NOT FOR PUBLICATION WITHOUT THE
APPROVAL OF THE APPELLATE DIVISION

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-0429-21

PEGGY BIRMINGHAM and
DUANE CARPINELLI,

Plaintiffs-Respondents,

v.

TRAVELERS NEW JERSEY INS.
CO., TRAVELERS INS. CO., and
ST. PAUL PROTECTIVE INS. CO.,

Defendants-Appellants.

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APPROVED FOR PUBLICATION
March 31, 2023
APPELLATE DIVISION

Argued October 12, 2022 – Decided March 31, 2023

Before Judges Accurso, Vernoia, and Natali.

On appeal from the Superior Court of New Jersey, Law Division, Gloucester County, Docket No. L-1009-20.

Kathleen D. Hannan argued the cause for appellant St. Paul Protective Insurance Company (Law Offices of Tina Newsome-Lee, attorneys; Kathleen D. Hannan, on the briefs).

Michael W. Glaze argued the cause for respondents (Hoffman DiMuzio, attorneys; Michael W. Glaze, on the brief).

The opinion of the court was delivered by

NATALI, J.A.D.

In this appeal, defendants challenge two Law Division orders.[1] The first granted summary judgment to plaintiffs Peggy Birmingham and Duane Carpinelli, and the second denied Travelers's summary judgment application. The court's decisions obligated Travelers to provide plaintiffs with the entire $15,000 limit of personal injury protection (PIP) benefits prescribed in their identical automobile insurance policies, without reducing those limits by the amount of the respective deductible and copayment obligations.

The court primarily based its decision on Lehrhoff v. Aetna Casualty and Surety Co., 271 N.J. Super. 340 (App. Div. 1994), finding the language in both policies' declaration pages clearly stated Travelers provided $15,000 of insurance for PIP medical benefits coverage and Travelers failed to inform adequately that those limits would be reduced by any deductible or copayment obligation. It therefore concluded any diminution to those coverage limits would be contrary to plaintiffs' reasonable expectations.

[1] Defendants St. Paul Protective Insurance Company, a subsidiary of the Travelers Companies, Inc., issued the two policies at issue in this appeal. As both parties, and the trial court, referred to defendants collectively as "Travelers," we similarly reference defendants in our opinion. In doing so, however, we note, Travelers contends plaintiffs incorrectly named Travelers New Jersey Ins. Co. and Travelers Ins[.] Co. as parties.

We have considered the record and arguments of counsel under our de novo standard of review, and we affirm the orders under review albeit for slightly different reasons than those expressed by the court. Simply put, nothing in the policies' declaration pages, coverage grants, or exclusions clearly communicated to either plaintiff that their statutorily mandated PIP limits of liability in either policy would be reduced by the amount of their chosen deductibles, particularly with respect to claims that exceed the coverage limits. That lack of clarity is nothing more than a "hidden pitfall," see Zacarias v. Allstate Ins. Co., 168 N.J. 590, 601 (2001), which we conclude obligates Travelers to pay the full limits of coverage, subject of course to the insured's payment of any applicable deductible or copayment obligation. Stated differently, Travelers's coverage limits are not reduced by the $250 and $2,500 deductible amounts under the circumstances here.

We also expressly reject Travelers's arguments that Roig v. Kelsey, 135 N.J. 500 (1994), Haines v. Taft, 237 N.J. 271 (2019), and the history of New Jersey's no-fault legislation compel a different result. Neither those cases nor the legislative history supports the reduction of statutorily prescribed limits when an insured agrees to pay any deductible or copayment obligation.

I.

Both plaintiffs sustained injuries in separate automobile accidents and sought PIP coverage from Travelers to cover their medical expenses. Birmingham's policy provided $15,000 in PIP coverage with a $2,500 deductible, and a twenty percent copayment obligation for any amount between the applicable deductible and $5,000.

After her accident, Birmingham sought reimbursement for PIP benefits in excess of the $15,000 limit. Travelers provided her with $12,000 in reimbursable medical expenses, after reducing her recoverable expenses by the policy's $2,500 deductible and a $500 copayment obligation and notified her that her PIP coverage had been exhausted.

