurers shall make benefits and required
799 property damage liability insurance coverage available through
800 normal marketing channels. Any insurer writing motor vehicle
801 liability insurance in this state who fails to comply with such
802 availability requirement as a general business practice shall be
803 deemed to have violated part IX of chapter 626, and such
804 violation shall constitute an unfair method of competition or an
805 unfair or deceptive act or practice involving the business of
806 insurance; and any such insurer committing such violation shall
807 be subject to the penalties afforded in such part, as well as
808 those which may be afforded elsewhere in the insurance code.
809 (2) AUTHORIZED EXCLUSIONS.--Any insurer may exclude
810 benefits:
811 (a) For injury sustained by the named insured and
812 relatives residing in the same household while occupying another

813 motor vehicle owned by the named insured and not insured under
814 the policy or for injury sustained by any person operating the
815 insured motor vehicle without the express or implied consent of
816 the insured.
817 (b) To any injured person, if such person's conduct
818 contributed to his or her injury under any of the following
819 circumstances:
820 1. Causing injury to himself or herself intentionally; or
821 2. Being injured while committing a felony.
822
823 Whenever an insured is charged with conduct as set forth in
824 subparagraph 2., the 30-day payment provision of paragraph
825 (4)(b) shall be held in abeyance, and the insurer shall withhold
826 payment of any personal injury protection benefits pending the
827 outcome of the case at the trial level. If the charge is nolle
828 prossed or dismissed or the insured is acquitted, the 30-day
829 payment provision shall run from the date the insurer is
830 notified of such action.
831 (3) INSURED'S RIGHTS TO RECOVERY OF SPECIAL DAMAGES IN
832 TORT CLAIMS.--No insurer shall have a lien on any recovery in
833 tort by judgment, settlement, or otherwise for personal injury
834 protection benefits, whether suit has been filed or settlement
835 has been reached without suit. An injured party who is entitled
836 to bring suit under the provisions of ss. 627.730-627.7405, or
837 his or her legal representative, shall have no right to recover
838 any damages for which personal injury protection benefits are
839 paid or payable. The plaintiff may prove all of his or her
840 special damages notwithstanding this limitation, but if special

841 damages are introduced in evidence, the trier of facts, whether
842 judge or jury, shall not award damages for personal injury
843 protection benefits paid or payable. In all cases in which a
844 jury is required to fix damages, the court shall instruct the
845 jury that the plaintiff shall not recover such special damages
846 for personal injury protection benefits paid or payable.
847 (4) BENEFITS; WHEN DUE.--Benefits due from an insurer
848 under ss. 627.730-627.7405 shall be primary, except that
849 benefits received under any workers' compensation law shall be
850 credited against the benefits provided by subsection (1) and
851 shall be due and payable as loss accrues, upon receipt of
852 reasonable proof of such loss and the amount of expenses and
853 loss incurred which are covered by the policy issued under ss.
854 627.730-627.7405. When the Agency for Health Care Administration
855 provides, pays, or becomes liable for medical assistance under
856 the Medicaid program related to injury, sickness, disease, or
857 death arising out of the ownership, maintenance, or use of a
858 motor vehicle, benefits under ss. 627.730-627.7405 shall be
859 subject to the provisions of the Medicaid program.
860 (a) An insurer may require written notice to be given as
861 soon as practicable after an accident involving a motor vehicle
862 with respect to which the policy affords the security required
863 by ss. 627.730-627.7405.
864 (b) Personal injury protection insurance benefits paid
865 pursuant to this section shall be overdue if not paid within 30
866 days after the insurer is furnished written notice of the fact
867 of a covered loss and of the amount of same. If such written
868 notice is not furnished to the insurer as to the entire claim,

869 any partial amount supported by written notice is overdue if not
870 paid within 30 days after such written notice is furnished to
871 the insurer. Any part or all of the remainder of the claim that
872 is subsequently supported by written notice is overdue if not
873 paid within 30 days after such written notice is furnished to
874 the insurer. When an insurer pays only a portion of a claim or
875 rejects a claim, the insurer shall provide at the time of the
876 partial payment or rejection an itemized specification of each
877 item that the insurer had reduced, omitted, or declined to pay
878 and any information that the insurer desires the claimant to
879 consider related to the medical necessity of the denied
880 treatment or to explain the reasonableness of the reduced
881 charge, provided that this shall not limit the introduction of
882 evidence at trial; and the insurer shall include the name and
883 address of the person to whom the claimant should respond and a
884 claim number to be referenced in future correspondence. However,
885 notwithstanding the fact that written notice has been furnished
886 to the insurer, any payment shall not be deemed overdue when the
887 insurer has reasonable proof to establish that the insurer is
888 not responsible for the payment. For the purpose of calculating
889 the extent to which any benefits are overdue, payment shall be
890 treated as being made on the date a draft or other valid
891 instrument which is equivalent to payment was placed in the
892 United States mail in a properly addressed, postpaid envelope
893 or, if not so posted, on the date of delivery. This paragraph
894 does not preclude or limit the ability of the insurer to assert
895 that the claim was unrelated, was not medically necessary, or
896 was unreasonable or that the amount of the charge was in excess

897 of that permitted under, or in violation of, subsection (5).
898 Such assertion by the insurer may be made at any time, including
899 after payment of the claim or after the 30-day time period for
900 payment set forth in this paragraph.

901 (c) All overdue payments shall bear simple interest at the
902 rate established under s. 55.03 or the rate established in the
903 insurance contract, whichever is greater, for the year in which
904 the payment became overdue, calculated from the date the insurer
905 was furnished with written notice of the amount of covered loss.
906 Interest shall be due at the time payment of the overdue claim
907 is made.

908 (d) The insurer of the owner of a motor vehicle shall pay
909 personal injury protection benefits for:

910 1. Accidental bodily injury sustained in this state by the
911 owner while occupying a motor vehicle, or while not an occupant
912 of a self-propelled vehicle if the injury is caused by physical
913 contact with a motor vehicle.

914 2. Accidental bodily injury sustained outside this state,
915 but within the United States of America or its territories or
916 possessions or Canada, by the owner while occupying the owner's
917 motor vehicle.

918 3. Accidental bodily injury sustained by a relative of the
919 owner residing in the same household, under the circumstances
920 described in subparagraph 1. or subparagraph 2., provided the
921 relative at the time of the accident is domiciled in the owner's
922 household and is not himself or herself the owner of a motor
923 vehicle with respect to which security is required under ss.
924 627.730-627.7405.

925 4. Accidental bodily injury sustained in this state by any
926 other person while occupying the owner's motor vehicle or, if a
927 resident of this state, while not an occupant of a self-
928 propelled vehicle, if the injury is caused by physical contact
929 with such motor vehicle, provided the injured person is not
930 himself or herself:
931 a. The owner of a motor vehicle with respect to which
932 security is required under ss. 627.730-627.7405; or
933 b. Entitled to personal injury benefits from the insurer
934 of the owner or owners of such a motor vehicle.
935 (e) If two or more insurers are liable to pay personal
936 injury protection benefits for the same injury to any one
937 person, the maximum payable shall be as specified in subsection
938 (1), and any insurer paying the benefits shall be entitled to
939 recover from each of the other insurers an equitable pro rata
940 share of the benefits paid and expenses incurred in processing
941 the claim.
942 (f) It is a violation of the insurance code for an insurer
943 to fail to timely provide benefits as required by this section
944 with such frequency as to constitute a general business
945 practice.
946 (g) Benefits shall not be due or payable to or on the
947 behalf of an insured person if that person has committed, by a
948 material act or omission, any insurance fraud relating to
949 personal injury protection coverage under his or her policy, if
950 the fraud is admitted to in a sworn statement by the insured or
951 if it is established in a court of competent jurisdiction. Any
952 insurance fraud shall void all coverage arising from the claim

953 related to such fraud under the personal injury protection
954 coverage of the insured person who committed the fraud,
955 irrespective of whether a portion of the insured person's claim
956 may be legitimate, and any benefits paid prior to the discovery
957 of the insured person's insurance fraud shall be recoverable by
958 the insurer from the person who committed insurance fraud in
959 their entirety. The prevailing party is entitled to its costs
960 and attorney's fees in any action in which it prevails in an
961 insurer's action to enforce its right of recovery under this
962 paragraph.
963 (5) CHARGES FOR TREATMENT OF INJURED PERSONS.--
964 (a) Any physician, hospital, clinic, or other person or
965 institution lawfully rendering treatment to an injured person
966 for a bodily injury covered by personal injury protection
967 insurance may charge the insurer and injured party only a
968 reasonable amount pursuant to this section for the services and
969 supplies rendered, and the insurer providing such coverage may
970 pay for such charges directly to such person or institution
971 lawfully rendering such treatment, if the insured receiving such
972 treatment or his or her guardian has countersigned the properly
973 completed invoice, bill, or claim form approved by the office
974 upon which such charges are to be paid for as having actually
975 been rendered, to the best knowledge of the insured or his or
976 her guardian. In no event, however, may such a charge be in
977 excess of the amount the person or institution customarily
978 charges for like services or supplies. With respect to a
979 determination of whether a charge for a particular service,
980 treatment, or otherwise is reasonable, consideration may be

981 given to evidence of usual and customary charges and payments
982 accepted by the provider involved in the dispute, and
983 reimbursement levels in the community and various federal and
984 state medical fee schedules applicable to automobile and other
985 insurance coverages, and other information relevant to the
986 reasonableness of the reimbursement for the service, treatment,
987 or supply.
988 (b)1. An insurer or insured is not required to pay a claim
989 or charges:
990 a. Made by a broker or by a person making a claim on
991 behalf of a broker;
992 b. For any service or treatment that was not lawful at the
993 time rendered;
994 c. To any person who knowingly submits a false or
995 misleading statement relating to the claim or charges;
996 d. With respect to a bill or statement that does not
997 substantially meet the applicable requirements of paragraph (d);
998 e. For any treatment or service that is upcoded, or that
999 is unbundled when such treatment or services should be bundled,
1000 in accordance with paragraph (d). To facilitate prompt payment
1001 of lawful services, an insurer may change codes that it
1002 determines to have been improperly or incorrectly upcoded or
1003 unbundled, and may make payment based on the changed codes,
1004 without affecting the right of the provider to dispute the
1005 change by the insurer, provided that before doing so, the
1006 insurer must contact the health care provider and discuss the
1007 reasons for the insurer's change and the health care provider's
1008 reason for the coding, or make a reasonable good faith effort to

1009 do so, as documented in the insurer's file; and
1010 f. For medical services or treatment billed by a physician
1011 and not provided in a hospital unless such services are rendered
1012 by the physician or are incident to his or her professional
1013 services and are included on the physician's bill, including
1014 documentation verifying that the physician is responsible for
1015 the medical services that were rendered and billed.
1016 2. Charges for medically necessary cephalic thermograms,
1017 peripheral thermograms, spinal ultrasounds, extremity
1018 ultrasounds, video fluoroscopy, and surface electromyography
1019 shall not exceed the maximum reimbursement allowance for such
1020 procedures as set forth in the applicable fee schedule or other
1021 payment methodology established pursuant to s. 440.13.
1022 3. Allowable amounts that may be charged to a personal
1023 injury protection insurance insurer and insured for medically
1024 necessary nerve conduction testing when done in conjunction with
1025 a needle electromyography procedure and both are performed and
1026 billed solely by a physician licensed under chapter 458, chapter
1027 459, chapter 460, or chapter 461 who is also certified by the
1028 American Board of Electrodiagnostic Medicine or by a board
1029 recognized by the American Board of Medical Specialties or the
1030 American Osteopathic Association or who holds diplomate status
1031 with the American Chiropractic Neurology Board or its
1032 predecessors shall not exceed 200 percent of the allowable
1033 amount under the participating physician fee schedule of
1034 Medicare Part B for year 2001, for the area in which the
1035 treatment was rendered, adjusted annually on August 1 to reflect
1036 the prior calendar year's changes in the annual Medical Care

