Section II
Proposed Rules

DEPARTMENT OF BANKING AND FINANCE

Division of Securities and Finance

RULE TITLE: RULE NO.:

Procedures for Determining Need for a New Cemetery Company 3D-30.0055

PURPOSE, EFFECT AND SUMMARY: The purpose of the proposed amendments is to implement the provisions of Chapter 2001-120, Laws of Florida. By repealing Sections 497.201(3) and (4), Florida Statutes, Chapter 2001-120 eliminates the requirement of a need determination by the Department of Banking and Finance in order to establish a new cemetery. Accordingly, the purpose of this proposed rulemaking is to repeal, Rule 3D-30.0055 which clarified procedures for determining need and was originally promulgated pursuant to Section 497.201, Florida Statutes.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: No statement of estimated regulatory cost has been prepared.

Any person who wishes to provide information regarding the statement of estimated regulatory costs, or to provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days of this notice.

SPECIFIC AUTHORITY: 497.103, 497.105 FS.

LAW IMPLEMENTED: Chapter 2001-120, Laws of Florida.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW (IF NOT REQUESTED, THIS HEARING WILL NOT BE HELD):

TIME AND DATE: 4:00 p.m., January 7, 2002

PLACE: Room 547, Fletcher Building, 101 East Gaines Street, Tallahassee, Florida

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Tim Wheaton, Room 636, Fletcher Building, 101 East Gaines Street, Tallahassee, FL 32399-0350, (850)410-9898

THE FULL TEXT OF THE PROPOSED RULE IS:

3D-30.0055 Procedures for Determining Need for a New Cemetery Company.

Specific Authority 497.103, 497.105 FS. Law Implemented 497.201 FS. History–New 3-1-99, Repealed ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Tim Wheaton, Fletcher Building, Room 636, 101 East Gaines Street, Tallahassee, FL 32399-0350, (850)410-9898

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Diana Evans, Chief of Funeral and Cemetery Services

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: August 10, 2001

DEPARTMENT OF INSURANCE

RULE TITLES: RULE NOS.:

Premium Growth Reporting 4-137.003

Reinsurance Summary Statement 4-137.011

PURPOSE AND EFFECT: The proposed amendment to Rule 4-137.003 would adopt a revised form for property and casualty insurers to report premium growth information to the Department. Proposed new Rule 4-137.011 would adopt a form for all insurers to use to report information to the Department relating to reinsurance.

SUMMARY: The information and filing requirement for reporting premium growth is contained in Section 624.4243(3), Florida Statutes. The revision to Rule 4-137.003 is necessary to correct the formula used for calculating the percentage of change in premium growth. Proposed new Rule 4-137.011 adopts a form for all insurers to report information on specific types of reinsurance agreements that is required to be filed by Section 624.610(11), Florida Statutes. Neither the form nor the filing requirement is new. However, the form has never been adopted by rule.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: No Statement of Estimated Regulatory Cost has been prepared.

Any person who wishes to provide information regarding the statement of estimated regulatory costs or to provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days of this notice.

SPECIFIC AUTHORITY: 624.308(1), 624.4243(3) FS.

LAW IMPLEMENTED: 624.4243(3), 624.610(11) FS.

IF REQUESTED IN WRITING WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW:

TIME AND DATE: 2:00 p.m. – 3:00 p.m., January 4, 2002

PLACE: Room 143, Larson Building, 200 E. Gaines St., Tallahassee, Florida

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this program, please advise the Department at least 5 calendar days before the program by contacting Yvonne White, (850)413-4214.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Sam Coskey, Senior Management Analyst, Bureau of Property and Casualty Insurer Solvency and Market Conduct, Division of Insurer Services, Department of Insurance, 200 E. Gaines Street, Room 216, Larson Building, Tallahassee, FL 32399-0329, (850)413-3148

THE FULL TEXT OF THE PROPOSED RULES IS:

4-137.003 Premium Growth Reporting.

Section 624.4243(3), Florida Statutes, requires that a form for reporting premium growth be adopted by rule for each insurer that has been authorized to transact property and casualty insurance in Florida for less than three years. Form DI4-1229 (rev. 7/01 ~~10/96~~) is hereby incorporated by reference to be the form specified in Section 624.4243(3), Florida Statutes, for reporting premium growth.

Specific Authority 624.4243(3) FS. Law Implemented 624.4243 FS. History–New 3-26-98, Amended ________.

4-137.011 Reinsurance Summary Statement.

Section 624.610(11), Florida Statutes, requires each domestic or commercially domiciled insurer ceding directly written risks of loss to file with the department one copy of a summary statement containing information about each treaty. The required information shall be filed on Form DI4-1433 (rev. 07/01), which is hereby incorporated by reference. Form DI4-1433 shall be filed within 30 days after receipt of a cover note or similar confirmation of coverage, or, without exception, no later than 6 months after the effective date of the reinsurance treaty.

Specific Authority 624.308(1) FS. Law Implemented 624.610(11) FS. History–New ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Sam Coskey, Senior Management Analyst, Bureau of Property and Casualty Solvency and Market Conduct, Division of Insurer Services, Department of Insurance

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Lee Roddenberry, Chief, Bureau of Property and Casualty Solvency and Market Conduct, Division of Insurer Services, Department of Insurance

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: October 19, 2001

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: November 9, 2001

DEPARTMENT OF INSURANCE

RULE TITLES:	RULE NOS.:
Rate Filing Procedures	4-149.003
Form Filing Procedures	4-149.021
Forms Adopted	4-149.022

PURPOSE AND EFFECT: To update the standardized data letter that life and health insurers must submit with every rate and form filing made with the Department of Insurance. To eliminate the need for filing multiple copies when filing forms. To provide consistency between the rate filing rule and the form filing rule with regard to disapprovals based on incomplete filings.

SUMMARY: Life and health insurers are required to file a form that summarizes the changes requested in an insurance rate or form filing. The Department is proposing to adopt a new standardized form that will be used with any type of life or health rate or form filing. This will eliminate the use of different forms for different types of filings. Only one copy of a filing would have to be submitted rather than two. Filings could be submitted by electronic mail. Incomplete filings would no longer be returned to the insurer.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: No Statement of Estimated Regulatory Cost has been prepared.

Any person who wishes to provide information regarding the statement of estimated regulatory costs, or to provide a proposal for a lower cost regulatory alternative, must do so in writing within 21 days of this notice.

SPECIFIC AUTHORITY: 624.308(1), 627.410(6)(b),(e) FS.

LAW IMPLEMENTED: 119.07(1)(b), 624.307, 625.121, 627.410, 627.476, 627.807 FS.

IF REQUESTED IN WRITING WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW:

TIME AND DATE: 10:00 a.m. – 12:00 p.m., January 4, 2002

PLACE: Room 143, Larson Building, 200 E. Gaines St., Tallahassee, Florida

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Frank Dino, Actuary, Division of Insurer Services, Department of Insurance, 200 E. Gaines Street, Room 312D, Larson Building, Tallahassee, FL 32399-0328, (850)413-5014

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this program should advise the Department at least 5 calendar days before the program by contacting Yvonne White, (850)413-4214.

THE FULL TEXT OF THE PROPOSED RULES IS:

4-149.003 Rate Filing Procedures.

(1)(a) Pooling. For purposes of submitting a rate filing under this part for individual policy forms and for group Medicare supplement and long-term care group policy forms, in order to encourage adequate risk sharing for all generations of policyholders, policy forms, whether open or closed, as defined in Rule 4-149.006(4)(d), F.A.C., providing for similar benefits, as defined in Rule 4-149.006(4)(q), F.A.C., shall be combined. Separate combinations may be used for policy forms defined in Rules 4-149.005(5) and 4-149.005(6), F.A.C.

(b) Credibility. In analyzing the experience of policy forms, the following sequence shall be used: if the Florida experience is comprised of fully credible data, as defined in Rule 4-149.006(4)(e), F.A.C., the Florida experience will be used; if not, then nationwide experience will be used as

described in Rule 4-149.006(4)(e), F.A.C. Once policy forms have been combined, they remain so for all rating purposes. When forms have been so combined, a rate revision request shall not differentiate between the experience of the individual forms. Where significant inconsistencies between rate levels exist between forms providing similar benefits, some deviation in rate revision granted shall be allowed to reduce these inconsistencies.

(2) Filing Format for Individual Policies and Group Policies and Certificates.

(a)1. All filings shall be made in accordance with paragraph (b) below.

2. All material submitted shall be legible. A filing which is illegible or which contains illegible material will be disapproved without any further processing ~~and will be either returned to the insurer if the insurer has provided the Department with an envelope large enough to contain the material and with sufficient prepaid postage to ensure its acceptance by the U.S. Postal Service or destroyed~~.

3. For purposes of the rules in this Part and the time periods in Section 627.410, Florida Statutes, a filing is considered "filed" with the Department upon the receipt of the material required by paragraph (b). Further, for purposes of the rules in this Part, the term "filed" does not mean "approved." The term "filed" refers to the date on which the filing is filed with the Department and is the date on which the approval process of Section 627.410, Florida Statutes, commences. "Filing" with the Department does not constitute approval of the rate filing.

(b) A health insurance rate filing shall consist of one copy of each of the following items ~~two copies of all of the items in subparagraphs 1. through 6. and one of the item in subparagraph 7. below, in addition to the requirements of subsection (1), above~~:

1. A brief letter explaining the type and nature of the filing. The letter shall indicate if the filing is for a new product, a rate revision, or a resubmission. If the filing is a resubmission, the letter shall indicate when the previous filing was submitted, the Florida filing number, and the date of the disapproval. ~~Letters requiring a reference to a Florida filing number will not be processed without the inclusion of the Florida filing number.~~

2. Form "1507, The Florida Department of Insurance, Treasurer and Fire Marshal Life and Health Forms and Rates Universal Standardized Data Letter", rev. 7/01, completely filled out in accordance with Form DI4-1507A, "The Florida Department of Insurance, Treasurer and Fire Marshal Life and Health Forms and Rates Universal Standardized Data Letter Instruction Sheet", rev. 7/01. ~~Form DI4-562A, "Standardized Data Letter/Florida Department of Insurance/Division of Insurer Services/Health Forms Filing," rev. 4/91; and Form DI4-562B, "Standardized Data Letter/Florida Department of Insurance/Division of Insurer Services/Health Rates Filing," rev. 7/91, which are hereby adopted and incorporated by reference, completely filled out, with the company's bar code label in the upper right hand corner of the forms, including the certifications, both completed in accordance with the instructions contained in Form DI4-562, "Standardized Data Letter/Health Insurance/Instruction Sheet," rev. 7/91, which is hereby adopted and incorporated by reference. Additional bar code labels may be obtained from the Bureau of Data Control, Insurance Research and Data Analysis, Larson Building, Tallahassee, FL 32399-0300. Requests must be made in writing and must include the company name, the company federal employer identification number, and payment of $30 for each company.~~

~~3. Form DI4-561, "Health Insurance Filing Requirements Summary," rev. 7/91, which is hereby adopted and incorporated by reference, completed for all filings, including form and rate filings.~~

3.~~4.~~ The actuarial memorandum, completed as required by Rule 4-149.006, F.A.C., "Actuarial Memorandum and Definitions."

4.~~5.~~ Rate pages that ~~which~~ define all proposed rates, rating factors and methodologies for determining rates applicable in the state. For companies which have a complete rate manual on file with the department, only the pages that are being changed need to be filed, unless requested by the Department.

5.~~6.~~ The material described in subsection (5), below, if applicable.

~~7. An envelope large enough to contain the material and with sufficient prepaid postage to ensure its acceptance by the U.S. Postal Service if the insurer wishes to have the material returned rather than destroyed as provided in paragraph (a), above.~~

(3) Filings~~, as that term is defined in subsections (1) and (2), above,~~ shall be mailed to: Bureau of Life and Health Forms & Rates, Division of Insurer Services, Department of Insurance, Post Office Box 8040, Tallahassee, FL 32301-8040 ~~32314-5320~~ or submitted electronically to lhfrbureau@doi.state.fl.us. All filings sent to the Department by Federal Express or any other form of special delivery shall be delivered to: Bureau of Life and Health Forms and Rates, Division of Insurer Services, Department of Insurance, 1st Floor, Larson Building, 200 East Gaines Street, Tallahassee, FL 32399-0328 ~~32301~~.

(4) Every insurer submitting a rate filing shall be notified as to whether the filing ~~has been deemed approved,~~ has been affirmatively approved by the Department~~,~~ or has been disapproved by the Department, including disapprovals for failure of the material to meet the definition of a "filing" or for illegibility, within any statutory review period of the date of receipt of the filing. Every insurer submitting a rate filing which does not comply with the requirements of Rules 4-149.001 through 4-149.006, F.A.C., or for which the Department determines that additional information is

necessary for a proper review, will be notified of the additional information necessary ~~deficiencies in the filing~~ within the statutory limit. Every insurer shall submit the required data by a date certain stated in the clarification ~~deficiency~~ letter, to allow the Department sufficient time to perform a proper review. Failure to correct the filing ~~deficiencies~~ by the date certain in the clarification ~~deficiency~~ letter will result in an affirmative disapproval of the filing by the Department.

(5) After April 18, 1994, an insurer that ~~which~~ agrees to administer or that ~~which~~ purchases the business under a policy form from another insurer shall provide calendar year experience since inception of the policy form (or the last 3 ~~three~~ years for a group policy form, with no separation of experience data by issue year required), in the detail presented in Rule 4-149.006(3)(b)23., F.A.C. If the insurer believes that the data is not reasonably available and cannot be reasonably reconstructed at reasonable expense, then the insurer shall consult with the Department in order to address the issue of the required lifetime loss ratio. If, after such consultation, the experience since inception (or the last 3 ~~three~~ years for a group policy form) is still required and is not provided, then any rate adjustment granted will be limited to the change in the Medical CPI for the most recent calendar year.

Specific Authority 624.308(1), 627.410(6)(b),(e) FS. Law Implemented 119.07(1)(b), 627.410 FS. History–New 7-1-85, Formerly 4-58.03, 4-58.003, Amended 8-23-93, 4-18-94, 8-22-95, ________.

4-149.021 Form Filing Procedures.

(1)(a)1. All filings shall be made in accordance with paragraph (b) below.

2. All material submitted shall be legible. A file which is illegible or which contains illegible material will be disapproved without any further processing ~~returned unprocessed~~. ~~No filing will be processed until it is complete. A complete filing consists of the material described in paragraph (b).~~

3. For purposes of the rules in this Part and the time periods in Section 627.410, Florida Statutes, a filing is considered "filed" with the Department upon the receipt of the material required by paragraph (b). For purposes of the rules in this Part, the term "filed" does not mean "approved." The term "filed" refers to the date on which the filing is filed with the Department and is the date on which the approval process of Section 627.410, Florida Statutes, commences. "Filing" with the Department does not constitute approval of the form filing.

(b) A ~~complete~~ form filing shall consist of one copy of each of the following items:

1. A brief transmittal letter~~, in triplicate,~~ explaining the type and nature of the filing, including the subject, the purpose, and any unusual features relative to products being sold by other companies. The letter shall also indicate if the filing is new or is a resubmission. If the filing is a resubmission, the letter shall indicate when the previous filing was submitted, the Florida filling number and the date of the ~~approval or~~ disapproval. If the filing is either a group life or a group annuity form, the letter shall indicate the Florida statute number under which the form is to be issued.

2. Form DI4-1507, "The Florida Department of Insurance, Treasurer and Fire Marshal Life and Health Forms and Rates Universal Standardized Data Letter", rev. 7/01, completely filled out in accordance with Form DI4-1507A, "The Florida Department of Insurance, Treasurer and Fire Marshal Life and Health Forms and Rates Universal Standardized Data Letter Instruction Sheet", rev. 7/01. ~~Form DI4-560, "Standardized Data Letter/Florida Department of Insurance/Division of Insurer Services/Forms Filing (Life and Annuities)," rev. 4/91, completely filled out, including the certification in Part III; or Form DI4-562A, "Standardized Data Letter/Florida Department of Insurance/Division of Insurer Services/Health Forms Filing," rev. 4/91, completely filled out, including the certification in Part III, completed in accordance with the instructions contained in Form DI4-562, "Standardized Data Letter/Health Insurance/Instruction Sheet," rev. 7/91. When submitted, both Form DI4-560 and Form DI4-562A shall contain the company's bar code label in the upper right hand corner of the form. Additional bar code labels may be obtained from the Document Processing Section, Division of Administration, Larson Building, Tallahassee, FL 32399-0311. The request must be in writing and must contain the company name, the federal employer identification number, and payment for $30 for each company.~~

~~3. Form DI4-561, "Health Insurance Filing Requirements Summary," rev. 7/91, for all health form filings.~~

3.~~4.~~ The checklist appropriate for the type of form being filed and any information required by that checklist. All forms and checklists are listed and adopted in Rule 4-149.022, F.A.C.

~~5. Form DI4-546, "Checklist Certification," rev. 4/91, signed by a company officer or a designated compliance person.~~

4.~~6.~~ Any certifications of ~~readability,~~ rates, cost indices, or other items, if required by the appropriate checklist or by rule.

5.~~7.~~ One copy ~~Three copies~~ of the form(s) being filed. Each form must include the name of the company, and each form must have an identifying form number in the lower left hand corner of the first page of the form.

6.~~8.~~ Each filing shall contain an actuarial memorandum, certified and signed by a qualified actuary. The actuarial memorandum for life and annuity product filings shall demonstrate compliance with the Standard Valuation Law. In addition, filings for life insurance products other than annuities shall demonstrate compliance with the Standard Nonforfeiture Law.

~~9. If the insurer wishes a copy of the form stamped with the Department's approval, the insurer shall include a self-addressed envelope, with sufficient postage affixed, as part of the form filing.~~

(2) Each filing shall contain forms for only one type of coverage, i.e., ordinary life, variable life, major medical, etc. However, a filing may contain more than one form if the forms are for the same type of coverage.

(3) Each filing shall contain forms for only one company.

(4) Combination forms, products that contain both life and health coverages, shall be submitted separately but simultaneously and shall ~~to the address in subsection (5), below. Each submission shall~~ be clearly marked to indicate that they are combination filings, one as life and one as health ~~whether the filing is for life or for health~~.

(5) Complete filings shall be mailed to: Bureau of Life and Health Forms & Rates, Division of Insurer Services, Department of Insurance, Post Office Box 8040 ~~5320~~, Tallahassee, FL 32301-8040 ~~32314-5320~~ or submitted electronically to lhfrbureau@doi.state.fl.us. All filings sent to the Department by Federal Express or any other form of special delivery shall be delivered to: Bureau of Life and Health Forms and Rates, Division of Insurer Services, Department of Insurance, 1st Floor, Larson Building, 200 East Gaines Street, Tallahassee, FL 32399-03228~~00~~.

(6) Every insurer submitting a form filing shall be notified as to whether the filing has been affirmatively approved by the Department, or has been disapproved by the Department, including disapprovals for failure of the material to meet the definition of a "filing" or for illegibility, within any statutory review period of the date of receipt of the filing. Every insurer submitting a form filing for which the Department determines that additional information is necessary for a proper review will be notified of the additional information within the statutory limit. Every insurer shall submit the required data by a date certain stated in the clarification letter to allow the Department sufficient time to perform a proper review. Failure to correct the filing by the date certain in the clarification letter will result in an affirmative disapproval of the filing by the Department. ~~Only complete filings in accordance with this rule will be processed. Any filing submitted without all of the required forms or information will be considered incomplete. All incomplete filings will be returned without processing.~~

(7) Definitions. As used in this rule:

(a) New Filing – A new filing is one that is being submitted for the first time. This includes submission of revisions to a previously approved form.

(b) Resubmission – A filing submission in response to a final disapproval from the Department is a resubmission. It is given a new filing number by the Department. This term does not apply to ongoing correspondence under the same filing number before an affirmative approval or disapproval by the Department.

Specific Authority 624.308 FS. Law Implemented 624.307, 625.121, 627.410, 627.476, 627.807 FS. History–New 10-29-91, Amended 8-23-93, 4-18-94, 8-22-95, 5-15-96,________.

4-149.022 Forms Adopted.

(1) The forms adopted in subsection (2), below, shall be used, as applicable, by insurers making form filings for life and accident insurance, annuities, and health insurance. All the forms in subsection (2), below, are hereby adopted and incorporated by reference. All forms may be obtained from the Document Processing Section, Division of Administration, Department of Insurance, Larson Building, Tallahassee, FL 32399-0311. Forms are also available and may be printed from the Department's website: www.doi.state.fl.us. All forms may be reproduced at will.

(2)(a) Form DI4-1507, "The Florida Department of Insurance, Treasurer and Fire Marshal Life and Health Forms and Rates Universal Standardized Data Letter", rev. 7/01.

(b) Form DI4-1507A, "The Florida Department of Insurance, Treasurer and Fire Marshal Life and Health Forms and Rates Universal Standardized Data Letter Instruction Sheet", rev. 7/01.

(a) through (z) renumbered (c) through (bb) No change.

~~(aa) Form DI4-546, "Checklist Certification," rev. 4/91.~~

(bb) through (ll) renumbered (cc) through (mm) No change.

~~(mm) Form DI4-560, "Standardized Data letter/Florida Department of Insurance/Division of Insurer Services/Forms Filing (Life and Annuities)," rev. 4/91.~~

~~(nn) Form DI4-561, "Health Insurance Filing Requirements Summary," rev. 7/91.~~

~~(oo) Form DI4-562A, "Standardized Data Letter/Florida Department of Insurance/Division of Insurer Services/Health Forms Filing," rev. 4/91.~~

~~(pp) Form DI4-562, "Standardized Data Letter/Health Insurance/Instruction Sheet," rev. 7/91.~~

Specific Authority 624.308 FS. Law Implemented 627.410 FS. History–New 10-29-91, Amended 5-15-96,________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Frank Dino, Bureau of Life and Health Forms and Rates, Division of Insurer Services, Department of Insurance

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Rich Robleto, Chief, Bureau of Life and Health Forms and Rates, Division of Insurer Services, Department of Insurance

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: October 3, 2001

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: October 19, 2001

DEPARTMENT OF INSURANCE

RULE TITLE:	RULE NO.:
Forms Adopted	4-149.022

PURPOSE AND EFFECT: The purpose of the proposed rule development is to adopt revised forms that are part of the policy form filing process for life and health insurance companies.

SUMMARY: The revised forms are checklists of Florida laws and rules that set forth various provisions which insurers are required to include in insurance policies. The checklists aid insurers in complying with Florida laws and rules. The revisions reflect the adoption of new statutes and rules, as well as amendments to existing statutes or rules, which have changed various policy provision requirements. Copies of the new forms are available and may be printed from the department's web site: www.doi.state.fl.us.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: No Statement of Estimated Regulatory Cost has been prepared.

Any person who wishes to provide information regarding the statement of estimated regulatory costs or to provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days of this notice.

SPECIFIC AUTHORITY: 624.308 FS.

LAW IMPLEMENTED: 627.410 FS.

IF REQUESTED IN WRITING WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW:

TIME AND DATE: 10:00 a.m. – 12:00 p.m., January 4, 2002

PLACE: Room 143, Larson Building, 200 E. Gaines Street, Tallahassee, Florida

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Frank Dino, Actuary, Division of Insurer Services, Department of Insurance, 200 E. Gaines Street, 312D Larson Building, Tallahassee, FL 32399-0328, (850)413-5014

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this program, please advise the Department at least 5 calendar days before the program by contacting Yvonne White, (850)413-4214.

THE FULL TEXT OF THE PROPOSED RULE IS:

4-149.022 Forms Adopted.

(1) The forms adopted in subsection (2), below, shall be used, as applicable, by insurers making form filings for life and accident insurance, annuities, and health insurance. All the forms in subsection (2), below, are hereby adopted and incorporated by reference. All forms may be obtained from the Document Processing Section, Division of Administration, Department of Insurance, Larson Building, Tallahassee, FL 32399-0311. Forms are additionally available and may be printed from the department's web site: www.doi.state.fl.us. All forms may be reproduced at will.

(2)(a) Form DI4-1507, "The Florida Department of Insurance, Treasurer and Fire Marshal Life and Health Forms and Rates Universal Standardized Data Letter", rev. 7/01.

(b) Form DI4-1507A, "The Florida Department of Insurance, Treasurer and Fire Marshal Life and Health Forms and Rates Universal Standardized Data Letter Instruction Sheet", rev. 7/01.

~~(c) Form DI4-519, "Filing Instructions for Group and Individual Health Insurance," rev. 4/91.~~

(c)~~(d)~~ Form DI4-520, "Florida Individual Health Application Checklist," rev. 4/91.

(d)~~(e)~~ Form DI4-521, "Florida Individual Health Contract Outline of Coverage Checklist," rev. 4/91.

~~(f) Form DI4-522, "Florida Individual Health Contracts Additional Items for Filings Checklist," rev. 4/91.~~

(e)~~(g)~~ Form DI4-523, "Florida Individual Health Contract Checklist," rev. 4/91.

(f)~~(h)~~ Form DI4-524, "Florida Out-of-State Group Health Checklist," rev. 4/91.

(g)~~(i)~~ Form DI4-525, "Florida Group Health Application Checklist for Employees, Labor Union and Association Groups," rev. 4/91.

