AGENDA
FINANCIAL SERVICES COMMISSION
Office of Insurance Regulation
Materials Available on the Web at:
http://www.floir.com/Sections/GovAffairs/FSC.aspx

February 7, 2013

MEMBERS
Governor Rick Scott
Attorney General Pam Bondi
Chief Financial Officer Jeff Atwater
Commissioner Adam Putnam

Contact: **Ashlee Falco**
(850-413-5069)

9:00 A.M.
LL-03, The Capitol
Tallahassee, Florida

ITEM	SUBJECT	RECOMMENDATION

1. Request for Approval for Adoption of Proposed Amendment to Rule 69O-170.0155; Forms

   The purpose of this rule amendment is to update and revise Form OIR-B1-1809 "Health Care Provider Certification of Eligibility" for Personal Injury Protection Benefits (PIP) due to statutory revisions as the result of H.B. 119 (Chapter 2012-197, Laws of Florida). The changes are technical edits to conform the form with the statute.

   (ATTACHMENT 1) **APPROVAL FOR FINAL ADOPTION**

2. Request for Approval for Adoption of Proposed Amendment to Rule 69O-176.013; Notification of Insured's Rights and Standard Disclosure Form

   The purpose of this rule amendment is to update and revise Form OIR-B1-1149 "Notification of Personal Injury Protection Benefits" in accordance with revisions to the PIP law as amended by HB119 (Chapter 2012-197, Laws of Florida). The form was revised to reflect that PIP benefits are now allocated for emergency medical treatment and a flat $5,000 death benefit. The form was also revised to incorporate technical edits regarding fraud reporting and billing disclosures.

   (ATTACHMENT 2) **APPROVAL FOR FINAL ADOPTION**

M E M O R A N D U M

DATE: January 23, 2013

TO: Kevin M. McCarty, Commissioner, Office of Insurance Regulation

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Jason Nelson

SUBJECT: Cabinet Agenda for February 7, 2013
Request for Final Approval to Adopt Amendments to
Rule 69O-170.0155
Forms
Assignment # 127736-12

The Office of Insurance Regulation requests that this proposed rule amendment be presented to the Cabinet aides on or before January 30, 2013 and to the Financial Services Commission on February 7, 2013, with a request for Final Approval to Adopt the proposed rule amendment. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on January 11, 2013.

The notice of proposed rule was published on December 17, 2012 in Volume 38, No. 92, of the *Register*. A hearing was not requested, therefore, a hearing was not held.

The purpose of this rule amendment is to update and revise Form OIR-B1-1809 "Health Care Provider Certification of Eligibility" for Personal Injury Protection Benefits (PIP) to be consistent with statutory revisions that resulted from of H.B. 119 (Chapter 2012-197, Laws of Florida). The changes are technical edits to conform the form with the statute.

Sections 624.308(1), 627.711, 627.736, 215.5586, 624.307(1), 624.424, 627.062, 627.0629, 627.0645, 627.711, 627.736, F.S., provide rulemaking authority and laws implemented for this rule.

The Legal Services Office has communicated with the Joint Administrative Procedures Committee, and ascertained that their review of the rule has been completed.

Stephen Fredrickson is the attorney handling this rule. Attached are: 1) the proposed rule(s); 2) any incorporated materials, such as forms; 3) copies of the rulemaking statutory authority and law implemented.

Approved for signature:

Belinda Miller, General Counsel

Approved for submission to Financial Services Commission:

Kevin M. McCarty, Commissioner
Office of Insurance Regulation

69O-170.0155 Forms.

The following forms are hereby adopted and incorporated by reference:

(1)(a)-(m) No change

(n) OIR-B1-1809 "Health Care Provider Certification of Eligibility" (Rev.01/2013 ~~New 1/2008~~).

(2) No change

Rulemaking Authority 624.308(1), 627.711, 627.736 FS. Law Implemented 215.5586, 624.307(1), 624.424, 627.062, 627.0629, 627.0645, 627.711, 627.736 FS. History–New 6-19-03, Formerly 4-170.0155, Amended 2-23-06, 12-26-06, 6-12-07, 7-17-07, 9-5-07, 3-13-08, 4-21-10 (1)(l), 4-21-10 (1)(k), 2-1-12,_____.

OFFICE OF INSURANCE REGULATION
PROPERTY & CASUALTY PRODUCT REVIEW

HEALTH CARE PROVIDER CERTIFICATION OF ELIGIBILITY FOR PIP BENEFITS

(This form is to be provided to the insurer providing coverage for injured patient)

I, _____, _____ pursuant to Section
(Print or type name) (Print or type title)
627.736(1)(a), Florida Statutes, under oath do swear and attest, based on the signing health care provider's personal knowledge, under penalty of perjury, that medical benefits as described in Section 627.736(1)(a), Florida Statutes are being provided by:

(Check all applicable boxes)

☐ 1. An entity wholly owned by one or more physicians licensed under chapter 458 or chapter 459, chiropractic physicians licensed under chapter 460, or dentists licensed under chapter 466 or by such practitioners and the spouse, parent, child, or sibling of such practitioners.

Please list the name(s), address(es), Florida practice license number(s) (including prefixes and suffixes, if any), and the percentage owned by each licensed health care practitioner having an ownership interest in the clinic. (Please add additional pages if necessary)

Name	Address	License Number	% Owned
Enter total from family members, below			
	Add all percentages owned. This sum must equal 100%		**100%**

Identification of Family Member Owners (When Applicable): Please provide requested information for the spouse, child, sibling or parent of the health care practitioner who has an ownership interest in the clinic, and the percentage owned. (Please add additional pages if necessary.)

Name	Address	Relationship to Practitioner	% Owned
	Enter % here and on Family Member Total, above (Add all percentages owned)		

☐ 2. An entity that owns or is wholly owned, directly or indirectly, by a hospital or hospitals.

Name of Hospital:_____

Explanation of ownership relationship to Hospital:

_____

_____

_____

_____

☐ 3. A health care clinic licensed under Part X of Chapter 400, Florida Statutes which is:

☐ a. Accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, or the Accreditation Association for Ambulatory Health Care, Inc.; or

Please state the name of the accrediting agency and the date of current accreditation:

_____Date_____

☐ b. A health care clinic that:

☐ 1. Has a medical director licensed under chapter 458, chapter 459, or chapter 460; and give the full name of Medical Director shown on the Board license and telephone number where director may be contacted.

Name on License_____ Lic.No._____

Telephone #_____

☐ 2. Has been continuously licensed for more than 3 years or is a publicly traded corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange; and

- license_____ HCC License #_____, effective date first HCC
- Name of Exchange (i.e. NYSE, NASDAQ) and Exchange symbol for company:

_____

☐ 3. Provides at least four of the following medical specialties:

☐ General medicine
☐ Physical therapy
☐ Prescribing or dispensing outpatient prescription medication
☐ Orthopedic medicine
☐ Physical medicine
☐ Laboratory services
☐ Radiography
☐ Physical rehabilitation

Note: Items 3. b. 1, 2 & 3 above are all required for eligibility.

_____ _____
(Signature) Executive Officer, Medical or Clinic Director (Title)

_____ _____
(Print or Type Name) (Board or Department of Health License No. with suffix)

_____
(Corporate Name of Entity or Clinic, as filed with Florida Department of State, i.e. Inc., LLC, LLP, P.A., etc.)

_____
(Address) (City) (State) (Zip) (Phone)

(AFTER AN INITIAL, NOTARIZED SUBMISSION TO AN INSURER THIS FORM MAY BE COPIED FOR SUBMISSION TO THAT INSURER, PROVIDED THERE HAS BEEN NO CHANGE TO THE INFORMATION CONTAINED ON THE FORM.)

Notarization of Health Care Provider:

STATE OF _____
COUNTY OF_____

Sworn to and subscribed before me this _____day of _____, 20__, by _____.

Personally Known_____OR Produced Identification_____(Type of Identification Produced)

Notary Signature _____

My commission expires: _____

69O-170.0155
Rulemaking Authority

624.308 Rules.—

(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.

627.711 Notice of premium discounts for hurricane loss mitigation; uniform mitigation verification inspection form.—

(1) Using a form prescribed by the Office of Insurance Regulation, the insurer shall clearly notify the applicant or policyholder of any personal lines residential property insurance policy, at the time of the issuance of the policy and at each renewal, of the availability and the range of each premium discount, credit, other rate differential, or reduction in deductibles, and combinations of discounts, credits, rate differentials, or reductions in deductibles, for properties on which fixtures or construction techniques demonstrated to reduce the amount of loss in a windstorm can be or have been installed or implemented. The prescribed form shall describe generally what actions the policyholders may be able to take to reduce their windstorm premium. The prescribed form and a list of such ranges approved by the office for each insurer licensed in the state and providing such discounts, credits, other rate differentials, or reductions in deductibles for properties described in this subsection shall be available for electronic viewing and download from the Department of Financial Services' or the Office of Insurance Regulation's Internet website. The Financial Services Commission may adopt rules to implement this subsection.

(2)(a) The Financial Services Commission shall develop by rule a uniform mitigation verification inspection form that shall be used by all insurers when submitted by policyholders for the purpose of factoring discounts for wind insurance. In developing the form, the commission shall seek input from insurance, construction, and building code representatives. Further, the commission shall provide guidance as to the length of time the inspection results are valid. An insurer shall accept as valid a uniform mitigation verification form signed by the following authorized mitigation inspectors:

1. A home inspector licensed under s. 468.8314 who has completed at least 3 hours of hurricane mitigation training approved by the Construction Industry Licensing Board which includes hurricane mitigation techniques and compliance with the uniform mitigation verification form and completion of a proficiency exam;
2. A building code inspector certified under s. 468.607;
3. A general, building, or residential contractor licensed under s. 489.111;
4. A professional engineer licensed under s. 471.015;
5. A professional architect licensed under s. 481.213; or
6. Any other individual or entity recognized by the insurer as possessing the necessary qualifications to properly complete a uniform mitigation verification form.

(b) An insurer may, but is not required to, accept a form from any other person possessing qualifications and experience acceptable to the insurer.

(3) A person who is authorized to sign a mitigation verification form must inspect the structures referenced by the form personally, not through employees or other persons, and must certify or attest to personal inspection of the structures referenced by the form. However, licensees under s. 471.015 or s. 489.111 may authorize a direct employee, who is not an independent contractor, and who possesses the requisite skill, knowledge and experience, to conduct a mitigation verification inspection. Insurers shall have the right to request and obtain information from the authorized mitigation inspector under s. 471.015 or s. 489.111, regarding any authorized employee's qualifications prior to accepting a mitigation verification form performed by an employee that is not licensed under s. 471.015 or s. 489.111.

(4) An authorized mitigation inspector that signs a uniform mitigation form, and a direct employee authorized to conduct mitigation verification inspections under paragraph (3), may not commit misconduct in performing hurricane mitigation inspections or in completing a uniform mitigation form that causes financial harm to a customer or their insurer; or that

jeopardizes a customer's health and safety. Misconduct occurs when an authorized mitigation inspector signs a uniform mitigation verification form that:

(a) Falsely indicates that he or she personally inspected the structures referenced by the form;

(b) Falsely indicates the existence of a feature which entitles an insured to a mitigation discount which the inspector knows does not exist or did not personally inspect;

(c) Contains erroneous information due to the gross negligence of the inspector; or

(d) Contains a pattern of demonstrably false information regarding the existence of mitigation features that could give an insured a false evaluation of the ability of the structure to withstand major damage from a hurricane endangering the safety of the insured's life and property.

(5) The licensing board of an authorized mitigation inspector that violates subsection (4) may commence disciplinary proceedings and impose administrative fines and other sanctions authorized under the authorized mitigation inspector's licensing act. Authorized mitigation inspectors licensed under s. 471.015 or s. 489.111 shall be directly liable for the acts of employees that violate subsection (4) as if the authorized mitigation inspector personally performed the inspection.

(6) An insurer, person, or other entity that obtains evidence of fraud or evidence that an authorized mitigation inspector or an employee authorized to conduct mitigation verification inspections under paragraph (3) has made false statements in the completion of a mitigation inspection form shall file a report with the Division of Insurance Fraud, along with all of the evidence in its possession that supports the allegation of fraud or falsity. An insurer, person, or other entity making the report shall be immune from liability, in accordance with s. 626.989(4), for any statements made in the report, during the investigation, or in connection with the report. The Division of Insurance Fraud shall issue an investigative report if it finds that probable cause exists to believe that the authorized mitigation inspector, or an employee authorized to conduct mitigation verification inspections under paragraph (3), made intentionally false or fraudulent statements in the inspection form. Upon conclusion of the investigation and a finding of probable cause that a violation has occurred, the Division of Insurance Fraud shall send a copy of the investigative report to the office and a copy to the agency responsible for the professional licensure of the authorized mitigation inspector, whether or not a prosecutor takes action based upon the report.

(7) An individual or entity who knowingly provides or utters a false or fraudulent mitigation verification form with the intent to obtain or receive a discount on an insurance premium to which the individual or entity is not entitled commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(8) At its expense, the insurer may require that a uniform mitigation verification form provided by a policyholder, a policyholder's agent, or an authorized mitigation inspector or inspection company be independently verified by an inspector, an inspection company, or an independent third-party quality assurance provider which possesses a quality assurance program before accepting the uniform mitigation verification form as valid.

627.736 Required personal injury protection benefits; exclusions; priority; claims.—

(1) REQUIRED BENEFITS.—An insurance policy complying with the security requirements of s. 627.733 must provide personal injury protection to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in the motor vehicle, and other persons struck by the motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to subsection (2) and paragraph (4)(e), to a limit of $10,000 in medical and disability benefits and $5,000 in death benefits resulting from bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:

(a) Medical benefits.—Eighty percent of all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices and

medically necessary ambulance, hospital, and nursing services if the individual receives initial services and care pursuant to subparagraph 1. within 14 days after the motor vehicle accident. The medical benefits provide reimbursement only for:

1. Initial services and care that are lawfully provided, supervised, ordered, or prescribed by a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, or a chiropractic physician licensed under chapter 460 or that are provided in a hospital or in a facility that owns, or is wholly owned by, a hospital. Initial services and care may also be provided by a person or entity licensed under part III of chapter 401 which provides emergency transportation and treatment.

2. Upon referral by a provider described in subparagraph 1., followup services and care consistent with the underlying medical diagnosis rendered pursuant to subparagraph 1. which may be provided, supervised, ordered, or prescribed only by a physician licensed under chapter 458 or chapter 459, a chiropractic physician licensed under chapter 460, a dentist licensed under chapter 466, or, to the extent permitted by applicable law and under the supervision of such physician, osteopathic physician, chiropractic physician, or dentist, by a physician assistant licensed under chapter 458 or chapter 459 or an advanced registered nurse practitioner licensed under chapter 464. Followup services and care may also be provided by any of the following persons or entities:

a. A hospital or ambulatory surgical center licensed under chapter 395.

b. An entity wholly owned by one or more physicians licensed under chapter 458 or chapter 459, chiropractic physicians licensed under chapter 460, or dentists licensed under chapter 466 or by such practitioners and the spouse, parent, child, or sibling of such practitioners.

c. An entity that owns or is wholly owned, directly or indirectly, by a hospital or hospitals.

d. A physical therapist licensed under chapter 486, based upon a referral by a provider described in this subparagraph.

e. A health care clinic licensed under part X of chapter 400 which is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, or the Accreditation Association for Ambulatory Health Care, Inc., or

(I) Has a medical director licensed under chapter 458, chapter 459, or chapter 460;

(II) Has been continuously licensed for more than 3 years or is a publicly traded corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange; and

(III) Provides at least four of the following medical specialties:

(A) General medicine.

(B) Radiography.

(C) Orthopedic medicine.

(D) Physical medicine.

(E) Physical therapy.

(F) Physical rehabilitation.

(G) Prescribing or dispensing outpatient prescription medication.

(H) Laboratory services.

3. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. up to $10,000 if a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, a physician assistant licensed under chapter 458 or chapter 459, or an advanced registered nurse practitioner licensed under chapter 464 has determined that the injured person had an emergency medical condition.

4. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. is limited to $2,500 if any provider listed in subparagraph 1. or subparagraph 2. determines that the injured person did not have an emergency medical condition.

5. Medical benefits do not include massage as defined in s. 480.033 or acupuncture as defined in s. 457.102, regardless of the person, entity, or licensee providing massage or

acupuncture, and a licensed massage therapist or licensed acupuncturist may not be reimbursed for medical benefits under this section.

6. The Financial Services Commission shall adopt by rule the form that must be used by an insurer and a health care provider specified in sub-subparagraph 2.b., sub-subparagraph 2.c., or sub-subparagraph 2.e. to document that the health care provider meets the criteria of this paragraph, which rule must include a requirement for a sworn statement or affidavit.

(b) Disability benefits.—Sixty percent of any loss of gross income and loss of earning capacity per individual from inability to work proximately caused by the injury sustained by the injured person, plus all expenses reasonably incurred in obtaining from others ordinary and necessary services in lieu of those that, but for the injury, the injured person would have performed without income for the benefit of his or her household. All disability benefits payable under this provision must be paid at least every 2 weeks.

(c) Death benefits.—Death benefits of $5,000 per individual. Death benefits are in addition to the medical and disability benefits provided under the insurance policy. The insurer may pay death benefits to the executor or administrator of the deceased, to any of the deceased's relatives by blood, legal adoption, or marriage, or to any person appearing to the insurer to be equitably entitled to such benefits.

Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and such insurer may not require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for providing such benefits. Insurers may not require that property damage liability insurance in an amount greater than $10,000 be purchased in conjunction with personal injury protection. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. An insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice violates part IX of chapter 626, and such violation constitutes an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance. An insurer committing such violation is subject to the penalties provided under that part, as well as those provided elsewhere in the insurance code.

(2) AUTHORIZED EXCLUSIONS.—Any insurer may exclude benefits:

(a) For injury sustained by the named insured and relatives residing in the same household while occupying another motor vehicle owned by the named insured and not insured under the policy or for injury sustained by any person operating the insured motor vehicle without the express or implied consent of the insured.