1037 Item of the Consumer Price Index for All Urban Consumers in the
1038 South Region as determined by the Bureau of Labor Statistics of
1039 the United States Department of Labor.
1040 4. Allowable amounts that may be charged to a personal
1041 injury protection insurance insurer and insured for medically
1042 necessary nerve conduction testing that does not meet the
1043 requirements of subparagraph 3. shall not exceed the applicable
1044 fee schedule or other payment methodology established pursuant
1045 to s. 440.13.
1046 5. Allowable amounts that may be charged to a personal
1047 injury protection insurance insurer and insured for magnetic
1048 resonance imaging services shall not exceed 175 percent of the
1049 allowable amount under the participating physician fee schedule
1050 of Medicare Part B for year 2001, for the area in which the
1051 treatment was rendered, adjusted annually on August 1 to reflect
1052 the prior calendar year's changes in the annual Medical Care
1053 Item of the Consumer Price Index for All Urban Consumers in the
1054 South Region as determined by the Bureau of Labor Statistics of
1055 the United States Department of Labor for the 12-month period
1056 ending June 30 of that year, except that allowable amounts that
1057 may be charged to a personal injury protection insurance insurer
1058 and insured for magnetic resonance imaging services provided in
1059 facilities accredited by the Accreditation Association for
1060 Ambulatory Health Care, the American College of Radiology, or
1061 the Joint Commission on Accreditation of Healthcare
1062 Organizations shall not exceed 200 percent of the allowable
1063 amount under the participating physician fee schedule of
1064 Medicare Part B for year 2001, for the area in which the

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1065 treatment was rendered, adjusted annually on August 1 to reflect
1066 the prior calendar year's changes in the annual Medical Care
1067 Item of the Consumer Price Index for All Urban Consumers in the
1068 South Region as determined by the Bureau of Labor Statistics of
1069 the United States Department of Labor for the 12-month period
1070 ending June 30 of that year. This paragraph does not apply to
1071 charges for magnetic resonance imaging services and nerve
1072 conduction testing for inpatients and emergency services and
1073 care as defined in chapter 395 rendered by facilities licensed
1074 under chapter 395.

1075 6. The Department of Health, in consultation with the
1076 appropriate professional licensing boards, shall adopt, by rule,
1077 a list of diagnostic tests deemed not to be medically necessary
1078 for use in the treatment of persons sustaining bodily injury
1079 covered by personal injury protection benefits under this
1080 section. The initial list shall be adopted by January 1, 2004,
1081 and shall be revised from time to time as determined by the
1082 Department of Health, in consultation with the respective
1083 professional licensing boards. Inclusion of a test on the list
1084 of invalid diagnostic tests shall be based on lack of
1085 demonstrated medical value and a level of general acceptance by
1086 the relevant provider community and shall not be dependent for
1087 results entirely upon subjective patient response.
1088 Notwithstanding its inclusion on a fee schedule in this
1089 subsection, an insurer or insured is not required to pay any
1090 charges or reimburse claims for any invalid diagnostic test as
1091 determined by the Department of Health.

1092 (c)1. With respect to any treatment or service, other than

1093 medical services billed by a hospital or other provider for
1094 emergency services as defined in s. 395.002 or inpatient
1095 services rendered at a hospital-owned facility, the statement of
1096 charges must be furnished to the insurer by the provider and may
1097 not include, and the insurer is not required to pay, charges for
1098 treatment or services rendered more than 35 days before the
1099 postmark date of the statement, except for past due amounts
1100 previously billed on a timely basis under this paragraph, and
1101 except that, if the provider submits to the insurer a notice of
1102 initiation of treatment within 21 days after its first
1103 examination or treatment of the claimant, the statement may
1104 include charges for treatment or services rendered up to, but
1105 not more than, 75 days before the postmark date of the
1106 statement. The injured party is not liable for, and the provider
1107 shall not bill the injured party for, charges that are unpaid
1108 because of the provider's failure to comply with this paragraph.
1109 Any agreement requiring the injured person or insured to pay for
1110 such charges is unenforceable.
1111 2. If, however, the insured fails to furnish the provider
1112 with the correct name and address of the insured's personal
1113 injury protection insurer, the provider has 35 days from the
1114 date the provider obtains the correct information to furnish the
1115 insurer with a statement of the charges. The insurer is not
1116 required to pay for such charges unless the provider includes
1117 with the statement documentary evidence that was provided by the
1118 insured during the 35-day period demonstrating that the provider
1119 reasonably relied on erroneous information from the insured and
1120 either:

1121 a. A denial letter from the incorrect insurer; or
1122 b. Proof of mailing, which may include an affidavit under
1123 penalty of perjury, reflecting timely mailing to the incorrect
1124 address or insurer.
1125 3. For emergency services and care as defined in s.
1126 395.002 rendered in a hospital emergency department or for
1127 transport and treatment rendered by an ambulance provider
1128 licensed pursuant to part III of chapter 401, the provider is
1129 not required to furnish the statement of charges within the time
1130 periods established by this paragraph; and the insurer shall not
1131 be considered to have been furnished with notice of the amount
1132 of covered loss for purposes of paragraph (4)(b) until it
1133 receives a statement complying with paragraph (d), or copy
1134 thereof, which specifically identifies the place of service to
1135 be a hospital emergency department or an ambulance in accordance
1136 with billing standards recognized by the Health Care Finance
1137 Administration.
1138 4. Each notice of insured's rights under s. 627.7401 must
1139 include the following statement in type no smaller than 12
1140 points:
1141
1142 BILLING REQUIREMENTS.--Florida Statutes provide that with
1143 respect to any treatment or services, other than certain
1144 hospital and emergency services, the statement of charges
1145 furnished to the insurer by the provider may not include, and
1146 the insurer and the injured party are not required to pay,
1147 charges for treatment or services rendered more than 35 days
1148 before the postmark date of the statement, except for past due

1149 amounts previously billed on a timely basis, and except that, if
1150 the provider submits to the insurer a notice of initiation of
1151 treatment within 21 days after its first examination or
1152 treatment of the claimant, the statement may include charges for
1153 treatment or services rendered up to, but not more than, 75 days
1154 before the postmark date of the statement.
1155 (d) All statements and bills for medical services rendered
1156 by any physician, hospital, clinic, or other person or
1157 institution shall be submitted to the insurer on a properly
1158 completed Centers for Medicare and Medicaid Services (CMS) 1500
1159 form, UB 92 forms, or any other standard form approved by the
1160 office or adopted by the commission for purposes of this
1161 paragraph. All billings for such services rendered by providers
1162 shall, to the extent applicable, follow the Physicians' Current
1163 Procedural Terminology (CPT) or Healthcare Correct Procedural
1164 Coding System (HCPCS), or ICD-9 in effect for the year in which
1165 services are rendered and comply with the Centers for Medicare
1166 and Medicaid Services (CMS) 1500 form instructions and the
1167 American Medical Association Current Procedural Terminology
1168 (CPT) Editorial Panel and Healthcare Correct Procedural Coding
1169 System (HCPCS). All providers other than hospitals shall include
1170 on the applicable claim form the professional license number of
1171 the provider in the line or space provided for "Signature of
1172 Physician or Supplier, Including Degrees or Credentials." In
1173 determining compliance with applicable CPT and HCPCS coding,
1174 guidance shall be provided by the Physicians' Current Procedural
1175 Terminology (CPT) or the Healthcare Correct Procedural Coding
1176 System (HCPCS) in effect for the year in which services were

1177 rendered, the Office of the Inspector General (OIG), Physicians
1178 Compliance Guidelines, and other authoritative treatises
1179 designated by rule by the Agency for Health Care Administration.
1180 No statement of medical services may include charges for medical
1181 services of a person or entity that performed such services
1182 without possessing the valid licenses required to perform such
1183 services. For purposes of paragraph (4)(b), an insurer shall not
1184 be considered to have been furnished with notice of the amount
1185 of covered loss or medical bills due unless the statements or
1186 bills comply with this paragraph, and unless the statements or
1187 bills are properly completed in their entirety as to all
1188 material provisions, with all relevant information being
1189 provided therein.
1190 (e)1. At the initial treatment or service provided, each
1191 physician, other licensed professional, clinic, or other medical
1192 institution providing medical services upon which a claim for
1193 personal injury protection benefits is based shall require an
1194 insured person, or his or her guardian, to execute a disclosure
1195 and acknowledgment form, which reflects at a minimum that:
1196 a. The insured, or his or her guardian, must countersign
1197 the form attesting to the fact that the services set forth
1198 therein were actually rendered;
1199 b. The insured, or his or her guardian, has both the right
1200 and affirmative duty to confirm that the services were actually
1201 rendered;
1202 c. The insured, or his or her guardian, was not solicited
1203 by any person to seek any services from the medical provider;
1204 d. That the physician, other licensed professional,

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1205 clinic, or other medical institution rendering services for
1206 which payment is being claimed explained the services to the
1207 insured or his or her guardian; and
1208 e. If the insured notifies the insurer in writing of a
1209 billing error, the insured may be entitled to a certain
1210 percentage of a reduction in the amounts paid by the insured's
1211 motor vehicle insurer.
1212 2. The physician, other licensed professional, clinic, or
1213 other medical institution rendering services for which payment
1214 is being claimed has the affirmative duty to explain the
1215 services rendered to the insured, or his or her guardian, so
1216 that the insured, or his or her guardian, countersigns the form
1217 with informed consent.
1218 3. Countersignature by the insured, or his or her
1219 guardian, is not required for the reading of diagnostic tests or
1220 other services that are of such a nature that they are not
1221 required to be performed in the presence of the insured.
1222 4. The licensed medical professional rendering treatment
1223 for which payment is being claimed must sign, by his or her own
1224 hand, the form complying with this paragraph.
1225 5. The original completed disclosure and acknowledgment
1226 form shall be furnished to the insurer pursuant to paragraph
1227 (4)(b) and may not be electronically furnished.
1228 6. This disclosure and acknowledgment form is not required
1229 for services billed by a provider for emergency services as
1230 defined in s. 395.002, for emergency services and care as
1231 defined in s. 395.002 rendered in a hospital emergency
1232 department, or for transport and treatment rendered by an