(h)~~(j)~~ Form DI4-526, "Florida Group Health Checklist for Employees, Labor Unions and Association Groups," rev. 4/91.

(i)~~(k)~~ Form DI4-527, "Florida Health Application Checklist for Debtor Groups," rev. 4/91.

(j)~~(l)~~ Form DI4-528, "Florida Additional Information Checklist for Debtor Groups," rev. 4/91.

(k)~~(m)~~ Form DI4-529, "Florida Group Health Contract Checklist for Debtor Groups," rev. 4/91.

~~(n) Form DI4-530, "Florida Group Health Application Checklist for Additional Groups/F.S. 627.656," rev. 4/91.~~

~~(o) Form DI4-531, "Florida Group Health Checklist for Additional Groups, Employees and Dependents," rev. 4/91.~~

~~(p) Form DI4-532, "Florida Franchise Health Contracts/F.S. 627.663/Additional Items for Filing Checklist," rev. 4/91.~~

~~(q) Form DI4-533, "Optional Coverages/F.S. 627.656/Additional Groups Checklist," rev. 4/91.~~

~~(r) Form DI4-534, "Florida Additional Groups Additional Information Checklist/F.S. 627.656 (F.S. 627.5565)," rev. 4/91.~~

(l)~~(s)~~ Form DI4-535, "Checklist for Blanket Health Contracts/F.S. 627.659," rev. 4/91.

(m)~~(t)~~ Form DI4-536, "Florida Franchise Health Application Checklist," rev. 4/91.

(n)~~(u)~~ Form DI4-537, "Florida Franchise Health Contract Outline of Coverage Checklist," rev. 4/91.

(o)~~(v)~~ Form DI4-538, "Florida Franchise Health Contract Checklist," rev. 4/91.

(p)~~(w)~~ Form DI4-539, "Florida Excess-Specific and Aggregate Checklist/Florida Statute 624.406," rev. 4/91.

(q)~~(x)~~ Form DI4-540, "Informational Memorandum Checklist/Florida Excess Specific and Aggregate/F.S. 624.406," rev. 4/91.

(r)~~(y)~~ Form DI4-541, "Florida Health Application Checklist for Long Term Care Groups," rev. 4/91.

(s)~~(z)~~ Form DI4-542, "Florida Long Term Care Checklist/Outline of Coverage," rev. 4/91.

(t)~~(aa)~~ Form DI4-543, "Florida Long Term Care Contract Checklist," rev. 4/91.

(u) Form DI4-1353, "Florida Pre-Paid Limited Health Services Contract Checklist," 7/00.

(v) Form DI4-1354, "Florida Individual Medicare Supplement Health Application Checklist," 7/00.

(w) Form DI4-1355, "Florida Medicare Supplement Contract Checklist," 7/00.

(x) Form DI4-1356, "Florida HMO Contract Checklist (Includes Individual, Large, And Small Group)," 7/00.

(y) Form DI4-1357, "Florida Small Group Health Checklist For Indemnity Plans Other Than Standard And Basic," 7/00.

(z) Form DI4-1358, "Florida Pre-Paid Limited Health Services Group Application," 7/00.

(aa) Form DI4-1359, "Florida Pre-Paid Limited Health Services Conversion Application," 7/00.

(bb) Form DI4-1360, "Florida Pre-Paid Limited Health Services Individual Application," 7/00.

(cc) Form DI4-1314, "Individual Fraternal Whole Life," 7/00.

(dd) Form DI4-1328, "Out-of-State Group Term Life," 7/00.

(ee) Form DI4-1329, "Out-of-State Group Whole Life," 7/00.

(ff) Form DI4-1330, "Out-of-State Group Universal Life," 7/00.

(gg) Form DI4-1342, "Group Enrollment Application Variable Annuity," 7/00.

(hh) Form DI4-1343, "Out-of-State Group Variable Life," 7/00.

(ii) Form DI4-1345, "Group Universal Life," 7/00.

(jj) Form DI4-1346, "Individual Life Application," 7/00.

(kk) Form DI4-1347, "Individual Fixed Annuity Application," 7/00.

(ll) Form DI4-1348, "Individual Variable Annuity Application," 7/00.

(mm) Form DI4-1349, "Group Enrollment Application (non variable annuity)," 7/00.

(nn) Form DI4-1350, "Master Group Application," 7/00.

(oo) Form DI4-1351, "Industrial Life Policy," 7/00.

(pp) Form DI4-1352, "Individual Non-Variable Annuity Policy," 7/00.

(qq) Form DI4-1363, "Group Non-Variable Annuity Policy," 7/00.

(rr) Form DI4-1364, "Individual Variable Annuity Policy," 7/00.

(ss) Form DI4-1365, "Group Variable Annuity Policy," 7/00.

(tt) Form DI4-1366, "Out-of State Group Annuity Policy," 7/00.

(uu) Form DI4-1367, "Endorsement, Amendments, Riders," 7/00.

(vv) Form DI4-1368, "Accelerated Death Benefit Rider," 7/00.

(ww) Form DI4-1369, "Credit Life and Disability," 7/00.

(xx) Form DI4-1382, "Individual Fraternal Term Life," 7/00.

(yy) Form DI4-1383, "Group Fraternal Term Life," 7/00.

(zz) Form DI4-1384, "Individual Variable Life," 7/00.

(aaa) Form DI4-1485, "Group Fraternal Term Life," 7/00.

(bbb) Form DI4-1486, "Group Fraternal Whole Life," 7/00.

(ccc) Form DI4-1487, "Group Fraternal Universal Life," 7/00.

(ddd) Form DI4-1488, "Group Term Life," 7/00.

(eee) Form DI4-1489, "Group Variable Life," 7/00.

(fff) Form DI4-1490, "Group Whole Life," 7/00.

(ggg) Form DI4-1491, "Individual Fraternal Universal Life," 7/00.

(hhh) Form DI4-1492, "Individual Fraternal Variable Life," 7/00.

(iii) Form DI4-1493, "Individual Term Life," 7/00.

(jjj) Form DI4-1494, "Individual Universal Life," 7/00.

(kkk) Form DI4-1496, "Individual Whole Life," 7/00.

~~(bb) Form DI4-545, "Filing Instructions for: Life, Annuities, Credit Life and Credit Disability, Variable Life and Variable Annuity Forms," rev. 4/91.~~

~~(cc) Form DI4-547, "Life and Annuity Individual Applications Checklist," rev. 4/91.~~

~~(dd) Form DI4-548, "Individual Ordinary Life Policies Checklist," rev. 4/91.~~

~~(ee) Form DI4-549, "In State Group Life Policies Checklist," rev. 4/91.~~

~~(ff) Form DI4-550, "Out of State Group Life Policies Checklist," rev. 4/91.~~

~~(gg) Form DI4-551, "Individual or Group Universal Life Policies and/or Variable Life Policies Checklist," rev. 4/91.~~

~~(hh) Form DI4-552, "Individual or Group Credit Life Policies Checklist," rev. 4/91.~~

~~(ii) Form DI4-553, "Individual or Group Credit Disability Policies Checklist," rev. 4/91.~~

~~(jj) Form DI4-554, "Industrial Life Policies Checklist," rev. 4/91.~~

~~(kk) Form DI4-555, "Fixed Annuity Checklist," rev. 4/91.~~

~~(ll) Form DI4-556, "Variable Annuity Checklist," rev. 4/91.~~

~~(mm) Form DI4-557, "Fixed or Variable Group Annuity Checklist," rev. 4/91.~~

Specific Authority 624.308 FS. Law Implemented 627.410 FS. History–New 10-29-91, Amended 5-15-96,________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Frank Dino, Bureau of Life and Health Forms and Rates, Division of Insurer Services, Department of Insurance

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Rich Robleto, Chief, Bureau of Life and Health Forms and Rates, Division of Insurer Services, Department of Insurance

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: October 3, 2001

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: October 19, 2001

DEPARTMENT OF TRANSPORTATION

RULE CHAPTER TITLE:	RULE CHAPTER NO.:
Incorporation by Reference	14-15
RULE TITLE:	RULE NO.:
Toll Facilities Description and Toll Rate Schedule	14-15.0081

PURPOSE AND EFFECT: The purpose of this notice of rulemaking is to allow the public an opportunity to provide input to changes in the Toll Facilities Description and Toll Rate Schedule required by the construction of the CR 470/Florida's Turnpike interchange. Section 338.155(1), Florida Statutes, does not permit the use of the State's toll facilities without paying a toll.

SUMMARY: The proposed action is being taken to determine the Toll Rate Schedule resulting from the Florida Department of Transportation's construction of the CR 470/Florida's Turnpike interchange. The project is located in Lake County. Tolls are proposed to be collected for vehicles entering the Turnpike northbound and exiting the Turnpike southbound. The toll rate public hearing is being held in conjunction with the Design Public Hearing for the interchange project, Financial Project ID 404214-1. The required Toll Rate Rule Development Workshop was held July 11, 2000.

SPECIFIC AUTHORITY: 334.044(2) FS.

LAW IMPLEMENTED: 338.222, 338.231, 338.155 FS.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: No Statement of Estimated Regulatory Cost has been prepared.

Any person who wishes to provide information regarding the statement of estimated regulatory costs, or to provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days of this notice.

A HEARING WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW:

TIME AND DATE: 7:00 p.m., January 24, 2002 (An informal open house will begin at 6:00 p.m.)

PLACE: Commission Meeting Room, Leesburg City Hall, 501 West Meadow Street, Leesburg, Florida 34748

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: James C. Myers, Administrative and Management Support Level IV, Florida Department of Transportation, Office of the General Counsel, 605 Suwannee Street, Mail Station 58, Tallahassee, Florida 32399-0458

THE FULL TEXT OF THE PROPOSED RULE IS:

14-15.0081 Toll Facilities Description and Toll Rate Schedule.

The Toll Facilities Description and Toll Rate Schedule, adopted November 15, 1987, and amended on February 8, 1988, August 1, 1988, February 2, 1989, May 10, 1989, July 1, 1991, August 1, 1991, November 6, 1991, July 11, 1993, November 28, 1993, September 18, 1994, June 6, 1995, July 9, 1995, January 1, 1996, March 31, 1996, April 28, 1996, June 2, 1996, July 28, 1996, September 23, 1997, November 24, 1997, February 12, 1998, June 30, 1998, July 29, 1998, January 6, 1999, February 9, 1999, April 29, 1999, June 21, 1999, ~~and~~ September 4, 2001, and__________, is hereby incorporated by this rule and made a part of the rules of the Department. Copies of this Department of Transportation Toll Facilities Description and Toll Rate Schedule and any amendments thereto are available at no more than cost.

Specific Authority 334.044(2), 338.155(1) FS. Law Implemented 338.222, 338.231, 338.155 FS. History–New 11-15-87, Amended 2-8-88, 8-1-88, 2-2-89, 5-10-89, 7-1-91, 8-1-91, 11-6-91, 7-11-93, 11-28-93, 9-18-94, 6-6-95, 7-9-95, 1-1-96, 3-31-96, 4-28-96, 6-2-96, 7-28-96, 9-23-97, 11-24-97, 2-12-98, 6-30-98, 7-29-98, 1-6-99, 2-9-99, 4-29-99, 6-21-99, 9-4-01,________.

NAME OF PERSON ORIGINATING PROPOSED RULE: James Ely, District Secretary, Turnpike District, and Deborah Stemle, Director, Office of Toll Operations

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Thomas F. Barry, Jr., P.E., Secretary

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: November 28, 2001

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: June 16, 2001

STATE BOARD OF ADMINISTRATION

RULE TITLES:	RULE NOS.:
Purpose	19-7.001
Pooled Investment Accounts	19-7.010
Rate of Return Calculation	19-7.011
Pool Participation	19-7.012
Reporting Procedures	19-7.013
Number of Accounts	19-7.014
Allocation of Earnings	19-7.015
Close of Business	19-7.016
Pooled Investment Account Reserve Fund	19-7.017

PURPOSE AND EFFECT: These proposed rules implement the provisions of Part IV of Chapter 218, Florida Statutes, regarding local government investment pools.

SUMMARY: Proposed amended Rule 19-7.001 sets out the purpose of the rules. Proposed amended Rule 19-7.010 describes Rules 19-7.010 through 19-7.016 as relating to the Local Government Pooled Investment Account. Proposed amended Rule 19-7.011 provides the rate of return calculation for the Pooled Investment Account. Proposed amended Rule 19-7.012 provides a method for investing surplus funds. Proposed amended Rule 19-7.013 provides reporting procedures for the pool. Proposed amended Rule 19-7.014 provides the maximum number of accounts. Proposed amended Rule 19-7.015 provides for allocation of earnings for accounts participating in the Pooled Investment Account. Proposed amended Rule 19-7.016 provides procedures for investments based on when the Board's records are balanced. Proposed amended Rule 19-7.017 provides procedures for establishing a reserve fund.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: The Board has prepared a statement and estimated the cost to be minimal.

Any person who wishes to provide information regarding the statement of estimated regulatory costs, or to provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days of this notice.

SPECIFIC AUTHORITY: 218.405, 218.412 FS.

LAW IMPLEMENTED: Ch. 218, Part IV FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW:

TIME AND DATE: 9:00 a.m. – 11:30 a.m., Thursday, January 3, 2002

PLACE: Room 116, Hermitage Conference Room, 1801 Hermitage Blvd., Tallahassee, Florida 32308

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Cindy Gokel, Assistant General Counsel, State Board of Administration, P. O. Drawer 13300, Tallahassee, FL 32317-3300, (850)413-1199

THE FULL TEXT OF THE PROPOSED RULES IS:

19-7.001 Purpose.

These rules are promulgated to provide guidance and to establish general operating procedures for the administration of the Local Government Surplus Funds Trust Fund.

Specific Authority 218.405, 218.412, ~~120.53(1), 218.409(4)~~ FS. Law Implemented Ch. 218, Part IV FS. History–New 8-24-82, Formerly 19-7.01, Repromulgated ________.

19-7.010 Pooled Investment Accounts.

Rules 19-7.010 through 19-7.016, F.A.C., are developed for the Local Government Pooled Investment Account pursuant to Section 218.409, Florida Statutes.

Specific Authority 218.405, 218.412, ~~120.53(1), 218.409(4)~~ FS. Law Implemented Ch. 218, Part IV FS. History–New 8-24-82, Formerly 19-7.10, Repromulgated ________.

19-7.011 Rate of Return Calculation.

The Rate of Return Calculation for the Pooled Investment Account shall be as follows:

(1) Daily Rate of Return:

DAE x 360

DRR = IB

DRR = Daily Rate of Return (stated as a decimal fraction)

DAE = Daily Accrued Earnings

IB = Investment Balance at Cost (End of Day)

(2) Moving 30 Day Average Rate of Return:

MAE x (360/30)

AIB

MRR = Monthly Average Rate of Return (stated as a decimal fraction)

MAE = 30 Previous Day's Cumulative DAE

AIB = Average Daily Investment Balance at Cost of the 30 previous days

(3) Definitions:

(a) Daily Accrued Earnings:

1. Accrued coupon income;

2. Accretion/Amortization on securities; and

3. Realized gains/losses on security sales.

All computations for the components of Daily Accrued Earnings are in conformance with the "Standard Securities Calculation Methods" published by the Securities Industry Association.

(b) Investment Balance at Cost (end of day) is the total of all investments held in inventory for the Pooled Investment Account totaled on a cost basis.

(c) Average Daily Investments Balance at Cost is the average of the daily investment balance at cost for each day of the time period cited.

Specific Authority 218.405, 218.412, ~~120.53(1), 218.409(4)~~ FS. Law Implemented 218.407(4) ~~Ch. 218, Part IV~~ FS. History–New 8-24-82, Formerly 19-7.11, Amended 4-8-92, Repromulgated ________.

19-7.012 Pool Participation.

All units of Local Government that qualify to be participants in the Local Government Surplus Funds Trust Fund after January 1,1982, will normally have surplus funds deposited into the Pooled Investment Account. If a unit of Local Government wishes to establish a separate account outside of the Pooled Investment Account, the Executive Director shall make a determination based on the following considerations: ~~The Executive Director of the Board may under special or unusual circumstances grant exceptions to this rule and authorize a participant to establish a separate account outside the Pooled Investment Account. In making the decision concerning said exception, the Executive Director shall take into account the following considerations:~~

(a) Magnitude of the deposit;

(b) Frequency of anticipated withdrawals;

(c) Special investment requirements of the unit of Local Government;

(d) Anticipated period of time between request to withdraw and required receipt of withdrawn funds; and

(e) Any other relevant information offered by the unit of Local Government. During the pendency of a major market disruption which causes a suspension of trading or liquidity is impaired, the Executive Director shall limit contributions to the fund or withdrawals from the fund to ensure that the Board can invest the monies entrusted to it exercising its fiduciary responsibility as trustee. ~~All withdrawals from the Pool of $20,000,000 or more may, at the option of the Executive Director of the Board, require two (2) days prior notice.~~ Funds designated by a unit of Local Government for the purpose of investment management by a private investment asset manager shall not be deposited into the Pooled Investment Account nor into any separate account established within the Local Government Surplus Funds Trust Fund.

Specific Authority 218.405, 218.412 ~~120.53(1), 218.409(4)~~ FS. Law Implemented 218.407(2), 218.409(1),(3) ~~Ch. 218, Part IV~~ FS. History–New 8-24-82, Formerly 19-7.12, Amended 12-20-87, 2-16-92, ________.

19-7.013 Reporting Procedures.

The State Board of Administration shall forward to each Pool participant a monthly statement containing each account's activity including deposits, withdrawals, balances, earnings and administrative expense charges. If no errors are reported to the Board within 14 days, the statement will be considered correct. A semi-annual portfolio activity statement will be forwarded to each participant.

Specific Authority 218.405, 218.412 FS. Law Implemented 218.409(6) ~~Ch. 218, Part IV~~ FS. History–New 8-24-82, Formerly 19-7.13, Amended 12-18-88, 11-7-99, Repromulgated ________.

19-7.014 Number of Accounts.

The maximum number of accounts allowed each participant shall be ten (10) ~~six (6)~~.

Specific Authority 218.405, 218.412 ~~120.53(1), 218.409(4)~~ FS. Law Implemented 218.409(5) ~~Ch. 218, Part IV~~ FS. History–New 8-24-82, Formerly 19-7.14, Amended 12-2-93, ________.

19-7.015 Allocation of Earnings.

The Local Government Surplus Funds Trust Fund System is used to keep current account balance information for individual accounts participating in the Pooled Investment Account and to apportion the pooled investment earnings back to each account. At the end of each month, pool month-to-date accrued earnings are apportioned to the participants directly proportionate to the respective net amounts deposited in the Fund and the length of time such amounts remain therein. The resulting proportionate amount is credited to each account at that time. An investment service charge ~~The administrative expense charge, per Rule 19-6.009, F.A.C.,~~ is then deducted from the account. If the investment service ~~administrative expense~~ charge is less than one dollar, a minimum charge of one dollar or the account ending balance, whichever is less, will be deducted as satisfaction of the investment service ~~administrative expense~~ charge for that month. If the account balance is less than $1.00, the account may be closed upon satisfaction of the investment service ~~administrative expense~~ charge.

Specific Authority 218.405, 218.412 ~~120.53(1), 218.409(4)~~ FS. Law Implemented 218.409(4) ~~Ch. 218, Part IV~~ FS. History–New 8-24-82, Formerly 19-7.15, Amended 6-26-95, ________.

19-7.016 Close of Business.

~~The Board's records are balanced daily with the bank. Therefore, it is necessary that all transactions be recorded and the accounts closed on a timely basis.~~ Any requests for funds to be returned or notification of funds to be wired for investment after 11:00 a.m. shall ~~may~~ be included in the following day's business. In the event that the Board is informed by 11 a.m. of a deposit for investment that day, and the funds are not transmitted to the Board's bank account by the close of business that day, which results in a shortfall, a fee shall be charged to the participant for each day until the shortfall is corrected. The fee will be based on the current ~~applicable~~ overdraft fee charged by the bank on the amount of the shortfall.

Specific Authority 218.405, 218.412 ~~120.53(1), 218.409(4)~~ FS. Law Implemented 218.409(2) ~~Ch. 218, Part IV~~ FS. History–New 8-24-82, Formerly 19-7.16, Amended 6-26-95, ________.

19-7.017 Pooled Investment Account Reserve Fund.

A ~~At the discretion of the Executive Director, a~~ Pooled Investment Account Reserve Fund shall ~~may~~ be established in order to protect the Pooled Investment Account in accordance with Section 218.409(3), F.S. ~~an amount determined by the Executive Director periodically but no less infrequently than once each three years to be reasonable and consistent with sound investment policy.~~ The funds required to establish said Reserve Fund shall be deducted from "pooled investment ~~gross~~ earnings" as the term is used in Rule 19-7.015, F.A.C. If ~~at any time the Executive Director of the Board determines that it is prudent to reduce~~ the size of the Reserve Fund is reduced, then the excess moneys in the Reserve Fund shall be distributed in accordance with the formula set forth in Rule 19-7.015, F.A.C., at the end of the month during which the Reserve Fund was reduced.

Specific Authority 218.405, 218.412 ~~120.53(1), 218.409(4)~~ FS. Law Implemented 218.409(3) ~~Ch. 218, Part IV~~ FS. History–New 8-17-92, Amended ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Tom Herndon, Executive Director, State Board of Administration

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Trustees of the State Board of Administration

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: November 27, 2001
DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: October 12, 2001

DEPARTMENT OF MANAGEMENT SERVICES

Division of State Employees' Insurance

RULE CHAPTER TITLE:	RULE CHAPTER NO.:
State Group Insurance Program	60P-1
RULE TITLES:	RULE NOS.:
Executive Offices and Telephone Number	60P-1.0015
Definitions	60P-1.003
Appeals	60P-1.004

PURPOSE AND EFFECT: To readopt each rule in this chapter, with minimal changes as noted, in order to avoid the statutory repeal that would otherwise occur on January 1, 2002, pursuant to Section 42 of Chapter 2001-43, Laws of Florida.

SUMMARY: Definitions of words and phrases that are used in Rule Chapters 60P-2, 60P-3, 60P-6, 60P-9 and 60P-10; procedure to appeal from a decision or intended decision of the Division of State Group Insurance determining a person's substantial interests.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: No statement of estimated regulatory cost was prepared.

Any person who wishes to provide information regarding regulatory costs or to provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days after this notice.

SPECIFIC AUTHORITY: 110.123(3)(c),(5), 110.161(5) FS.

LAW IMPLEMENTED: 110.123, 17.04, 110.161, 110.12315 FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW (IF NOT REQUESTED, THIS HEARING WILL NOT BE HELD):

TIME AND DATE: 10:00 a.m., December 28, 2001

PLACE: Room 260L, 4050 Esplanade Way, Tallahassee, Florida

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Frederick J. Springer, Office of the General Counsel, Department of Management Services, 4050 Esplanade Way, Suite 260, Tallahassee FL 32399-0950, (850)487-1898

THE FULL TEXT OF THE PROPOSED RULES IS:

60P-1.0015 Executive Offices and Telephone Number.

The executive offices of the State Group Insurance Program are as follows:

Division of State Employees' Insurance
4040 Esplanade Way
Tallahassee, FL 32399-0949

Telephone Number (850)921-4600 SUNCOM 291-4600.

Specific Authority 120.53(1)(a) FS. Law Implemented 110.123 FS. History–New 8-22-96, Repromulgated ________.

60P-1.003 Definitions.

For the purpose of administering the State Group Insurance Program, the following words and terms shall have the meaning indicated:

(1) "Administrator" means the Department of Management Services, hereinafter referred to as "Administrator" or "Department."

(2) "Appeal" means the filing of a petition pursuant to Rule 60P-1.004, and the proceeding that results from such filing. ~~an administrative proceeding in which a petition, in compliance with Section 120.57, Florida Statutes, and Rule 60-4, Florida Administrative Code, is filed requesting a hearing. Petitions shall be sent to the Division of State Employees' Insurance, 4040 Esplanade Way, Tallahassee, FL 32399-0949.~~

(3) "Cancellation" means the loss of coverage, with a right of reinstatement, caused by a failure to pay the required premiums for two consecutive months.

(4) "Continuation coverage" means coverage that is identical to the coverage provided under the Health Program to active employees which must be offered to qualifying employees and dependents in accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA).

(5) "Conversion plan" means a standard policy as is issued by the servicing agent to direct payment subscribers at applicable rates then in effect. An insured shall have the right to apply directly to the servicing agent in writing within thirty-one (31) days of the termination date of coverage under the Program.

(6) "Coverage" means the provision of plan benefits to a subscriber and eligible dependents.

(7) "Eligible children" shall mean the subscriber's own children, legally adopted children or children placed in the subscriber's home for the purpose of adoption in accordance with Chapter 63, Florida Statutes, stepchildren for whom the employee or retiree is financially responsible, or any other children for whom the subscriber has established legal guardianship in accordance with Chapter 744, Florida Statutes, foster children, or any other unmarried children for whom the subscriber has been granted court-ordered temporary or other custody. Such children are eligible for coverage as follows:

(a) From their date of birth to the end of the month in which their nineteenth (19th) birthday occurs;

(b) From their nineteenth (19th) birthday to the end of the calendar year in which their twenty-fifth (25th) birthday occurs, if they are dependent upon the subscriber for support and are either living with the subscriber or enrolled in any

school, college or university which provides training or educational activities, and which is certified or licensed by a state or foreign country.

