

## G.O.C. STAFF RULE ABSTRACT

DEPARTMENT: Transportation

DIVISION: Legal

SUBJECT: Inspection and copying of public records

STATUTORY AUTHORITY: Tennessee Code Annotated, Section 10-7-503(g)

EFFECTIVE DATES: February 4, 2019 to June 30, 2019

FISCAL IMPACT: None

STAFF RULE ABSTRACT:

Rule 1680-04-02-.01: Purpose. This rule expresses the purpose of Chapter 1680-04-02 to make TDOT's public records available for inspection and copying by citizens of Tennessee, in accordance with the directives contained in T.C.A. § 10-7-.503(g), while also preserving the confidentiality of records or information protected from public disclosure under State or Federal law.

Rule 1680-04-02-.02: Definitions. This rule defines "public records" and other terms commonly used in Chapter 1680-04-02.

Rule 1680-04-02-.03: Requesting Access to Public Records. This rule establishes the general process for making requests to inspect or obtain copies of public records, as required in T.C.A. § 10-7-503(g)(1). It also designates the General Counsel, or employees under the supervision of the General Counsel, as the Public Records Request Coordinator, as required in T.C.A. § 10-7-503(g)(4). It provides generally that requests for the inspection or copying of TDOT's records should be made or referred to the Public Records Request Coordinator or to the Community Relations Division if the request is from a member of the news media. The rule also identifies the TDOT Community Relations Division website where TDOT posts notices of public meetings or hearings and the websites where TDOT makes a wide variety of forms, documents, publications, and resources available to the public via the internet.

Rule 1680-04-02-.04: Responding to Public Records Requests. This rule establishes the process for responding to public records requests, including redaction practices, as required in T.C.A. § 10-7-503(g)(2). Specifically, the rule sets out the relative roles and responsibilities of the Public Records Request Coordinator and the various Records Custodians within TDOT, including the process for withholding confidential or privileged records and for redacting confidential information from otherwise public records.

Rule 1680-04-02-.05: Inspection of Records. This rule establishes specific procedures for responding to requests to inspect public records.

Rule 1680-04-02-.06: Copies of Records. This rule establishes specific procedures for obtaining copies of public records.

Rule 1680-04-02-.07: Fees and Charges for Producing Copies of Public Records. This rule establishes the copy fees and labor charges that are required to obtain copies of public records, as well as the procedures for billing and payment, as required in T.C.A. § 10-7503(g)(3). The rule also provides for the waiver of copy fees and charges in certain circumstances.

Rule 1680-04-02-.08: Appendix. This rule publishes the optional written forms that may, but are not required, to be used to request public records and to respond to public records requests.

NOTE:

This new rule was filed with the secretary of state with no redline comparison.

**Public Hearing Comments**

One copy of a document that satisfies T.C.A. § 4-5-222 must accompany the filing.

See attached Responses to Public Comments.

**Rulemaking Hearing Rules  
of the Tennessee Department of Transportation**

**Chapter 1680-04-02  
Inspection and Copying of Public Records**

**Responses to Public Comments**

I. INTRODUCTION

On April 24, 2018, the Tennessee Department of Transportation (“TDOT”) filed a notice of rulemaking hearing with the Secretary of State inviting public comment on the proposed new rules in Chapter 1680-04-02, Inspection and Copying of Public Records. These rules are promulgated under the Commissioner of Transportation’s rulemaking authority under T.C.A. § 4-3-2303(2) and T.C.A. § 10-7-506, and in accordance with the directives contained in T.C.A. § 10-7-503(g).

In accordance with T.C.A. § 4-5-203(a)(1), TDOT transmitted a copy of the notice of rulemaking to the Office of Open Records Counsel who in turn, at TDOT’s request, shared the notice of rulemaking with the Advisory Committee on Open Government.

TDOT held a public rulemaking hearing on June 25, 2018, to receive public comment on proposed revisions to Chapter 1680-04-02. A copy of the transcript of the public hearing is available for inspection at TDOT by contacting the TDOT Office of General Counsel, Suite 300, James K. Polk Building, 505 Deaderick Street, Nashville, TN 37243; telephone number (615) 741-2941; or by email at [TDOT.RecordsRequest@tn.gov](mailto:TDOT.RecordsRequest@tn.gov). In addition, TDOT received written comments from Ms. Deborah Fisher, Executive Director of the Tennessee Coalition for Open Government.

II. SUMMARY OF COMMENTS AND RESPONSES

In accordance with T.C.A. § 4-5-222 and Tennessee Department of State Rule 1360-01-02-.05(1), TDOT summarizes the written comments and comments received at the public rulemaking hearing and makes the following responses to these comments.

Rule 1680-04-02-.01 – Purpose.

There were no public comments addressed specifically to this proposed rule, and there is no change in the final rule.

Rule 1680-04-02-.02 – Definitions

There were no public comments addressed specifically to this proposed rule, and there is no change in the final rule.

Rule 1680-04-02-.03 – Requesting Access to Public Records.

Comments from Tennessee Coalition on Open Government:

Paragraph (6) of the proposed rule states that “Proof of Tennessee citizenship may be required as a condition to inspect or receive copies of public records.” Ms. Deborah Fisher, Executive Director of Tennessee Coalition for Open Government, requests that TDOT modify the proposed rule to:

1. Consider state residency only when fulfilling the public records request will take an unusually large amount of time and effort;
2. State that requestors may affirm residency through a checkbox on a Public Records Request Form, in an email, or verbally and only require proof of residency if there is a plausible reason to believe the requestor is not a resident;
3. Delete the denial option on the Public Records Response Form [presented in Rule 1680-04-02-.08(2)] stating the “No proof of TN citizenship was presented with your request”; and
4. Eliminate any reference under the “Public Record Request Coordinator” provision [in Rule 1680-04-02-.04(1)(b)] that would conflict with a policy of not requiring identification “except under limited and reasonable circumstances.”

Response:

The Tennessee Public Records Act (“TPRA”) expressly provides that a state agency’s public records shall be open during normal business hours for personal inspection “by any citizen of this state.” T.C.A. § 10-7-503(a)(2)(A). It does not create a right of inspection for anyone who is not a citizen of Tennessee. Moreover, the TPRA expressly states that a governmental agency may require any person requesting access to public records to present photographic or other forms of identification. T.C.A. § 10-7-503(a)(7)(vi). The Office of Open Records Counsel’s model public records policy, upon which TDOT’s proposed rules are largely based, specifically contemplates that state agencies may require proof of Tennessee citizenship to obtain access to public records. Further, the model Public Records Request Form and Public Record Request Response Form attached to the model policy, and which are copied almost verbatim in Rule 1680-04-02-.08, specifically ask whether the requestor is a Tennessee citizen and allow for denial of a public records request based on lack of Tennessee citizenship or proof thereof.

TDOT's proposed rule is permissive on the issue of Tennessee citizenship. It says only that proof of Tennessee citizenship "may be required" in order to inspect or obtain copies of public records. The public records request and response forms reproduced in Rule 1680-04-02-.08, Appendix, are optional, not required. In practice, most public records requests come to TDOT by letter or email, and most responses are made via email, including the generic email address TDOT specifically provides for making public records requests. The status or proof of Tennessee citizenship is seldom specifically addressed in a public records request or response, except in some instances where the request comes from an out-of-state address.

TDOT believes that it is best to continue addressing the proof of citizenship issue on a case-by-case basis. However, to make it clear that documentary proof of Tennessee citizenship need not be required in every case, the final rules will be modified as follows:

1. A sentence will be added to paragraph (6) of Rule 1680-04-02-.03 to state that any questions regarding proof of citizenship should be directed to the Public Records Request Coordinator ("PRRC");
2. Regarding the role of the PRRC under Rule 1680-04-02-.04:
  - a. Part (1)(a)2 will be modified to provide that the PRRC will determine whether proof of Tennessee citizenship should be required;
  - b. Part (1)(b)1 will be modified to state that the PRRC shall advise the requestor of any determinations made regarding proof of Tennessee citizenship "if required"; and
3. Regarding the optional Public Records Request Response Form contained in Rule 1680-04-02-.08(2), the checkbox lines for basing denial of a public records request based on lack of citizenship will also be modified by the "if required" qualifying language.

#### Additional Modification to Rule 1680-04-02-.03

The final rule will also be modified to include a new paragraph (7) to notify potential requestors that a wide variety of public records and information is available to the public via TDOT's internet website. This is consistent with the provision in the Office of Open Records Counsel's model public records policy that recommends state agencies describe where public notices, meeting notices, and frequently requested records are posted. The new paragraph (7) further advises that individual TDOT divisions may have their own online records request forms; that TDOT makes no warranties to the public regarding the use of online records for

anything other than informational purposes; and that the use of some online records may be restricted by law, e.g., 23 U.S.C. § 409 prohibits the use of certain federal-aid safety project records from being used for litigation purposes.

Rule 1680-04-02-.04 – Responding to Public Records Requests.

Comments from Tennessee Coalition on Open Government:

See comments included under Rule 1680-04-02-.03 above, particularly at Item 4.

Response:

See responses included under Rule 1680-04-02-.03 above, particularly at Item 2.

Rule 1680-04-02-.05 – Inspection of Records.

There were no public comments addressed specifically to this proposed rule, and there is no change in the final rule.

Rule 1680-04-02-.06 – Copies of Records.

Comments from Tennessee Coalition on Open Government:

Ms. Deborah Fisher, Executive Director, Tennessee Coalition for Open Government, requests that TDOT modify the proposed rule to clarify whether a requestor is allowed to photograph a record.

Response:

The final rule is modified to clarify that a requestor may use a personal camera or cell phone to take a picture of a page or frame of a record so long as the integrity of the record is maintained. It is also modified to clarify the copying and use of records available on TDOT's internet website.

Rule 1680-04-02-.07 – Fees and Charges for Producing Copies of Public Records.

Comments from Tennessee Coalition on Open Government:

Ms. Deborah Fisher, Executive Director of the Tennessee Coalition for Open Government, suggests modifying the proposed rule to allow for a discretionary fee waiver or fee reduction system, specifically by waiving all labor-related fees, when the request is "for records that are being sought for the public interest of increasing public knowledge about government actions and policies" as opposed to a "commercial request" for the purpose of soliciting business.

Ms. Fisher further requests modifying proposed Rule 1680-04-02-.07(8) by reducing the cost for providing copies of downloaded electronic records from the proposed rate of \$10.00 per flash drive or equivalent to the actual cost or by allowing the requestor to provide a new, unopened flash drive.

Response:

The Department declines to adopt the suggested discretionary fee waiver. Generally speaking, the Tennessee Public Records Act does not distinguish between public records requests based upon the intended use of such records. See, e.g., Office of Open Records Counsel, Frequently Asked Questions, at <http://www.comptroller.tn.gov/openrecords/faq.asp> (stating generally that a records custodian may not ask a requestor why certain records are being requested); but see T.C.A. § 10-7-506(c) (authorizing a public agency to charge developmental costs, in addition to standard copy fees and charges, for copies of computer generated maps or other similar geographic data having commercial value, but allowing standard copy fees and charges only when the record is requested for a personal non-business use by an individual or a news gathering use by the news media). Accordingly, the Department declines to question or characterize the motivation of a requestor for public records or to base copy fees and charges on the requestor's intended use of the records. However, the final rule is modified in paragraph (2) to provide that TDOT may waive copy fees and charges if the records are provided to federal, state, or local government agencies; to a person or entity that will use the records to perform work for or on behalf of TDOT; or to a person or entity from whom TDOT is acquiring real property and the records pertain to the acquisition of that property.

Regarding the charge for a flash drive onto which electronic records may be downloaded, the Department is revising the final rule at paragraph (8) to provide that the requestor shall be charged for the flash drive, compact disc, or equivalent at the current cost at TDOT. The Department declines to adopt the request to allow the requestor to provide the flash drive, compact disc, or equivalent because of the potential security risk.

Rule 1680-04-02-.08 – Appendix: Forms.

Comments from Tennessee Coalition on Open Government

See comments included under Rule 1680-04-02-.03 above, particularly at Item 3.

Response:

See responses included under Rule 1680-04-02-.03 above, particularly at Item 3.

## Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process, all agencies shall conduct a review of whether a proposed rule or rule affects small business.

### Introduction

T.C.A. § 10-7-503(g) directs state agencies, by no later than January 1, 2019, to promulgate rules regarding access to public records addressing the following matters:

- (a) The process for making requests to inspect public records or receive copies of public records and a copy of any required request form;
- (b) The process for responding to requests, including redaction practices;
- (c) A statement of any fees charged for copies of public records and the procedures for billing and payment; and
- (d) The name or title and the contact information of the individual or individuals within such governmental entity designated as the public records request coordinator.

The purpose of these rules is to establish procedures, in accordance with T.C.A. § 10-7-503(g), to accommodate requests from the public to inspect or obtain copies of public records maintained by the Tennessee Department of Transportation while at the same time preserving the confidentiality of confidential records or information as provided in State and Federal law.

### Analysis of Impact on Small Business<sup>1</sup> (T.C.A. § 4-5-402)

- (1) The extent to which the rule may overlap, duplicate, or conflict with other federal, state, and local governmental rules:

These rules are largely based on the Office of Open Records Counsel's Model Public Records Policy. They do not overlap or conflict with any other federal, state, or local governmental rules.

- (2) Clarity, conciseness, and lack of ambiguity in the rule:

The rules are drafted to be clear and concise.

- (3) The establishment of flexible compliance and reporting requirements for small business:

These rules do not contain any compliance or reporting requirements.

- (4) The establishment of friendly schedules or deadlines for compliance and reporting requirements for small business:

These rules do not contain any compliance or reporting requirements.

- (5) The consolidation or simplification of compliance or reporting requirements for small business:

These rules do not contain any compliance or reporting requirements.

- (6) The establishment of performance standards for small business as opposed to design or operational standards required in the proposed rule:

These rules do not contain any design, operational, or performance standards for business.

- (7) The unnecessary creation of entry barriers or other effects that stifle entrepreneurial activity, curb innovation, or increase costs:

These rules do not regulate the conduct of any business.

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<sup>1</sup> Per T.C.A. § 4-5-102(13) "small business" means "a business entity, including its affiliates, that employs fifty (50) or fewer full-time employees."

Economic Impact Statement (T.C.A. § 4-5-403)

- (1) The type or types of small business and an identification and estimate of the number of small businesses subject to the proposed rule that would bear the cost of, or directly benefit from the proposed rule:

These rules establish procedures, in accordance with T.C.A. § 10-7-503(g), to accommodate requests from the public to inspect or obtain copies of public records maintained by the Tennessee Department of Transportation. The owners of small businesses will be able to obtain the same benefits—i.e., access to public records – and they will bear the same costs for obtaining copies of public records as any other citizens of the State of Tennessee.

- (2) The projected reporting, recordkeeping and other administrative costs required for compliance with the proposed rule, including the type of professional skills necessary for preparation of the report or record:

These rules do not contain any reporting, recordkeeping, or other compliance costs. The only costs are copy fees and charges for those who request copies of public records.

- (3) A statement of the probable effect on impacted small businesses and consumers:

These rules have no different impact on small businesses or consumers than on any other member of the public.

- (4) A description of any less burdensome, less intrusive or less costly alternative methods of achieving the purpose and objectives of the proposed rule that may exist, and to what extent the alternative means might be less burdensome on small business:

The objective of these rules is to make TDOT's public records accessible to citizens of the State of Tennessee. Small businesses, or the owners of small businesses, are treated the same as any other member of the public.

- (5) A comparison of the proposed rule with any federal or state counterparts:

These rules are largely based on the Office of Open Records Counsel's Model Public Records Policy.

- (6) Analysis of the effect of the possible exemption of small businesses from all or any part of the requirements contained in the proposed rule:

Small businesses, or the owners of small businesses, are treated the same as any other member of the public.

## **Impact on Local Governments**

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 “any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments.” (See Public Chapter Number 1070 (<http://publications.tnsosfiles.com/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

These rules establish procedures for access to TDOT’s public records and they apply to local government officials the same as any other citizen of Tennessee, except that Rule 1680-04-02-.07(2)(b) authorizes the waiver of copy fees and charges for copies of public records provided to local, state, or federal governmental agencies or officials.

**Additional Information Required by Joint Government Operations Committee**

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A)** A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

See attached summary of Chapter 1680-04-02 as promulgated in these Rulemaking Hearing Rules. A copy of TDOT Policy 101-06, Inspection and Copying of Public Records (effective 10-13-2017), which these new rules will replace, is also attached for reference.

The current policy and the new rules are formatted differently, but they are substantially the same in content except that the new rules:

- Expand on the purpose of the new rules by including the directives established in T.C.A. § 10-7-503(g);
- Add a paragraph to describe the records and information available to the public on TDOT's website;
- Clarify that proof of Tennessee citizenship need not be required in every instance;
- Further clarify that a requestor may take a photograph of a page or frame of a record so long as the integrity of the record is maintained or may download and print records from TDOT's website;
- Provide additional circumstances under which copy fees and charges may be waived; and
- Reduce the charge for providing copies of electronic records on a flash drive or equivalent from a flat rate of \$10.00 to the actual current cost to TDOT.

- (B)** A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

T.C.A. § 10-7-503(g) directs state agencies, by no later than January 1, 2019, to promulgate rules regarding access to public records addressing the following matters:

- The process for making requests to inspect public records or receive copies of public records and a copy of any required request form;
- The process for responding to requests, including redaction practices;
- A statement of any fees charged for copies of public records and the procedures for billing and payment; and
- The name or title and the contact information of the individual or individuals within such governmental entity designated as the public records request coordinator.

- (C)** Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

The Tennessee Coalition for Open Government offered comments on the proposed rules and requested some modifications to the rules. TDOT did make some changes to the rules in response to those comments. See attached Responses to Public Comments.

- (D)** Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule or the necessity to promulgate the rule;

None.

- (E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

None.

- (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

John H. Reinbold, General Counsel

- (G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

John H. Reinbold, General Counsel

- (H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

John H. Reinbold, General Counsel, Tennessee Department of Transportation, Suite 300, James K. Polk Building, 505 Deaderick Street, Nashville, TN 37243; telephone number (615) 741-2941.

- (I) Any additional information relevant to the rule proposed for continuation that the committee requests.

None at this time.

**Department of State  
Division of Publications**

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Nashville, TN 37243  
Phone: 615-741-2650  
Email: [publications.information@tn.gov](mailto:publications.information@tn.gov)

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Sequence Number: 11-05-18  
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Effective Date: 2/4/19

# Rulemaking Hearing Rule(s) Filing Form

*Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).*

*Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).*

<b>Agency/Board/Commission:</b>	Tennessee Department of Transportation
<b>Division:</b>	Legal Division
<b>Contact Person:</b>	John H. Reinbold, General Counsel
<b>Address:</b>	505 Deaderick Street, Suite 300, Nashville, TN
<b>Zip:</b>	37243
<b>Phone:</b>	615-741-2941
<b>Email:</b>	<a href="mailto:John.Reinbold@tn.gov">John.Reinbold@tn.gov</a>

**Revision Type (check all that apply):**

- Amendment  
 New  
 Repeal

**Rule(s)** (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please make sure that ALL new rule and repealed rule numbers are listed in the chart below. Please enter only ONE Rule Number/Rule Title per row)

Chapter Number	Chapter Title
1680-04-02	Inspection and Copying of Public Records
Rule Number	Rule Title
1680-04-02-.01	Purpose.
1680-04-02-.02	Definitions.
1680-04-02-.03	Requesting Access to Public Records.
1680-04-02-.04	Responding to Public Records Requests.
1680-04-02-.05	Inspection of Records.
1680-04-02-.06	Copies of Records.
1680-04-02-.07	Fees and Charges for Producing Copies of Public Records.
1680-04-02-.08	Appendix: Forms.

Place substance of rules and other info here. Please be sure to include a detailed explanation of the changes being made to the listed rule(s). Statutory authority must be given for each rule change. For information on formatting rules go to [http://sos-tn-gov-files.s3.amazonaws.com/forms/Rulemaking%20Guidelines\\_September2016.pdf](http://sos-tn-gov-files.s3.amazonaws.com/forms/Rulemaking%20Guidelines_September2016.pdf).

1680-04-02-.01 Purpose.

- (1) The Tennessee Public Records Act provides that public records shall, at all times during business hours, be open for personal inspection by any citizen of this State, and those in charge of the records shall not refuse such right of inspection to any citizen, unless otherwise provided by State law.
- (2) The purpose of these rules is to establish procedures to accommodate requests from the public to inspect or obtain copies of public records maintained by the Tennessee Department of Transportation, to the extent that such public records are open to inspection by citizens of the State of Tennessee under the Tennessee Public Records Act, while at the same time preserving the confidentiality of confidential records or confidential information as provided in State or Federal law.
- (3) Pursuant to T.C.A. § 10-7-503(g), these rules provide for:
  - (a) The process for making requests to inspect public records or receive copies of public records and a copy of any required request form;
  - (b) The process for responding to requests, including redaction practices;
  - (c) A statement of any fees charged for copies of public records and the procedures for billing and payment; and
  - (d) The name or title and the contact information of the individual or individuals within the Department designated as the public records request coordinator.
- (4) Consistent with the Tennessee Public Records Act and these rules, TDOT personnel shall timely and efficiently provide access and assistance to persons requesting to view or receive copies of public records. No provisions in these rules shall be used to hinder access to open public records. However, the integrity and organization of public records, as well as the efficient and safe operation of this Department, shall be protected as provided by current law.
- (5) Concerns about the implementation of these rules should be addressed to the Public Records Request Coordinator for TDOT or to the Office of Open Records Counsel.

Authority: T.C.A. §§ 4-3-2303(2), 10-7-503, and 10-7-506.

1680-04-02-.02 Definitions.

- (1) "Department" or "TDOT" means the State of Tennessee Department of Transportation.
- (2) "Office of Open Records Counsel" or "OORC" means the office established under T.C.A. § 8-4-601, et seq., within the Office of the State of Tennessee Comptroller of the Treasury.
- (3) "Public Records" means all documents, papers, letters, maps, books, photographs, microfilms, electronic data processing files and output, films, recordings, or other material, regardless of physical form or characteristic, made or received pursuant to law or ordinance or in connection with the transaction of official business by any governmental agency.
- (4) "Public Records Request Coordinator" or "PRRC" means the individual, or individuals, designated in Rule 1680-04-02-.03 who has, or have, the responsibility to ensure public record requests are routed to the appropriate records custodian and are fulfilled in accordance with T.C.A. § 10-7-503, et seq., of the Tennessee Public Records Act. The PRRC may also be a records custodian.
- (5) "Records Custodian" means the office, official or employee lawfully responsible for the direct custody

and care of a public record. The records custodian is not necessarily the original preparer or receiver of the record.

- (6) "Requestor" means a person seeking access to a public record or public records, whether it is for the purpose of inspection or duplication.
- (7) "Tennessee Public Records Act" or "TPRA" means the State law codified in T.C.A. § 10-7-501, et seq., regarding access to public records.

Authority: T.C.A. §§ 4-3-2303(2), 10-7-503, and 10-7-506.

1680-04-02-.03 Requesting Access to Public Records.

- (1) Public record requests, except those requests generated by the news media, should generally be made, or referred, to the Public Records Request Coordinator, or his or her designee, in order to ensure that public records requests are routed to the appropriate records custodian and fulfilled in a timely manner. A simple request to inspect or duplicate a readily available public record may be made to, and handled by, the applicable records custodian.
- (2) The designated PRRC for TDOT is the General Counsel; provided, however, that responsibilities of the PRRC under this rule may be delegated to one or more employees under the supervision of the PRRC. The PRRC may be contacted at:

Office of General Counsel  
Tennessee Department of Transportation  
3rd Floor, James K. Polk Building  
505 Deaderick Street  
Nashville, Tennessee 37243  
Telephone: (615) 741-2941  
Email: TDOT.RecordsRequest@tn.gov

- (3) All news media requests for information and documents shall be directed to TDOT's Community Relations Division, which may be contacted at:

Community Relations Division  
Tennessee Department of Transportation  
7th Floor, James K. Polk Building  
505 Deaderick Street  
Nashville, Tennessee 37243  
Telephone: (615) 741-7736

- (4) Requests for inspection of public records may be made orally or in writing but shall not be required to be made in writing. Requestors may use the Public Records Request Form provided in the Appendix or any other written form of communication such as mail or email. There shall be no charge for inspection of public records.
- (5) Requests for copies, or requests for inspection and copies, of public records shall be made in writing. Requestors may use the Public Records Request Form provided in the Appendix or any other written form of communication such as mail or electronic mail. There shall be a charge for producing copies of public records, in accordance with Rule 1680-04-02-.07.
- (6) Proof of Tennessee citizenship may be required as a condition to inspect or receive copies of public records. Any questions regarding proof of Tennessee citizenship should be directed to the Public Records Request Coordinator.
- (7) Public Records and Information Available on TDOT's Internet Website.
  - (a) TDOT posts notices of scheduled public meetings and hearings on its internet website at <https://www.tn.gov/tdot/transportation-quick-links/upcoming-events.html>.

- (b) In addition, TDOT makes a wide variety of TDOT forms, documents, publications, and resources available to the public via TDOT's internet website at <https://www.tn.gov/tdot>, and particularly through the Index of Services at <https://www.tn.gov/tdot/find-local-information111.html>. Examples of files that are available online include, without limitation, TDOT's Long Range Transportation Plan, Statewide Transportation Improvement Program (STIP), and current Three-Year Comprehensive Multimodal Program (3-Year Plan); information on current transportation projects (by Region); weekly lane closure information; current traffic conditions (TDOT SmartWay); information regarding project funding programs and other transportation programs administered by TDOT; state, county, and city maps; roadway inventory data; bridge inventory and appraisal reports; standard roadway and structures drawings; various procedural manuals and guidelines; standard specifications for road and bridge construction; construction contract and prequalification forms; Disadvantaged Business Enterprise (DBE) information; construction contract bid letting information; prequalification procedures and current advertisements for consultant services; and information on how to obtain various types of permits from TDOT, including permits for driveways, outdoor advertising, overweight/overdimensional vehicle movements, and utility installations.
- (c) Individual TDOT divisions may have their own online written forms for requesting copies of particular types of records for which they are the records custodian.
- (d) To the extent that such online files are accessible to members of the public who have no business or official relationship with TDOT, the files are made available for informational purposes only. TDOT makes no warranty of any kind, express or implied, regarding these files and specifically makes no warranty that any of these files are fit for any other use or particular purpose. The user of such files assumes all risk and liability for any losses, damages, claims or expenses resulting from the use or possession of any files provided by TDOT.
- (e) Further, by making records available for inspection online, TDOT does not waive any restrictions on the use of such records that may be applicable under law, including without limitation 23 U.S.C. § 409, which prohibits certain types of federal-aid safety project related records from being subject to discovery or admitted into evidence in any civil action for damages.