1233 ambulance provider licensed pursuant to part III of chapter 401.
1234 7. The Financial Services Commission shall adopt, by rule,
1235 a standard disclosure and acknowledgment form that shall be used
1236 to fulfill the requirements of this paragraph, effective 90 days
1237 after such form is adopted and becomes final. The commission
1238 shall adopt a proposed rule by October 1, 2003. Until the rule
1239 is final, the provider may use a form of its own which otherwise
1240 complies with the requirements of this paragraph.
1241 8. As used in this paragraph, "countersigned" means a
1242 second or verifying signature, as on a previously signed
1243 document, and is not satisfied by the statement "signature on
1244 file" or any similar statement.
1245 9. The requirements of this paragraph apply only with
1246 respect to the initial treatment or service of the insured by a
1247 provider. For subsequent treatments or service, the provider
1248 must maintain a patient log signed by the patient, in
1249 chronological order by date of service, that is consistent with
1250 the services being rendered to the patient as claimed. The
1251 requirements of this subparagraph for maintaining a patient log
1252 signed by the patient may be met by a hospital that maintains
1253 medical records as required by s. 395.3025 and applicable rules
1254 and makes such records available to the insurer upon request.
1255 (f) Upon written notification by any person, an insurer
1256 shall investigate any claim of improper billing by a physician
1257 or other medical provider. The insurer shall determine if the
1258 insured was properly billed for only those services and
1259 treatments that the insured actually received. If the insurer
1260 determines that the insured has been improperly billed, the

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1261 insurer shall notify the insured, the person making the written
1262 notification and the provider of its findings and shall reduce
1263 the amount of payment to the provider by the amount determined
1264 to be improperly billed. If a reduction is made due to such
1265 written notification by any person, the insurer shall pay to the
1266 person 20 percent of the amount of the reduction, up to $500. If
1267 the provider is arrested due to the improper billing, then the
1268 insurer shall pay to the person 40 percent of the amount of the
1269 reduction, up to $500.
1270 (g) An insurer may not systematically downcode with the
1271 intent to deny reimbursement otherwise due. Such action
1272 constitutes a material misrepresentation under s.
1273 626.9541(1)(i)2.
1274 (6) DISCOVERY OF FACTS ABOUT AN INJURED PERSON;
1275 DISPUTES.--
1276 (a) Every employer shall, if a request is made by an
1277 insurer providing personal injury protection benefits under ss.
1278 627.730-627.7405 against whom a claim has been made, furnish
1279 forthwith, in a form approved by the office, a sworn statement
1280 of the earnings, since the time of the bodily injury and for a
1281 reasonable period before the injury, of the person upon whose
1282 injury the claim is based.
1283 (b) Every physician, hospital, clinic, or other medical
1284 institution providing, before or after bodily injury upon which
1285 a claim for personal injury protection insurance benefits is
1286 based, any products, services, or accommodations in relation to
1287 that or any other injury, or in relation to a condition claimed
1288 to be connected with that or any other injury, shall, if

1289 requested to do so by the insurer against whom the claim has
1290 been made, furnish forthwith a written report of the history,
1291 condition, treatment, dates, and costs of such treatment of the
1292 injured person and why the items identified by the insurer were
1293 reasonable in amount and medically necessary, together with a
1294 sworn statement that the treatment or services rendered were
1295 reasonable and necessary with respect to the bodily injury
1296 sustained and identifying which portion of the expenses for such
1297 treatment or services was incurred as a result of such bodily
1298 injury, and produce forthwith, and permit the inspection and
1299 copying of, his or her or its records regarding such history,
1300 condition, treatment, dates, and costs of treatment; provided
1301 that this shall not limit the introduction of evidence at trial.
1302 Such sworn statement shall read as follows: "Under penalty of
1303 perjury, I declare that I have read the foregoing, and the facts
1304 alleged are true, to the best of my knowledge and belief." No
1305 cause of action for violation of the physician-patient privilege
1306 or invasion of the right of privacy shall be permitted against
1307 any physician, hospital, clinic, or other medical institution
1308 complying with the provisions of this section. The person
1309 requesting such records and such sworn statement shall pay all
1310 reasonable costs connected therewith. If an insurer makes a
1311 written request for documentation or information under this
1312 paragraph within 30 days after having received notice of the
1313 amount of a covered loss under paragraph (4)(a), the amount or
1314 the partial amount which is the subject of the insurer's inquiry
1315 shall become overdue if the insurer does not pay in accordance
1316 with paragraph (4)(b) or within 10 days after the insurer's

1317 receipt of the requested documentation or information, whichever
1318 occurs later. For purposes of this paragraph, the term "receipt"
1319 includes, but is not limited to, inspection and copying pursuant
1320 to this paragraph. Any insurer that requests documentation or
1321 information pertaining to reasonableness of charges or medical
1322 necessity under this paragraph without a reasonable basis for
1323 such requests as a general business practice is engaging in an
1324 unfair trade practice under the insurance code.
1325 (c) In the event of any dispute regarding an insurer's
1326 right to discovery of facts under this section, the insurer may
1327 petition a court of competent jurisdiction to enter an order
1328 permitting such discovery. The order may be made only on motion
1329 for good cause shown and upon notice to all persons having an
1330 interest, and it shall specify the time, place, manner,
1331 conditions, and scope of the discovery. Such court may, in order
1332 to protect against annoyance, embarrassment, or oppression, as
1333 justice requires, enter an order refusing discovery or
1334 specifying conditions of discovery and may order payments of
1335 costs and expenses of the proceeding, including reasonable fees
1336 for the appearance of attorneys at the proceedings, as justice
1337 requires.
1338 (d) The injured person shall be furnished, upon request, a
1339 copy of all information obtained by the insurer under the
1340 provisions of this section, and shall pay a reasonable charge,
1341 if required by the insurer.
1342 (e) Notice to an insurer of the existence of a claim shall
1343 not be unreasonably withheld by an insured.
1344 (7) MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON;

1345 REPORTS.--
1346 (a) Whenever the mental or physical condition of an
1347 injured person covered by personal injury protection is material
1348 to any claim that has been or may be made for past or future
1349 personal injury protection insurance benefits, such person
1350 shall, upon the request of an insurer, submit to mental or
1351 physical examination by a physician or physicians. The costs of
1352 any examinations requested by an insurer shall be borne entirely
1353 by the insurer. Such examination shall be conducted within the
1354 municipality where the insured is receiving treatment, or in a
1355 location reasonably accessible to the insured, which, for
1356 purposes of this paragraph, means any location within the
1357 municipality in which the insured resides, or any location
1358 within 10 miles by road of the insured's residence, provided
1359 such location is within the county in which the insured resides.
1360 If the examination is to be conducted in a location reasonably
1361 accessible to the insured, and if there is no qualified
1362 physician to conduct the examination in a location reasonably
1363 accessible to the insured, then such examination shall be
1364 conducted in an area of the closest proximity to the insured's
1365 residence. Personal protection insurers are authorized to
1366 include reasonable provisions in personal injury protection
1367 insurance policies for mental and physical examination of those
1368 claiming personal injury protection insurance benefits. An
1369 insurer may not withdraw payment of a treating physician without
1370 the consent of the injured person covered by the personal injury
1371 protection, unless the insurer first obtains a valid report by a
1372 Florida physician licensed under the same chapter as the

1373 treating physician whose treatment authorization is sought to be
1374 withdrawn, stating that treatment was not reasonable, related,
1375 or necessary. A valid report is one that is prepared and signed
1376 by the physician examining the injured person or reviewing the
1377 treatment records of the injured person and is factually
1378 supported by the examination and treatment records if reviewed
1379 and that has not been modified by anyone other than the
1380 physician. The physician preparing the report must be in active
1381 practice, unless the physician is physically disabled. Active
1382 practice means that during the 3 years immediately preceding the
1383 date of the physical examination or review of the treatment
1384 records the physician must have devoted professional time to the
1385 active clinical practice of evaluation, diagnosis, or treatment
1386 of medical conditions or to the instruction of students in an
1387 accredited health professional school or accredited residency
1388 program or a clinical research program that is affiliated with
1389 an accredited health professional school or teaching hospital or
1390 accredited residency program. The physician preparing a report
1391 at the request of an insurer and physicians rendering expert
1392 opinions on behalf of persons claiming medical benefits for
1393 personal injury protection, or on behalf of an insured through
1394 an attorney or another entity, shall maintain, for at least 3
1395 years, copies of all examination reports as medical records and
1396 shall maintain, for at least 3 years, records of all payments
1397 for the examinations and reports. Neither an insurer nor any
1398 person acting at the direction of or on behalf of an insurer may
1399 materially change an opinion in a report prepared under this
1400 paragraph or direct the physician preparing the report to change

1401 such opinion. The denial of a payment as the result of such a
1402 changed opinion constitutes a material misrepresentation under
1403 s. 626.9541(1)(i)2.; however, this provision does not preclude
1404 the insurer from calling to the attention of the physician
1405 errors of fact in the report based upon information in the claim
1406 file.
1407 (b) If requested by the person examined, a party causing
1408 an examination to be made shall deliver to him or her a copy of
1409 every written report concerning the examination rendered by an
1410 examining physician, at least one of which reports must set out
1411 the examining physician's findings and conclusions in detail.
1412 After such request and delivery, the party causing the
1413 examination to be made is entitled, upon request, to receive
1414 from the person examined every written report available to him
1415 or her or his or her representative concerning any examination,
1416 previously or thereafter made, of the same mental or physical
1417 condition. By requesting and obtaining a report of the
1418 examination so ordered, or by taking the deposition of the
1419 examiner, the person examined waives any privilege he or she may
1420 have, in relation to the claim for benefits, regarding the
1421 testimony of every other person who has examined, or may
1422 thereafter examine, him or her in respect to the same mental or
1423 physical condition. If a person unreasonably refuses to submit
1424 to an examination, the personal injury protection carrier is no
1425 longer liable for subsequent personal injury protection
1426 benefits.
1427 (8) APPLICABILITY OF PROVISION REGULATING ATTORNEY'S
1428 FEES.--With respect to any dispute under the provisions of ss.

1429 627.730-627.7405 between the insured and the insurer, or between
1430 an assignee of an insured's rights and the insurer, the
1431 provisions of s. 627.428 shall apply, except as provided in
1432 subsection (10) ~~(11)~~.
1433 ~~(9)(a) Each insurer which has issued a policy providing~~
1434 ~~personal injury protection benefits shall report the renewal,~~
1435 ~~cancellation, or nonrenewal thereof to the Department of Highway~~
1436 ~~Safety and Motor Vehicles within 45 days from the effective date~~
1437 ~~of the renewal, cancellation, or nonrenewal. Upon the issuance~~
1438 ~~of a policy providing personal injury protection benefits to a~~
1439 ~~named insured not previously insured by the insurer thereof~~
1440 ~~during that calendar year, the insurer shall report the issuance~~
1441 ~~of the new policy to the Department of Highway Safety and Motor~~
1442 ~~Vehicles within 30 days. The report shall be in such form and~~
1443 ~~format and contain such information as may be required by the~~
1444 ~~Department of Highway Safety and Motor Vehicles which shall~~
1445 ~~include a format compatible with the data processing~~
1446 ~~capabilities of said department, and the Department of Highway~~
1447 ~~Safety and Motor Vehicles is authorized to adopt rules necessary~~
1448 ~~with respect thereto. Failure by an insurer to file proper~~
1449 ~~reports with the Department of Highway Safety and Motor Vehicles~~
1450 ~~as required by this subsection or rules adopted with respect to~~
1451 ~~the requirements of this subsection constitutes a violation of~~
1452 ~~the Florida Insurance Code. Reports of cancellations and policy~~
1453 ~~renewals and reports of the issuance of new policies received by~~
1454 ~~the Department of Highway Safety and Motor Vehicles are~~
1455 ~~confidential and exempt from the provisions of s. 119.07(1).~~
1456 ~~These records are to be used for enforcement and regulatory~~