Carpinelli's policy included identical PIP limits and copayment obligations but included a reduced $250 deductible. Following his accident, he too applied for PIP benefits and like Birmingham, his covered expenses exceeded the coverage limits. In administering Carpinelli's claim, Travelers provided him with $13,800 in medical expenses, reducing his recoverable expenses by the $250 deductible and $950 copayment obligations, and later informed him that his PIP limits were also exhausted.

Plaintiffs' policies contained multiple references to the aforementioned PIP coverage limits, deductibles, and copayment obligations. For example, the declaration page of Birmingham's policy stated her PIP coverage included "Medical Expenses" with a $15,000 limit and a $2,500 "Deductible." Similarly, the declaration page in Carpinelli's policy recited that Travelers provided PIP coverage for "Medical Expenses" subject to a $15,000 limit and a $250 "Deductible." Further, both policies' declaration pages included a section which expressly informed both plaintiffs that the "Policy Coverage Sections and Endorsements that Form a Part of This Policy" included the "Personal Injury Protection Section," which in turn directed them to that section of the policy.

Under the "Limits of Liability" provision in the PIP section of the policy, Travelers instructed its insureds how it would apply deductibles and copayments for PIP medical expenses.[2] Travelers specifically stated, "any amounts payable for medical expense benefits as a result of any one accident shall be: [r]educed by the $250 statutory deductible" or shall be "reduced only by the optional

[2] The PIP policy section provides other limits of recoverable expenses not at issue in this appeal, such as extended medical expense benefits, added income continuation benefits, essential services benefits, funeral expense benefits, and death benefits.

deductible" and are "[s]ubject to a copayment of [twenty percent] for the amount between the deductible that applies and $5,000."

The policies referred to and incorporated the "New Jersey Auto Insurance Buyer's Guide" (Buyer's Guide), in accordance with N.J.S.A. 39:6A-23 and N.J.A.C. 11:3-15.4(a). The Buyer's Guide included a description of the manner in which Travelers would apply the deductible and copayment obligation where an accident resulted in a claim of $10,000 of recoverable medical expenses:

> Sam and Jane each have an accident that results in $10,000 of medical expenses. Sam chose the minimum $250 deductible. He pays the $250 deductible plus the $950 (20 percent of the $4,750 that is left of the first $5,000) and the insurer pays the remaining $8,800. Jane chose the $2,500 PIP deductible for a 25 percent reduction in the PIP premium. She pays the first $2,500 as the deductible. She also pays $500 (20 percent of the $2,500 that is left of the first $5,000) and the insurer pays the remaining $7,000.

After Travelers reduced their recoverable medical expenses as detailed above, plaintiffs sued to compel it to pay the full amount of medical expenses up to the $15,000 policy limit without reduction, after application of the deductible or copayments, and also sought attorneys' fees and costs. Travelers moved for summary judgment and asserted that plaintiffs' claims should be dismissed as they both exhausted all available coverage under their respective policies after Travelers paid plaintiffs' recoverable medical expenses.

Plaintiffs, in turn, cross-moved for summary judgment, and asserted that pursuant to N.J.S.A. 39:6A-4.3, Travelers is required "to provide a minimum of $15,000 in medical expense benefit coverage." In support of their motion, plaintiffs relied on our decision in Lehrhoff and contended that based on the express language in the declaration pages they reasonably expected to receive the full amount of their policy limits for any covered medical expense, without any reduction in those limits by operation of the deductibles. Plaintiffs further submitted excerpts of ledgers from other insurance companies that purportedly revealed those other insurers did not reduce PIP limits by the respective deductible or copayment obligations, instead providing the entire limit, subject to the insured satisfying the deductible or copayment.