Authority: T.C.A. §§ 4-3-2303(2), 10-7-503, and 10-7-506.

1680-04-02-.04 Responding to Public Records Requests.

(1) Public Record Request Coordinator

- (a) The PRRC, or an employee under the supervision of the PRRC, will review public record requests and make an initial determination of the following:
  1. If TDOT is the custodian of the records;
  2. If the requestor provided evidence of Tennessee citizenship (if required) or whether such proof should be required; and
  3. If the records requested are described with sufficient specificity to identify them.
- (b) The PRRC, or an employee under the supervision of the PRRC, shall acknowledge receipt of the request and take any of the following appropriate actions:
  1. Advise the requestor of any determinations made regarding proof of Tennessee citizenship (if required); form(s) required for copies; copy fees and labor threshold and waivers, if applicable; and aggregation of multiple or frequent requests;
  2. If appropriate, deny the request in writing, in whole or in part, providing the appropriate ground as enumerated in TDOT's Public Records Request Response Form, or other written communication, including any of the following:

- (i) Lack of evidence of Tennessee citizenship (if required);
  - (ii) Lack of specificity in the request;
  - (iii) Non-existence of the requested records;
  - (iv) Lack of custody or control over the requested records; or
  - (v) An exemption under the Tennessee Public Records Act or other provision of law making the requested record confidential or not subject to public disclosure;
3. If appropriate, contact the requestor to see if the request can be clarified or narrowed;
  4. Forward the records request to the appropriate records custodian at TDOT; or
  5. If requested records are in the custody of a different governmental entity, and the PRRC knows the correct governmental entity, advise the requestor of the correct governmental entity and PRRC for that entity, if known.

(2) Records Custodian

- (a) Upon receiving a specific public records request, a records custodian shall promptly make the requested public record or records available, if practicable, in accordance with T.C.A. § 10-7-503. If the request involves multiple records from one or more offices within TDOT that cannot be readily identified, located, and provided to the requestor, or if the records custodian is uncertain whether an applicable exemption applies, the records custodian shall immediately refer the request to the PRRC.
- (b) The PRRC shall, within seven (7) business days from the receipt of the request, send the requestor a completed Public Records Request Response Form, or other written communication, if it is not practicable to provide requested records promptly because additional time is necessary:
  1. To determine whether the requested records exist;
  2. To search for, retrieve, or otherwise gain access to records;
  3. To determine whether the records are open or confidential;
  4. To redact records; or
  5. For other similar reasons.
- (c) If a records custodian believes that a public records request, or a part of the request, should be denied, he or she shall inform the PRRC who shall determine whether to deny the request, in whole or part, in writing as provided in subparagraph (1)(b) of this rule, using the Public Records Request Response Form or other written communication.
- (d) If a records custodian reasonably determines production of records should be segmented because the records request is for a large volume of records, or additional time is necessary to prepare the records for access, the records custodian shall refer the requests to the PRRC, and the PRRC shall use the Public Records Request Response Form, or other written communication, to notify the requestor that production of the records will be in segments and that a records production schedule will be provided as expeditiously as practicable. If appropriate, the records custodian or PRRC should contact the requestor to see if the request can be narrowed.
- (e) If a records custodian or the PRRC discovers records responsive to a records request were omitted, the records custodian or PRRC will contact the requestor concerning the omission

and produce the records as quickly as possible.

(3) Confidential Records and Redaction

- (a) If the PRRC determines that the requested records are considered confidential or privileged records under Federal or State law and are not available for public inspection, the PRRC shall communicate such determination to the requestor in writing. However, nothing in these rules shall be construed to require TDOT to generate a detailed description of each confidential record withheld from inspection, such as may be required with respect to the production of documents in discovery under the Tennessee Rules of Civil Procedure.
- (b) If a requested record contains confidential information that is not open for public inspection, the records custodian shall prepare a redacted copy prior to providing access. If questions arise concerning redaction, the records custodian shall coordinate with the PRRC, legal counsel, or other appropriate parties regarding review and redaction of records. The records custodian and the PRRC may also consult with the OORC or with the Office of the Attorney General and Reporter.
- (c) Whenever a redacted record is provided, a records custodian or PRRC shall provide the requestor with the basis for redaction. The basis given shall be general in nature and not disclose confidential information.

Authority: T.C.A. §§ 4-3-2303(2), 10-7-503, and 10-7-506.

1680-04-02-.05 Inspection of Records.

- (1) There shall be no charge for inspection of public records.
- (2) The location for inspection of records within TDOT's offices will be determined by either the PRRC or the records custodian.
- (3) Under reasonable circumstances, the PRRC or a records custodian may require an appointment for inspection or may require inspection of records at an alternate location.
- (4) The Tennessee Public Records Act grants Tennessee citizens the right to access open public records that exist at the time of the request. Nothing in the TPRA or these rules shall be construed as requiring a records custodian or the PRRC to sort through files to compile information or to create or recreate a record that does not exist.

Authority: T.C.A. §§ 4-3-2303(2), 10-7-503, and 10-7-506.

1680-04-02-.06 Copies of Records.

- (1) A records custodian or the PRRC shall promptly respond to a request for copies of public records in accordance with the procedures set forth in 1680-04-02-.04.
- (2) Copies will be available for pickup at a location specified by the records custodian or the PRRC or may be delivered to the mailing address specified by the requestor.
- (3) At the discretion of the PRRC, commercial copy services may be used for copying a large volume of public records. In such event, the requestor shall be responsible for the commercial copying costs.
- (4) TDOT, or its contractors or agents, shall maintain custody of its records at all times. A requestor shall not be allowed to take custody of any TDOT record, nor shall any requestor be allowed to use a personal photocopier or scanner to make photocopies, download electronic or digital records, reproduce computer disks, or otherwise mechanically reproduce any TDOT record; provided, however, that:
  - (a) A requestor may use a personal camera or cell phone to take a photograph of a page or frame of a record, or may make personal notes or manually copy the contents of a TDOT record, so

long as the integrity of the record is maintained; and

- (b) A person may use his or her own equipment to download and print, for personal information or fair use purposes, any TDOT document that is accessible to the public on TDOT's internet website. See Rule 1680-04-02-.03, paragraph (7), regarding access to and use of TDOT records available online.

Authority: T.C.A. §§ 4-3-2303(2), 10-7-503, and 10-7-506.

1680-04-02-.07 Fees and Charges for Producing Copies of Public Records.

- (1) Records custodians or the PRRC shall provide requestors with an itemized estimate of the fees and charges prior to producing copies of records. After the copies have been made, the records custodian or PRRC shall itemize the fees and charges and send an invoice to the requestor. Prepayment of the copy costs shall be required before producing copies of the requested records.
- (2) The PRRC or a records custodian may waive payment of copy fees and labor charges under any of the following circumstances:
  - (a) The applicable fees and charges do not exceed \$5.00;
  - (b) The records are provided to federal, state, or local governmental agencies or officials;
  - (c) The records are provided to a person or entity that will use the records to perform work for or on behalf of TDOT; or
  - (d) The records pertain to the acquisition of real property from a person or entity and are provided to that person or entity.

- (3) Fees for making copies are as follows:

<u>Record page size</u>	<u>Fee (black and white)</u>	<u>Fee (color)</u>
8 ½" x 11" or 8 ½" x 14" (letter or legal size)	\$0.15 per page	\$0.50 per page
11" x 17" or 12" x 18"	\$1.00 per page	\$1.50 per page
24" x 36"	\$2.00 per page	\$4.00 per page
> 24" x 36"	\$.75/sq. ft.	\$1.50/sq. ft.

- (4) In addition to the copy fees described in paragraph (3) above, labor charges for the time, in hours, to produce copies of records shall be imposed whenever the time exceeds one (1) hour. Labor charges shall be calculated by multiplying the base hourly wage rate of each employee by the time each employee spends in identifying, locating, and copying the records, minus the first hour of the most highly paid employee.
- (5) If the copies of the requested records are delivered by mail, the costs of delivery, including postage, shall be included in the copy charge.
- (6) At TDOT's discretion, an outside copying vendor may be used to make copies of the requested records. If so, an employee of TDOT shall transport the records to and from the vendor and maintain custody of the records at all times. The requestor shall pay the actual costs assessed by the vendor and any applicable employee labor charges as provided in paragraph (4) above.
- (7) If the requested records are in the custody of, and produced by, a TDOT contractor or consultant, the requestor shall pay the total labor and copying costs billed to TDOT by the contractor or consultant.
- (8) If TDOT maintains the requested public record(s) in an electronic format, copies of the record(s) may

be provided to the requestor in an electronic format, as follows:

- (a) The record(s) may be downloaded to a flash drive or compact disc (or equivalent) provided by TDOT. The requestor shall be charged for the flash drive or compact disc (or equivalent) at the current cost to TDOT. Downloading to a flash drive or compact disc (or equivalent) from outside TDOT will not be allowed.
  - (b) If the requested record exists in an electronic format that may be transmitted by email, there will no copy fee for transmitting the record.
  - (c) If the time required to identify, locate, and download or transmit the requested electronic records exceeds one hour, the production of the copies shall be subject to the labor charge described in paragraph (4) above.
- (9) TDOT may aggregate record requests in accordance with the Frequent and Multiple Request Policy promulgated by the Office of Open Records Counsel when more than four (4) requests are received within a calendar month either from a single individual or a group of individuals deemed working in concert. The PRRC is responsible for making the determination that a group of individuals are working in concert. The PRRC or the records custodian must inform the individual that they have been deemed to be working in concert and that they have the right to appeal the decision to the OORC.
- (10) Payment shall be remitted by check or money order made payable to the State of Tennessee Department of Transportation.

Authority: T.C.A. §§ 4-3-2303(2) and 10-7-503.

The following forms may be used, but are not required, to request inspection or copies of public records and to respond to public records requests, respectively:

- (1) Public Records Request Form:

PUBLIC RECORDS REQUEST FORM

The Tennessee Public Records Act (TPRA) grants Tennessee citizens the right to access open public records that exist at the time of the request. The TPRA does not require records custodians to compile information or create or recreate records that do not exist.

To: Public Records Request Coordinator  
Office of General Counsel  
Tennessee Department of Transportation  
3rd floor, James K. Polk Building  
505 Deaderick Street  
Nashville, Tennessee 37243

From: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the requestor a Tennessee citizen? \_\_\_ Yes \_\_\_ No

Request: \_\_\_ Inspection  
\_\_\_ Copy/Duplicate

If costs for copies are assessed, the requestor will receive an estimate. Delivery will be made by first class mail unless the requestor specifies otherwise.

Records Requested:

Provide a detailed description of the record(s) requested, including type of record(s), timeframe or dates for the record(s) sought, and subject matter or key words related to the record(s). Under the TPRA, record requests must be sufficiently detailed to enable a governmental entity to identify the specific records sought. As such, your request must provide enough detail to enable the records custodian responding to the request to identify the specific records you are seeking.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Requestor and Date

\_\_\_\_\_  
Signature of PRRC and Date

(2) Public Records Request Response Form:

PUBLIC RECORDS REQUEST RESPONSE FORM

Office of General Counsel  
Tennessee Department of Transportation  
3rd floor, James K. Polk Building  
505 Deaderick Street  
Nashville, Tennessee 37243

[Date]

[Requestor's Name and Contact Information]:

In response to your public records request received on \_\_\_\_\_, our office is taking the action(s) as indicated below:

- The public records responsive to your request will be made available for inspection:  
Location: \_\_\_\_\_ Date/Time: \_\_\_\_\_
- Copies of public records responsive to your request are:
  - Attached
  - Available for pickup at the following location: \_\_\_\_\_
  - Being delivered via U.S. Mail or other method: \_\_\_\_\_
- Your request is being denied on the following grounds:
  - Your request was not sufficiently detailed to enable identification of the specific requested records. You need to provide additional information to identify the records.
  - No such records exist or this office does not maintain records responsive to your request.
  - No proof of TN citizenship was presented with your request (if required). Your request will be reconsidered upon presentation of an adequate form of identification.
  - You are not a Tennessee citizen (if required).
  - You have not paid the copying/production fees.
  - The following state, federal, or other applicable law prohibits disclosure of the requested records: \_\_\_\_\_.
- It is not practicable for the records you requested to be made promptly available for inspection and/or copying because:
  - It has not yet been determined that records responsive to your request exist; or
  - TDOT is still in the process of retrieving, reviewing and/or redacting the requested records.

The time reasonable necessary to produce the records or information and/or to make a determination of a proper response to your request is:  
\_\_\_\_\_.

If you have any additional questions regarding your record request please contact:

\_\_\_\_\_.

Sincerely,

[Records Custodian or PRRC/Name and Contact Information]

Authority: T.C.A. §§ 4-3-2303(2), 10-7-503, 10-7-506.

\* If a roll-call vote was necessary, the vote by the Agency on these rulemaking hearing rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the \_\_\_\_\_ (board/commission/ other authority) on \_\_\_\_\_ (mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: (04/24/18)

Rulemaking Hearing(s) Conducted on: (add more dates). (06/25/18)

Date: 7-30-18

Signature: [Handwritten Signature]

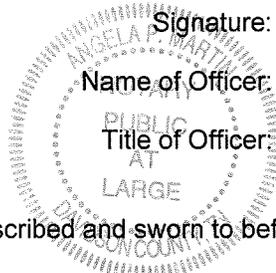
Name of Officer: John Schroer

Title of Officer: Commissioner

Subscribed and sworn to before me on: 7-30-2018

Notary Public Signature: Angela P. Martin

My commission expires on: 1-6-2020



Agency/Board/Commission: \_\_\_\_\_

Rule Chapter Number(s): \_\_\_\_\_

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slatery III  
Herbert H. Slatery III  
Attorney General and Reporter

11/1/2018  
Date

**Department of State Use Only**

Filed with the Department of State on: 11/6/18

Effective on: 2/4/19

[Handwritten Signature]

Tre Hargett  
Secretary of State

2018 NOV -5 AM 11:15  
RECEIVED  
SECRETARY OF STATE  
PUBLIC AFFAIRS

## G.O.C. STAFF RULE ABSTRACT

DEPARTMENT: Board of Water Quality, Oil and Gas

DIVISION: Water Resources

SUBJECT: Public Water Systems

STATUTORY AUTHORITY: The Revised Total Coliform Rule is a federally mandated rule and has been promulgated under 40 C.F.R. 141.851-.862. These rules are being promulgated under the authority of Tennessee Code Annotated, Sections 68-221-701 et seq. and 4-5-201 et seq.

EFFECTIVE DATES: February 17, 2019 to June 30, 2019

FISCAL IMPACT: Minimal

STAFF RULE ABSTRACT: These changes are being made to respond to the Environmental Protection Agency's review of Tennessee's Revised Total Coliform Rules and their conformance with federal law; to reference the Department's electronic reporting rules for making electronic submissions when the forms are made available by the Department for this purpose; to modify and clarify requirements regarding the operation and maintenance of public water systems to facilitate compliance; to conform with state law; and to make housekeeping changes.

## Public Hearing Comments

One copy of a document that satisfies T.C.A. § 4-5-222 must accompany the filing.

**Comment:** A commenter questioned the authority behind and reasoning for the amendment to paragraph (20) of Rule 0400-45-01-.17 to require public notification if the fluoride level exceeds 1.5 mg/L. The commenter also thought the notifications would be burdensome for municipalities.

**Response:** The Board is amending paragraph (20) of Rule 0400-45-01-.17 to be consistent with Tenn. Code Ann. § 68-221-709, enacted May 2017.

**Comment:** A commenter pointed out a typographical error in Rule 0400-45-01-.17(8)(c). The word "Finishing" in the first sentence should be replaced with "Finished."

**Response:** The typographical correction has been made.

**Comment:** A commenter suggests that the word "all" be deleted from Rule 0400-45-01-.17(6)(b)3 in order to allow the systems to operate much as they have in the past. Without the change, systems would be required to incorporate all aspects of the manual into their plan.

**Response:** The Board agrees and the word "all" has been removed from 0400-45-01-.17(6)(b)3.

**Comment:** A commenter also noticed in Rule 0400-45-01-.17(6)(b)3 that the title of the referenced document was incorrect and suggesting revising it to avoid confusion.

**Response:** The Board agrees and the title of the referenced document has been corrected to be identical to the document published by the Department as intended.

## Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process, all agencies shall conduct a review of whether a proposed rule or rule affects small business.

- (1) The type or types of small business and an identification and estimate of the number of small businesses subject to the proposed rule that would bear the cost of, or directly benefit from the proposed rule.

All community and non-community public water systems are affected by the Revised Total Coliform Rule. This is a federal rule that the Board is promulgating to maintain continuing primary enforcement authority from EPA. Small businesses that serve water to the public and meet the definition of a public water system are all regulated by the Revised Total Coliform Rule. There are approximately 184 water systems that would be considered small businesses. Of the 184, the majority of the businesses are campgrounds and resorts (99), followed by boat docks/marinas (23), restaurants (16), gas stations/markets (15) and manufacturing/service industries (31).

- (2) The projected reporting, recordkeeping, and other administrative costs required for compliance with the proposed rule, including the type of professional skills necessary for preparation of the report or record.

These rule amendments will not result in an increase in cost and will not require any additional skills to comply.

- (3) A statement of the probable effect on impacted small businesses and consumers.

The rule amendments may result in a minimal increase in staff time, but will have a negligible, if any, economic impact on small businesses.

- (4) A description of any less burdensome, less intrusive or less costly alternative methods of achieving the purpose and objectives of the proposed rule that may exist, and to what extent the alternative means might be less burdensome to small business.

No less burdensome method has been identified. The Revised Total Coliform Rule amendments are required by federal law. The amendment regarding public notification if the fluoride level exceeds 1.5 mg/L is required by state law. The proposed rules do not include any new requirements that are more burdensome than what is mandated by state or federal law. However, these rules, as they pertain to sampling frequencies for some public water systems, do offer clarification and aid in system compliance by retaining the current requirements that are derived from previous federal regulation.

- (5) A comparison of the proposed rule with any federal or state counterparts.

The Revised Total Coliform Rule is a federal rule, published in 40 CFR 141.851-861. The state rule mirrors the federal rule with the exception of the Board choosing to retain the aspects of the existing Total Coliform Rule regarding sampling frequencies in order to minimize confusion and tracking issues, and to be more protective of public health.

- (6) Analysis of the effect of the possible exemption of small businesses from all or any part of the requirements contained in the proposed rule.

The Board is unable to exempt small businesses from these rules because these rules are either mandated by federal or state law or intended to bring needed clarifications that will result in greater compliance and as a result more protection to public health and the environment.

## **Impact on Local Governments**

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 “any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments.” (See Public Chapter Number 1070 (<http://publications.tnsosfiles.com/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

The Board of Water Quality, Oil and Gas anticipates that this rulemaking will not result in an increase in expenditures or decrease in revenues for local governments.

**Additional Information Required by Joint Government Operations Committee**

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A)** A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

These changes are being made to respond to EPA's review of Tennessee's Revised Total Coliform Rules and their conformance with federal law; to reference the Department's electronic reporting rules for making electronic submissions when the forms are made available by the Department for this purpose; to modify and clarify requirements regarding operation and maintenance of public water systems to facilitate compliance; to conform with state law; and to make housekeeping changes.

- (B)** A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

The Revised Total Coliform Rule is a federally mandated rule and has been promulgated under 40 C.F.R. 141.851-.862 and these rules are being promulgated under the authority of Tenn. Code Ann. §§ 68-221-701 et seq. and 4-5-201 et seq.

- (C)** Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

These rule amendments impact public drinking water systems and certified laboratories. The TN Association of Utility Districts representing public water systems communicated its support for the changes.

- (D)** Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule or the necessity to promulgate the rule;

The Board of Water Quality, Oil and Gas is not aware of any.

- (E)** An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

There will be no significant increases or decreases in revenue or expenditures resulting from these rule amendments.

- (F)** Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

David Money  
Division of Water Resources  
Columbia Environmental Field Office  
1421 Hampshire Pike  
Columbia, Tennessee 38401  
931-840-4172  
[david.money@tn.gov](mailto:david.money@tn.gov)

- (G)** Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Mallorie Kerby  
Assistant General Counsel  
Office of General Counsel

- (H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

Office of General Counsel  
Tennessee Department of Environment and Conservation  
William R. Snodgrass Tennessee Tower  
312 Rosa L. Parks Avenue, 2nd Floor  
Nashville, Tennessee 37243  
(615) 532-0108  
[Mallorie.Kerby@tn.gov](mailto:Mallorie.Kerby@tn.gov)

- (I) Any additional information relevant to the rule proposed for continuation that the committee requests.

The Board of Water Quality, Oil and Gas is not aware of any requests.

**Department of State  
Division of Publications**

312 Rosa L. Parks Avenue, 8th Floor Snodgrass/TN Tower  
Nashville, TN 37243  
Phone: 615-741-2650  
Email: [publications.information@tn.gov](mailto:publications.information@tn.gov)

**For Department of State Use Only**

Sequence Number: 11-11-18  
Rule ID(s): 7405  
File Date: 11/19/18  
Effective Date: 2/17/19

# Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

<b>Agency/Board/Commission:</b>	Board of Water Quality, Oil and Gas
<b>Division:</b>	Water Resources
<b>Contact Person:</b>	David Money
<b>Address:</b>	Columbia Environmental Field Office 1421 Hampshire Pike Columbia, Tennessee
<b>Zip:</b>	38401
<b>Phone:</b>	931-840-4172
<b>Email:</b>	<a href="mailto:david.money@tn.gov">david.money@tn.gov</a>

**Revision Type (check all that apply):**

- Amendment  
 New  
 Repeal

**Rule(s)** (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please make sure that ALL new rule and repealed rule numbers are listed in the chart below. Please enter only ONE Rule Number/Rule Title per row)

Chapter Number	Chapter Title
0400-45-01	Public Water Systems
Rule Number	Rule Title
0400-45-01-.01	Authority
0400-45-01-.04	Definitions
0400-45-01-.05	Supervision of Design and Construction
0400-45-01-.14	Laboratory Certification
0400-45-01-.17	Operation and Maintenance Requirements
0400-45-01-.18	Reporting Requirements
0400-45-01-.19	Notification of Customers
0400-45-01-.31	Filtration and Disinfection
0400-45-01-.33	Control of Lead and Copper
0400-45-01-.34	Drinking Water Source Protection
0400-45-01-.40	Ground Water Rule
0400-45-01-.41	Revised Total Coliform Rule

Place substance of rules and other info here. Please be sure to include a detailed explanation of the changes being made to the listed rule(s). Statutory authority must be given for each rule change. For information on formatting rules go to

[http://sos-tn-gov-files.s3.amazonaws.com/forms/Rulemaking%20Guidelines\\_September2016.pdf](http://sos-tn-gov-files.s3.amazonaws.com/forms/Rulemaking%20Guidelines_September2016.pdf).

Chapter 0400-45-01  
Public Water Systems

Amendments

Rule 0400-45-01-.01 Authority is amended by deleting it in its entirety and substituting instead the following:

- (1) These rules and regulations are issued under the authority of ~~Public Acts of 1983, Chapter 324 the~~ Tennessee Safe Drinking Water Act of 1983, T.C.A. §§ 68-221-701 et seq.
- (2) The Division of Water ~~Supply~~ Resources is responsible for the supervision of public water systems.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Paragraphs (11), (22), (50), (60), (67), (68), (72), (78), (79), (85), (87), (94), (101), and (105) of Rule 0400-45-01-.04 Definitions are amended by deleting them in their entirety and substituting instead the following:

- (11) "~~Community Water Systems~~ water system" means a public water system which serves at least ~~fifteen (15)~~ service connections used by year round residents or regularly serves at least ~~twenty five (25)~~ year round residents.
- (22) "Department" when used in these ~~regulations shall mean~~ rules means the Division of Water ~~Supply~~ Resources, Tennessee Department of Environment and Conservation, or one of the Division's ~~Field~~ Offices ~~field offices~~.
- (50) "~~Human Consumption~~" — "Human consumption" means the use of water that involves any drinking or ingestion of the water by humans, any human skin contact, or food preparation where the food is not brought to boiling temperatures after contact with the water.
- (60) "~~Maximum Contaminant Level~~" "Maximum contaminant level" or "MCL" means the maximum permissible level of a contaminant in water which is delivered at the free flowing outlet of the ultimate user of a public water system, except in the case of turbidity where the maximum permissible level is measured at the point of entry to the distribution system. Contaminants added to the water under circumstances controlled by the user, except those resulting from corrosion of piping and plumbing caused by water quality, are excluded from this definition.
- (67) "~~Non-Community Water System~~" "Non-community water system" means a public water system that is not a community water system. A non-community water system is either a "transient non-community water system" (TNCWS) or a "non-transient non-community water system" (NTNCWS).
- (68) "~~Non-Transient Non-Community Water System~~" or "NTNCWS" "Non-transient non-community water system" or "NTNCWS" means a non-community water system that regularly serves at least ~~twenty five (25)~~ of the same persons over six ~~(6)~~ months per year.
- (72) "~~Plan Documents~~" mean "Plan documents" means reports, proposals, preliminary plans, survey and basis of design data, general and detailed construction plans, profiles, specifications and all other information pertaining to public water system planning.
- (78) "~~Primary Drinking Water Regulation~~" "Primary drinking water regulation" means a regulation ~~rule~~ promulgated by the Department ~~Board~~ which:
  - (a) ~~applies~~ Applies to public water systems;

- (b) ~~specifies~~ Specifies contaminants which, in the judgment of the Department, may have any adverse effect on the health of persons;
- (c) ~~specified~~ Specifies for each such contaminant ~~either;~~ either:
1. ~~a~~ A maximum contaminant level, if, in the judgment of the Department, it is economically and technologically feasible to ascertain the level of such contaminant in water in public water systems, or
  2. ~~if~~ If, in the judgment of the Department, it is not economically or technologically feasible to so ascertain the level of such contaminant, each treatment technique known to the Department which leads to a reduction in the level of such contaminant sufficient to satisfy the requirements of Rule 0400-45-01-.06; and
- (d) ~~contains~~ Contains criteria and procedures to assure a supply of drinking water which dependably complies with such maximum contaminant ~~levels;~~ levels or treatment ~~techniques~~ techniques, including quality control and testing procedures to insure compliance with such levels and to insure proper operation and maintenance of the system, and requirements ~~to~~ regarding (i) the minimum quality of water which may be taken into the system and (ii) siting for new facilities for public water systems.
- (79) ~~"Public Water System"~~ "Public water system" means a system for the provision of piped water for human consumption if ~~such~~ the system serves 15 or more connections or which regularly serves 25 or more individuals daily at least 60 days out of the year and includes:
- (a) ~~any~~ Any collection, treatment, storage or distribution facility under control of the operator of such system and used primarily in connection with such system; and
  - (b) ~~any~~ Any collection or pre-treatment storage facility not under such control which is used primarily in connection with such system.
- The population of a water system shall be determined by actual count or by multiplying the household factor by the number of connections in the system. The household factor shall be taken from the latest federal census for that county or city. Water systems serving multi-family residences such as apartment complexes and mobile home parks shall include each individual residence unit as a connection in determining the population for the system.
- (85) ~~"Sanitary Survey"~~ "Sanitary survey" means an on-site review of the water source, facilities, equipment, operation and maintenance of a public water system for the purpose of evaluating the adequacy of such sources, facilities, equipment, operation and maintenance for producing and distributing safe drinking water.
- (87) ~~"Secondary Drinking Water Regulation"~~ "Secondary drinking water regulation" means a regulation ~~rule~~ promulgated by the Department ~~Board~~ Board which applies to public water systems and which specifies the maximum contaminant levels which, in the judgment of the Department ~~Board~~, are requisite to protect the public welfare. Such ~~regulations~~ rules may vary according to geographic and other circumstances, and ~~may~~ apply to any contaminant in drinking water ~~which may~~:
- (a) ~~which may adversely~~ Adversely affect the odor or appearance of such water and consequently may cause the persons served by the public water system providing such water to discontinue its use; ~~or~~
  - (b) ~~which may otherwise~~ Otherwise adversely affect the public welfare. Such ~~regulations may vary according to geographic and other circumstances.~~
- (94) ~~"Supplier of Water"~~ "Supplier of water" means any person who owns or operates a public water system.
- (101) ~~"Transient Non-Community Water System"~~ or ~~"TNCWS"~~ "Transient non-community water system" or "TNCWS" means a non-community water system that regularly serves at least ~~twenty-five (25)~~ individuals daily at least ~~sixty (60)~~ days out of the year. A transient ~~non community~~ non-community water system is a

public water supply system that generally serves a transient population such as hotels, motels, restaurants, camps, service stations churches, industry, and rest stops.