1457 ~~purposes only, including the generation by the department of~~
1458 ~~data regarding compliance by owners of motor vehicles with~~
1459 ~~financial responsibility coverage requirements. In addition, the~~
1460 ~~Department of Highway Safety and Motor Vehicles shall release,~~
1461 ~~upon a written request by a person involved in a motor vehicle~~
1462 ~~accident, by the person's attorney, or by a representative of~~
1463 ~~the person's motor vehicle insurer, the name of the insurance~~
1464 ~~company and the policy number for the policy covering the~~
1465 ~~vehicle named by the requesting party. The written request must~~
1466 ~~include a copy of the appropriate accident form as provided in~~
1467 ~~s. 316.065, s. 316.066, or s. 316.068.~~
1468 ~~(b) Every insurer with respect to each insurance policy~~
1469 ~~providing personal injury protection benefits shall notify the~~
1470 ~~named insured or in the case of a commercial fleet policy, the~~
1471 ~~first named insured in writing that any cancellation or~~
1472 ~~nonrenewal of the policy will be reported by the insurer to the~~
1473 ~~Department of Highway Safety and Motor Vehicles. The notice~~
1474 ~~shall also inform the named insured that failure to maintain~~
1475 ~~personal injury protection and property damage liability~~
1476 ~~insurance on a motor vehicle when required by law may result in~~
1477 ~~the loss of registration and driving privileges in this state,~~
1478 ~~and the notice shall inform the named insured of the amount of~~
1479 ~~the reinstatement fees required by s. 627.733(7). This notice~~
1480 ~~is for informational purposes only, and no civil liability shall~~
1481 ~~attach to an insurer due to failure to provide this notice.~~
1482 (9) ~~(10)~~ An insurer may negotiate and enter into contracts
1483 with licensed health care providers for the benefits described
1484 in this section, referred to in this section as "preferred

1485 providers," which shall include health care providers licensed
1486 under chapters 458, 459, 460, 461, and 463. The insurer may
1487 provide an option to an insured to use a preferred provider at
1488 the time of purchase of the policy for personal injury
1489 protection benefits, if the requirements of this subsection are
1490 met. If the insured elects to use a provider who is not a
1491 preferred provider, whether the insured purchased a preferred
1492 provider policy or a nonpreferred provider policy, the medical
1493 benefits provided by the insurer shall be as required by this
1494 section. If the insured elects to use a provider who is a
1495 preferred provider, the insurer may pay medical benefits in
1496 excess of the benefits required by this section and may waive or
1497 lower the amount of any deductible that applies to such medical
1498 benefits. If the insurer offers a preferred provider policy to a
1499 policyholder or applicant, it must also offer a nonpreferred
1500 provider policy. The insurer shall provide each policyholder
1501 with a current roster of preferred providers in the county in
1502 which the insured resides at the time of purchase of such
1503 policy, and shall make such list available for public inspection
1504 during regular business hours at the principal office of the
1505 insurer within the state.
1506 (10) ~~(11)~~ DEMAND LETTER.--
1507 (a) As a condition precedent to filing any action for
1508 benefits under this section, the insurer must be provided with
1509 written notice of an intent to initiate litigation. Such notice
1510 may not be sent until the claim is overdue, including any
1511 additional time the insurer has to pay the claim pursuant to
1512 paragraph (4)(b).

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1513 (b) The notice required shall state that it is a "demand
1514 letter under s. 627.736(10) ~~(11)~~" and shall state with
1515 specificity:
1516 1. The name of the insured upon which such benefits are
1517 being sought, including a copy of the assignment giving rights
1518 to the claimant if the claimant is not the insured.
1519 2. The claim number or policy number upon which such claim
1520 was originally submitted to the insurer.
1521 3. To the extent applicable, the name of any medical
1522 provider who rendered to an insured the treatment, services,
1523 accommodations, or supplies that form the basis of such claim;
1524 and an itemized statement specifying each exact amount, the date
1525 of treatment, service, or accommodation, and the type of benefit
1526 claimed to be due. A completed form satisfying the requirements
1527 of paragraph (5)(d) or the lost-wage statement previously
1528 submitted may be used as the itemized statement. To the extent
1529 that the demand involves an insurer's withdrawal of payment
1530 under paragraph (7)(a) for future treatment not yet rendered,
1531 the claimant shall attach a copy of the insurer's notice
1532 withdrawing such payment and an itemized statement of the type,
1533 frequency, and duration of future treatment claimed to be
1534 reasonable and medically necessary.
1535 (c) Each notice required by this subsection must be
1536 delivered to the insurer by United States certified or
1537 registered mail, return receipt requested. Such postal costs
1538 shall be reimbursed by the insurer if so requested by the
1539 claimant in the notice, when the insurer pays the claim. Such
1540 notice must be sent to the person and address specified by the

1541 insurer for the purposes of receiving notices under this
1542 subsection. Each licensed insurer, whether domestic, foreign, or
1543 alien, shall file with the office designation of the name and
1544 address of the person to whom notices pursuant to this
1545 subsection shall be sent which the office shall make available
1546 on its Internet website. The name and address on file with the
1547 office pursuant to s. 624.422 shall be deemed the authorized
1548 representative to accept notice pursuant to this subsection in
1549 the event no other designation has been made.
1550 (d) If, within 15 days after receipt of notice by the
1551 insurer, the overdue claim specified in the notice is paid by
1552 the insurer together with applicable interest and a penalty of
1553 10 percent of the overdue amount paid by the insurer, subject to
1554 a maximum penalty of $250, no action may be brought against the
1555 insurer. If the demand involves an insurer's withdrawal of
1556 payment under paragraph (7)(a) for future treatment not yet
1557 rendered, no action may be brought against the insurer if,
1558 within 15 days after its receipt of the notice, the insurer
1559 mails to the person filing the notice a written statement of the
1560 insurer's agreement to pay for such treatment in accordance with
1561 the notice and to pay a penalty of 10 percent, subject to a
1562 maximum penalty of $250, when it pays for such future treatment
1563 in accordance with the requirements of this section. To the
1564 extent the insurer determines not to pay any amount demanded,
1565 the penalty shall not be payable in any subsequent action. For
1566 purposes of this subsection, payment or the insurer's agreement
1567 shall be treated as being made on the date a draft or other
1568 valid instrument that is equivalent to payment, or the insurer's

1569 written statement of agreement, is placed in the United States
1570 mail in a properly addressed, postpaid envelope, or if not so
1571 posted, on the date of delivery. The insurer shall not be
1572 obligated to pay any attorney's fees if the insurer pays the
1573 claim or mails its agreement to pay for future treatment within
1574 the time prescribed by this subsection.
1575 (e) The applicable statute of limitation for an action
1576 under this section shall be tolled for a period of 15 business
1577 days by the mailing of the notice required by this subsection.
1578 (f) Any insurer making a general business practice of not
1579 paying valid claims until receipt of the notice required by this
1580 subsection is engaging in an unfair trade practice under the
1581 insurance code.
1582 <u>(11)</u>~~(12)~~ CIVIL ACTION FOR INSURANCE FRAUD.--An insurer
1583 shall have a cause of action against any person convicted of, or
1584 who, regardless of adjudication of guilt, pleads guilty or nolo
1585 contendere to insurance fraud under s. 817.234, patient
1586 brokering under s. 817.505, or kickbacks under s. 456.054,
1587 associated with a claim for personal injury protection benefits
1588 in accordance with this section. An insurer prevailing in an
1589 action brought under this subsection may recover compensatory,
1590 consequential, and punitive damages subject to the requirements
1591 and limitations of part II of chapter 768, and attorney's fees
1592 and costs incurred in litigating a cause of action against any
1593 person convicted of, or who, regardless of adjudication of
1594 guilt, pleads guilty or nolo contendere to insurance fraud under
1595 s. 817.234, patient brokering under s. 817.505, or kickbacks
1596 under s. 456.054, associated with a claim for personal injury

1597 protection benefits in accordance with this section.
1598 (12) ~~(13)~~ MINIMUM BENEFIT COVERAGE.--If the Financial
1599 Services Commission determines that the cost savings under
1600 personal injury protection insurance benefits paid by insurers
1601 have been realized due to the provisions of this act, prior
1602 legislative reforms, or other factors, the commission may
1603 increase the minimum $10,000 benefit coverage requirement. In
1604 establishing the amount of such increase, the commission must
1605 determine that the additional premium for such coverage is
1606 approximately equal to the premium cost savings that have been
1607 realized for the personal injury protection coverage with limits
1608 of $10,000.
1609 (13) ~~(14)~~ FRAUD ADVISORY NOTICE.--Upon receiving notice of
1610 a claim under this section, an insurer shall provide a notice to
1611 the insured or to a person for whom a claim for reimbursement
1612 for diagnosis or treatment of injuries has been filed, advising
1613 that:
1614 (a) Pursuant to s. 626.9892, the Department of Financial
1615 Services may pay rewards of up to $25,000 to persons providing
1616 information leading to the arrest and conviction of persons
1617 committing crimes investigated by the Division of Insurance
1618 Fraud arising from violations of s. 440.105, s. 624.15, s.
1619 626.9541, s. 626.989, or s. 817.234.
1620 (b) Solicitation of a person injured in a motor vehicle
1621 crash for purposes of filing personal injury protection or tort
1622 claims could be a violation of s. 817.234, s. 817.505, or the
1623 rules regulating The Florida Bar and should be immediately
1624 reported to the Division of Insurance Fraud if such conduct has

1625 taken place.

1626 Section 14. Notwithstanding the repeal of the Florida
1627 Motor Vehicle No-Fault Law, which occurred on October 1, 2007,
1628 section 627.737, Florida Statutes, is revived and reenacted to
1629 read:

1630 627.737 Tort exemption; limitation on right to damages;
1631 punitive damages.--

1632 (1) Every owner, registrant, operator, or occupant of a
1633 motor vehicle with respect to which security has been provided
1634 as required by ss. 627.730-627.7405, and every person or
1635 organization legally responsible for her or his acts or
1636 omissions, is hereby exempted from tort liability for damages
1637 because of bodily injury, sickness, or disease arising out of
1638 the ownership, operation, maintenance, or use of such motor
1639 vehicle in this state to the extent that the benefits described
1640 in s. 627.736(1) are payable for such injury, or would be
1641 payable but for any exclusion authorized by ss. 627.730-
1642 627.7405, under any insurance policy or other method of security
1643 complying with the requirements of s. 627.733, or by an owner
1644 personally liable under s. 627.733 for the payment of such
1645 benefits, unless a person is entitled to maintain an action for
1646 pain, suffering, mental anguish, and inconvenience for such
1647 injury under the provisions of subsection (2).

1648 (2) In any action of tort brought against the owner,
1649 registrant, operator, or occupant of a motor vehicle with
1650 respect to which security has been provided as required by ss.
1651 627.730-627.7405, or against any person or organization legally
1652 responsible for her or his acts or omissions, a plaintiff may

1653 recover damages in tort for pain, suffering, mental anguish, and
1654 inconvenience because of bodily injury, sickness, or disease
1655 arising out of the ownership, maintenance, operation, or use of
1656 such motor vehicle only in the event that the injury or disease
1657 consists in whole or in part of:

1658 (a) Significant and permanent loss of an important bodily
1659 function.