After considering the parties' oral arguments, the court issued an order and oral decision denying Travelers's application and granting plaintiffs' cross-motion for summary judgment. It later issued a separate order requiring Travelers to compensate plaintiffs for their reasonable attorneys' fees and costs.[3]

As noted, the court relied on Lehrhoff, explaining resolution of the issue turned on "language indicative to the . . . average insured," who is not "sophisticated" and therefore, "should be held to . . . what is contained in the

[3] Travelers has not appealed the court's attorneys' fee award.

declaration sheet." The court found the language of both policies would lead the "average person . . . [to] expect to be able to rely upon $15,000 of coverage in medical expenses." The court further explained the declaration page did not contain an "asterisk" or "other identifying feature" that would have alerted plaintiffs that they would be receiving less than $15,000 in coverage, and in the absence of such clarifying language the court was "reluctant to foist upon . . . [plaintiffs] an expectation that is contrary to what would appear to the average person when they read that declaration sheet." The court also rejected Travelers's reliance on Roig and Haines, explaining the issue before it presented "an entirely different scenario." This appeal followed.

II.

Travelers first contends the court incorrectly limited its analysis to the literal PIP coverage amounts listed in the policies' declaration pages and ignored other limiting language in the policy, contrary to Zacarias. Travelers claims the declaration pages unequivocally put plaintiffs on notice their PIP coverage was subject to corresponding sections of the policy, and those sections unambiguously explained how the copayments and deductibles reduced the coverage due under the policy. Travelers further supports its argument by referencing the policies' attached Buyer's Guide, claiming it specifically

provided an explanation of PIP coverage, outlined its computation, and included an example of its application.

Travelers also claims plaintiffs' interpretation of the policies contravenes the legislative history of New Jersey's no-fault law, N.J.S.A. 39:6A-4, principally relying on Roig, 135 N.J. at 500, and Haines, 237 N.J. at 271. It specifically maintains plaintiffs' alleged entitlement to the entire $15,000 of coverage would result in an increase of premiums, as carriers "would be exposed to pay the full coverage amount" regardless of the selected deductible or copayment. According to Travelers, insurers included deductible and copayment obligations in standard automobile policies to lower the cost of insurance "by requiring the insured to fund the most minor of medical expenses and to allow coordination with other insurance." Thus, Travelers argues ruling in favor of plaintiffs would result in a "double incentive" for insureds to choose a higher deductible, as it would yield lower premiums and greater available benefits. Finally, Travelers asserts its computation of PIP coverage is not an "outlier" compared to other insurance companies.

In response, plaintiffs reprise their arguments to the trial court and maintain Travelers is obligated to pay the entire $15,000 in PIP coverage limits after insureds first satisfy their respective deductible or copayment obligations

as that precise amount of coverage is required by statute. Plaintiffs further assert the declaration sheets did not "provide notice to the insureds that the policy limit stated on the . . . sheet was being reduced or was less than stated," and "implore" us to uphold the court's decision for "broader reasons," specifically that "the statute sets the limit and no policy language may lessen or reduce that limit."

We agree with plaintiffs and conclude the court correctly determined the Travelers's policies did not clearly express to a reasonable insured the statutory limits of liability would be reduced for their covered claims. We also find Travelers's criticism of the court's failure to abide by the language on the declaration pages incorporating and referencing all terms and conditions is misdirected, as it failed to identify any provision in the policy supporting a result whereby an insured who agreed to pay the required deductible or copayment also agreed to a reduced limit of liability for the carrier.

In any event, to the extent Travelers sought to issue a policy that clearly and unambiguously stated policy limits would be reduced through payment of the deductible or medical expenses, it likely would have needed regulatory and legislative approval to so do, as any such proposal would need to address that N.J.S.A. 39:6A-4.3 clearly prescribes the minimum statutory limit for medical expense benefits for PIP coverage as $15,000. See N.J.A.C. 39:6A-4.3(e);

N.J.A.C. 11:3-3.1; see also Rutgers Cas. Ins. Co. v. LaCroix, 194 N.J. 515 (2008) (stating "N.J.S.A. 39:6A-4.3 is clear and unambiguous on its face and admits of only one interpretation . . . . [t]he minimum compulsory PIP benefits coverage mandated by statute is $15,000 per person per accident") (internal quotations omitted). On this point, we have stated "the PIP statute controls when [there is a] conflict[] with an insurance policy, even if the . . . Commissioner approves the policy's language." See Estate of Leeman v. Eagle Ins. Co., 309 N.J. Super. 525, 533 (App. Div. 1998).