(b) To any injured person, if such person's conduct contributed to his or her injury under any of the following circumstances:

1. Causing injury to himself or herself intentionally; or
2. Being injured while committing a felony.

Whenever an insured is charged with conduct as set forth in subparagraph 2., the 30-day payment provision of paragraph (4)(b) shall be held in abeyance, and the insurer shall withhold payment of any personal injury protection benefits pending the outcome of the case at the trial level. If the charge is nolle prossed or dismissed or the insured is acquitted, the 30-day payment provision shall run from the date the insurer is notified of such action.

(3) INSURED'S RIGHTS TO RECOVERY OF SPECIAL DAMAGES IN TORT CLAIMS.—No insurer shall have a lien on any recovery in tort by judgment, settlement, or otherwise for personal injury protection benefits, whether suit has been filed or settlement has been reached without suit. An injured party who is entitled to bring suit under the provisions of ss. 627.730-627.7405, or his or her legal representative, shall have no right to recover any damages for which personal injury protection benefits are paid or payable. The plaintiff may prove all of his or her special damages notwithstanding this limitation, but if special

damages are introduced in evidence, the trier of facts, whether judge or jury, shall not award damages for personal injury protection benefits paid or payable. In all cases in which a jury is required to fix damages, the court shall instruct the jury that the plaintiff shall not recover such special damages for personal injury protection benefits paid or payable.

(4) PAYMENT OF BENEFITS.—Benefits due from an insurer under ss. 627.730-627.7405 are primary, except that benefits received under any workers' compensation law must be credited against the benefits provided by subsection (1) and are due and payable as loss accrues upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued under ss. 627.730-627.7405. If the Agency for Health Care Administration provides, pays, or becomes liable for medical assistance under the Medicaid program related to injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle, the benefits under ss. 627.730-627.7405 are subject to the Medicaid program. However, within 30 days after receiving notice that the Medicaid program paid such benefits, the insurer shall repay the full amount of the benefits to the Medicaid program.

(a) An insurer may require written notice to be given as soon as practicable after an accident involving a motor vehicle with respect to which the policy affords the security required by ss. 627.730-627.7405.

(b) Personal injury protection insurance benefits paid pursuant to this section are overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same. However:

1. If written notice of the entire claim is not furnished to the insurer, any partial amount supported by written notice is overdue if not paid within 30 days after written notice is furnished to the insurer. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within 30 days after written notice is furnished to the insurer.

2. If an insurer pays only a portion of a claim or rejects a claim, the insurer shall provide at the time of the partial payment or rejection an itemized specification of each item that the insurer had reduced, omitted, or declined to pay and any information that the insurer desires the claimant to consider related to the medical necessity of the denied treatment or to explain the reasonableness of the reduced charge if this does not limit the introduction of evidence at trial. The insurer must also include the name and address of the person to whom the claimant should respond and a claim number to be referenced in future correspondence.

3. If an insurer pays only a portion of a claim or rejects a claim due to an alleged error in the claim, the insurer, at the time of the partial payment or rejection, shall provide an itemized specification or explanation of benefits due to the specified error. Upon receiving the specification or explanation, the person making the claim, at the person's option and without waiving any other legal remedy for payment, has 15 days to submit a revised claim, which shall be considered a timely submission of written notice of a claim.

4. Notwithstanding the fact that written notice has been furnished to the insurer, payment is not overdue if the insurer has reasonable proof that the insurer is not responsible for the payment.

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

6. This paragraph does not preclude or limit the ability of the insurer to assert that the claim was unrelated, was not medically necessary, or was unreasonable or that the amount of the charge was in excess of that permitted under, or in violation of, subsection (5). Such assertion may be made at any time, including after payment of the claim or after the 30-day period for payment set forth in this paragraph.

(c) Upon receiving notice of an accident that is potentially covered by personal injury protection benefits, the insurer must reserve $5,000 of personal injury protection benefits for payment to physicians licensed under chapter 458 or chapter 459 or dentists licensed under chapter 466 who provide emergency services and care, as defined in s. 395.002, or who provide hospital inpatient care. The amount required to be held in reserve may be used only to pay claims from such physicians or dentists until 30 days after the date the insurer receives notice of the accident. After the 30-day period, any amount of the reserve for which the insurer has not received notice of such claims may be used by the insurer to pay other claims. The time periods specified in paragraph (b) for payment of personal injury protection benefits are tolled for the period of time that an insurer is required to hold payment of a claim that is not from such physician or dentist to the extent that the personal injury protection benefits not held in reserve are insufficient to pay the claim. This paragraph does not require an insurer to establish a claim reserve for insurance accounting purposes.

(d) All overdue payments bear simple interest at the rate established under s. 55.03 or the rate established in the insurance contract, whichever is greater, for the quarter in which the payment became overdue, calculated from the date the insurer was furnished with written notice of the amount of covered loss. Interest is due at the time payment of the overdue claim is made.

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

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

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

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

4. Accidental bodily injury sustained in this state by any other person while occupying the owner's motor vehicle or, if a resident of this state, while not an occupant of a self-propelled vehicle if the injury is caused by physical contact with such motor vehicle, if the injured person is not:

a. The owner of a motor vehicle with respect to which security is required under ss. 627.730-627.7405; or

b. Entitled to personal injury benefits from the insurer of the owner of such a motor vehicle.

(f) If two or more insurers are liable for paying personal injury protection benefits for the same injury to any one person, the maximum payable is as specified in subsection (1), and the insurer paying the benefits is entitled to recover from each of the other insurers an equitable pro rata share of the benefits paid and expenses incurred in processing the claim.

(g) It is a violation of the insurance code for an insurer to fail to timely provide benefits as required by this section with such frequency as to constitute a general business practice.

(h) Benefits are not due or payable to or on the behalf of an insured person if that person has committed, by a material act or omission, insurance fraud relating to personal injury protection coverage under his or her policy, if the fraud is admitted to in a sworn statement by the insured or established in a court of competent jurisdiction. Any insurance fraud voids all coverage arising from the claim related to such fraud under the personal injury protection coverage of the insured person who committed the fraud, irrespective of whether a portion of the insured person's claim may be legitimate, and any benefits paid before the

discovery of the fraud is recoverable by the insurer in its entirety from the person who committed insurance fraud. The prevailing party is entitled to its costs and attorney fees in any action in which it prevails in an insurer's action to enforce its right of recovery under this paragraph.

(i) If an insurer has a reasonable belief that a fraudulent insurance act, for the purposes of s. 626.989 or s. 817.234, has been committed, the insurer shall notify the claimant, in writing, within 30 days after submission of the claim that the claim is being investigated for suspected fraud. Beginning at the end of the initial 30-day period, the insurer has an additional 60 days to conduct its fraud investigation. Notwithstanding subsection (10), no later than 90 days after the submission of the claim, the insurer must deny the claim or pay the claim with simple interest as provided in paragraph (d). Interest shall be assessed from the day the claim was submitted until the day the claim is paid. All claims denied for suspected fraudulent insurance acts shall be reported to the Division of Insurance Fraud.

(j) An insurer shall create and maintain for each insured a log of personal injury protection benefits paid by the insurer on behalf of the insured. If litigation is commenced, the insurer shall provide to the insured a copy of the log within 30 days after receiving a request for the log from the insured.

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

(a) A physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for a bodily injury covered by personal injury protection insurance may charge the insurer and injured party only a reasonable amount pursuant to this section for the services and supplies rendered, and the insurer providing such coverage may pay for such charges directly to such person or institution lawfully rendering such treatment if the insured receiving such treatment or his or her guardian has countersigned the properly completed invoice, bill, or claim form approved by the office upon which such charges are to be paid for as having actually been rendered, to the best knowledge of the insured or his or her guardian. However, such a charge may not exceed the amount the person or institution customarily charges for like services or supplies. In determining whether a charge for a particular service, treatment, or otherwise is reasonable, consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, reimbursement levels in the community and various federal and state medical fee schedules applicable to motor vehicle and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply.

1. The insurer may limit reimbursement to 80 percent of the following schedule of maximum charges:

a. For emergency transport and treatment by providers licensed under chapter 401, 200 percent of Medicare.

b. For emergency services and care provided by a hospital licensed under chapter 395, 75 percent of the hospital's usual and customary charges.

c. For emergency services and care as defined by s. 395.002 provided in a facility licensed under chapter 395 rendered by a physician or dentist, and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community.

d. For hospital inpatient services, other than emergency services and care, 200 percent of the Medicare Part A prospective payment applicable to the specific hospital providing the inpatient services.

e. For hospital outpatient services, other than emergency services and care, 200 percent of the Medicare Part A Ambulatory Payment Classification for the specific hospital providing the outpatient services.

f. For all other medical services, supplies, and care, 200 percent of the allowable amount under:

(I) The participating physicians fee schedule of Medicare Part B, except as provided in sub-sub-subparagraphs (II) and (III).

(II) Medicare Part B, in the case of services, supplies, and care provided by ambulatory surgical centers and clinical laboratories.

(III) The Durable Medical Equipment Prosthetics/Orthotics and Supplies fee schedule of Medicare Part B, in the case of durable medical equipment.

However, if such services, supplies, or care is not reimbursable under Medicare Part B, as provided in this sub-subparagraph, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers' compensation, as determined under s. 440.13 and rules adopted thereunder which are in effect at the time such services, supplies, or care is provided. Services, supplies, or care that is not reimbursable under Medicare or workers' compensation is not required to be reimbursed by the insurer.

2. For purposes of subparagraph 1., the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect on March 1 of the year in which the services, supplies, or care is rendered and for the area in which such services, supplies, or care is rendered, and the applicable fee schedule or payment limitation applies throughout the remainder of that year, notwithstanding any subsequent change made to the fee schedule or payment limitation, except that it may not be less than the allowable amount under the applicable schedule of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B.

3. Subparagraph 1. does not allow the insurer to apply any limitation on the number of treatments or other utilization limits that apply under Medicare or workers' compensation. An insurer that applies the allowable payment limitations of subparagraph 1. must reimburse a provider who lawfully provided care or treatment under the scope of his or her license, regardless of whether such provider is entitled to reimbursement under Medicare due to restrictions or limitations on the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes. However, subparagraph 1. does not prohibit an insurer from using the Medicare coding policies and payment methodologies of the federal Centers for Medicare and Medicaid Services, including applicable modifiers, to determine the appropriate amount of reimbursement for medical services, supplies, or care if the coding policy or payment methodology does not constitute a utilization limit.

4. If an insurer limits payment as authorized by subparagraph 1., the person providing such services, supplies, or care may not bill or attempt to collect from the insured any amount in excess of such limits, except for amounts that are not covered by the insured's personal injury protection coverage due to the coinsurance amount or maximum policy limits.

5. Effective July 1, 2012, an insurer may limit payment as authorized by this paragraph only if the insurance policy includes a notice at the time of issuance or renewal that the insurer may limit payment pursuant to the schedule of charges specified in this paragraph. A policy form approved by the office satisfies this requirement. If a provider submits a charge for an amount less than the amount allowed under subparagraph 1., the insurer may pay the amount of the charge submitted.

(b)1. An insurer or insured is not required to pay a claim or charges:

a. Made by a broker or by a person making a claim on behalf of a broker;

b. For any service or treatment that was not lawful at the time rendered;

c. To any person who knowingly submits a false or misleading statement relating to the claim or charges;

d. With respect to a bill or statement that does not substantially meet the applicable requirements of paragraph (d);

e. For any treatment or service that is upcoded, or that is unbundled when such treatment or services should be bundled, in accordance with paragraph (d). To facilitate prompt payment of lawful services, an insurer may change codes that it determines have been

improperly or incorrectly upcoded or unbundled and may make payment based on the changed codes, without affecting the right of the provider to dispute the change by the insurer, if, before doing so, the insurer contacts the health care provider and discusses the reasons for the insurer's change and the health care provider's reason for the coding, or makes a reasonable good faith effort to do so, as documented in the insurer's file; and

f. For medical services or treatment billed by a physician and not provided in a hospital unless such services are rendered by the physician or are incident to his or her professional services and are included on the physician's bill, including documentation verifying that the physician is responsible for the medical services that were rendered and billed.

2. The Department of Health, in consultation with the appropriate professional licensing boards, shall adopt, by rule, a list of diagnostic tests deemed not to be medically necessary for use in the treatment of persons sustaining bodily injury covered by personal injury protection benefits under this section. The list shall be revised from time to time as determined by the Department of Health, in consultation with the respective professional licensing boards. Inclusion of a test on the list shall be based on lack of demonstrated medical value and a level of general acceptance by the relevant provider community and may not be dependent for results entirely upon subjective patient response. Notwithstanding its inclusion on a fee schedule in this subsection, an insurer or insured is not required to pay any charges or reimburse claims for an invalid diagnostic test as determined by the Department of Health.

(c) With respect to any treatment or service, other than medical services billed by a hospital or other provider for emergency services and care as defined in s. 395.002 or inpatient services rendered at a hospital-owned facility, the statement of charges must be furnished to the insurer by the provider and may not include, and the insurer is not required to pay, charges for treatment or services rendered more than 35 days before the postmark date or electronic transmission date of the statement, except for past due amounts previously billed on a timely basis under this paragraph, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement. The injured party is not liable for, and the provider may not bill the injured party for, charges that are unpaid because of the provider's failure to comply with this paragraph. Any agreement requiring the injured person or insured to pay for such charges is unenforceable.

1. If the insured fails to furnish the provider with the correct name and address of the insured's personal injury protection insurer, the provider has 35 days from the date the provider obtains the correct information to furnish the insurer with a statement of the charges. The insurer is not required to pay for such charges unless the provider includes with the statement documentary evidence that was provided by the insured during the 35-day period demonstrating that the provider reasonably relied on erroneous information from the insured and either:

a. A denial letter from the incorrect insurer; or

b. Proof of mailing, which may include an affidavit under penalty of perjury, reflecting timely mailing to the incorrect address or insurer.

2. For emergency services and care rendered in a hospital emergency department or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401, the provider is not required to furnish the statement of charges within the time periods established by this paragraph, and the insurer is not considered to have been furnished with notice of the amount of covered loss for purposes of paragraph (4)(b) until it receives a statement complying with paragraph (d), or copy thereof, which specifically identifies the place of service to be a hospital emergency department or an ambulance in accordance with billing standards recognized by the federal Centers for Medicare and Medicaid Services.

3. Each notice of the insured's rights under s. 627.7401 must include the following statement in at least 12-point type:

BILLING REQUIREMENTS.—Florida law provides that with respect to any treatment or services, other than certain hospital and emergency services, the statement of charges furnished to the insurer by the provider may not include, and the insurer and the injured party are not required to pay, charges for treatment or services rendered more than 35 days before the postmark date of the statement, except for past due amounts previously billed on a timely basis, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement.

(d) All statements and bills for medical services rendered by a physician, hospital, clinic, or other person or institution shall be submitted to the insurer on a properly completed Centers for Medicare and Medicaid Services (CMS) 1500 form, UB 92 forms, or any other standard form approved by the office or adopted by the commission for purposes of this paragraph. All billings for such services rendered by providers must, to the extent applicable, follow the Physicians' Current Procedural Terminology (CPT) or Healthcare Correct Procedural Coding System (HCPCS), or ICD-9 in effect for the year in which services are rendered and comply with the CMS 1500 form instructions, the American Medical Association CPT Editorial Panel, and the HCPCS. All providers, other than hospitals, must include on the applicable claim form the professional license number of the provider in the line or space provided for "Signature of Physician or Supplier, Including Degrees or Credentials." In determining compliance with applicable CPT and HCPCS coding, guidance shall be provided by the Physicians' Current Procedural Terminology (CPT) or the Healthcare Correct Procedural Coding System (HCPCS) in effect for the year in which services were rendered, the Office of the Inspector General, Physicians Compliance Guidelines, and other authoritative treatises designated by rule by the Agency for Health Care Administration. A statement of medical services may not include charges for medical services of a person or entity that performed such services without possessing the valid licenses required to perform such services. For purposes of paragraph (4)(b), an insurer is not considered to have been furnished with notice of the amount of covered loss or medical bills due unless the statements or bills comply with this paragraph and are properly completed in their entirety as to all material provisions, with all relevant information being provided therein.

(e)1. At the initial treatment or service provided, each physician, other licensed professional, clinic, or other medical institution providing medical services upon which a claim for personal injury protection benefits is based shall require an insured person, or his or her guardian, to execute a disclosure and acknowledgment form, which reflects at a minimum that:

a. The insured, or his or her guardian, must countersign the form attesting to the fact that the services set forth therein were actually rendered;

b. The insured, or his or her guardian, has both the right and affirmative duty to confirm that the services were actually rendered;

c. The insured, or his or her guardian, was not solicited by any person to seek any services from the medical provider;

d. The physician, other licensed professional, clinic, or other medical institution rendering services for which payment is being claimed explained the services to the insured or his or her guardian; and

e. If the insured notifies the insurer in writing of a billing error, the insured may be entitled to a certain percentage of a reduction in the amounts paid by the insured's motor vehicle insurer.

2. The physician, other licensed professional, clinic, or other medical institution rendering services for which payment is being claimed has the affirmative duty to explain the services

rendered to the insured, or his or her guardian, so that the insured, or his or her guardian, countersigns the form with informed consent.

3. Countersignature by the insured, or his or her guardian, is not required for the reading of diagnostic tests or other services that are of such a nature that they are not required to be performed in the presence of the insured.

4. The licensed medical professional rendering treatment for which payment is being claimed must sign, by his or her own hand, the form complying with this paragraph.

5. The original completed disclosure and acknowledgment form shall be furnished to the insurer pursuant to paragraph (4)(b) and may not be electronically furnished.

6. The disclosure and acknowledgment form is not required for services billed by a provider for emergency services and care as defined in s. 395.002 rendered in a hospital emergency department, or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401.

7. The Financial Services Commission shall adopt, by rule, a standard disclosure and acknowledgment form to be used to fulfill the requirements of this paragraph.