- (105) ~~“Viable Water System”~~ “Viable water system” means a public water system which has the commitment and the financial, managerial, and technical capacity to consistently comply with the Tennessee Safe Drinking Water Act and these regulations rules.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Subparagraph (a) of paragraph (8) of Rule 0400-45-01-.05 Supervision of Design and Construction is amended by deleting it in its entirety and substituting instead the following:

- (a) Ownership and Operational Organization – No person shall operate a public water system without notifying the Division of Water Supply Resources prior to placing the new system in operation. Any person operating a public water system other than an individual, a municipality, any agency or instrumentality of the United States, any facility owned and operated by the State of Tennessee, or any organization otherwise exempt by law must have a charter or appropriate authorization lawfully issued as set forth in one or more of the following:

Utility District Law of 1937 – T.C.A. §§ 7-82-101 et seq.

Tennessee Business Corporation Act – T.C.A. §§ 48-11-101 et seq.

Tennessee Nonprofit Corporation Act – T.C.A. §§ 48-51-101 et seq.

General Corporation Act – T.C.A. §§ 48-1-101 et seq.

Tennessee Regulatory Authority Regulation of Public Utilities by Commission – T.C.A. §§ 65-4-101 et seq.

Urban Type Public Facilities – T.C.A. §§ 5-16-101 et seq.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Paragraph (13) of Rule 0400-45-01-.05 Supervision of Design and Construction is amended by deleting it in its entirety and substituting instead the following:

- (13) Delegation of Plans Review Authority – Under T.C.A § 68-221-706, any unit of local government may petition the Commissioner for certification to review and approve plans for water distribution facilities within its jurisdiction. The unit of local government must have adequate experience and expertise in water distribution and must adopt standards and impose requirements which are at least as stringent as the Department's. The request for certification must be in writing and contain at least the following:
- (a) The names of the individual(s) responsible for the review and approval together with his/her experience and education. This person(s) must be employed by the unit of local government and be a registered professional engineer in Tennessee.
  - (b) A copy of the standards, requirements and design criteria legally adopted and enforceable by the unit of local government.
  - (c) The type of projects the unit of local government wishes to receive certification to review. This may include but is not limited to water lines, distribution pumping stations and distribution storage tanks.
  - (d) Procedures for maintaining records of all projects reviewed and approved by the unit of local government.
  - (e) The wording to be used on the approval stamp.
  - (f) Plans review authority fee.

The Division of Water Supply Resources will be responsible for reviewing the application for certification and shall have up to 60 days from the receipt of the complete application to make a written response. Units of local government will not be certified to review projects involving state or federal funds, raw water pump stations, new water sources, treatment facilities, sludge handling facilities, or any project designed

by the staff of the local government. Any unit of local government which receives certification for plans review shall submit one copy of any plan documents it has approved to the Division of Water Supply Resources. This shall be done within 10 days of the local government's approval. The commissioner may periodically review the unit of local government's plans review program and prescribe changes as deemed appropriate. The Division of Water Supply Resources may execute a written agreement with a unit of local government which has received plans review certification. Failure to comply with the terms of the agreement may result in revocation of the plans review certification.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Subparagraph (b) of paragraph (1) of Rule 0400-45-01-.14 Laboratory Certification is amended by deleting it in its entirety and substituting instead the following:

- (b) The Tennessee Laboratory Certification Program is established for the purpose of evaluating laboratories to determine technical capability to analyze for one or more groups of the contaminants, disinfectant residuals, disinfection byproducts and disinfectant precursors listed in Rules 0400-45-01-.06 through 0400-45-01-.10, 0400-45-01-.12, 0400-45-01-.21, 0400-45-01-.24 through 0400-45-01-.26, and 0400-45-01-.36 through 0400-45-01-.40. Designation of Department laboratory certification officer(s) shall be from these experienced professional staff members assigned to of the Department of Environment and Conservation, Division of Water Supply Resources and certified by the U.S. Environmental Protection Agency. Certification Officer(s) officer(s) shall supervise the certification program.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Subparagraph (c) of paragraph (1) of Rule 0400-45-01-.14 Laboratory Certification is amended by deleting it in its entirety and substituting instead the following:

- (c) A laboratory desiring certification in microbiological and/or chemical analysis shall make written application to the Department of Environment and Conservation, Division of Water Supply Resources. The applicant shall indicate those group(s) of contaminants for which it seeks certification:

Chemistry

1. General (wet)
2. Inorganic
3. Organic Chemicals
4. Disinfection Byproducts
5. Polychlorinated Biphenyls (PCBs)
6. Radiochemistry
7. Microbiology
  - (i) Enzyme Substrate Coliforms
  - (ii) Membrane Filter Coliforms
  - (iii) Heterotrophic Plate Count
  - (iv) Enterococci

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Subparagraph (c) of paragraph (2) of Rule 0400-45-01-.14 Laboratory Certification is amended by deleting it in its entirety and substituting instead the following:

- (c) On an annual basis and with each application for certification or recertification, all laboratories except Tennessee Public Water Systems public water systems shall convey to the Department, Division of Water Supply Resources, payment for the activities necessary for each group of contaminants for which it desires certification or recertification. All laboratories except Tennessee Public Water Systems public water systems shall pay annually an administrative certification fee as listed in the fee schedule. The fee schedule is as follows:

Fee Type	Fee in Dollars
1. Administrative In-State	\$1000

2.	Administrative Out-of-State Out-of-State	\$750
3.	General Chemistry-Turbidity, Corrosivity, pH	\$500
4.	Inorganics- Trace Metals, Sodium, Nitrite, Nitrate, Fluoride, Sulfate, Cyanide, Asbestos, Chlorite, and Bromate	\$500
5.	Organics	\$500
6.	Disinfection Byproducts-Trihalomethanes and Haloacetic acids	\$500
7.	Polychlorinated Biphenyls (PCB)	\$500
8.	Radiochemistry	\$500
9.	Enzyme Substrate-Total Coliform and E.-Coli	\$500
10.	Membrane Filter- Total Coliform, Fecal Coliform, E.-Coli	\$500
11.	Heterotrophic Plate Count	\$500
12.	Enterococci	\$500

- (i) Certification fees shall be retained by the Department even if the laboratory applying for certification does not qualify for certification.
- (ii) If the certification fee is not paid within 30 days after the receipt of the invoice, certification of the laboratory is automatically revoked.
- (iii) The reinstatement fee for a laboratory that fails to pay its certification fee by the invoice due date shall be \$500 in addition to the fees specified in this subparagraph.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Subparagraph (e) of paragraph (5) of Rule 0400-45-01-.14 Laboratory Certification is amended by deleting it in its entirety and substituting instead the following:

- (e) Failure to report to the Department ~~on Departmental forms~~ analytical results as specified by Rule 0400-45-01-.18. Analytical results must be submitted on forms furnished by the Department. Forms may be obtained from the Division of Water Supply Resources. A certified laboratory shall submit results of its analyses to both the appropriate Department's field office and the Department's central office ~~on forms furnished by the Department.~~

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Paragraph (1) of Rule 0400-45-01-.17 Operation and Maintenance Requirements is amended by deleting it in its entirety and substituting instead the following:

- (1) (a) All community water systems which are designated as a surface supply or groundwater under the direct influence of surface water and classified as a filtration system and all iron removal plants which use gravity filters must have an operator in attendance and responsible for the treatment process when the plant is in operation. Gravity iron removal plants and groundwater under the direct influence of surface water filtration plants which have installed continuous monitoring equipment including equipment for turbidity and chlorine residual with alarms and/or shutdown ability may seek written approval from the Department to operate the treatment plant in an automated mode without an operator in attendance. All iron removal plants with pressure filters and using a ~~ground-water~~ groundwater source from an approved sand and gravel formation will not be required to have an operator in attendance during all periods of operation provided suitable protection, acceptable to the Department, is provided.
- (b) Non-community water systems which are classified as a surface supply will be required to have a full time operator in attendance unless certain continuous monitoring equipment is installed.
- (c) Pursuant to T.C.A. § 68-221-904, all operators in direct responsible charge of a water supply system, including the treatment plant and/or distribution system, must be certified by the Department as competent to operate ~~same~~ the water supply system.
- (d) Because the proper operation and maintenance of water systems is critical to a system's ability to provide safe water to the public and to comply with these rules, all water supply systems must

comply with the provisions of Chapter 0400-49-01. A violation of those rules is a violation of this rule as well.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Paragraph (2) of Rule 0400-45-01-.17 Operation and Maintenance Requirements is amended by deleting it in its entirety and substituting instead the following:

- (2) (a) All community water systems and those non-community water systems classified as a surface source shall compile and maintain accurate daily operating records of the water works system on forms prepared and furnished by the Department. The daily operating records shall be submitted in a timely manner so they are received by the Department no later than ten days after the end of the reporting month. Any special reports, deemed necessary by the Department to assure continuous satisfactory operation of the water system, shall be submitted to the Department.
- (b) Water systems which desire to use their own forms to report the daily operating results to the Department must have prior written approval of the form from the Department.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Paragraph (6) of Rule 0400-45-01-.17 Operation and Maintenance Requirements is amended by deleting it in its entirety and substituting instead the following:

- (6) (a) Pursuant to T.C.A. § 68-221-711(6), the installation, allowing the installation, or maintenance of any cross-connection, auxiliary intake, or bypass is prohibited unless the source and quality of water from the auxiliary supply, the method of connection, and the use and operation of such cross-connection, auxiliary intake, or bypass has been approved by the Department. The arrangement of sewer, soil, or other drain lines or conduits carrying sewage or other wastes in such a manner that the sewage or waste may find its way into any part of the public water system is prohibited.
- (b) 1. All community water systems must adopt an ordinance or policy ~~prohibiting all of the above~~ outlining the prohibitions in subparagraph (a) of this paragraph and submit a copy of the executed ordinance or policy to the Department for written approval. All community water systems shall develop a written plan for a cross-connection control program to detect and eliminate or protect the system from hazards associated with cross-connections. The written plan must be approved by the Department.
2. After adoption and approval of the cross-connection ordinance or policy and plan, each community water system must establish an ongoing program ~~for the detection and elimination of~~ to detect and eliminate or protect the system from hazards associated with cross-connections. Records of the cross-connection control program must be maintained by the supplier of water ~~supplier~~ and shall include such items as date of inspection, person contacted, recommendations, follow-up, and testing results.
- (a) 3. ~~Public water systems must develop and implement an ongoing cross-connection program. Cross-connection plans and policies shall present all information in conformance with the~~ "Cross-Connection Control Manual and Design Criteria for Community Public Water Systems Cross-Connection Control Plans, Ordinances and Policies" as published by the Department.
- (b) 4. ~~The public water system~~ Community water systems shall ensure that cross-connections between the distribution system and a consumer's plumbing are surveyed and/or inspected and determined not to exist or contain a significant risk or are eliminated or controlled by the installation of an approved backflow preventer commensurate with the degree of hazard.
5. Non-community water systems shall ensure that unprotected cross-connections are not allowed to exist within the water system. The non-community water system shall conduct periodic inspections of the water system and maintain a statement of inspection

completion to include acknowledgement of the hazards associated with cross-connections.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Paragraph (7) of Rule 0400-45-01-.17 Operation and Maintenance Requirements is amended by deleting it in its entirety and substituting instead the following:

- (7) All community water system ~~systems~~ shall prepare and maintain an emergency operations plan in order to safeguard the water supply and to alert the public of unsafe drinking water in the event of natural or man-made disasters. Emergency operation plans shall be consistent with guidelines established by the Department and shall be reviewed and approved in writing by the Department. Systems shall include a drought management plan as a part of the emergency operations plan. The emergency operations plan, including the drought management portion, shall be reviewed, updated, and submitted to the Department at least once every three years. The drought management ~~plans~~ plan portions of the emergency operations shall be submitted for approval as follows:
- (a) Systems serving 3,000 or more connections including consecutive systems: June 30, 2016.
  - (b) Systems serving more than 1,000 connections and less than 3,000 connections including consecutive systems: June 30, 2017.
  - (c) Systems serving 1,000 connections or less: June 30, 2018.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Paragraph (8) of Rule 0400-45-01-.17 Operation and Maintenance Requirements is amended by deleting it in its entirety and substituting instead the following:

- (8) (a) General-Public water systems, construction contractors, and engineers shall follow and document sanitary practices used in inspecting, constructing or repairing water lines, finished water storage facilities, filters water treatment facilities, and wells. ~~In lieu of writing their own disinfection standard operating procedures, public~~ Public water systems, construction contractors, and engineers and contractors may chose to shall follow the latest edition of the AWWA standards C-651, C-652, C-653, C-654, or equivalent methods provided the method has been approved in writing by the department Department and is available during the inspection, construction, maintenance, or repair activity. ~~In lieu of following AWWA standards or approved equivalent methods, public water systems, construction contractors, and engineers may write their own disinfection standard operating procedures. Disinfection standard operating procedures shall be approved in writing by the Department and be available during the inspection, construction, maintenance, or repair activity.~~

The documentation shall include disinfection procedures used, bacteriological sample results, construction logs, ~~standard operating procedures and repair logs~~ and may include photographs where appropriate. All wells, pipes, tanks, filters, filter media and other materials shall be properly disinfected prior to being placed in service. Any disinfectant used to disinfect shall be NSF approved or plain household bleach and used in a manner that assures sufficient contact time and concentration to inactivate any pathogens present. Bacteriological results including line repair records indicating adequacy of disinfection shall be maintained on file by the public water system for five years. ~~All public water systems, contractors, and engineers shall prepare and follow standard disinfection procedures approved by the Department when inspecting, maintaining, repairing or constructing lines, tanks, filters and wells. Procedures to ensure that water containing excessive concentrations of disinfectant is not supplied to the customers or discharged in such manner as to harm the environment shall be implemented.~~

All materials used for new or repaired water lines, storage facilities, ~~filters, filter media,~~ water treatment facilities, and wells will be inspected prior to use for any evidence of gross contamination. Any contamination observed shall be removed and the materials protected during installation.

- (b) ~~Disinfection Bacteriological Sampling of New Facilities-Bacteriological samples will be collected and analyzed to verify the effectiveness of the disinfection practices prior to placing new facilities in service. Bacteriological samples shall be collected to determine the effectiveness of the installation process including protecting the pipe material during storage, installation, and disinfection. Bacteriological samples for finished water storage facilities, water treatment facilities, and wells shall be collected as specified by AWWA standards C-652, C-653, and C-654.~~

~~This can be Adequacy of disinfection of new lines shall be demonstrated by collecting two sets of microbiological samples 24 hours apart or collecting a single set of microbiological samples 48 hours or longer after flushing the highly chlorinated water from the lines. In either case microbiological samples in each set will be collected at approximately 2,500-foot intervals with samples near the beginning point, and at the end point, and at the end of each branch line, unless written approval of alternate sampling frequency and distance between sampling points approval has been obtained from the Department. Where sanitary conditions were not maintained before, during or after construction, an additional bacteriological sample shall be collected from a location representing the water from the contaminated area. Unsanitary conditions include failure to document the sanitary handling of materials, to conduct construction inspections and to maintain records, and to document sanitary practices during construction and other hazards such trench flooding during construction. If the newly constructed facility yields positive bacterial samples, additional flushing, disinfection and bacteriological sampling shall be repeated until the water is coliform free the line shall be flushed, and re-sampled. If subsequent samples are positive, the line shall be re-disinfected, flushed and sampled again.~~

- (c) ~~Disinfection Bacteriological Sampling of Existing Facilities-Drinking water mains, Facilities~~

~~1. Finished water storage facilities, and filters water treatment facilities, and wells that have been partially dewatered compromised and potential contamination is introduced during inspection or repair shall, after the repair or inspection is completed, be disinfected, and flushed prior to placing it back in service be disinfected, flushed, and sampled as specified by AWWA standards C-652, C-653, and C-654. Bacteriological samples shall be collected immediately or as soon as possible after the repair is completed and from a location representing the water contained in the repaired line, tank or filter compromised facility. The repaired facility may be returned to service prior to obtaining bacteriological results. If the repaired facility yields positive bacterial samples, additional flushing, disinfection and bacteriological sampling shall be repeated until the water is coliform free.~~

~~2. Drinking water mains where positive pressure has not been maintained during inspection or repair shall be disinfected and flushed prior to being placed back in service. Disinfection and flushing shall be in accordance with AWWA standard C-651 or other method approved in writing by the Department. Bacteriological samples shall be collected immediately after the repair is completed and from a location representing the water contained in the repaired main. The repaired main may be returned to service prior to obtaining bacteriological results. If the repaired main has been placed back into service and yields positive bacteriological samples, the main shall be flushed and re-sampled. One sample is to be collected at the original positive site, one sample is to be collected upstream of the repair and one sample is to be collected in the downstream area of the repair. Sampling shall continue until the water is coliform free.~~

~~4.3. If one-half or more of either the original or repeat bacteriological samples collected from the repaired or renovated facility are total coliform positive, the system shall notify the Department within 30 days that it has reviewed its disinfection and sampling practices in an attempt to identify why the positive samples occurred and revise its disinfection and sampling plans accordingly.~~

~~2.4. If any public water system collects a fecal coliform positive repeat sample or e-coli E-coli positive repeat sample or a total coliform positive repeat sample following an initial positive fecal coliform or e-coli E-coli sample collected from the repaired or renovated facility, the system shall notify the Department within 24 hours 24 hours and issue a tier Tier 1 public notice using the language specified in Appendix B of Rule 0400-45-01-.19.~~

- (d) Inspectors, contractors, operators, public water systems or engineers that fail to document and follow adequate disinfection procedures, and fail to collect bacteriological samples during repairs, inspections or maintenance activities that potentially would compromise the microbial quality of the water shall issue a boil water advisory to the customers served by that portion of the public water system prior to returning the facility to service. The boil water advisory shall remain in effect until satisfactory microbial tests results and written approval from the Department are obtained.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Paragraph (15) of Rule 0400-45-01-.17 Operation and Maintenance Requirements is amended by deleting it in its entirety and substituting instead the following:

- (15) All community water systems serving 50 or more service connections must have and maintain up-to-date maps of the distribution system. These maps must show the locations of the water mains, sizes of mains, valves, blow-offs or flush hydrants, air-release valves, and fire hydrants. One up-to-date copy of the overall system distribution map(s) is to be submitted to the Division of Water Supply Resources every five years.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Paragraph (20) of Rule 0400-45-01-.17 Operation and Maintenance Requirements is amended by deleting it in its entirety and substituting instead the following:

- (20) Each public water system adjusting the fluoride content to the finished water must monitor for fluoride quarterly using a certified laboratory and the calculation of the fluoride level will be by running annual average. If the quarterly analysis of a water sample from a public water system by a certified laboratory confirms that the level of fluoride in the sample exceeds 1.5 mg/L, the public water system must provide notification to its customers of the exceedance in the same manner as prescribed in paragraph (8) of Rule 0400-45-01-.19. The water system must begin monthly fluoride monitoring using a certified laboratory for analysis. Once the monthly analyses confirm that the fluoride level is less than 1.5 mg/L for three (3) consecutive months, the public water system may resume quarterly monitoring for fluoride.

The recommended level of fluoridation in the finished water is 0.7 mg/l. Any public water system which determines to initiate or permanently cease fluoridation treatment of its water supply shall notify its customers, the local environmental field office within the department of environment and conservation Department of Environment and Conversation, and the commissioner of the department of health of its decision to discontinue fluoridation Commissioner of the Department of Health in the manner and within the timeframe as specified by T.C.A. § 68-221-708(c).

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Paragraph (33) of Rule 0400-45-01-.17 Operation and Maintenance Requirements is amended by deleting it in its entirety and substituting instead the following:

- (33) All public water systems shall properly maintain their distribution system finished water storage tanks and clearwells. Each community water system shall establish and maintain a maintenance file on each of its finished water and distribution storage tanks and clearwells. These maintenance files must be available for inspection by Department personnel. These files must include the dates and results records of all routine water storage tank and clearwell inspections by system personnel, any reports of detailed professional inspections of the water storage tanks facilities by contractor personnel, dates and details of routine tank cleanings and surface flushings, and dates and details of all tank and clearwell maintenance activities. The tank and clearwell inspection records shall include dates of the inspections; the sanitary, coating and structural conditions of the tank water storage facility; and all recommendations for needed maintenance activities. Community Water Systems water systems shall have a professional inspection performed and a written report produced on each of their finished water and distribution storage tanks and clearwells at least once every five years. Non-community water systems shall have a professional inspection performed and written report performed produced on each of their atmospheric pressure finished water and distribution storage tanks and clearwells no less frequently than every five years. Records of these inspections shall be available to the Department personnel for inspection. Persons

conducting underwater inspections of distribution system finished water storage tanks and clearwells shall comply with AWWA standard ~~C652-92~~ C-652-11 or later versions of the standard.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Paragraph (41) of Rule 0400-45-01-.17 Operation and Maintenance Requirements is amended by deleting it in its entirety and substituting instead the following:

- (41) Verifications for benchtop turbidimeters are comparisons to approved reference materials. Verifications for continuous turbidimeters are comparisons to approved reference materials or comparisons to a properly calibrated benchtop turbidimeter. Secondary reference materials are assigned a value immediately after acceptable primary calibration has been completed. Acceptable verifications for turbidity measurements greater than 0.5 NTU must agree within  $\pm 10\%$  from the reading assigned to the reference material after primary calibration. Acceptable verifications for measurements 0.5 NTU or less must be within  $\pm 0.05$  NTU or less from the reading assigned to the reference material after primary calibration. When comparisons are made from a continuous turbidimeter to a benchtop turbidimeter, the continuous measurement must be within  $\pm 10\%$  of the benchtop reading for measurements above 0.5 NTU and  $\pm 0.05$  NTU for reading 0.5 NTU or less. When acceptable verifications are not achieved the instrument must be re-calibrated with primary standards according to paragraph (40) of this rule. Approved reference materials for benchtop and continuous turbidimeters are primary standards and materials suggested by the manufacturer such as sealed sample cells filled with metal oxide particles in a polymer gel and turbid glass tubes. ~~The 0.5 NTU ICE PICTM from Hach is an approved reference material for secondary turbidity verifications for Hach continuous turbidimeters when utilized as per Manufacturers' recommendations.~~ All other reference materials for turbidimeter verifications must be approved in writing by the Department. Verifications for turbidimeters must be performed according to the following:
- (a) Verification of benchtop turbidimeters must be performed daily and documented. Verifications must include a sample in the expected working range of the instrument or as close to the working range as possible. Documentation must include: assigned reference material value after calibration, recorded daily reading for all reference standards, instrument identification, and date.
  - (b) Combined filter effluent turbidimeters as required by part (5)(c)1 of Rule 0400-45-01-.31 must be verified daily and documented. When reference material is utilized documentation must include: instrument identification, date, assigned reference material value after calibration, and daily value for reference material. When comparisons to benchtop turbidimeters are utilized documentation must include: instrument identification, date, continuous turbidimeter value, and benchtop turbidimeter value.
  - (c) Individual filter turbidimeters as required by part (5)(c)4 of Rule 0400-45-01-.31 must be verified weekly.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Rule 0400-45-01-.18 Reporting Requirements is amended by adding a new paragraph (9) to read as follows:

- (9) Electronic Reporting. A person is required to submit reports and certifications to the Department in order for a person to comply with this rule chapter (0400-45-01). The Commissioner may make forms available electronically or allow these reports to be submitted electronically and, if submitted electronically, then that electronic submission shall comply with the requirements of Chapter 0400-01-40.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

APPENDIX A TO Rule 0400-45-01-.19 NPDWR VIOLATIONS AND OTHER SITUATIONS REQUIRING PUBLIC NOTICE immediately following part 3 of subparagraph (d) of paragraph (11) of Rule 0400-45-01-.19 Notification of Customers is amended by deleting it its entirety and substituting instead the following:

APPENDIX A TO Rule 0400-45-01-.19

NPDWR VIOLATIONS AND OTHER SITUATIONS REQUIRING PUBLIC NOTICE<sup>1</sup>

Contaminant	MCL/MRDL/TT violations <sup>2</sup>		Monitoring & testing procedure violations	
	Tier of public notice required	Citation	Tier of public notice required	Citation
I. Violations of National Primary Drinking Water Regulations (NPDWR): <sup>3</sup>				
A. Microbiological Contaminants				
1. a. Total coliform bacteria †	2	0400-45-01-.06(4)(a)	3	0400-45-01-.07(1) and (2); <del>0400-45-01-.41(10)(c) through (d)</del> 0400-45-01-.07(3) through (4); 0400-45-01-.06(4)(c)
1. b. Total coliform (TT violations resulting from failure to perform assessments or corrective actions, monitoring violations, and reporting violations) ‡	2	0400-45-01-.41(10)(a) through (b)1	3	0400-45-01-.41(10)(c) through (d)
1. c. Seasonal system failure to follow Department-approved start-up plan prior to serving water to the public or failure to provide certification to the Department. ‡	2	0400-45-01-.41(10)(b)2	3	0400-45-01-.41(10)(d)3
2. a. Fecal coliform/E. coli †	1	0400-45-01-.06(4)(b)	<sup>4</sup> 1,3	0400-45-01-.07(1) and (2) 0400-45-01-.06(4)(c)
2. b. E. coli ‡	1	0400-45-01-.41(10)(a)	3	0400-45-01-.41(10)(c) 0400-45-01-.41(10)(d)1 and 2
2. c. E. coli (TT violations resulting from failure to perform level 2 assessments or corrective action) ‡.	2	0400-45-01-.41(10)(b)1		
3. Turbidity MCL	2	0400-45-01-.06(3)(a)	3	0400-45-01-.08
4. Turbidity MCL(average of 2 days' samples > 2 NTU)	<sup>5</sup> 2,1	0400-45-01-.06(3)(b)	3	0400-45-01-.08
5. Turbidity (for TT violations resulting from a Single exceedance of maximum allowable turbidity level)	<sup>6</sup> 2,1	0400-45-01-.31(2)(a) 0400-45-01-.31(2)(a) 0400-45-01-.31(4)(a)2 0400-45-01-.31(4)(b)2 0400-45-01-.31(4)(b)2 0400-45-01-.31(4)(b)2	3	0400-05-01-.31 0400-45-01-.31 0400-45-01-.31 0400-45-01-.31
6. Surface Water Treatment Rule violations other than violations resulting from single exceedance of max. allowable turbidity level (TT) [0400-45-01-.31(4)]	2	0400-05-01-.31(1)-(4)	3	0400-45-01-.31(4)
7. Interim Enhanced Surface Water Treatment Rule violations, other than violations resulting from single exceedance of max turbidity level (TT) [0400-45-01-.31(4)]	<sup>7</sup> 2	0400-45-01-.31(1)-(4)	3	0400-45-01-.31(4)
8. Filter Backwash Recycling Rule Violations	2	0400-05-01-.31(9)	3	0400-45-01-.31(9)(b) and (d)
9. Long term 1 Enhanced Surface Water Treatment Rule Violations	2	0400-45-01-.31(4)	3	0400-45-01-.31(6)
10. LT2ESWTR violation	2	0400-45-01-.39(11)-(21)	<sup>22</sup> 2,3	0400-45-01-.39(2)-(6) 0400-45-01-.39(9)-(10)

11. Ground Water Rule violations	2	Rule 0400-45-01-.40(5)	3	0400-45-01-.40(3)(m) 0400-45-01-.40(4)(d)
<b>B. Inorganic Chemicals (IOCs)</b>				
1. Antimony	2	0400-45-01-.06(1)(b)1	3	0400-45-01-.09
2. Arsenic	2	<sup>9</sup> 0400-45-01-.06(1)(b)2	3	<sup>11</sup> 0400-45-01-.09
3. Asbestos (fibers >10 µm)	2	0400-45-01-.06(1)(b)3	3	0400-45-01-.09
4. Barium	2	0400-45-01-.06(1)(b)5	3	0400-45-01-.09
5. Beryllium	2	0400-45-01-.06(1)(b)4	3	0400-45-01-.09
6. Cadmium	2	0400-45-01-.06(1)(b)6	3	0400-45-01-.09
7. Chromium (total)	2	0400-45-01-.06(1)(b)7	3	0400-45-01-.09
8. Cyanide	2	0400-45-01-.06(1)(b)8	3	0400-45-01-.09
9. Fluoride	2	0400-45-01-.06(1)(b)9	3	0400-45-01-.09
10. Mercury (inorganic)	2	0400-45-01-.06(1)(b)10	3	0400-45-01-.09
11. Nickel	2	0400-45-01-.06(1)(b)11	3	0400-45-01-.09
12. Nitrate	1	0400-45-01-.06(1)(b)12	<sup>12</sup> 1,3	0400-45-01-.09
13. Nitrite	1	0400-45-01-.06(1)(b)13	<sup>12</sup> 1,3	0400-45-01-.09
14. Total Nitrate and Nitrite	1	0400-45-01-.06(1)(b)14	3	0400-45-01-.09
15. Selenium	2	0400-45-01-.06(1)(b)15	3	0400-45-01-.09
16. Thallium	2	0400-45-01-.06(1)(b)16	3	0400-45-01-.09
<b>C. Lead and Copper Rule (Action Level for lead is 0.015 mg/L, for copper is 1.3 mg/L)</b>				
1. Lead and Copper Rule (TT)	2	0400-45-01-.33(1)-(6)	3	0400-45-01-.33
<b>D. Synthetic Organic Chemicals (SOCs)</b>				
1. 2,4-D	2	0400-45-01-.06(2)(a)6	3	0400-45-01-.10
2. 2,4,5-TP (Silvex)	2	0400-45-01-.06(2)(a)14	3	0400-45-01-.10
3. Alachlor	2	0400-45-01-.06(2)(a)1	3	0400-45-01-.10
4. Atrazine	2	0400-45-01-.06(2)(a)2	3	0400-45-01-.10
5. Benzo(a)pyrene (PAHs)	2	0400-45-01-.06(2)(a)16	3	0400-45-01-.10
6. Carbofuran	2	0400-45-01-.06(2)(a)3	3	0400-45-01-.10
7. Chlordane	2	0400-45-01-.06(2)(a)4	3	0400-45-01-.10
8. Dalapon	2	0400-45-01-.06(2)(a)17	3	0400-45-01-.10
9. Di (2-ethylhexyl) adipate	2	0400-45-01-.06(2)(a)18	3	0400-45-01-.10
10. Di (2-ethylhexyl) phthalate	2	0400-45-01-.06(2)(a)19	3	0400-45-01-.10
11. Dibromochloropropane	2	0400-45-01-.06(2)(a)5	3	0400-45-01-.10
12. Dinoseb	2	0400-45-01-.06(2)(a)20	3	0400-45-01-.10
13. Dioxin (2,3,7,8-TCDD)	2	0400-45-01-.06(2)(a)29	3	0400-45-01-.10
14. Diquat	2	0400-45-01-.06(2)(a)21	3	0400-45-01-.10
15. Endothall	2	0400-45-01-.06(2)(a)22	3	0400-45-01-.10
16. Endrin	2	0400-45-01-.06(2)(a)30	3	0400-45-01-.10
17. Ethylene Dibromide	2	0400-45-01-.06(2)(a)7	3	0400-45-01-.10
18. Glyphosate	2	0400-45-01-.06(2)(a)23	3	0400-45-01-.10
19. Heptachlor	2	0400-45-01-.06(2)(a)8	3	0400-45-01-.10
20. Heptachlor epoxide	2	0400-45-01-.06(2)(a)9	3	0400-45-01-.10
21. Hexachlorobenzene	2	0400-05-01-.06(2)(a)24	3	0400-45-01-.10
22. Hexachlorocyclo-pentadiene	2	0400-45-01-.06(2)(a)25	3	0400-45-01-.10
23. Lindane	2	0400-45-01-.06(2)(a)10	3	0400-45-01-.10
24. Methoxychlor	2	0400-05-01-.06(2)(a)11	3	0400-45-01-.10
25. Oxamyl (Vydate)	2	0400-45-01-.06(2)(a)26	3	0400-45-01-.10
26. Pentachlorophenol	2	0400-45-01-.06(2)(a)15	3	0400-45-01-.10

27. Picloram	2	0400-45-01-.06(2)(a)27	3	0400-45-01-.10
28. Polychlorinated biphenyls (PCBs)	2	0400-45-01-.06(2)(a)12	3	0400-45-01-.10
29. Simazine	2	0400-45-01-.06(2)(a)28	3	0400-45-01-.10
30. Toxaphene	2	0400-45-01-.06(2)(a)13	3	0400-45-01-.10
<b>E. Volatile Organic Chemicals (VOCs)</b>				
1. Benzene	2	0400-45-01-.25(2)(e)	3	0400-45-01-.26
2. Carbon tetrachloride	2	0400-45-01-.25(2)(b)	3	0400-45-01-.26
3. Chlorobenzene (monochlorobenzene)	2	0400-45-01-.25(2)(l)	3	0400-45-01-.26
4. o-Dichlorobenzene	2	0400-45-01-.25(2)(m)	3	0400-45-01-.26
5. p-Dichlorobenzene	2	0400-45-01-.25(2)(h)	3	0400-45-01-.26
6. 1,2-Dichloroethane	2	0400-45-01-.25(2)(d)	3	0400-45-01-.26
7. 1,1-Dichloroethylene	2	0400-45-01-.25(2)(f)	3	0400-45-01-.26
8. cis-1,2-Dichloroethylene	2	0400-45-01-.25(2)(i)	3	0400-45-01-.26
9. trans-1,2-Dichloroethylene	2	0400-45-01-.25(2)(q)	3	0400-45-01-.26
10. Dichloromethane	2	0400-45-01-.25(2)(s)	3	0400-45-01-.26
11. 1,2-Dichloropropane	2	0400-45-01-.25(2)(j)	3	0400-45-01-.26
12. Ethylbenzene	2	0400-45-01-.25(2)(k)	3	0400-45-01-.26
13. Styrene	2	0400-45-01-.25(2)(n)	3	0400-45-01-.26
14. Tetrachloroethylene	2	0400-45-01-.25(2)(o)	3	0400-45-01-.26
15. Toluene	2	0400-45-01-.25(2)(p)	3	0400-45-01-.26
16. 1,2,4-Trichlorobenzene	2	0400-45-01-.25(2)(t)	3	0400-45-01-.26
17. 1,1,1-Trichloroethane	2	0400-45-01-.25(2)(g)	3	0400-45-01-.26
18. 1,1,2-Trichloroethane	2	0400-45-01-.25(2)(u)	3	0400-45-01-.26
19. Trichloroethylene	2	0400-45-01-.25(2)(a)	3	0400-45-01-.26
20. Vinyl chloride	2	0400-45-01-.25(2)(c)	3	0400-45-01-.26
21. Xylenes (total)	2	0400-45-01-.25(2)(r)	3	0400-45-01-.26
<b>F. Radioactive Contaminants</b>				
1. Beta/positron emitters	2	0400-45-01-.06(5)(b)	3	0400-45-01-.11
2. Alpha emitters	2	0400-45-01-.06(5)(a)	3	0400-45-01-.11
3. Combined radium (226 & 228)	2	0400-45-01-.06(5)(a)2	3	0400-45-01-.11
4. Uranium	<sup>92</sup> 2	0400-45-01-.06(5)(c)	<sup>10</sup> -3	0400-45-01-.11
<b>G. Disinfection Byproducts (DBPs), Byproduct Precursors, Disinfectant Residuals.</b> Where Disinfection is used in the treatment of drinking water, disinfectants combine with organic and inorganic matter present in water to form chemicals called disinfection byproducts (DBPs). EPA sets standards for controlling the levels of disinfectants and DBPs in drinking water including trihalomethanes (THMs) and haloacetic acids (HAAs). <sup>13</sup>				
1. Total trihalomethanes (TTHMs)	2	<sup>14</sup> 0400-45-01-.06(6)(b)	3	0400-45-01-.36, .37, and .38
2. Haloacetic Acids (HAA5)	2	0400-45-01-.06(6)(b)	3	0400-45-01-.36, .37 and .38
3. Bromate	2	0400-45-01-.06(6)(a)	3	0400-45-01-.36
4. Chlorite	2	0400-45-01-.06(6)(a)	3	0400-45-01-.36
5. Chlorine (MRDL)	2	0400-45-01-.06(6)(c)	3	0400-45-01-.36
6. Chloramine (MRDL)	2	0400-45-01-.06(6)(c)	3	0400-45-01-.36
7. Chlorine dioxide (MRDL), where any 2 consecutive daily samples at entrance to distribution system only are above MRDL	2	0400-45-01-.36(7)(c)2(ii)	2 <sup>15</sup> , 3	0400-45-01-.36
8. Chlorine dioxide (MRDL), where sample(s) in distribution system the next day are also above MRDL	<sup>16</sup> 1	0400-45-01-.36(7)(c)2(i)	1	0400-45-01-.36
9. Control of DBP precursors—TOC (TT)	2	0400-45-01-.36(7)(d)	3	0400-45-01-.36
10. Bench marking and disinfection profiling	N/A	N/A	3	0400-45-01-.36
11. Development of monitoring plan	N/A	N/A	3	0400-45-01-.36
<b>H. Other Treatment Techniques</b>				
1. Acrylamide (TT)	2	0400-45-01-.17(31)	N/A	N/A
2. Epichlorohydrin (TT)	2	0400-45-01-.17(31)	N/A	N/A
<b>II. Unregulated Contaminant Monitoring:<sup>17</sup></b>				
<b>A. Unregulated contaminants</b>				
B. Nickel	2	0400-45-01-.06(1)(b)11	3	0400-45-01-.09
<b>III. Public Notification for Variances and Exemptions:</b>				
A. Operation under a variance or exemption	3	<sup>18</sup> 0400-45-01-.19(1)	N/A	N/A
B. Violation of conditions of a variance or	2	0400-45-01-.19(1)	N/A	N/A

exemption <sup>19</sup>				
IV. Other Situations Requiring Public Notification:				
A. Fluoride secondary maximum contaminant Level (SMCL) exceedance	3	0400-45-01-.19(1)(a)3(iii)	N/A	N/A
B. Exceedance of nitrate MCL for non-community systems, as allowed by department	1	0400-45-01-.19(1)(a)3(ii)	N/A	N/A
C. Availability of unregulated contaminant monitoring data	3	0400-45-01-.19(7)	N/A	N/A
D. Waterborne disease outbreak	1	0400-45-01-.31(2)(c)2	N/A	N/A
E. Other waterborne emergency <sup>20</sup>	1	N/A	N/A	N/A
F. Other situations as determined by the department	<sup>21</sup> 1, 2, 3	N/A	N/A	N/A
G. Source Water Sample Positive for GWR Fecal indicators: E. coli or enterococci	1	0400-45-01-.40(3)(l)	N/A	N/A

## Appendix A – Endnotes

† Until March 31, 2016

‡ Beginning April 1, 2016

- Violations and other situations not listed in this table (e.g., failure to prepare Consumer Confidence Reports), do not require notice, unless otherwise determined by the department. The department may, at its option, also require a more stringent public notice tier (e.g., Tier 1 instead of Tier 2 or Tier 2 instead of Tier 3) for specific violations and situations listed in this Appendix, as authorized under subparagraphs (2)(a) and (3)(a) of Rule 0400-45-01-19.
- MCL – Maximum contaminant level, MRDL – Maximum residual disinfectant level, TT-Treatment technique.
- The term Violations of National Primary Drinking Water Regulations (NPDWR) is used here to include violations of MCL, MRDL, treatment technique, monitoring, and testing procedure requirements.
- Failure to test for fecal coliform or E.coli is a Tier 1 violation if testing is not done after any repeat sample tests positive for coliform. All other total coliform monitoring and testing procedure violations are Tier 3.
- Systems that violate the turbidity MCL of 2 NTU based on an average of measurements over two consecutive days must consult with the department within 24 hours after learning of the violation. Based on this consultation, the department may subsequently decide to elevate the violation to Tier 1. If a system is unable to make contact with the department in the 24-hour period, the violation is automatically elevated to Tier 1.
- Systems with treatment technique violations involving a single exceedance of a maximum turbidity limit under the Surface Water Treatment Rule, Interim Enhanced Surface Water Treatment Rule, or the Long Term 1 Enhanced Surface Water Treatment Rule (0400-45-01-.31) are required to consult with the Department within 24 hours after learning of the violation. Based on this consultation, the department may subsequently decide to elevate the violation to Tier 1. If a system is unable to make contact with the department in the 24-hour period, the violation is automatically elevated to Tier 1.
- Most of the requirements of the Interim Enhanced Surface Water Treatment Rule 0400-45-01-.31 become effective January 1, 2002 for Subpart H systems (surface water systems and ~~ground-water~~ groundwater systems under the direct influence of surface water) serving at least 10,000 persons. The Surface Water Treatment Rule remains in effect for systems serving at least 10,000 persons even after 2002; the Interim Enhanced Surface Water Treatment Rule adds additional requirements and does not in many cases supersede the SWTR.
- The arsenic MCL citations are effective January 23, 2006, or the effective date of this rule whichever comes first.
- The uranium MCL tier 2 violation citations are effective December 8, 2003 for all community water systems.
- The uranium tier 3 violations are effective December 8, 2003, for all community water systems.
- The arsenic Tier 3 MCL violations are effective January 23, 2006 or the effective date of this rule whichever comes first.
- Failure to take a confirmation sample within 24 hours for nitrate or nitrite after an initial sample exceeds the MCL is a Tier 1 violation. Other monitoring violations for nitrate are Tier 3.
- Subpart H community and non-transient non-community systems serving ≥10,000 must comply with new DBP MCLs, disinfectant MRDLs, and related monitoring requirements beginning January 1, 2002. All other community and non-transient non-community systems must meet the MCLs and MRDLs beginning January 1, 2004. Subpart H transient non-community systems serving 10,000 or more persons and using chlorine dioxide as a disinfectant or oxidant must comply with the chlorine dioxide MRDL beginning January 1, 2002. Subpart H transient non-community systems serving fewer than 10,000 persons and using only ~~ground-water~~ groundwater not under the direct influence of surface water and using chlorine dioxide as a disinfectant or oxidant must comply with the chlorine dioxide MRDL beginning January 1, 2004.
- Paragraph (6) of Rule 0400-45-01-.06 and subparagraphs (5)(a) and (b) of Rule 0400-45-01-.36 apply until paragraphs (1) through (11) of Rule 0400-45-01-.38 take effect under the schedule in subparagraph (1)(c) of Rule 0400-45-01-.38.
- Failure to monitor for chlorine dioxide at the entrance to the distribution system the day after exceeding the MRDL at the entrance to the distribution system is a Tier 2 violation.
- If any daily sample taken at the entrance to the distribution system exceeds the MRDL for chlorine dioxide and one or more samples taken in the distribution system the next day exceed the MRDL, Tier 1 notification is required. Failure to take the required samples in the distribution system after the MRDL is exceeded at the entry point also triggers Tier 1 notification.
- Some water systems must monitor for certain unregulated contaminants.
- This citation refers to §§1415 and 1416 of the Safe Drinking Water Act. §§1415 and 1416 require that “a schedule prescribed... for a public water system granted a variance [or exemption] shall require compliance by the system...”
- In addition to §§1415 and 1416 of the Safe Drinking Water Act, 40 CFR 142.307 specifies the items and schedule milestones that must be included in a variance for small systems.
- Other waterborne emergencies require a Tier 1 public notice under subparagraph (2)(a) of Rule 0400-45-01-.19 for situations that do not meet the definition of a waterborne disease outbreak given in Rule 0400-45-01-.04 but that still have the potential to have serious adverse effects on health as a result of short-term exposure. These could include outbreaks not related to treatment deficiencies, as well as situations that have the potential to cause outbreaks, such as failures or significant interruption in water treatment processes, natural disasters that disrupt the water supply or distribution system, chemical spills, or unexpected loading of possible pathogens onto the source water.

21. The department may place other situations in any tier it believes appropriate, based on threat to public health.
22. Failure to collect three or more samples for cryptosporidium analysis is a Tier 2 violation requiring special notice as specified in paragraph (11) of Rule 0400-45-01-.19. All other monitoring and testing procedure violations are Tier 3.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Part 5 of subparagraph (b) of paragraph (2) of Rule 0400-45-01-.31 Filtration and Disinfection is amended by deleting it in its entirety and substituting instead the following:

5. The public water system must comply with the maximum contaminant level (MCL) for total coliforms and E.coli in paragraph (4) of Rule 0400-45-01-.06. The system must achieve the standard at a frequency of at least 11 months of the 12 previous months that the system served water to the public, on an ongoing basis, unless the Department determines that failure to meet this requirement was not caused by a deficiency in treatment of the source water.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Subparagraph (b) of paragraph (5) of Rule 0400-45-01-.31 Filtration and Disinfection is amended by deleting introductory text and substituting instead the following, while its subsequent parts remain unchanged:

- (b) The A public water system that uses a groundwater source under the direct influence of surface water and does not provide filtration treatment must comply with the maximum contaminant level (MCL) for total coliforms in paragraph (4) of Rule 0400-45-01-.06 and the MCL for E. coli in subparagraph (4)(g) of Rule 0400-45-01-.06. The system must achieve the standard at a frequency of at least 11 months of the 12 previous months that the system served water to the public, on an ongoing basis, unless the Department determines that failure to meet this requirement was not caused by a deficiency in treatment of the source water.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Subparagraph (c) of paragraph (5) of Rule 0400-45-01-.31 Filtration and Disinfection is amended by deleting it in its entirety and substituting instead the following:

- (c) ~~Until March 31, 2016, the residual disinfectant concentration must be measured at least at the same points in the distribution system and at the same time as total coliforms are sampled, as specified in paragraph (1) of Rule 0400-45-01-.07. Beginning April 1, 2016, the residual disinfectant concentration must be measured at least at the same points in the distribution system and at the same time as total coliforms are sampled, as specified in paragraphs (4) through (8) of Rule 0400-45-01-.41. The Department may allow a public water system which uses both a surface water source or a ground water source under direct influence of surface water, and a ground water source, to take disinfectant residual samples at points other than the total coliform sampling points if the Department determines that such points are more representative of treated (disinfected) water quality within the distribution system. Heterotrophic bacteria, measured as heterotrophic plate count (HPC) as specified in part (10)(a)4 of Rule 0400-45-01-.14, may be measured in lieu of residual disinfectant concentration~~ Monitoring requirements for systems using filtration treatment. A public water system that uses a surface water source or a groundwater source under the direct influence of surface water and provides filtration treatment must monitor in accordance with this subparagraph beginning June 29, 1993, or when filtration is installed, whichever is later.

1. Turbidity as required by paragraph (4) of this rule must be continuously measured and recorded on representative samples of the system's combined filtered water while the system serves water to the public. The highest turbidity value obtained during each four-hour period must be reported. A public water system may substitute grab sample monitoring if approved by the Department. For any system using slow sand filtration or filtration treatment other than conventional treatment, direct filtration, or diatomaceous earth filtration, the Department may reduce the sampling frequency to once per day if it determines that less frequent monitoring is sufficient to indicate effective filtration performance. For systems serving 500 or fewer persons, the Department may reduce the turbidity sampling frequency to once per day, regardless of the type of filtration treatment

used, if the Department determines that less frequent monitoring is sufficient to indicate effective filtration performance. The highest turbidity measured each four hours must be reported according to the following four hour segments: 12:01 a.m. to 4:00 a.m., 4:01 to 8:00 a.m., 8:01 to 12 noon, 12:01 to 4:00 p.m., 4:01 p.m. to 8:00 p.m., 8:01 to 12 midnight. The intake of the combined filter effluent turbidity monitor shall be located at or near the entry point to the clearwell or at a location approved by the Department.

2. The residual disinfectant concentration of the water entering the distribution system must be monitored continuously, and the lowest value must be recorded each day. If there is a failure in the continuous monitoring equipment, grab sampling every 4 four hours may be conducted in lieu of continuous monitoring, but for no more than 5 five working days following the failure of the equipment. Systems serving 3,300 or fewer persons may take grab samples each day in lieu of providing continuous monitoring on an ongoing basis at the frequencies prescribed below:

System Size by Population	Samples/ day <sup>1</sup>
≤500	1
501 to 1,000	2
1,001 to 2,500	3
2,501 to 3,300	4

<sup>1</sup>The day's samples cannot be taken at the same time. The sampling intervals are subject to Department review and approval.

If at any time the free residual disinfectant concentration falls below 0.2 mg/l in a system using grab sampling in lieu of continuous monitoring, the system must take a grab sample every 4 four hours until the free residual disinfectant concentration is equal to or greater than 0.2 mg/l.