1660 (b) Permanent injury within a reasonable degree of medical
1661 probability, other than scarring or disfigurement.

1662 (c) Significant and permanent scarring or disfigurement.

1663 (d) Death.

1664 (3) When a defendant, in a proceeding brought pursuant to
1665 ss. 627.730-627.7405, questions whether the plaintiff has met
1666 the requirements of subsection (2), then the defendant may file
1667 an appropriate motion with the court, and the court shall, on a
1668 one-time basis only, 30 days before the date set for the trial
1669 or the pretrial hearing, whichever is first, by examining the
1670 pleadings and the evidence before it, ascertain whether the
1671 plaintiff will be able to submit some evidence that the
1672 plaintiff will meet the requirements of subsection (2). If the
1673 court finds that the plaintiff will not be able to submit such
1674 evidence, then the court shall dismiss the plaintiff's claim
1675 without prejudice.

1676 (4) In any action brought against an automobile liability
1677 insurer for damages in excess of its policy limits, no claim for
1678 punitive damages shall be allowed.

1679 Section 15. Notwithstanding the repeal of the Florida
1680 Motor Vehicle No-Fault Law, which occurred on October 1, 2007,

1681 section 627.739, Florida Statutes, is revived and reenacted to
1682 read:
1683 627.739 Personal injury protection; optional limitations;
1684 deductibles.--
1685 (1) The named insured may elect a deductible or modified
1686 coverage or combination thereof to apply to the named insured
1687 alone or to the named insured and dependent relatives residing
1688 in the same household, but may not elect a deductible or
1689 modified coverage to apply to any other person covered under the
1690 policy.
1691 (2) Insurers shall offer to each applicant and to each
1692 policyholder, upon the renewal of an existing policy,
1693 deductibles, in amounts of $250, $500, and $1,000. The
1694 deductible amount must be applied to 100 percent of the expenses
1695 and losses described in s. 627.736. After the deductible is met,
1696 each insured is eligible to receive up to $10,000 in total
1697 benefits described in s. 627.736(1). However, this subsection
1698 shall not be applied to reduce the amount of any benefits
1699 received in accordance with s. 627.736(1)(c).
1700 (3) Insurers shall offer coverage wherein, at the election
1701 of the named insured, the benefits for loss of gross income and
1702 loss of earning capacity described in s. 627.736(1)(b) shall be
1703 excluded.
1704 (4) The named insured shall not be prevented from electing
1705 a deductible under subsection (2) and modified coverage under
1706 subsection (3). Each election made by the named insured under
1707 this section shall result in an appropriate reduction of premium
1708 associated with that election.

1709 (5) All such offers shall be made in clear and unambiguous
1710 language at the time the initial application is taken and prior
1711 to each annual renewal and shall indicate that a premium
1712 reduction will result from each election. At the option of the
1713 insurer, the requirements of the preceding sentence are met by
1714 using forms of notice approved by the office, or by providing
1715 the following notice in 10-point type in the insurer's
1716 application for initial issuance of a policy of motor vehicle
1717 insurance and the insurer's annual notice of renewal premium:
1718 For personal injury protection insurance, the named insured may
1719 elect a deductible and to exclude coverage for loss of gross
1720 income and loss of earning capacity ("lost wages"). These
1721 elections apply to the named insured alone, or to the named
1722 insured and all dependent resident relatives. A premium
1723 reduction will result from these elections. The named insured is
1724 hereby advised not to elect the lost wage exclusion if the named
1725 insured or dependent resident relatives are employed, since lost
1726 wages will not be payable in the event of an accident.
1727 Section 16. Notwithstanding the repeal of the Florida
1728 Motor Vehicle No-Fault Law, which occurred on October 1, 2007,
1729 section 627.7401, Florida Statutes, is revived and reenacted to
1730 read:
1731 627.7401 Notification of insured's rights.--
1732 (1) The commission, by rule, shall adopt a form for the
1733 notification of insureds of their right to receive personal
1734 injury protection benefits under the Florida Motor Vehicle No-
1735 Fault Law. Such notice shall include:
1736 (a) A description of the benefits provided by personal

1737 injury protection, including, but not limited to, the specific
1738 types of services for which medical benefits are paid,
1739 disability benefits, death benefits, significant exclusions from
1740 and limitations on personal injury protection benefits, when
1741 payments are due, how benefits are coordinated with other
1742 insurance benefits that the insured may have, penalties and
1743 interest that may be imposed on insurers for failure to make
1744 timely payments of benefits, and rights of parties regarding
1745 disputes as to benefits.
1746 (b) An advisory informing insureds that:
1747 1. Pursuant to s. 626.9892, the Department of Financial
1748 Services may pay rewards of up to $25,000 to persons providing
1749 information leading to the arrest and conviction of persons
1750 committing crimes investigated by the Division of Insurance
1751 Fraud arising from violations of s. 440.105, s. 624.15, s.
1752 626.9541, s. 626.989, or s. 817.234.
1753 2. Pursuant to s. 627.736(5)(e)1., if the insured notifies
1754 the insurer of a billing error, the insured may be entitled to a
1755 certain percentage of a reduction in the amount paid by the
1756 insured's motor vehicle insurer.
1757 (c) A notice that solicitation of a person injured in a
1758 motor vehicle crash for purposes of filing personal injury
1759 protection or tort claims could be a violation of s. 817.234, s
1760 817.505, or the rules regulating The Florida Bar and should be
1761 immediately reported to the Division of Insurance Fraud if such
1762 conduct has taken place.
1763 (2) Each insurer issuing a policy in this state providing
1764 personal injury protection benefits must mail or deliver the

1765 notice as specified in subsection (1) to an insured within 21
1766 days after receiving from the insured notice of an automobile
1767 accident or claim involving personal injury to an insured who is
1768 covered under the policy. The office may allow an insurer
1769 additional time to provide the notice specified in subsection
1770 (1) not to exceed 30 days, upon a showing by the insurer that an
1771 emergency justifies an extension of time.
1772 (3) The notice required by this section does not alter or
1773 modify the terms of the insurance contract or other requirements
1774 of this act.
1775 Section 17. Notwithstanding the repeal of the Florida
1776 Motor Vehicle No-Fault Law, which occurred on October 1, 2007,
1777 section 627.7403, Florida Statutes, is revived and reenacted to
1778 read:
1779 627.7403 Mandatory joinder of derivative claim.--In any
1780 action brought pursuant to the provisions of s. 627.737 claiming
1781 personal injuries, all claims arising out of the plaintiff's
1782 injuries, including all derivative claims, shall be brought
1783 together, unless good cause is shown why such claims should be
1784 brought separately.
1785 Section 18. Notwithstanding the repeal of the Florida
1786 Motor Vehicle No-Fault Law, which occurred on October 1, 2007,
1787 section 627.7405, Florida Statutes, is revived and reenacted to
1788 read:
1789 627.7405 Insurers' right of
1790 reimbursement.--Notwithstanding any other provisions of ss.
1791 627.730-627.7405, any insurer providing personal injury
1792 protection benefits on a private passenger motor vehicle shall

1793 have, to the extent of any personal injury protection benefits
1794 paid to any person as a benefit arising out of such private
1795 passenger motor vehicle insurance, a right of reimbursement
1796 against the owner or the insurer of the owner of a commercial
1797 motor vehicle, if the benefits paid result from such person
1798 having been an occupant of the commercial motor vehicle or
1799 having been struck by the commercial motor vehicle while not an
1800 occupant of any self-propelled vehicle.
1801 Section 19. This act revives and reenacts, with
1802 amendments, the Florida Motor Vehicle No-Fault Law, which
1803 expired by operation of law on October 1, 2007. This act is
1804 intended to be remedial and curative in nature and to minimize
1805 confusion concerning the changes made by this act to ss.
1806 627.730-627.7405, Florida Statutes. Therefore, the Florida Motor
1807 Vehicle No-Fault Law shall continue to be codified as ss.
1808 627.730-627.7405, Florida Statutes, notwithstanding the repeal
1809 of those sections contained in s. 19, chapter 2003-411, Laws of
1810 Florida.
1811 Section 20. Effective January 15, 2008, and applicable to
1812 policies issued or renewed on or after that date, subsections
1813 (1) and (4), paragraphs (a), (b), and (c) of subsection (5),
1814 subsection (8), and paragraphs (d) and (e) of subsection (10) of
1815 section 627.736, Florida Statutes, as reenacted and amended by
1816 this act, are amended, subsections (11), (12), and (13) of that
1817 section, as reenacted and amended by this act, are renumbered as
1818 subsections (12), (13), and (14), respectively, and a new
1819 subsection (11) and subsections (15) and (16) are added to that
1820 section, to read:

1821 627.736 Required personal injury protection benefits;
1822 exclusions; priority; claims.--
1823 (1) REQUIRED BENEFITS.--Every insurance policy complying
1824 with the security requirements of s. 627.733 shall provide
1825 personal injury protection to the named insured, relatives
1826 residing in the same household, persons operating the insured
1827 motor vehicle, passengers in such motor vehicle, and other
1828 persons struck by such motor vehicle and suffering bodily injury
1829 while not an occupant of a self-propelled vehicle, subject to
1830 the provisions of subsection (2) and paragraph (4)(e)~~(d)~~, to a
1831 limit of $10,000 for loss sustained by any such person as a
1832 result of bodily injury, sickness, disease, or death arising out
1833 of the ownership, maintenance, or use of a motor vehicle as
1834 follows:
1835 (a) Medical benefits.--Eighty percent of all reasonable
1836 expenses for medically necessary medical, surgical, X-ray,
1837 dental, and rehabilitative services, including prosthetic
1838 devices, and medically necessary ambulance, hospital, and
1839 nursing services. However, the medical benefits shall provide
1840 reimbursement only for such services and care that are provided,
1841 ordered, or prescribed by a physician licensed under chapter 458
1842 or chapter 459 or a dentist licensed under chapter 466 or that
1843 are provided by any of the following persons or entities:
1844 1. A chiropractic physician licensed under chapter 460.
1845 2. A hospital or ambulatory surgical center licensed under
1846 chapter 395.
1847 3. A person or entity licensed under ss. 401.2101-401.45
1848 that provides emergency transportation and treatment.