III.

We review a ruling on summary judgment de novo, applying the same legal standard as the trial court. Townsend v. Pierre, 221 N.J. 36, 59 (2015). "Summary judgment must be granted if 'the pleadings, depositions, answers to interrogatories and admissions on file, together with the affidavits, if any, show there is no genuine issue as to any material fact challenged and that the moving party is entitled to a judgment . . . as a matter of law.'" Town of Kearny v. Brandt, 214 N.J. 76, 91 (2013) (quoting R. 4:46-2(c)). We accord no special deference to the trial court's legal conclusions. Nicholas v. Mynster, 213 N.J. 463, 478 (2013).

In addition to our standard of review, we consider both parties' arguments in the context of well-settled principles governing insurance contract interpretation. "Generally, the words of an insurance policy are to be given their plain, ordinary meaning." Gibson v. Callaghan, 158 N.J. 662, 670 (1999). Where a policy contains no ambiguities, "courts should not write for the insured a better policy of insurance than the one purchased." Zacarias, 168 N.J. at 596 (quoting Gibson, 158 N.J. at 670).

In certain instances, insurance policies, like those issued by Travelers here, are "contracts of adhesion and as such, are subject to special rules of interpretation." Ibid. (quoting Gibson, 158 N.J. at 670); Meier v. N.J. Life Ins. Co., 101 N.J. 597, 611-12 (1986). In those circumstances, we give "special scrutiny" to those contracts because of the "stark imbalance between insurance companies and insureds in their respective understanding of the terms and conditions of insurance policies." Zacarias, 168 N.J. at 594.

In addition, when there is ambiguity in such insurance contracts, courts interpret the contract to comport with the principles of contra proferentem, Oxford Realty Grp. Cedar v. Travelers Excess & Surplus Lines Co., 229 N.J. 196, 208 (2017), and evaluate the ambiguous terms in light of the reasonable expectations of the insured, even if a close reading of the written text reveals a

contrary meaning, Zacarias, 168 N.J. at 594. An ambiguity arises in an insurance contract when "the phrasing of the policy is so confusing that the average policyholder cannot make out the boundaries of coverage." Weedo v. Stone-E-Brick, Inc., 81 N.J. 233, 247 (1979).

Such confusion arises when "the text appears overly technical or contains hidden pitfalls, cannot be understood without employing subtle or legalistic distinction, is obscured by fine print, or requires strenuous study to comprehend." Zacarias, 168 N.J. at 601. (citations omitted). When the policy language is unambiguous, however, courts will apply it without addressing the insured's expectations. Oxford Realty Grp. Cedar, 229 N.J. at 212.

Here, the ambiguity in the policies is primarily animated by the lack of clarity as to the effect of a deductible or copayment on the policies' limits. For example, as noted, within the policy's explanation of its liability limits for medical expenses, Travelers informed both plaintiffs "any amounts payable for medical expense benefits as a result of any one accident shall be: [r]educed by the $250 statutory deductible" or shall be "reduced only by the optional deductible" and are "[s]ubject to a copayment of [twenty percent] for the amount between the deductible that applies and $5,000" (emphasis added). This

language clearly instructs an insured's recoverable expense will be so reduced, not that the limit of liability will be impaired.

Likewise, the referenced Buyer's Guide only addresses situations when a party's recovered medical expenses are below the policy limit, resulting in a reduction in the amount reimbursed. Again, in no section of the declaration page, coverage provisions, limits of liability section, or exclusionary language does Travelers clearly state the statutorily mandated coverage limits would be reduced by the amounts an insured pays for the required deductible and copayment.