8. As used in this paragraph, the term "countersign" or "countersignature" means a second or verifying signature, as on a previously signed document, and is not satisfied by the statement "signature on file" or any similar statement.

9. The requirements of this paragraph apply only with respect to the initial treatment or service of the insured by a provider. For subsequent treatments or service, the provider must maintain a patient log signed by the patient, in chronological order by date of service, which is consistent with the services being rendered to the patient as claimed. The requirement to maintain a patient log signed by the patient may be met by a hospital that maintains medical records as required by s. 395.3025 and applicable rules and makes such records available to the insurer upon request.

(f) Upon written notification by any person, an insurer shall investigate any claim of improper billing by a physician or other medical provider. The insurer shall determine if the insured was properly billed for only those services and treatments that the insured actually received. If the insurer determines that the insured has been improperly billed, the insurer shall notify the insured, the person making the written notification, and the provider of its findings and reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to a written notification by any person, the insurer shall pay to the person 20 percent of the amount of the reduction, up to $500. If the provider is arrested due to the improper billing, the insurer shall pay to the person 40 percent of the amount of the reduction, up to $500.

(g) An insurer may not systematically downcode with the intent to deny reimbursement otherwise due. Such action constitutes a material misrepresentation under s. 626.9541(1)(i)2.

(h) As provided in s. 400.9905, an entity excluded from the definition of a clinic shall be deemed a clinic and must be licensed under part X of chapter 400 in order to receive reimbursement under ss. 627.730-627.7405. However, this licensing requirement does not apply to:

1. An entity wholly owned by a physician licensed under chapter 458 or chapter 459, or by the physician and the spouse, parent, child, or sibling of the physician;

2. An entity wholly owned by a dentist licensed under chapter 466, or by the dentist and the spouse, parent, child, or sibling of the dentist;

3. An entity wholly owned by a chiropractic physician licensed under chapter 460, or by the chiropractic physician and the spouse, parent, child, or sibling of the chiropractic physician;

4. A hospital or ambulatory surgical center licensed under chapter 395;

5. An entity that wholly owns or is wholly owned, directly or indirectly, by a hospital or hospitals licensed under chapter 395; or

6. An entity that is a clinical facility affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows.

(6) DISCOVERY OF FACTS ABOUT AN INJURED PERSON; DISPUTES.—

(a) If a request is made by an insurer providing personal injury protection benefits under ss. 627.730-627.7405 against whom a claim has been made, an employer must furnish, in a form approved by the office, a sworn statement of the earnings, since the time of the bodily injury and for a reasonable period before the injury, of the person upon whose injury the claim is based.

(b) Every physician, hospital, clinic, or other medical institution providing, before or after bodily injury upon which a claim for personal injury protection insurance benefits is based, any products, services, or accommodations in relation to that or any other injury, or in relation to a condition claimed to be connected with that or any other injury, shall, if requested by the insurer against whom the claim has been made, furnish a written report of the history, condition, treatment, dates, and costs of such treatment of the injured person and why the items identified by the insurer were reasonable in amount and medically necessary, together with a sworn statement that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained and identifying which portion of the expenses for such treatment or services was incurred as a result of such bodily injury, and produce, and allow the inspection and copying of, his or her or its records regarding such history, condition, treatment, dates, and costs of treatment if this does not limit the introduction of evidence at trial. Such sworn statement must read as follows: "Under penalty of perjury, I declare that I have read the foregoing, and the facts alleged are true, to the best of my knowledge and belief." A cause of action for violation of the physician-patient privilege or invasion of the right of privacy may not be brought against any physician, hospital, clinic, or other medical institution complying with this section. The person requesting such records and such sworn statement shall pay all reasonable costs connected therewith. If an insurer makes a written request for documentation or information under this paragraph within 30 days after having received notice of the amount of a covered loss under paragraph (4)(a), the amount or the partial amount that is the subject of the insurer's inquiry is overdue if the insurer does not pay in accordance with paragraph (4)(b) or within 10 days after the insurer's receipt of the requested documentation or information, whichever occurs later. As used in this paragraph, the term "receipt" includes, but is not limited to, inspection and copying pursuant to this paragraph. An insurer that requests documentation or information pertaining to reasonableness of charges or medical necessity under this paragraph without a reasonable basis for such requests as a general business practice is engaging in an unfair trade practice under the insurance code.

(c) In the event of a dispute regarding an insurer's right to discovery of facts under this section, the insurer may petition a court of competent jurisdiction to enter an order permitting such discovery. The order may be made only on motion for good cause shown and upon notice to all persons having an interest, and must specify the time, place, manner, conditions, and scope of the discovery. In order to protect against annoyance, embarrassment, or oppression, as justice requires, the court may enter an order refusing discovery or specifying conditions of discovery and may order payments of costs and expenses of the proceeding, including reasonable fees for the appearance of attorneys at the proceedings, as justice requires.

(d) The injured person shall be furnished, upon request, a copy of all information obtained by the insurer under this section, and pay a reasonable charge, if required by the insurer.

(e) Notice to an insurer of the existence of a claim may not be unreasonably withheld by an insured.

(f) In a dispute between the insured and the insurer, or between an assignee of the insured's rights and the insurer, upon request, the insurer must notify the insured or the assignee that the policy limits under this section have been reached within 15 days after the limits have been reached.

(g) An insured seeking benefits under ss. 627.730-627.7405, including an omnibus insured, must comply with the terms of the policy, which include, but are not limited to, submitting to an examination under oath. The scope of questioning during the examination under oath is limited to relevant information or information that could reasonably be expected to lead to relevant information. Compliance with this paragraph is a condition precedent to receiving benefits. An insurer that, as a general business practice as determined by the office, requests an examination under oath of an insured or an omnibus insured without a reasonable basis is subject to s. 626.9541.

(7) MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON; REPORTS.—

(a) Whenever the mental or physical condition of an injured person covered by personal injury protection is material to any claim that has been or may be made for past or future personal injury protection insurance benefits, such person shall, upon the request of an insurer, submit to mental or physical examination by a physician or physicians. The costs of any examinations requested by an insurer shall be borne entirely by the insurer. Such examination shall be conducted within the municipality where the insured is receiving treatment, or in a location reasonably accessible to the insured, which, for purposes of this paragraph, means any location within the municipality in which the insured resides, or any location within 10 miles by road of the insured's residence, provided such location is within the county in which the insured resides. If the examination is to be conducted in a location reasonably accessible to the insured, and if there is no qualified physician to conduct the examination in a location reasonably accessible to the insured, such examination shall be conducted in an area of the closest proximity to the insured's residence. Personal protection insurers are authorized to include reasonable provisions in personal injury protection insurance policies for mental and physical examination of those claiming personal injury protection insurance benefits. An insurer may not withdraw payment of a treating physician without the consent of the injured person covered by the personal injury protection, unless the insurer first obtains a valid report by a Florida physician licensed under the same chapter as the treating physician whose treatment authorization is sought to be withdrawn, stating that treatment was not reasonable, related, or necessary. A valid report is one that is prepared and signed by the physician examining the injured person or reviewing the treatment records of the injured person and is factually supported by the examination and treatment records if reviewed and that has not been modified by anyone other than the physician. The physician preparing the report must be in active practice, unless the physician is physically disabled. Active practice means that during the 3 years immediately preceding the date of the physical examination or review of the treatment records the physician must have devoted professional time to the active clinical practice of evaluation, diagnosis, or treatment of medical conditions or to the instruction of students in an accredited health professional school or accredited residency program or a clinical research program that is affiliated with an accredited health professional school or teaching hospital or accredited residency program. The physician preparing a report at the request of an insurer and physicians rendering expert opinions on behalf of persons claiming medical benefits for personal injury protection, or on behalf of an insured through an attorney or another entity, shall maintain, for at least 3 years, copies of all examination reports as medical records and shall maintain, for at least 3 years, records of all payments for the examinations and reports. Neither an insurer nor any person acting at the direction of or on behalf of an insurer may materially change an opinion in a report prepared under this paragraph or direct the physician preparing the report to change such opinion. The denial of a payment as the result of such a changed opinion constitutes a material misrepresentation under s. 626.9541(1)(i)2.; however, this provision does not preclude the insurer from calling to the attention of the physician errors of fact in the report based upon information in the claim file.

(b) If requested by the person examined, a party causing an examination to be made shall deliver to him or her a copy of every written report concerning the examination rendered by

an examining physician, at least one of which reports must set out the examining physician's findings and conclusions in detail. After such request and delivery, the party causing the examination to be made is entitled, upon request, to receive from the person examined every written report available to him or her or his or her representative concerning any examination, previously or thereafter made, of the same mental or physical condition. By requesting and obtaining a report of the examination so ordered, or by taking the deposition of the examiner, the person examined waives any privilege he or she may have, in relation to the claim for benefits, regarding the testimony of every other person who has examined, or may thereafter examine, him or her in respect to the same mental or physical condition. If a person unreasonably refuses to submit to or fails to appear at an examination, the personal injury protection carrier is no longer liable for subsequent personal injury protection benefits. An insured's refusal to submit to or failure to appear at two examinations raises a rebuttable presumption that the insured's refusal or failure was unreasonable.

(8) APPLICABILITY OF PROVISION REGULATING ATTORNEY FEES.—With respect to any dispute under the provisions of ss. 627.730-627.7405 between the insured and the insurer, or between an assignee of an insured's rights and the insurer, the provisions of ss. 627.428 and 768.79 apply, except as provided in subsections (10) and (15), and except that any attorney fees recovered must:

(a) Comply with prevailing professional standards;

(b) Not overstate or inflate the number of hours reasonably necessary for a case of comparable skill or complexity; and

(c) Represent legal services that are reasonable and necessary to achieve the result obtained.

Upon request by either party, a judge must make written findings, substantiated by evidence presented at trial or any hearings associated therewith, that any award of attorney fees complies with this subsection. Notwithstanding s. 627.428, attorney fees recovered under ss. 627.730-627.7405 must be calculated without regard to a contingency risk multiplier.

(9) PREFERRED PROVIDERS.—An insurer may negotiate and contract with preferred providers for the benefits described in this section, which include health care providers licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 463. The insurer may provide an option to an insured to use a preferred provider at the time of purchasing the policy for personal injury protection benefits, if the requirements of this subsection are met. If the insured elects to use a provider who is not a preferred provider, whether the insured purchased a preferred provider policy or a nonpreferred provider policy, the medical benefits provided by the insurer shall be as required by this section. If the insured elects to use a provider who is a preferred provider, the insurer may pay medical benefits in excess of the benefits required by this section and may waive or lower the amount of any deductible that applies to such medical benefits. If the insurer offers a preferred provider policy to a policyholder or applicant, it must also offer a nonpreferred provider policy. The insurer shall provide each insured with a current roster of preferred providers in the county in which the insured resides at the time of purchase of such policy, and shall make such list available for public inspection during regular business hours at the insurer's principal office within the state.

(10) DEMAND LETTER.—

(a) As a condition precedent to filing any action for benefits under this section, written notice of an intent to initiate litigation must be provided to the insurer. Such notice may not be sent until the claim is overdue, including any additional time the insurer has to pay the claim pursuant to paragraph (4)(b).

(b) The notice must state that it is a "demand letter under s. 627.736" and state with specificity:

1. The name of the insured upon which such benefits are being sought, including a copy of the assignment giving rights to the claimant if the claimant is not the insured.
2. The claim number or policy number upon which such claim was originally submitted to the insurer.
3. To the extent applicable, the name of any medical provider who rendered to an insured the treatment, services, accommodations, or supplies that form the basis of such claim; and an itemized statement specifying each exact amount, the date of treatment, service, or accommodation, and the type of benefit claimed to be due. A completed form satisfying the requirements of paragraph (5)(d) or the lost-wage statement previously submitted may be used as the itemized statement. To the extent that the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet rendered, the claimant shall attach a copy of the insurer's notice withdrawing such payment and an itemized statement of the type, frequency, and duration of future treatment claimed to be reasonable and medically necessary.

(c) Each notice required by this subsection must be delivered to the insurer by United States certified or registered mail, return receipt requested. Such postal costs shall be reimbursed by the insurer if requested by the claimant in the notice, when the insurer pays the claim. Such notice must be sent to the person and address specified by the insurer for the purposes of receiving notices under this subsection. Each licensed insurer, whether domestic, foreign, or alien, shall file with the office the name and address of the designated person to whom notices must be sent which the office shall make available on its Internet website. The name and address on file with the office pursuant to s. 624.422 is deemed the authorized representative to accept notice pursuant to this subsection if no other designation has been made.

(d) If, within 30 days after receipt of notice by the insurer, the overdue claim specified in the notice is paid by the insurer together with applicable interest and a penalty of 10 percent of the overdue amount paid by the insurer, subject to a maximum penalty of $250, no action may be brought against the insurer. If the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet rendered, no action may be brought against the insurer if, within 30 days after its receipt of the notice, the insurer mails to the person filing the notice a written statement of the insurer's agreement to pay for such treatment in accordance with the notice and to pay a penalty of 10 percent, subject to a maximum penalty of $250, when it pays for such future treatment in accordance with the requirements of this section. To the extent the insurer determines not to pay any amount demanded, the penalty is not payable in any subsequent action. For purposes of this subsection, payment or the insurer's agreement shall be treated as being made on the date a draft or other valid instrument that is equivalent to payment, or the insurer's written statement of agreement, is placed in the United States mail in a properly addressed, postpaid envelope, or if not so posted, on the date of delivery. The insurer is not obligated to pay any attorney fees if the insurer pays the claim or mails its agreement to pay for future treatment within the time prescribed by this subsection.

(e) The applicable statute of limitation for an action under this section shall be tolled for 30 business days by the mailing of the notice required by this subsection.

(11) FAILURE TO PAY VALID CLAIMS; UNFAIR OR DECEPTIVE PRACTICE.—

(a) An insurer is engaging in a prohibited unfair or deceptive practice that is subject to the penalties provided in s. 626.9521 and the office has the powers and duties specified in ss. 626.9561-626.9601 if the insurer, with such frequency so as to indicate a general business practice:

1. Fails to pay valid claims for personal injury protection; or
2. Fails to pay valid claims until receipt of the notice required by subsection (10).

(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.

(12) CIVIL ACTION FOR INSURANCE FRAUD.—An insurer shall have a cause of action against any person convicted of, or who, regardless of adjudication of guilt, pleads guilty or nolo contendere to insurance fraud under s. 817.234, patient brokering under s. 817.505, or kickbacks under s. 456.054, associated with a claim for personal injury protection benefits in accordance with this section. An insurer prevailing in an action brought under this subsection may recover compensatory, consequential, and punitive damages subject to the requirements and limitations of part II of chapter 768, and attorney's fees and costs incurred in litigating a cause of action against any person convicted of, or who, regardless of adjudication of guilt, pleads guilty or nolo contendere to insurance fraud under s. 817.234, patient brokering under s. 817.505, or kickbacks under s. 456.054, associated with a claim for personal injury protection benefits in accordance with this section.

(13) MINIMUM BENEFIT COVERAGE.—If the Financial Services Commission determines that the cost savings under personal injury protection insurance benefits paid by insurers have been realized due to the provisions of this act, prior legislative reforms, or other factors, the commission may increase the minimum $10,000 benefit coverage requirement. In establishing the amount of such increase, the commission must determine that the additional premium for such coverage is approximately equal to the premium cost savings that have been realized for the personal injury protection coverage with limits of $10,000.

(14) FRAUD ADVISORY NOTICE.—Upon receiving notice of a claim under this section, an insurer shall provide a notice to the insured or to a person for whom a claim for reimbursement for diagnosis or treatment of injuries has been filed, advising that:

(a) Pursuant to s. 626.9892, the Department of Financial Services may pay rewards of up to $25,000 to persons providing information leading to the arrest and conviction of persons committing crimes investigated by the Division of Insurance Fraud arising from violations of s. 440.105, s. 624.15, s. 626.9541, s. 626.989, or s. 817.234.

(b) Solicitation of a person injured in a motor vehicle crash for purposes of filing personal injury protection or tort claims could be a violation of s. 817.234, s. 817.505, or the rules regulating The Florida Bar and should be immediately reported to the Division of Insurance Fraud if such conduct has taken place.

(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.—A notice, documentation, transmission, or communication of any kind required or authorized under ss. 627.730-627.7405 may be transmitted electronically if it is transmitted by secure electronic data transfer that is consistent with state and federal privacy and security laws.

(17) NONREIMBURSIBLE CLAIMS.—Claims generated as a result of activities that are unlawful pursuant to s. 817.505 are not reimbursable under the Florida Motor Vehicle No-Fault Law.

215.5586 My Safe Florida Home Program.—There is established within the Department of Financial Services the My Safe Florida Home Program. The department shall provide fiscal accountability, contract management, and strategic leadership for the program, consistent with this section. This section does not create an entitlement for property owners or obligate the state in any way to fund the inspection or retrofitting of residential property in this state. Implementation of this program is subject to annual legislative appropriations. It is the intent of the Legislature that the My Safe Florida Home Program provide trained and certified inspectors to perform inspections for owners of site-built, single-family, residential properties and grants to eligible applicants as funding allows. The program shall develop and implement a comprehensive and coordinated approach for hurricane damage mitigation that may include the following:

(1) HURRICANE MITIGATION INSPECTIONS.—

(a) Certified inspectors to provide home-retrofit inspections of site-built, single-family, residential property may be offered to determine what mitigation measures are needed, what insurance premium discounts may be available, and what improvements to existing residential properties are needed to reduce the property's vulnerability to hurricane damage. The Department of Financial Services shall contract with wind certification entities to provide hurricane mitigation inspections. The inspections provided to homeowners, at a minimum, must include:

1. A home inspection and report that summarizes the results and identifies recommended improvements a homeowner may take to mitigate hurricane damage.
2. A range of cost estimates regarding the recommended mitigation improvements.
3. Insurer-specific information regarding premium discounts correlated to the current mitigation features and the recommended mitigation improvements identified by the inspection.