3. The Until March 31, 2016, the residual disinfectant concentration must be measured at least at the same points in the distribution system and at the same time as total coliforms are sampled, as specified in paragraph (1) of Rule 0400-45-01-.07. Beginning April 1, 2016, the residual disinfectant concentration must be measured at least at the same points in the distribution system and at the same time as total coliforms are sampled, as specified in paragraphs (4) through (8) of Rule 0400-45-01-.41. The Department may allow a public water system which uses both a surface water source or a ground-water groundwater source under direct influence of surface water, and a ground-water groundwater source to take disinfectant residual samples at points other than the total coliform sampling points if the Department determines that such points are more representative of treated (disinfected) water quality within the distribution system. Heterotrophic bacteria, measured as heterotrophic plate count (HPC) as specified in part (10)(a)4 of Rule 0400-45-01-.14, may be measured in lieu of residual disinfectant concentration.
4. In addition to monitoring required by parts 1, 2 and 3 of this subparagraph, a subpart H system serving 10,000 or more persons using conventional filtration treatment or direct filtration must conduct continuous monitoring of turbidity for each individual filter using an approved method in subparagraph (10)(b) of Rule 0400-45-01-.14 and must calibrate turbidimeters using the procedure specified in paragraphs (40) and (41) of Rule 0400-45-01-.17. Systems must record the results of individual filter monitoring every 15 minutes. In addition to monitoring required by parts 1, 2 and 3 of this subparagraph by January 14, 2005, a subpart H system serving fewer than 10,000 persons using conventional filtration treatment or direct filtration must conduct continuous monitoring of turbidity for each individual filter using an approved method in subparagraph (10)(b) of Rule 0400-45-01-.14 and must calibrate turbidimeters using the procedure specified in paragraphs (40) and (41) of Rule 0400-45-01-.17. Systems must record the results of individual filter monitoring every 15 minutes.
5. If there is a failure in the continuous turbidity monitoring equipment, the system must conduct grab sampling every four hours in lieu of continuous monitoring until the

turbidimeter is repaired and back on-line. A system has a maximum of five working days after failure to repair the equipment or it is in violation.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Part 2 of subparagraph (a) of paragraph (7) of Rule 0400-45-01-.33 Control of Lead and Copper is amended deleting it in its entirety and substituting instead the following:

2. A public water system shall review at least the information on lead, copper, and galvanized steel under paragraph (4) (1) of Rule 0400-45-01-.21 when conducting a materials evaluation. When an evaluation of the information collected pursuant to paragraph (4) (1) of Rule 0400-45-01-.21 is insufficient to locate the requisite number of lead and copper sampling sites that meet the targeting criteria in subparagraph (a) of this paragraph, the water system shall review at least the sources of information listed below in order to identify a sufficient number of sampling sites. In addition, the system shall seek to collect such information in the course of its normal operations (e.g., checking service line materials when reading water meters or performing maintenance activities):
  - (i) ~~a#~~ All plumbing codes, permits, and records in the files of the building department(s) which indicate the plumbing materials that are installed within publicly and privately owned structures connected to the distribution system;
  - (ii) ~~a#~~ All inspections and records of the distribution system that indicate the material composition of the service connections that connect a structure to the distribution system; and
  - (iii) ~~a#~~ All existing water quality information, which includes the results of all prior analyses of the system or individual structures connected to the system, indicating locations that may be particularly susceptible to high lead or copper concentrations.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Part 4 of subparagraph (a) of paragraph (2) of Rule 0400-45-01-.34 Drinking Water Source Protection is amended by deleting it in its entirety and substituting instead the following:

4. Wellhead Protection Plan: The Plan to be provided by Category 1 PWS shall consist of the required photographs, Zone 1 and 2 marked on the topographic map, the contaminant source inventory, and the steps the PWS is taking to protect the area within Zone 1. The steps must include plans for hazardous chemical storage on the property, hazardous chemical use within Zone 1, plans for spill response and may include posting as a wellhead protection area in the immediate vicinity of the well or spring. Other provisions may also be included. Two copies of the Plan shall be provided to the Division of Water ~~Supply~~ Resources.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Subpart (i) of part 4 of subparagraph (b) of paragraph (2) of Rule 0400-45-01-.34 Drinking Water Source Protection is amended by deleting it in its entirety and substituting instead the following:

- (i) The Plan to be provided by Category 2 PWS shall consist of the required photographs, zones 1 and 2 marked on a topographic map, the contaminant source inventory and the steps the PWS is taking to protect/manage the wellhead protection area. The steps must include plans for hazardous chemical storage on the property, hazardous chemical use within Zones 1 and 2 and spill response notification in Zone 1. Other steps may be included such as proposed local ordinances. Two copies of the Plan shall be provided to the Division of Water ~~Supply~~ Resources.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Subpart (i) of part 5 of subparagraph (b) of paragraph (2) of Rule 0400-45-01-.34 Drinking Water Source Protection is amended by deleting it in its entirety and substituting instead the following:

- (i) The PWS shall submit to the Division of Water ~~Supply~~ Resources copies of the letters and other documentation to verify and document the compliance with part 5 of this subparagraph.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Subpart (i) of part 4 of subparagraph (c) of paragraph (2) of Rule 0400-45-01-.34 Drinking Water Source Protection is amended by deleting it in its entirety and substituting instead the following:

- (i) The Plan to be provided by Category 3 PWS shall consist of the required photographs, Zones 1 and 2 marked on a topographic map, the contaminant source inventory, and the steps the PWS is taking to protect/manage the wellhead protection area. The steps must at least include plans for hazardous chemical storage on the property, hazardous chemical use within Zones 1 and 2, spill response notification in Zone 1 and proposed local ordinances in cooperation with the city or county government or county/ regional planning commission. Two copies of the Plan must be provided to the Division of Water Supply Resources.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Subpart (i) of part 4 of subparagraph (d) of paragraph (2) of Rule 0400-45-01-.34 Drinking Water Source Protection is amended by deleting it in its entirety and substituting instead the following:

- (i) The Plan to be provided by Category 4 PWS shall consist of the required photographs, Zones 1 and 2 marked on a topographic map, the contaminant source inventory, and the steps the PWS is taking to protect/manage the wellhead protection area. The steps must, at least, include plans for hazardous chemical storage on the property, hazardous chemical use within Zones 1 and 2, spill response notification in Zone 1 and proposed local ordinances in cooperation with the city or county government or county/regional planning commission. Two copies of the Plan shall be provided to the Division of Water Supply Resources.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Subparagraph (c) of paragraph (3) of Rule 0400-45-01-.34 Drinking Water Source Protection is amended by deleting it in its entirety and substituting instead the following:

- (c) New PWS wells must receive site approval from the Department before drilling. New well approval is conditioned upon the PWS complying with all applicable ~~Drinking Water Source Regulations~~ drinking water source approval requirements. Approval of new wells by the Division of Water Supply Resources will depend on the ability of the PWS to provide the highest degree of reliable control of the area. The Department may deny its approval for new wells to be put into service if these requirements cannot be met.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Part 2 of subparagraph (b) of paragraph (3) of Rule 0400-45-01-.40 Ground Water Rule is amended by deleting it in its entirety and substituting instead the following:

- 2. If approved by the Department, systems with more than one ~~ground-water~~ groundwater source may meet the requirements of this subparagraph by sampling representative ~~ground-water~~ groundwater source or sources. If directed by the Department, systems must submit for Department approval a triggered source water monitoring plan that identifies one or more ~~ground-water~~ groundwater sources that are representative of each

monitoring site in the system's sample siting plan under paragraph (1) of Rule 0400-45-01-.07 until March 31, 2016 or under paragraph (3) of Rule 0400-45-01-.41 beginning April 1, 2016, and that the system intends to use for representative sampling under this paragraph.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Part 2 of subparagraph (f) of paragraph (4) of Rule 0400-45-01-.41 Revised Total Coliform Rule is amended by deleting it in its entirety and substituting instead the following:

2. A seasonal system must monitor every month that it is in operation unless it meets the criteria in subparts (i), ~~(ii)~~, and ~~(iii)~~ (iii) of this part to be eligible for monitoring less frequently than monthly beginning April 1, 2016, except as provided under subparagraph (c) of this paragraph.
  - (i) Seasonal systems monitoring less frequently than monthly must have an approved sample siting plan that designates the time period for monitoring based on site-specific considerations (e.g., during periods of highest demand or highest vulnerability to contamination). Seasonal systems must collect compliance samples during this time period.
  - (ii) To be eligible for quarterly monitoring, the system must meet the criteria in subparagraph (e) of this paragraph.
  - (iii) To be eligible for quarterly monitoring and remain on a reduced monitoring schedule, the system must serve 1,000 or less persons per month.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Subparagraph (d) of paragraph (5) of Rule 0400-45-01-.41 Revised Total Coliform Rule is amended by deleting it in its entirety.

- ~~(d) Additional routine monitoring the month following a total coliform positive sample. Non-community systems monitoring quarterly must collect at least three routine samples during the next month following one or more total coliform positive samples (with or without a Level 1 treatment technique trigger). Systems may either collect samples at regular time intervals throughout the month or may collect all required routine samples on a single day if samples are taken from different sites. Systems must use the results of additional routine samples in coliform treatment technique trigger calculations.~~

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

Part 3 of subparagraph (a) of paragraph (6) of Rule 0400-45-01-.41 Revised Total Coliform Rule is amended by deleting it in its entirety and substituting instead the following:

3. Once all monitoring required by this paragraph and in paragraph (8) of this rule has been completed for a calendar month, systems must determine whether any coliform treatment technique triggers specified in paragraph (9) of this rule have been exceeded. If any trigger has been exceeded, systems must complete assessments as required by paragraph (9) of this rule.

Authority: T.C.A. §§ 68-221-701 et seq. and 4-5-201 et seq.

\* If a roll-call vote was necessary, the vote by the Agency on these rulemaking hearing rules was as follows:

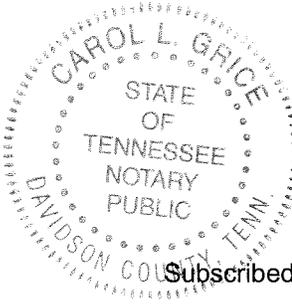
<b>Board Member</b>	<b>Aye</b>	<b>No</b>	<b>Abstain</b>	<b>Absent</b>	<b>Signature (if required)</b>
<b>Dr. Gary G. Bible</b> (Oil and Gas Industry)	X				
<b>Elaine Boyd</b> (Commissioner's Designee, Department of Environment and Conservation)	X				
<b>James W. Cameron III</b> (Small Generator of Water Pollution representing Automotive Interests)	X				
<b>Jill E. Davis</b> (Municipalities)	X				
<b>Mayor Kevin Davis</b> (Counties)	X				
<b>Derek Gernt</b> (Oil or Gas Property Owner)	X				
<b>C. Monty Halcomb</b> (Environmental Interests)				X	
<b>Charlie R. Johnson</b> (Public-at-large)	X				
<b>Judy Manners</b> (Commissioner's Designee, Department of Health)	X				
<b>John McClurkan</b> (Commissioner's Designee, Department of Agriculture)	X				
<b>Frank McGinley</b> (Agricultural Interests)	X				
<b>D. Anthony Robinson</b> (Manufacturing Industry)	X				

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Board of Water Quality, Oil and Gas on 04/17/2018, and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: (10/25/17)

Rulemaking Hearing(s) Conducted on: (add more dates). (12/19/17)



Date: April 17, 2018

Signature: James W. Cameron III

Name of Officer: James W. Cameron III

Title of Officer: Board Chairman

Subscribed and sworn to before me on: April 17, 2018

Notary Public Signature: Carol L. Grice

My commission expires on: March 3, 2020

Agency/Board/Commission: Board of Water Quality, Oil and Gas

Rule Chapter Number(s): 0400-45-01

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slattery III  
Herbert H. Slattery III  
Attorney General and Reporter

11/15/2018 Date

**Department of State Use Only**

Filed with the Department of State on: 11/19/18

Effective on: 12/17/19

Tre Hargett  
Tre Hargett  
Secretary of State

RECEIVED  
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SECRETARY OF STATE  
PUBLIC AFFAIRS

## G.O.C. STAFF RULE ABSTRACT

DEPARTMENT: State Board of Education

SUBJECT: Administrative Rules and Regulations

STATUTORY AUTHORITY: T.C.A. § 49-1-302(5)(A) grants the State Board of Education the power to adopt policies concerning the qualifications, requirements and standards of and provide the licenses and certificates for all public school teachers, principals, assistant principals, supervisors and directors of schools.

EFFECTIVE DATES: February 27, 2019 through June 30, 2019

FISCAL IMPACT: Not Applicable

STAFF RULE ABSTRACT: Career and Technical Education (CTE) requires directors to submit a completed matrix during their first three (3) years of employment as a CTE director. The department has various measures to determine the completion of the majority of the items listed on the CTE director matrix and have processes in place for follow up with directors who are not completing their expected duties. Additionally, the majority of CTE directors are required to earn Tennessee Academy for School Leaders (TASL) credit, as most have an administrator endorsement.

As the purpose of the matrix is to verify that CTE directors are meeting the expectations of their role, the department has refined its structures in order to effectively capture this information without additional reporting. Therefore, the department recommended an update to the Employment Standards rule to remove this requirement, which is a duplication of reporting efforts from CTE administrators.

## **Regulatory Flexibility Addendum**

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process, all agencies shall conduct a review of whether a proposed rule or rule affects small business.

This rule does not affect small businesses.

### **Impact on Local Governments**

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (<http://state.tn.us/sos/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

This rule does not have a projected impact on local governments.

**Additional Information Required by Joint Government Operations Committee**

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

Career and Technical Education (CTE) requires directors to submit a completed matrix during their first three (3) years of employment as a CTE director. The department has various measures to determine the completion of the majority of the items listed on the CTE director matrix and have processes in place for follow up with directors who are not completing their expected duties. Additionally, the majority of CTE directors are required to earn Tennessee Academy for School Leaders (TASL) credit, as most have an administrator endorsement.

As the purpose of the matrix is to verify that CTE directors are meeting the expectations of their role, the department has refined its structures in order to effectively capture this information without additional reporting. Therefore, the department recommended an update to the Employment Standards rule to remove this requirement, which is a duplication of reporting efforts from CTE administrators.

- (B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

T.C.A. § 49-1-302(5)(A) grants the State Board of Education the power to adopt policies concerning the qualifications, requirements and standards of and provide the licenses and certificates for all public school teachers, principals, assistant principals, supervisors and directors of schools;

- (C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

CTE Directors are most directly affected by this rule and have neither urged adoption nor rejection of it. The Department of Education and the State Board of Education urge adoption of this rule.

- (D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule or the necessity to promulgate the rule;

N/A

- (E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

N/A

- (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Nathan James  
[Nathan.James@tn.gov](mailto:Nathan.James@tn.gov)

Elizabeth Fiveash  
[Elizabeth.Fiveash@tn.gov](mailto:Elizabeth.Fiveash@tn.gov)

- (G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Nathan James  
[Nathan.James@tn.gov](mailto:Nathan.James@tn.gov)

Elizabeth Fiveash  
[Elizabeth.Fiveash@tn.gov](mailto:Elizabeth.Fiveash@tn.gov)

**(H)** Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

Nathan James  
[Nathan.James@tn.gov](mailto:Nathan.James@tn.gov)  
1st Floor, Andrew Johnson Tower  
710 James Robertson Parkway  
Nashville, TN 37243  
(615)-532-3528

Elizabeth Fiveash  
[Elizabeth.Fiveash@tn.gov](mailto:Elizabeth.Fiveash@tn.gov)  
9th Floor, Andrew Johnson Tower  
710 James Robertson Parkway  
Nashville, TN 37243  
(615)- 253-1960

**(I)** Any additional information relevant to the rule proposed for continuation that the committee requests.

N/A

**Department of State  
Division of Publications**

312 Rosa L. Parks Avenue, 8th Floor Snodgrass/TN Tower  
Nashville, TN 37243  
Phone: 615-741-2650  
Email: [publications.information@tn.gov](mailto:publications.information@tn.gov)

**For Department of State Use Only**

Sequence Number: 11-19-18  
Rule ID(s): 7605  
File Date: 11/29/18  
Effective Date: 2/27/19

## Proposed Rule(s) Filing Form

*Proposed rules are submitted pursuant to Tenn. Code Ann. §§ 4-5-202, 4-5-207, and 4-5-229 in lieu of a rulemaking hearing. It is the intent of the Agency to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within ninety (90) days of the filing of the proposed rule with the Secretary of State. To be effective, the petition must be filed with the Agency and be signed by ten (10) persons who will be affected by the amendments, or submitted by a municipality which will be affected by the amendments, or an association of ten (10) or more members, or any standing committee of the General Assembly. The agency shall forward such petition to the Secretary of State.*

*Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).*

<b>Agency/Board/Commission:</b>	State Board of Education
<b>Division:</b>	
<b>Contact Person:</b>	Amy Owen
<b>Address:</b>	Andrew Johnson Tower, 1st Floor 710 James Robertson Pkwy
<b>Zip:</b>	37243
<b>Phone:</b>	(615) 532-1776
<b>Email:</b>	<a href="mailto:Amy.Owen@tn.gov">Amy.Owen@tn.gov</a>

**Revision Type (check all that apply):**

- Amendment  
 New  
 Repeal

**Rule(s)** (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please make sure that **ALL** new rule and repealed rule numbers are listed in the chart below. Please enter only **ONE** Rule Number/Rule Title per row)

Chapter Number	Chapter Title
0520-01-02	Administrative Rules and Regulations
Rule Number	Rule Title
0520-01-02-.03	Employment Standards

## AMENDMENT

Rule 0520-01-02-.03, Employment Standards is amended by deleting partial language in subparagraph (9)(h), so that as amended it shall read as follows:

### **0520-01-02-.03 EMPLOYMENT STANDARDS.**

- (1) A teacher or principal shall hold a valid Tennessee teacher license with an endorsement covering the work assignment as provided in T.C.A. Title 49, Chapter 5.
- (2) A teacher may teach up to two (2) sections of one (1) course outside the area of endorsement. For a teacher to teach more than one (1) course or more than two (2) sections of one (1) course outside the area of endorsement, an employment standard waiver must be requested and approved. Teachers assigned two (2) or more sections of a course outside the area of endorsement before June 30, 1976 may continue to teach those courses until a new assignment is made by the local school officials.
- (3) Districts and schools may exercise the following endorsement flexibility for educators:
  - (a) A classroom teacher with an endorsement in elementary education or early childhood education is eligible to teach any subject, including art, music, and physical education in the grades covered by the endorsement as part of the teacher's regular classroom assignment.
  - (b) A teacher with a professional license may teach Algebra I at any grade level if they have:
    1. An endorsement to teach at least through grade eight (8);
    2. A passing score on the middle school math PRAXIS; and
    3. Successful completion of a state-approved training OR a passing score on a supplemental test in the content area approved for this purpose by the Department of Education.
  - (c) The Department of Education may provide additional endorsement flexibility as appropriate.
- (4) A teacher in grades kindergarten through eight (8) who teaches art, music, or physical education for the major portion of the day shall be endorsed in art, music, or physical education respectively. However, a teacher endorsed in elementary education who was assigned to teach music, art, or physical education for the major portion of the day during the 1990-91 school year may continue to teach the specific course until such time as a new assignment is made by the local school officials.
- (5) Principals.
  - (a) Assistant principals, teaching principals, or dual assignment personnel with more than fifty percent (50%) of their responsibilities involved in instructional leadership must be properly licensed or be enrolled in a State Board approved instructional leadership preparation program.
  - (b) A principal shall hold one (1) of the following endorsements: instructional leader or professional administrator license.
  - (c) A principal, with the approval of the superintendent, shall establish and implement an annual plan for personal professional development in accordance with guidelines established by the State Board of Education.
  - (d) A principal of a school with less than 225 students shall not be required to meet the requirements of (b).

**RULES  
OF  
THE TENNESSEE DEPARTMENT OF EDUCATION  
THE STATE BOARD OF EDUCATION**

**CHAPTER 0520-01-02  
ADMINISTRATIVE RULES AND  
REGULATIONS**

**0520-01-02-.03 EMPLOYMENT STANDARDS.**

- (1) A teacher or principal shall hold a valid Tennessee teacher license with an endorsement covering the work assignment as provided in T.C.A. Title 49, Chapter 5.
- (2) A teacher may teach up to two (2) sections of one (1) course outside the area of endorsement. For a teacher to teach more than one (1) course or more than two (2) sections of one (1) course outside the area of endorsement, an employment standard waiver must be requested and approved. Teachers assigned two (2) or more sections of a course outside the area of endorsement before June 30, 1976 may continue to teach those courses until a new assignment is made by the local school officials.
- (3) Districts and schools may exercise the following endorsement flexibility for educators:
  - (a) A classroom teacher with an endorsement in elementary education or early childhood education is eligible to teach any subject, including art, music, and physical education in the grades covered by the endorsement as part of the teacher's regular classroom assignment.
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    1. An endorsement to teach at least through grade eight (8);
    2. A passing score on the middle school math PRAXIS; and
    3. Successful completion of a state-approved training OR a passing score on a supplemental test in the content area approved for this purpose by the Department of Education.
  - (c) The Department of Education may provide additional endorsement flexibility as appropriate.
- (4) A teacher in grades kindergarten through eight (8) who teaches art, music, or physical education for the major portion of the day shall be endorsed in art, music, or physical education respectively. However, a teacher endorsed in elementary education who was assigned to teach music, art, or physical education for the major portion of the day during the 1990-91 school year may continue to teach the specific course until such time as a new assignment is made by the local school officials.
- (5) Principals.
  - (a) Assistant principals, teaching principals, or dual assignment personnel with more than fifty percent (50%) of their responsibilities involved in instructional leadership must be properly licensed or be enrolled in a State Board approved instructional leadership preparation program.

- (b) A principal shall hold one (1) of the following endorsements: instructional leader or professional administrator license.
- (c) A principal, with the approval of the superintendent, shall establish and implement an annual plan for personal professional development in accordance with guidelines established by the State Board of Education.
- (d) A principal of a school with less than 225 students shall not be required to meet the requirements of (b).

(6) Teaching Personnel in Gifted Education

- (a) A classroom teacher in special or general education providing direct instruction to students identified by state criteria as intellectually gifted students shall meet the following employment standards:
  - 1. The teacher shall be endorsed in the appropriate general education area or must hold the appropriate special education endorsement; and
  - 2. The teacher shall meet one (1) of the following standards:
    - (i) The teacher shall work in consultation with a teacher who meets the standards for consulting teachers listed in (b); or
    - (ii) The teacher shall have completed six (6) semester hours of college or university course work or the equivalent contact hours in teaching gifted students approved by the Department of Education; or
    - (iii) The teacher shall hold an endorsement in gifted education.
- (b) A consulting teacher in special or general education who works with other teachers or who teaches classes especially designed for gifted students in grades pre-kindergarten through twelve (12) shall meet the following employment standards:
  - 1. The consulting teacher shall be endorsed in the appropriate general education area or must hold the appropriate special education endorsement; and
  - 2. The consulting teacher shall meet one (1) of the following standards:
    - (i) The consulting teacher shall have completed six (6) semester hours of college or university coursework or the equivalent contact hours in teaching gifted students approved by the Department of Education; or
    - (ii) The consulting teacher shall hold an endorsement in gifted education.
- (c) An individual who serves as a gifted education coordinator in special or general education shall meet one (1) of the following employment standards:
  - 1. The individual shall hold an educator license with an endorsement in gifted education; or
  - 2. The individual shall hold an educator license and shall have completed six (6) semester hours of college or university coursework or the equivalent contact hours in teaching gifted students approved by the Department of Education; or

3. The individual shall hold a license endorsed in one (1) of the following instructional leader or professional administrator license.
  - (d) A classroom teacher who was endorsed in special education prior to September 1, 1989 and who served gifted students prior to July 1, 1988, may continue to teach eligible intellectually gifted students, provided that they have completed an in-service training program approved by the Department of Education.
- (7) Teachers of Computer Technology, Grades 9-12.
  - (a) A teacher of personal computing, computer productivity applications, and interactive multimedia design shall have a valid Tennessee teacher license with an endorsement in grades six (6) through twelve (12) or seven (7) through twelve (12) and shall have completed the equivalent of six (6) semester hours of computer course work or have the appropriate endorsement.
  - (b) A teacher of programming languages and advanced placement computer science shall have a valid Tennessee teacher license with an endorsement grades six (6) through twelve (12) and seven (7) through twelve (12) and shall have completed the equivalent of twelve (12) semester hours of computer course work including six (6) semester hours of programming.
- (8) Career and Technical Education.
  - (a) A teacher of agricultural education shall hold a valid Tennessee teacher license with appropriate endorsement.
  - (b) A teacher of marketing education shall hold a valid Tennessee teacher license with appropriate endorsement.
  - (c) A teacher of health science education shall have completed one (1) year of successful employment experience, obtained through full-time or part-time status, within the past five (5) years in a related health occupation prior to teaching.
  - (d) Other occupational educators shall be a high school graduate or higher. The teacher shall have a minimum of one (1) to five (5) years of appropriate and current work experience in the field for which application is made and based on the respective requirements of the endorsement. A combination of career and technical education at the postsecondary level from a state approved institution, or other accredited public or private institution, may also be evaluated. The amount of credit awarded for work experience through postsecondary education shall depend on the endorsement and related industry.
- (9) Other Instructional and Related Personnel.
  - (a) A school counselor shall hold the appropriate license and endorsement for the grade levels assigned.
  - (b) A school psychologist shall hold a valid license with the school psychologist endorsement.
  - (c) A school social worker shall hold a license with the school social work endorsement.
  - (d) A supervisor of instruction shall hold a valid Tennessee license endorsed in instructional leader or professional administrator license.

1. Individuals employed for the first time as a supervisor of instruction shall be employed with the instructional leader or professional administrator license endorsement for a maximum of three (3) years. After three (3) years, for continued employment as a supervisor of instruction, the supervisor of instruction must be recommended for and attain the professional administrator endorsement. In the event that the candidate changes employment prior to obtaining the professional administrator endorsement, the candidate may be employed again as a beginning supervisor of instruction prior to obtaining the professional administrator endorsement.
  1. Any person who performs the duties of a supervisor of instruction, regardless of the title of such person's position, must have the endorsement or license required of a supervisor of instruction.
  2. Persons having an endorsement as a supervisor of instruction as of August 31, 1994, shall be issued a professional administrator license and shall not be required to meet the requirements of 1 or 2.
- (e) A supervisor of special education shall:
1. Hold a valid Tennessee license with one (1) of the following endorsements: instructional leader or professional administrator license and shall have three (3) years of experience with programs for children with disabilities; or
  2. Hold a master's degree and a valid Tennessee teacher license with endorsement in at least one (1) area of special education and shall have three (3) years of experience with programs for children with disabilities.
- (f) Any person who performs the duties of a supervisor of instruction, regardless of the title of such person's position, must have the endorsement or license required of a supervisor of instruction.
- (g) Persons having an endorsement as supervisor of instruction as of August 31, 1994, shall be issued a professional administrator license.
- (h) Persons holding career and technical education supervisory positions, including local directors, supervisors, coordinator specialists, assistant principals for career and technical education, and center administrators, shall have one (1) of the following sets of qualifications:
1. A bachelor's degree in career and technical education from an accredited four (4)- year college or university, three (3) years of teaching experience in an approved career and technical education program and two (2) years of appropriate employment experience in a recognized occupation, ~~and completion of (by July 1, 2008 or within a three (3)-year period from the date of employment) the required matrix of career and technical core competencies for professional development;~~ or
  2. A bachelor's degree with a career and technical education endorsement, three (3) years teaching experience, two (2) years of appropriate work experience, ~~and completion of (by July 1, 2008 or within a three (3)-year period from the date of employment) the required matrix of career and technical core competencies for professional development;~~ or
  3. An endorsement as a ~~p~~Pre-KKk-12 administrator or secondary supervisor or

~~principal and completion of (by July 1, 2008 or within a three (3) year period from the date of employment) the required matrix of career and technical core competencies for professional development.~~

- (i) Educational assistants shall have no less than a high school education or an equivalency high school diploma; those who have completed one (1) or more years of college shall be given preference in employment.
- (j) A director of schools appointed by the local board of education elected by the general public shall only be required to have a baccalaureate degree.
- (k) All individuals employed by local school systems to provide educational interpreting for students who are deaf, deaf-blind, or hard of hearing must hold a valid Tennessee School Services Personnel license with the appropriate endorsement or must meet the following employment standards:
  - 1. Non-licensed educational interpreters employed by a local school system prior to January 2021, shall satisfy the following requirements by January 1, 2021:
    - (i) Obtain a passing score on the written portion of the Educational Interpreter Performance Assessment (EIPA); and
    - (ii) Obtain a minimum score of 3.0 on the performance assessment portion of the EIPA.
  - 2. All non-licensed educational interpreters employed by a local schools system on January 1, 2021, or after, shall satisfy the following requirements:
    - (i) Hold at a minimum an associate's degree;
    - (ii) Obtain a passing score on the written portion of the Educational Interpreter Performance Assessment (EIPA); and
    - (iii) Obtain a minimum score of 3.0 on the performance assessment portion of the EIPA.

