**RULES**
**OF**
**THE DEPARTMENT OF COMMERCE AND INSURANCE**
**DIVISION OF INSURANCE**

# CHAPTER 0780—1—34
# ELIMINATING UNFAIR DISCRIMINATION

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**0780—1—34—.01 PURPOSE.** The purpose of this regulation is to eliminate the act of denying benefits or coverage unfairly in the terms and conditions of insurance contracts and in the underwriting criteria of insurance carriers. It is not intended to prohibit reasonable and justifiable differences in premium rates based upon sound actuarial principles or actual or reasonably anticipated experience.

***Authority:*** *T.C.A. §§56—8—104 and 56—8—113.* ***Administrative History:*** *Rule filed April 19, 1976; effective May 19, 1976. Amendment filed March 29, 1985; effective May 1, 1985.*

**0780—1—34—.02 DEFINTIONS.**

(1) Contract — any insurance policy, plan, or binder, including any rider or endorsement thereto offered by an insurer.

(2) Insurer — any insurance company, association, reciprocal or inter-insurance exchange, hospital or medical service corporation or plan, health maintenance organization, fraternal benefit society or beneficial association.

***Authority:*** *T.C.A., Title 56, Chapter 8.* ***Administrative History:*** *Rule filed April 19, 1976; effective May 19, 1976.*

**0780—1—34—.03 APPLICABILITY AND SCOPE.**

(1) This regulation shall apply to all contracts delivered or issued for delivery in this state by an insurer on or after January 1, 1977, to all existing group, franchise or blanket contracts which are amended or renewed on or after June 1, 1976 and to all policy forms submitted for approval on or after June 1, 1976, provided however that in the case of contracts issued pursuant to all collective bargaining agreement this regulation shall apply on the first date after June 1, 1976 upon which any new bargaining agreement first becomes effective.

(2) This regulation does not apply to or affect the right of fraternal benefit societies to determine eligibility requirements for membership. If a fraternal benefit society does, however, admit members of both sexes, this regulation is applicable to the insurance benefits available to members thereof.

(3) The portions of this regulation dealing with discrimination on the basis of blindness or partial blindness shall apply to all contracts delivered or issued for delivery in this state by an insurer on or after June 8, 1985 and to all existing group, franchise or blanket contracts which are amended or renewed on or after June 8, 1985; provided, however, that in the case of contracts issued pursuant to all collective bargaining agreements this regulation shall apply on the first date after June 8, 1985 upon which any new bargaining agreement first becomes effective.

***Authority:*** *T.C.A. §§56—8—104 and 56—8—113.* ***Administrative History:*** *Rule filed April 19, 1976; effective May 19, 1976. Amendment filed March 29, 1985; effective May 1, 1985.*

**0780—1—34—.04 AVAILABILITY REQUIREMENTS.**

(1) Availability of any insurance contract shall not be denied to an insured or prospective insured solely on the basis of sex or marital status of the insured or prospective insured. The amount of benefits payable, or any term, conditions or type of coverage shall not be restricted, modified, excluded, or reduced solely on the basis of the sex or marital status of the insured or prospective insured except to the extent the amount of benefits, term, conditions or type of coverage vary as a result of the application of rate differentials permitted under the Tennessee Insurance Code. However, nothing in this regulation shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependents benefits. Specific examples of practices prohibited by this regulationinclude but are not limited to the following:

(a) Denying coverage to females gainfully employed at home, employed part-time or employed by relatives when coverage is offered to males similarly employed.

(b) Denying policy riders to females when the riders are available to males.

(c) Denying maternity benefits to unmarried females covered under a contract if maternity coverage is available to married females under such contract, provided that this shall not be construed to require that benefits must be payable for normal pregnancies under either group or individual insurance contracts.

(d) Denying, under group contracts, dependent coverage to husbands of female employees, when dependent coverage is available to wives of male employees.

(e) Denying disability income contracts to employed women when coverage is offered to men similarly employed.

(f) Treating complications of pregnancy differently from any other illness or sickness under the contract. Complications of pregnancy means:

1. conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and

2. non-elective cesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

(g) Restricting, reducing, modifying, or excluding benefits payable for disorders of the genital organs of only one sex.

(h) Offering lower maximum monthly benefits to women than to men who are in the same classification under a disability income contract.

(i) Offering more restrictive benefit periods and more restrictive definitions of disability to women than to men in the same classifications under a disability income contract.

(j) Establishing different conditions by sex under which the policyholder may renew a contract or exercise benefit options contained in the contract.

(Rule 0780—1—34—.04, continued)

(k) Limiting the amount of coverage an insured or prospective insured may purchase based upon the insured's or prospective insured's martial status unless such limitation is for the purpose of defining persons eligible for dependents benefits.

(2) An insurer shall not refuse to insure, or refuse to continue to insure, or limit the amount, extent or kind of coverage available to an individual, or charge an individual a different rate for the same coverage solely because of blindness or partial blindness; provided, however, with respect to all other conditions, including the underlying cause of the blindness or partial blindness, persons who are blind or partially blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as are sighted persons.

(a) Refusal to insure includes denial by an insurer of disability insurance coverage on the grounds that the policy defines ''disability'' as being presumed in the event that the insured loses his/her eyesight. However, an insurer may exclude from coverage disabilities, consisting solely of blindness or partial blindness when such condition existed at the time the policy was issued.

***Authority:*** *T.C.A. §§56—8—104 and 56—8—113.* ***Administrative History:*** *Rule filed April 19, 1976; effective May 19, 1976. Amendment filed April 10, 1981; effective May 26, 1981. Amendment filed March 29, 1985; effective May 1, 1985.*