The following example properly illustrates Travelers's liability in a scenario, like this one, where medical expenses exceed $15,000:

> Sam and Jane each have an accident that results in $18,000 of medical expenses. Sam chose the minimum $250 deductible. He pays the $250 deductible plus $950 (20 percent of the $4,750 that is left of the first $5,000), the insurer pays its limit of $15,000, and Sam is responsible for the remaining $1,800. Jane chose the $2,500 PIP deductible for a 25 percent reduction in the PIP premium. She pays the first $2,500 as the deductible. She also pays $500 (20 percent of the $2,500 that is left of the first $5,000) and the insurer pays the remaining $15,000.

If we were to accept Travelers's interpretation, the following example details the significant consequences to insureds with an identical $18,000 claim and whose deductible payments reduce the $15,000 coverage limit:

> Sam and Jane each have an accident that results in $18,000 of medical expenses. Sam chose the minimum $250 deductible. He pays the $250 deductible plus $950 (20 percent of the $4,750 that is left of the first $5,000), the insurer pays 13,800, and Sam is responsible for the remaining $4,200. Jane chose the $2,500 PIP deductible for a 25 percent reduction in the PIP premium. She pays the first $2,500 as the deductible. She also pays $500 (20 percent of the $2,500 that is left of the first $5,000) and the insurer pays $12,000. Jane is responsible for the remaining $6,000.

Contrary to Travelers's argument, Zacarias does not compel a result in its favor. In that case, the Court found no ambiguity in a policy's declaration pages when it clearly alerted an insured that coverage was subject to exclusions in the policy, and the exclusion was plainly and directly worded. Zacarias, 168 N.J. at 602-03. In reaching its decision, the Court did not interpret Lehrhoff's holding to "require an insurer to include an . . . exclusion on the policy's declaration sheet in all cases," id. at 602, nor did it conclude an insurance contract is rendered ambiguous simply "because its declarations sheet, definition section, and exclusion provisions are separately presented," id. at 603. The Court did, however, emphasize the importance of the declaration pages as related to the

insured's reasonable expectations, and in doing so, endorsed Lehrhoff, while nonetheless finding no ambiguity. Ibid.

Here, both the declaration pages and the corresponding PIP policy section fully supports an insured's, like plaintiffs', reasonable expectation they would receive the full $15,000 of PIP coverage upon satisfaction of the deductible or copayment. Specifically, the declaration pages of both policies provided limited reference to PIP coverage and did not mention any exclusion or limitation regarding the application of the deductibles and copayments to the policies' limits. Indeed, the declaration pages simply alerted plaintiffs that Travelers provided $15,000 in their PIP "Medical Expenses Limit."

While we acknowledge the declaration pages "alerted the insured that the coverages and limits of liability [we]re subject to the [PIP] provision[] of the policy," id. at 602-03, a review of that policy language yields a result unlike that in Zacarias. There, the Court determined the relevant exclusion's wording was "direct and ordinary," and did not "require an entangled and professional interpretation to be understood." Id. at 601. No such circumstance exists here, as the PIP policy language lacks any explanation or warning to inform plaintiffs' reasonable expectations of a reduction in the $15,000 limit, with respect to claims exceeding that amount. Even a "painstaking study of the policy

provisions" would have no effect on plaintiffs' expectations. Id. at 595 (quoting Sparks v. St. Paul Ins. Co., 100 N.J. 325, 338-39 (1985)). Consequently, there was simply no reason for plaintiffs to anticipate a scenario where Travelers would provide less than $15,000 of PIP coverage, subject of course, to their deductible and copayment obligations.

IV.

Next, Travelers contends the court's decision is contrary to New Jersey's no-fault statute and relevant case law. As Travelers explains, deductibles and copayments were included in the mandatory automobile insurance policies at issue to lower costs, by ensuring the insured would bear most of the minor costs of medical expenses, while allowing for the coordination with other insurance. Travelers maintains plaintiffs' interpretation of their policies would result in an overall increase in premiums, and in turn, an increase in the cost of insurance. Travelers further asserts if plaintiffs prevail, it will create a "double incentive" for insureds to choose a higher deductible, yielding better benefits then what they paid for. We disagree.