Compensation of non-licensed individuals providing educational interpreting shall be determined by the local school system and shall take into consideration the level of preparation, training, and work requirements.

- (l) An audiologist shall hold a license with audiologist endorsement.
  - (m) A school speech-language pathologist shall hold a school service personnel license with the school speech language pathologist endorsement.
  - (n) A school speech-language teacher hired by a local school system to work under the direction of a school speech-language pathologist shall hold a school speech-language teacher license (A or B), a teacher license with a school speech-language teacher endorsement or a teacher license with an endorsement 068 or 464.
- (10) Personal Finance.
- (a) A teacher of personal finance shall hold a valid secondary or K-12 Tennessee teacher license; and

1. Complete a minimum of fourteen (14) clock hours of training provided by the State Department of Education on use of the state adopted Personal Finance curriculum; or
  2. Complete fourteen (14) clock hours of training on Personal Finance provided by State Department of Education-approved organizations and/or institutions of higher education.
- (b) Teachers licensed to teach Economics, Business, Marketing, and Family and Consumer Sciences meet these employment standards and may be exempted from the training requirements of subparagraph (a).
- (11) School Nutrition Program Directors.
- (a) School nutrition program directors hired on or after July 1, 2015, shall complete at least eight (8) hours of food safety training either not more than five (5) years prior to the employee's start date or within thirty (30) days of the employee's start date and shall meet the following criteria:
1. School nutrition program directors employed by LEAs with a student enrollment of 500 to 2,499 must meet one (1) of the following criteria:
    - (i) Bachelor's degree or equivalent educational experience with academic major in food and nutrition, food service management, dietetics, family and consumer sciences, nutrition education, culinary arts, business, or a related field;
    - (ii) Bachelor's degree in any academic major and a School Nutrition Association Level 3 Certificate in School Nutrition;
    - (iii) A valid Tennessee teacher license with a school food service supervisor endorsement;
    - (iv) Bachelor's degree in any academic major and at least one (1) year of relevant school nutrition experience;
    - (v) Associate's degree or equivalent educational experience, with academic major in food and nutrition, food service management, dietetics, family and consumer sciences, nutrition education, culinary arts, business, or a related field and at least one (1) year of relevant school nutrition programs experience; or
    - (vi) High school diploma, or equivalency diploma, and at least three (3) years of relevant experience in school nutrition programs.
  2. School nutrition program directors employed by LEAs with a student enrollment of 2,500 to 9,999 must meet one (1) of the following criteria:
    - (i) Bachelor's degree or equivalent educational experience with academic major in food and nutrition, food service management, dietetics, family and consumer sciences, nutrition education, culinary arts, business, or a related field;
    - (ii) Bachelor's degree in any academic major and a School Nutrition Association Level 3 Certificate in School Nutrition;

- (iii) A valid Tennessee teacher license with a school food service supervisor endorsement;
  - (iv) Bachelor's degree in any academic major and at least two (2) years of relevant school nutrition experience; or
  - (v) Associate's degree or equivalent educational experience, with academic major in food and nutrition, food service management, dietetics, family and consumer sciences, nutrition education, culinary arts, business, or a related field and at least two (2) years of relevant school nutrition programs experience.
3. School nutrition program directors employed by LEAs with a student enrollment of more than 10,000 must meet one (1) of the following criteria:
- (i) Bachelor's degree or equivalent educational experience with academic major in food and nutrition, food service management, dietetics, family and consumer sciences, nutrition education, culinary arts, business, or a related field;
  - (ii) Bachelor's degree in any academic major and a School Nutrition Association Level 3 Certificate in School Nutrition;
  - (iii) A valid Tennessee teacher license with a school food service supervisor endorsement; or
  - (iv) Bachelor's degree in any academic major and at least five (5) years of experience in management of school nutrition programs.

**Authority:** T.C.A. §§ 49-1-302, 49-2-301, 49-5-108; 49-6-6006, and Section 86 of Chapter 535 of the Public Acts of 1992. **Administrative History:** Original rule certified June 10, 1974. Amendment filed July 10, 1974; effective July 10, 1974. Amendment filed June 30, 1975; effective July 30, 1975. Amendment filed July 15, 1976; effective August 15, 1976. Amendment filed February 28, 1978; effective March 30, 1978. Amendment filed January 9, 1979; effective February 23, 1979. Amendment and new rule filed October 15, 1979; effective January 8, 1980. Amendment filed November 13, 1981; effective March 16, 1982. Amendment filed June 4, 1982; effective September 30, 1982. Amendment filed August 17, 1983; effective November 14, 1983. Amendment filed August 20, 1984; effective November 13, 1984. Amendment filed September 26, 1985; effective December 14, 1985. Amendment filed May 8, 1986; effective June 27, 1986. Amendment filed September 20, 1987; effective December 22, 1987. Amendment filed October 18, 1988; effective January 29, 1989. Amendment filed November 9, 1989; effective February 28, 1990. Amendment filed July 11, 1990; effective October 29, 1990. Repeal and new rule filed March 16, 1992; effective June 29, 1992. Amendment filed May 12, 1992; effective August 29, 1992. Amendment filed September 1, 1992; effective December 29, 1992. Amendment filed August 10, 1993; effective December 29, 1993. Amendment filed November 22, 1993; effective March 30, 1994. Amendment filed January 21, 1994; effective May 31, 1994. Amendment filed March 31, 1994; effective June 14, 1994. Amended by Public Chapter No. 957, Acts of 1994; effective May 10, 1994. (See Attorney General Opinion No. 094-080). Amendment filed January 31, 1995; effective May 31, 1995. Amendment filed May 31, 1996; effective September 27, 1996. Amendment filed October 17, 1997; effective February 27, 1998. Amendment filed May 28, 1999; effective September 28, 1999. Amendment filed July 31, 2000; effective November 28, 2000. Amendment filed March 1, 2005; effective July 29, 2005. Amendments filed May 19, 2005; effective September 28, 2005. Amendment filed June 15, 2005; effective October 28, 2005. Amendment filed March 23, 2007; effective July 27, 2007. Amendments filed September 6, 2007; effective January 28,

*2008. Amendment filed May 30, 2008; effective September 26, 2008. Amendment filed July 17, 2009; effective December 29, 2009. Amendments filed February 6, 2013; effective July 29, 2013. Amendments filed September 6, 2013; effective February 28, 2014. Amendment filed May 8, 2014; effective October 29, 2014. Amendment filed May 26, 2015; effective August 24, 2015. Amendment filed September 22, 2015; effective December 21, 2015.*

\* If a roll-call vote was necessary, the vote by the Agency on these rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)
Haden Bawcum	X				
Darrell Cobbins	X				
Nick Darnell	X				
Bob Eby	X				
Mike Edwards				X	
Gordon Ferguson	X				
Lillian Hartgrove	X				
Elissa Kim	X				
Wendy Tucker	X				

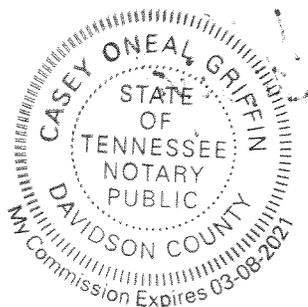
I certify that this is an accurate and complete copy of proposed rules, lawfully promulgated and adopted by the Tennessee State Board of Education on 07/27/2018, and is in compliance with the provisions of T.C.A. § 4-5-222. The Secretary of State is hereby instructed that, in the absence of a petition for proposed rules being filed under the conditions set out herein and in the locations described, he is to treat the proposed rules as being placed on file in his office as rules at the expiration of ninety (90) days of the filing of the proposed rule with the Secretary of State.

Date: 10/29/18

Signature: Amy Owen

Name of Officer: Amy Owen

Title of Officer: Director of Policy and Research



Subscribed and sworn to before me on: 10/29/18

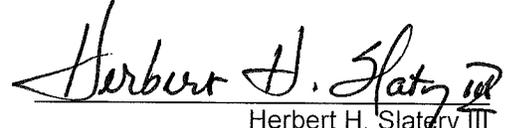
Notary Public Signature: C. Griffin

My commission expires on: 3-8-21

Agency/Board/Commission: State Board of Education

Rule Chapter Number(s): 0520-01-02-.03

All proposed rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

  
Herbert H. Slatery III  
Attorney General and Reporter

11/15/2018  
Date

**Department of State Use Only**

Filed with the Department of State on: 11/29/18

Effective on: 2/27/19

  
Tre Hargett  
Secretary of State

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## G.O.C. STAFF RULE ABSTRACT

<u>DEPARTMENT:</u>	Department of General Services
<u>DIVISION:</u>	Office of General Counsel
<u>SUBJECT:</u>	Access to Public Records
<u>STATUTORY AUTHORITY:</u>	Effective April 12, 2018, Public Chapter 712 requires that all state agencies must, by January 1, 2019, promulgate rules governing the process for receiving and responding to public record requests in accordance with the Uniform Administrative Procedures Act. Tenn. Code Ann. § 10-7-503(g).
<u>EFFECTIVE DATES:</u>	February 24, 2019 through June 30, 2019
<u>FISCAL IMPACT:</u>	None
<u>STAFF RULE ABSTRACT:</u>	<p>0690-06-02.01 Purpose and Scope</p> <ul style="list-style-type: none"><li>•The purpose and scope of these rules is to establish procedures for public records requests received by the Department.</li><li>•The focus of these rules is to provide economical and efficient access to public records.</li></ul> <p>0690-06-02.02 Definitions</p> <ul style="list-style-type: none"><li>•These definitions mirror the terms and definitions in T.C.A. § 10-7-503.</li></ul> <p>0690-06-02.03 Requesting Access to Public Records</p> <ul style="list-style-type: none"><li>•Requests may be made to the PRRC in person, by telephone, fax, mail, email, or online.</li><li>•A request for inspection is not required to be made in writing.</li><li>•An in person request can be made during the Department's regular business hours M-F 8:30AM 4:30PM. Except for holidays.</li><li>•A request for copies shall be made to the PRRC in writing. The requester may use the OORC public records request form.</li><li>•The request must be sufficiently detailed to enable the Department to identify the records for inspection or copying.</li></ul>

- Proof of TN citizenship is required at the time the requester makes a request. Proof of citizenship is met by presenting a government issued photo ID, although the PRRC may accept an alternative form of id. If a requester has previously provided proof of TN citizenship, the PRRC may waive the requirement.

#### 0690-06-02.04 Responding to Public Records Requests

- Upon receipt, the PRRC will review the request and determine the following:

- Did the requester provide evidence of TN citizenship?

- Are the records requested described with sufficient specificity to identify?

- Is the Department of General Services the custodian of the requested records?

- Are the records requested not subject to disclosure based on federal or state laws or rules?

- If labor charges apply, the PRRC will inform the requester in writing of the reasonable copying and labor charges and any determinations made regarding aggregation of multiple or frequent requests.

- The PRRC and the records custodian shall make any public record available, unless it is specifically exempt from disclosure.

- If the PRRC cannot promptly provide the requested records, then within 7 business days the PRRC shall:

- Make the public record available to the requester;

- Deny the request in writing and include the basis of denial;

- Give the requester a written explanation of the time reasonably necessary to produce the public record(s);

- If the PRRC denies the request in writing, they shall provide grounds for denial. This may include, but is not limited to:

- Requester is not a TN citizen;

- Request lacks specificity;

- Record is not subject to disclosure (and the provision of the law making the record not subject to disclosure shall be included in the written denial);

- The department is not the custodian of the requested records;

- The records don't exist; or

- Another legal ground for denial.

- If the records are in the custody of another agency and the PRRC knows the governmental agency where the

request should be made, the PRRC will give the name of the other entity and the PRRC for that entity.

- If certain portions of the records need to be redacted, the Department will provide a redacted copy to the requester and the basis for the redaction.

#### 0690-06-02.05 Inspection or Copies of Records

- There will be no charge to inspect records. The requester must schedule an appointment with the PRRC to inspect the records.

- The requester can make copies of personally inspected records, but the requester cannot connect any personal equipment to a Department computer.

- Once the Department decides to fulfill the request, the Department will promptly make the copies available to the requester in the following manner:

- For pickup at a location specified by the PRRC;
  - By regular mail delivery to the requester's TN

address;

- By electronic delivery to the requester's requested email address;

- This inspection process goes into more detail than the previous policy.

#### 0690-06-02.06 Charges, Payment and Waivers

- The Department's assessment of charges for the copying and labor to produce copies of the requested records shall be based on the most current version of the schedule of reasonable charges issued by the OORC.

- The Department's labor threshold will be two hours.

- The requester shall receive a written and itemized estimate of the copying or labor charges prior to producing the copies.

- Before the records are provided, the requester shall agree in writing to pay the charges.

- If charges are < \$10.00 the charges may be waived by the PRRC.

- If a vendor is used, the Department shall charge the requester the vendor's costs.

- The Commissioner or the Commissioner's designee may waive or reduce the fees with a written determination that the waiver would be in the best interest of the public.

#### 0690-06-02.07 Aggregation of Frequent and Multiple Requests

- The Department will aggregate records in accordance with the reasonable charges for frequent and multiple requests promulgated by the OORC when more than 4 requests are received in a month from an individual or a group of individuals who are working in concert.

- The PRRC will determine whether or not a group of individuals are working in concert and the PRRC will inform them that they have been deemed to be working in concert. This decision may be appealed to the OORC.

0690-06-02.08 Failure to Inspect Copies

- If a requester makes 2 or more requests to view a record within a 6 month period and fails to view the records within 15 business days of notification, the Department does not have to comply with the requester's future requests for 6 months from the date of the second request, unless the failure to view the record was for good cause.

- In the previous policy, the failure of a requester to inspect a record was not addressed.

NOTE:

This new rule was filed with the Secretary of State with no redline comparison.

## Public Hearing Comments

One copy of a document that satisfies T.C.A. § 4-5-222 must accompany the filing.

*The following comment was submitted by email on 10/01/18 by Deborah Fisher, Executive Director, Tennessee Coalition for Open Government.*

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### TCOG Comments on Tennessee Department of General Services Rules Regarding Public Records Requests

Oct. 1, 2018

By Deborah Fisher, Executive Director of Tennessee Coalition for Open Government

Thank you for the opportunity to make comments on the Tennessee Department of General Service's proposed rules on public records requests.

Tennessee Coalition for Open Government is a nonprofit organization founded in 2003 for the purpose of educating the public about the importance of open government and helping citizens understand the rights of access to public records, open meetings and courts.

Its members include the Tennessee Press Association, the Tennessee Association of Broadcasters, the League of Women Voters, the ACLU, the Beacon Center of Tennessee, several Tennessee news organizations and journalists, individual citizens, other nonprofit groups, First Amendment attorneys and former public and government officials.

We conduct a Help Line, primarily answering questions and helping journalists and citizens who are trying to get public records from government entities.

We believe access to public records provides essential oversight and accountability of government and that this is essential for citizens to effectively participate in a democracy.

This year, TCOG completed an audit of 306 local government entities in which we examined their public records policies. That audit, whose results were published in May, can be found on our website at <http://tcog.info/public-records-policy-audit/>. We found troubling trends regarding new strict requirements of identification before accessing public records as well as practices that make it too expensive for citizens to obtain records.

Our comments about the Tennessee Department of General Service's rules are aimed at supporting prompt access to public records and eliminating obstacles that hinder and thwart access to records that are in the public interest.

State agencies have a special obligation in that many of their records are in Nashville yet they serve citizens throughout the state. Technology is available to solve the problem of distance of course and we want to make sure citizens benefit from that technology and not have to drive to Nashville or incur additional costs for the process of accessing public records simply because of where they live.

Overall, we think most of the Tennessee Department of General Services Rules are reasonable and citizen friendly. We particularly appreciate the two-hour threshold before charging labor for making copies. And we appreciate the department's clear rules allowing someone to make copies personally of inspected public records.

There are just two areas we would like to address.

#### Identification requirement

The Tennessee Department of General Service's policy says that proof of Tennessee citizenship is required as a condition to inspect or receive copies of public records.

This rule thwarts access to public records, and create a chilling effect on accessing public records. Public records are, well, public and should be easily accessible to the public. If you are a member of the public, there should be no restriction on accessing public records.

We think the Tennessee Department of General Services should eliminate its residency requirement for accessing public records. The law clearly does not require someone be a resident before a state agency provide access to or copies of public records. This should be obvious as the department provides records to non-residents and out-of-state businesses all of the time.

If the department wishes to limit access to public records of non-residents in some circumstances, we suggest it outline in its rules under what specific conditions it wishes to do so. And in those circumstances, take the necessary steps to verify residency through whatever means makes sense.

For example, perhaps the department, does not want to fulfill voluminous requests from out-of-state commercial requesters if it is not required to do so by law. This could be outlined in the rule.

But we are concerned that a blanket residency requirement — and the resulting blanket rule to require a driver's license or photo identification issued by the state — has become a routine way to delay access (whether unintentionally or intentionally) to public records — in direct conflict with the law that requires prompt access.

In fact, in the past several months, our organization has received numerous complaints from citizens and journalists faced with seemingly new requirements of having to provide a copy of their driver's license to local and state government entities before their request would be considered (sometimes they have to do this over and over with the same agency). This always delays access to public records — and of course, creates more bureaucracy and paperwork within the government entity itself.

In one example, a person made a request only to receive a denial letter seven business days later stating that his request was denied because he did not provide a driver's license with the request. His request was clear that he worked for a local company. Still, in the face of this, the government agency filled out a denial form, mailed it and then had to process the second request by the person who resubmitted with a copy of a redacted driver's license. This whole process, which should have taken one day, took weeks.

In another case, a county commissioner from East Tennessee requested minutes from two public meetings of a state board that oversees standards for local jails. She was denied access for several weeks based on not providing a driver's license, even though she had made public records requests of the board before and received public records before. (It was pretty obvious which jail she was interested in.)

Several emails back and forth between her and the state lawyer over proof of residency wasted time and effort. The state agency's attorney had every reason to think the person was who she said she was and no reason to think she was not. Yet he would not budge on this rule. Why should an attorney with a state agency be wasting time on something so absurd as denying access to minutes of a public meeting to anyone? The zeal with which he pursued the county commissioner's driver's license was, frankly, disturbing.

There are other reasons for eliminating the department's residency requirement for accessing public records related to the hurdles it places upon people who work or live in Tennessee.

For one, there are often people who live in a border state but work in Tennessee. A very good example that our organization hears about repeatedly are news reporters who may live over the border in Bristol, Virginia, or just outside Chattanooga in Georgia but they work in Tennessee at news organizations. They often get denied access to public records because their home address is in another state. But they clearly work for an organization in Tennessee and are performing an important function that provides a public good — disseminating information to the public. The same can be said of journalists who work for news organizations based in other states but whose information products are distributed in Tennessee.

Some people have just moved to Tennessee and have not yet updated their driver's license information. College students who live in a dorm may maintain their permanent address with their parents, and their driver's license, in another state. They are living here. Should they be denied access to public records?

Eliminating residency requirements — or only requiring residency in certain circumstances that you outline in your rule — would have many benefits for our government as well:

- For one, It would reduce work and save time for government employees — saving taxpayer money.
- It would reduce the chance that a requirement for proof of residency will be abused — or perceived to be

abused — by a government official to delay fulfillment of a records request. See the state attorney example above.

- It would help residents who fear emailing or mailing a copy of their driver's license for privacy reasons. This is particularly important for state agencies who are dealing with residents all over the state who may not be able to drive to Nashville.
- It would reduce the need of a government entity to handle and store confidential information — i.e., driver's license numbers or other private citizen information on documents.
- It would help residents who struggle with technology to make a copy of their driver's license. Some residents don't have ready access to a copy machine or technology, or don't fully understand how to take a digital picture, blocking out their driver's license number, to email it. This is particularly important for state agencies who likely get public records requests from residents throughout the state, and cannot or do not wish to drive to Nashville to make their public records request.
- It would help residents who do not have a driver's license or Tennessee identification document.
- It would improve compliance with the spirit and letter of the law.
- And finally — it would promote a friendly and accessible culture in a government agency committed to transparency to citizens

If the agency wants to require residency before filling a public records request — which we strongly oppose because of all the reasons outlined above — we strongly urge that you allow verbal confirmation of residency by the requestor himself, or a checkbox or a form, or simply a statement by the requester if he or she mails or emails a request. There is no evidence that people will lie about this, and we do not believe they would. If an agency suspected a person were lying when the person said they were a resident — perhaps because they provided an out-of-state mailing the address — the agency could ask them about it.

#### Under Inspection or Copies of Records

In No. 1 under this section, the agency states that if someone wants to inspect public records that the requestor must schedule an appointment. However, the law states "All state, county and municipal records shall, at all times during business hours, which for public hospitals shall be during the business hours of their administrative offices, be open for personal inspection by any citizen of this state, and those in charge of the records shall not refuse such right of inspection to any citizen, unless otherwise provided by state law."

If a person appears at the state agency and requests to inspect records, the law requires that records be made promptly available unless it is not practicable. We understand that there are reasons that records might not be readily available, and acknowledge that there are times that appointments should be made to inspect records because of this and other reasons. In fact, it may be that most times an agency will need time to compile records and get them ready for inspection. But we don't think that a blanket rule requiring an appointment in all instances comports with the law. We suggest changing the rule language to say that a requestor may be asked to schedule an appointment to inspect records under reasonable circumstances.

Thank you again for accepting our comments on behalf of Tennessee Coalition for Open Government.

#### *Department of General Services Response to Deborah Fisher*

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Dear Ms. Fisher,

Thank you for submitting your comments regarding the Department of General Services' published Notice of Rulemaking Hearing concerning the adoption of new rules governing public records requests. As you are aware, the rulemaking hearing was conducted on October 3, 2018; your comments were included in the record of the rulemaking hearing.

I am writing to address your comments and concerns with the rules. You addressed two main areas of concern:

- The identification requirement; and
- Scheduling an appointment to inspect records.

As you pointed out, the rules provide that proof of Tennessee citizenship is required as a condition to inspect or receive copies of public records. This requirement is in accordance with Tennessee law, T.C.A. § 10-7-503(a), which provides that "all state, county and municipal records ... shall at all times, during business hours, be open for personal inspection by any citizen of Tennessee, and those in charge of such records shall not refuse such

right of inspection to any citizen, unless otherwise provided by state law.” The Department understands your concern that this would cause a chilling effect on accessing public records and would delay access to public records, but limiting access to Tennessee citizens allows the Department of General Services to follow the law and serve its State customers more efficiently and effectively.

During the rulemaking hearing, it was noted that Virginia has a similar law to Tennessee’s (Virginia’s Freedom of Information Act (FOIA)), which grants Virginia citizens access to all public records, but grants no such right to non-Virginians. This was challenged, and the Supreme Court held in *McBurney v. Young* that, because Virginia’s citizens-only FOIA provision neither abridges any of petitioners’ fundamental privileges and immunities nor impermissibly regulates commerce, petitioners’ constitutional claims fail. The section of the Tennessee code that permits a State agency to limit public record requests to Tennessee citizens is specifically mentioned in the *McBurney* case as a freedom of information law that is similar to Virginia’s. *McBurney v. Young*, 569 U.S. 221, 237, 133 S. Ct. 1709, 1720, 185 L. Ed. 2d 758 (2013).

Your second concern in the Department’s rules was the requirement that an individual schedule an appointment in order to inspect public records. The law provides that “[a]ll state, county and municipal records shall, at all times during business hours...be open for personal inspection by any citizen of this state, and those in charge of the records shall not refuse such right of inspection to any citizen, unless otherwise provided by state law.” It is the Department’s position that requiring an appointment for the inspection during business hours does not limit an individual’s right to inspect records. An appointment allows Department staff to prepare the necessary documents for the individual and create a proper time for inspection that is agreeable to both the requestor and Department staff.

We appreciate you taking the time to review the Notice of Rulemaking Hearing and submit your comments.

**Regulatory Flexibility Addendum**

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process, all agencies shall conduct a review of whether a proposed rule or rule affects small business.

The newly created Access to Public Records of the Department of General Services Rules will not affect small business.

## **Impact on Local Governments**

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 “any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments.” (See Public Chapter Number 1070 (<http://publications.tnsosfiles.com/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

The newly created Access to Public Records of the Department of General Services Rules will not have a projected impact on local government.

## Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

### 0690-06-02.01 Purpose and Scope

- The purpose and scope of these rules is to establish procedures for public records requests received by the Department.
- The focus of these rules is to provide economical and efficient access to public records.

### 0690-06-02.02 Definitions

- These definitions mirror the terms and definitions in T.C.A. § 10-7-503.

### 0690-06-02.03 Requesting Access to Public Records

- Request may be made to the PRRC in person, by telephone, fax, mail, email or online.
- A request for inspection is not required to be made in writing.
- An in person request can be made during the Department's regular business hours M-F 8:30AM – 4:30PM. Except for holidays.
- A request for copies shall be made to the PRRC in writing. The requestor may use the OORC public records request form.
- The request must be sufficiently detailed to enable the Department to identify the records for inspection or copying.
- Proof of TN citizenship is required at the time the requestor makes a request. Proof of citizenship is met by presenting a government issued photo ID, although the PRRC may accept an alternative form of id. If a requestor has previously provided proof of TN citizenship, the PRRC may waive the requirement.