1849 4. An entity wholly owned by one or more physicians
1850 licensed under chapter 458 or chapter 459, chiropractic
1851 physicians licensed under chapter 460, or dentists licensed
1852 under chapter 466 or by such practitioner or practitioners and
1853 the spouse, parent, child, or sibling of that practitioner or
1854 those practitioners.
1855 5. An entity wholly owned, directly or indirectly, by a
1856 hospital or hospitals.
1857 6. A health care clinic licensed under ss. 400.990-400.995
1858 that is:
1859 a. Accredited by the Joint Commission on Accreditation of
1860 Healthcare Organizations, the American Osteopathic Association,
1861 the Commission on Accreditation of Rehabilitation Facilities, or
1862 the Accreditation Association for Ambulatory Health Care, Inc.;
1863 or
1864 b. A health care clinic that:
1865 (I) Has a medical director licensed under chapter 458,
1866 chapter 459, or chapter 460;
1867 (II) Has been continuously licensed for more than 3 years
1868 or is a publicly traded corporation that issues securities
1869 traded on an exchange registered with the United States
1870 Securities and Exchange Commission as a national securities
1871 exchange; and
1872 (III) Provides at least four of the following medical
1873 specialties:
1874 (A) General medicine.
1875 (B) Radiography.
1876 (C) Orthopedic medicine.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1877 (D) Physical medicine.
1878 (E) Physical therapy.
1879 (F) Physical rehabilitation.
1880 (G) Prescribing or dispensing outpatient prescription
1881 medication.
1882 (H) Laboratory services.
1883
1884 The Financial Services Commission shall adopt by rule the form
1885 that must be used by an insurer and a health care provider
1886 specified in subparagraph 4., subparagraph 5., or subparagraph
1887 6. to document that the health care provider meets the criteria
1888 of this paragraph, which rule must include a requirement for a
1889 sworn statement or affidavit ~~Such benefits shall also include~~
1890 ~~necessary remedial treatment and services recognized and~~
1891 ~~permitted under the laws of the state for an injured person who~~
1892 ~~relies upon spiritual means through prayer alone for healing, in~~
1893 ~~accordance with his or her religious beliefs; however, this~~
1894 ~~sentence does not affect the determination of what other~~
1895 ~~services or procedures are medically necessary~~.
1896 (b) Disability benefits.--Sixty percent of any loss of
1897 gross income and loss of earning capacity per individual from
1898 inability to work proximately caused by the injury sustained by
1899 the injured person, plus all expenses reasonably incurred in
1900 obtaining from others ordinary and necessary services in lieu of
1901 those that, but for the injury, the injured person would have
1902 performed without income for the benefit of his or her
1903 household. All disability benefits payable under this provision
1904 shall be paid not less than every 2 weeks.

1905 (c) Death benefits.--Death benefits equal to the lesser of
1906 $5,000 or the remainder of unused personal injury protection
1907 benefits per individual. The insurer may pay such benefits to
1908 the executor or administrator of the deceased, to any of the
1909 deceased's relatives by blood or legal adoption or connection by
1910 marriage, or to any person appearing to the insurer to be
1911 equitably entitled thereto.
1912
1913 Only insurers writing motor vehicle liability insurance in this
1914 state may provide the required benefits of this section, and no
1915 such insurer shall require the purchase of any other motor
1916 vehicle coverage other than the purchase of property damage
1917 liability coverage as required by s. 627.7275 as a condition for
1918 providing such required benefits. Insurers may not require that
1919 property damage liability insurance in an amount greater than
1920 $10,000 be purchased in conjunction with personal injury
1921 protection. Such insurers shall make benefits and required
1922 property damage liability insurance coverage available through
1923 normal marketing channels. Any insurer writing motor vehicle
1924 liability insurance in this state who fails to comply with such
1925 availability requirement as a general business practice shall be
1926 deemed to have violated part IX of chapter 626, and such
1927 violation shall constitute an unfair method of competition or an
1928 unfair or deceptive act or practice involving the business of
1929 insurance; and any such insurer committing such violation shall
1930 be subject to the penalties afforded in such part, as well as
1931 those which may be afforded elsewhere in the insurance code.
1932 (4) BENEFITS; WHEN DUE.--Benefits due from an insurer

1933 under ss. 627.730-627.7405 shall be primary, except that
1934 benefits received under any workers' compensation law shall be
1935 credited against the benefits provided by subsection (1) and
1936 shall be due and payable as loss accrues, upon receipt of
1937 reasonable proof of such loss and the amount of expenses and
1938 loss incurred which are covered by the policy issued under ss.
1939 627.730-627.7405. When the Agency for Health Care Administration
1940 provides, pays, or becomes liable for medical assistance under
1941 the Medicaid program related to injury, sickness, disease, or
1942 death arising out of the ownership, maintenance, or use of a
1943 motor vehicle, benefits under ss. 627.730-627.7405 shall be
1944 subject to the provisions of the Medicaid program.
1945 (a) An insurer may require written notice to be given as
1946 soon as practicable after an accident involving a motor vehicle
1947 with respect to which the policy affords the security required
1948 by ss. 627.730-627.7405.
1949 (b) Personal injury protection insurance benefits paid
1950 pursuant to this section shall be overdue if not paid within 30
1951 days after the insurer is furnished written notice of the fact
1952 of a covered loss and of the amount of same. If such written
1953 notice is not furnished to the insurer as to the entire claim,
1954 any partial amount supported by written notice is overdue if not
1955 paid within 30 days after such written notice is furnished to
1956 the insurer. Any part or all of the remainder of the claim that
1957 is subsequently supported by written notice is overdue if not
1958 paid within 30 days after such written notice is furnished to
1959 the insurer. When an insurer pays only a portion of a claim or
1960 rejects a claim, the insurer shall provide at the time of the

1961 partial payment or rejection an itemized specification of each
1962 item that the insurer had reduced, omitted, or declined to pay
1963 and any information that the insurer desires the claimant to
1964 consider related to the medical necessity of the denied
1965 treatment or to explain the reasonableness of the reduced
1966 charge, provided that this shall not limit the introduction of
1967 evidence at trial; and the insurer shall include the name and
1968 address of the person to whom the claimant should respond and a
1969 claim number to be referenced in future correspondence. However,
1970 notwithstanding the fact that written notice has been furnished
1971 to the insurer, any payment shall not be deemed overdue when the
1972 insurer has reasonable proof to establish that the insurer is
1973 not responsible for the payment. For the purpose of calculating
1974 the extent to which any benefits are overdue, payment shall be
1975 treated as being made on the date a draft or other valid
1976 instrument which is equivalent to payment was placed in the
1977 United States mail in a properly addressed, postpaid envelope
1978 or, if not so posted, on the date of delivery. This paragraph
1979 does not preclude or limit the ability of the insurer to assert
1980 that the claim was unrelated, was not medically necessary, or
1981 was unreasonable or that the amount of the charge was in excess
1982 of that permitted under, or in violation of, subsection (5).
1983 Such assertion by the insurer may be made at any time, including
1984 after payment of the claim or after the 30-day time period for
1985 payment set forth in this paragraph.
1986 (c) Upon receiving notice of an accident that is
1987 potentially covered by personal injury protection benefits, the
1988 insurer must reserve $5,000 of personal injury protection

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1989 benefits for payment to physicians licensed under chapter 458 or
1990 chapter 459 who provide emergency services and care, as defined
1991 in s. 395.002(9), or who provide hospital inpatient care. The
1992 amount required to be held in reserve may be used only to pay
1993 claims from such physicians until 30 days after the date the
1994 insurer receives notice of the accident. After the 30-day
1995 period, any amount of the reserve for which the insurer has not
1996 received notice of a claim from a physician who provided
1997 emergency services and care or who provided hospital inpatient
1998 care may then be used by the insurer to pay other claims. The
1999 time periods specified in paragraph (b) for required payment of
2000 personal injury protection benefits shall be tolled for the
2001 period of time that an insurer is required by this paragraph to
2002 hold payment of a claim that is not from a physician who
2003 provided emergency services and care or who provided hospital
2004 inpatient care.
2005 (d) ~~(c)~~ All overdue payments shall bear simple interest at
2006 the rate established under s. 55.03 or the rate established in
2007 the insurance contract, whichever is greater, for the year in
2008 which the payment became overdue, calculated from the date the
2009 insurer was furnished with written notice of the amount of
2010 covered loss. Interest shall be due at the time payment of the
2011 overdue claim is made.
2012 (e) ~~(d)~~ The insurer of the owner of a motor vehicle shall
2013 pay personal injury protection benefits for:
2014 1. Accidental bodily injury sustained in this state by the
2015 owner while occupying a motor vehicle, or while not an occupant
2016 of a self-propelled vehicle if the injury is caused by physical

2017 contact with a motor vehicle.
2018 2. Accidental bodily injury sustained outside this state,
2019 but within the United States of America or its territories or
2020 possessions or Canada, by the owner while occupying the owner's
2021 motor vehicle.
2022 3. Accidental bodily injury sustained by a relative of the
2023 owner residing in the same household, under the circumstances
2024 described in subparagraph 1. or subparagraph 2., provided the
2025 relative at the time of the accident is domiciled in the owner's
2026 household and is not himself or herself the owner of a motor
2027 vehicle with respect to which security is required under ss.
2028 627.730-627.7405.
2029 4. Accidental bodily injury sustained in this state by any
2030 other person while occupying the owner's motor vehicle or, if a
2031 resident of this state, while not an occupant of a self-
2032 propelled vehicle, if the injury is caused by physical contact
2033 with such motor vehicle, provided the injured person is not
2034 himself or herself:
2035 a. The owner of a motor vehicle with respect to which
2036 security is required under ss. 627.730-627.7405; or
2037 b. Entitled to personal injury benefits from the insurer
2038 of the owner or owners of such a motor vehicle.
2039 (f) ~~(e)~~ If two or more insurers are liable to pay personal
2040 injury protection benefits for the same injury to any one
2041 person, the maximum payable shall be as specified in subsection
2042 (1), and any insurer paying the benefits shall be entitled to
2043 recover from each of the other insurers an equitable pro rata
2044 share of the benefits paid and expenses incurred in processing

2045 the claim.
2046 (g) ~~(f)~~ It is a violation of the insurance code for an
2047 insurer to fail to timely provide benefits as required by this
2048 section with such frequency as to constitute a general business
2049 practice.
2050 (h) ~~(g)~~ Benefits shall not be due or payable to or on the
2051 behalf of an insured person if that person has committed, by a
2052 material act or omission, any insurance fraud relating to
2053 personal injury protection coverage under his or her policy, if
2054 the fraud is admitted to in a sworn statement by the insured or
2055 if it is established in a court of competent jurisdiction. Any
2056 insurance fraud shall void all coverage arising from the claim
2057 related to such fraud under the personal injury protection
2058 coverage of the insured person who committed the fraud,
2059 irrespective of whether a portion of the insured person's claim
2060 may be legitimate, and any benefits paid prior to the discovery
2061 of the insured person's insurance fraud shall be recoverable by
2062 the insurer from the person who committed insurance fraud in
2063 their entirety. The prevailing party is entitled to its costs
2064 and attorney's fees in any action in which it prevails in an
2065 insurer's action to enforce its right of recovery under this
2066 paragraph.
2067 (5) CHARGES FOR TREATMENT OF INJURED PERSONS.--
2068 (a)1. Any physician, hospital, clinic, or other person or
2069 institution lawfully rendering treatment to an injured person
2070 for a bodily injury covered by personal injury protection
2071 insurance may charge the insurer and injured party only a
2072 reasonable amount pursuant to this section for the services and

2073 supplies rendered, and the insurer providing such coverage may
2074 pay for such charges directly to such person or institution
2075 lawfully rendering such treatment, if the insured receiving such
2076 treatment or his or her guardian has countersigned the properly
2077 completed invoice, bill, or claim form approved by the office
2078 upon which such charges are to be paid for as having actually
2079 been rendered, to the best knowledge of the insured or his or
2080 her guardian. In no event, however, may such a charge be in
2081 excess of the amount the person or institution customarily
2082 charges for like services or supplies. With respect to a
2083 determination of whether a charge for a particular service,
2084 treatment, or otherwise is reasonable, consideration may be
2085 given to evidence of usual and customary charges and payments
2086 accepted by the provider involved in the dispute, and
2087 reimbursement levels in the community and various federal and
2088 state medical fee schedules applicable to automobile and other
2089 insurance coverages, and other information relevant to the
2090 reasonableness of the reimbursement for the service, treatment,
2091 or supply.
2092 2. The insurer may limit reimbursement to 80 percent of
2093 the following schedule of maximum charges:
2094 a. For emergency transport and treatment by providers
2095 licensed under chapter 401, 200 percent of Medicare.
2096 b. For emergency services and care provided by a hospital
2097 licensed under chapter 395, 75 percent of the hospital's usual
2098 and customary charges.
2099 c. For emergency services and care rendered by a physician
2100 and related hospital inpatient services rendered by a physician,