(c) Such children who are mentally or physically disabled shall be eligible to continue coverage after attainment of the above age limits and while the subscriber's family coverage is in effect provided such children are incapable of self-sustaining employment by reason of such mental or physical disability and chiefly dependent upon the subscriber for support and maintenance.

(d) Such children who are over the above age limits at the time of the subscriber's enrollment in the Program, and who are mentally or physically disabled, shall be eligible for coverage if they are incapable of self-sustaining employment by reason of such mental or physical disability and chiefly dependent upon the employee or retiree for support and maintenance.

(8) "Eligible dependents" shall mean the following:

(a) The wife or husband of the employee or retiree and any eligible children.

(b) The eligible children of a surviving spouse.

(c) The newborn child of an eligible child from the date of birth until the end of the month the child attains eighteen (18) months of age.

(d) Children of law enforcement, probation, or correctional officers who were killed in the line of duty and who are attending a college or university beyond their eighteenth (18th) birthday.

(9) "Employee contribution" means that portion of the total premium required by the subscriber to keep the insurance in force.

(10) "Family coverage" means the provision of Plan benefits under a single plan for a subscriber and one or more of his or her eligible dependents.

(11) "Financially responsible" shall mean the degree of financial support sufficient to claim the eligible dependent as an exemption on the subscriber's Federal income tax return.

(12) "Health maintenance organization (HMO) service area" means the geographic area composed of a county or contiguous counties for which the HMO has received a Certificate of Authority issued by the Florida Department of Insurance to provide or arrange for comprehensive health services and for which the HMO has received approval to offer such services to state employees residing in the area.

(13) "Health Program" means the insurance plans offered to eligible subscribers.

(14) "Individual coverage" means the provision of plan benefits for the subscriber only.

(15) "Initial eligibility period" means the sixty (60) day period beginning on the date a person first becomes employed by the state.

(16) "Open enrollment period" means a period designated by the Department during which time eligible persons may enroll or make changes in the Health Program.

(17) "Qualifying status change (OSC) event" or "OSC event" means the change in employment status, for subscriber or spouse, family status or significant change in health coverage of the employee or spouse attributable to the spouse's employment.

(18) "Servicing agent" means an insurance carrier or professional administrator selected by competitive bid, or request for proposal process and contracted by the Department to process and pay health insurance claims for subscribers and eligible dependents insured under the Health Program and to provide other specific services required by the Department.

(19) "State contribution" means that portion of the total premium appropriated by law.

(20) "Subscriber" means the employee, retiree, surviving spouse, terminated employee or individual with continuation coverage participating in the State Group Insurance Program.

(21) "Suspension" means the temporary loss of coverage caused by a failure to pay the required premiums for one month.

(22) "Termination" means the loss of coverage, without a right for reinstatement, caused by a failure to pay the required premiums for three or more consecutive months.

(23) "Total disability" means disability of an employee resulting from disease or injury which completely and continuously prevents the employee from engaging in any and every occupation or business and from performing any and all work for compensation or profit.

(24) "Total premium or full premium" means the total amount equal to the State contribution plus an amount equal to the employee contribution as determined by the Legislature in the General Appropriations Act.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 11-2-76, Amended 2-3-77, 6-30-77, 7-1-80, Formerly 22K-1.03, Amended 7-16-86, 9-25-86, 4-11-88, Formerly 22K-1.103, Amended 8-22-96, Repromulgated as Amended ________.

60P-1.004 Appeals.

Any party whose substantial interests have been or will be determined by a decision or intended decision of the Division of State Group ~~Employees'~~ Insurance and who desires to contest the agency's decision or intended decision shall submit a petition for an administrative hearing that complies with Rule 28-106.201 ~~60-4.012~~, Florida Administrative Code, if there is a dispute of material fact, or Rule 28-106.301 if there is no dispute of material fact. The ~~Such~~ petition must be received by the agency clerk of the Department ~~Division of State Employees' Insurance~~ within twenty-one (21) calendar days after notice of the decision or intended decision is received by the party. The clerk's address is Office of General Counsel, Department of Management Services, 4050 ~~Petitions shall be sent to the Division of State Employees' Insurance, 4040~~

Esplanade Way, Tallahassee, FL 32399-0949.~~,~~ Proceedings shall be conducted ~~for consideration~~ pursuant to Chapter 120, Florida Statutes, and Rule Chapter 28-106.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-22-96, Repromulgated as Amended ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Garrett R. Blanton, Deputy Secretary, Department of Management Services

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Cynthia A. Henderson, Secretary, Department of Management Services

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: November 19, 2001

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: November 2, 2001

DEPARTMENT OF MANAGEMENT SERVICES

Division of State Group Insurance

RULE CHAPTER TITLE:	RULE CHAPTER NO.:
State Group Health Self-Insurance Plan	60P-2
RULE TITLES:	RULE NOS.:
Eligibility	60P-2.001
Enrollment	60P-2.002
Changes in Coverage	60P-2.003
Subscriber Change	60P-2.0035
Spouse Program	60P-2.0036
Effective Date of Coverage	60P-2.004
Other Changes in Information	60P-2.005
Employee Contributions	60P-2.006
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Employees Not on Payroll/Return to Payroll	60P-2.012
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Overpayment of Claims	60P-2.016
Payment of Claims	60P-2.017
Review of Claims	60P-2.019
Date of Receipt	60P-2.020

PURPOSE AND EFFECT: To readopt each rule in this chapter, with minor changes as noted, in order to avoid the statutory repeal that would otherwise occur on January 1, 2002, pursuant to Section 42 of Chapter 2001-43, Laws of Florida.

SUMMARY: Group insurance of several kinds for state officers and employees under Section 110.123, Florida Statutes; the prescription drug program under Section 110.12315; and the pretax benefits program under Section 110.161.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: No statement of estimated regulatory cost was prepared.

Any person who wishes to provide information regarding regulatory costs or to provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days after this notice.

SPECIFIC AUTHORITY: 110.123(3)(c),(5), 110.161(5) FS.

LAW IMPLEMENTED: 110.123, 17.04, 110.161, 110.12315 FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW (IF NOT REQUESTED, THIS HEARING WILL NOT BE HELD):

TIME AND DATE: 10:00 a.m., December 28, 2001

PLACE: Room 260L, 4050 Esplanade Way, Tallahassee, Florida

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Frederick J. Springer, Office of the General Counsel, Department of Management Services, 4050 Esplanade Way, Suite 260, Tallahassee FL 32399-0950, (850)487-1898

THE FULL TEXT OF THE PROPOSED RULES IS:

60P-2.001 Eligibility.

(1) Eligibility to participate in the Health Program will be in accordance with Section 110.123, Florida Statutes.

(2) Eligible dependents may only participate under a family coverage.

(3) The surviving spouse may participate in the Health Program with family coverage if there are eligible children to be covered; otherwise, the surviving spouse may only participate under an individual coverage.

(4) In order to participate in a HMO, the subscriber must reside in the HMO service area; if the subscriber is a state employee, he or she must either reside or work in the HMO service area.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 10-8-79, Amended 10-22-79, 7-1-80, 9-13-82, 8-7-83, Formerly 22K-1.14, Amended 7-16-86, Formerly 22K-1.201, Amended 8-22-96, Repromulgated ________.

60P-2.002 Enrollment.

(1) An employee or state officer may apply for enrollment in the Health Program through the employing agency personnel office:

(a) During the first sixty (60) calendar days of state employment or a new term of office;

(b) During open enrollment;

(c) Within thirty-one (31) days of a OSC of losing other group health coverage;

(d) Within thirty-one (31) days of a OSC of an increase in the number of work hours for an employee;

(e) Within thirty-one days prior to termination of employment and before the effective date of retirement.

(2) The employing agency shall request an effective date of coverage for enrollment in the Health Program in accordance with Rule 60P-2.004, F.A.C., and indicate such date on the application along with the following required employee and agency information:

(a) Employee's name, social security number, birth date, sex, home mailing address, employment status, pay plan, employment date, SAMAS organizational code, I.D. code, and other insurance carriers;

(b) Dependent's name, social security number, birth date, sex, date dependent was acquired, relationship of dependent, documentation verifying dependent eligibility;

(c) Employee's requested plan type, type of coverage and Spouse Program eligibility;

(d) Contains the signature and date of the employee and authorized signature and date of the employing agency certifying eligibility of the employee.

(3) The employee acknowledges that eligibility and enrollment are governed by Section 110.123, Florida Statutes; authorizes the State to reduce salary as often and in amount necessary to continue coverage; authorizes the State to deduct from salary any underpayment of employee contribution or overpayment of claims; acknowledges that premiums may change from time to time; authorizes any licensed physician or medical facility to release medical records of insureds to the health plan; certifies notification of COBRA rights and agrees to notify the Department at the time any dependent becomes ineligible for coverage; and agrees that all statements made on the application are complete and true.

(4) After completion by the employee and employing agency, the employing agency shall enter applicable information into the state insurance computer data base and retain the application.

(5) Upon learning of the death of an insured employee with family coverage, the agency personnel office, by certified mail, will notify the surviving spouse of his or her eligibility to continue coverage under the Health Program. A surviving spouse of a retiree shall be notified by the Department. Such notice shall advise the surviving spouse of the following:

(a) That family coverage may be continued if there are eligible children to be covered; otherwise the spouse may continue participation only under individual coverage;

(b) The amount of the applicable monthly total premium;

(c) That in order to continue coverage the surviving spouse must complete an application in accordance with subsection 60P-2.002(2), F.A.C. The application must be submitted with one month's total premium to the personnel office of the deceased employee's agency and forwarded to the Department, or submitted to the Department for a retiree, either within thirty-one (31) calendar days after the end of the month in which the deceased employee died or within thirty-one (31) calendar days after receipt of the notice of eligibility to continue coverage, whichever is later.

(6) In no case shall any subscriber or subscriber's eligible dependent be covered simultaneously under two coverages within the Group Health Program.

(7) An employee who applies for enrollment and is enrolled in the Health Program shall automatically be enrolled in the Pretax Premium Plan of the Flexible Benefits Program unless the employee submits a signed rejection which shall include the employee's name, social security number, address, agency and a statement that this decision cannot be changed until the next open enrollment period.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 10-8-78, Amended 5-22-79, 10-22-79, 4-15-80, 7-1-80, 9-13-82, 8-7-83, Formerly 22K-1.15, Amended 7-16-86, 9-25-86, Formerly 22K-1.202, Amended 8-22-96, Repromulgated ________.

60P-2.003 Changes in Coverage.

(1) An employee enrolled in the Health Program may apply for a change to family coverage or individual coverage within thirty-one (31) calendar days of a OSC event if the change is consistent with the event or during the open enrollment period.

(2) A retiree, surviving spouse or participant with continuation coverage enrolled with family coverage may apply to change to individual coverage at any time, however, those enrolled with individual coverage may apply for a change to family coverage within thirty-one (31) calendar days of the date of acquisition of or loss of other group coverage for any eligible dependent or during the open enrollment period.

(3) A subscriber enrolled with individual coverage may apply for a change to family coverage prior to acquiring any eligible dependent. Since family coverage is effective the first day of any given month, a subscriber who will acquire the eligible dependent and is desirous of having immediate coverage of such dependent must:

(a) Submit an application and pay a full month's premium prior to the first day of the month in which the dependent will be acquired. Otherwise, coverage cannot be effective on the actual date of acquisition.

(b) A subscriber applying for family coverage under (3)(a) above may also add any other eligible dependents.

(4) If a subscriber enrolled with family coverage under an HMO plan is divorced, he or she may transfer such family coverage to the State Self Insurance Plan within thirty-one (31) calendar days after a covered dependent child is moved out of the HMO Plan's service area with the individual awarded custody of such child or during the open enrollment period.

(5) An HMO subscriber who no longer resides in the HMO's service area; if an employee, no longer resides or works; must change HMO plans or transfer to the State Self Insured Plan.

(6) The employing agency shall request an effective date for the change in accordance with Rules 60P-2.004 and 60P-2.002, and indicate such date on the application.

(7) All applications for coverage changes must be approved by the Department, subject to the following:

(a) The Department shall approve a coverage change if the completed application is submitted to the employing agency within thirty-one (31) calendar days of and is consistent with the OSC event.

(b) Documentation substantiating an OSC event is as follows:

1. If changing to family coverage, proof of family status change or proof of loss of other group coverage is required.

2. If changing to individual coverage, proof of family status change or proof of change of employment status is required.

3. If adding an eligible dependent to family coverage, proof of family status change is required.

4. If terminating coverage, proof of family status change or proof of employment change is required.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 10-8-78, Amended 10-22-79, 9-13-82, 8-7-83, Formerly 22K-1.16, Amended 7-16-86, 9-25-86, Formerly 22K-1.203, Amended 8-22-96, Repromulgated ________.

60P-2.0035 Subscriber Change.

(1) If an employee has family coverage and the employee's spouse is also employed by the State, coverage may be transferred to the spouse's name without loss of benefits, if the employee terminates employment with the State or is on approved leave without pay, suspension or lay off, provided such change is made prior to the termination of coverage.

(2) If a retiree has family coverage and the retiree's spouse is a retiree eligible to participate in the Health Program, coverage may be transferred to the spouse's name or to two individual coverages without loss of benefits provided such change is made prior to the termination of coverage.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-22-96, Repromulgated ________.

60P-2.0036 Spouse Program.

(1) Participation in the spouse program is voluntary and available to any married state employee whose spouse is also a state employee. Subject to the following conditions either employee may apply for the spouse program at any time by submitting an application in accordance with subsection 60P-2.002(2), F.A.C.:

(a) If one employee is insured as an eligible dependent under the other employee's family coverage; or

(b) If either employee is applying for family coverage in accordance with Rule 60P-2.002 or 60P-2.003, F.A.C.

(2) If either employee becomes ineligible for the state contribution after the spouse program is in effect, eligibility for the spouse program shall cease. Both employees shall immediately report the ineligibility in accordance with Rule 60P-2.002(2), F.A.C., to their agency personnel office to avoid an underpayment of premiums. Should the employee who is not eligible for the state contribution return to work, the spouse program shall not become effective unless either employee submits a completed spouse program application in accordance to subsection (1) above.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-22-96, Repromulgated ________.

60P-2.004 Effective Date of Coverage.

(1) The effective date of coverage requested by the employing agency for enrollment or changes in coverage in the Health Program by an employee shall always be the first day of a month, subject to the following:

(a) Subject to the requirements of subsections (2), (3), and (4), the requested effective date for new enrollees shall be no later than the first day of the month for which a full month's premium may be deducted using single deductions based upon the employee's signature date on the application.

(b) The requested effective date shall be no earlier than the first day of the month following the employee's signature date; however, in no case shall such effective date be prior to or on the employee's employment date.

(2) The coverage of an employee applying for enrollment during his or her initial enrollment period shall become effective as follows:

(a) If the employee's agency personnel office enters the application information as required in subsection 60P-2.002(4), F.A.C., into the state insurance computer system data base prior to the requested effective date, coverage shall be effective on the date requested.

(b) If the employee's agency personnel office does not enter the application information as required in subsection 60P-2.002(3), F.A.C., into the state insurance computer system data base, coverage shall be effective on the date requested provided the Department receives the completed application prior to the requested effective date. If the application is received by the Department after the requested effective date, coverage shall be effective on the first day of the month following the date the application is received. However, if the proper full month's premium is received by the Department prior to the requested effective date, coverage shall become effective on the date requested, even though the application may not be received until after such date.

(3) Coverage changes shall be effective as follows:

(a) If the completed application for a family to individual coverage change is received by the Department before the requested effective date, but after a designated monthly payroll due date, such change shall be effective on the date requested.

(b) If the completed application for an individual to family coverage change is received by the Department after the designated monthly payroll due date but before the requested date of coverage, such change shall be effective on the date requested provided the employee's personal check or money order for the additional employee contribution not payroll deducted is received by the Department prior to the requested effective date. If the completed application is received after the requested effective date, the coverage change shall be effective the first of the month following the date such application and additional employee contribution are received.

(4) The effective date of coverage for an eligible dependent acquired while family coverage is in effect shall be the date such dependent is acquired.

(5) Changes in coverage requested by a retiree or surviving spouse shall become effective the first day of the month following receipt of a written request for such changes by the Department.

(6) The effective date of all enrollments and or changes made during the open enrollment period shall be designated by the Department.

(7) The effective date of coverage for an employee enrolling due to a pending retirement application shall be no later than the retirement date.

(8) The effective date of coverage for enrollment or changes will be determined by the Department if an error or omission occurs by the employee's agency personnel office.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 10-8-78, Amended 10-22-79, 7-1-80, 9-13-82, 8-7-83, Formerly 22K-1.17, Amended 7-16-86, 9-25-86, Formerly 22K-1.204, Amended 8-22-96, Repromulgated ________.

60P-2.005 Other Changes in Information.

(1) Any change in the following data shall be immediately reported by the employee to the agency personnel office by completing an application in accordance with subsection 60P-2.002(2), F.A.C., and such application shall be immediately forwarded to the Department by the employing agency:

(a) Social Security Number;

(b) Name;

(c) Address;

(d) Eligible Dependents;

(e) Marital Status; or

(f) Employment Status.

(2) A retired employee or surviving spouse shall report any such change to the Department.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 10-8-78, Amended 10-11-79, 7-1-80, 9-13-82, 8-7-83, Formerly 22K-1.18, Amended 7-16-86, Formerly 22K-1.205, Amended 8-22-96, Repromulgated ________.

60P-2.006 Employee Contributions.

(1) Employee contributions are due in advance of each month of coverage and shall be paid as follows:

(a) The initial month's employee contribution shall be paid by personal check, money order or payroll deduction; however, the initial month's premium for surviving spouses or retirees shall only be paid by personal checks or money orders. If the employee contribution is not received by the Department prior to the end of the month for which coverage is to be effective, such coverage shall not be effective.

(b) Employee contributions due after the initial month shall be payroll deducted if there are sufficient funds to make the deduction. If there are insufficient funds for payroll deduction, employee contributions shall be paid monthly by personal check or money order.

(c) Premiums due from employees who are off the payroll, surviving spouses ineligible to receive monthly warrants as beneficiaries of deceased employees, retirees, or insureds having continuation coverage shall be paid monthly by personal checks or money orders.

(d) It shall be the responsibility of the employing agency to initiate payroll deductions or receive the employee contributions and to timely remit the same to the Department.

(2) Payroll deductions for insurance coverage shall be made in such a manner that a full month's premium has been deducted prior to the requested effective date of coverage.

(3) Double payroll deductions shall be made for an employee on an academic contract or who is regularly employed for less than twelve (12) months. However, double deductions shall not be made for an employee who is paid monthly or applies for a change in coverage. No deduction shall be taken on a supplemental payroll.

(4) Employee contributions shall not be accepted for coverage beyond the end of the month following the month in which the employee terminates employment, except as provided in subsection 60P-2.002(5) and paragraph 60P-2.011(2)(a), F.A.C.

(5) The agency personnel office shall submit all personal checks or money orders, along with purpose, subscriber and agency I.D. and coverage period, from any employee, retiree or surviving spouse to the Department prior to the first day of the applicable coverage month. A late payment from a retiree, surviving spouse or an employee on approved leave without pay, workers' compensation, layoff or suspension, or an insured having continuation coverage will be accepted as a late payment if it is received by the Department on or before the last day of the coverage month; however, payment will not be accepted after such date and coverage will be terminated.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 10-8-78, Amended 10-22-79, 4-15-80, 7-1-80, 9-13-82, 8-7-83, Formerly 22K-1.19, Amended 7-16-86, Formerly 22K-1.206, Amended 8-22-96, Repromulgated ________.

60P-2.007 Underpayment of Contributions.

(1) For employees, retirees and surviving spouses on the active or retiree payroll:

(a) When it has been determined that a contribution has been underpaid, the Department shall notify the employee, retiree or surviving spouse of the underpayment by certified mail and shall notify the employee's agency of the underpayment. This notice will advise the employee, retiree or surviving spouse of the nature of the underpayment and the methodology used to determine this amount and will request the employee, retiree or surviving spouse to contact his or her agency or the Department to resolve the problem so that future contributions will be correct. The notice shall advise of the following procedures for resolving the underpayment:

1. If the full amount of the underpayment is not received by the Department within thirty (30) calendar days from the date of receipt of the notification of underpayment or if approval is not granted in accordance with subparagraph (1)(a)2., or if an administrative hearing is not requested in accordance with subparagraph (1)(a)3., the retiree's or surviving spouse's coverage shall be terminated. With respect to the employee, the Department will request the Department of Banking and Finance to initiate involuntary wage deductions where applicable.

2. If the underpayment involves more than one coverage period, the Department may approve an installment payment program provided a written request for such program is received from the employee, retiree or surviving spouse within thirty (30) calendar days from the date of the notification of underpayment; provided, however, that any such installment payment program is subject to approval of the Department of Banking and Finance in accordance with Section 17.04, Florida Statutes. Payroll deductions must be used whenever the employee is receiving a state payroll warrant issued by the Department of Banking and Finance.

3. The employee, retiree or surviving spouse may request an administrative hearing pursuant to Section 120.57, Florida Statutes, provided such request is received by the Department within twenty-one (21) calendar days from the date of receipt of the notification of underpayment. Such notice shall be mailed to the address on file.

(b) When it has been determined that an agency has underpaid its contribution, the Department shall notify the agency of the underpayment in writing. Such notice will advise the agency that the full amount of the underpayment should be received by the Department within forty-five (45) calendar days from the date of the letter. The agency shall take appropriate action to insure that future state contributions are correct. Should any agency become more than sixty (60) days delinquent in payment of this obligation, the Department shall certify to the Comptroller the amount due and request the Comptroller to recover such underpayment in accordance with Section 17.04, Florida Statutes.

(2) For subscribers off the payroll:

(a) As it applies to the employee, when it is determined that none of the required contribution is paid by the end of the coverage month, coverage will be canceled effective the first day of that month.

(b) As it applies to all others, when it is determined that none of the required premium is paid by the coverage month, coverage will terminate effective the first day of the month.

(c) If less than the required contribution is paid, the subscriber and the employee's agency will be notified as described in subsection 60P-2.007(1), F.A.C.

(3) An employee whose coverage is suspended in accordance with subsection (2)(a) may only apply for reenrollment in the Health Program by settling all underpayment claims and resubmitting an application during the open enrollment period. A retiree, surviving spouse or an insured with continuation coverage whose coverage is terminated in accordance with subsection (2)(b) may not reenroll in the Health Program.

(4) When it has been determined that an employee contribution has been underpaid, the Department shall notify the servicing agent to suspend the payment of claims until such underpayment has been resolved.

(5) Claims rejected by the Group Health Self Insurance Plan due to underpayment of premium shall be reprocessed upon receipt by the Department of the full amount of the underpayment or an approved signed agreement for installment repayment from the employee, retiree or surviving spouse, provided such claims were initially submitted to the Group Health Self Insurance Plan within sixteen (16) months from the date medical expenses were incurred.

Specific Authority 110.123(5) FS. Law Implemented 17.04, 110.123 FS. History–New 10-8-78, Amended 7-19-79, 10-22-79, 7-1-80, 9-13-82, 8-7-83, Formerly 22K-1.20, Amended 7-16-86, 9-25-86, Formerly 22K-1.207, Amended 8-22-96, Repromulgated ________.

60P-2.008 Overpayment of Contributions.

(1) Whenever the employee's agency becomes aware of a total premium payment that is more than the amount required for the type of coverage selected, the agency shall take appropriate action to request a refund for the overpayment of premiums and to correct the contributions for any subsequent periods. The Department shall make such corrections for retired employees, surviving spouses and insureds with continuation coverage.

(2) Requests for refunds of any premium overpayments must be submitted by the employing agency.

(3) If an employee contribution has been overpaid and the Department is aware of a claim overpayment on behalf of any insured, a refund of the employee contribution overpayment shall not be processed until the claim overpayment has been resolved pursuant to Rule 60P-2.016, F.A.C.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 10-8-78, Amended 10-22-79, 7-1-80, 9-12-82, 8-7-83, Formerly 22K-1.21, Amended 7-16-86, Formerly 22K-1.208, Amended 8-22-96, Repromulgated ________.

60P-2.009 State Contribution.

Any state officer, full-time employee or part-time employee participating in the Health Program shall be entitled to the state contribution or prorated state contribution if any of the following conditions exist:

(1) The employee is at work or on approved leave with pay for a minimum of one day in the month previous to the month of coverage.

(2) The employee is either on academic contract or is regularly employed for less than twelve (12) months, provided the employee has worked at least eight (8) months during the prior consecutive twelve (12) month period. Such employee shall receive the state contribution for the entire twelve (12) months.

(3) The employee is on Workers' Compensation disability leave.

(4) The employee successfully appeals a suspension and receives full back pay. In such cases, the employee shall receive the state contribution during the time of the suspension provided the employee continued coverage under the Health Program during the period of such suspension and was receiving the state contribution at the time of suspension.