To better understand Travelers's arguments, we discuss the evolution of New Jersey's no-fault scheme, the legislative history of N.J.S.A. 39:6A-4, and its interpretative case law. N.J.S.A. 39:6A-1 to -35, or the New Jersey

Automobile Reparation Reform Act, L. 1972, c. 70, §§ 1-19, established the principle of "no-fault coverage" by requiring all automobile liability insurance policies to provide for "the payment of benefits without regard to negligence, liability or fault of any kind, to the named insured and members of [their] family residing in [their] household who sustained bodily injury as a result of an accident . . . ." L. 1972, c. 70, § 4 (enacting N.J.S.A. 39:6A-4).

Beginning in 1983, the Legislature specified that "[t]he [PIP] coverage of the named insured shall be the primary coverage for the named insured" and for resident relatives who were not named insureds under policies of their own. L. 1983, c. 362, § 12 (enacting N.J.S.A. 39:6A-4.2). Another significant addition in 1983 was the introduction of deductibles. L. 1983, c. 362, § 13 (enacting N.J.S.A. 39:6A-4.3). The enactment required insurers to offer, "at appropriately reduced premiums," the "coverage options" of "medical expense benefit deductibles in amounts of $500, $1,000 and $2,500 for any one accident for any one person." Ibid.

Further, the legislative history explained that "[t]his option would permit an insured to coordinate his automobile insurance coverage with other forms of health coverage," and to do so "at reduced premiums stated as a percentage of the coverage premium." Sponsor Statement to A. 3981 (Sept. 22, 1983). The

press release to the Governor's signing statement of the 1983 PIP amendments that first provided for deductibles and made them optional, described them as a vehicle "to permit policyholders to choose full PIP coverage or to coordinate coverage with existing medical coverage." Press Release to Governor's Signing Statement to A-3981 2 (Oct. 4, 1983) (L. 1983, c. 362).

The Legislature correspondingly amended the language of N.J.S.A. 39:6A-4 to provide that any "[b]enefits payable under this section" were to be "subject to any deductibles or exclusions elected by the policyholder" pursuant to the concurrent amendment of N.J.S.A. 39:6A-4.3. L. 1983, c. 362, § 7 (referencing id. § 13). In addition, the Legislature further amended N.J.S.A. 39:6A-4.3 to provide:

> No insurer or health provider providing benefits to an insured who has elected a deductible pursuant to . . . this section shall have a right of subrogation for the amount of benefits paid pursuant to a deductible elected thereunder.
>
> [L. 1983, c. 362, § 13.]

The Legislature made a similar amendment to N.J.S.A. 39:6A-12, which prohibits either side in a civil damages action against the tortfeasor from presenting evidence "of the amounts collectible or paid" to an injured person pursuant to PIP coverage. That statute was part of the original no-fault

enactments. L. 1972, c. 70, § 12. The 1983 amendment added the specification that an injured party could nonetheless sue the tortfeasor for recovery of "uncompensated economic loss," but it also expanded the definition of inadmissible evidence from just "amounts collectible or paid . . . to an injured person" to "includ[e] the amounts of any deductibles or exclusions elected by the named insured." L. 1983, c. 362, § 12.

In 1988, the Legislature made deductibles mandatory by amending N.J.S.A. 39:6A-4 to require medical expense benefit payments to be "subject to a deductible of $250" per accident, as well as to a copayment of twenty percent on benefits payable between that amount and $5,000. L. 1988, c. 119, § 3. If the insured elected a higher deductible pursuant to N.J.S.A. 39:6A-4.3, the twenty-percent copayment would apply to benefits payable between the elected amount and $5,000. L. 1988, c. 119, § 38. The Legislature also updated the anti-subrogation provision in N.J.S.A. 39:6A-4.3 to include copayments, ibid., and it fixed an apparent oversight by adding the anti-subrogation provision to N.J.S.A. 39:6A-4. L. 1988, c. 119, § 3.