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2101 the usual and customary charges in the community.
2102 d. For hospital inpatient services, other than emergency
2103 services and care, 200 percent of the Medicare Part A
2104 prospective payment applicable to the specific hospital
2105 providing the inpatient services.
2106 e. For hospital outpatient services, other than emergency
2107 services and care, 200 percent of the Medicare Part A Ambulatory
2108 Payment Classification for the specific hospital providing the
2109 outpatient services.
2110 f. For all other medical services, supplies, and care, 200
2111 percent of the applicable Medicare Part B fee schedule. However,
2112 if such services, supplies, or care are not reimbursable under
2113 Medicare Part B, the insurer may limit reimbursement to 80
2114 percent of the maximum reimbursable allowance under workers'
2115 compensation, as determined under s. 440.13 and rules adopted
2116 thereunder which are in effect at the time such services,
2117 supplies, or care are provided. Services, supplies, or care that
2118 are not reimbursable under Medicare or workers' compensation are
2119 not required to be reimbursed by the insurer.
2120 3. For purposes of subparagraph 2., the applicable fee
2121 schedule or payment limitation under Medicare is the fee
2122 schedule or payment limitation in effect at the time the
2123 services, supplies, or care were rendered and for the area in
2124 which such services were rendered.
2125 4. Subparagraph 2. does not allow the insurer to apply any
2126 limitation on the number of treatments or other utilization
2127 limits that apply under Medicare or workers' compensation. An
2128 insurer that applies the allowable payment limitations of

2129 subparagraph 2. must reimburse a provider who lawfully provided
2130 care or treatment under the scope of his or her license,
2131 regardless of whether such provider would be entitled to
2132 reimbursement under Medicare due to restrictions or limitations
2133 on the types or discipline of health care providers who may be
2134 reimbursed for particular procedures or procedure codes.
2135 5. If an insurer limits payment as authorized by
2136 subparagraph 2., the person providing such services, supplies,
2137 or care may not bill or attempt to collect from the insured any
2138 amount in excess of such limits, except for amounts that are not
2139 covered by the insured's personal injury protection coverage due
2140 to the coinsurance amount or maximum policy limits.
2141 (b)1. An insurer or insured is not required to pay a claim
2142 or charges:
2143 a. Made by a broker or by a person making a claim on
2144 behalf of a broker;
2145 b. For any service or treatment that was not lawful at the
2146 time rendered;
2147 c. To any person who knowingly submits a false or
2148 misleading statement relating to the claim or charges;
2149 d. With respect to a bill or statement that does not
2150 substantially meet the applicable requirements of paragraph (d);
2151 e. For any treatment or service that is upcoded, or that
2152 is unbundled when such treatment or services should be bundled,
2153 in accordance with paragraph (d). To facilitate prompt payment
2154 of lawful services, an insurer may change codes that it
2155 determines to have been improperly or incorrectly upcoded or
2156 unbundled, and may make payment based on the changed codes,

2157 without affecting the right of the provider to dispute the
2158 change by the insurer, provided that before doing so, the
2159 insurer must contact the health care provider and discuss the
2160 reasons for the insurer's change and the health care provider's
2161 reason for the coding, or make a reasonable good faith effort to
2162 do so, as documented in the insurer's file; and
2163 f. For medical services or treatment billed by a physician
2164 and not provided in a hospital unless such services are rendered
2165 by the physician or are incident to his or her professional
2166 services and are included on the physician's bill, including
2167 documentation verifying that the physician is responsible for
2168 the medical services that were rendered and billed.
2169 ~~2. Charges for medically necessary cephalic thermograms,~~
2170 ~~peripheral thermograms, spinal ultrasounds, extremity~~
2171 ~~ultrasounds, video fluoroscopy, and surface electromyography~~
2172 ~~shall not exceed the maximum reimbursement allowance for such~~
2173 ~~procedures as set forth in the applicable fee schedule or other~~
2174 ~~payment methodology established pursuant to s. 440.13.~~
2175 ~~3. Allowable amounts that may be charged to a personal~~
2176 ~~injury protection insurance insurer and insured for medically~~
2177 ~~necessary nerve conduction testing when done in conjunction with~~
2178 ~~a needle electromyography procedure and both are performed and~~
2179 ~~billed solely by a physician licensed under chapter 458, chapter~~
2180 ~~459, chapter 460, or chapter 461 who is also certified by the~~
2181 ~~American Board of Electrodiagnostic Medicine or by a board~~
2182 ~~recognized by the American Board of Medical Specialties or the~~
2183 ~~American Osteopathic Association or who holds diplomate status~~
2184 ~~with the American Chiropractic Neurology Board or its~~

2185 ~~predecessors shall not exceed 200 percent of the allowable~~
2186 ~~amount under the participating physician fee schedule of~~
2187 ~~Medicare Part B for year 2001, for the area in which the~~
2188 ~~treatment was rendered, adjusted annually on August 1 to reflect~~
2189 ~~the prior calendar year's changes in the annual Medical Care~~
2190 ~~Item of the Consumer Price Index for All Urban Consumers in the~~
2191 ~~South Region as determined by the Bureau of Labor Statistics of~~
2192 ~~the United States Department of Labor.~~
2193 ~~4. Allowable amounts that may be charged to a personal~~
2194 ~~injury protection insurance insurer and insured for medically~~
2195 ~~necessary nerve conduction testing that does not meet the~~
2196 ~~requirements of subparagraph 3. shall not exceed the applicable~~
2197 ~~fee schedule or other payment methodology established pursuant~~
2198 ~~to s. 440.13.~~
2199 ~~5. Allowable amounts that may be charged to a personal~~
2200 ~~injury protection insurance insurer and insured for magnetic~~
2201 ~~resonance imaging services shall not exceed 175 percent of the~~
2202 ~~allowable amount under the participating physician fee schedule~~
2203 ~~of Medicare Part B for year 2001, for the area in which the~~
2204 ~~treatment was rendered, adjusted annually on August 1 to reflect~~
2205 ~~the prior calendar year's changes in the annual Medical Care~~
2206 ~~Item of the Consumer Price Index for All Urban Consumers in the~~
2207 ~~South Region as determined by the Bureau of Labor Statistics of~~
2208 ~~the United States Department of Labor for the 12-month period~~
2209 ~~ending June 30 of that year, except that allowable amounts that~~
2210 ~~may be charged to a personal injury protection insurance insurer~~
2211 ~~and insured for magnetic resonance imaging services provided in~~
2212 ~~facilities accredited by the Accreditation Association for~~

2213 ~~Ambulatory Health Care, the American College of Radiology, or~~
2214 ~~the Joint Commission on Accreditation of Healthcare~~
2215 ~~Organizations shall not exceed 200 percent of the allowable~~
2216 ~~amount under the participating physician fee schedule of~~
2217 ~~Medicare Part B for year 2001, for the area in which the~~
2218 ~~treatment was rendered, adjusted annually on August 1 to reflect~~
2219 ~~the prior calendar year's changes in the annual Medical Care~~
2220 ~~Item of the Consumer Price Index for All Urban Consumers in the~~
2221 ~~South Region as determined by the Bureau of Labor Statistics of~~
2222 ~~the United States Department of Labor for the 12-month period~~
2223 ~~ending June 30 of that year. This paragraph does not apply to~~
2224 ~~charges for magnetic resonance imaging services and nerve~~
2225 ~~conduction testing for inpatients and emergency services and~~
2226 ~~care as defined in chapter 395 rendered by facilities licensed~~
2227 ~~under chapter 395.~~
2228 2.~~6.~~ The Department of Health, in consultation with the
2229 appropriate professional licensing boards, shall adopt, by rule,
2230 a list of diagnostic tests deemed not to be medically necessary
2231 for use in the treatment of persons sustaining bodily injury
2232 covered by personal injury protection benefits under this
2233 section. The initial list shall be adopted by January 1, 2004,
2234 and shall be revised from time to time as determined by the
2235 Department of Health, in consultation with the respective
2236 professional licensing boards. Inclusion of a test on the list
2237 of invalid diagnostic tests shall be based on lack of
2238 demonstrated medical value and a level of general acceptance by
2239 the relevant provider community and shall not be dependent for
2240 results entirely upon subjective patient response.

2241 Notwithstanding its inclusion on a fee schedule in this
2242 subsection, an insurer or insured is not required to pay any
2243 charges or reimburse claims for any invalid diagnostic test as
2244 determined by the Department of Health.
2245 (c)1. With respect to any treatment or service, other than
2246 medical services billed by a hospital or other provider for
2247 emergency services as defined in s. 395.002 or inpatient
2248 services rendered at a hospital-owned facility, the statement of
2249 charges must be furnished to the insurer by the provider and may
2250 not include, and the insurer is not required to pay, charges for
2251 treatment or services rendered more than 35 days before the
2252 postmark date <u>or electronic transmission</u> date of the statement,
2253 except for past due amounts previously billed on a timely basis
2254 under this paragraph, and except that, if the provider submits
2255 to the insurer a notice of initiation of treatment within 21
2256 days after its first examination or treatment of the claimant,
2257 the statement may include charges for treatment or services
2258 rendered up to, but not more than, 75 days before the postmark
2259 date of the statement. The injured party is not liable for, and
2260 the provider shall not bill the injured party for, charges that
2261 are unpaid because of the provider's failure to comply with this
2262 paragraph. Any agreement requiring the injured person or insured
2263 to pay for such charges is unenforceable.
2264 2. If, however, the insured fails to furnish the provider
2265 with the correct name and address of the insured's personal
2266 injury protection insurer, the provider has 35 days from the
2267 date the provider obtains the correct information to furnish the
2268 insurer with a statement of the charges. The insurer is not

2269 required to pay for such charges unless the provider includes
2270 with the statement documentary evidence that was provided by the
2271 insured during the 35-day period demonstrating that the provider
2272 reasonably relied on erroneous information from the insured and
2273 either:
2274 a. A denial letter from the incorrect insurer; or
2275 b. Proof of mailing, which may include an affidavit under
2276 penalty of perjury, reflecting timely mailing to the incorrect
2277 address or insurer.
2278 3. For emergency services and care as defined in s.
2279 395.002 rendered in a hospital emergency department or for
2280 transport and treatment rendered by an ambulance provider
2281 licensed pursuant to part III of chapter 401, the provider is
2282 not required to furnish the statement of charges within the time
2283 periods established by this paragraph; and the insurer shall not
2284 be considered to have been furnished with notice of the amount
2285 of covered loss for purposes of paragraph (4)(b) until it
2286 receives a statement complying with paragraph (d), or copy
2287 thereof, which specifically identifies the place of service to
2288 be a hospital emergency department or an ambulance in accordance
2289 with billing standards recognized by the Health Care Finance
2290 Administration.
2291 4. Each notice of insured's rights under s. 627.7401 must
2292 include the following statement in type no smaller than 12
2293 points:
2294
2295 BILLING REQUIREMENTS.--Florida Statutes provide that with
2296 respect to any treatment or services, other than certain