(5) The employee successfully appeals a dismissal and receives full back pay. In such cases, the employee shall receive the state contribution during the time of dismissal provided the employee was receiving the state contribution at the time of dismissal and, upon reinstatement, pays all back employee contributions in order to have continuous coverage under the Health Program.

(6) When the spouse of an employee is also a state officer, full-time employee, or part-time employee, and both are covered under the Health Program, and the spouse is listed as an eligible dependent under the employee's family coverage, the spouse shall also be eligible to receive the designated state contribution beginning with the coverage month following receipt of the applications by the Department.

(7) The state contribution for a part-time employee shall be on a pro rata basis so that the percentage of the cost contributed for the part-time employee shall bear that relation to the percentage of cost contributed for a similar full-time employee that the part-time employee's normal workday bears to a full-time employee's normal workday.

(8) The state contribution for full-time employees or part-time permanent employees shall continue in the respective proportions for a minimum of twelve (12) weeks for any such employee who has been granted an approved medical leave of absence.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 10-8-78, Amended 10-22-79, 7-1-80, 9-13-82, Formerly 22K-1.22, Amended 7-16-86, Formerly 22K-1.209, Amended 8-22-96, Repromulgated ________.

60P-2.010 Agency Changes.

(1) A change from one state agency to another state agency does not constitute a change in qualifying status ~~new employment~~; therefore, enrollment or coverage eligibility does not change.

(2) When an insured employee changes from one state agency to another state agency, the new agency shall request a copy of the employee's insurance file from the former agency and notify the Department in a timely manner as not to interrupt insurance coverage. If payroll deductions cannot be made by the new agency in time to maintain continuous coverage, the employee must pay the required employee contribution by personal check or money order.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 10-8-78, Amended 7-1-80, 9-13-82, Formerly 22K-1.23, Amended 7-16-86, 9-25-86, Formerly 22K-1.210, Amended 8-22-96, Repromulgated as Amended ________.

60P-2.011 Retirees.

(1) An employee who retires on regular retirement or who has received approval of disability retirement prior to his or her last day of employment and is covered under the Health Program as of the last day of employment, must elect one of the following options:

(a) To continue coverage by submitting an application in accordance with subsection 60P-2.002(2), F.A.C. Such application and a personal check or money order for one month's full premium must be received by the employee's former agency personnel office and forwarded to the Department no later than thirty-one (31) calendar days after the employee's last day of employment; or

(b) To terminate coverage under the Health Program.

(2) An employee who applies for disability retirement and who has not been approved or rejected prior to his or her last day of employment, but was covered under the Health Program as of the last day of employment, shall have the following options:

(a) The employee may continue coverage in the Health Program pending such approval or rejection by paying the full monthly premium by personal check or money order to the Department in accordance with Rule 60P-2.006, F.A.C. If coverage is continued and:

1. The disability retirement is subsequently approved, the employee must complete an application in accordance with subsection 60P-2.011(1)(a), F.A.C.

2. The disability retirement is subsequently rejected, coverage under the Program will terminate the end of the month in which such application is rejected. However, the subscriber may apply for continuation coverage offered by the administrator or convert to a direct pay plan offered by the Servicing Agent pursuant to Rule 60P-2.015, F.A.C.

(b) The employee may elect not to continue coverage in the Health Program pending the determination of disability retirement and thereby allow such coverage to terminate on the last day for which contributions have been paid. If coverage is allowed to terminate and:

1. The disability retirement is subsequently approved, the employee may apply for reenrollment in the Health Program subject to the following requirements:

a. The employee shall complete an application in accordance with subsection 60P-2.011(1)(a), F.A.C., indicating the disability retirement status and submit to the former agency personnel office who must forward such application to the Department no later than thirty-one (31) calendar days after the date of approval of the disability retirement;

b. The retiree shall pay all back premiums from the date of termination of coverage within thirty-one (31) calendar days after the date of approval of the disability retirement since coverage must be continuous.

2. The disability retirement is subsequently rejected, coverage under the Program will terminate on the last day for which premiums had been paid and the subscriber shall not be eligible for reenrollment in the Health Program, continuation coverage nor conversion to a direct pay plan.

(3) An employee who does not elect to continue coverage as provided in this Section or terminates coverage after retirement shall not be eligible to reenter the Health Program at a later date unless subsequently reemployed by the State.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 10-8-78, Amended 7-1-80, 9-13-82, Formerly 22K-1.24, Amended 7-16-86, Formerly 22K-1.211, Amended 8-22-96, Repromulgated ________.

60P-2.012 Employees Not on Payroll/Return to Payroll.

(1) For all employees not on payroll, premiums shall be paid in monthly amounts by personal check or money order during the period the employee is not on the payroll. An employee who is not on the payroll during the calendar month, whether paid biweekly or monthly, shall pay the full premium for that month by either payroll deduction, or by personal check or money order. The insured employee has the responsibility for remitting the required premiums to continue coverage in effect. The agency from which the employee goes off the payroll shall be responsible for receiving these premiums and forwarding them to the Department pursuant to subsection 60P-2.006(5), F.A.C.

(2) Leave Without Pay.

(a) An insured employee granted leave without pay shall be eligible to continue coverage while on such leave provided the employee pays the full premium and notifies the Department in accordance with subsection 60P-2.002(2), F.A.C.

(b) An employee who does not continue coverage while on leave without pay may only apply for reenrollment in the Health Program after returning to work and by submitting an application in accordance with subsection 60P-2.002(2), F.A.C., to the agency personnel office within thirty-one (31) calendar days after returning to work or during the open enrollment period.

(3) Suspension. A suspended employee may continue coverage as an employee on leave without pay by paying the full cost of the premium. If an employee successfully appeals a suspension and receives full back pay, the employee is then entitled to the state contribution during the time of the suspension provided he or she was receiving the state contribution at the time of the suspension. An employee on suspension who does not continue insurance coverage may only apply for reenrollment in the Health Program after returning to work and by submitting an application in accordance with subsection 60P-2.002(2), F.A.C., to the agency personnel office during the thirty-one (31) calendar day period after returning to work or during the open enrollment period.

(4) An employee on leave without pay or suspension, as described in this section, who does not pay the premiums to continue coverage during such leave or suspension because of circumstances subsequently deemed as “extreme hardship” by the Department, may apply for reinstatement of coverage within thirty-one (31) calendar days after returning to work by making a request to the Department and agreeing to pay all back premiums. Such request must be in writing and submitted through the employing agency. The employee must demonstrate by clear and convincing evidence that the employee has suffered severe financial hardship resulting from a sudden or unexpected illness or accident to the employee or a dependent. If the Department approves the employee’s request, reinstatement will occur upon the Department’s receipt of a personal check or money order for the back premiums for the period not on payroll. Upon reinstatement, the employee may file claims for reimbursement of charges for covered services and supplies received during the period not on payroll.

(5) Layoff. An employee who is laid off in accordance with the rules promulgated by the Department shall be eligible to continue coverage while laid off for a period not to exceed two (2) years from the date of layoff, provided the employee pays the full premiums. An employee who does not continue coverage during such period, may only apply for reenrollment in the Health Program after returning to work and by submitting an application in accordance with subsection 60P-2.002(2), F.A.C., to the agency personnel office within thirty-one (31) calendar days after returning to work or during the open enrollment period.

(6) Workers’ Compensation Disability Leave.

(a) An employee who is on Workers’ Compensation disability leave is eligible to continue in the Health Program and shall be entitled to the state contribution during such leave. The agency shall collect personal checks or money orders on a month-to-month basis for the employee contributions during

the period the employee will not be on the payroll and submit the contributions to the Department pursuant to subsection 60P-2.006(5), F.A.C.

(b) An employee who does not continue coverage under the Health Program while on Workers' Compensation disability leave may only reenroll in the Health Program during the open enrollment period after such employee returns to work.

(7) Less than year round employment.

(a) An employee on an academic contract or who is regularly employed for less than twelve (12) months and who has worked at least eight (8) months during the prior consecutive twelve (12) month period is eligible to continue in the Health Program and receive the state contribution for a period not to exceed four (4) months while such employee is off the payroll.

(b) Employee contributions for such employees must be paid by advance payroll deductions, by collecting a single personal check or money order for the employee contribution for the entire period the employee will not be on the payroll or on a month-to-month basis.

(8) Military Leave. An insured employee granted military leave as defined under Personnel Chapter 60K-5, F.A.C., shall be eligible to continue enrollment in the Health Program while on such leave provided the employee pays the full premium. An employee who does not continue coverage while on military leave may apply for reenrollment in the Health Program as follows:

(a) If the employee returns to work within ninety (90) calendar days after separation from active military service, the employee may enroll in the Health Program for the type of coverage in effect immediately prior to going on military leave, by submitting an application in accordance with subsection 60P-2.002(2), F.A.C., to the agency personnel office within thirty-one (31) calendar days of returning to work. At the employee's option, coverage under the Health Program may be effective the first day of the month in which the employee separates from active military service, provided the employee pays all back premiums. In addition, the Group Health Self Insurance Plan's preexisting condition provision will not apply for persons insured under the employee's coverage in effect immediately prior to the employee's military leave.

(b) If the employee returns to work but does not enroll in the Health Program within thirty-one (31) calendar days of such return, the employee may only enroll during the open enrollment.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 10-8-78, Amended 10-22-79, 7-1-80, 9-13-82, Formerly 22K-1.25, Amended 7-16-86, 9-25-86, Formerly 22K-1.212, Amended 8-22-96, Repromulgated ________.

60P-2.013 Dismissed Employees.

(1) If an insured employee is dismissed, he or she is no longer eligible for coverage under the Health Program, but may apply to the Department for continuation coverage within sixty (60) calendar days after notification of eligibility by the Department or purchase a conversion plan offered by the servicing agent within 31 days.

(2) If an insured employee is dismissed, successfully appeals the dismissal and is reinstated, the employee shall have the following options:

(a) If the employee is reinstated with full back pay and desires to have continuous coverage, he or she shall pay all back employee contributions and apply for reenrollment in the Health Program by completing and submitting an application in accordance with subsection 60P-2.002(2), F.A.C., to the agency personnel office within thirty-one (31) calendar days after returning to work.

(b) If the employee is reinstated without back pay and desires to have continuous coverage he or she shall pay all back premiums and apply for reenrollment in the Health Program by completing and submitting an application in accordance with subsection 60P-2.002(2), F.A.C., to the personnel office within thirty-one (31) calendar days after returning to work.

(c) If an employee is reinstated with or without full back pay and does not desire to have continuous coverage, the employee may apply for reenrollment in the Health Program by completing and submitting an application in accordance with subsection 60P-2.002(2) and Rule 60P-2.004, F.A.C., to the agency personnel office within thirty-one (31) calendar days after returning to work or during the open enrollment period.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 10-8-78, Amended 6-10-80, Formerly 22K-1.26, Amended 7-16-86, 9-25-86, Formerly 22K-1.213, Amended 8-22-96, Repromulgated ________.

60P-2.014 Returned Checks.

(1) Personal checks will be accepted by the Department for payment of premium in accordance with Rule 60P-2.006, F.A.C.; however, personal checks signed by a person other than the employee for payment of the employee's premium must have the following information recorded on the back of the check regarding the identity of such person:

(a) The full name;

(b) Residence address, city, state, zip code;

(c) Home telephone number;

(d) Business telephone number;

(e) Place of employment;

(f) Sex;

(g) Date of birth;

(h) Height;

(i) Race.

(2) When a check for the employee contribution is returned for nonpayment, a certified letter will be mailed directly to the signer of the check requesting payment of the amount due plus a service charge of fifteen ($15.00) dollars or five percent (5%) of the face amount of the check, whichever is greater. If the signer of the check is someone other than the insured, a certified letter will be mailed to the insured, requesting payment of the amount due plus the service charge. If payment in full has not been received within ten (10) calendar days of receipt of the certified letter, the insured's insurance coverage shall be terminated.

(3) An employee whose coverage is terminated in accordance with this section may only apply for reenrollment in the Health Program during the open enrollment period after making restitution for all dishonored checks. A retiree or surviving spouse whose coverage is terminated in accordance with this section, shall not reenter the Health Program.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 10-8-78, Amended 10-22-79, 7-1-80, 9-13-82, 8-7-83, Formerly 22K-1.27, Amended 7-16-86, 9-25-86, Formerly 22K-1.214, Amended 8-22-96, Repromulgated ________.

60P-2.015 Terminations and Conversions.

(1) Coverage under the Health Program shall continue through the last day of the month for which a premium has been paid.

(2) An employee terminated from state employment for any reason or placed in other than a salaried position shall not be eligible to continue in the Health Program. Upon termination of coverage, the employee may, if eligible, purchase continuation coverage available through the Department or purchase a conversion plan offered by the servicing agent.

(3) Coverage of an eligible dependent will terminate on the last day of the month in which they no longer meet the provisions of subsections 60P-1.003(6), F.A.C.

(4) The Department must receive notice within sixty (60) calendar days of the date such eligible dependents lose coverage under the Health Program, in order to offer the option to purchase continuation coverage available through the Department, otherwise the dependents shall be given the right to purchase a conversion plan offered by the servicing agent.

(5) A surviving spouse who remarries shall not be eligible to continue in the Health Program as a surviving spouse but may purchase continuation coverage through the Department or purchase a conversion plan offered by the servicing agent.

(6) A terminated employee, eligible dependent or surviving spouse wishing to purchase continuation coverage must apply to the Department within sixty (60) calendar days after notification of eligibility for such coverage. A terminated employee, eligible dependent or surviving spouse desiring to purchase a conversion plan offered by the servicing agent, must apply directly to the servicing agent, in writing, within thirty-one (31) calendar days after continuation coverage terminates. The servicing agent shall then issue such standard contract or policy as is issued to direct payment subscribers and at its stipulated rates then in effect.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 10-8-78, Amended 10-22-79, 7-1-80, 9-13-82, 8-7-83, Formerly 22K-1.28, Amended 7-16-86, Formerly 22K-1.215, Amended 8-22-96, Repromulgated ________.

60P-2.016 Overpayment of Claims.

(1) Whenever the Department becomes aware of an overpayment or the erroneous payment in the settlement of a claim for reimbursement of incurred expenses under the Health Program, the Department will notify the subscriber, in writing, of an overpayment. This notice will advise the subscriber of the nature of the overpayment, the methodology used to determine this amount and of the following procedures to resolve the overpayment:

(a) If the full amount of the overpayment is not received by the Department within sixty (60) calendar days from date of receipt of the notification of overpayment or if approval is not granted in accordance with paragraph (1)(b), or if an administrative hearing is not requested in accordance with paragraph (1)(c), the Department will instruct the servicing agent not to pay any further claims submitted under the individual or family coverage of the subscriber. The Department will also request the Department of Banking and Finance to initiate involuntary wage deductions where applicable.

(b) If the overpayment is greater than $50, the Department shall approve an installment payment program provided a written request justifying such program is received from the subscriber within sixty (60) calendar days from the date of notification of overpayment; and provided, however, that any such installment payment program is approved by the Department of Banking and Finance in accordance with Section 17.04, Florida Statutes. Payroll deductions must be used whenever the employee is receiving a state payroll warrant issued by the Department of Banking and Finance.

(c) The subscriber may request an administrative hearing pursuant to Section 120.57, Florida Statutes, and Rule Chapter 60-4 provided such request is received by the Department within twenty-one (21) calendar days from the date of receipt of the notification of overpayment.

(2) Overpayments which are detected beyond the period provided by law shall be deemed uncollectible.

(3) Claims rejected by the servicing agent as instructed by the Department shall be reprocessed upon receipt by the Department of the full amount of the overpayment or an approved signed agreement for installment repayment from the subscriber, provided such claims were initially submitted to the servicing agent within sixteen (16) months from the date medical expenses were incurred.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 7-16-86, Formerly 22K-1.216, Amended 8-22-96, Repromulgated ________.

60P-2.017 Payment of Claims.

Payment of claims for reimbursement of covered expenses under an individual or family coverage is contingent upon certification by the subscriber of the following:

(1) The names, sex, social security numbers, addresses and birthdays of eligible dependents;

(2) The name and address of any insurance company or employer with whom a group health insurance policy is carried by the subscriber or dependent and the group number of such policy;

(3) Any additional information deemed necessary by the Department for the clarification of information previously provided.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 7-16-86, Formerly 22K-1.217, Amended 8-22-96, Repromulgated ________.

60P-2.019 Review of Claims.

(1) Any subscriber who disagrees with the servicing agent's decision concerning the payment of benefits under the Group Health Self Insurance Plan shall request the Division of State Employees' Insurance to review the payment or denial of benefits by writing the Division of State Employees' Insurance at 4040 Esplanade Way, Tallahassee, FL 32399-0950 or by calling (850)921-4603 or Suncom 291-4603.

(2) Any subscriber who disagrees with a decision concerning the payment of benefits under any of the qualified health maintenance organizations shall file a grievance with the HMO. If resolution is not reached through the HMO's internal grievance procedure, a formal grievance shall be filed with the Statewide Subscriber Provider Assistance Panel by writing the Agency for Health Care Administration.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-22-96, Repromulgated ________.

60P-2.020 Date of Receipt.

Date of receipt of applications, personal checks, money orders, or agency checks by the Department shall be the date of the Department's date stamp shown.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-22-96, Repromulgated ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Garrett R. Blanton, Deputy Secretary, Department of Management Services

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Cynthia A. Henderson, Secretary, Department of Management Services

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: November 19, 2001

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: November 2, 2001

DEPARTMENT OF MANAGEMENT SERVICES

Division of State Employees' Insurance

RULE CHAPTER TITLE:	RULE CHAPTER NO.:
State Group Life Insurance Plan	60P-3
RULE TITLES:	RULE NOS.:
Eligibility	60P-3.004
Enrollment	60P-3.005
Effective Date of Coverage	60P-3.006
Changes in Coverage	60P-3.007
Changes in Information	60P-3.008
Payment of Employee Contributions	60P-3.009
Underpayment of Contributions	60P-3.010
Overpayment of Premiums	60P-3.011
State Contribution	60P-3.012
Agency Changes	60P-3.013
Retirees	60P-3.014
Employees Not on Payroll	60P-3.015
Dismissed Employees	60P-3.016
Returned Checks	60P-3.017
Terminations and Conversions	60P-3.018

PURPOSE AND EFFECT: To readopt each rule in this chapter, with minimal changes as noted, in order to avoid the statutory repeal that would otherwise occur on January 1, 2002, pursuant to Section 42 of Chapter 2001-43, Laws of Florida.

SUMMARY: Group life insurance for state officers and employees under Section 110.123, Florida Statutes.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: No statement of estimated regulatory cost was prepared.

Any person who wishes to provide information regarding regulatory costs or to provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days after this notice.

SPECIFIC AUTHORITY: 110.123(3)(c),(5), 110.161(5) FS.

LAW IMPLEMENTED: 110.123, 17.04, 110.161, 110.12315 FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW (IF NOT REQUESTED, THIS HEARING WILL NOT BE HELD):

TIME AND DATE: 10:00 a.m., December 28, 2001

PLACE: Room 260L, 4050 Esplanade Way, Tallahassee, Florida

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Frederick J. Springer, Office of the General Counsel, Department of Management Services, 4050 Esplanade Way, Suite 260, Tallahassee FL 32399-0950, (850)487-1898

THE FULL TEXT OF THE PROPOSED RULES IS:

60P-3.004 Eligibility.

An employee or retiree, is eligible to participate in the Life Plan, in accordance with the provisions of this Chapter.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-12-80, Formerly 22K-1.43, 22K-1.043, 22K-1.301, Amended 8-26-96, Repromulgated ________.

60P-3.005 Enrollment.

(1) An employee may apply through his or her personnel office before or during the initial eligibility period or during the open enrollment period. A state officer may apply during the first sixty (60) calendar days after beginning a new term of office or during the open enrollment period.

(2) It shall be the responsibility of the employing agency to assist the employee in completing the application, entering information into the insurance data base, placing a copy of such application in the employee's personnel file and forwarding the application to the Department.

(3) Participation in the Life Plan shall be voluntary on the part of all employees or retirees. If the employee or retiree does not elect to enroll in the Life Plan, he or she must give written refusal. If an employee's refusal is not received by the employing agency within sixty (60) calendar days of employment, the agency shall immediately certify such lack of action in writing and shall place it in the employee's personnel file and a copy shall be given to the employee.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-12-80, Formerly 22K-1.44, 22K-1.044, 22K-1.302, Amended 8-26-96, Repromulgated ________.

60P-3.006 Effective Date of Coverage.

The effective date of coverage for an employee under the Life Plan shall be as follows:

(1) If the employee applies for enrollment in the Life Plan during the initial eligibility period, the effective date of coverage shall be the first day of the month in which a full month's premium has been received by the Department or the employee's agency.

(2) If the employee applies for enrollment in the Life Plan during open enrollment, the effective date of coverage shall be the date designated by the Department.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-12-80, Formerly 22K-1.45, 22K-1.045, 22K-1.303, Amended 8-26-96, Repromulgated ________.

60P-3.007 Changes in Coverage.

For an employee, the amount of life insurance and accidental death and dismemberment (AD&D) will change with a change in the employee's age, annual salary or job status depending on the employee's class. For an employee age 71 or over, or a retired employee, the amount of life insurance and AD&D will be $1,500.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-12-80, Formerly 22K-1.46, 22K-1.046, 22K-1.304, Amended 8-26-96, Repromulgated ________.

60P-3.008 Changes in Information.

Name and beneficiary changes shall be submitted to in writing the employee's agency personnel office and placed in the employee's personnel file. A retiree must submit such request in writing to the Department. If so submitted, the effective date of such change shall be the date the request is signed.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-12-80, Formerly 22K-1.47, 22K-1.047, 22K-1.305, Amended 8-26-96, Repromulgated ________.

60P-3.009 Payment of Employee Contributions.

(1) Employee contributions are due in advance of each month's coverage.

(2) Payroll deductions for insurance coverage should always be made in such a manner that a full month's employee contribution has been deducted prior to the first day of the following month's coverage using authorized payroll procedures.

(3) Personal checks or money orders shall only be used for the correction of employee contributions, payment while off the payroll or when payroll deductions cannot be made for initial enrollment; otherwise, employee contributions shall be made by payroll deductions.

(4) The agency shall submit all personal checks or money orders to the Department. Each such check or money order shall be transmitted in a manner to be received by the Department prior to the first day of the month for which the employee contribution is being paid. Late payments for employees on leave without pay, Workers' Compensation, disability leave, layoff or suspension status, will be accepted if they are received by the Department on or before the last day of the coverage month for which premiums are being paid; however, payment will not be accepted after such date and coverage will be terminated except as provided in subsection 60P-3.015(4), F.A.C.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-12-80, Formerly 22K-1.48, 22K-1.048, 22K-1.306, Amended 8-26-96, Repromulgated ________.

60P-3.010 Underpayment of Contributions.

(1) For employees or retiree's on the payroll:

(a) When it has been determined that an employee's or retiree's contribution has been underpaid, the Department shall notify the employee or retiree of the underpayment by certified letter and shall send a copy of such notification to the employee's agency. This notice will advise the employee or retiree of the following provisions:

1. If the full amount of the underpayment is not received by the Department within thirty (30) calendar days from the date of the notification of the underpayment or if approval is not granted in accordance with subsection (1)(a)2., or if an administrative hearing is not requested in accordance with

subsection (1)(a)3., the retiree's coverage shall be terminated. With respect to the employee, the Department will request the Department of Banking and Finance initiate involuntary wage deductions where applicable.

2. If the underpayment involves more than one coverage period, the Department may approve an installment payment program, provided a written request for such program is received from the employee or retiree within thirty (30) calendar days from the date of notification of underpayment. However, any such installment payment program is subject to approval of the Department of Banking and Finance in accordance with Section 17.04, Florida Statutes. Payroll deductions must be used whenever the employee is receiving a state payroll warrant issued by the Department of Banking and Finance. The period of payment shall not extend beyond two (2) years from the date of approval.

3. The employee or retiree may request an administrative hearing pursuant to Section 120.57, Florida Statutes, provided such request is received by the Department within twenty-one (21) calendar days from the date of receipt of the notification of underpayment.

(b) When it has been determined that an agency has underpaid its contribution, the Department shall notify the agency of the underpayment in writing. Such notice will advise the agency that the full amount of the underpayment must be received by the Department within forty-five (45) calendar days from the date of the letter. The agency shall take appropriate action to ensure that future premium payments are correct. Should any state agency become more than sixty (60) days delinquent in payment of this obligation, the Department shall certify the amount due and request the Department of Banking and Finance recover such underpayment in accordance with Section 17.04, Florida Statutes.

(2) For employees or retirees off the payroll:

(a) When it has been determined that none of the required contribution has been paid by the end of the coverage month, an employee's coverage will be cancelled and a retiree's coverage will be terminated effective the first day of that month.

(b) If some, but not all of the required contribution has been paid, the retiree, employee and the employee's agency will be notified as described in subsection (1)(a).

(3) An employee whose coverage is cancelled in accordance with subsection (2) may only apply for reenrollment in the Life Plan by settling all underpayments and submitting an application in accordance with subsection 60P-3.005(3), F.A.C. during the open enrollment period. A retired employee whose coverage is terminated in accordance with subsection (1) or (2) may not reenter the Plan.