### 0690-06-02.04 Responding to Public Records Requests

- Upon receipt, the PRRC will review the request and determine the following:
  - Did the requestor provide evidence of TN citizenship?
  - Are the records requested described with sufficient specificity to identify?
  - Is the Department of General Services the custodian of the requested records?
  - Are the records requested not subject to disclosure based on federal or state laws or rules?
  - If labor charges apply, the PRRC will inform the requestor in writing of the reasonable copying and labor charges and any determinations made regarding aggregation of multiple or frequent requests.
- The PRRC and the records custodian shall make any public record available, unless it is specifically exempt from disclosure.
- If the PRRC cannot promptly provide the requested records, then within 7 business days the PRRC shall:
  - Make the public record available to the requestor;
  - Deny the request in writing and include the basis of denial;
  - Give the requestor a written explanation of the time reasonably necessary to produce the public record(s);
- If the PRRC denies the request in writing, they shall provide grounds for denial. This may include, but is not limited to:
  - Requestor is not a TN citizen;
  - Request lacks specificity;
  - Record is not subject to disclosure (and the provision of the law making the record not subject to disclosure shall be included in the written denial);
  - The department is not the custodian of the requested records;
  - The records don't exist; or
  - Another legal ground for denial.
- If the records are in the custody of another agency and the PRRC knows the governmental agency where the request should be made, the PRRC will give the name of the other entity and the PRRC for that entity.
- If certain portions of the records need to be redacted, the Department will provide a redacted copy to the requestor and the basis for the redaction.

0690-06-02.05 Inspection or Copies of Records

- There will be no charge to inspect records. The requestor must schedule an appointment with the PRRC to inspect the records.
- The requestor can make copies of personally inspected records, but the requestor cannot connect any personal equipment to a Department computer.
- Once the Department decides to fulfill the request, the Department will promptly make the copies available to the requestor in the following manner:
  - For pickup at a location specified by the PRRC;
  - By regular mail delivery to the requestor's TN address;
  - By electronic delivery to the requestor's requested email address;
  - This inspection process goes into more detail than the previous policy.

0690-06-02.06 Charges, Payment and Waivers

- The Department's assessment of charges for the copying and labor to produce copies of the requested records shall be based on the most current version of the schedule of reasonable charges issued by the OORC.
- The Department's labor threshold will be two hours.
- The requestor shall receive a written and itemized estimate of the copying or labor charges prior to producing the copies.
- Before the records are provided, the requestor shall agree in writing to pay the charges.
- If charges are < \$10.00 the charges may be waived by the PRRC.
- If a vendor is used, the Department shall charge the requestor the vendor's costs.
- The Commissioner or the Commissioner's designee may waive or reduce the fees with a written determination that the waiver would be in the best interest of the public.

0690-06-02.07 Aggregation of Frequent and Multiple Requests

- The Department will aggregate records in accordance with the reasonable charges for frequent and multiple requests promulgated by the OORC when more than 4 requests are received in a month from an individual or a group of individuals who are working in concert.
- The PRRC will determine whether or not a group of individuals are working in concert and the PRRC will inform them that they have been deemed to be working in concert. This decision may be appealed to the OORC.

0690-06-02.08 Failure to Inspect Copies

- If a requestor makes 2 or more requests to view a record within a 6 month period and fails to view the records within 15 business days of notification, the Department does not have to comply with the requestor's future requests for 6 months from the date of the second request. Unless the failure to view the record was for good cause.
- In the previous policy, the failure of a requestor to inspect a record was not addressed.

**(B)** A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

Effective April 12, 2018, Public Chapter 712 requires that all state agencies must, by January 1, 2019, promulgate rules governing the process for receiving and responding to public record requests in accordance with the Uniform Administrative Procedures Act. Tenn. Code Ann. § 10-7-503(g).

**(C)** Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

One identified interested organization, the Tennessee Coalition for Open Government, submitted their suggested. Those comments and DGS response is above.

**(D)** Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule or the necessity to promulgate the rule;

No opinions of the Attorney General and reporter or any judicial ruling directly relates to the rules or the

necessity to promulgate the rule.

- (E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

There is no fiscal impact in State and local government revenues and expenditure resulting from the promulgation of this rule.

- (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Christy Allen, General Counsel, Department of General Services.

- (G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Christy Allen, General Counsel, Department of General Services.

- (H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

Christy Allen

W.R. Snodgrass TN Tower, 22<sup>nd</sup> Floor

312 Rosa L. Parks Avenue - Nashville, Tennessee

37243

615-741-5922

Christy.Allen@tn.gov

- (I) Any additional information relevant to the rule proposed for continuation that the committee requests.

As a new rule, there is no red line comparison.

**Department of State  
Division of Publications**

312 Rosa L. Parks Ave., 8th Floor, Snodgrass/TN Tower  
Nashville, TN 37243  
Phone: 615-741-2650  
Email: [publications.information@tn.gov](mailto:publications.information@tn.gov)

**For Department of State Use Only**

Sequence Number: 11-18-18  
Rule ID(s): 7547  
File Date: 11/26/18  
Effective Date: 2/24/19

# Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

**Agency/Board/Commission:** Department of General Services  
**Division:** Office of General Counsel  
**Contact Person:** Christy Allen  
**Address:** W.R. Snodgrass TN Tower, 22<sup>nd</sup> Floor  
312 Rosa L. Parks Avenue - Nashville, Tennessee  
**Zip:** 37243  
**Phone:** 615-741-5922  
**Email:** [Christy.Allen@tn.gov](mailto:Christy.Allen@tn.gov)

**Revision Type (check all that apply):**

- Amendment  
 New  
 Repeal

**Rule(s)** (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please make sure that **ALL** new rule and repealed rule numbers are listed in the chart below. Please enter only **ONE** Rule Number/Rule Title per row)

Chapter Number	Chapter Title
0690-06-02	Access to Public Records of the Department of General Services
Rule Number	Rule Title
0690-06-02-.01	Purpose and Scope
0690-06-02-.02	Definitions
0690-06-02-.03	Requesting Access to Public Records
0690-06-02-.04	Responding to Public Records Requests
0690-06-02-.05	Inspection or Copies of Records
0690-06-02-.06	Charges, Payment and Waivers
0690-06-02-.07	Aggregation of Frequent and Multiple Requests
0690-06-02-.08	Failure to Inspect Copies

Place substance of rules and other info here. Please be sure to include a detailed explanation of the changes being made to the listed rule(s). Statutory authority must be given for each rule change. For information on formatting rules go to

[http://sos-tn-gov-files.s3.amazonaws.com/forms/Rulemaking%20Guidelines\\_September2016.pdf](http://sos-tn-gov-files.s3.amazonaws.com/forms/Rulemaking%20Guidelines_September2016.pdf).

Chapter 0690-06-02  
Access to Public Records of the Department of General Services

Chapter 0690-06-02 Access to Public Records of the Department of General Services is a new rule.

Authority: T.C.A. §§4-3-1102, 4-4-103, 10-7-503 and 10-7-506

Chapter 0690-06-02  
Access to Public Records of the Department of General Services

New Rule

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0690-06-02-.08 Failure to Inspect Copies

Rule 0690-06-02-.01 Purpose and Scope.

- (1) The purpose of these rules is to establish procedures regarding public records requests received by the State of Tennessee Department of General Services, and to provide economical and efficient access to Public Records subject to the Tennessee Public Records Act in Tennessee Code Annotated §10-7-501, et seq.
- (2) This rule shall be applied consistently throughout the various offices and divisions of the Department of General Services.

Authority: T.C.A. §§4-3-1102, 4-4-103, 10-7-503 and 10-7-506.

Rule 0690-06-02-.02 Definitions.

- (1) "Department" means the State of Tennessee Department of General Services.
- (2) "Office of Open Records Counsel" or "OORC" means the State of Tennessee Office of Open Records Counsel, established pursuant to T.C.A. §8-4-601 et seq., or any successor office or entity.
- (3) "Public Records" means all documents, papers, letters, maps, books, photographs, microfilms, electronic data processing files and output, films, sound recordings, or other material, regardless of physical form or characteristics, made or received pursuant to law or ordinance or in connection with the transaction of official business by any governmental agency, not otherwise protected by law or exempt from disclosure under the TPRA.
- (4) "Public Records Request Coordinator" or "PRRC" means any individual within the Department of General Services whose role it is to ensure public records requests are routed to the appropriate Records Custodian and are fulfilled in accordance with the TPRA.
- (5) "Records Custodian" means any office, official or employee of the Department of General Services lawfully responsible for the direct custody and care of a public record. The Records

Custodian is not necessarily the original preparer or receiver of the record.

- (6) "Requestor" is an individual or citizen seeking access to a public record, whether it is for inspection or duplication.
- (7) "TPRA" is the Tennessee Public Records Act in T.C.A. §10-7-501, et seq.

Authority: T.C.A. §§4-3-1102, 4-4-103, 10-7-503 and 10-7-506.

Rule 0690-06-02-.03 Requesting Access to Public Records.

- (1) A Requestor may request access to Public Records maintained and received by the Department by making a request in person, by telephone, fax, mail, email or online, depending on whether the Requestor is asking to inspect or receive copies of the Public Records. All public record requests should be directed to the Department's PRRC. Any employee of the Department who receives what they believe may be a public records request, formal or informal, shall immediately notify the PRRC.
- (2) Requests for inspection are not required to be made in writing.
- (3) An in-person request to inspect a Public Record shall be made during the Department's regular business hours from 8:00AM to 4:30PM Central Time, Monday through Friday, except for holidays.
- (4) A Requestor shall make a request for copies of Public Records in writing to the PRRC. When submitting a written request for copies, a Requestor may, but is not required to, use the OORC Public Records Request Form, which is located on the Tennessee Comptroller of the Treasury website on the OORC page.
- (5) Any request for inspection or copying of a Public Record shall be sufficiently detailed to enable the Department to identify the specific records for inspection or copying.

Department of General Services  
Attn: Public Records Request Coordinator  
312 Rosa L. Parks Avenue, TN Tower, 22<sup>nd</sup> Floor  
Nashville, TN 37243  
p: (615) 741-2081 f: (615)-532-8594

[General.Services@tn.gov](mailto:General.Services@tn.gov)

[https://stateofennessee.formstack.com/forms/dgs\\_public\\_records\\_request](https://stateofennessee.formstack.com/forms/dgs_public_records_request)

- (6) At the same time that a Requestor makes a request to inspect or receive copies of a Public Record, the Requestor shall provide proof of Tennessee citizenship, which is required as a condition that must be met prior to inspecting or receiving copies of Public Records. A Requestor shall show proof of Tennessee citizenship by presenting his or her government-issued photo identification that includes the Requestor's address. To the extent that the Requestor cannot provide government-issued photo identification, the PRRC may accept an alternative form of identification. The PRRC may waive the requirement of having the Requestor present government-issued photo identification if the Requestor has previously provided proof of Tennessee citizenship or if it can be verified that the Requestor is a Tennessee citizen by information contained in the public domain.

Authority: T.C.A. §§4-3-1102, 4-4-103, 10-7-503 and 10-7-506.

Rule 0690-06-02-.04 Responding to Public Records Requests.

- (1) Upon receipt of a public records request, the PRRC will review the request and make a determination of the following:
  - (a) If the Requestor provided evidence of Tennessee citizenship pursuant to rule 0690-06-02-.03;

- (b) If the records requested are described with sufficient specificity to identify them;
  - (c) If the Department is the custodian of the Public Records;
  - (d) If the records requested, or any of their contents, are not subject to disclosure based on applicable federal or state laws or rules; and
  - (e) If applicable, the Department will inform the Requestor, in writing, of the reasonable copying and labor charges to produce copies and any determinations made regarding aggregation of multiple or frequent requests.
- (2) The PRRC, in conjunction with the Records Custodian, shall make available any Public Record not specifically exempt from disclosure.
- (a) In the event it is not practicable to promptly provide requested records because additional time is necessary to determine whether the requested records exist; to search for, retrieve, or otherwise gain access to records; to determine whether the records are subject to inspection; to redact records; or for other similar reasons, then within seven (7) business days of a public records request, the PRRC shall:
    1. Make the Public Record available to the Requestor;
    2. Deny the request in writing, including the basis for the denial; or
    3. Furnish the Requestor written explanation of the time reasonably necessary to produce the Public Record.
- (3) If appropriate, the Department will deny the request in writing, providing the ground for denial which may include, but shall not be limited to:
- (a) The Requestor is not, or has not presented evidence, of being a Tennessee citizen;
  - (b) The request lacks specificity;
  - (c) The Public Record is not subject to disclosure under the TPRA. The provision in the law making the Public Record not subject to public disclosure shall be identified in the written denial;
  - (d) The Department is not the custodian of the requested Public Record;
  - (e) The records do not exist; or
  - (f) Any other legal ground for denial.
- (4) If requested records are in the custody of a different governmental entity, and the PRRC knows the correct governmental entity to which the public records request should be made, the PRRC will advise the Requestor of the correct governmental entity and the PRRC for that entity, if known.
- (5) If a Public Record contains information not subject to disclosure under the TPRA, the Department shall prepare a redacted copy of the Public Record prior to providing access. Whenever a redacted record is provided, the Department should provide the Requestor with the basis for redaction.

Authority: T.C.A. §§4-3-1102, 4-4-103, 10-7-503 and 10-7-506.

Rule 0690-06-02-.05 Inspection or Copies of Records.

- (1) There shall be no charge to inspect Public Records. In order to inspect Public Records pursuant

to a public records request, the Requestor must schedule an appointment with the PRRC to inspect the requested records.

- (2) The Requestor will be allowed to make copies of personally inspected Public Records with his or her own personal equipment; however, the Requestor will not be allowed to connect any personal equipment directly to a Department computer, including, but not limited to, utilizing a flash drive, in order to make copies of Public Records.
- (3) If the Department determines to fulfill the request, the Department shall promptly respond to a public records request for copies of Public Records by making the copies available to the Requestor in the following manner:
  - (a) For pickup at a location specified by the PRRC;
  - (b) By regular mail delivery through the United States Postal Service to the Requestor's home address or other acceptable address within Tennessee; or
  - (c) By electronic delivery of copies to an email address provided by the Requestor. Copies will be delivered by email to an email address designated by the Requestor.

Authority: T.C.A. §§4-3-1102, 4-4-103, 10-7-503 and 10-7-506.

#### Rule 0690-06-02-.06 Charges, Payment and Waivers.

- (1) The Department shall assess charges for the copying and labor required to produce copies of the requested Public Records based on the most current version of the Schedule of Reasonable Charges, issued by the OORC, with the exception that the Department's labor threshold will be two (2) hours. The Schedule of Reasonable Charges is available on the Tennessee Comptroller of the Treasury's website on the OORC page.
- (2) The Department shall provide a Requestor with a written, itemized estimate of the copying or labor charges prior to producing copies of records. The Requestor must agree, in writing, to pay the charges prior to the Department producing the Public Records. Payment in advance will be required before producing requested Public Records.
- (3) When charges for copies and labor do not exceed \$10.00, the charges may be waived by the PRRC.
- (4) Payment of charges shall be payable to the Department of General Services in the form of a cashier's check, money order, or other reliable means as determined by the Department.
- (5) Should the Department use an outside vendor to compile, review or redact Public Records in response to a public records request, then the Department shall charge the Requestor the vendor's costs.
- (6) The Commissioner, or the Commissioner's designee, may waive or reduce any part of the fees calculated under these rules upon a written determination that such waiver or reduction would be in the best interests of the public.

Authority: T.C.A. §§4-3-1102, 4-4-103, 10-7-503 and 10-7-506.

#### Rule 0690-06-02-.07 Aggregation of Frequent and Multiple Requests.

- (1) The Department will aggregate record requests in accordance with the Reasonable Charges for Frequent and Multiple Requests promulgated by the OORC when more than four (4) requests are received within a calendar month either from a single individual or a group of individuals deemed to be working in concert. Records requests will be aggregated at the Department level.
- (2) The PRRC is responsible for making the determination that a group of individuals are working in concert. The PRRC must inform the individuals that they have been deemed to be working in

concert and that they have the right to appeal the decision to the OORC.

Authority: T.C.A. §§4-3-1102, 4-4-103, 10-7-503 and 10-7-506.

Rule 0690-06-02-.08 Failure to Inspect Copies.

If a Requestor makes two (2) or more requests to view a Public Record within a six-month period and, for each request, the Requestor fails to view the Public Record within fifteen (15) business days of receiving notification that the record is available to view, the Department is not required to comply with any public records request from the Requestor for a period of six (6) months from the date of the second request to view the Public Record unless the Department determines failure to view the Public Record was for good cause.

Authority: T.C.A. §§4-3-1102, 4-4-103, 10-7-503 and 10-7-506.

\* If a roll-call vote was necessary, the vote by the Agency on these rulemaking hearing rules was as follows

No roll call vote was taken. There were no members of the public present for the meeting. The rule making hearing was recorded and public comments (delivered by email beforehand) were discussed. Those public comments are detailed in a later section of this form.

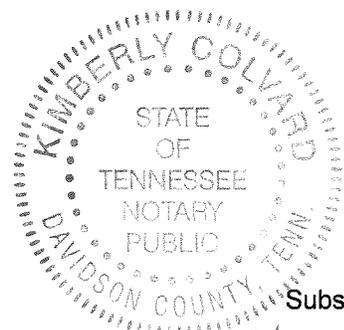
Board Member	Aye	No	Abstain	Absent	Signature (if required)

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Commissioner of General Services (board/commission/ other authority) on 11/01/2018 (mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: August 13, 2018

Rulemaking Hearing(s) Conducted on: (add more dates). October 3, 2018



Date: NOVEMBER 2018

Signature: [Handwritten Signature]

Name of Officer: Bob Oglesby

Title of Officer: Commissioner, Department of General Services

Subscribed and sworn to before me on: November 2018

My Commission Expires 3/8/2021

Notary Public Signature: [Handwritten Signature]

My commission expires on: March 8, 2021

Agency/Board/Commission: \_\_\_\_\_

Rule Chapter Number(s): \_\_\_\_\_

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

[Handwritten Signature]  
 Herbert H. Slattery III  
 Attorney General and Reporter  
11/15/2018  
 Date

**Department of State Use Only**

Filed with the Department of State on: 11/26/18

Effective on: 2/24/19

[Handwritten Signature]  
 Tre Hargett  
 Secretary of State

SECRETARY OF STATE  
 PUBLIC AFFAIRS  
 2018 NOV 26 PM 3:31  
 NICHOLAS...

## G.O.C. STAFF RULE ABSTRACT

**DEPARTMENT:** Commerce and Insurance

**DIVISION:** Insurance Division

**SUBJECT:** Medicare Supplement Insurance Minimum Standards

**STATUTORY AUTHORITY:** This rulemaking is in response to the Centers for Medicare & Medicaid Services (CMS) notice placed in the Federal Register on September 1, 2017. 82 FR 41684. The notice announced the changes made by the Medicare Access and CHIP Reauthorization of 2015 (MACRA). The notice recognized the current Model Regulation adopted by the National Association of Insurance Commissioners (NAIC). Model law 651 sets the minimum NAIC Medicare Supplement Insurance Minimum Standards for policies issued on or after January 1, 2020, and must be fully adopted by this date.

**EFFECTIVE DATES:** February 18, 2019 through June 30, 2019

**FISCAL IMPACT:** None

**STAFF RULE ABSTRACT:** This rulemaking adopts the latest revisions made to the NAIC Model Regulation for Medicare Supplement Insurance minimum Standards. The proposed rule adds a new Rule 0780-01-58-.12. This new Rule establishes the new minimum standard for all Medicare supplement policies issued on or after January 1, 2020. Every Rule that comes after this new addition was renumbered. Also, there were numerous technical changes. The Division changed the charts and wording throughout the Chapter to make them consistent. Further, the Division deleted outdated Rule 0780-01-58-.28, Effective Date, removed improper citations, and removed unnecessary wording that was no longer applicable.

## **Public Hearing Comments**

### **Comment 1**

One comment was received regarding a need for policy form guidance to implement the revisions to Rule 0780-01-58. Specifically, the revision changed the benefit chart of Medigap plans offered and sold on or after January 1, 2020. This chart is included in Medigap Outlines of Coverage, a filed form in Tennessee. With the revision of this Rule, insurers selling Medigap plans will need to revise their Outlines of Coverage forms. The commenter requested that the Insurance Division consider allowing insurers to file addendums to their existing Tennessee Outlines of Coverage changing the Medigap plan benefit chart. In this respect, the commenter submitted a draft proposed bulletin with this comment for the Insurance Division to adopt. The proposed bulletin limits addendums to one revised Medigap plan benefit chart.

### **Response to Comment 1**

In order to comply with the Medicare Access and CHIP Reauthorization Act (MACRA), and this revised Rule, insurers will need to revise their Outlines of Coverage. The Insurance Division is currently reviewing multiple options to see what is the best way to handle this issue, including reviewing the submitted proposed bulletin. Currently, the Insurance Division has not decided on how the Outlines of Coverage updates will need to be filed.

### **Comment 2**

One comment was received regarding a typographical error in Rule 0780-01-58-.12(3). The Rule incorrectly referenced Rule 0780-01-58-.11 instead of 0780-01-58-.12.

### **Response to Comment 2**

The typographical error has been corrected. The Rule now correctly refers to Rule 0780-01-58-.12.

## Regulatory Flexibility Analysis

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(2) and T.C.A. § 4-5-203(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

The Department of Commerce and Insurance has considered whether the proposed rules in these Rulemaking Hearing Rules are such that they will have an economic impact on small businesses (businesses with fifty (50) or fewer employees). The proposed rules are not anticipated to have a significant impact on small businesses. T.C.A. §§ 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a), Omnibus Budget Reconciliation Act of 1990, Pub L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008) and Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015) authorize the Commissioner to promulgate rules in order to regulate the rate structures for Medicare supplement policies or certificates. The proposed amendment does the following:

1. Adds Rule 0780-01-58-.12 regarding Medicare Supplement policies involving persons whose eligibility begins on or after January 1, 2020, and renumbers all of the subsequent rules.
2. Changes the charts and wording throughout to make the rule consistent with federal law.
3. Removes Rule 0780-01-58-.29, removes citations, and removes unnecessary wording that is no longer applicable.
4. Corrects grammatical mistakes.

The addition of Rule 0780-01-58-.12 is a requirement by the Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015) (MACRA). MACRA requires this rule be in place by January 1, 2020.

The outcome of the analysis set forth in Tenn. Code Ann. § 4-5-403 is as follows:

- (1) The type or types of small business and an identification and estimate of the number of small businesses subject to the proposed rule that would bear the cost of, or directly benefit from the proposed rule.

The proposed rules will only apply to insurance companies writing Medicare supplement policies or certificates. While there may be some insurance companies considered to be small business affected by these rules, it is estimated that this number is small. These small businesses are not anticipated to bear any cost with the implementation of this rule.

- (2) The projected reporting, recordkeeping and other administrative costs required for compliance with the proposed rule, including the type of professional skills necessary for preparation of the report or record.

The projected reporting, recordkeeping, and other administrative costs associated with compliance with this proposed rule, are not anticipated to increase from that which exists under the current rules these proposed rules amend.

- (3) A statement of the probable effect on impacted small businesses and consumers.

The effect on small businesses is minimal. The proposed amendment will not affect consumers who are eligible for Medicare Supplement Insurance prior to January 1, 2020. They will still have the same opportunities to choose any of the currently offered Medicare Supplement Policies. Consumers who become eligible for Medicare Supplement Insurance on or after January 1, 2020, will have fewer plan options. However, this will not negatively affect Tennessee consumers because all states are required to implement this change by January 1, 2020.

- (4) A description of any less burdensome, less intrusive or less costly alternative methods of achieving the purpose and objectives of the proposed rule that may exist, and to what extent the alternative means might be less burdensome to small business.

There are no alternative methods to make the proposed rule less costly, less intrusive, or less burdensome.

(5) A comparison of the proposed rule with any federal or state counterparts.

42 U.S.C.A. § 1395ss(b)(1)(A) requires states that approve Medicare supplemental policies to enforce standards with respect to such policies equal to or more stringent than the NAIC Model Standards. Section 15(A) of the 2016 Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act ("Act") requires insurers to obtain approval for Medicare supplement policy rates by filing the rates along with supporting documentation with the Commissioner in accordance with the filing requirements prescribed by the Commissioner. Rule 0780-01-58-.17 similarly provides that insurers doing business in Tennessee are required to obtain rate approval by filing such rates with the Commissioner along with supporting documentation.

Most states have similar language permitting the Director and/or Commissioner of Insurance of that state to use discretion in approving certain rate methodologies if they are proven to be reasonable by supporting documentation.

(6) Analysis of the effect of the possible exemption of small businesses from all or any part of the requirements contained in the proposed rule.

Only insurance companies writing Medicare supplement policies or certificates are required to comply with this rule. Exempting any company from these proposed rules would place Tennessee residents at a risk of receiving disparate rating for Medicare supplement policies or certificates issued within the State of Tennessee.

## **Impact on Local Governments**

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (<http://publications.tnsosfiles.com/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

This rule will not impact local governments.

**Additional Information Required by Joint Government Operations Committee**

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

This rulemaking adopts the latest revisions made to the NAIC Model Regulation for Medicare Supplement Insurance Minimum Standards. The proposed rule adds a new Rule 0780-01-58-.12. This new Rule establishes the new minimum standard for all Medicare supplement policies issued on or after January 1, 2020. Every Rule that comes after this new addition was renumbered. Also, there were numerous technical changes. The Division changed the charts and wording throughout the Chapter to make them consistent. Further, the Division deleted outdated Rule 0780-01-58-.28, Effective Date, removed improper citations, and removed unnecessary wording that was no longer applicable.

- (B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

This rulemaking is in response to the Centers for Medicare & Medicaid Services ("CMS") notice placed in the Federal Register on September 1, 2017. 82 FR 41684. The notice announced the changes made by the Medicare Access and CHIP Reauthorization of 2015 (MACRA). The notice recognized the current Model Regulation adopted by the National Association of Insurance Commissioners ("NAIC"). Model Law 651 sets the minimum NAIC Medicare Supplement Insurance Minimum Standards for policies issued on or after January 1, 2020, and must be fully adopted by this date.

- (C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

The health insurance industry urges adoption of this rule.

- (D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule or the necessity to promulgate the rule;

None known.

- (E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

None anticipated.

- (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Michael Humphreys, Assistant Commissioner for Insurance; Rachel Jrade-Rice, Director of Insurance; Miles Brooks Jr., Assistant General Counsel for Insurance.

- (G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Miles Brooks Jr., Assistant General Counsel for Insurance; Rachel Jade-Rice, Director for Insurance

- (H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

Davy Crockett Tower, 8<sup>th</sup> Floor, 500 James Robertson Parkway, Nashville, Tennessee 37243; 615-253-8706; miles.brooks@tn.gov; Rachel.Jrade-Rice@tn.gov.