2297 hospital and emergency services, the statement of charges
2298 furnished to the insurer by the provider may not include, and
2299 the insurer and the injured party are not required to pay,
2300 charges for treatment or services rendered more than 35 days
2301 before the postmark date of the statement, except for past due
2302 amounts previously billed on a timely basis, and except that, if
2303 the provider submits to the insurer a notice of initiation of
2304 treatment within 21 days after its first examination or
2305 treatment of the claimant, the statement may include charges for
2306 treatment or services rendered up to, but not more than, 75 days
2307 before the postmark date of the statement.
2308 (8) APPLICABILITY OF PROVISION REGULATING ATTORNEY'S
2309 FEES.--With respect to any dispute under the provisions of ss.
2310 627.730-627.7405 between the insured and the insurer, or between
2311 an assignee of an insured's rights and the insurer, the
2312 provisions of s. 627.428 shall apply, except as provided in
2313 subsections ~~subsection~~ (10) and (15).
2314 (10) DEMAND LETTER.--
2315 (d) If, within 30 ~~15~~ days after receipt of notice by the
2316 insurer, the overdue claim specified in the notice is paid by
2317 the insurer together with applicable interest and a penalty of
2318 10 percent of the overdue amount paid by the insurer, subject to
2319 a maximum penalty of $250, no action may be brought against the
2320 insurer. If the demand involves an insurer's withdrawal of
2321 payment under paragraph (7)(a) for future treatment not yet
2322 rendered, no action may be brought against the insurer if,
2323 within 30 ~~15~~ days after its receipt of the notice, the insurer
2324 mails to the person filing the notice a written statement of the

2325 insurer's agreement to pay for such treatment in accordance with
2326 the notice and to pay a penalty of 10 percent, subject to a
2327 maximum penalty of $250, when it pays for such future treatment
2328 in accordance with the requirements of this section. To the
2329 extent the insurer determines not to pay any amount demanded,
2330 the penalty shall not be payable in any subsequent action. For
2331 purposes of this subsection, payment or the insurer's agreement
2332 shall be treated as being made on the date a draft or other
2333 valid instrument that is equivalent to payment, or the insurer's
2334 written statement of agreement, is placed in the United States
2335 mail in a properly addressed, postpaid envelope, or if not so
2336 posted, on the date of delivery. The insurer is ~~shall~~ not ~~be~~
2337 obligated to pay any attorney's fees if the insurer pays the
2338 claim or mails its agreement to pay for future treatment within
2339 the time prescribed by this subsection.
2340 (e) The applicable statute of limitation for an action
2341 under this section shall be tolled for a period of 30 ~~15~~
2342 business days by the mailing of the notice required by this
2343 subsection.
2344 (11) FAILURE TO PAY VALID CLAIMS; UNFAIR OR DECEPTIVE
2345 PRACTICE.--
2346 (a) If an insurer fails to pay valid claims for personal
2347 injury protection with such frequency so as to indicate a
2348 general business practice, the insurer is engaging in a
2349 prohibited unfair or deceptive practice that is subject to the
2350 penalties provided in s. 626.9521 and the office has the powers
2351 and duties specified in ss. 626.9561-626.9601 with respect
2352 thereto.

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(b) Notwithstanding s. 501.212, the Department of Legal Affairs may investigate and initiate actions for a violation of this subsection, including, but not limited to, the powers and duties specified in part II of chapter 501.

(15) ALL CLAIMS BROUGHT IN A SINGLE ACTION.--In any civil action to recover personal injury protection benefits brought by a claimant pursuant to this section against an insurer, all claims related to the same health care provider for the same injured person shall be brought in one action, unless good cause is shown why such claims should be brought separately. If the court determines that a civil action is filed for a claim that should have been brought in a prior civil action, the court may not award attorney's fees to the claimant.

(16) SECURE ELECTRONIC DATA TRANSFER.--An electronic notice, documentation, transmission, or communication of any kind required or authorized under ss. 627.730-627.7405 must be transmitted by secure electronic data transfer that is consistent with state and federal privacy and security laws.

Section 21. Effective January 15, 2008, and applicable to policies issued or renewed on or after that date, section 627.739, Florida Statutes, as reenacted by this act, is amended to read:

627.739 Personal injury protection; optional limitations~~, deductibles~~.--

(1) The named insured may elect ~~a deductible or~~ modified coverage as specified in subsection (2) ~~or combination thereof~~ to apply to the named insured alone or to the named insured and dependent relatives residing in the same household~~,~~ but may not

2381 elect ~~a deductible or~~ modified coverage to apply to any other
2382 person covered under the policy.
2383 ~~(2) Insurers shall offer to each applicant and to each~~
2384 ~~policyholder, upon the renewal of an existing policy,~~
2385 ~~deductibles, in amounts of $250, $500, and $1,000. The~~
2386 ~~deductible amount must be applied to 100 percent of the expenses~~
2387 ~~and losses described in s. 627.736. After the deductible is met,~~
2388 ~~each insured is eligible to receive up to $10,000 in total~~
2389 ~~benefits described in s. 627.736(1). However, this subsection~~
2390 ~~shall not be applied to reduce the amount of any benefits~~
2391 ~~received in accordance with s. 627.736(1)(c).~~
2392 (2)~~(3)~~ Insurers shall offer coverage wherein, at the
2393 election of the named insured, the benefits for loss of gross
2394 income and loss of earning capacity described in s.
2395 627.736(1)(b) shall be excluded.
2396 (3)~~(4)~~ The named insured shall not be prevented from
2397 electing ~~a deductible under subsection (2) and~~ modified coverage
2398 under subsection (2) ~~(3)~~. Each election made by the named
2399 insured under this section shall result in an appropriate
2400 reduction of premium associated with that election.
2401 (4)~~(5)~~ ~~All~~ Such offer ~~offers~~ shall be made in clear and
2402 unambiguous language at the time the initial application is
2403 taken and prior to each annual renewal and shall indicate that a
2404 premium reduction will result from such ~~each~~ election. At the
2405 option of the insurer, the requirements of the preceding
2406 sentence are met by using forms of notice approved by the
2407 office~~,~~ or by providing the following notice in 10-point type in
2408 the insurer's application for initial issuance of a policy of

2409 motor vehicle insurance and the insurer's annual notice of
2410 renewal premium:
2411
2412 For personal injury protection insurance, the named insured may
2413 elect ~~a deductible and~~ to exclude coverage for loss of gross
2414 income and loss of earning capacity ("lost wages"). This
2415 election applies ~~These elections apply~~ to the named insured
2416 alone~~,~~ or to the named insured and all dependent resident
2417 relatives. A premium reduction will result from this election
2418 ~~these elections~~. The named insured is hereby advised not to
2419 elect the lost wage exclusion if the named insured or dependent
2420 resident relatives are employed, since lost wages will not be
2421 payable in the event of an accident.
2422 Section 22. (1) The Legislature intends that the
2423 provisions of this act reviving and reenacting the Florida Motor
2424 Vehicle No-Fault Law apply to policies issued on or after the
2425 effective date of this act.
2426 (2) Each insurer that issued coverage for a motor vehicle
2427 that is subject to the Florida Motor Vehicle No-Fault Law shall,
2428 within 30 days after the effective date of this act, mail or
2429 deliver a revised notice of the premium and policy changes to
2430 each policyholder whose policy has an effective date on or after
2431 the effective date of this act and who was previously issued a
2432 motor vehicle insurance policy or sent a renewal notice based on
2433 the assumption that the Florida Motor Vehicle No-Fault Law would
2434 be repealed on October 1, 2007. For a renewal policy, the
2435 coverage must provide the same limits of personal injury
2436 protection coverage, the same deductible from personal injury

2437 protection coverage, and the same limits of medical payments
2438 coverage as provided in the prior policy, unless the
2439 policyholder elects different limits that are available. The
2440 effective date of the revised policy or renewal shall be the
2441 same as the effective date specified in the prior notice. The
2442 revised notice of premium and coverage changes is exempt from
2443 the requirements of ss. 627.7277, 627.728, and 627.7282, Florida
2444 Statutes. The policyholder has a period of 30 days, or a longer
2445 period if specified by the insurer, following receipt of the
2446 revised notice within which to pay any additional amount of
2447 premium due and thereby maintain the policy in force as
2448 specified in this section. Alternatively, the policyholder may
2449 cancel the policy within this time period and obtain a refund of
2450 the unearned premium. If the policyholder fails to timely
2451 respond to the notice, the insurer must cancel the policy and
2452 return any unearned premium to the insured. The date on which
2453 the policy will be canceled shall be stated in the notice and
2454 may not be less than 35 days after the date of the notice. The
2455 amount of unearned premium due to the policyholder shall be
2456 calculated on a pro rata basis. The failure of an insurer to
2457 timely mail or deliver a revised notice as required by this
2458 subsection does not affect the other requirements of this
2459 section.
2460 (3) With respect to a policy providing personal injury
2461 protection coverage having an effective date between the
2462 effective date of this act and January 14, 2008, inclusive, the
2463 insurer shall use the forms and rates it had in effect on
2464 September 30, 2007, for all coverages in that policy unless the

2465 insurer makes a new rate or form filing that is approved by the
2466 Office of Insurance Regulation or otherwise legally allowed.
2467 (4) The Legislature recognizes that some persons have been
2468 issued a motor vehicle insurance policy effective on or after
2469 October 1, 2007, and before the effective date of this act,
2470 which does not include personal injury protection, based upon
2471 the expected repeal of the Florida Motor Vehicle No-Fault Law on
2472 October 1, 2007, pursuant to s. 19, chapter 2003-411, Laws of
2473 Florida. Any such person:
2474 (a) May continue to own and operate a motor vehicle in
2475 this state without being subject to any sanction for failing to
2476 maintain personal injury protection coverage if that person
2477 continues to meet statutory requirements relating to property
2478 damage liability coverage and obtains personal injury protection
2479 coverage that takes effect no later than December 1, 2007.
2480 (b) Is not subject to the provisions of s. 627.737,
2481 Florida Statutes, relating to the exemption from tort liability
2482 with respect to injuries sustained by the person in a motor
2483 vehicle crash occurring while the policy without personal injury
2484 protection coverage is in effect but not later than November 30,
2485 2007. This paragraph also applies during such period to any
2486 person who would have been covered under a personal injury
2487 protection policy if such a policy had been maintained on such
2488 motor vehicle.
2489 (5) Each insurer shall, by October 31, 2007, provide
2490 written notification to each insured referred to in subsection
2491 (4) informing the insured that he or she must obtain personal
2492 injury protection coverage that takes effect no later than

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2493 December 1, 2007. Such notice must include the premium for such
2494 coverage and the premium credit, if any, which will be provided
2495 for other coverage, such as bodily injury liability coverage or
2496 uninsured motorist coverage, as required by subsection (4).
2497 Alternatively, the insurer may add an endorsement to the policy
2498 to provide personal injury protection coverage as required by
2499 law, effective no later than December 1, 2007, without requiring
2500 any additional payment from the insured, and shall provide
2501 written notification to the insured of such endorsement by
2502 October 31, 2007.
2503 Section 23. Except as otherwise expressly provided in this
2504 act, this act shall take effect upon becoming a law.