(4) Underpayments which are detected beyond the period provided by law shall be deemed uncollectible.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-12-80, Formerly 22K-1.49, 22K-1.049, 22K-1.307, Amended 8-26-96, Repromulgated ________.

60P-3.011 Overpayment of Premiums.

(1) Whenever the employee's agency becomes aware of a premium payment that is more than the amount required for the type of coverage selected, the agency shall take appropriate action to request a refund for the overpayment and ensure that future state or employee contributions are correct. The Department shall take corrective action for retired employees.

(2) Requests for refunds of any employee and or state contribution overpayments for active employees must be submitted by the employing agency. The Department shall initiate refunds for retired employees.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-12-80, Formerly 22K-1.50, 22K-1.050, 22K-1.308, Amended 8-26-96, Repromulgated ________.

60P-3.012 State Contribution.

Any state officer, full-time employee, or part-time employee participating in the Plan shall receive the state contribution or prorated state contribution if any of the following conditions exist:

(1) The employee is at work or on approved leave for a minimum of one day in the month previous to the month of coverage.

(2) The employee is either on academic contract or if regularly employed for less than twelve (12) months, provided the employee has worked at least eight (8) months during the prior consecutive twelve (12) month period. Such employee shall receive the state contribution for the entire twelve (12) months.

(3) The employee is on Workers' Compensation disability leave.

(4) The employee successfully appeals a suspension and receives full back pay. In such cases, the employee shall receive the state contribution for the period of suspension provided the employee continued coverage under the Life Plan during the period of suspension and was receiving the state contribution at the time of suspension.

(5) The employee successfully appeals a dismissal and receives full back pay. In such cases, the employee shall receive the state contribution for the period of the dismissal: provided the employee was receiving the state contribution at the time of dismissal and, upon reinstatement, pays all back employee contributions in order to have continuous coverage under the Life Plan.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-12-80, Formerly 22K-1.51, 22K-1.051, 22K-1.309, Amended 8-26-96, Repromulgated ________.

60P-3.013 Agency Changes.

(1) A change from one state agency to another state agency does not constitute a change in qualifying ~~new employment~~ status; therefore, enrollment or coverage eligibility does not change.

(2) When an insured employee changes from one state agency to another state agency, the former agency shall forward a copy of the employee's current application and subsequent change requests, if any, to the new agency prior to the termination of coverage since coverage must be continuous. If a payroll deduction cannot be made by the new agency in time to maintain continuous coverage, the employee must pay the required employee contribution by personal check or money order.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-12-80, Formerly 22K-1.52, 22K-1.052, 22K-1.310, Amended 8-26-96, Repromulgated as Amended ________.

60P-3.014 Retirees.

(1) An employee who retires and is covered under the Life Plan must elect one of the following options:

(a) Submit a request to continue coverage during retirement. The request should include the retiree's name, social security number, date of retirement, date of last payroll deduction, signature of retiree, and date of agreement that the amount of life insurance shall be $1,500 and the AD&D benefits shall not exceed $1,500. However, the benefit for employees who cease active employment due to total disability would be based on the annual salary at the time of disability, subject to the age change factor. Such request and a personal check or money order for one full month's premium must be received by the employee's former agency and forwarded along with the original application and any beneficiary change requests to the Department no later than thirty-one (31) calendar days after the employee's last day of employment; or

(b) Submit a request to terminate coverage under the Life Plan. Such request shall include an acknowledgement that the retiree may not reenroll at a later date. The request shall be submitted to the employee's former agency and forwarded to the Department no later than thirty-one (31) calendar days after the employee's last day of employment. If the employee does not submit the request within thirty-one (31) calendar days after the last day of employment, the agency shall immediately prepare a request to terminate coverage and send it to the Department. Copies shall be put in the employee's personnel file and given to the employee.

(2)(a) An employee who applies for disability retirement and who has not received approval thereof prior to his or her last day of employment, but was covered under the Life Plan, as of the last day of employment, shall have the following options:

(b) The employee may continue coverage in the Life Plan pending such approval or rejection by submitting a request to continue coverage in accordance with paragraph 60P-3.014(1)(a), F.A.C. and paying the full premium for each month of coverage by personal check or money order to his or her former personnel office and in accordance with Rule 60P-3.009, F.A.C.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-12-80, Formerly 22K-1.53, 22K-1.053, 22K-1.311, Amended 8-26-96, Repromulgated ________.

60P-3.015 Employees Not on Payroll.

(1) For employees not on payroll, premiums shall be paid in monthly amounts by personal check or money order during the period the employee is not on the payroll. An employee who is not on the payroll for an entire payroll period, whether paid biweekly or monthly, should have the total monthly premium for that month paid by either payroll deduction, or by personal check or money order. The employing agency shall be responsible for receiving premiums and forwarding them to the Department pursuant to Rule 60P-3.009, F.A.C.

(2) Leave without pay. An employee on approved leave without pay shall be eligible to continue coverage while on such leave provided the employee pays the full premium. An employee who does not continue coverage while on approved leave without pay may only apply for reenrollment in the Life Plan after return to work and submitting an application in accordance with subsection 60P-3.005(2), F.A.C. to their personnel office within thirty-one (31) calendar days after return to work or during the open enrollment period.

(3) Suspension. A suspended employee may continue coverage during the period of suspension by paying the full premium. An employee on suspension who does not continue insurance coverage may only apply for reenrollment in the Life Plan after return to work and submitting an application in accordance with Rule 60P-3.005, F.A.C. during the thirty-one (31) calendar day period after return to work or during the open enrollment period. If an employee successfully appeals a suspension and receives full back pay, the employee is then entitled to the state contribution during the time of the suspension, provided he or she was receiving the state contributions prior to the suspension.

(4) An employee on approved leave without pay or suspension as described in this section who does not pay premiums to continue coverage during such leave or suspension because of circumstances subsequently deemed "extreme hardship" by the Department, may apply for reinstatement of coverage within thirty-one (31) calendar days after return to active work by making a request to the Department and agreeing to pay all back premiums. Such requests must be in writing and submitted through the employee's agency. The employee must demonstrate by clear and convincing evidence that the existence of a severe financial hardship resulting from the loss of income or a sudden or unexpected illness or accident to the employee or dependent. If the Department approves the employee's request,

reinstatement will occur upon the Department's receipt of a personal check or money order for the premiums for the period not on payroll.

(5) Layoff. An employee who is laid off in accordance with a plan approved by the Department shall be eligible to continue coverage while laid off not to exceed two (2) years from the date of layoff, provided the employee pays the appropriate employee contribution. An employee who does not continue coverage during such two year period, may only apply for reenrollment in the Life Plan after return to work and by submitting an application in accordance with subsection 60P-3.005(2), F.A.C. within thirty-one (31) days of returning to work or during the open enrollment period.

(6) Workers' Compensation disability leave. An employee who is on Workers' Compensation disability leave is eligible to continue in the Life Plan and shall be entitled to the state contribution during such leave. The employee shall pay the employee contribution by personal check or money order and submit it to the agency on a month-to-month basis during the period the employee is not on the payroll. The agency shall be responsible for forwarding such checks or money orders to the Department within five (5) business days. An employee who does not continue coverage under the Life Plan while on Workers' Compensation disability leave may only reenroll in the Life Plan during the open enrollment period after returning to work.

(7) Less than year round employment.

(a) An employee on an academic contract, or if regularly employed for less than twelve (12) months, has worked at least eight (8) months during the prior consecutive twelve (12) month period, is eligible to continue in the Life Plan and receive the state contribution for a period not to exceed four (4) months while such employee is off the payroll.

(b) Employee contributions for such employees must be paid by advance payroll deductions, by collecting a single personal check or money order for the employee contribution for the entire period the employees will not be on the payroll or on a month-to-month basis.

(8) Military leave. An insured employee granted military leave as defined under Personnel Chapter 60K-5, F.A.C. shall be eligible to continue coverage while on such leave, provided the employee pays the full premium. Premiums shall be submitted to the agency for transmittal to the Department. If the employee does not continue coverage while on military leave, the employee may apply for reenrollment in the Plan within thirty-one (31) calendar days after reemployment by the State.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-12-80, Formerly 22K-1.54, 22K-1.054, 22K-1.312, Amended 8-26-96, Repromulgated ________.

60P-3.016 Dismissed Employees.

(1) An insured employee who is dismissed, is no longer eligible for coverage under the Life Plan, but may convert to an individual policy offered by the servicing agent within thirty-one (31) calendar days of termination of coverage for an amount equal to or less than the amount of insurance which ceases because of such termination.

(2) An insured employee, who successfully appeals a dismissal and is reinstated may apply for reenrollment in the Life Plan pursuant to Rule 60P-3.005, F.A.C.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-12-80, Formerly 22K-1.55, 22K-1.055, 22K-1.313, Amended 8-26-96, Repromulgated ________.

60P-3.017 Returned Checks.

(1) When a check for the employee contribution is returned for nonpayment, a certified letter will be mailed directly to the signer of the check requesting payment of the amount due plus a service charge of fifteen dollars ($15) or five percent (5%) of the face amount of the check, whichever is greater. If the signer of the check is someone other than the insured, a certified letter will be mailed to the insured, requesting payment of the amount due plus the service charge.

(2) An employee whose coverage is terminated in accordance with this Section may only apply for enrollment in the Life Plan during the open enrollment period after making restitution for all dishonored checks. A retired employee whose coverage is terminated in accordance with this Section may not reenter the Life Plan.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-12-80, Formerly 22K-1.56, 22K-1.056, 22K-1.314, Amended 8-26-96, Repromulgated ________.

60P-3.018 Terminations and Conversions.

An employee terminated from state employment for any reason or placed in other than a salaried position shall not be eligible to continue in the Life Plan, but may convert to an individual policy plan by applying to the Carrier, in writing, within thirty-one (31) calendar days after his or her coverage terminates under the Plan.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-12-80, Formerly 22K-1.57, 22K-1.057, 22K-1.315, Amended 8-26-96, Repromulgated ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Garrett R. Blanton, Deputy Secretary, Department of Management Services

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Cynthia A. Henderson, Secretary, Department of Management Services

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: November 19, 2001

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: November 2, 2001

DEPARTMENT OF MANAGEMENT SERVICES

Division of State Employees' Insurance

RULE CHAPTER TITLE:	RULE CHAPTER NO.:
General Provisions and Definitions	60P-6
RULE TITLES:	RULE NOS.:
Definitions	60P-6.006
Enrollment	60P-6.0063
Coverage Period	60P-6.0065
Changes in Participation	60P-6.0068
Termination of Participation	60P-6.007
Benefits	60P-6.0075
Continuation of Participation	60P-6.0079
Submission of Claims for Reimbursement	60P-6.0081
Underpayment	60P-6.009
Forfeitures	60P-6.010

PURPOSE AND EFFECT: To readopt each rule in this chapter verbatim in order to avoid the statutory repeal that would otherwise occur on January 1, 2002, pursuant to Section 42 of Chapter 2001-43, Laws of Florida. No amendments will be made in this proceeding.

SUMMARY: Group insurance of several kinds for state officers and employees under Section 110.123, Florida Statutes; the prescription drug program under Section 110.12315; and the pretax benefits program under Section 110.161.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: No statement of estimated regulatory cost was prepared.

Any person who wishes to provide information regarding regulatory costs or to provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days after this notice.

SPECIFIC AUTHORITY: 110.123(3)(c),(5), 110.161(5) FS.

LAW IMPLEMENTED: 110.123, 17.04, 110.161, 110.12315 FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW (IF NOT REQUESTED, THIS HEARING WILL NOT BE HELD):

TIME AND DATE: 10:00 a.m., December 28, 2001

PLACE: Room 260L, 4050 Esplanade Way, Tallahassee, Florida

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Frederick J. Springer, Office of the General Counsel, Department of Management Services, 4050 Esplanade Way, Suite 260, Tallahassee, FL 32399-0950, (850)487-1898

THE FULL TEXT OF THE PROPOSED RULES IS:

60P-6.006 Definitions.

Unless otherwise expressly stated whenever used in Chapter 60P-6, F.A.C., the following terms shall have the respective meaning indicated:

(1) "Claim Filing Deadline" is April 15 following the participant's period of eligibility. All initial prior plan year claims filings must be postmarked or received, when not mailed, at the Department on or prior to this date to be considered for processing.

(2) "Claim filing run-out period" is the period during which the Department will accept documentation in support of claims filed within the claim filing deadline. This period will not extend beyond June 30 following the end of the prior plan year.

(3) "Dependent" means:

(a) An individual for whom the participant is entitled to a tax deduction under the Internal Revenue Code; requires full time care because of a physical or mental incapacity; or is the spouse of the participant and is physically or mentally incapable of caring for himself or herself.

(4) "Dependent Care Expenses" means expenses incurred by a participant for the care of an eligible dependent as defined in applicable Internal Revenue Code to permit a participant and spouse, if any, to be gainfully employed.

(5) "Dependent care reimbursement account" means an account under which an employee may set aside money, on a pretax basis via salary reduction to pay for qualified daycare expenses.

(6) "Participant" means an employee who has enrolled in the Program for a period of coverage, and who has not become ineligible for participation at any time during the period of coverage.

(7) "Health care expenses" means any unreimbursed eligible expenses incurred by a participant or by a spouse or dependent of such participant for medical care.

(8) "Health care reimbursement account" means an account under which an employee may set aside money, on a pretax basis via salary reduction to pay for qualified health care expenses.

(9) "Period of coverage" means the Plan Year or that portion of the Plan Year during which coverage of benefits under the Plan is available to and elected by the participant.

(10) "Program" means the Florida Flexible Benefits Program established pursuant to Section 110.161, Florida Statutes.

(11) "Plan year" means a 12-month period beginning January 1 and ending December 31.

(12) "Salary reduction agreement" means an agreement by and between the State and the employee, in which the employee elects to participate in the Program.

(13) "Qualifying status change (QSC) event" or "QSC event" means the change in employment status, for subscriber or spouse, family status or significant change in health coverage of the employee or spouse attributable to the spouse's employment.

Specific Authority 110.161(5) FS. Law Implemented 110.161 FS. History–New 8-3-89, Amended 4-17-91, Formerly 22FB-1.006, Amended 8-26-96, Repromulgated ________.

60P-6.0063 Enrollment.

(1) Those employees participating in the Health Program or Life Plan through premium contributions shall be enrolled in the Pretax Premium Plan in accordance with subsection 60P-2.002(7), F.A.C.

(2) Those employees participating in a supplemental insurance plan shall be enrolled in the Pretax Premium Plan.

(3) Eligible employees may elect to enroll in the Reimbursement Plan within sixty (60) calendar days of employment, within thirty-one (31) calendar days of a QSC event, or during open enrollment by completing an application in accordance with subsection 60P-2.002(2), F.A.C. Such application shall include an annual election amount for either or both reimbursement account(s).

Specific Authority 110.161(5) FS. Law Implemented 110.161 FS. History–New 8-26-96, Repromulgated ________.

60P-6.0065 Coverage Period.

The coverage period shall be the Plan Year. However, with respect to the Pretax Premium Plan, when an employee becomes eligible to participate during a Plan Year, the coverage period, in the absence of the submission of a written waiver, will begin on the first day of the first month which follows sixty (60) calendar days after enrollment into the State Group Insurance Program and continues throughout the Plan Year. With respect to the Reimbursement Plan, the coverage period shall be the Plan Year. However, when an employee becomes eligible to participate during a Plan Year, an adjusted coverage period will be from the date that the completed application is received at the Department or the date of the occurrence of the qualifying event, whichever is later, through the last day of that Plan Year, provided that required contributions are made.

Specific Authority 110.161(5) FS. Law Implemented 110.161 FS. History–New 8-26-96, Repromulgated ________.

60P-6.0068 Change in Participation.

(1) A participant's salary reduction amount shall be increased or decreased automatically to correspond to any changes in employee contributions where, during the Plan Year, there has been a change in the cost of the premium under the State Health Insurance Program.

(2) An election made under the Pretax Premium Plan shall be irrevocable during the Plan Year except when a participant experiences a QSC event.

(3) A participant may revoke an existing election and make a new benefit election for the remaining period of coverage when a QSC event is or has been experienced, provided that the new election is consistent with the event and the request for such a change is made within thirty-one (31) calendar days of the event's occurrence by submission of an application to the Department. Such application shall be required in addition to any insurance applications that may be required to comply with Chapter 60P-2, F.A.C. The Department shall determine if the requested benefit change is consistent with the change in status. Documentation of the occurrence of the change in status is required.

(4) Retirees under the State University System Phased Retirement Program who elect to continue their coverage shall be treated as having taken an unpaid leave of absence upon returning to employment, if they return during the same Plan Year.

(5) A participant may revoke an existing election if employment is terminated during the Plan Year. However, the participant may not make a new benefit election for the remaining portion of the Plan Year. A participant who fails to make the required contributions to the Medical Reimbursement Account in accordance with the salary reduction agreement at any time during the coverage period will have benefit payments suspended, regardless of account balance, until payment of required contributions resumes.

Specific Authority 110.161(5) FS. Law Implemented 110.161 FS. History–New 8-26-96, Repromulgated ________.

60P-6.007 Termination of Participation.

(1) Contributions under any pretax plan shall not be discontinued, except in the event of termination of participation as provided in this section. Any contribution made under any Plan may not be refunded to the participant. Reimbursements made under any Reimbursement Plan shall not be considered refunds of contributions.

(2) A participant shall continue to participate in any pretax plan until the earlier of the following dates:

(a) The date the participant ceases to be an eligible employee, unless the participant elects to continue coverage in the Medical Reimbursement Account by continuing payment of contributions; or

(b) The date on which the coverage period ends due to non-payment of contributions for a Medical Reimbursement Account; or

(c) The date the Plan Year ends.

(3) Upon subsequent employment with the State, an eligible employee who has terminated participation in the Plan shall be entitled to recommence participation as follows:

(a) If the participant is rehired as an eligible employee within 31 calendar days of termination and during the same Plan Year in which employment terminated, the participant shall not be allowed to make any new benefit elections under the Plan and will have the same level of benefits as were in effect immediately prior to the termination of employment unless there has been a Qualifying Status Change other than the termination and rehire.

(b) If reemployment as an eligible employee occurs during the same Plan Year in which employment terminated but occurs more than 31 calendar days after termination, and the participant has revoked his earlier benefit election, the participant shall not be entitled to recommence participation until the following Plan Year. However, the employee will be entitled to elect insurance coverage under the State Group Health Insurance Program on an after-tax basis, in accordance with Chapter 60P-2, F.A.C.

(c) If reemployment occurs during a Plan Year subsequent to the one in which termination occurred, the employee shall be entitled to recommence participation upon reemployment and can make new benefit elections for the new Plan Year in accordance with rules and procedures established for newly-hired and newly-eligible employees.

Specific Authority 110.161(5) FS. Law Implemented 110.161 FS. History–New 8-3-89, Amended 4-17-91, Formerly 22FB-1.007, Amended 8-26-96, Repromulgated ________.

60P-6.0075 Benefits.

(1) Subject to the limitations provided under the Internal Revenue Code to avoid discrimination, the amount of salary reduction which a participant may elect under the Pretax Premium Plan shall be the aggregate amount of employee premiums for coverage under the State Group Insurance Program.

(2) All participants' contributions to any reimbursement account under the Program shall be made by salary reduction except in the case of certain participants of the Medical Reimbursement Account whose employment has terminated.

(3) A participant's gross compensation shall not be affected by participation in any Plan. A participant who contributes to a deferred compensation plan or a tax sheltered annuity may be required to adjust his contributions to such programs. Employee contributions under the State University System Optional Retirement Program will be computed on the participant's adjusted gross income automatically.

Specific Authority 110.161(5) FS. Law Implemented 110.161 FS. History–New 8-26-96, Repromulgated ________.

60P-6.0079 Continuation of Participation.

(1) Upon termination of employment, the participant may desire to continue in the Medical Reimbursement Account and satisfy his or her annual election. The participant must notify the Department of his or her desire to continue no later than sixty (60) calendar days from the later of:

(a) The employment termination date;

(b) The date the participant is notified by the Department of his or her eligibility to continue participation.

(2) Continuation in the Medical Reimbursement Account requires that the participant satisfy his or her annual election by one of the following methods:

(a) Arranging, in advance of termination, to have all or part of the remaining balance deducted from his or her payment for annual or sick leave through payroll deduction on a pretax basis. Any amount needed to satisfy the annual election after this deduction is taken must be paid by personal check or money order within forty-five (45) calendar days of the participant's election to continue participation;

(b) Making a single after-tax payment by check or money order for 100% of the remaining balance due within forty-five (45) calendar days of the participant's election to continue participation;

(c) Making monthly after-tax payments by check or money order for the required monthly contribution made as an active employee. Such payments must be made no later than the first of each month. The first payment must be made within forty-five (45) calendar days of the participant's election to continue participation.

Specific Authority 110.161(5) FS. Law Implemented 110.161 FS. History–New 8-26-96, Repromulgated ________.

60P-6.0081 Submission of Claims for Reimbursement.

(1) The participant shall submit to the Department a request which shall include the following:

(a) Social security number, name, address, work and home telephone numbers;

(b) A description of the expenses;

1. For medical expenses, the patient's name, the dates and descriptions of services, and the expenses the participant is claiming for reimbursement;

2. For dependent day care expenses, the dependent's name, the dates and descriptions of services, and the expenses the participant is claiming that are directly associated with the day care provided to the dependent;

(c) A statement certifying that the expenses claimed were incurred by the participant or my eligible dependent on the dates indicated, such expenses have not and will not be reimbursed by any other plan and are eligible for reimbursement, and such expenses are not eligible as deductions or credits when filing a federal income tax return;

(d) Signature of the participant, date signed, and accompanied by documentation of the expense incurred.

(2) Claims for expenses covered by insurance must include a statement from the insurer indicating the patient's responsibility for the expense(s). Expenses shall be reimbursed only in accordance with the level of benefits in effect at the time the expense was incurred. Expenses shall be deemed incurred at the time such services are rendered.

(3) Initial requests for reimbursement for expenses incurred during a participant's period of coverage must be postmarked or received if not mailed, at the Department no later than April 15 following the prior Plan Year.

(4) For requests filed prior to the claims filing deadline and rejected due to lack of proper documentation, such documentation must be submitted, within the claims filing run-out period.

Specific Authority 110.161(5) FS. Law Implemented 110.161 FS. History–New 8-26-96, Repromulgated ________.

60P-6.009 Underpayment.

(1) If non-payment of the required contribution to any plan occurs as a result of an authorized leave without pay, the amount of such contribution will be adjusted and payment will resume with the next payroll check.

(2) Upon receipt of the required contributions, participation in any plan will resume as if no break had occurred.

(3) If payment of required contributions does not resume, no reimbursement will be made for expenses incurred after the last date of the coverage period for which the required contribution was made.

(4) Collection efforts will be made to ensure that a participant satisfies his annual elections.

Specific Authority 110.161(5) FS. Law Implemented 110.161 FS. History–New 8-26-96, Repromulgated ________.

60P-6.010 Forfeitures.

With respect to the Reimbursement Plan, if unused portions of the participant's annual election remain in an account for which otherwise eligible claims are not received prior to the claims filing deadline, these funds shall be forfeited. Administrative expenses shall be debited from the Pretax Trust Fund and any remaining balance shall be transferred to the State Health Trust Fund.

Specific Authority 110.161(5) FS. Law Implemented 110.161 FS. History–New 8-26-96, Repromulgated ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Garrett R. Blanton, Deputy Secretary, Department of Management Services

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Cynthia A. Henderson, Secretary, Department of Management Services

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: November 19, 2001

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: November 2, 2001

DEPARTMENT OF MANAGEMENT SERVICES

Division of State Employees' Insurance

RULE CHAPTER TITLE:	RULE CHAPTER NO.:
State Group Disability Income Self Insurance Plan	60P-9
RULE TITLES:	RULE NOS.:
Definitions	60P-9.001
Eligibility	60P-9.002
Enrollment	60P-9.003
Effective Date of Coverage	60P-9.004
Benefits	60P-9.005
Payment of Premiums	60P-9.006
Employing Agency Change	60P-9.007
Termination of Coverage	60P-9.009

PURPOSE AND EFFECT: To readopt each rule in this chapter, with minimal changes as noted, in order to avoid the statutory repeal that would otherwise occur on January 1, 2002, pursuant to Section 42 of Chapter 2001-43, Laws of Florida.

SUMMARY: Group disability income insurance for state officers and employees under Section 110.123, Florida Statutes.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: No statement of estimated regulatory cost was prepared.

Any person who wishes to provide information regarding regulatory costs or to provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days after this notice.

SPECIFIC AUTHORITY: 110.123(3)(c),(5), 110.161(5) FS.

LAW IMPLEMENTED: 110.123, 17.04, 110.161, 110.12315 FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW (IF NOT REQUESTED, THIS HEARING WILL NOT BE HELD):

TIME AND DATE: 10:00 a.m., December 28, 2001

PLACE: Room 260L, 4050 Esplanade Way, Tallahassee, Florida

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Frederick J. Springer, Office of the General Counsel, Department of Management Services, 4050 Esplanade Way, Suite 260, Tallahassee FL 32399-0950, (850)487-1898

THE FULL TEXT OF THE PROPOSED RULES IS:

60P-9.001 Definitions.