(b) To qualify for selection by the department as a wind certification entity to provide hurricane mitigation inspections, the entity shall, at a minimum, meet the following requirements:

1. Use hurricane mitigation inspectors who:

a. Are certified as a building inspector under s. 468.607;

b. Are licensed as a general or residential contractor under s. 489.111;

c. Are licensed as a professional engineer under s. 471.015 and who have passed the appropriate equivalency test of the building code training program as required by s. 553.841;

d. Are licensed as a professional architect under s. 481.213; or

e. Have at least 2 years of experience in residential construction or residential building inspection and have received specialized training in hurricane mitigation procedures. Such training may be provided by a class offered online or in person.

2. Use hurricane mitigation inspectors who also:

a. Have undergone drug testing and a background screening. The department may conduct criminal record checks of inspectors used by wind certification entities. Inspectors must submit a set of the fingerprints to the department for state and national criminal history checks and must pay the fingerprint processing fee set forth in s. 624.501. The fingerprints shall be sent by the department to the Department of Law Enforcement and forwarded to the Federal Bureau of Investigation for processing. The results shall be returned to the department for screening. The fingerprints shall be taken by a law enforcement agency, designated examination center, or other department-approved entity; and

b. Have been certified, in a manner satisfactory to the department, to conduct the inspections.

3. Provide a quality assurance program including a reinspection component.

(c) The department shall implement a quality assurance program that includes a statistically valid number of reinspections.

(d) An application for an inspection must contain a signed or electronically verified statement made under penalty of perjury that the applicant has submitted only a single application for that home.

(e) The owner of a site-built, single-family, residential property may apply for and receive an inspection without also applying for a grant pursuant to subsection (2) and without meeting the requirements of paragraph (2)(a).

(2) MITIGATION GRANTS.—Financial grants shall be used to encourage single-family, site-built, owner-occupied, residential property owners to retrofit their properties to make them less vulnerable to hurricane damage.

(a) For a homeowner to be eligible for a grant, the following criteria must be met:

1. The homeowner must have been granted a homestead exemption on the home under chapter 196.
2. The home must be a dwelling with an insured value of $300,000 or less. Homeowners who are low-income persons, as defined in s. 420.0004(11), are exempt from this requirement.
3. The home must have undergone an acceptable hurricane mitigation inspection after May 1, 2007.
4. The home must be located in the "wind-borne debris region" as that term is defined in s. 1609.2, International Building Code (2006), or as subsequently amended.
5. The building permit application for initial construction of the home must have been made before March 1, 2002.

An application for a grant must contain a signed or electronically verified statement made under penalty of perjury that the applicant has submitted only a single application and must have attached documents demonstrating the applicant meets the requirements of this paragraph.

(b) All grants must be matched on a dollar-for-dollar basis up to a total of $10,000 for the actual cost of the mitigation project with the state's contribution not to exceed $5,000.

(c) The program shall create a process in which contractors agree to participate and homeowners select from a list of participating contractors. All mitigation must be based upon the securing of all required local permits and inspections and must be performed by properly licensed contractors. Mitigation projects are subject to random reinspection of up to at least 5 percent of all projects. Hurricane mitigation inspectors qualifying for the program may also participate as mitigation contractors as long as the inspectors meet the department's qualifications and certification requirements for mitigation contractors.

(d) Matching fund grants shall also be made available to local governments and nonprofit entities for projects that will reduce hurricane damage to single-family, site-built, owner-occupied, residential property. The department shall liberally construe those requirements in favor of availing the state of the opportunity to leverage funding for the My Safe Florida Home Program with other sources of funding.

(e) When recommended by a hurricane mitigation inspection, grants may be used for the following improvements:

1. Opening protection.
2. Exterior doors, including garage doors.
3. Brace gable ends.
4. Reinforcing roof-to-wall connections.
5. Improving the strength of roof-deck attachments.
6. Upgrading roof covering from code to code plus.
7. Secondary water barrier for roof.

The department may require that improvements be made to all openings, including exterior doors and garage doors, as a condition of reimbursing a homeowner approved for a grant. The department may adopt, by rule, the maximum grant allowances for any improvement allowable under this paragraph.

(f) Grants may be used on a previously inspected existing structure or on a rebuild. A rebuild is defined as a site-built, single-family dwelling under construction to replace a home that was destroyed or significantly damaged by a hurricane and deemed unlivable by a regulatory authority. The homeowner must be a low-income homeowner as defined in paragraph (g), must have had a homestead exemption for that home prior to the hurricane, and must be intending to rebuild the home as that homeowner's homestead.

(g) Low-income homeowners, as defined in s. 420.0004(11), who otherwise meet the requirements of paragraphs (a), (c), (e), and (f) are eligible for a grant of up to $5,000 and

are not required to provide a matching amount to receive the grant. Additionally, for low-income homeowners, grant funding may be used for repair to existing structures leading to any of the mitigation improvements provided in paragraph (e), limited to 20 percent of the grant value. The program may accept a certification directly from a low-income homeowner that the homeowner meets the requirements of s. 420.0004(11) if the homeowner provides such certification in a signed or electronically verified statement made under penalty of perjury.

(h) The department shall establish objective, reasonable criteria for prioritizing grant applications, consistent with the requirements of this section.

(i) The department shall develop a process that ensures the most efficient means to collect and verify grant applications to determine eligibility and may direct hurricane mitigation inspectors to collect and verify grant application information or use the Internet or other electronic means to collect information and determine eligibility.

(3) EDUCATION AND CONSUMER AWARENESS.—The department may undertake a statewide multimedia public outreach and advertising campaign to inform consumers of the availability and benefits of hurricane inspections and of the safety and financial benefits of residential hurricane damage mitigation. The department may seek out and use local, state, federal, and private funds to support the campaign.

(4) ADVISORY COUNCIL.—There is created an advisory council to provide advice and assistance to the department regarding administration of the program. The advisory council shall consist of:

(a) A representative of lending institutions, selected by the Financial Services Commission from a list of at least three persons recommended by the Florida Bankers Association.

(b) A representative of residential property insurers, selected by the Financial Services Commission from a list of at least three persons recommended by the Florida Insurance Council.

(c) A representative of home builders, selected by the Financial Services Commission from a list of at least three persons recommended by the Florida Home Builders Association.

(d) A faculty member of a state university, selected by the Financial Services Commission, who is an expert in hurricane-resistant construction methodologies and materials.

(e) Two members of the House of Representatives, selected by the Speaker of the House of Representatives.

(f) Two members of the Senate, selected by the President of the Senate.

(g) The Chief Executive Officer of the Federal Alliance for Safe Homes, Inc., or his or her designee.

(h) The senior officer of the Florida Hurricane Catastrophe Fund.

(i) The executive director of Citizens Property Insurance Corporation.

(j) The director of the Florida Division of Emergency Management.

Members appointed under paragraphs (a)-(d) shall serve at the pleasure of the Financial Services Commission. Members appointed under paragraphs (e) and (f) shall serve at the pleasure of the appointing officer. All other members shall serve as voting ex officio members. Members of the advisory council shall serve without compensation but may receive reimbursement as provided in s. 112.061 for per diem and travel expenses incurred in the performance of their official duties.

(5) FUNDING.—The department may seek out and leverage local, state, federal, or private funds to enhance the financial resources of the program.

(6) RULES.—The Department of Financial Services shall adopt rules pursuant to ss. 120.536(1) and 120.54 to govern the program; implement the provisions of this section; including rules governing hurricane mitigation inspections and grants, mitigation contractors, and training of inspectors and contractors; and carry out the duties of the department under this section.

(7) HURRICANE MITIGATION INSPECTOR LIST.—The department shall develop and maintain as a public record a current list of hurricane mitigation inspectors authorized to conduct hurricane mitigation inspections pursuant to this section.

(8) PUBLIC OUTREACH FOR CONTRACTORS AND REAL ESTATE BROKERS AND SALES ASSOCIATES.—The program shall develop brochures for distribution to general contractors, roofing contractors, and real estate brokers and sales associates licensed under part I of chapter 475 explaining the benefits to homeowners of residential hurricane damage mitigation. The program shall encourage contractors to distribute the brochures to homeowners at the first meeting with a homeowner who is considering contracting for home or roof repairs or contracting for the construction of a new home. The program shall encourage real estate brokers and sales associates licensed under part I of chapter 475 to distribute the brochures to clients prior to the purchase of a home. The brochures may be made available electronically.

(9) CONTRACT MANAGEMENT.—The department may contract with third parties for grants management, inspection services, contractor services for low-income homeowners, information technology, educational outreach, and auditing services. Such contracts shall be considered direct costs of the program and shall not be subject to administrative cost limits, but contracts valued at $1 million or more shall be subject to review and approval by the Legislative Budget Commission. The department shall contract with providers that have a demonstrated record of successful business operations in areas directly related to the services to be provided and shall ensure the highest accountability for use of state funds, consistent with this section.

(10) INTENT.—It is the intent of the Legislature that grants made to residential property owners under this section shall be considered disaster-relief assistance within the meaning of s. 139 of the Internal Revenue Code of 1986, as amended.

(11) REPORTS.—The department shall make an annual report on the activities of the program that shall account for the use of state funds and indicate the number of inspections requested, the number of inspections performed, the number of grant applications received, and the number and value of grants approved. The report shall be delivered to the President of the Senate and the Speaker of the House of Representatives by February 1 of each year.

624.307 General powers; duties.—

(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

624.424 Annual statement and other information.—

(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing of an annual or quarterly statement. The statements shall contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally utilized by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form for financial statements approved by the National Association of Insurance Commissioners in 2002, and may adopt subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office or such organization as the office may designate all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.

(b) Each insurer's annual statement must contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, under criteria established by rule of the commission. In adopting the rule, the commission must consider any criteria established by the National Association of Insurance Commissioners. The office may require semiannual updates of the annual statement of opinion as to a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance or title insurance.

(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must

submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to implement this subsection, which rules must be in substantial conformity with the 1998 Model Rule Requiring Annual Audited Financial Reports adopted by the National Association of Insurance Commissioners or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. No insurer may raise as a defense in any action, any exception to, waiver of, or interpretation of accounting requirements, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.
(b) Total number of policies canceled.
(c) Total number of policies nonrenewed.
(d) Number of policies canceled due to hurricane risk.
(e) Number of policies nonrenewed due to hurricane risk.
(f) Number of new policies written.
(g) Total dollar value of structure exposure under policies that include wind coverage.
(h) Number of policies that exclude wind coverage.

627.062 Rate standards.—

(1) The rates for all classes of insurance to which the provisions of this part are applicable may not be excessive, inadequate, or unfairly discriminatory.

(2) As to all such classes of insurance:

(a) Insurers or rating organizations shall establish and use rates, rating schedules, or rating manuals that allow the insurer a reasonable rate of return on the classes of insurance written in this state. A copy of rates, rating schedules, rating manuals, premium credits or discount schedules, and surcharge schedules, and changes thereto, must be filed with the office under one of the following procedures:

1. If the filing is made at least 90 days before the proposed effective date and is not implemented during the office's review of the filing and any proceeding and judicial review, such filing is considered a "file and use" filing. In such case, the office shall finalize its review by issuance of a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing. The notice of intent to approve and the notice of intent to disapprove constitute agency action for purposes of the Administrative Procedure Act. Requests for supporting information, requests for mathematical or mechanical corrections, or notification to the insurer by the office of its preliminary findings does not toll the 90-day period during any such proceedings and subsequent judicial review. The rate shall be deemed approved if the office does not issue a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing.

2. If the filing is not made in accordance with subparagraph 1., such filing must be made as soon as practicable, but within 30 days after the effective date, and is considered a "use and file" filing. An insurer making a "use and file" filing is potentially subject to an order by the office to return to policyholders those portions of rates found to be excessive, as provided in paragraph (h).

3. For all property insurance filings made or submitted after January 25, 2007, but before May 1, 2012, an insurer seeking a rate that is greater than the rate most recently approved by the office shall make a "file and use" filing. For purposes of this subparagraph, motor vehicle collision and comprehensive coverages are not considered property coverages.

(b) Upon receiving a rate filing, the office shall review the filing to determine if a rate is excessive, inadequate, or unfairly discriminatory. In making that determination, the office shall, in accordance with generally accepted and reasonable actuarial techniques, consider the following factors:

1. Past and prospective loss experience within and without this state.
2. Past and prospective expenses.
3. The degree of competition among insurers for the risk insured.
4. Investment income reasonably expected by the insurer, consistent with the insurer's investment practices, from investable premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves. The commission may adopt rules using reasonable techniques of actuarial science and economics to specify the manner in which insurers calculate investment income attributable to classes of insurance written in this state and the manner in which investment income is used to calculate insurance rates. Such

manner must contemplate allowances for an underwriting profit factor and full consideration of investment income which produce a reasonable rate of return; however, investment income from invested surplus may not be considered.

5. The reasonableness of the judgment reflected in the filing.

6. Dividends, savings, or unabsorbed premium deposits allowed or returned to Florida policyholders, members, or subscribers.

7. The adequacy of loss reserves.

8. The cost of reinsurance. The office may not disapprove a rate as excessive solely due to the insurer having obtained catastrophic reinsurance to cover the insurer's estimated 250-year probable maximum loss or any lower level of loss.

9. Trend factors, including trends in actual losses per insured unit for the insurer making the filing.

10. Conflagration and catastrophe hazards, if applicable.

11. Projected hurricane losses, if applicable, which must be estimated using a model or method found to be acceptable or reliable by the Florida Commission on Hurricane Loss Projection Methodology, and as further provided in s. 627.0628.

12. A reasonable margin for underwriting profit and contingencies.

13. The cost of medical services, if applicable.

14. Other relevant factors that affect the frequency or severity of claims or expenses.

(c) In the case of fire insurance rates, consideration must be given to the availability of water supplies and the experience of the fire insurance business during a period of not less than the most recent 5-year period for which such experience is available.

(d) If conflagration or catastrophe hazards are considered by an insurer in its rates or rating plan, including surcharges and discounts, the insurer shall establish a reserve for that portion of the premium allocated to such hazard and maintain the premium in a catastrophe reserve. Removal of such premiums from the reserve for purposes other than paying claims associated with a catastrophe or purchasing reinsurance for catastrophes must be approved by the office. Any ceding commission received by an insurer purchasing reinsurance for catastrophes must be placed in the catastrophe reserve.

(e) After consideration of the rate factors provided in paragraphs (b), (c), and (d), the office may find a rate to be excessive, inadequate, or unfairly discriminatory based upon the following standards:

1. Rates shall be deemed excessive if they are likely to produce a profit from Florida business which is unreasonably high in relation to the risk involved in the class of business or if expenses are unreasonably high in relation to services rendered.

2. Rates shall be deemed excessive if, among other things, the rate structure established by a stock insurance company provides for replenishment of surpluses from premiums, if the replenishment is attributable to investment losses.

3. Rates shall be deemed inadequate if they are clearly insufficient, together with the investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply.

4. A rating plan, including discounts, credits, or surcharges, shall be deemed unfairly discriminatory if it fails to clearly and equitably reflect consideration of the policyholder's participation in a risk management program adopted pursuant to s. 627.0625.

5. A rate shall be deemed inadequate as to the premium charged to a risk or group of risks if discounts or credits are allowed which exceed a reasonable reflection of expense savings and reasonably expected loss experience from the risk or group of risks.

6. A rate shall be deemed unfairly discriminatory as to a risk or group of risks if the application of premium discounts, credits, or surcharges among such risks does not bear a reasonable relationship to the expected loss and expense experience among the various risks.

(f) In reviewing a rate filing, the office may require the insurer to provide, at the insurer's expense, all information necessary to evaluate the condition of the company and the reasonableness of the filing according to the criteria enumerated in this section.

(g) The office may at any time review a rate, rating schedule, rating manual, or rate change; the pertinent records of the insurer; and market conditions. If the office finds on a preliminary basis that a rate may be excessive, inadequate, or unfairly discriminatory, the office shall initiate proceedings to disapprove the rate and shall so notify the insurer. However, the office may not disapprove as excessive any rate for which it has given final approval or which has been deemed approved for 1 year after the effective date of the filing unless the office finds that a material misrepresentation or material error was made by the insurer or was contained in the filing. Upon being notified, the insurer or rating organization shall, within 60 days, file with the office all information that, in the belief of the insurer or organization, proves the reasonableness, adequacy, and fairness of the rate or rate change. The office shall issue a notice of intent to approve or a notice of intent to disapprove pursuant to paragraph (a) within 90 days after receipt of the insurer's initial response. In such instances and in any administrative proceeding relating to the legality of the rate, the insurer or rating organization shall carry the burden of proof by a preponderance of the evidence to show that the rate is not excessive, inadequate, or unfairly discriminatory. After the office notifies an insurer that a rate may be excessive, inadequate, or unfairly discriminatory, unless the office withdraws the notification, the insurer may not alter the rate except to conform to the office's notice until the earlier of 120 days after the date the notification was provided or 180 days after the date of implementing the rate. The office, subject to chapter 120, may disapprove without the 60-day notification any rate increase filed by an insurer within the prohibited time period or during the time that the legality of the increased rate is being contested.

(h) If the office finds that a rate or rate change is excessive, inadequate, or unfairly discriminatory, the office shall issue an order of disapproval specifying that a new rate or rate schedule, which responds to the findings of the office, be filed by the insurer. The office shall further order, for any "use and file" filing made in accordance with subparagraph (a)2., that premiums charged each policyholder constituting the portion of the rate above that which was actuarially justified be returned to the policyholder in the form of a credit or refund. If the office finds that an insurer's rate or rate change is inadequate, the new rate or rate schedule filed with the office in response to such a finding is applicable only to new or renewal business of the insurer written on or after the effective date of the responsive filing.

(i) Except as otherwise specifically provided in this chapter, for property and casualty insurance the office may not directly or indirectly:

1. Prohibit any insurer, including any residual market plan or joint underwriting association, from paying acquisition costs based on the full amount of premium, as defined in s. 627.403, applicable to any policy, or prohibit any such insurer from including the full amount of acquisition costs in a rate filing; or

2. Impede, abridge, or otherwise compromise an insurer's right to acquire policyholders, advertise, or appoint agents, including the calculation, manner, or amount of such agent commissions, if any.