In 1998 the Legislature enacted the Automobile Insurance Cost Reduction Act (AICRA), L. 1998, c. 21, which became the subject of case law that addressed the legislative intent related to PIP deductibles. Prior to the enactment

of AICRA, our Supreme Court addressed the 1983 enactment of PIP deductibles and observed that "[t]he Legislature hoped that those optional deductibles would reduce the cost of automobile insurance by shifting some of the rising medical-expense costs to alternative forms of health insurance." Roig, 135 N.J. at 505. It further noted the Legislature amended N.J.S.A. 39:6A-12 at the same time to render deductibles "specifically excluded from recovery," while also adding the provision that "[n]othing in this section shall be construed to limit the right of recovery, against the tortfeasor, of uncompensated economic loss sustained by the injured party." Id. at 506; L. 1983, c. 362, § 11.

The Roig Court held that this exclusion of deductibles was the controlling provision because the Legislature still did not want deductibles to be compensable, at least not by lawsuits that were "fault-based." Roig, 135 N.J. at 501, 515-16. According to the court "New Jersey motorists" already "paid a lower annual insurance premium because of the mandatory PIP medical deductible and copayment," and a right to recover them from the tortfeasor "would be antithetical to the entire no-fault statutory scheme" by reinstituting judicial determinations of fault. Id. at 514. The Court explained that "our overriding goal has consistently been to determine the Legislature's intent in enacting a statute," id. at 515, and that "we consider not only the particular

statute in question, but also the entire legislative scheme of which it is a part," ibid. (quoting Kimmelman v. Henkels & McKoy, Inc., 108 N.J. 123, 129 (1987)), notwithstanding the contrary implication of a provision read "literally," as opposed to "sensibly" in context, id. at 515-16 (quoting State v. State Troopers Fraternal Ass'n, 134 N.J. 393, 418 (1993) (citations omitted)).

Six years after AICRA, we held the Legislature declined the Roig Court's implicit invitation to override its holding and make deductibles and copayments recoverable. D'Aloia v. Georges, 372 N.J. Super. 246, 250-51 (App. Div. 2004). Instead, AICRA left N.J.S.A. 39:6A-12 unchanged, and it modified the definition of "economic loss" in N.J.S.A. 39:6A-2(k), which N.J.S.A. 39:6A-12 incorporates, to include uncompensated "medical expenses" but without naming deductibles and copayments. Id. at 250; L. 1998, c. 21, § 2. Further, AICRA also left intact the anti-subrogation provision in N.J.S.A. 39:6A-4 and -4.3, which did name deductibles and copayments as unrecoverable items. D'Aloia, 372 N.J. Super. at 250. Similarly, in Haines v. Taft, 450 N.J. Super. 295, 308-09 (App. Div. 2017), rev'd on other grounds, 237 N.J. at 271, we adhered to D'Aloia's reasoning and affirmed Roig's recognition that "the Legislature intended to bar the recovery of minor expenses, such as deductibles and copayments, as a trade-off for lower premiums." Id. at 306-07.

We have considered Travelers's arguments in light of the aforementioned legislative history in conjunction with the Roig, D'Aloia, and Haines decisions, and we reject its contention the trial court's decision compelling it to pay the $15,000 statutory limit without reduction by an insured's deductible or copayment violates N.J.S.A. 39:6A-4 or the holdings in those cases. In reaching this conclusion, we are mindful it appears those holdings were animated by a general understanding that the Legislature, commencing in 1983, was focused on amending the no-fault PIP regime to effectuate a reduction in the cost of automobile insurance and did so, in part, through a calculated effort to avoid the recovery of PIP deductibles in actions against tortfeasors, and we further accept Travelers's argument that the legislative intent was indicative of a general lack of solicitude for recovering PIP deductibles.

Our decision, however, does not vitiate the goals of the no-fault statutory scheme, nor does it violate the principles set forth in Roig, D'Aloia, and Haines, as plaintiffs do not dispute their obligation to pay the listed deductibles and copayments. Similarly, we reject Travelers's assertion there exists a "double incentive" for an insured to choose the higher deductible which receives lower premiums and greater benefits. That argument ignores and misunderstands risk transfer principles associated with deductibles and copayments.