For the purpose of administering this Plan, the following words and terms shall have the meaning indicated:

(1) "Active work" or "actively at work" means the actual expenditure of time and energy by the employee, performing duties pertaining to the employee's job in the place where and in the manner in which such job is performed on a continuing basis.

(2) "Basic daily earnings" means the employee's annual salary divided by 364.

(3) "Employee" means an individual holding a salaried Senior Management Service or Selected Exempt Service position with any state agency.

(4) "Plan" shall mean the State of Florida Group Disability Income Insurance Plan adopted pursuant to Section 110.123(3), Florida Statutes.

(5) "Sickness" means illness or disease and is inclusive of pregnancy and resulting childbirth, miscarriage, abortion or complications.

(6) "Totally disabled" means that the employee is completely unable, due to sickness or injury or both, to perform the duties pertaining to his or her employment and is under the direct care of a physician.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-26-96, Repromulgated ________.

60P-9.002 Eligibility.

Eligibility to participate in the Plan will be in accordance with Section 110.123, Florida Statutes.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-26-96, Repromulgated ________.

60P-9.003 Enrollment.

(1) Enrollment in the Plan is automatic upon an employee's appointment to an eligible position.

(2) An employee may elect to refuse coverage by signing a refusal statement and submitting it to his or her personnel office.

(3) An employee who previously refused coverage may apply for enrollment by submitting a written request to the Department.

Specific Authority 110.123(5), 20.05(5) FS. Law Implemented 110.123 FS. History–New 8-26-96, Repromulgated ________.

60P-9.004 Effective Date of Coverage.

The effective date of coverage for an employee under the Plan shall be as follows:

(1) The date of an employee's appointment to an eligible position; unless the employee is disabled or under a physician's care on account of sickness or injury and not actively at work on that date, the effective date will be the date the employee resumes active work.

(2) The effective date of an employee who has previously refused coverage will be the first day of the month following the receipt of the employee's written request to enroll; unless the employee is disabled or under a physician's care on account of sickness or injury and not actively at work on that date, the effective date will be the date the employee resumes active work.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-26-96, Repromulgated ________.

60P-9.005 Benefits.

If an employee, while insured under the Plan and as a result of sickness or injury, becomes totally disabled, the Plan will pay biweekly benefits to the employee for the period of such disability. Such benefits are payable in an amount of sixty-five (65) percent of the employee's basic daily earnings at the date of disability. Benefits are payable from the first benefit day of any one continuous period of disability up to a maximum of one year (364 days) subject to the following:

(1) The "first benefit day" shall be the later of:

(a) The thirty-first (31st) day of continuous disability,

(b) The date following the day that an employee exhausts all accumulated leave credits including annual leave, sick leave, sick pool leave and personal holiday leave.

(2) Benefits paid under the Plan will be reduced by any benefits paid or payable:

(a) Under any Workers' Compensation Act or similar legislation; and

(b) As primary and family benefits under the Social Security Act; and

(c) As regular or disability retirement benefits under the State of Florida Retirement System.

(3) Successive periods of disability separated by less than one work week of continuous active work with the employer will be considered one continuous period of disability unless the later disability is due to causes entirely unrelated to the causes of the previous disability and commences after return to active work for at least one full day.

(4) Plan benefits will be suspended at the employees' anniversary date and will recommence on the date following the day that an employee exhausts all accumulated leave credits including annual leave, sick leave, sick pool leave and personal holiday leave.

(5) Any claim files must contain the following information:

(a) Employee information including the employee's full name, Social Security number, address, telephone number, date of birth, signature of compliance and medical release, sex, occupation, marital status, spouse's name and date of birth, children's names and dates of birth, a description of the disability, date of the disability, date first treated for the disability, date of the last day worked due to disability, date returned to work full or part time, and any benefits paid or payable under Workers' Compensation, Florida Retirement or Social Security and the employee's signature.

(b) Employer information including the employee hire date, certification of last day worked and date returned to work, salary at time of disability, accumulated leave balances, agency name, SAMAS organizational code, address and telephone number, and authorized personnel signature.

(c) Attending physicians' statement including a physical history, diagnosis, dates of treatment, nature of treatment, progress notes, impairment levels, prognosis, rehabilitation remarks, and the physician's name, address, telephone number, licenses and signature.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-26-96, Repromulgated ________.

60P-9.006 Payment of Premiums.

(1) The employing agency will pay 100% of the premium for each employee participating in the Plan, while that employee is on the active state payroll.

(2) The employing agency will pay 100% of the premium for an employee on an approved medical leave, unless the employee is receiving Plan benefits.

(3) In the event of an employee changing agencies and remaining in a Senior Management or Select Exempt position, the agency employing on the first day of a month will be responsible for paying 100% of the premium for that month.

(4) The employee may pay the full monthly premium by submitting a personal check or money order to his or her personnel office for transmittal to the Department:

(a) If the employee is on an approved leave without pay, but not to exceed six months.

(b) In the event of layoff, but not to exceed one month.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-26-96, Repromulgated ________.

60P-9.007 Employing Agency Change.

Movement from one state agency to another state agency does not constitute a change in qualifying status ~~new employment~~, therefore, enrollment requirements do not change. If the change results in the loss of Senior Management or Select Exempt status, coverage will continue until the last day of the month for which premiums have been paid.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-26-96, Repromulgated ________.

60P-9.009 Termination of Coverage.

The date of termination of coverage will be as follows:

(1) In the event of termination of employment, the employment termination date.

(2) In the event the employee requests to cancel coverage, the last day of the month in which the Department receives a signed waiver of coverage.

(3) In the event an employee terminates his or her position in Senior Management or Select Exempt status but remains a state employee, the last day of the month for which premiums have been paid.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-26-96, Repromulgated ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Garrett R. Blanton, Deputy Secretary, Department of Management Services

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Cynthia A. Henderson, Secretary, Department of Management Services

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: November 19, 2001

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: November 2, 2001

DEPARTMENT OF MANAGEMENT SERVICES

Division of State Employees' Insurance

RULE CHAPTER TITLE:	RULE CHAPTER NO.:
Supplemental Insurance Plan	60P-10
RULE TITLES:	RULE NOS.:
Eligibility	60P-10.001
Enrollment	60P-10.002
Changes in Coverage	60P-10.003
Effective Date of Coverage	60P-10.004
Payment of Premiums	60P-10.005
Overpayment of Premiums	60P-10.006
Agency Changes	60P-10.007
Leave Without Pay/Suspension	60P-10.008
Terminations and Conversions	60P-10.009

PURPOSE AND EFFECT: To readopt each rule in this chapter, with minimal changes as noted, in order to avoid the statutory repeal that would otherwise occur on January 1, 2002, pursuant to Section 42 of Chapter 2001-43, Laws of Florida.

SUMMARY: Group supplemental insurance for state officers and employees under Section 110.123, Florida Statutes.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: No statement of estimated regulatory cost was prepared.

Any person who wishes to provide information regarding regulatory costs or to provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days after this notice.

SPECIFIC AUTHORITY: 110.123(3)(c),(5), 110.161(5) FS.
LAW IMPLEMENTED: 110.123, 17.04, 110.161, 110.12315 FS.
IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW (IF NOT REQUESTED, THIS HEARING WILL NOT BE HELD):
TIME AND DATE: 10:00 a.m., December 28, 2001
PLACE: Room 260L, 4050 Esplanade Way, Tallahassee, Florida
THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Frederick J. Springer, Office of the General Counsel, Department of Management Services, 4050 Esplanade Way, Suite 260, Tallahassee FL 32399-0950, (850)487-1898

THE FULL TEXT OF THE PROPOSED RULES IS:

60P-10.001 Eligibility.
An employee is eligible to participate in a supplemental insurance plan in accordance with Section 110.123, Florida Statutes.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-22-96, Repromulgated ________.

60P-10.002 Enrollment.

(1) An employee may apply for enrollment in a supplemental insurance plan through his or her personnel office during:

(a) During the first sixty (60) calendar days of state employment or a new term of office;

(b) During open enrollment;

(c) Within thirty-one (31) days of a QSC of losing group health coverage;

(d) Within thirty-one (31) days of a QSC of an increase in the number of work hours for an employee.

(2) The employing agency shall request an effective date of coverage for enrollment in supplemental insurance plan in accordance with Rule 60P-10.004, F.A.C. and indicate such date on an application along with other required employee and agency information. This information shall include:

(a) Employee's and eligible dependent's name, social security number, birth date, sex, employee's home mailing address, employment date, SAMAS organizational code, company, product, coverage code, option codes, and action to be taken;

(b) Contains the signature and date of the employee and authorized signature and date of the employing agency certifying eligibility of the employee.

(3) The employee acknowledges that eligibility and enrollment are governed by the provisions of Chapter 60P-1, F.A.C.; authorizes the State to reduce salary as often and in amount necessary to continue coverage; acknowledges premiums may change from time to time; agrees to notify the Department at the time any dependent becomes ineligible for coverage; and agrees that all statements made on application are complete and true.

(4) The completed application shall be forwarded to the Department by the employing agency prior to the requested effective date.

(5) Attach the original company application, completed and signed by the employee and certified by the employing agency.

(6) An employee enrolled in a supplemental insurance plan shall automatically be enrolled in the pretax premium plan pursuant to Chapter 60P-6, F.A.C.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-22-96, Repromulgated ________.

60P-10.003 Changes in Coverage.

(1) An employee may elect, change, or cancel coverage within thirty-one (31) days of a Qualified Status Change (QSC) event if the change is consistent with the event pursuant to subsection 60P-2.003(7), F.A.C. or during the open enrollment period.

(2) The employing agency shall request an effective date for a change in coverage in accordance with Rule 60P-10.004, F.A.C.

(3) The Department shall approve a coverage change if the completed application is submitted within thirty-one (31) calendar days of the QSC event and the proper documentation is provided.

(4) If an employee wants to decline coverage after reviewing any underwritten policy by any company, such employee must complete and sign the required application terminating the election prior to the end of the month in which coverage would take effect.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-22-96, Repromulgated ________.

60P-10.004 Effective Date of Coverage.

(1) The effective date of coverage requested by the employing agency for enrollment or changes in coverage in a supplemental insurance plan shall always be the first day of the month for which a full month's premium may be deducted using single deductions based upon the employee's signature date on the application. The requested effective date shall be no earlier than the first day of the month following the employee's signature date; however, in no case shall such effective date be prior to or on the employee's employment date. In the case of supplemental policies which require underwriting approval, the effective date of coverage shall be the first day of the month initially requested, following approval or in which a full month's premium can be deducted.

(2) The effective date of coverage for enrollment or changes will be determined by the Department if an error or omission occurs by the employee's agency personnel office.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-22-96, Repromulgated ________.

60P-10.005 Payment of Premiums.

(1) Premiums are due one month in advance of each month of coverage and shall be paid as follows:

(a) For employees on payroll, premiums shall be payroll deducted;

(b) For employees off payroll, premiums shall be paid monthly by personal check or money order and forwarded to the supplemental company.

(2) Double payroll deductions shall be made for an employee on an academic contract or who is regularly employed for less than twelve (12) months. However, double deductions shall not be made for an employee who is paid monthly or applies for a change in coverage. No deduction shall be taken on a supplemental payroll.

(3) Employee premiums shall not be accepted for coverage beyond the end of the month following the month in which the employee terminates employment.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-22-96, Repromulgated ________.

60P-10.006 Overpayment of Premiums.

When the Department becomes aware of a premium overpayment it shall:

(1) Correct the coverage codes and or deductions;

(2) Initiate a refund request;

(3) Notify the employee, employee's agency, and the supplemental company.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-22-96, Repromulgated ________.

60P-10.007 Agency Changes.

(1) A change from one state agency to another state agency does not constitute a change in qualifying status ~~new employment~~; therefore, enrollment or coverage eligibility does not change.

(2) When an uninsured employee changes from one state agency to another state agency the new agency shall request a copy of the employee's insurance file from the former agency and notify the Department in a timely fashion as not to interrupt insurance coverage. If payroll deductions cannot be made by the new agency in time to maintain continuous coverage, the employee must pay the required employee contribution by personal check or money order.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-22-96, Repromulgated as Amended ________.

60P-10.008 Leave Without Pay/Suspension.

(1) An employee who elects to continue coverage while on leave without pay shall do so by paying monthly premiums to the supplemental company in accordance with Rule 60P-10.005, F.A.C.;

(2) An employee choosing to terminate coverage while on approved leave without pay or suspension must cancel coverage through his or her employing agency and may only apply for reenrollment in a supplemental insurance plan by submitting an application in accordance with Rule 60P-10.003, F.A.C., to their personnel office within thirty-one (31) calendar days after returning to work or during the open enrollment period.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-22-96, Repromulgated ________.

60P-10.009 Terminations and Conversions.

(1) Coverage under any supplemental insurance plan shall continue through the last day of the month for which a premium has been paid.

(2) An employee terminated from state employment for any reason or placed in other than a salaried position shall not be eligible to continue in any pretax supplemental insurance plan. Upon termination of coverage, the employee may, if eligible purchase continuation coverage or a conversion plan offered by the supplemental company.

Specific Authority 110.123(5) FS. Law Implemented 110.123 FS. History–New 8-22-96, Repromulgated ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Garrett R. Blanton, Deputy Secretary, Department of Management Services

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Cynthia A. Henderson, Secretary, Department of Management Services

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: November 19, 2001

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: November 2, 2001

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

Board of Barbers'

RULE TITLE:	RULE NO.:
General Information	61G3-15.006

PURPOSE AND EFFECT: The Board proposes to update the existing rule.

SUMMARY: The Board has determined that this rule should be amended to delete rule text that is not necessary.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: No Statement of Estimated Regulatory Cost was prepared.

Any person who wishes to provide information regarding the statement of estimated costs, or to provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days of this notice.

SPECIFIC AUTHORITY: 120.53(1)(a), 119.07(1)(a), 476.064(4) FS.

LAW IMPLEMENTED: 120.53(1), 455.205, 119.07(1)(a) FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE SCHEDULED AND ANNOUNCED IN THE FAW:

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Julie Baker, Executive Director, Barbers' Board, Northwood Centre, 1940 N. Monroe Street, Tallahassee, Florida 32399-0750

THE FULL TEXT OF THE PROPOSED RULE IS:

61G3-15.006 General Information ~~and Forms~~.

(1) through (2) No change.

~~(3) The following forms are used by the Department and may be obtained by writing to the Board's office:~~

~~(a) Examination application;~~

~~(b) Reexamination application;~~

~~(c) Barbershop application;~~

~~(d) Barbershop transfer of ownership or location application.~~

Specific Authority 120.53(1), 119.07(1)(a), 476.064(4) FS. Law Implemented 120.53(1), 455.205, 119.07(1)(a) FS. History–New 7-16-80, Formerly 21C-15.06, 21C-15.006, Amended 10-30-95, 2-14-96, ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Board of Barbers'

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Board of Barbers'

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: October 22, 2001

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: August 18, 2000

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

Board of Barbers'

RULE TITLE: RULE NO.:

Change of Ownership or Location of Barbershops 61G3-19.013

PURPOSE AND EFFECT: The Board proposes to update the existing rule.

SUMMARY: The proposed changes amend the change of ownership of barbershops.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: No Statement of Estimated Regulatory Cost was prepared.

Any person who wishes to provide information regarding the statement of estimated costs, or to provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days of this notice.

SPECIFIC AUTHORITY: 476.064(4) FS.

LAW IMPLEMENTED: 476.184(7) FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE SCHEDULED AND ANNOUNCED IN THE FAW:

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Julie Baker, Executive Director, Barbers' Board, Northwood Centre, 1940 N. Monroe Street, Tallahassee, Florida 32399-0750

THE FULL TEXT OF THE PROPOSED RULE IS:

61G3-19.013 Change of Ownership or Location of Barbershops.

The change in ownership or location of a barbershop requires issuance of a new license pursuant to Rule 61G3-19.011 and Chapter 476, Florida Statutes.

~~(1) Prior to opening a shop which has new ownership the owner must:~~

~~(a) File a new application on forms prescribed by the Department of Business and Professional Regulation;~~

~~(b) Pay the appropriate fee as outlined in Rule 21C-20.004;~~

~~(c) Surrender the old license with applications;~~

~~(d) Be issued a new barbershop license as outlined in Rule 61G3-19.010, Florida Administrative Code.~~

Specific Authority 476.064(4) FS. Law Implemented 476.184(7) FS. History–New 4-27-86, Formerly 21C-19.013, Amended ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Board of Barbers'

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Board of Barbers'

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: October 22, 2001

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: November 8, 2001

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

Board of Barbers'

RULE TITLE: RULE NO.:

Aggravating and Mitigating Circumstances 61G3-21.002

PURPOSE AND EFFECT: The Board proposes to update the existing rule.

SUMMARY: The Board has determined that this rule should be amended to delete rule text that is not necessary.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: No Statement of Estimated Regulatory Cost was prepared.

Any person who wishes to provide information regarding the statement of estimated costs, or to provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days of this notice.

SPECIFIC AUTHORITY: 455.2273, 476.064(4) FS.
LAW IMPLEMENTED: 455.2273 FS.
IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE SCHEDULED AND ANNOUNCED IN THE FAW:
THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Julie Baker, Executive Director, Barbers' Board, Northwood Centre, 1940 N. Monroe Street, Tallahassee, Florida 32399-0750

THE FULL TEXT OF THE PROPOSED RULE IS:

61G3-21.002 Aggravating and Mitigating Circumstances.
Circumstances which may be considered for the purposes of mitigation or aggravation of penalty shall include, but are not limited to, the following:

(1) through (4) No change.

~~(5) The severity of the offense.~~

(5)~~(6)~~ The danger to the public.

~~(7) The number of repetitions of offenses.~~

(6)~~(8)~~ The number of complaints filed against the licensee.

(7)~~(9)~~ The length of time the licensee has practiced.

(8)~~(10)~~ The actual damage, physical or otherwise, to the licensee's customer.

(9)~~(11)~~ The deterrent effect of the penalty imposed.

(10)~~(12)~~ The effect of the penalty upon the licensee's livelihood.

(11)~~(13)~~ Any efforts at rehabilitation.

(12)~~(14)~~ Any other mitigating or aggravating circumstances.

Specific Authority 455.2273, 476.064(4) FS. Law Implemented 455.2273 FS. History–New 11-25-86, Formerly 21C-21.002, Amended ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Board of Barbers'
NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Board of Barbers'
DATE PROPOSED RULE APPROVED BY AGENCY HEAD: October 22, 2001
DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: November 8, 2001

DEPARTMENT OF HEALTH

Board of Hearing Aid Specialists

RULE TITLES:	RULE NOS.:
Continuing Education Programs	64B6-5.002
Reporting Continuing Education Attendance	64B6-5.003

PURPOSE AND EFFECT: The Board proposes to update the existing rules.
SUMMARY: The Board has decided to update the existing rules with regards to continuing education programs and reporting continuing education attendance.
SUMMARY OF STATEMENT OF ESTIMATED REGULATORY: No Statement of Estimated Regulatory Cost was prepared.
Any person who wishes to provide information regarding the statement of estimated costs, or provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days of this notice.
SPECIFIC AUTHORITY: 456.013(6),(8), 484.044, 484.047(4), 484.0501(7) FS.
LAW IMPLEMENTED: 484.047(4), 484.050(7) FS.
IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE HELD SCHEDULED AND ANNOUNCED IN THE FAW.
THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Sue Foster, Board Executive Director, Board of Hearing Aid Specialists, 4052 Bald Cypress Way, Bin # C08, Tallahassee, Florida 32399-3258

THE FULL TEXT OF THE PROPOSED RULES IS:

64B6-5.002 Continuing Education Programs.

(1) through (6) No change.

(7) Effective for the biennium beginning in 2001, each Hearing Aid Specialist shall attend and certify attending two hours and may take up to four (4) hours per biennium of continuing education which includes the topics of Human Immunodeficiency Virus, Acquired Immune Deficiency Syndrome, and other communicable illness to protect both the recipient and dispenser; modes of transmission, infection control procedures, clinical management, and prevention of any communicable illness. Such continuing education shall be accepted by the Board toward the continuing education requirement prescribed in Rule 64B6-5.001, F.A.C. Up to four hours of continuing education relating to these topics shall be accepted for the 1999-2001 biennium. Each Hearing Aid Specialist shall attend and certify attending a Board approved two hour continuing education course relating to the prevention of medical errors. The 2-hour course shall count toward the total number of continuing education hours required for license renewal.

Specific Authority 456.013(6),(7),(8), 484.044, 484.047(4) FS. Law Implemented 484.047(4) FS. History–New 4-1-85, Formerly 21JJ-15.002, Amended 8-5-87, 2-16-89, 6-21-89, 1-10-90, 8-19-91, 10-21-91, Formerly 21JJ-5.006, Amended 11-20-95, Formerly 61G9-5.006, Amended 9-23-99, 11-9-00, ________.

64B6-5.003 Reporting Continuing Education Attendance.

(1) The licensee shall submit a statement on a form, provided by the Department, in which the licensee affirms that he has completed the continuing education required for license renewal. Failure to submit the completed form by February 28 ~~January 31~~, of every odd biennial renewal year shall be grounds for denying license renewal. The licensee shall retain for 4 years such receipts or certificates which establish completion of required continuing education during each

biennium. The Department shall randomly audit a sufficient number of licensees' continuing education records to assure compliance with continuing education requirements.

(2) No change.

Specific Authority 484.044, 484.047(4), 484.0501(7) FS. Law Implemented 484.050(7) FS. History–New 4-1-85, Formerly 21JJ-15.003, Amended 8-5-87, 1-10-90, 8-19-91, 10-21-91, Formerly 21JJ-5.007, 61G9-5.007, Amended ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Board of Hearing Aid Specialists

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Board of Hearing Aid Specialists

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: October 15, 2001

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: September 28, 2001

DEPARTMENT OF HEALTH

Board of Massage Therapy

RULE TITLE:	RULE NO.:
Disciplinary Guidelines	64B7-30.002

PURPOSE AND EFFECT: The Board of Massage Therapy determined it necessary to review and update the disciplinary guidelines and further define the penalties for each violation.

SUMMARY: Revisions to existing disciplinary guidelines for the Board of Massage Therapy to set out meaningful penalty ranges and incorporate legislative changes.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: A summary has not been prepared regarding the proposed rule.

Any person who wishes to provide information regarding the statement of estimated regulatory costs, or to provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days of this notice.

SPECIFIC AUTHORITY: 456.073(4), 456.079(1),(3),(4), 480.035(7) FS.

LAW IMPLEMENTED: 456.073(4), 456.079(1),(2),(3),(4), 480.041, 480.046, 480.047 FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE A HEARING WILL BE SCHEDULED AND ANNOUNCED IN THE FAW.

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this meeting, is asked to advise the agency at least 5 calendar days before the meeting by contacting Karen Eaton, Executive Director, Board of Massage Therapy. If you are hearing or speech impaired, please contact the agency by calling (850)245-4162.

All written material received by the Department within 21 days of the date of publication of this notice shall be made a part of the official record.

Section 286.0105, Florida Statutes, provides that, if a person decides to appeal any decision made by the department with respect to any matter considered at this hearing, they will need a record of proceedings, and for such purposes, they may need to ensure that a verbatim record of the proceedings is made, which record includes the testimony and evidence upon which the appeal is based.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Karen Eaton, Executive Director, Board of Massage Therapy, Division of Medical Quality Assurance, Department of Health, 4052 Bald Cypress Way, BIN #C06, Tallahassee, Florida 32399-3256

THE FULL TEXT OF THE PROPOSED RULE IS:

64B7-30.002 Disciplinary Guidelines.

(1) When the Board finds that an applicant, apprentice, provisional licensee or licensee whom it regulates under Chapter 480, Florida Statues, has committed any of the acts set forth in Sections 480.0485, 480.046, 480.047, and 456.072, Florida Statutes, it shall issue a final order imposing appropriate penalties within the ranges recommended in the following disciplinary guidelines after consideration of the aggravating and mitigating factors set forth in subsection three (3) of this rule.

(a) 480.046(1)(a)

Licensee	First Offense: Suspension and $250 fine. Subsequent offense $1000 fine and revocation. If the offense is fraudulent misrepresentation, the first offense is a $10,000.00 fine, the second offense is a $10,000.00 fine and suspension of license and subsequent offense is a $10,000.00 fine and revocation of the license.
Applicant	Denial of licensure. If the offense is fraudulent misrepresentation, denial of licensure and a $10,000.00 fine. ~~$1000 fine and revocation; denial of licensure and prohibition on reapplication for 2-5 years~~
456.072(1)(h)	Revocation through error of department of board
(b) 480.046(1)(b) or ~~&~~ 456.072(1)(f)	Licensee: Impose discipline consistent with penalty or actions imposed in other jurisdiction. Applicant: deny licensure. ~~Deny licensure; or grant licensure with restrictions and $250 fine; or imposed discipline consistent with these guidelines~~.