(j) With respect to residential property insurance rate filings, the rate filing must account for mitigation measures undertaken by policyholders to reduce hurricane losses.

(k)1. A residential property insurer may make a separate filing limited solely to an adjustment of its rates for reinsurance, the cost of financing products used as a replacement for reinsurance, financing costs incurred in the purchase of reinsurance, and the actual cost paid due to the application of the cash build-up factor pursuant to s. 215.555(5)(b) if the insurer:

a. Elects to purchase financing products such as a liquidity instrument or line of credit, in which case the cost included in filing for the liquidity instrument or line of credit may not result in a premium increase exceeding 3 percent for any individual policyholder. All costs

contained in the filing may not result in an overall premium increase of more than 15 percent for any individual policyholder.

b. Includes in the filing a copy of all of its reinsurance, liquidity instrument, or line of credit contracts; proof of the billing or payment for the contracts; and the calculation upon which the proposed rate change is based demonstrating that the costs meet the criteria of this section.

2. An insurer that purchases reinsurance or financing products from an affiliated company may make a separate filing only if the costs for such reinsurance or financing products are charged at or below charges made for comparable coverage by nonaffiliated reinsurers or financial entities making such coverage or financing products available in this state.

3. An insurer may make only one filing per 12-month period under this paragraph.

4. An insurer that elects to implement a rate change under this paragraph must file its rate filing with the office at least 45 days before the effective date of the rate change. After an insurer submits a complete filing that meets all of the requirements of this paragraph, the office has 45 days after the date of the filing to review the rate filing and determine if the rate is excessive, inadequate, or unfairly discriminatory.

The provisions of this subsection do not apply to workers' compensation, employer's liability insurance, and motor vehicle insurance.

(3)(a) For individual risks that are not rated in accordance with the insurer's rates, rating schedules, rating manuals, and underwriting rules filed with the office and that have been submitted to the insurer for individual rating, the insurer must maintain documentation on each risk subject to individual risk rating. The documentation must identify the named insured and specify the characteristics and classification of the risk supporting the reason for the risk being individually risk rated, including any modifications to existing approved forms to be used on the risk. The insurer must maintain these records for at least 5 years after the effective date of the policy.

(b) Individual risk rates and modifications to existing approved forms are not subject to this part or part II, except for paragraph (a) and ss. 627.402, 627.403, 627.4035, 627.404, 627.405, 627.406, 627.407, 627.4085, 627.409, 627.4132, 627.4133, 627.415, 627.416, 627.417, 627.419, 627.425, 627.426, 627.4265, 627.427, and 627.428, but are subject to all other applicable provisions of this code and rules adopted thereunder.

(c) This subsection does not apply to private passenger motor vehicle insurance.

(d)1. The following categories or kinds of insurance and types of commercial lines risks are not subject to paragraph (2)(a) or paragraph (2)(f):

a. Excess or umbrella.

b. Surety and fidelity.

c. Boiler and machinery and leakage and fire extinguishing equipment.

d. Errors and omissions.

e. Directors and officers, employment practices, fiduciary liability, and management liability.

f. Intellectual property and patent infringement liability.

g. Advertising injury and Internet liability insurance.

h. Property risks rated under a highly protected risks rating plan.

i. General liability.

j. Nonresidential property, except for collateral protection insurance as defined in s. 624.6085.

k. Nonresidential multiperil.

l. Excess property.

m. Burglary and theft.

n. Any other commercial lines categories or kinds of insurance or types of commercial lines risks that the office determines should not be subject to paragraph (2)(a) or paragraph

(2)(f) because of the existence of a competitive market for such insurance, similarity of such insurance to other categories or kinds of insurance not subject to paragraph (2)(a) or paragraph (2)(f), or to improve the general operational efficiency of the office.

2. Insurers or rating organizations shall establish and use rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on insurance and risks described in subparagraph 1. which are written in this state.

1 3. An insurer must notify the office of any changes to rates for insurance and risks described in subparagraph 1. within 30 days after the effective date of the change. The notice must include the name of the insurer, the type or kind of insurance subject to rate change, total premium written during the immediately preceding year by the insurer for the type or kind of insurance subject to the rate change, and the average statewide percentage change in rates. Underwriting files, premiums, losses, and expense statistics with regard to such insurance and risks written by an insurer must be maintained by the insurer and subject to examination by the office. Upon examination, the office, in accordance with generally accepted and reasonable actuarial techniques, shall consider the rate factors in paragraphs (2)(b), (c), and (d) and the standards in paragraph (2)(e) to determine if the rate is excessive, inadequate, or unfairly discriminatory.

4. A rating organization must notify the office of any changes to loss cost for insurance and risks described in subparagraph 1. within 30 days after the effective date of the change. The notice must include the name of the rating organization, the type or kind of insurance subject to a loss cost change, loss costs during the immediately preceding year for the type or kind of insurance subject to the loss cost change, and the average statewide percentage change in loss cost. Actuarial data with regard to changes to loss cost for risks not subject to paragraph (2)(a) or paragraph (2)(f) must be maintained by the rating organization for 2 years after the effective date of the change and are subject to examination by the office. The office may require the rating organization to incur the costs associated with an examination. Upon examination, the office, in accordance with generally accepted and reasonable actuarial techniques, shall consider the rate factors in paragraphs (2)(b)-(d) and the standards in paragraph (2)(e) to determine if the rate is excessive, inadequate, or unfairly discriminatory.

(4) The establishment of any rate, rating classification, rating plan or schedule, or variation thereof in violation of part IX of chapter 626 is also in violation of this section.

(5) With respect to a rate filing involving coverage of the type for which the insurer is required to pay a reimbursement premium to the Florida Hurricane Catastrophe Fund, the insurer may fully recoup in its property insurance premiums any reimbursement premiums paid to the fund, together with reasonable costs of other reinsurance; however, except as otherwise provided in this section, the insurer may not recoup reinsurance costs that duplicate coverage provided by the fund. An insurer may not recoup more than 1 year of reimbursement premium at a time. Any under-recoupment from the prior year may be added to the following year's reimbursement premium, and any over-recoupment must be subtracted from the following year's reimbursement premium.

(6)(a) If an insurer requests an administrative hearing pursuant to s. 120.57 related to a rate filing under this section, the director of the Division of Administrative Hearings shall expedite the hearing and assign an administrative law judge who shall commence the hearing within 30 days after the receipt of the formal request and enter a recommended order within 30 days after the hearing or within 30 days after receipt of the hearing transcript by the administrative law judge, whichever is later. Each party shall have 10 days in which to submit written exceptions to the recommended order. The office shall enter a final order within 30 days after the entry of the recommended order. The provisions of this paragraph may be waived upon stipulation of all parties.

(b) Upon entry of a final order, the insurer may request a expedited appellate review pursuant to the Florida Rules of Appellate Procedure. It is the intent of the Legislature that

the First District Court of Appeal grant an insurer's request for an expedited appellate review.

(7) The provisions of this subsection apply only to rates for medical malpractice insurance and control to the extent of any conflict with other provisions of this section.

(a) Any portion of a judgment entered or settlement paid as a result of a statutory or common-law bad faith action and any portion of a judgment entered which awards punitive damages against an insurer may not be included in the insurer's rate base and used to justify a rate or rate change. Any common-law bad faith action identified as such, any portion of a settlement entered as a result of a statutory or common-law action, or any portion of a settlement wherein an insurer agrees to pay specific punitive damages may not be used to justify a rate or rate change. The portion of the taxable costs and attorney's fees which is identified as being related to the bad faith and punitive damages may not be included in the insurer's rate base and used to justify a rate or rate change.

(b) Upon reviewing a rate filing and determining whether the rate is excessive, inadequate, or unfairly discriminatory, the office shall consider, in accordance with generally accepted and reasonable actuarial techniques, past and present prospective loss experience, using loss experience solely for this state or giving greater credibility to this state's loss data after applying actuarially sound methods of assigning credibility to such data.

(c) Rates shall be deemed excessive if, among other standards established by this section, the rate structure provides for replenishment of reserves or surpluses from premiums when the replenishment is attributable to investment losses.

(d) The insurer must apply a discount or surcharge based on the health care provider's loss experience or establish an alternative method giving due consideration to the provider's loss experience. The insurer must include in the filing a copy of the surcharge or discount schedule or a description of the alternative method used, and provide a copy, as approved by the office, to policyholders at the time of renewal and to prospective policyholders at the time of application for coverage.

(e) Each medical malpractice insurer must make a rate filing under this section, sworn to by at least two executive officers of the insurer, at least once each calendar year.

(8)(a) The chief executive officer or chief financial officer of a property insurer and the chief actuary of a property insurer must certify under oath and subject to the penalty of perjury, on a form approved by the commission, the following information, which must accompany a rate filing:

1. The signing officer and actuary have reviewed the rate filing;

2. Based on the signing officer's and actuary's knowledge, the rate filing does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading;

3. Based on the signing officer's and actuary's knowledge, the information and other factors described in paragraph (2)(b), including, but not limited to, investment income, fairly present in all material respects the basis of the rate filing for the periods presented in the filing; and

4. Based on the signing officer's and actuary's knowledge, the rate filing reflects all premium savings that are reasonably expected to result from legislative enactments and are in accordance with generally accepted and reasonable actuarial techniques.

(b) A signing officer or actuary who knowingly makes a false certification under this subsection commits a violation of s. 626.9541(1)(e) and is subject to the penalties under s. 626.9521.

(c) Failure to provide such certification by the officer and actuary shall result in the rate filing being disapproved without prejudice to be refiled.

(d) The certification made pursuant to paragraph (a) is not rendered false if, after making the subject rate filing, the insurer provides the office with additional or supplementary information pursuant to a formal or informal request from the office. However, the actuary

who is primarily responsible for preparing and submitting such information must certify the information in accordance with the certification required under paragraph (a) and the penalties in paragraph (b), except that the chief executive officer, chief financial officer, or chief actuary need not certify the additional or supplementary information.

(e) The commission may adopt rules and forms to administer this subsection.

(9) The burden is on the office to establish that rates are excessive for personal lines residential coverage with a dwelling replacement cost of $1 million or more or for a single condominium unit with a combined dwelling and contents replacement cost of $1 million or more. Upon request of the office, the insurer shall provide such loss and expense information as the office reasonably needs to meet this burden.

(10) Any interest paid pursuant to s. 627.70131(5) may not be included in the insurer's rate base and may not be used to justify a rate or rate change.

627.0629 Residential property insurance; rate filings.—

(1) It is the intent of the Legislature that insurers provide savings to consumers who install or implement windstorm damage mitigation techniques, alterations, or solutions to their properties to prevent windstorm losses. A rate filing for residential property insurance must include actuarially reasonable discounts, credits, or other rate differentials, or appropriate reductions in deductibles, for properties on which fixtures or construction techniques demonstrated to reduce the amount of loss in a windstorm have been installed or implemented. The fixtures or construction techniques must include, but are not limited to, fixtures or construction techniques that enhance roof strength, roof covering performance, roof-to-wall strength, wall-to-floor-to-foundation strength, opening protection, and window, door, and skylight strength. Credits, discounts, or other rate differentials, or appropriate reductions in deductibles, for fixtures and construction techniques that meet the minimum requirements of the Florida Building Code must be included in the rate filing. The office shall determine the discounts, credits, other rate differentials, and appropriate reductions in deductibles that reflect the full actuarial value of such revaluation, which may be used by insurers in rate filings.

(2)(a) A rate filing for residential property insurance made on or before the implementation of paragraph (b) may include rate factors that reflect the manner in which building code enforcement in a particular jurisdiction addresses the risk of wind damage; however, such a rate filing must also provide for variations from such rate factors on an individual basis based on an inspection of a particular structure by a licensed home inspector, which inspection may be at the cost of the insured.

(b) A rate filing for residential property insurance made more than 150 days after approval by the office of a building code rating factor plan submitted by a statewide rating organization shall include positive and negative rate factors that reflect the manner in which building code enforcement in a particular jurisdiction addresses risk of wind damage. The rate filing shall include variations from standard rate factors on an individual basis based on inspection of a particular structure by a licensed home inspector. If an inspection is requested by the insured, the insurer may require the insured to pay the reasonable cost of the inspection. This paragraph applies to structures constructed or renovated after the implementation of this paragraph.

(c) The premium notice shall specify the amount by which the rate has been adjusted as a result of this subsection and shall also specify the maximum possible positive and negative adjustments that are approved for use by the insurer under this subsection.

(3) A rate filing made on or after July 1, 1995, for mobile home owner's insurance must include appropriate discounts, credits, or other rate differentials for mobile homes constructed to comply with American Society of Civil Engineers Standard ANSI/ASCE 7-88, adopted by the United States Department of Housing and Urban Development on July 13, 1994, and that also comply with all applicable tie-down requirements provided by state law.

(4) The Legislature finds that separate consideration and notice of hurricane insurance premiums will assist consumers by providing greater assurance that hurricane premiums

are lawful and by providing more complete information regarding the components of property insurance premiums. Effective January 1, 1997, a rate filing for residential property insurance shall be separated into two components, rates for hurricane coverage and rates for all other coverages. A premium notice reflecting a rate implemented on the basis of such a filing shall separately indicate the premium for hurricane coverage and the premium for all other coverages.

(5) In order to provide an appropriate transition period, an insurer may implement an approved rate filing for residential property insurance over a period of years. Such insurer must provide an informational notice to the office setting out its schedule for implementation of the phased-in rate filing. The insurer may include in its rate the actual cost of private market reinsurance that corresponds to available coverage of the Temporary Increase in Coverage Limits, TICL, from the Florida Hurricane Catastrophe Fund. The insurer may also include the cost of reinsurance to replace the TICL reduction implemented pursuant to s. 215.555(17)(d)9. However, this cost for reinsurance may not include any expense or profit load or result in a total annual base rate increase in excess of 10 percent.

(6) Any rate filing that is based in whole or part on data from a computer model may not exceed 15 percent unless there is a public hearing.

(7) An insurer may implement appropriate discounts or other rate differentials of up to 10 percent of the annual premium to mobile home owners who provide to the insurer evidence of a current inspection of tie-downs for the mobile home, certifying that the tie-downs have been properly installed and are in good condition.

(8) A property insurance rate filing that includes any adjustments related to premiums paid to the Florida Hurricane Catastrophe Fund must include a complete calculation of the insurer's catastrophe load, and the information in the filing may not be limited solely to recovery of moneys paid to the fund.

627.0645 Annual filings.—

(1) Each rating organization filing rates for, and each insurer writing, any line of property or casualty insurance to which this part applies, except:

(a) Workers' compensation and employer's liability insurance; or

(b) Commercial property and casualty insurance as defined in s. 627.0625(1) other than commercial multiple line and commercial motor vehicle,

shall make an annual base rate filing for each such line with the office no later than 12 months after its previous base rate filing, demonstrating that its rates are not inadequate.

(2)(a) Deviations filed by an insurer to any rating organization's base rate filing are not subject to this section.

(b) The office, after receiving a request to be exempted from the provisions of this section, may, for good cause due to insignificant numbers of policies in force or insignificant premium volume, exempt a company, by line of coverage, from filing rates or rate certification as required by this section.

(3) The filing requirements of this section shall be satisfied by one of the following methods:

(a) A rate filing prepared by an actuary which contains documentation demonstrating that the proposed rates are not excessive, inadequate, or unfairly discriminatory pursuant to the applicable rating laws and pursuant to rules of the commission.

(b) If no rate change is proposed, a filing which consists of a certification by an actuary that the existing rate level produces rates which are actuarially sound and which are not inadequate, as defined in s. 627.062.

(4) An insurer may satisfy the annual filing requirements of this section by being a member or subscriber of a licensed rating organization which complies with the requirements of this section.

(5) If an insurer does not employ or otherwise retain the services of an actuary, the insurer's rate filing or certification that rates are actuarially sound shall be prepared by insurer personnel or consultants with a minimum of 5 years' experience in insurance ratemaking. A rate filing or certification prepared by a consultant must be reviewed and signed by an employee of the insurer who is authorized to approve rate filings.

(6) If at the time a filing is required under this section an insurer is in the process of completing a rate review, the insurer may apply to the office for an extension of up to an additional 30 days in which to make the filing. The request for extension must be received by the office no later than the date the filing is due.

(7) Nothing in this section limits the office's authority to review rates at any time or to find that a rate or rate change is excessive, inadequate, or unfairly discriminatory pursuant to s. 627.062.

(8) As used in this section, the term "actuary" means an individual who is a member of the Casualty Actuarial Society.

(9) If an insurer fails to meet the filing requirements of this section and does not submit the filing within 60 days after the date the filing is due, the office may, in addition to any other penalty authorized by law, order the insurer to discontinue the issuance of policies for the line of insurance for which the required filing was not made until such time as the office determines that the required filing is properly submitted.

M E M O R A N D U M

DATE: January 11, 2013

TO: Kevin M. McCarty, Commissioner, Office of Insurance Regulation

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Jason Nelson

SUBJECT: Cabinet Agenda for February 7, 2013
Request for Final Approval to Adopt Amendments to
Rule 69O-176.013
Notification of Insured's Rights and Standard Disclosure Form
Assignment # 129415-12

The Office of Insurance Regulation requests that this proposed rule amendment be presented to the Cabinet aides on or before January 30, 2013 and to the Financial Services Commission on February 7, 2013, with a request for Final Approval to Adopt the proposed rule amendment. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on January 11, 2013.

The notice of proposed rule was published on December 17, 2012 in Volume 38, No. 92, of the *Register.* A hearing was not requested, therefore, a hearing was not held.

The purpose of this rule amendment is to update and revise Form OIR-B1-1149 " Notification of Personal Injury Protection Benefits" in accordance with revisions to the PIP law as amended by HB119 (Chapter 2012-197, Laws of Florida). The form was revised to reflect that PIP benefits are now allocated for emergency medical treatment and a flat $5,000 death benefit. The form was also revised to incorporate technical edits regarding fraud reporting and billing disclosures.