A "deductible is an amount of risk that the insured has agreed to assume in exchange for a lower premium cost for the insurance policy." City of Asbury Park v. Star Ins. Co., 242 N.J. 596, 612 (2020). See also Am. Nurses Ass'n v. Passaic Gen. Hosp., 98 N.J. 83, 88 (1984) (explaining a deductible's "functional purpose is simply to alter the point at which an insurance company's obligation to pay will ripen"); Black's Law Dictionary 519 (11th ed. 2019) (defining deductible as "the portion of the loss to be borne by an insured before the insurer becomes liable for payment"). Similarly, a copayment is an agreed out-of-pocket amount set by an insurance plan, which the insured agrees to pay. See Black's Law Dictionary at 423 (defining copayment as "[a] fixed amount that a[n] [insured] pays to an [insurance] provider according to the terms of the [insured]'s . . . plan").

An insured who selects a lower deductible, such as Carpinelli, presents the carrier with a lower threshold for coverage liability in the first instance, and, for that reason, the insured generally pays a higher premium. In contrast, an insured who selects a higher deductible, such as Birmingham, presents the insurer with a higher coverage threshold and therefore a reduced risk of liability for coverage, and, for those reasons, the insured typically pays a lower premium, assuming similar coverages and underwriting considerations. Travelers's

arguments regarding a double incentive therefore miss the point, as it ignores the reality of the differing risks retained by plaintiffs.

Finally, we address a case we raised with the parties at oral argument, IMO Industries Inc. v. Transamerica Corp., 437 N.J. Super. 577, 622 (App. Div. 2014). In IMO, the insured, a successor to a manufacturer of industrial and military machinery products, sought coverage from its primary and excess liability insurers for asbestos-related personal injury claims brought against it. Id. at 588. In that case, we resolved a series of complex long-tail insurance coverage issues, including: exhaustion of fronting policies through the application of Owens-Illinois's[4] allocation methodology; the finality of underlying settlements between policyholders and primary insurers where the excess insurer declined to participate; the limits of multi-year policies and stub-policies; the erosion of policy limits by self-insured retentions (SIR); indemnification by insurers for uncovered claims; and the insured's right to a jury trial where it predominantly sought equitable remedies. Id. at 613-36.

We concluded, among other holdings, that in the context of commercial insurance policies that deductibles "erode" the policy limit, meaning the payable amount per covered event is decreased by the deductible amount. In that case,

[4] Owens-Illinois, Inc. v. United Ins. Co., 138 N.J. 437 (1994).

we relied on federal case law and a liability insurance treatise, Barry R. Ostrager & Thomas R. Newman, Handbook on Insurance Coverage Disputes § 13.13[a] (12th ed. vol. 2, 2004), to distinguish deductibles from an SIR. IMO, 437 N.J. Super. at 622. We explained that contrary to a deductible, an SIR "is an amount that an insured retains and covers before insurance coverage begins to apply," but that it "does not reduce the limits of an insurance policy." Ibid. (quoting and then citing In re Sept. 11th Liab. Ins. Coverage Cases, 333 F. Supp. 2d 111, 124 n.7 (S.D.N.Y. 2004)).

We are satisfied that our holding in IMO is not dispositive with respect to the issues before us for two reasons. First, IMO involved a commercial general liability policy between two sophisticated parties, not statutorily mandated coverage contained in an automobile policy whose relevant terms and conditions were not subject to negotiation. Second, the IMO court relied in part on Benjamin Moore & Co. v. Aetna Co., 179 N.J. 87 (2004), which involved a policy that expressly provided the insurer's "'obligation to pay damages on behalf of the insured applies only to that amount of the limits of insurance that remains after deducting the [d]eductible [a]mount stated in the schedule of this endorsement.'" Id. at 93 (emphasis added). No such language exists in the Travelers's policies.

To the extent we have not addressed any of the parties' remaining arguments it is because we conclude they are without sufficient merit to warrant discussion in a written opinion. R. 2:11-3(e)(1)(E).

Affirmed.

I hereby certify that the foregoing is a true copy of the original on file in my office.

CLERK OF THE APPELLATE DIVISION