(c) 480.046(1)(c) or ~~&~~ 456.072(1)(c)	
Misdemeanors	First offense: $250 fine, second offense: $500 fine & probation, third offense: $500 fine and suspension. ~~$250 fine & probation~~
Felonies	First offense: $500 fine & probation, second offense: $500 fine and suspension, third offense: $1,000 fine and revocation. ~~$500 fine & suspension~~
Crimes relating to assault, battery, abuse or which otherwise cause bodily harm, prostitution or solicitation for prostitution	$1,000 & revocation
(d) 480.046(1)(d)	First offense: $500 fine & reprimand, second offense: $750 fine and probation, third offense: $1,000 fine & suspension.
(e) 480.046(1)(e) or ~~&~~ 456.072(1)(j)	First offense: $1,000 fine & suspension, second offense: $1,000 fine and revocation for a minimum of 2 years, third offense: permanent revocation. ~~$1,000 fine & revocation~~
(f) 480.046(1)(f) or ~~&~~ 456.072(1)(a) or ~~&~~ (m)	First offense: $500 fine & reprimand, second offense: $500 fine & probation, third offense: $1,000 fine & suspension. If the offense is fraud, first offense: $10,000 fine, subsequent offense: $10,000 fine & revocation. ~~$500 fine & probation~~
(g) 480.046(1)(g)	First offense: probation, second offense: suspension, third offense: revocation. ~~Suspension or revocation.~~
(h) 480.046(1)(h) ~~1. repeated malpractice~~	First offense: $1,000 fine & probation, second offense: $1,000 fine & suspension, third offense: $1,000 fine & revocation. ~~$1,000 fine & suspension~~
~~2. gross malpractice~~	~~Revocation~~
(i) 480.046(1)(i) or ~~&~~ 456.072(1)(o)	First offense: $1,000 fine & probation, second offense: $1,000 fine & suspension, third offense: $1,000 fine & revocation. ~~$500 fine & probation~~
(j) 480.046(1)(j) or ~~&~~ 456.072(1)(p)	First offense: $250 fine & probation, second offense: $500 fine & suspension, third offense: $1,000 fine & revocation. ~~$500 fine & probation~~
(k) 480.046(1)(k)	Unless an offense specifically set forth below, first offense: $250 fine, subsequent offense: $250 fine & probation. ~~$250 fine to probation~~
1. through 6. No change.	
7. 480.047(1)(c)	First offense: $1,000 fine & revocation, subsequent offense: $1,000 fine & revocation for minimum of 2 years. ~~$1,000 fine & revocation~~
8. 480.047(1)(d)	
Licensee	First offense: $1,000 fine, second offense: $1,000 fine & revocation.
Applicant	First offense: denial of licensure, subsequent offense: denial licensure and prohibition on reapplication for 2-5 years. ~~$1,000 fine and/or revocation; denial of licensure and prohibition on reapplication for 2-5 years~~
9. No change	
10. 480.047(1)(f)	
Licensee	First offense: $1,000 fine & probation, second offense: $1,000 fine & suspension, third offense: $1,000 fine & revocation.
Applicant	First offense: denial or licensure, subsequent offense: denial of licensure and prohibition on reapplication for 2-5 years. ~~$1,000 fine and/or revocation; denial of licensure and prohibition on reapplication for 2-5 years~~
11. 480.047(1)(g)	
Licensee	First offense: $1,000 fine & probation, subsequent offense: $1,000 fine & revocation.
Applicant	First offense: denial of licensure, subsequent offense: denial of licensure and prohibition on reapplication for 2-5 years. ~~$1,000 fine and/or revocation; denial of licensure and prohibition on reapplication for 2-5 years.~~
Failure to respond to continuing education audit	First offense: $500 fine & suspension, subsequent offense: $500 fine & revocation. ~~$500 fine~~

(l) 480.046(1)(l)	First offense: $500 fine & suspension, second offense: $1,000 fine & suspension, third offense: $1,000 fine & revocation. ~~$500 fine & suspension~~
(m) 480.046(1)(m)	First offense: $250 fine & reprimand, second offense: $500 fine & suspension, third offense: $1,000 fine & revocation.
(n) 480.046(1)(n)	
1. Establishment license	No change
2. Establishment license suspended –site owned by massage therapist	First offense: Suspension of owner's massage therapy license, subsequent offense: revocation by massage therapist of owner's massage therapy license. ~~Revocation of owner's massage therapy license~~
~~3. Establishment never licensed~~	~~$500 fine & reprimand~~
(o) 456.072(1)(g) false report to department regarding violation	First offense: $500 fine & suspension, subsequent offense: $1,000 fine & revocation. ~~$500 fine & suspension~~
(p) 456.072(1)(i) failure to report violator	First offense: $500 fine & reprimand, subsequent offense: $1,000 fine & suspension. ~~$500 fine & reprimand~~
(q) 456.072(1)(l) filing a false report required by law	First offense: $500 fine & probation, subsequent offense: $1,000 fine & revocation.
(r) 456.072(1)(n) influencing client for financial gain	First offense: $500 fine & probation, subsequent offense: $1,000 fine & revocation.
(s) 456.072(1)(r) interfering with an investigation or inspection	First offense: $500 fine & probation, subsequent offense: $1,000 fine & revocation.
(t) 456.072(1)(d) intentionally violating a rule of the board or department	First offense: $1000 fine & suspension, subsequent offense: $1,000 fine & revocation.
(u) 456.072(1)(k) failure to perform any legal obligation placed on licensee	First offense: $250 fine, second offense: $500 fine, subsequent offense: $1,000 fine.

(v) 456.072(1)(q) violating any provision of Ch. or failure to comply with a lawfully issued subpoena of the department	First offense: $250 fine & probation, second offense: $500 fine & probation, third offense: $1,000 fine & suspension.
(w) 456.072(1)(u) engaging or attempting to engage a patient or client in verbal or physical sexual activity	First offense: $1000 fine & probation, subsequent to offense: $1000 fine and revocation.
(x) 456.072(1)(w) Failing to report to the Board within 30days after the licensee has been found guilty of or entered a plea of nolo contendere to, regardless of adjudication, a crime in any jurisdiction	First offense: $500 fine if non violent, non sexual and non felony, second offense: $500 fine & suspension, third offense: $1,000 fine & revocation. If a crime of violence, sexual crime or felony, first offense: $1,000 fine & suspension, subsequent offense: $1,000 fine & revocation.
(y) 456.072(1)(w) Failing to report to the Board in writing on or before October 1, 2001, any convictions, findings of guilt or pleas of nolo contendere that occurred prior to July 1, 1999, and not previously reported to the Board	If the crime is non violent, non sexual, and non felony: $500 fine. If a crime of violence, sexual crime, or felony: $1,000 fine & revocation.
(z) 456.072(1)(x) Using information about people involved in motor vehicle accidents which has been derived	First offense: $500 fine & probation, second offense: $500 fine & suspension, third offense: $500 fine & revocation.

from accident
reports made by
law enforcement
officers or persons
involved in accidents,
or using information
published in a
newspaper or other
news publication or
through a radio or
television broadcast
that has used
information gained
from such reports, for
the purpose of
commercial or any other
solicitation whatsoever
of the people involved
in such accidents

(2) No change.

(3) Based upon consideration of aggravating or mitigating factors, present in an individual case, the Board may apply any penalty within the range of penalties for the violations charged in paragraphs (1) and (2) above. The Board shall consider as aggravating or mitigating factors the following:

(a) The severity of the offense; (b) The danger to the public;

(c) The number of repetitions of offenses;

(b)(d) The length of time since the violation;

(c)(e) The number of times the licensee has been previously disciplined by the Board;

(d)(f) The length of time licensee has practiced;

(e)(g) The actual damage, physical or otherwise caused by the violation;

(f)(h) The deterrent effect of the penalty imposed;

(g)(i) The effect of the penalty upon the licensees livelihood;

(h)(j) Any effort of rehabilitation by the licensee;

(i)(k) The actual knowledge of the licensee pertaining to the violation;

(j)(l) Attempts by the licensee to correct or stop violation or refusal by licensee

(k)(m) Related violations against licensee in another state including findings of guilty or innocence, penalty imposed and penalties served;

(l)(n) Actual negligence of the licensee pertaining to any violation;

(m)(o) Penalties imposed for related offenses under subsections (1) and (2) above;

(n)(p) Any other mitigating or aggravating circumstances.

(4)(a) through (c) No change.

(d) Imposition of an administrative fine not to exceed $10,000.00 $5,000 for each count or separate offense.

(e) through (g) No change.

(5) The provisions of subsection (1) through (4) above are not intended and shall not be construed to limit the ability of the Board to informally dispose of disciplinary actions by stipulation, agreed settlement, or consent order pursuant to Section 120.57(4)(3).

(6) through (8) No change.

Specific Authority 456.072(2), 456.073(4), 456.079(1),(3),(4), 480.035(7) FS. Law Implemented 456.072(2), 456.073(4), 456.079(1),(2),(3),(4), 480.041, 480.046, 480.047 FS. History–New 3-26-87, Formerly 21L-30.002, Amended 9-30-93, 12-12-93, 8-16-94, 10-1-95, 2-5-96, 5-12-96, 5-29-97, Formerly 61G11-30.002, Amended 2-18-98, 11-4-98, 1-26-00,________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Board of Massage Therapy, Division of Medical Quality Assurance, Department of Health, 4052 Bald Cypress Way, BIN #C06, Tallahassee, Florida 32399-3256

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Karen Eaton, Executive Director, Board of Massage Therapy, Division of Medical Quality Assurance, Department of Health, 4052 Bald Cypress Way, BIN #C06, Tallahassee, Florida 32399-3256

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: July 27, 2001 and October 26, 2001

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: May 18, 2001

DEPARTMENT OF HEALTH

Board of Occupational Therapy Practice

RULE TITLES:	RULE NOS.:
Fees; Initial License	64B11-3.006
Fees; Renewal of License	64B11-3.007

PURPOSE AND EFFECT: The Board proposes to raise fees for assistants so that they are closer to the actual costs for initial license and renewal of licensure.

SUMMARY: The Board is raising the fees for, initial license and renewal of license to comply with the current cost for obtaining these licenses.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY: No Statement of Estimated Regulatory Cost was prepared.

Any person who wishes to provide information regarding the statement of estimated costs, or provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days of this notice.

SPECIFIC AUTHORITY: 456.013(2), 468.204, 468.221 FS.

LAW IMPLEMENTED: 456.013(2), 468.221 FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE HELD AT A TIME, DATE AND PLACE TO BE PUBLISHED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Kaye Howerton, Board Executive Director, Board of Occupational Therapy Practice, 4052 Bald Cypress Way, Bin #C05, Tallahassee, Florida 32399-3255

THE FULL TEXT OF THE PROPOSED RULES IS:

64B11-3.006 Fees; Initial License.

Each applicant for occupational therapy assistant licensure shall submit an initial licensure fee in the amount of $75 ~~$50~~ to the Department. The initial licensure fee shall be submitted with the application fee set forth in Rule 64B11-3.001, F.A.C. A check or money order shall be payable to the order of the Department of Health.

Specific Authority 456.013(2), 468.204, 468.221 FS. Law Implemented 456.013(2), 468.221 FS. History–New 4-28-76, Amended 8-9-76,11-15-78, 9-9-85, Formerly 21M-14.07, Amended 6-29-89, Formerly 21M-14.007, 61F6-14.007, 59R-62.007, Amended 12-20-98, ________.

64B11-3.007 Fees; Renewal of License.

Each licensed occupational therapy assistant shall submit a biennial fee of $150.00 ~~$50.00~~ by check or money order made payable to the order of the Department of Health ~~no later than January 31 of each biennial period~~.

Specific Authority 468.204, 468.221 FS. Law Implemented 468.221 FS. History–New 4-28-76, Amended 8-9-76, 11-15-78, 9-9-85, Formerly 21M-14.08, Amended 6-29-89, 7-23-91, Formerly 21M-14.008, 61F6-14.008, 59R-62.008, Amended ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Board of Occupational Therapy Practice

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Board of Occupational Therapy Practice

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: August 9, 2001

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: July 25, 2001

DEPARTMENT OF HEALTH

Board of Occupational Therapy Practice

RULE TITLE:	RULE NO.:
Requirement for License Renewal of an Active License	64B11-5.001

PURPOSE AND EFFECT: The Board proposes to update the existing rule text to include prevention of medical error education.

SUMMARY: The Board is fulfilling the requirement that an active license shall be renewed once the licensee has paid the renewal fee set forth and has complied with all the requirements.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY: No Statement of Estimated Regulatory Cost was prepared.

Any person who wishes to provide information regarding the statement of estimated costs, or provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days of this notice.

SPECIFIC AUTHORITY: 456.036, 468.219 FS.

LAW IMPLEMENTED: 456.033, 456.036, 468.219 FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE HELD SCHEDULED AND ANNOUNCED IN THE FAW.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Kaye Howerton, Board Executive Director, Board of Occupational Therapy Practice, 4052 Bald Cypress Way, Bin #C05, Tallahassee, Florida 32399-3255

THE FULL TEXT OF THE PROPOSED RULE IS:

64B11-5.001 Requirements for License Renewal of an Active License.

An active license shall be renewed upon demonstration that the licensee has paid the renewal fee set forth in Rule 64B11-2.009 or 64B11-3.007, F.A.C., respectively, and has complied with the following requirements:

(1) As a condition to the renewal of an active license, an occupational therapist must complete twenty-four (24) hours of approved continuing education per biennium.

(2) As a condition to the renewal of an active license, an occupational therapist assistant must complete twenty-four (24) hours of approved continuing education per biennium.

(3) A licensee may perform no more than six (6) hours of continuing education as home study education per biennium.

(4) In addition to the twenty-four (24) hours of continuing education required herein for license renewal, the licensee shall complete two (2) hours of HIV/AIDS education as set forth in Section 456.033, F.S., or a course in end of life care and palliative health care, so long as the licensee has completed an approved two (2) hour HIV/AIDS course in the immediately biennium.

(5) The licensee must retain such receipts, vouchers, certificates or other papers necessary to document completion of the required continuing education for a period of not less than four (4) years from the date the course was taken. The Board will audit licensees at random to assure that the continuing education requirements have been met.

(6) All continuing education programs and courses meeting the requirements of Rule 64B11-6.001, F.A.C., taken after January 31, 1995 and prior to October 30, 1995 shall be deemed approved continuing education for purposes of this rule.

(7) Those persons certified for licensure in the second half of the biennium are exempt from the continuing education requirements for that biennium.

(8) Active status licensees may apply to the Board for inactive license status at any time by paying a $50 fee to change licensure status. Additionally, the licensee shall pay any applicable inactive status renewal fee or delinquent fee.

Specific Authority 456.036, 468.219 FS. Law Implemented 456.033, 456.036, 468.219 FS. History–New 4-17-95, Amended 10-30-95, 3-11-96, Formerly 59R-64.060, Amended 9-23-99, 10-18-01, ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Board of Occupational Therapy

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Board of Occupational Therapy

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: November 24, 2001

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: November 9, 2001

DEPARTMENT OF HEALTH

Board of Occupational Therapy Practice

RULE TITLE:	RULE NO.:
Inactive and Delinquent Status Fees	64B11-5.006

PURPOSE AND EFFECT: The Board proposes to raise inactive and delinquent status fees so that they are closer to the actual costs.

SUMMARY: The Board is raising the fees for Inactive and Delinquent Status Fees to comply with the current cost for obtaining these licenses.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY: No Statement of Estimated Regulatory Cost was prepared.

Any person who wishes to provide information regarding the statement of estimated costs, or provide a proposal for a lower cost regulatory alternative

SPECIFIC AUTHORITY: 468.221 FS.

LAW IMPLEMENTED: 468.221 FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE SCHEDULED AND ANNOUNCED IN THE FAW.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Kaye Howerton, Board Executive Director, Board of Occupational Therapy Practice, 4052 Bald Cypress Way, Bin #C05, Tallahassee, Florida 32399-3255

THE FULL TEXT OF THE PROPOSED RULE IS:

64B11-5.006 Inactive and Delinquent Status Fees.

The fees for individuals holding a license pursuant to Section 468.221, F.S., shall be as follows:

(1) The fee for an inactive status license shall be $75.00 ~~$50.00~~.

~~(2) The fee for processing a licensee's request to change licensure status at any time other than at the beginning of a licensure cycle shall be $50.00.~~

(2)~~(3)~~ The fee for delinquent status as set forth in subsection 456.036(7), F.S., shall be $100.00.

(3)~~(4)~~ The fee for reactivation of an inactive license shall be $200.00 ~~$100.00~~.

(4)~~(5)~~ The fee for renewal of an inactive license shall be $75.00 ~~$50.00~~.

Specific Authority 468.221 FS. Law Implemented 468.221 FS. History–New 4-17-95, Formerly 59R-64.040, Amended ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Board of Occupational Therapy

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Board of Occupational Therapy

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: August 9, 2001

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: July 25, 2001

DEPARTMENT OF HEALTH

Board of Osteopathic Medicine

RULE TITLES:	RULE NOS.:
Application for Licensure	64B15-6.002
Physician Assistant Licensure	64B15-6.003
Physician Assistant Licensure Renewal	64B15-6.0035
Notice of Noncompliance	64B15-6.0105
Citation Authority	64B15-6.01051

PURPOSE AND EFFECT: The purpose of the amendments to Rule 64B15-6.002 is to change the word "certification" to "licensure" where ever it appears in the rule text. Amendments are being made to Rule 64B15-6.003 which will set forth the requirements for licensure for physician assistants. The purpose of the amendments to Rule 64B15-6.0035 is to update the requirements for renewal for physician assistants. Two new rules are being promulgated which will address notice of noncompliance and citation authority.

SUMMARY: The Board proposes to amend Rule 64B15-6.002 by changing the word "certification" to "licensure" throughout the rule text. The Board is amending Rule 64B15-6.003 to update the requirements for physician assistants applying for licensure. The Board is amending Rule 64B15-6.0035 by updating the requirements necessary for renewal for physician assistants. The Board is promulgating a new rule entitled "Notice of Noncompliance", which will set forth violations for which the Board authorizes the Agency to issue a notice of noncompliance. The Board is also creating a new rule, numbered 64B15-6.01051, to address violations along with the accompanying penalty which may be disposed of by citation.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: No Statement of Estimated Regulatory Cost was prepared.

Any person who wishes to provide information regarding the statement of estimated costs, or to provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days of this notice.

SPECIFIC AUTHORITY: 456.073(3), 456.077, 459.005, 459.022, 459.022(7)(f),(12) FS.

LAW IMPLEMENTED: 120.53(1)(a), 456.073(3), 456.077, 459.015, 459.022(7)(f),(12) FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE SCHEDULED AND ANNOUNCED IN THE FAW.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Karen Eaton, Executive Director, Board of Osteopathic Medicine/MQA, 4052 Bald Cypress Way, Bin #C03, Tallahassee, Florida 32399-3256

THE FULL TEXT OF THE PROPOSED RULES IS:

64B15-6.002 Application for Licensure ~~Certification~~.

(1) All persons applying for licensure ~~certification~~ as a physician assistant shall submit an application to the Department on forms approved by the Council and the Board and provided by the Department. The application shall be accompanied by the application fee.

(2) The application may not be used for more than one year from the date of receipt by the Council of the original application form and fee. The fee to be paid at the time of application for licensure ~~certification~~ shall be as set forth in Rule 64B15-10.002, F.A.C. After one year from the date that the original application and fee have been received in the Council office, a new application and fee shall be required from any applicant who desires licensure ~~certification~~ as a physician assistant.

Specific Authority 459.005 FS. Law Implemented 459.022 FS. History–New 10-18-77, Formerly 21R-6.02, Amended 10-28-87, 4-21-88, 5-20-91, 3-16-92, Formerly 21R-6.002, 61F9-6.002, 59W-6.002, Amended 6-7-98, ________.

64B15-6.003 Physician Assistant Licensure ~~Certification~~.

(1) No change.

(2) Applicants for licensure who have not passed the NCCPA licensure examination within five (5) attempts shall be required to complete a minimum of three (3) months in a full-time review course at an accredited physician assistant program approved by the Chair of the Physician Assistant Committee, which completion shall be documented by a letter signed by the head of the program stating that the applicant has satisfactorily completed the course.

(3)~~(2)~~ No change.

(4) The applicant must submit notarized statements attesting to the following:

(a) Completion of three hours of all Category I, American Medical Association Continuing Medical Education which includes the topics of Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome: the disease and its spectrum of clinical manifestations; epidemiology of the disease; related infections including TB; treatment, counseling, and prevention; transmission from healthcare worker to patient and patient to healthcare worker; universal precautions and isolation techniques; and legal issues related to the disease. If the applicant has not already completed the required continuing medical education, upon submission of an affidavit of good cause, the applicant will be allowed six months to complete this requirement.

(b) Completion of one hour of continuing medical education on domestic violence which includes information on the number of patients in that professional's practice who are likely to be victims of domestic violence and the number who are likely to be perpetrators of domestic violence, screening procedures for determining whether a patient has any history of being either a victim or a perpetrator of domestic violence, and instruction on how to provide such patients with information on, or how to refer such patient to, resources in the local community, such as domestic violence centers and other advocacy groups, that provide legal aid, shelter, victim counseling, batterer counseling, or child protection services, and which is approved by any state or federal government agency, or nationally affiliated professional association, or any provider of Category I or II American Medical Association Continuing Medical Education. Home study courses approved by the above agencies will be acceptable. If the applicant has not already completed the required continuing medical education, upon submission of an affidavit of good cause, the applicant will be allowed six months to complete this requirement.

(c) Completion of two hours of continuing medical education relating to prevention of medical errors which includes a study of root cause analysis, error reduction and prevention, and patient safety, and which is approved by any state or federal government agency, or nationally affiliated professional association, or any provider of Category I or II American Medical Association Continuing Medical Education. One hour of a two hour course which is provided by a facility licensed pursuant to Chapter 395, F.S. for its employees may be used to partially meet this requirement.

(5)~~(3)~~ Licensure ~~Certification~~ as a Prescribing Physician Assistant.

(a) All persons applying for licensure ~~certification~~ as a prescribing physician assistant shall submit an application to the Council on a form approved by the Council and provided by the Department. The application shall be accompanied by the application fee.

(b) No change.

(c) The applicant shall have completed a minimum of 3 months of clinical experience in the specialty area of the supervising physician. For purposes of this rule, this means 3 continuous months of full-time practice or its equivalent,

following full licensure ~~certification~~ as a physician assistant, within the 4 years immediately preceding the filing of the application.

(d) The fee for licensure ~~certification~~ as a prescribing Physician Assistant shall be as set forth in Rule 64B15-6.013, F.A.C., and shall be in addition to any other applicable fees in said rule. No additional fees will be required for any separate application for a distinct area of practice, or a change in practice setting during the same biennium.

Specific Authority 459.005, 459.022, 458.347(7) FS. Law Implemented 120.53(1)(a), 459.022 FS. History–New 10-18-77, Formerly 21R-6.03, Amended 10-28-87, 4-21-88, 4-18-89, 9-26-90, 5-20-91, 10-28-91, 3-16-92, Formerly 21R-6.003, Amended 11-4-93, 3-29-94, Formerly 61F9-6.003, Amended 2-1-95, Formerly 59W-6.003, Amended 6-7-98,________.

64B15-6.0035 Physician Assistant Licensure ~~Certification~~ Renewal.

(1) A Physician Assistant must renew his licensure ~~certification~~ on a biennial basis.

(2) Requirements for Renewal.

(a) through (c) No change.

(d) For all licensees no more and no less than one hour shall consist of training in domestic violence which includes information on the number of patients in that professional's practice who are likely to be victims of domestic violence and the number who are likely to be perpetrators of domestic violence, screening procedures for determining whether a patient has any history of being either a victim or a perpetrator of domestic violence, and instruction on how to provide such patients with information on, or how to refer such patients to, resources in the local community, such as domestic violence centers and other advocacy groups, that provide legal aid, shelter, victim counseling, batterer counseling, or child protection services, and which is approved by any state or federal government agency, or nationally affiliated professional association, or any provider of Category I or II American Medical Association Continuing Medical Education. Home study courses approved by the above agencies will be acceptable.

(e) For all licensees one hour of Category I American Medical Association Continuing Medical Education which includes the topics of Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome; the modes of transmission, including transmission from healthcare worker to patient and patient to healthcare worker; infection control procedures, including universal precautions; epidemiology of the disease; related infections including TB; clinical management, prevention; and current Florida law on AIDS and its impact on testing, confidentiality of test results, and treatment of patients. Any hours of said CME may also be counted toward the CME license renewal requirements. In order for a course to count as meeting this requirement, licensees practicing in Florida must clearly demonstrate that the course includes Florida law in HIV/AIDS and its impact on testing, confidentiality of test results, and treatment of patients. Only Category I hours shall be accepted.

(f) Notwithstanding the provisions of subsections (d) and (e), above, a physician assistant may complete continuing education on end-of-life care and palliative health care in lieu of continuing education in HIV/AIDS or domestic violence, if that physician assistant has completed the HIV/AIDS or domestic violence continuing education in the immediately preceding biennium. This allows for end-of-life care and palliative health care continuing education to substitute for HIV/AIDS or domestic violence continuing education in alternate biennia.