Sections 624.308(1), 627.7401(1), 624.307(1), 627.736, 627.7401, 627.745, F.S., provide rulemaking authority and laws implemented for this rule.

The Legal Services Office has communicated with the Joint Administrative Procedures Committee, and ascertained that their review of this rule has been completed.

Stephen Fredrickson is the attorney handling this rule. Attached are: 1) the proposed rule(s); 2) any incorporated materials, such as forms; 3) copies of the rulemaking statutory authority and law implemented.

Approved for signature:

Belinda Miller, General Counsel

Approved for submission to Financial Services Commission:

Kevin M. McCarty, Commissioner
Office of Insurance Regulation

69O-176.013 Notification of Insured's Rights and Standard Disclosure Form; Personal Injury Protection Benefits.

(1) Each insurer issuing a policy in this state providing personal injury protection benefits shall mail or deliver Form OIR-B1-1149 (Revised 01/2013 ~~8/30/06~~) "Notification of Personal Injury Protection Benefits" to an insured within 21 days after receiving from the insured notice of an automobile accident or claim involving personal injury to an insured who is covered under the policy.

(2) and (3) no change

Rulemaking Authority 624.308(1), 627.7401(1) FS. Law Implemented 624.307(1), 627.736, 627.7401, 627.745 FS. History–New 10-1-94, Amended 12-6-00, 1-20-02, Formerly 4-176.013, Amended 3-8-04, 8-23-07,_____.

NOTIFICATION OF PERSONAL INJURY PROTECTION BENEFITS
YOUR PERSONAL INJURY PROTECTION RIGHTS AND BENEFITS UNDER THE FLORIDA MOTOR VEHICLE NO-FAULT LAW

The Florida Motor Vehicle No-Fault Law does two things:

(1) It establishes a limited exemption from liability for injuries caused to others in an automobile accident; and

(2) It establishes personal injury protection (PIP) benefits to pay for certain losses resulting from an accident.

LEGAL RESPONSIBILITIES AND RIGHTS

Who is covered?

(1) If you are a resident of Florida and own a motor vehicle, you are required to purchase PIP. You are covered by PIP if you are the named insured. You, the insured, are covered by PIP while driving your vehicle or when a passenger in another's vehicle. You are also covered while outside a motor vehicle if struck and injured by a motor vehicle.

(2) Resident relatives who live with you, the insured, may be covered by your PIP benefits while they are driving your car, as passengers in your or another's car, and while pedestrians if struck and injured by a motor vehicle.

(3) Others who are injured while driving your insured motor vehicle or who are injured while a passenger in your insured motor vehicle or who are injured as a pedestrian when struck by your insured motor vehicle may be covered by your PIP.

(4) If you or your insured relatives living with you are injured while outside Florida, and are in your insured motor vehicle, you and your insured relatives are covered under PIP as long as the injury occurs within the United States, its territories or possessions, or in Canada.

FRAUD ADVISORY NOTICE: Solicitation of a person injured in a motor vehicle crash for purposes of filing personal injury protection or tort claims could be a violation of Florida law or the rules regulating The Florida Bar and should be immediately reported to the Division of Insurance Fraud on-line at www.MyFloridaCFO.com/fraud or by calling 1-800-378-0445 from within Florida or 850-413-3261 from outside of Florida.

EXCEPTIONS

If your passengers or relatives living with you have a motor vehicle licensed in Florida or own a motor vehicle required to be licensed in Florida, they are not covered by your PIP coverage. They must purchase PIP for themselves to have coverage.

EXCLUSIONS

An insurer may exclude no-fault benefits:

(1) For injury sustained by any person operating the insured motor vehicle without your express or implied consent.

(2) To any injured person, if his/her conduct contributed to the injury under either of the following circumstances:

(a) causing injury to himself intentionally; or

(b) being injured while committing a felony.

(3) For injuries sustained by the named insured and relatives residing in the same household while occupying another motor vehicle owned by the named insured and not insured under the policy.

BENEFITS

The minimum limits for no-fault personal injury protection benefits are:

- $10,000 per person for loss resulting from bodily injury, sickness, or disease arising out of the ownership, maintenance, or use of a motor vehicle if a physician, dentist, physician assistant, or advanced registered nurse practitioner has determined that the injured person had an emergency medical condition.
- $2,500 per person for loss resulting from bodily injury, sickness, or disease arising out of the ownership, maintenance, or use of a motor vehicle if a physician, dentist, chiropractic physician, physician assistant, advanced registered nurse practitioner, physical therapist or person licensed to provide emergency transportation and treatment has determined that the injured person did not have an emergency medical condition,
- Disability benefits, which combined with medical benefits cannot exceed $10,000, and
- $5,000 per individual for death benefits.

MEDICAL PAYMENTS

PIP medical benefits pays 80 percent of for all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices and medically necessary ambulance, hospital and nursing services. Medical benefits are only paid if the individual receives initial services and care within 14 days after the motor vehicle accident. Medical benefits do not include massage or acupuncture, regardless of the person, entity, or licensee providing massage or acupuncture and a licensed massage therapist or licensed acupuncturist may not be reimbursed for medical benefits.

Note: If you have medical payments coverage through your auto insurance policy, then the medical payments coverage will be secondary to PIP coverage. The excess medical expenses, the 20 percent not covered by PIP, and the deductible may or may not be covered by the additional medical payments coverage depending on your particular policy.

BILLING REQUIREMENTS

Florida law provides that with respect to any treatment or services, other than certain hospital and emergency services, the statement of charges furnished to the insurer by the provider may not include, and the insurer and the injured party are not required to pay, charges for treatment or services rendered more than 35 days before the postmark date of the statement, except for past due amounts previously billed on a timely basis, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement. The insured has a responsibility to furnish the provider with the correct name and address of the personal injury protection insurer. Failure to do so may result in delayed reimbursements to the provider.

At your initial treatment or service provided you will be required to sign a disclosure and acknowledgement form stating that the services were actually rendered, it is your right and duty to confirm that those services were rendered, you were not solicited to seek services from the provider, the provider explained the services, and if you notify the insurer of a billing error you may be entitled to a share of the insurer's savings.

ADVISORY NOTICE: You may be entitled to a certain percentage of a reduction in the amount paid by the motor vehicle insurer if you notify that insurer of a billing error.

DISABILITY BENEFITS

PIP pays 60 percent of disability benefits for any loss of gross income and loss of earning capacity per individual from inability to work because of an injury sustained in an accident. Disability benefits also cover all expenses reasonably incurred for household services that, if not for injury, the injured person would have performed. Benefits must be paid not less than every two weeks.

DEATH BENEFITS

PIP pays $5,000 per individual in death benefits. Death benefits are in addition to the medical and disability benefits provided under the insurance policy. The insurer may pay death benefits to the executor or administrator of the deceased, to any of the deceased's relatives, including those related by marriage, or to any person appearing to the insurer to be equitably entitled to the payment.

OPTIONAL DEDUCTIBLES AND LIMITATIONS

1. Persons subject to deductibles may be able to recover the amount of the deductible from a tortfeasor otherwise exempt from liability under Section 627.737, F.S.
2. Deductibles must be applied to the entire amount of any expenses and losses described under required personal injury protection benefits. After the deductible is met, each insured is eligible to receive up to $10,000 in benefits. Thus, for instance, an insured with a $1,000 deductible would have to incur $13,500 in medical expenses (assuming no disability or death benefits) in order to receive the entire $10,000 in benefits [($13,500-$1,000) x 80%].
3. Deductibles of $250, $500 and $1,000 must be offered but may not be required.
4. You may have elected that the benefits from loss of gross income and loss of earning capacity (disability benefits) be excluded from your PIP benefits.

COORDINATION OF BENEFITS

PIP benefits are primary over other insurance coverage, except that workers' compensation benefits received will be credited against PIP benefits. This means that your PIP

insurer is ultimately responsible for payment of your claim. How this works in a specific situation depends upon the contract language in the other insurance policy.

PAYMENT OF BENEFITS

PIP benefits will be payable as loss accrues and reasonable proof of the loss and the expenses are provided. Before PIP benefits are paid, an insurer may require written notice be given as soon as possible after an accident involving a motor vehicle.

PIP benefits are overdue if not paid within 30 days after the insurer is provided written notice of a covered loss and of the total amount of the claim. If a partial claim is made, that partial amount must be paid within 30 days after the insurer receives written notice.

Any part, or all of the remainder, of the claim that is later supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer. However, any payment shall not be deemed overdue when the insurer has reasonable proof showing that the insurer is not responsible for the payment even though written notice has been furnished to the insurer.

For the purpose of calculating overdue payments, payment is considered as being made on the date it was postmarked or, if not posted, on the date of delivery. All overdue payments will pay simple interest at the rate established in your policy, or pursuant to s. 55.03, F.S., whichever is greater.

WHAT DO I DO TO RESOLVE DISPUTES REGARDING PIP BENEFITS?

(1) In the event you are having a dispute with the insurer for PIP benefits, you may demand mediation of the claim before resorting to the courts by filing a request with the Department of Financial Services "Department" on Form DFS-10-510 provided by the Department.

(2) Mediation is an informal process whereby a neutral mediator selected by the Department will work together with you and the insurer to resolve the dispute.

You may reach the Department at 877-693-5236 within Florida or 850-413-3089 from out of state.

PLEASE NOTE: This description of your rights contains general statements and should not be construed to enhance, alter, or amend your rights under your policy and Florida law.

FRAUD ADVISORY NOTICE: The Department of Financial Services may pay rewards of up to $25,000 to persons providing information leading to the arrest and conviction of persons committing crimes investigated by the Division of Insurance Fraud arising from violations of certain Florida Statutes. You may report such fraud on-line at www.MyFloridaCFO.com/fraud or by calling 1-800-378-0445 from within Florida or 850-413-3261 from outside of Florida.

69O-176.013
Rulemaking Authority

624.308 Rules.—

(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.

627.7401 Notification of insured's rights.—

(1) The commission, by rule, shall adopt a form for the notification of insureds of their right to receive personal injury protection benefits under the Florida Motor Vehicle No-Fault Law. Such notice shall include:

(a) A description of the benefits provided by personal injury protection, including, but not limited to, the specific types of services for which medical benefits are paid, disability benefits, death benefits, significant exclusions from and limitations on personal injury protection benefits, when payments are due, how benefits are coordinated with other insurance benefits that the insured may have, penalties and interest that may be imposed on insurers for failure to make timely payments of benefits, and rights of parties regarding disputes as to benefits.

(b) An advisory informing insureds that:

1. Pursuant to s. 626.9892, the Department of Financial Services may pay rewards of up to $25,000 to persons providing information leading to the arrest and conviction of persons committing crimes investigated by the Division of Insurance Fraud arising from violations of s. 440.105, s. 624.15, s. 626.9541, s. 626.989, or s. 817.234.

2. Pursuant to s. 627.736(5)(e)1., if the insured notifies the insurer of a billing error, the insured may be entitled to a certain percentage of a reduction in the amount paid by the insured's motor vehicle insurer.

(c) A notice that solicitation of a person injured in a motor vehicle crash for purposes of filing personal injury protection or tort claims could be a violation of s. 817.234, s 817.505, or the rules regulating The Florida Bar and should be immediately reported to the Division of Insurance Fraud if such conduct has taken place.

(2) Each insurer issuing a policy in this state providing personal injury protection benefits must mail or deliver the notice as specified in subsection (1) to an insured within 21 days after receiving from the insured notice of an automobile accident or claim involving personal injury to an insured who is covered under the policy. The office may allow an insurer additional time to provide the notice specified in subsection (1) not to exceed 30 days, upon a showing by the insurer that an emergency justifies an extension of time.

(3) The notice required by this section does not alter or modify the terms of the insurance contract or other requirements of this act.

624.307 General powers; duties.—

(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

627.736 Required personal injury protection benefits; exclusions; priority; claims.—

(1) REQUIRED BENEFITS.—An insurance policy complying with the security requirements of s. 627.733 must provide personal injury protection to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in the motor vehicle, and other persons struck by the motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to subsection (2) and paragraph (4)(e), to a limit of $10,000 in medical and disability benefits and $5,000 in death benefits resulting from bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:

(a) Medical benefits.—Eighty percent of all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices and medically necessary ambulance, hospital, and nursing services if the individual receives

initial services and care pursuant to subparagraph 1. within 14 days after the motor vehicle accident. The medical benefits provide reimbursement only for:

1. Initial services and care that are lawfully provided, supervised, ordered, or prescribed by a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, or a chiropractic physician licensed under chapter 460 or that are provided in a hospital or in a facility that owns, or is wholly owned by, a hospital. Initial services and care may also be provided by a person or entity licensed under part III of chapter 401 which provides emergency transportation and treatment.

2. Upon referral by a provider described in subparagraph 1., followup services and care consistent with the underlying medical diagnosis rendered pursuant to subparagraph 1. which may be provided, supervised, ordered, or prescribed only by a physician licensed under chapter 458 or chapter 459, a chiropractic physician licensed under chapter 460, a dentist licensed under chapter 466, or, to the extent permitted by applicable law and under the supervision of such physician, osteopathic physician, chiropractic physician, or dentist, by a physician assistant licensed under chapter 458 or chapter 459 or an advanced registered nurse practitioner licensed under chapter 464. Followup services and care may also be provided by any of the following persons or entities:

a. A hospital or ambulatory surgical center licensed under chapter 395.

b. An entity wholly owned by one or more physicians licensed under chapter 458 or chapter 459, chiropractic physicians licensed under chapter 460, or dentists licensed under chapter 466 or by such practitioners and the spouse, parent, child, or sibling of such practitioners.

c. An entity that owns or is wholly owned, directly or indirectly, by a hospital or hospitals.

d. A physical therapist licensed under chapter 486, based upon a referral by a provider described in this subparagraph.

e. A health care clinic licensed under part X of chapter 400 which is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, or the Accreditation Association for Ambulatory Health Care, Inc., or

(I) Has a medical director licensed under chapter 458, chapter 459, or chapter 460;

(II) Has been continuously licensed for more than 3 years or is a publicly traded corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange; and

(III) Provides at least four of the following medical specialties:

(A) General medicine.

(B) Radiography.

(C) Orthopedic medicine.

(D) Physical medicine.

(E) Physical therapy.

(F) Physical rehabilitation.

(G) Prescribing or dispensing outpatient prescription medication.

(H) Laboratory services.

3. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. up to $10,000 if a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, a physician assistant licensed under chapter 458 or chapter 459, or an advanced registered nurse practitioner licensed under chapter 464 has determined that the injured person had an emergency medical condition.

4. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. is limited to $2,500 if any provider listed in subparagraph 1. or subparagraph 2. determines that the injured person did not have an emergency medical condition.

5. Medical benefits do not include massage as defined in s. 480.033 or acupuncture as defined in s. 457.102, regardless of the person, entity, or licensee providing massage or

acupuncture, and a licensed massage therapist or licensed acupuncturist may not be reimbursed for medical benefits under this section.

6. The Financial Services Commission shall adopt by rule the form that must be used by an insurer and a health care provider specified in sub-subparagraph 2.b., sub-subparagraph 2.c., or sub-subparagraph 2.e. to document that the health care provider meets the criteria of this paragraph, which rule must include a requirement for a sworn statement or affidavit.

(b) Disability benefits.—Sixty percent of any loss of gross income and loss of earning capacity per individual from inability to work proximately caused by the injury sustained by the injured person, plus all expenses reasonably incurred in obtaining from others ordinary and necessary services in lieu of those that, but for the injury, the injured person would have performed without income for the benefit of his or her household. All disability benefits payable under this provision must be paid at least every 2 weeks.

(c) Death benefits.—Death benefits of $5,000 per individual. Death benefits are in addition to the medical and disability benefits provided under the insurance policy. The insurer may pay death benefits to the executor or administrator of the deceased, to any of the deceased's relatives by blood, legal adoption, or marriage, or to any person appearing to the insurer to be equitably entitled to such benefits.

Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and such insurer may not require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for providing such benefits. Insurers may not require that property damage liability insurance in an amount greater than $10,000 be purchased in conjunction with personal injury protection. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. An insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice violates part IX of chapter 626, and such violation constitutes an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance. An insurer committing such violation is subject to the penalties provided under that part, as well as those provided elsewhere in the insurance code.

(2) AUTHORIZED EXCLUSIONS.—Any insurer may exclude benefits:

(a) For injury sustained by the named insured and relatives residing in the same household while occupying another motor vehicle owned by the named insured and not insured under the policy or for injury sustained by any person operating the insured motor vehicle without the express or implied consent of the insured.

(b) To any injured person, if such person's conduct contributed to his or her injury under any of the following circumstances:

1. Causing injury to himself or herself intentionally; or
2. Being injured while committing a felony.

Whenever an insured is charged with conduct as set forth in subparagraph 2., the 30-day payment provision of paragraph (4)(b) shall be held in abeyance, and the insurer shall withhold payment of any personal injury protection benefits pending the outcome of the case at the trial level. If the charge is nolle prossed or dismissed or the insured is acquitted, the 30-day payment provision shall run from the date the insurer is notified of such action.

(3) INSURED'S RIGHTS TO RECOVERY OF SPECIAL DAMAGES IN TORT CLAIMS.—No insurer shall have a lien on any recovery in tort by judgment, settlement, or otherwise for personal injury protection benefits, whether suit has been filed or settlement has been reached without suit. An injured party who is entitled to bring suit under the provisions of ss. 627.730-627.7405, or his or her legal representative, shall have no right to recover any damages for which personal injury protection benefits are paid or payable. The plaintiff may prove all of his or her special damages notwithstanding this limitation, but if special

damages are introduced in evidence, the trier of facts, whether judge or jury, shall not award damages for personal injury protection benefits paid or payable. In all cases in which a jury is required to fix damages, the court shall instruct the jury that the plaintiff shall not recover such special damages for personal injury protection benefits paid or payable.

(4) PAYMENT OF BENEFITS.—Benefits due from an insurer under ss. 627.730-627.7405 are primary, except that benefits received under any workers' compensation law must be credited against the benefits provided by subsection (1) and are due and payable as loss accrues upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued under ss. 627.730-627.7405. If the Agency for Health Care Administration provides, pays, or becomes liable for medical assistance under the Medicaid program related to injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle, the benefits under ss. 627.730-627.7405 are subject to the Medicaid program. However, within 30 days after receiving notice that the Medicaid program paid such benefits, the insurer shall repay the full amount of the benefits to the Medicaid program.

(a) An insurer may require written notice to be given as soon as practicable after an accident involving a motor vehicle with respect to which the policy affords the security required by ss. 627.730-627.7405.

(b) Personal injury protection insurance benefits paid pursuant to this section are overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same. However:

1. If written notice of the entire claim is not furnished to the insurer, any partial amount supported by written notice is overdue if not paid within 30 days after written notice is furnished to the insurer. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within 30 days after written notice is furnished to the insurer.

2. If an insurer pays only a portion of a claim or rejects a claim, the insurer shall provide at the time of the partial payment or rejection an itemized specification of each item that the insurer had reduced, omitted, or declined to pay and any information that the insurer desires the claimant to consider related to the medical necessity of the denied treatment or to explain the reasonableness of the reduced charge if this does not limit the introduction of evidence at trial. The insurer must also include the name and address of the person to whom the claimant should respond and a claim number to be referenced in future correspondence.

3. If an insurer pays only a portion of a claim or rejects a claim due to an alleged error in the claim, the insurer, at the time of the partial payment or rejection, shall provide an itemized specification or explanation of benefits due to the specified error. Upon receiving the specification or explanation, the person making the claim, at the person's option and without waiving any other legal remedy for payment, has 15 days to submit a revised claim, which shall be considered a timely submission of written notice of a claim.

4. Notwithstanding the fact that written notice has been furnished to the insurer, payment is not overdue if the insurer has reasonable proof that the insurer is not responsible for the payment.

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

6. This paragraph does not preclude or limit the ability of the insurer to assert that the claim was unrelated, was not medically necessary, or was unreasonable or that the amount of the charge was in excess of that permitted under, or in violation of, subsection (5). Such assertion may be made at any time, including after payment of the claim or after the 30-day period for payment set forth in this paragraph.

(c) Upon receiving notice of an accident that is potentially covered by personal injury protection benefits, the insurer must reserve $5,000 of personal injury protection benefits for payment to physicians licensed under chapter 458 or chapter 459 or dentists licensed under chapter 466 who provide emergency services and care, as defined in s. 395.002, or who provide hospital inpatient care. The amount required to be held in reserve may be used only to pay claims from such physicians or dentists until 30 days after the date the insurer receives notice of the accident. After the 30-day period, any amount of the reserve for which the insurer has not received notice of such claims may be used by the insurer to pay other claims. The time periods specified in paragraph (b) for payment of personal injury protection benefits are tolled for the period of time that an insurer is required to hold payment of a claim that is not from such physician or dentist to the extent that the personal injury protection benefits not held in reserve are insufficient to pay the claim. This paragraph does not require an insurer to establish a claim reserve for insurance accounting purposes.

(d) All overdue payments bear simple interest at the rate established under s. 55.03 or the rate established in the insurance contract, whichever is greater, for the quarter in which the payment became overdue, calculated from the date the insurer was furnished with written notice of the amount of covered loss. Interest is due at the time payment of the overdue claim is made.

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

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

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

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

4. Accidental bodily injury sustained in this state by any other person while occupying the owner's motor vehicle or, if a resident of this state, while not an occupant of a self-propelled vehicle if the injury is caused by physical contact with such motor vehicle, if the injured person is not:

a. The owner of a motor vehicle with respect to which security is required under ss. 627.730-627.7405; or

b. Entitled to personal injury benefits from the insurer of the owner of such a motor vehicle.

(f) If two or more insurers are liable for paying personal injury protection benefits for the same injury to any one person, the maximum payable is as specified in subsection (1), and the insurer paying the benefits is entitled to recover from each of the other insurers an equitable pro rata share of the benefits paid and expenses incurred in processing the claim.

(g) It is a violation of the insurance code for an insurer to fail to timely provide benefits as required by this section with such frequency as to constitute a general business practice.

(h) Benefits are not due or payable to or on the behalf of an insured person if that person has committed, by a material act or omission, insurance fraud relating to personal injury protection coverage under his or her policy, if the fraud is admitted to in a sworn statement by the insured or established in a court of competent jurisdiction. Any insurance fraud voids all coverage arising from the claim related to such fraud under the personal injury protection coverage of the insured person who committed the fraud, irrespective of whether a portion of the insured person's claim may be legitimate, and any benefits paid before the

discovery of the fraud is recoverable by the insurer in its entirety from the person who committed insurance fraud. The prevailing party is entitled to its costs and attorney fees in any action in which it prevails in an insurer's action to enforce its right of recovery under this paragraph.

(i) If an insurer has a reasonable belief that a fraudulent insurance act, for the purposes of s. 626.989 or s. 817.234, has been committed, the insurer shall notify the claimant, in writing, within 30 days after submission of the claim that the claim is being investigated for suspected fraud. Beginning at the end of the initial 30-day period, the insurer has an additional 60 days to conduct its fraud investigation. Notwithstanding subsection (10), no later than 90 days after the submission of the claim, the insurer must deny the claim or pay the claim with simple interest as provided in paragraph (d). Interest shall be assessed from the day the claim was submitted until the day the claim is paid. All claims denied for suspected fraudulent insurance acts shall be reported to the Division of Insurance Fraud.

(j) An insurer shall create and maintain for each insured a log of personal injury protection benefits paid by the insurer on behalf of the insured. If litigation is commenced, the insurer shall provide to the insured a copy of the log within 30 days after receiving a request for the log from the insured.

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

(a) A physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for a bodily injury covered by personal injury protection insurance may charge the insurer and injured party only a reasonable amount pursuant to this section for the services and supplies rendered, and the insurer providing such coverage may pay for such charges directly to such person or institution lawfully rendering such treatment if the insured receiving such treatment or his or her guardian has countersigned the properly completed invoice, bill, or claim form approved by the office upon which such charges are to be paid for as having actually been rendered, to the best knowledge of the insured or his or her guardian. However, such a charge may not exceed the amount the person or institution customarily charges for like services or supplies. In determining whether a charge for a particular service, treatment, or otherwise is reasonable, consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, reimbursement levels in the community and various federal and state medical fee schedules applicable to motor vehicle and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply.

1. The insurer may limit reimbursement to 80 percent of the following schedule of maximum charges:

a. For emergency transport and treatment by providers licensed under chapter 401, 200 percent of Medicare.

b. For emergency services and care provided by a hospital licensed under chapter 395, 75 percent of the hospital's usual and customary charges.

c. For emergency services and care as defined by s. 395.002 provided in a facility licensed under chapter 395 rendered by a physician or dentist, and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community.

d. For hospital inpatient services, other than emergency services and care, 200 percent of the Medicare Part A prospective payment applicable to the specific hospital providing the inpatient services.

e. For hospital outpatient services, other than emergency services and care, 200 percent of the Medicare Part A Ambulatory Payment Classification for the specific hospital providing the outpatient services.

f. For all other medical services, supplies, and care, 200 percent of the allowable amount under:

(I) The participating physicians fee schedule of Medicare Part B, except as provided in sub-sub-subparagraphs (II) and (III).

(II) Medicare Part B, in the case of services, supplies, and care provided by ambulatory surgical centers and clinical laboratories.

(III) The Durable Medical Equipment Prosthetics/Orthotics and Supplies fee schedule of Medicare Part B, in the case of durable medical equipment.

However, if such services, supplies, or care is not reimbursable under Medicare Part B, as provided in this sub-subparagraph, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers' compensation, as determined under s. 440.13 and rules adopted thereunder which are in effect at the time such services, supplies, or care is provided. Services, supplies, or care that is not reimbursable under Medicare or workers' compensation is not required to be reimbursed by the insurer.

2. For purposes of subparagraph 1., the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect on March 1 of the year in which the services, supplies, or care is rendered and for the area in which such services, supplies, or care is rendered, and the applicable fee schedule or payment limitation applies throughout the remainder of that year, notwithstanding any subsequent change made to the fee schedule or payment limitation, except that it may not be less than the allowable amount under the applicable schedule of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B.

3. Subparagraph 1. does not allow the insurer to apply any limitation on the number of treatments or other utilization limits that apply under Medicare or workers' compensation. An insurer that applies the allowable payment limitations of subparagraph 1. must reimburse a provider who lawfully provided care or treatment under the scope of his or her license, regardless of whether such provider is entitled to reimbursement under Medicare due to restrictions or limitations on the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes. However, subparagraph 1. does not prohibit an insurer from using the Medicare coding policies and payment methodologies of the federal Centers for Medicare and Medicaid Services, including applicable modifiers, to determine the appropriate amount of reimbursement for medical services, supplies, or care if the coding policy or payment methodology does not constitute a utilization limit.

4. If an insurer limits payment as authorized by subparagraph 1., the person providing such services, supplies, or care may not bill or attempt to collect from the insured any amount in excess of such limits, except for amounts that are not covered by the insured's personal injury protection coverage due to the coinsurance amount or maximum policy limits.

5. Effective July 1, 2012, an insurer may limit payment as authorized by this paragraph only if the insurance policy includes a notice at the time of issuance or renewal that the insurer may limit payment pursuant to the schedule of charges specified in this paragraph. A policy form approved by the office satisfies this requirement. If a provider submits a charge for an amount less than the amount allowed under subparagraph 1., the insurer may pay the amount of the charge submitted.

(b)1. An insurer or insured is not required to pay a claim or charges:

a. Made by a broker or by a person making a claim on behalf of a broker;

b. For any service or treatment that was not lawful at the time rendered;

c. To any person who knowingly submits a false or misleading statement relating to the claim or charges;

d. With respect to a bill or statement that does not substantially meet the applicable requirements of paragraph (d);

e. For any treatment or service that is upcoded, or that is unbundled when such treatment or services should be bundled, in accordance with paragraph (d). To facilitate prompt payment of lawful services, an insurer may change codes that it determines have been

improperly or incorrectly upcoded or unbundled and may make payment based on the changed codes, without affecting the right of the provider to dispute the change by the insurer, if, before doing so, the insurer contacts the health care provider and discusses the reasons for the insurer's change and the health care provider's reason for the coding, or makes a reasonable good faith effort to do so, as documented in the insurer's file; and

f. For medical services or treatment billed by a physician and not provided in a hospital unless such services are rendered by the physician or are incident to his or her professional services and are included on the physician's bill, including documentation verifying that the physician is responsible for the medical services that were rendered and billed.

2. The Department of Health, in consultation with the appropriate professional licensing boards, shall adopt, by rule, a list of diagnostic tests deemed not to be medically necessary for use in the treatment of persons sustaining bodily injury covered by personal injury protection benefits under this section. The list shall be revised from time to time as determined by the Department of Health, in consultation with the respective professional licensing boards. Inclusion of a test on the list shall be based on lack of demonstrated medical value and a level of general acceptance by the relevant provider community and may not be dependent for results entirely upon subjective patient response. Notwithstanding its inclusion on a fee schedule in this subsection, an insurer or insured is not required to pay any charges or reimburse claims for an invalid diagnostic test as determined by the Department of Health.

(c) With respect to any treatment or service, other than medical services billed by a hospital or other provider for emergency services and care as defined in s. 395.002 or inpatient services rendered at a hospital-owned facility, the statement of charges must be furnished to the insurer by the provider and may not include, and the insurer is not required to pay, charges for treatment or services rendered more than 35 days before the postmark date or electronic transmission date of the statement, except for past due amounts previously billed on a timely basis under this paragraph, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement. The injured party is not liable for, and the provider may not bill the injured party for, charges that are unpaid because of the provider's failure to comply with this paragraph. Any agreement requiring the injured person or insured to pay for such charges is unenforceable.

1. If the insured fails to furnish the provider with the correct name and address of the insured's personal injury protection insurer, the provider has 35 days from the date the provider obtains the correct information to furnish the insurer with a statement of the charges. The insurer is not required to pay for such charges unless the provider includes with the statement documentary evidence that was provided by the insured during the 35-day period demonstrating that the provider reasonably relied on erroneous information from the insured and either:

a. A denial letter from the incorrect insurer; or

b. Proof of mailing, which may include an affidavit under penalty of perjury, reflecting timely mailing to the incorrect address or insurer.

2. For emergency services and care rendered in a hospital emergency department or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401, the provider is not required to furnish the statement of charges within the time periods established by this paragraph, and the insurer is not considered to have been furnished with notice of the amount of covered loss for purposes of paragraph (4)(b) until it receives a statement complying with paragraph (d), or copy thereof, which specifically identifies the place of service to be a hospital emergency department or an ambulance in accordance with billing standards recognized by the federal Centers for Medicare and Medicaid Services.

3. Each notice of the insured's rights under s. 627.7401 must include the following statement in at least 12-point type:

BILLING REQUIREMENTS.—Florida law provides that with respect to any treatment or services, other than certain hospital and emergency services, the statement of charges furnished to the insurer by the provider may not include, and the insurer and the injured party are not required to pay, charges for treatment or services rendered more than 35 days before the postmark date of the statement, except for past due amounts previously billed on a timely basis, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement.

(d) All statements and bills for medical services rendered by a physician, hospital, clinic, or other person or institution shall be submitted to the insurer on a properly completed Centers for Medicare and Medicaid Services (CMS) 1500 form, UB 92 forms, or any other standard form approved by the office or adopted by the commission for purposes of this paragraph. All billings for such services rendered by providers must, to the extent applicable, follow the Physicians' Current Procedural Terminology (CPT) or Healthcare Correct Procedural Coding System (HCPCS), or ICD-9 in effect for the year in which services are rendered and comply with the CMS 1500 form instructions, the American Medical Association CPT Editorial Panel, and the HCPCS. All providers, other than hospitals, must include on the applicable claim form the professional license number of the provider in the line or space provided for "Signature of Physician or Supplier, Including Degrees or Credentials." In determining compliance with applicable CPT and HCPCS coding, guidance shall be provided by the Physicians' Current Procedural Terminology (CPT) or the Healthcare Correct Procedural Coding System (HCPCS) in effect for the year in which services were rendered, the Office of the Inspector General, Physicians Compliance Guidelines, and other authoritative treatises designated by rule by the Agency for Health Care Administration. A statement of medical services may not include charges for medical services of a person or entity that performed such services without possessing the valid licenses required to perform such services. For purposes of paragraph (4)(b), an insurer is not considered to have been furnished with notice of the amount of covered loss or medical bills due unless the statements or bills comply with this paragraph and are properly completed in their entirety as to all material provisions, with all relevant information being provided therein.

(e)1. At the initial treatment or service provided, each physician, other licensed professional, clinic, or other medical institution providing medical services upon which a claim for personal injury protection benefits is based shall require an insured person, or his or her guardian, to execute a disclosure and acknowledgment form, which reflects at a minimum that:

a. The insured, or his or her guardian, must countersign the form attesting to the fact that the services set forth therein were actually rendered;

b. The insured, or his or her guardian, has both the right and affirmative duty to confirm that the services were actually rendered;

c. The insured, or his or her guardian, was not solicited by any person to seek any services from the medical provider;

d. The physician, other licensed professional, clinic, or other medical institution rendering services for which payment is being claimed explained the services to the insured or his or her guardian; and

e. If the insured notifies the insurer in writing of a billing error, the insured may be entitled to a certain percentage of a reduction in the amounts paid by the insured's motor vehicle insurer.

2. The physician, other licensed professional, clinic, or other medical institution rendering services for which payment is being claimed has the affirmative duty to explain the services

rendered to the insured, or his or her guardian, so that the insured, or his or her guardian, countersigns the form with informed consent.

3. Countersignature by the insured, or his or her guardian, is not required for the reading of diagnostic tests or other services that are of such a nature that they are not required to be performed in the presence of the insured.

4. The licensed medical professional rendering treatment for which payment is being claimed must sign, by his or her own hand, the form complying with this paragraph.

5. The original completed disclosure and acknowledgment form shall be furnished to the insurer pursuant to paragraph (4)(b) and may not be electronically furnished.

6. The disclosure and acknowledgment form is not required for services billed by a provider for emergency services and care as defined in s. 395.002 rendered in a hospital emergency department, or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401.

7. The Financial Services Commission shall adopt, by rule, a standard disclosure and acknowledgment form to be used to fulfill the requirements of this paragraph.

8. As used in this paragraph, the term "countersign" or "countersignature" means a second or verifying signature, as on a previously signed document, and is not satisfied by the statement "signature on file" or any similar statement.

9. The requirements of this paragraph apply only with respect to the initial treatment or service of the insured by a provider. For subsequent treatments or service, the provider must maintain a patient log signed by the patient, in chronological order by date of service, which is consistent with the services being rendered to the patient as claimed. The requirement to maintain a patient log signed by the patient may be met by a hospital that maintains medical records as required by s. 395.3025 and applicable rules and makes such records available to the insurer upon request.

(f) Upon written notification by any person, an insurer shall investigate any claim of improper billing by a physician or other medical provider. The insurer shall determine if the insured was properly billed for only those services and treatments that the insured actually received. If the insurer determines that the insured has been improperly billed, the insurer shall notify the insured, the person making the written notification, and the provider of its findings and reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to a written notification by any person, the insurer shall pay to the person 20 percent of the amount of the reduction, up to $500. If the provider is arrested due to the improper billing, the insurer shall pay to the person 40 percent of the amount of the reduction, up to $500.

(g) An insurer may not systematically downcode with the intent to deny reimbursement otherwise due. Such action constitutes a material misrepresentation under s. 626.9541(1)(i)2.