(g) Completion of two hours of continuing medical education relating to prevention of medical errors which includes a study of root cause analysis, error reduction and prevention, and patient safety, and which is approved by any state or federal government agency, or nationally affiliated professional association, or any provider of Category I or II American Medical Association Continuing Medical Education. One hour or a two hour course which is provided by a facility licensed pursuant to Chapter 395, F.S., for its employees may be used to partially meet this requirement.

~~(d) Submission of proof of completion of the HIV/AIDS education requirement set forth in Section 456.033, F.S. In lieu of completing the HIV/AIDS education requirement, licensees are permitted to substitute a course in end-of-life care and palliative health care, provided the licensee has completed the HIV/AIDS education requirement in the immediately preceding biennium.~~

~~(e) Submission of proof of completion of the domestic violence education requirement set forth in Section 456.031, F.S. In lieu of completing the domestic violence course, licensees are permitted to substitute a course in end-of-life care and palliative health care, provided the licensee has completed the domestic violence requirement in the immediately preceding biennium.~~

(3) Upon request by the Board or Department, the licensee must submit satisfactory documentation of compliance with the requirements set forth above.

(4)~~(3)~~ Renewal of Licensure ~~Certification~~ as a Prescribing Physician Assistant. In addition to the requirements of paragraph (2) above, a prescribing physician assistant shall attest to having completed a minimum of 10 hours of continuing education in the specialty area(s) of the supervising physician(s), during the previous 2 years. These hours may be utilized to meet the general continuing education requirement.

(5)~~(4)~~ Licensure ~~Certification~~ Renewal Application.

(a) through (b) No change.

(6)~~(5)~~ No change.

Specific Authority 459.005 FS. Law Implemented 459.022(7)(b),(c) FS. History–New 10-28-87, Amended 4-21-88, 1-3-93, Formerly 21R-6.0035, Amended 11-4-93, 3-29-94, Formerly 61F9-6.0035, 59W-6.0035, Amended 6-7-98, 10-16-01,________.

64B15-6.0105 Notice of Noncompliance.

(1) Pursuant to Section 456.073(3), Florida Statutes, the Department is authorized to provide a notice of noncompliance for an initial offense of a minor violation if the Board establishes by rule a list of minor violations. A minor violation is one which does not endanger the public health, safety, and welfare and which does not demonstrate a serious inability to practice the profession. A notice of noncompliance in lieu of other action is authorized only if the violation is not a repeat violation and only if there is only one violation. If there are multiple violations, then the Agency may not issue a notice of noncompliance, but must prosecute the violations under the other provisions of Section 456.073, Florida Statutes. A notice of noncompliance may be issued to a licensee for a first time violation of one or both of the violations listed in subsection (3)(b). Failure of a licensee to take action in correcting the violation within 15 days after notice shall result in the institution of regular disciplinary proceedings.

(2) The Department shall submit to the Board a monthly report detailing the number of notices given, the number of cases completed through receipt of a notarized statement of compliance from the licensee, and the types of violations for which notices of noncompliance have been issued. Notices of noncompliance shall be considered by the probable cause panels when reviewing a licensee's subsequent violations of a same or similar offense.

(3) The following violations are those for which the Board authorizes the Agency to issue a notice of noncompliance:

(a) Failing to include the specific disclosure statement required by Section 456.062, F.S., in any advertisement for a free, discounted fee, or reduced fee service, examination or treatment.

(b) Violating any of the following provisions of chapter 458, as prohibited by Section 459.022(7)(f) and 459.015(1)(bb), Florida Statutes:

1. Section 459.022(1), Florida Statutes, which provides for criminal penalties for the practice as a physician assistant without an active license. A notice of noncompliance would be issued for this violation only if the subject of the investigation met the following criteria: the subject was the holder of a license to practice as a physician assistant at all time material to the matter; that license was otherwise in good standing; and that license was or will be renewed and placed in an active status within 90 days of the date it reverted to delinquent status based on failure to renew the license. If the license was in a delinquent status for more than 90 days and the individual continued to practice, then the matter would proceed under the other provisions of Section 456.073 and 456.035(1), Florida Statutes.

2. Failing to notify the Board of a change of practice location, contrary to Sections 459.008(3) and 456.035(1), Florida Statutes.

Specific Authority 456.073(3), 459.005, 459.022(7)(f),(12) FS. Law Implemented 456.073(3), 459.015, 459.022(7)(f),(12) FS. History–New ________.

64B15-6.01051 Citation Authority.

(1) Pursuant to Section 456.077, Florida Statutes, the Board sets forth below those violations for which there is no substantial threat to the public health, safety, and welfare; or, if there is a substantial threat to the public health, safety, and welfare, such potential for harm has been removed prior to the issuance of the citation. Next to each violation is the penalty to be imposed. In addition to any administrative fine imposed, the Respondent may be required by the Department to pay the costs of investigation.

(2) If the violation constituted a substantial threat to the public health, safety, and welfare, such potential for harm must have been removed prior to issuance of the citation.

(3) The following violations with accompanying penalty may be disposed of by citation with the specified penalty:

VIOLATIONS	PENALTY
(a) CME violations (Sections 459.022(7)(b), 459.015(1)(g), (bb), 456.072(1)(e), (s), F.S.)	Within twelve months of the date the citation is issued, Respondent must submit certified documentation of completion of all CME requirements for the period for which the citation was issued; prior to renewing the license for the next biennium, Respondent must document compliance with the CME requirements for the relevant period; AND pay a $250 fine
1. Failure to document required HIV/AIDS CME. (456.033, F.S.)	$250 fine
2. Failure to document required domestic violence CME. (456.031, F.S.)	$250 fine
3. Failure to document both the required HIV/AIDS and domestic violence CME.	$500 fine
4. Documentation of some, but not all, 100 hours of required CME for license renewal.	$25 fine for each hour not documented
(b) Obtaining license renewal by fraud or misrepresentation (Section 459.022(7)(f) and 459.015(1)(a), F.S.).	$2500 fine

(c) Failure to document any of the 100 hours of required CME for license renewal (Sections 459.022(7)(b), 459.015(1)(bb), F.S.).	$2500 fine
(d) Practice on an inactive or delinquent license (Sections 456.036(1), 459.013(1)(a), 459.022(7)(f), 459.015(1)(bb), F.S.).	
1. For a period of up to nine months.	$100 for each month or part thereof.
2. For a period of nine months to twelve months.	$150 for each month or part thereof.
(e) Failure to notify Department of change of practice address (Sections 456.035, 459.008(3), 459.015(1)(g), 459.022(7)(f), F.S.).	$125 fine
(f) Failure of the physician assistant to clearly identify that he/she is a physician assistant. (Section 459.022(4)(e)1., 459.022(7)(f), 459.015(1)(g), F.S.)	$250 fine

(4) Citations shall be issued to licensees by the Bureau of Investigative Services only after review by the legal staff of the Agency for Health Care Administration, Division of Regulation. Such review may be by telephone, in writing, or by facsimile machine.

(5) The procedures described herein apply only for an initial offense of the alleged violation. Subsequent violation(s) of the same rule or statute shall require the procedures of Section 456.073, Florida Statutes, to be followed. In addition, should an initial offense for which a citation could be issued occur in conjunction with other violations, then the procedures of Section 456.073, Florida Statutes, shall apply.

(6) The subject has 30 days from the date the citation becomes a final order to pay any fine imposed and costs. All fines and costs are to be made payable to the "Department of Health" and sent to the Department of Health in Tallahassee. A copy of the citation shall accompany the payment of the fine.

(7) The Agency for Health Care Administration shall, at the end of each calendar quarter, submit a report to the Board of the citations issued, which report shall contain the name of the subject, the violation, fine imposed, and the number of subjects who dispute the citation and chose to follow the procedures of Section 456.073, Florida Statutes.

Specific Authority 456.077, 459.005, 459.022(7)(f),(12) FS. Law Implemented 456.077, 459.015, 459.022(7)(f),(12) FS. History–New ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Council on Physician Assistants

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Board of Osteopathic Medicine

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: September 21, 2001

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: November 2, 2001

DEPARTMENT OF HEALTH

Board of Osteopathic Medicine

RULE TITLES:	RULE NOS.:
Application, Certification and License Fees	64B15-10.002
Active Status Fees	64B15-10.003
Inactive Status Fee	64B15-10.0031
Unlicensed Activity Fee	64B15-10.0075
Processing of Status Fee	64B15-10.008
Delinquent Status Fee	64B15-10.009
Fees for Board Approved Continuing Education Providers	64B15-10.010

PURPOSE AND EFFECT: The purpose of the amendments to Rule 64B15-10.002, F.A.C., is to rename the rule title, delete unnecessary rule text in an attempt to further clarify the rule text. The purpose of the amendments to Rule 64B15-10.003, F.A.C., is to rename the rule title and to include the word "renewal" to the rule text. The purpose of the amendments to Rule 64B15-10.0031, F.A.C., is to rename the rule title and also add the word "renewal" to the rule text. The Board is promulgating a new rule, numbered 64B15-10.0075, F.A.C., which will address an unlicensed activity fee. Rule 64B15-10.008, F.A.C., is being amended to change the rule title and text to reflect the same. Rule 64B15-10.009, F.A.C., is being amended to increase the delinquency fee. The Board is promulgating a new rule, numbered 64B15-10.010, F.A.C., which will address the fees for board approved continuing education providers.

SUMMARY: The Board is amending Rule 64B15-10.002, F.A.C., by renaming the rule title, deleting unnecessary rule text and to include language for licensure fees. The Board is amending Rule 64B15-10.003, F.A.C., to rename the rule title and to include the word "renewal" to the rule text. The purpose of the amendments to Rule 64B15-10.0031, F.A.C., is to rename the rule title and also add the word "renewal" to the rule text. A new rule is being created by the Board, numbered 64B15-10.0075, F.A.C., which will address an unlicensed activity fee. Rule 64B15-10.008, F.A.C., is being amended to change the rule title and text to reflect the same. Rule 64B15-10.009, F.A.C., is being amended to increase the delinquency fee. The Board is creating a new rule, numbered 64B15-10.010, F.A.C., which will address the fees for board approved continuing education providers.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: No Statement of Estimated Regulatory Cost was prepared.

Any person who wishes to provide information regarding the statement of estimated costs, or to provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days of this notice.

SPECIFIC AUTHORITY: Section 14(8), 94-119, Laws of Florida, 456.013(2), 456.024(1), 456.036, 459.005, 459.0077, 459.009(2), (3), 459.0092 FS.

LAW IMPLEMENTED: Section 14(8), 94-119, Laws of Florida, 456.013(2), 456.036, 459.007, 459.008, 459.0077, 459.009(3)(b), 459.0092, 459.022(7)(b) FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE SCHEDULED AND ANNOUNCED IN THE FAW.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Karen Eaton, Executive Director, Board of Osteopathic Medicine/MQA, 4052 Bald Cypress Way, Bin #C03, Tallahassee, Florida 32399-3256

THE FULL TEXT OF THE PROPOSED RULES IS:

64B15-10.002 Application~~,~~ and Licensure Fees ~~Certification and License Fees~~.

(1) The application fee for an osteopathic physician license shall be $200. This fee is nonrefundable.

~~(2) The initial certification fee paid upon submission of the application for certification as a physician assistant shall be $200 if the initial licensure occurs during the first year or any fraction thereof of the biennial period, and $100 if initial licensure occurs during the second year or any fraction thereof, of the biennial period.~~

(3) through (4) renumbered (2) through (3) No change.

~~(5) The application fee for a physician assistant certificate shall be $100. This fee is nonrefundable.~~

(4)~~(6)~~ No change.

(5) Physician assistant fees shall be those set out in Rule 64B15-6.013.

Specific Authority 456.013(2), 456.025(1), 459.0077, 459.0092 FS. Law Implemented 456.013(2), 459.007, 459.0077, 459.0092 FS. History–New 10-23-79, Amended 10-3-83, Formerly 21R-10.02, Amended 5-13-87, 4-21-88, 10-28-91, 11-9-92, 4-1-93, Formerly 21R-10.002, 61F9-10.002, Amended 12-28-95, Formerly 59W-10.002, Amended 12-13-98, ________.

64B15-10.003 Active Status Renewal Fees.

Licenses shall be renewed biennially in accordance with the rules of the Department. Biennial active status renewal fee for osteopathic physicians ~~licensed pursuant to Sections 459.006, 459.007 and 459.0075, F.S.,~~ shall be $400.

Specific Authority 459.005, 459.009(2), (3)(b) FS. Law Implemented 459.008, 459.009(3)(b), 459.022(7)(b) FS. History–New 10-23-79, Amended 10-3-83, 4-8-84, Formerly 21R-10.03, Amended 5-13-87, 4-21-88, 7-19-89, 10-28-91, Formerly 21R-10.003, 61F9-10.003, Amended 2-1-95, Formerly 59W-10.003, Amended 12-13-98, ________.

64B15-10.0031 Inactive Status Renewal Fee.

The renewal fee for inactive status license shall be ~~:~~

~~(1)~~ $200 for an osteopathic physician;

~~(2) $100 for an osteopathic physician's assistant.~~

Specific Authority 456.036 FS. Law Implemented 456.036 FS. History–New 4-17-95, Formerly 59W-10.0031, Amended ________.

64B15-10.0075 Unlicensed Activity Fee.

The Department of Health is authorized to collect an additional $5.00 with each initial licensure fee and each biennial renewal fee for the purpose of investigating and prosecuting the unlicensed practice of osteopathic medicine.

Specific Authority 456.065, 459.005 FS. Law Implemented 456.065 FS. History–New ________.

64B15-10.008 Change ~~Processing~~ of Status ~~Change~~ Fee.

A licensee shall pay a change of status ~~processing~~ fee of one hundred dollars ($100) when the licensee applies for a change in licensure status at any time other than during licensure renewal. The renewal period shall begin ninety (90) days prior to the end of the biennium and shall end on the last day of the biennium.

Specific Authority Section 14(8), 94-119, Laws of Florida. Law Implemented Section 14(8), 94-119, Laws of Florida. History–New 2-1-95, Formerly 59W-10.008, Amended ________.

64B15-10.009 Delinquent Status Fee.

~~(1)~~ A delinquent status licensee shall pay a delinquency fee of four ~~two~~ hundred dollars ($400) ~~($200)~~ when the licensee applies for active or inactive status.

~~(2) A delinquent status physician assistant licensee shall pay a delinquency fee of two hundred dollars ($200) when the licensee applies for active or inactive status.~~

Specific Authority 456.036 FS. Law Implemented 456.036 FS. History–New 2-1-95, Amended 12-28-95, Formerly 59W-10.009, Amended 11-27-97, ________.

64B15-10.010 Fees for Board Approved Continuing Education Providers.

(1) The initial fee for approval as a continuing education provider shall be $250.

(2) The biennial renewal fee for an approved continuing education provider shall be $250.

Specific Authority 456.025(2), 459.005 FS. Law Implemented 456.025(2) FS. History–New ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Board of Osteopathic Medicine

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Board of Osteopathic Medicine

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: September 21, 2001

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: November 2, 2001

DEPARTMENT OF HEALTH

Board of Osteopathic Medicine

RULE TITLES:	RULE NOS.:
Delinquent License	64B15-12.008
Osteopathic Faculty Certificate	64B15-12.009

PURPOSE AND EFFECT: The purpose of the rule amendment to Rule 64B15-12.008, F.A.C., is to add the words "renewal" and "change of status" to the rule text. A new rule is being promulgated to address an osteopathic faculty certificate.

SUMMARY: The Board proposes to amend Rule 64B15-12.008, F.A.C., by adding the word "renewal" and to change the processing fee to change of status fee. The Board is creating a new rule which will set forth the requirements necessary for a faculty member to obtain an osteopathic faculty certificate.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: No Statement of Estimated Regulatory Cost was prepared.

Any person who wishes to provide information regarding the statement of estimated costs, or to provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days of this notice.

SPECIFIC AUTHORITY: Sect. 14, 94-119, Laws of Florida, 459.005, 459.0077 FS.

LAW IMPLEMENTED: Sect. 14, 94-119, Laws of Florida, 459.0077 FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Karen Eaton, Executive Director, Board of Osteopathic Medicine/MQA, 4052 Bald Cypress Way, Bin #C03, Tallahassee, Florida 32399-3256

THE FULL TEXT OF THE PROPOSED RULES IS:

64B15-12.008 Delinquent License.

(1) through (2) No change.

(3) The delinquent status licensee who applies for active or inactive license status shall:

(a) No change.

(b) Pay to the board either the active status or inactive status renewal fee, the delinquency fee, and if applicable the change of status ~~processing~~ fee; and

(c) No change.

Specific Authority Sect. 14, 94-119, Laws of Florida. Law Implemented Sect. 14, 94-119, Laws of Florida. History–New 11-28-94, Formerly 59W-12.008, Amended ________.

64B15-12.009 Osteopathic Faculty Certificate.

(1) An Osteopathic Faculty Certificate may be issued by the Department to a faculty member of a school accredited by the American Osteopathic Association upon the request of the dean of the school if the faculty member has demonstrated to the Board that:

(a) The faculty member is currently licensed to practice osteopathic medicine in another jurisdiction of the United States; and

(b) Is a graduate of a school of osteopathic medicine accredited by the American Osteopathic Association; and

(c) Files an application and otherwise meets the requirements contained in s. 459.0055, F.S.; and

(d) Has submitted the application fee required by subsection 64B15-10.002(6), F.A.C.

(2) An Osteopathic Faculty Certificate authorizes the holder to practice only in conjunction with his or her teaching duties at an accredited school of osteopathic medicine or in its affiliated teaching hospitals or clinics.

(3) Faculty Certificates shall automatically expire upon termination of the holder's relationship with the school or after a period of 24 months, whichever occurs first. Faculty Certificates are subject to cancellation or revocation by the Board for failure to comply with Chapters 456 and 459, F.S. and Chapter 64B15, F.A.C.

Specific Authority 459.005, 459.0077 FS. Law Implemented 459.0077 FS. History–New ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Board of Osteopathic Medicine

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Board of Osteopathic Medicine

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: September 21, 2001

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: November 2, 2001

DEPARTMENT OF HEALTH

Board of Osteopathic Medicine

RULE TITLES:	RULE NOS.:
Application for Board Approved Provider Status	64B15-13.004
Standards for Board Approved Providers	64B15-13.0045

PURPOSE AND EFFECT: The Board is promulgating Rule 64B15-13.004, F.A.C. to set forth language for entities or individuals who wish to apply for provider status. Rule 64B15-13.0045, F.A.C., is also a new rule being created to address the standards for entities or individuals who wish to apply for provider status.

SUMMARY: The Board has determined that it is necessary to create two new rules which will address the proper procedure for entities or individuals who wish to apply for provider status and the standards required in order to obtain provider status.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: No Statement of Estimated Regulatory Cost was prepared.

Any person who wishes to provide information regarding the statement of estimated costs, or to provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days of this notice.

SPECIFIC AUTHORITY: 456.027, 459.005, 459.0055 FS.

LAW IMPLEMENTED: 456.027, 459.0055 FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE SCHEDULED AND ANNOUNCED IN THE FAW.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Karen Eaton, Executive Director, Board of Osteopathic Medicine/MQA, 4052 Bald Cypress Way, Bin #C03, Tallahassee, Florida 32399-3256

THE FULL TEXT OF THE PROPOSED RULES IS:

64B15-13.004 Application for Board Approved Provider Status.

(1) Entities or individuals who wish to become approved providers of continuing education must submit the approval fee set forth in subsection 64B15-10.010(1), F.A.C., and an application which contains the following information, and which is accompanied by the following documentation:

(a) The name of the contact person who will fulfill the reporting and documentation requirements for approved providers and who will assure the provider's compliance with Rule 64B15-13.0045, F.A.C.; and

(b) The qualifications of all instructors, which may be evidenced by a curriculum vitae or professional licensure in the subject area taught.

(2) Provider approval may be granted for a period not to exceed the time from the date of approval to the end of the next successive licensure biennium after approval was obtained. Application for renewal of provider status shall be made at lest 90 days prior to the end of the biennium in which approval expires and must be accompanied by the biennial renewal fee set forth in subsection 64B15-15.010(2), F.A.C. Renewal applications shall contain all information required for initial provider approval as well as course outlines and information evidencing compliance with Rule 64B15-13.0045, F.A.C., for each course offered during the provider status.

Specific Authority 456.027, 459.0055 FS. Law Implemented 456.027, 459.0055 FS. History–New ________.

64B15-13.0045 Standards for Board Approved Providers.

Approved continuing professional education providers and providers authorized pursuant to Rule 64B15-13.004, F.A.C., shall comply with the following requirements:

(1) All courses shall reflect appropriate didactic and clinical training for the subject matter and shall be designed to meet specifically stated educational objectives.

(2) Instructors shall be adequately qualified by training, experience or licensure to teach specified courses.

(3) Facilities and equipment for each course in which patients are treated during instruction shall be adequate for the subject matter and method of instruction.

(4) Course length shall be sufficient to provide meaningful education in the subject matter presented. One half hour or one hour of continuing education credit shall be awarded for each 25 or 50 minutes of actual classroom or clinical instruction, respectively. No continuing education credit shall be awarded for participation of less than 25 minutes.

(5) Providers shall provide written certification to each participant who completes a continuing education course or portion of that course which consists of at least 25 minutes of instruction. Certification shall include the participant's name and license number, the provider's name and number, the course title, instructor, location, date offered and hours of continuing education credit awarded, and validation through the signature of the provider, official representative or instructor.

(6) Providers shall maintain records of each course offering for 4 years following each licensure biennium during which the course was offered. Course records shall include a course outline which reflects its educational objectives, the instructor's name, the date and location of the course, participants' evaluations of the course, the hours of continuing education credit awarded for each participant and a roster of participants by name and license number.

(7) Providers' records and courses shall be subject to Board review. Failure to maintain the standards set forth in this rule shall subject the provider to the suspension or rescission of the providership.

(8) Providers shall comply with rules promulgated by the Department of Health concerning the electronic transmission of course attendance information necessary to implement the electronic tracking system.

Specific Authority 456.027, 459.0055 FS. Law Implemented 456.027, 459.0055 FS. History–New ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Board of Osteopathic Medicine

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Board of Osteopathic Medicine

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: September 21, 2001

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: November 2, 2001

DEPARTMENT OF HEALTH

Board of Osteopathic Medicine

RULE TITLE:	RULE NO.:
Violations and Penalties	64B15-19.002

PURPOSE AND EFFECT: The purpose of the rule amendments is to increase the fine in subsection (14) of this rule and add new offenses for which the Board may impose a penalty.

SUMMARY: The Board is amending this rule to include new offenses for which the Board shall impose penalties and the fine for deceptive, untrue or fraudulent misrepresentations in the practice of medicine is being increased from $5,000 to $10,000.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: No Statement of Estimated Regulatory Cost was prepared.

Any person who wishes to provide information regarding the statement of estimated costs, or to provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days of this notice.

SPECIFIC AUTHORITY: 456.079, 459.015(5) FS.

LAW IMPLEMENTED: 456.072, 456.079 FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE SCHEDULED AND ANNOUNCED IN THE FAW.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Karen Eaton, Executive Director, Board of Osteopathic Medicine/MQA, 4052 Bald Cypress Way, Bin #C03, Tallahassee, Florida 32399-3256

THE FULL TEXT OF THE PROPOSED RULE IS:

64B15-19.002 Violations and Penalties.

In imposing discipline upon applicants and licensees, the board shall act in accordance with the following disciplinary guidelines and shall impose a penalty within the range corresponding to the violations set forth below. The statutory language is intended to provide a description of the violation and is not a complete statement of the violation; the complete statement may be found in the statutory provision cited directly under each violation description.

(1) through (13) No change.

(14) Deceptive, untrue, or fraudulent misrepresentations in the practice of medicine.

(456.072(1)(a) & (m) & 459.015(1)(m), F.S.)

FIRST OFFENSE:	reprimand and $10,000 ~~$5,000~~ fine	denial of licensure or suspension to be followed by probation and $10,000 fine

SECOND OFFENSE: No change.

(15) through (55) No change.

(56) Performing or attempting to perform health care services on the wrong patient, a wrong procedure, an unauthorized, unnecessary or unrelated procedure. (456.072(1)(aa), F.S.)

FIRST OFFENSE:	denial or probation and $5,000 fine	denial or revocation and $10,000 fine
SECOND OFFENSE:	denial or suspension and $10,000 fine	denial or revocation and $10,000 fine

(57) Leaving a foreign body in a patient such as a sponge, clamp, forceps, surgical needle or other paraphernalia. (456.072(1)(bb), F.S.)

FIRST OFFENSE:	denial or probation and $5,000 fine	denial or revocation and $10,000 fine
SECOND OFFENSE:	denial or suspension and $10,000 fine	denial or revocation and $10,000 fine

Specific Authority 456.079, 459.015(5) FS. Law Implemented 456.072, 456.079 FS. History–New 9-30-87, Amended 10-28-91, 1-12-93, Formerly 21R-19.002, 61F9-19.002, 59W-19.002, Amended 2-2-98, 2-11-01, 6-7-01, ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Board of Osteopathic Medicine

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Board of Osteopathic Medicine

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: September 21, 2001

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: November 2, 2001