(h) As provided in s. 400.9905, an entity excluded from the definition of a clinic shall be deemed a clinic and must be licensed under part X of chapter 400 in order to receive reimbursement under ss. 627.730-627.7405. However, this licensing requirement does not apply to:

1. An entity wholly owned by a physician licensed under chapter 458 or chapter 459, or by the physician and the spouse, parent, child, or sibling of the physician;

2. An entity wholly owned by a dentist licensed under chapter 466, or by the dentist and the spouse, parent, child, or sibling of the dentist;

3. An entity wholly owned by a chiropractic physician licensed under chapter 460, or by the chiropractic physician and the spouse, parent, child, or sibling of the chiropractic physician;

4. A hospital or ambulatory surgical center licensed under chapter 395;

5. An entity that wholly owns or is wholly owned, directly or indirectly, by a hospital or hospitals licensed under chapter 395; or

6. An entity that is a clinical facility affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows.

(6) DISCOVERY OF FACTS ABOUT AN INJURED PERSON; DISPUTES.—
(a) If a request is made by an insurer providing personal injury protection benefits under ss. 627.730-627.7405 against whom a claim has been made, an employer must furnish, in a form approved by the office, a sworn statement of the earnings, since the time of the bodily injury and for a reasonable period before the injury, of the person upon whose injury the claim is based.
(b) Every physician, hospital, clinic, or other medical institution providing, before or after bodily injury upon which a claim for personal injury protection insurance benefits is based, any products, services, or accommodations in relation to that or any other injury, or in relation to a condition claimed to be connected with that or any other injury, shall, if requested by the insurer against whom the claim has been made, furnish a written report of the history, condition, treatment, dates, and costs of such treatment of the injured person and why the items identified by the insurer were reasonable in amount and medically necessary, together with a sworn statement that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained and identifying which portion of the expenses for such treatment or services was incurred as a result of such bodily injury, and produce, and allow the inspection and copying of, his or her or its records regarding such history, condition, treatment, dates, and costs of treatment if this does not limit the introduction of evidence at trial. Such sworn statement must read as follows: "Under penalty of perjury, I declare that I have read the foregoing, and the facts alleged are true, to the best of my knowledge and belief." A cause of action for violation of the physician-patient privilege or invasion of the right of privacy may not be brought against any physician, hospital, clinic, or other medical institution complying with this section. The person requesting such records and such sworn statement shall pay all reasonable costs connected therewith. If an insurer makes a written request for documentation or information under this paragraph within 30 days after having received notice of the amount of a covered loss under paragraph (4)(a), the amount or the partial amount that is the subject of the insurer's inquiry is overdue if the insurer does not pay in accordance with paragraph (4)(b) or within 10 days after the insurer's receipt of the requested documentation or information, whichever occurs later. As used in this paragraph, the term "receipt" includes, but is not limited to, inspection and copying pursuant to this paragraph. An insurer that requests documentation or information pertaining to reasonableness of charges or medical necessity under this paragraph without a reasonable basis for such requests as a general business practice is engaging in an unfair trade practice under the insurance code.
(c) In the event of a dispute regarding an insurer's right to discovery of facts under this section, the insurer may petition a court of competent jurisdiction to enter an order permitting such discovery. The order may be made only on motion for good cause shown and upon notice to all persons having an interest, and must specify the time, place, manner, conditions, and scope of the discovery. In order to protect against annoyance, embarrassment, or oppression, as justice requires, the court may enter an order refusing discovery or specifying conditions of discovery and may order payments of costs and expenses of the proceeding, including reasonable fees for the appearance of attorneys at the proceedings, as justice requires.
(d) The injured person shall be furnished, upon request, a copy of all information obtained by the insurer under this section, and pay a reasonable charge, if required by the insurer.
(e) Notice to an insurer of the existence of a claim may not be unreasonably withheld by an insured.
(f) In a dispute between the insured and the insurer, or between an assignee of the insured's rights and the insurer, upon request, the insurer must notify the insured or the assignee that the policy limits under this section have been reached within 15 days after the limits have been reached.

(g) An insured seeking benefits under ss. 627.730–627.7405, including an omnibus insured, must comply with the terms of the policy, which include, but are not limited to, submitting to an examination under oath. The scope of questioning during the examination under oath is limited to relevant information or information that could reasonably be expected to lead to relevant information. Compliance with this paragraph is a condition precedent to receiving benefits. An insurer that, as a general business practice as determined by the office, requests an examination under oath of an insured or an omnibus insured without a reasonable basis is subject to s. 626.9541.

(7) MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON; REPORTS.—

(a) Whenever the mental or physical condition of an injured person covered by personal injury protection is material to any claim that has been or may be made for past or future personal injury protection insurance benefits, such person shall, upon the request of an insurer, submit to mental or physical examination by a physician or physicians. The costs of any examinations requested by an insurer shall be borne entirely by the insurer. Such examination shall be conducted within the municipality where the insured is receiving treatment, or in a location reasonably accessible to the insured, which, for purposes of this paragraph, means any location within the municipality in which the insured resides, or any location within 10 miles by road of the insured's residence, provided such location is within the county in which the insured resides. If the examination is to be conducted in a location reasonably accessible to the insured, and if there is no qualified physician to conduct the examination in a location reasonably accessible to the insured, such examination shall be conducted in an area of the closest proximity to the insured's residence. Personal protection insurers are authorized to include reasonable provisions in personal injury protection insurance policies for mental and physical examination of those claiming personal injury protection insurance benefits. An insurer may not withdraw payment of a treating physician without the consent of the injured person covered by the personal injury protection, unless the insurer first obtains a valid report by a Florida physician licensed under the same chapter as the treating physician whose treatment authorization is sought to be withdrawn, stating that treatment was not reasonable, related, or necessary. A valid report is one that is prepared and signed by the physician examining the injured person or reviewing the treatment records of the injured person and is factually supported by the examination and treatment records if reviewed and that has not been modified by anyone other than the physician. The physician preparing the report must be in active practice, unless the physician is physically disabled. Active practice means that during the 3 years immediately preceding the date of the physical examination or review of the treatment records the physician must have devoted professional time to the active clinical practice of evaluation, diagnosis, or treatment of medical conditions or to the instruction of students in an accredited health professional school or accredited residency program or a clinical research program that is affiliated with an accredited health professional school or teaching hospital or accredited residency program. The physician preparing a report at the request of an insurer and physicians rendering expert opinions on behalf of persons claiming medical benefits for personal injury protection, or on behalf of an insured through an attorney or another entity, shall maintain, for at least 3 years, copies of all examination reports as medical records and shall maintain, for at least 3 years, records of all payments for the examinations and reports. Neither an insurer nor any person acting at the direction of or on behalf of an insurer may materially change an opinion in a report prepared under this paragraph or direct the physician preparing the report to change such opinion. The denial of a payment as the result of such a changed opinion constitutes a material misrepresentation under s. 626.9541(1)(i)2.; however, this provision does not preclude the insurer from calling to the attention of the physician errors of fact in the report based upon information in the claim file.

(b) If requested by the person examined, a party causing an examination to be made shall deliver to him or her a copy of every written report concerning the examination rendered by

an examining physician, at least one of which reports must set out the examining physician's findings and conclusions in detail. After such request and delivery, the party causing the examination to be made is entitled, upon request, to receive from the person examined every written report available to him or her or his or her representative concerning any examination, previously or thereafter made, of the same mental or physical condition. By requesting and obtaining a report of the examination so ordered, or by taking the deposition of the examiner, the person examined waives any privilege he or she may have, in relation to the claim for benefits, regarding the testimony of every other person who has examined, or may thereafter examine, him or her in respect to the same mental or physical condition. If a person unreasonably refuses to submit to or fails to appear at an examination, the personal injury protection carrier is no longer liable for subsequent personal injury protection benefits. An insured's refusal to submit to or failure to appear at two examinations raises a rebuttable presumption that the insured's refusal or failure was unreasonable.

(8) APPLICABILITY OF PROVISION REGULATING ATTORNEY FEES.—With respect to any dispute under the provisions of ss. 627.730-627.7405 between the insured and the insurer, or between an assignee of an insured's rights and the insurer, the provisions of ss. 627.428 and 768.79 apply, except as provided in subsections (10) and (15), and except that any attorney fees recovered must:

(a) Comply with prevailing professional standards;

(b) Not overstate or inflate the number of hours reasonably necessary for a case of comparable skill or complexity; and

(c) Represent legal services that are reasonable and necessary to achieve the result obtained.

Upon request by either party, a judge must make written findings, substantiated by evidence presented at trial or any hearings associated therewith, that any award of attorney fees complies with this subsection. Notwithstanding s. 627.428, attorney fees recovered under ss. 627.730-627.7405 must be calculated without regard to a contingency risk multiplier.

(9) PREFERRED PROVIDERS.—An insurer may negotiate and contract with preferred providers for the benefits described in this section, which include health care providers licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 463. The insurer may provide an option to an insured to use a preferred provider at the time of purchasing the policy for personal injury protection benefits, if the requirements of this subsection are met. If the insured elects to use a provider who is not a preferred provider, whether the insured purchased a preferred provider policy or a nonpreferred provider policy, the medical benefits provided by the insurer shall be as required by this section. If the insured elects to use a provider who is a preferred provider, the insurer may pay medical benefits in excess of the benefits required by this section and may waive or lower the amount of any deductible that applies to such medical benefits. If the insurer offers a preferred provider policy to a policyholder or applicant, it must also offer a nonpreferred provider policy. The insurer shall provide each insured with a current roster of preferred providers in the county in which the insured resides at the time of purchase of such policy, and shall make such list available for public inspection during regular business hours at the insurer's principal office within the state.

(10) DEMAND LETTER.—

(a) As a condition precedent to filing any action for benefits under this section, written notice of an intent to initiate litigation must be provided to the insurer. Such notice may not be sent until the claim is overdue, including any additional time the insurer has to pay the claim pursuant to paragraph (4)(b).

(b) The notice must state that it is a "demand letter under s. 627.736" and state with specificity:

1. The name of the insured upon which such benefits are being sought, including a copy of the assignment giving rights to the claimant if the claimant is not the insured.
2. The claim number or policy number upon which such claim was originally submitted to the insurer.
3. To the extent applicable, the name of any medical provider who rendered to an insured the treatment, services, accommodations, or supplies that form the basis of such claim; and an itemized statement specifying each exact amount, the date of treatment, service, or accommodation, and the type of benefit claimed to be due. A completed form satisfying the requirements of paragraph (5)(d) or the lost-wage statement previously submitted may be used as the itemized statement. To the extent that the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet rendered, the claimant shall attach a copy of the insurer's notice withdrawing such payment and an itemized statement of the type, frequency, and duration of future treatment claimed to be reasonable and medically necessary.

(c) Each notice required by this subsection must be delivered to the insurer by United States certified or registered mail, return receipt requested. Such postal costs shall be reimbursed by the insurer if requested by the claimant in the notice, when the insurer pays the claim. Such notice must be sent to the person and address specified by the insurer for the purposes of receiving notices under this subsection. Each licensed insurer, whether domestic, foreign, or alien, shall file with the office the name and address of the designated person to whom notices must be sent which the office shall make available on its Internet website. The name and address on file with the office pursuant to s. 624.422 is deemed the authorized representative to accept notice pursuant to this subsection if no other designation has been made.

(d) If, within 30 days after receipt of notice by the insurer, the overdue claim specified in the notice is paid by the insurer together with applicable interest and a penalty of 10 percent of the overdue amount paid by the insurer, subject to a maximum penalty of $250, no action may be brought against the insurer. If the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet rendered, no action may be brought against the insurer if, within 30 days after its receipt of the notice, the insurer mails to the person filing the notice a written statement of the insurer's agreement to pay for such treatment in accordance with the notice and to pay a penalty of 10 percent, subject to a maximum penalty of $250, when it pays for such future treatment in accordance with the requirements of this section. To the extent the insurer determines not to pay any amount demanded, the penalty is not payable in any subsequent action. For purposes of this subsection, payment or the insurer's agreement shall be treated as being made on the date a draft or other valid instrument that is equivalent to payment, or the insurer's written statement of agreement, is placed in the United States mail in a properly addressed, postpaid envelope, or if not so posted, on the date of delivery. The insurer is not obligated to pay any attorney fees if the insurer pays the claim or mails its agreement to pay for future treatment within the time prescribed by this subsection.

(e) The applicable statute of limitation for an action under this section shall be tolled for 30 business days by the mailing of the notice required by this subsection.

(11) FAILURE TO PAY VALID CLAIMS; UNFAIR OR DECEPTIVE PRACTICE.—

(a) An insurer is engaging in a prohibited unfair or deceptive practice that is subject to the penalties provided in s. 626.9521 and the office has the powers and duties specified in ss. 626.9561-626.9601 if the insurer, with such frequency so as to indicate a general business practice:

1. Fails to pay valid claims for personal injury protection; or
2. Fails to pay valid claims until receipt of the notice required by subsection (10).

(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.

(12) CIVIL ACTION FOR INSURANCE FRAUD.—An insurer shall have a cause of action against any person convicted of, or who, regardless of adjudication of guilt, pleads guilty or nolo contendere to insurance fraud under s. 817.234, patient brokering under s. 817.505, or kickbacks under s. 456.054, associated with a claim for personal injury protection benefits in accordance with this section. An insurer prevailing in an action brought under this subsection may recover compensatory, consequential, and punitive damages subject to the requirements and limitations of part II of chapter 768, and attorney's fees and costs incurred in litigating a cause of action against any person convicted of, or who, regardless of adjudication of guilt, pleads guilty or nolo contendere to insurance fraud under s. 817.234, patient brokering under s. 817.505, or kickbacks under s. 456.054, associated with a claim for personal injury protection benefits in accordance with this section.

(13) MINIMUM BENEFIT COVERAGE.—If the Financial Services Commission determines that the cost savings under personal injury protection insurance benefits paid by insurers have been realized due to the provisions of this act, prior legislative reforms, or other factors, the commission may increase the minimum $10,000 benefit coverage requirement. In establishing the amount of such increase, the commission must determine that the additional premium for such coverage is approximately equal to the premium cost savings that have been realized for the personal injury protection coverage with limits of $10,000.

(14) FRAUD ADVISORY NOTICE.—Upon receiving notice of a claim under this section, an insurer shall provide a notice to the insured or to a person for whom a claim for reimbursement for diagnosis or treatment of injuries has been filed, advising that:

(a) Pursuant to s. 626.9892, the Department of Financial Services may pay rewards of up to $25,000 to persons providing information leading to the arrest and conviction of persons committing crimes investigated by the Division of Insurance Fraud arising from violations of s. 440.105, s. 624.15, s. 626.9541, s. 626.989, or s. 817.234.

(b) Solicitation of a person injured in a motor vehicle crash for purposes of filing personal injury protection or tort claims could be a violation of s. 817.234, s. 817.505, or the rules regulating The Florida Bar and should be immediately reported to the Division of Insurance Fraud if such conduct has taken place.

(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.—A notice, documentation, transmission, or communication of any kind required or authorized under ss. 627.730-627.7405 may be transmitted electronically if it is transmitted by secure electronic data transfer that is consistent with state and federal privacy and security laws.

(17) NONREIMBURSIBLE CLAIMS.—Claims generated as a result of activities that are unlawful pursuant to s. 817.505 are not reimbursable under the Florida Motor Vehicle No-Fault Law.

627.745 Mediation of claims.—

(1)(a) In any claim filed with an insurer for personal injury in an amount of $10,000 or less or any claim for property damage in any amount, arising out of the ownership, operation, use, or maintenance of a motor vehicle, either party may demand mediation of the claim prior to the institution of litigation.

(b) A request for mediation shall be filed with the department on a form approved by the department. The request for mediation shall state the reason for the request for mediation and the issues in dispute which are to be mediated. The filing of a request for mediation tolls the applicable time requirements for filing suit for a period of 60 days following the conclusion of the mediation process or the time prescribed in s. 95.11, whichever is later.

(c) The insurance policy must specify in detail the terms and conditions for mediation of a first-party claim.

(d) The mediation shall be conducted as an informal process in which formal rules of evidence and procedure need not be observed. Any party participating in a mediation must have the authority to make a binding decision. All parties must mediate in good faith.

(e) The department shall randomly select mediators. Each party may once reject the mediator selected, either originally or after the opposing side has exercised its option to reject a mediator.

(f) Costs of mediation shall be borne equally by both parties unless the mediator determines that one party has not mediated in good faith.

(g) Only one mediation may be requested for each claim, unless all parties agree to further mediation.

(2) Upon receipt of a request for mediation, the department shall refer the request to a mediator. The mediator shall notify the applicant and all interested parties, as identified by the applicant, and any other parties the mediator believes may have an interest in the mediation, of the date, time, and place of the mediation conference. The conference may be held by telephone, if feasible. The mediation conference shall be held within 45 days after the request for mediation.

(3)(a) The department shall approve mediators to conduct mediations pursuant to this section. All mediators must file an application under oath for approval as a mediator.

(b) To qualify for approval as a mediator, a person must meet the following qualifications:

1. Possess a masters or doctorate degree in psychology, counseling, business, accounting, or economics, be a member of The Florida Bar, be licensed as a certified public accountant, or demonstrate that the applicant for approval has been actively engaged as a qualified mediator for at least 4 years prior to July 1, 1990.

2. Within 4 years immediately preceding the date the application for approval is filed with the department, have completed a minimum of a 40-hour training program approved by the department and successfully passed a final examination included in the training program and approved by the department. The training program shall include and address all of the following:

a. Mediation theory.

b. Mediation process and techniques.

c. Standards of conduct for mediators.

d. Conflict management and intervention skills.

e. Insurance nomenclature.

(4) The department must adopt rules of procedure for claims mediation, taking into consideration a system which:

(a) Is fair.

(b) Promotes settlement.

(c) Avoids delay.

(d) Is nonadversarial.

(e) Uses a framework for modern mediating technique.

(f) Controls costs and expenses of mediation.

(5) Disclosures and information divulged in the mediation process are not admissible in any subsequent action or proceeding relating to the claim or to the cause of action giving rise to the claim. A person demanding mediation under this section may not demand or request mediation after a suit is filed relating to the same facts already mediated.