- (I) Any additional information relevant to the rule proposed for continuation that the committee requests.

None.

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**For Department of State Use Only**

Sequence Number: 11-12-18  
Rule ID(s): 7492  
File Date: 11/20/18  
Effective Date: 2/13/19

# Rulemaking Hearing Rule(s) Filing Form

*Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).*

*Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).*

<b>Agency/Board/Commission:</b>	Tennessee Department of Commerce and Insurance
<b>Division:</b>	Insurance Division
<b>Contact Person:</b>	Miles Brooks Jr., Assistant General Counsel for Insurance
<b>Address:</b>	Davy Crockett Tower, 8 <sup>th</sup> Floor 500 James Robertson Parkway Nashville, Tennessee
<b>Zip:</b>	37243
<b>Phone:</b>	615-253-8706
<b>Email:</b>	Miles.brooks@tn.gov

**Revision Type (check all that apply):**

- Amendment
- New
- Repeal

**Rule(s)** (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please make sure that **ALL** new rule and repealed rule numbers are listed in the chart below. Please enter only **ONE** Rule Number/Rule Title per row)

Chapter Number	Chapter Title
0780-01-58	Medicare Supplement Insurance Minimum Standards.
Rule Number	Rule Title
0780-01-58-.01	Purpose.
0780-01-58-.02	Authority.
0780-01-58-.03	Applicability and Scope.
0780-01-58-.04	Definitions.
0780-01-58-.05	Policy Definitions and Terms.
0780-01-58-.06	Policy Provisions.
0780-01-58-.07	Minimum Benefit Standards for Pre Standardized Medicare Supplement Benefit Plan Policies Issued for Delivery prior to July 1, 1992.
0780-01-58-.08	Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued or Delivered On or After July 1, 1992 and With an Effective Date of Coverage Prior to June 1, 2010.
0780-01-58-.09	Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery With An Effective Date of Coverage On or After June 1, 2010.

0780-01-58-.10	Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery After July 1, 1992 and With an Effective Date of Coverage Prior to June 1, 2010.
0780-01-58-.11	Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery With an Effective Date of Coverage On or After June 1, 2010.
0780-01-58-.12	Standard Medicare Supplement Benefit Plans for 2020 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After January 1, 2020.
0780-01-58-.13	Medicare Select Policies and Certificates.
0780-01-58-.14	Open Enrollment.
0780-01-58-.15	Guaranteed Issue for Eligible Persons.
0780-01-58-.16	Standards for Claims Payment.
0780-01-58-.17	Loss Ratio Standards and Refund or Credit of Premium.
0780-01-58-.18	Filing and Approval of Policies and Certificates and Premium Rates.
0780-01-58-.19	Permitted Compensation Arrangements.
0780-01-58-.20	Required Disclosure Provisions.
0780-01-58-.21	Requirements for Application Forms and Replacement Coverage.
0780-01-58-.22	Filing Requirements for Advertising.
0780-01-58-.23	Standards for Marketing.
0780-01-58-.24	Appropriateness of Recommended Purchase and Excessive Insurance.
0780-01-58-.25	Reporting of Multiple Policies.
0780-01-58-.26	Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates.
0780-01-58-.27	Prohibition Against Use of Genetic Information and Requests for Genetic Testing.
0780-01-58-.28	Severability.
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**RULES  
OF  
TENNESSEE DEPARTMENT OF COMMERCE AND INSURANCE  
DIVISION OF INSURANCE  
CHAPTER 0780-01-58  
MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS**

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0780-01-58-.05	Policy Definitions and Terms.	0780-01-58-.167	Loss Ratio Standards and Refund or Credit of Premium.
0780-01-58-.06	Policy Provisions.		
0780-01-58-.07	Minimum Benefit Standards for Pre-Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery Prior to July 1, 1992.	0780-01-58-.178	Filing and Approval of Policies and Certificates and Premium Rates.
		0780-01-58-.189	Permitted Compensation Arrangements.
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		0780-01-58-.201	Requirements for Application Forms and Replacement Coverage.
		0780-01-58-.212	Filing Requirements for Advertising Standards for Marketing.
0780-01-58-.09	Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery With An Effective Date of Coverage On or After June 1, 2010.	0780-01-58-.223	Appropriateness of Recommended Purchase and Excessive Insurance.
		0780-01-58-.234	Reporting of Multiple Policies.
		0780-01-58-.245	Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates.
0780-01-58-.10	Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery After July 1, 1992 and With an Effective Date of Coverage Prior to June 1, 2010.	0780-01-58-.256	Prohibition Against Use of Genetic Information and Requests for Genetic Testing.
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0780-01-58-.12	Standard Medicare Supplement Benefit Plans for 2020 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After January 1, 2020.		

**0780-01-58-.01 PURPOSE.**

The purpose of this Chapter is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

**Authority:** *T.C.A. §§ ~~56-1-701~~, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., 56-7-1453, 56-7-1454, 56-7-1455, 56-7-1457, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a), and Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), and Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008), and Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015).*

### 0780-01-58-.02 AUTHORITY.

This Chapter is issued pursuant to the authority vested in the commissioner under T.C.A. §§ 56-7-1401 *et seq.*, specifically, T.C.A. § 56-7-1454.

**Authority:** *T.C.A. §§ ~~56-1-701~~, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., 56-7-1453, 56-7-1454, 56-7-1455, 56-7-1457, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a), and Omnibus Budget Reconciliation Act of 1990, Pub L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), and Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008), and Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015).*

### 0780-01-58-.03 APPLICABILITY AND SCOPE.

- (1) Except as otherwise specifically provided in Rules 0780-01-58-.07, 0780-01-58-.~~45~~16, 0780-01-58-.~~46~~17, 0780-01-58-.~~49~~20, and 0780-01-58-.~~24~~25, this Chapter shall apply to:
  - (a) All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this Chapter; and
  - (b) All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this state.
- (2) This Chapter shall not apply to a policy or contract of one (1) or more employers or labor organizations, or of the trustees of a fund established by one (1) or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

**Authority:** *T.C.A. §§ ~~56-1-701~~, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., 56-7-1453, 56-7-1454, 56-7-1455, 56-7-1457, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a), and Omnibus Budget Reconciliation Act of 1990, Pub L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), and Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008), and Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015).*

### 0780-01-58-.04 DEFINITIONS.

- (1) "Applicant" means:
  - (a) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and
  - (b) In the case of a group Medicare supplement policy, the proposed certificate holder.
- (2) "Bankruptcy" means when a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.
- (3) "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.
- (4) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.
- (5) "Commissioner" means the commissioner of commerce and insurance.

- (6) "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.
- (7) (a) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:
1. A group health plan;
  2. Health insurance coverage;
  3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
  4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928;
  5. Chapter 55 of Title 10 United States Code (CHAMPUS);
  6. A medical care program of the Indian Health Service or of a tribal organization;
  7. A state health benefits risk pool;
  8. A health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);
  9. A public health plan as defined in federal regulation; and
  10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code U.S.C. § 2504(e)).
- (b) "Creditable coverage" shall not include one or more, or any combination of, the following:
1. Coverage only for accident or disability income insurance, or any combination thereof;
  2. Coverage issued as a supplement to liability insurance;
  3. Liability insurance, including general liability insurance and automobile liability insurance;
  4. Workers' compensation or similar insurance;
  5. Automobile medical payment insurance;
  6. Credit-only insurance;
  7. Coverage for on-site medical clinics; and
  8. Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.
- (c) "Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:
1. Limited scope dental or vision benefits;

2. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and
  3. Such other similar, limited benefits as are specified in federal regulations.
- (d) "Creditable coverage" shall not include the following benefits if offered as independent, non-coordinated benefits:
1. Coverage only for a specified disease or illness; and
  2. Hospital indemnity or other fixed indemnity insurance.
- (e) "Creditable coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:
1. Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;
  2. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; and
  3. Similar supplemental coverage provided to coverage under a group health plan.
- (8) "Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section § 1002 (Employee Retirement Income Security Act).
- (9) "Insolvency" means when an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.
- (10) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.
- (11) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.
- (12) "Medicare Advantage plan" means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. § 1395w-28(b)(1), and includes:
- (a) Coordinated care plans that provide health care services, including but not limited to health maintenance organization plans with or without a point-of-service option, plans offered by provider-sponsored organizations, and preferred provider organization plans;
  - (b) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and
  - (c) Medicare Advantage private fee-for-service plans.
- (13) "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. § Section 1395 *et. seq.*) or an issued policy under a demonstration project specified in 42 U.S.C. § 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or

surgical expenses of persons eligible for Medicare. "Medicare supplement policy" does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under § 1833(a)(1)(A) of the Social Security Act.

- (14) "Pre-Standardized Medicare supplement benefit plan," "Pre-Standardized benefit plan" or "Pre-Standardized plan" means a group or individual policy of Medicare supplement insurance issued prior to July 1, 1992.
- (15) "1990 Standardized Medicare supplement benefit plan," "1990 Standardized benefit plan" or "1990 plan" means a group or individual policy of Medicare supplement insurance issued on or after July 1, 1992, and with an effective date for coverage prior to June 1, 2010, and includes Medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.
- (16) "2010 Standardized Medicare supplement benefit plan," "2010 Standardized benefit plan" or "2010 plan" means a group or individual policy of Medicare supplement insurance issued with an effective date of coverage on or after June 1, 2010.
- (17) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.
- (18) "Secretary" means the Secretary of the United States Department of Health and Human Services.

**Authority:** *T.C.A. §§ ~~56-1-704~~, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., ~~56-7-1453, 56-7-1454, 56-7-1455, 56-7-1457, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a)~~, and Omnibus Budget Reconciliation Act of 1990, Pub L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), and Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008), and Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015).*

#### **0780-01-58-.05 POLICY DEFINITIONS AND TERMS.**

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms that conform to the requirements of this Rule.

- (1) "Accident," "accidental injury," or "accidental means" shall be defined to employ "result" language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.
  - (a) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."
  - (b) The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.
- (2) "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare program.
- (3) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare program.

- (4) "Health care expenses" means, for purposes of Rule 0780-01-58-~~1617~~, expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.
- (5) "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.
- (6) "Medicare" shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.
- (7) "Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.
- (8) "Physician" shall not be defined more restrictively than as defined in the Medicare program.
- (9) "Sickness" shall not be defined to be more restrictive than the following: "Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force." The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

**Authority:** *T.C.A. §§ ~~56-1-701~~, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., ~~56-7-1453, 56-7-1454, 56-7-1455, 56-7-1457, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a)~~, and Omnibus Budget Reconciliation Act of 1990, Pub L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), ~~and Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008)~~, and Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015).*

#### **0780-01-58-.06 POLICY PROVISIONS.**

- (1) Except for permitted preexisting condition clauses as described in Rules 0780-1-58-.07(1)(a), 0780-01-58-.08(1)(a), and 0780-01-58-.09(1)(a) of this Chapter, no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.
- (2) No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.
- (3) No Medicare supplement policy or certificate in force in the state shall contain benefits that duplicate benefits provided by Medicare.
- (4) (a) Subject to Rules 0780-01-58-.07(1)(d), (e), and (g), and Rule 0780-01-58-.08(1)(d) and (e) of this Chapter, a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006, shall be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.
- (b) A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

- (c) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:
1. The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Part D plan; and;
  2. Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

**Authority:** *T.C.A. §§ ~~56-1-701~~, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., ~~56-7-1453~~, ~~56-7-1454~~, ~~56-7-1455~~, ~~56-7-1457~~, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a), and Omnibus Budget Reconciliation Act of 1990, Pub L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), and Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008), and Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015).*

**0780-01-58-.07 MINIMUM BENEFIT STANDARDS FOR MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY PRIOR TO JULY 1, 1992.**

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

- (1) General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this Chapter.
  - (a) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.
  - (b) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.
  - (c) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.
  - (d) A "non-cancellable," "guaranteed renewable," or "non-cancellable and guaranteed renewable" Medicare supplement policy shall not:
    1. Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or
    2. Be cancelled or non-renewed by the issuer solely on the grounds of deterioration of health.
  - (e) 1. Except as authorized by the commissioner of this state, an issuer shall neither cancel nor non-renew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

2. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in part 4. the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:
    - (i) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and
    - (ii) An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Rule 0780-01-58-.09(2) of this Chapter.
  3. If membership in a group is terminated, the issuer shall:
    - (i) Offer the certificate holder the conversion opportunities described in part 2.; or
    - (ii) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.
  4. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.
- (f) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.
- (g) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this ~~subsection~~ Paragraph.
- (2) Minimum Benefit Standards.
- (a) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first (61st) day through the ninetieth (90th) day in any Medicare benefit period;
  - (b) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;
  - (c) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;
  - (d) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days;

- (e) Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations unless replaced in accordance with federal regulations or already paid for under Medicare Part B;
- (f) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Medicare Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible [~~\$100~~147];
- (g) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Medicare Part A, subject to the Medicare deductible amount.

**Authority:** *T.C.A. §§ ~~56-1-701, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., 56-7-1453, 56-7-1454, 56-7-1455, 56-7-1457, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a), and Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), and Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008), and Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015).~~*

**0780-01-58-.08 BENEFIT STANDARDS FOR 1990 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED OR DELIVERED ON OR AFTER JULY 1, 1992, AND WITH AN EFFECTIVE DATE OF COVERAGE PRIOR TO JUNE 1, 2010.**

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after July 1, 1992, and with an effective date of coverage prior to June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

- (1) General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this Chapter.
  - (a) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.
  - (b) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.
  - (c) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.
  - (d) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.
  - (e) Each Medicare supplement policy shall be guaranteed renewable.

1. The issuer shall not cancel or non-renew the policy solely on the ground of health status of the individual.
  2. The issuer shall not cancel or non-renew the policy for any reason other than nonpayment of premium or material misrepresentation.
  3. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under part 5., the issuer shall offer certificate holders an individual Medicare supplement policy which, at the option of the certificate holder:
    - (i) Provides for continuation of the benefits contained in the group policy, or
    - (ii) Provides for benefits that otherwise meet the requirements of this Paragraph.
  4. If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall
    - (i) Offer the certificate holder the conversion opportunity described in part 3., or
    - (ii) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.
  5. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.
  6. If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subparagraph.
- (f) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.
- (g) 1. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period, not to exceed twenty-four (24) months, in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.
2. If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstated effective as of the date of termination of entitlement as of the termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

3. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act. If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstated effective as of the date of loss of coverage if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.
  4. Reinstitution of coverages as described in parts 2. and 3.:
    - (i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;
    - (ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstatement of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and
    - (iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.
- (h) If an issuer makes a written offer to the Medicare Supplement policyholders or certificate holders of one or more of its plans, to exchange during a specified period from his or her 1990 Standardized plan as described in Rule 0780-01-58-.10 of this Chapter to a 2010 Standardized plan as described in Rule 0780-01-58-.11 of this Chapter, the offer and subsequent exchange shall comply with the following requirements:
1. An issuer need not provide justification to the commissioner if the insured replaces a 1990 Standardized policy or certificate with an issue age rated 2010 Standardized policy or certificate at the insured's original issue age and duration. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the commissioner according to the state's rate filing procedure.
  2. The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.
  3. An issuer may not apply new pre-existing condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 Standardized policy or certificate of the insured, but may apply pre-existing condition limitations of no more than six (6) months to any added benefits contained in the new 2010 Standardized policy or certificate not contained in the exchanged policy.

4. The new policy or certificate shall be offered to all policyholders or certificate holders within a given plan, except where the offer or issue would be in violation of state or federal law.
- (2) Standards for Basic (Core) Benefits Common to Benefit Plans "A" to "J". Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.
    - (a) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first (61st) day through the ninetieth (90th) day in any Medicare benefit period;
    - (b) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;
    - (c) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;
    - (d) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;
    - (e) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;
  - (3) Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by Rule 0780-01-58-.10 of this Chapter.
    - (a) Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.
    - (b) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first (21st) day through the one hundredth (100th) day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.
    - (c) Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.
    - (d) Eighty Percent (80%) of the Medicare Part B Excess Charges: Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.
    - (e) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

- (f) Basic Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar (\$250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars (\$1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.
- (g) Extended Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar (\$250) calendar year deductible to a maximum of three thousand dollars (\$3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.
- (h) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars (\$250), and a lifetime maximum benefit of fifty thousand dollars (\$50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.
- (i)
  - 1. Preventive Medical Care Benefit: Coverage for the following preventive health services not covered by Medicare:
    - (i) An annual clinical preventive medical history and physical examination that may include tests and services from part 2. and patient education to address preventive health care measures;
    - (ii) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.
  - 2. Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars (\$120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.
- (j) At-Home Recovery Benefit: Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.
  - 1. For purposes of this benefit, the following definitions shall apply:
    - (i) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.
    - (ii) "Care provider" means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

- (iii) "Home" shall mean any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.
- (iv) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a twenty-four (24) hour period of services provided by a care provider is one visit.

2. Coverage Requirements and Limitations.

- (i) At-home recovery services provided must be primarily services which assist in activities of daily living.
- (ii) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.
- (iii) Coverage is limited to:
  - (I) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;
  - (II) The actual charges for each visit up to a maximum reimbursement of forty dollars (\$40) per visit;
  - (III) One thousand six hundred dollars (\$1,600) per calendar year;
  - (IV) Seven (7) visits in any one week;
  - (V) Care furnished on a visiting basis in the insured's home;
  - (VI) Services provided by a care provider as defined in this Rule;
  - (VII) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;
  - (VIII) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare approved home health care visit.

3. Coverage is excluded for:

- (i) Home care visits paid for by Medicare or other government programs; and
- (ii) Care provided by family members, unpaid volunteers or providers who are not care providers.

(4) Standards for Plans K and L.

(a) Standardized Medicare supplement benefit plan "K" shall consist of the following:

1. Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the sixty-first (61st) through the ninetieth (90th) day in any Medicare benefit period;
2. Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first (91st) through the one hundred fiftieth (150th) day in any Medicare benefit period;
3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;
4. Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in part 10.;
5. Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the twenty-first (21st) day through the one hundredth (100th) day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in part 10.;
6. Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in part 10.;
7. Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood, (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in part 10.;
8. Except for coverage provided in part 10., coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described part 10.;
9. Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and
10. Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of four thousand dollars (\$4000) in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(b) Standardized Medicare supplement benefit plan "L" shall consist of the following:

1. The benefits described in subparagraph (a), parts 1., 2., 3. and 9.
2. The benefit described in subparagraph (a), parts 4., 5., 6., 7. and 8., but substituting seventy-five percent (75%) for fifty percent (50%); and
3. The benefit described in subparagraph (a), part 10., but substituting two thousand dollars (\$2000) for four thousand dollars (\$4000).

**Authority:** *T.C.A. §§ ~~56-1-701~~, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., 56-7-1453, 56-7-1454, 56-7-1455, 56-7-1457, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a), and Omnibus Budget Reconciliation Act of 1990, Pub L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), and Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008), and Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015).*

**0780-01-58-.09 BENEFIT STANDARDS FOR 2010 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY WITH AN EFFECTIVE DATE OF COVERAGE ON OR AFTER JUNE 1, 2010.**

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date of coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1990 Standardized Medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued with an effective date of coverage before June 1, 2010, remain subject to the requirements of T.C.A. Title 56, Chapter 7, Part 14 and all applicable benefit standards in Rules 0780-01-58-.07 and 0780-01-58-.08 of this Chapter.

- (1) General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this ~~regulation~~ Chapter.
  - (a) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.
  - (b) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.
  - (c) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.
  - (d) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.
  - (e) Each Medicare supplement policy shall be guaranteed renewable.
    1. The issuer shall not cancel or non-renew the policy solely on the ground of health status of the individual.

2. The issuer shall not cancel or non-renew the policy for any reason other than nonpayment of premium or material misrepresentation.
  3. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under part 5., the issuer shall offer certificate holders an individual Medicare supplement policy which, at the option of the certificate holder:
    - (i) Provides for continuation of the benefits contained in the group policy; or
    - (ii) Provides for benefits that otherwise meet the requirements of this Rule.
  4. If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:
    - (i) Offer the certificate holder the conversion opportunity described in part 3.; or
    - (ii) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.
  5. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.
- (f) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.
- (g)
1. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period, not to exceed twenty-four (24) months, in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.
  2. If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstated (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.
  3. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended for any period that may be provided by federal regulation at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act. If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstated, effective as of the date of loss of coverage, if

the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

4. Reinstitution of coverages as described in parts 2. and 3.:
  - (i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;
  - (ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and
  - (iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.
- (2) Standards for Basic (Core) Benefits Common to Medicare Supplement Insurance Benefit Plans A, B, C, D, F, F with High Deductible, G, M and N. Every issuer of Medicare supplement insurance benefit plans shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.
  - (a) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first (61st) day through the ninetieth (90th) day in any Medicare benefit period;
  - (b) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;
  - (c) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;
  - (d) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;
  - (e) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;
  - (f) Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
- (3) Standards for Additional Benefits. The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, F with High Deductible, G, M, and N as provided by Rule 0780-01-58-.11 of this Chapter.

- (a) Medicare Part A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period.
- (b) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period.
- (c) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first (21st) day through the one hundredth (100th) day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.
- (d) Medicare Part B Deductible: Coverage for one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.
- (e) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.
- (f) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars (\$250), and a lifetime maximum benefit of fifty thousand dollars (\$50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

**Authority:** T.C.A. §§ ~~56-1-701, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., 56-7-1453, 56-7-1454, 56-7-1455, 56-7-1457, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a)~~, and *Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), and Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008), and Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015)*.

**0780-01-58-.10 STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 1990 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY ON OR AFTER JULY 1, 1992, AND WITH AN EFFECTIVE DATE OF COVERAGE PRIOR TO JUNE 1, 2010.**

- (1) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits, as defined in Rule 0780-01-58-.08(2) of this Chapter.
- (2) No groups, packages or combinations of Medicare supplement benefits other than those listed in this Rule shall be offered for sale in this state, except as may be permitted in Rule 0780-01-58-.10(7) and in Rule 0780-01-58-.~~42~~13 of this Chapter.
- (3) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "L" listed in this ~~subsection-Rule~~ and conform to the definitions in Rule 0780-01-58-.04 of this Chapter. Each benefit shall be structured in accordance with the format provided in Rule 0780-01-58-.08(2) and Rule 0780-01-58-.08(3), or Rule 0780-01-58-.08(4) and list the benefits in the order shown in this ~~subsection-Rule~~. For purposes of this Rule, "structure, language, and format" means style, arrangement and overall content of a benefit.
- (4) An issuer may use, in addition to the benefit plan designations required in Paragraph (3), other designations to the extent permitted by law.

(5) Make-up of benefit plans:

- (a) Standardized Medicare supplement benefit plan "A" shall be limited to the basic (core) benefits common to all benefit plans, as defined in Rule 0780-01-58-.08(2) of this regulation Chapter.
- (b) Standardized Medicare supplement benefit plan "B" shall include only the following: The core benefit as defined in Rule 0780-01-58-.08(2) of this Chapter, plus the Medicare Part A deductible as defined in Rule 0780-01-58-.08(3)(a) of this Chapter.
- (c) Standardized Medicare supplement benefit plan "C" shall include only the following: The core benefit as defined in Rule 0780-01-58-.08(2) of this Chapter, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as defined in Rules 0780-01-58-.08(3)(a), (b), (c), and (h) of this Chapter, respectively.
- (d) Standardized Medicare supplement benefit plan "D" shall include only the following: The core benefit as defined in Rule 0780-01-58-.08(2) of this Chapter, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in an foreign country and the at-home recovery benefit as defined in Rules 0780-01-58-.08(3)(a), (b), (h), and (j) of this Chapter, respectively.
- (e) Standardized Medicare supplement benefit plan "E" shall include only the following: The core benefit as defined in Rule 0780-01-58-.08(2) of this Chapter, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in Rules 0780-01-58-.08(3)(a), (b), (h), and (i) of this Chapter, respectively.
- (f) Standardized Medicare supplement benefit plan "F" shall include only the following: The core benefit as defined in Rule 0780-01-58-.08(2) of this Chapter, plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Rules 0780-01-58-.08(3)(a), (b), (c), (e), and (h) of this Chapter, respectively.
- (g) Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: one hundred percent (100%) of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in Rule 0780-1-58-.08(2) of this Chapter, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Rules 0780-01-58-.08(3)(a), (b), (c), (e), and (h) of this Chapter, respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be one thousand five hundred dollars (\$1500) for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve (12) month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars (\$10).
- (h) Standardized Medicare supplement benefit plan "G" shall include only the following: The core benefit as defined in Rule 0780-01-58-.08(2) of this Chapter, plus the Medicare Part A deductible, skilled nursing facility care, eighty percent (80%) of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home

recovery benefit as defined in Rules 0780-01-58-.08(3)(a), (b), (d), (h), and (j) of this Chapter, respectively.

- (i) Standardized Medicare supplement benefit plan "H" shall consist of only the following: The core benefit as defined in Rule 0780-01-58-.08(2) of this Chapter, plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit and medically necessary emergency care in a foreign country as defined in Rules 0780-01-58-.08(3)(a), (b), (f), and (h) of this Chapter, respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.
  - (j) Standardized Medicare supplement benefit plan "I" shall consist of only the following: The core benefit as defined in Rule 0780-01-58-.08(2) of this Chapter, plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as defined in Rules 0780-01-58-.08(3)(a), (b), (e), (f), (h), and (j) of this Chapter, respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.
  - (k) Standardized Medicare supplement benefit plan "J" shall consist of only the following: The core benefit as defined in Rule 0780-01-58-.08(2) of this Chapter, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as defined in Rules 0780-01-58-.08(3)(a), (b), (c), (e), (g), (h), (i), and (j) of this Chapter, respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.
  - (l) Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: one hundred percent (100%) of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in Rule 0780-01-58-.08(2) of this Chapter, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in Rules 0780-01-58-.08(3)(a), (b), (c), (e), (g), (h), (i), and (j) of this Chapter, respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be one thousand five hundred (\$1500) for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve (12) month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars (\$10). The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.
- (6) Make-up of two Medicare supplement plans mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA);
- (a) Standardized Medicare supplement benefit plan "K" shall consist of only those benefits described in Rule 0780-01-58-.08(4)(a) of this Chapter.
  - (b) Standardized Medicare supplement benefit plan "L" shall consist of only those benefits described in Rule 0780-01-58-.08(4)(b) of this Chapter.
- (7) New or Innovative Benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a

policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

**Authority:** *T.C.A. §§ ~~56-1-701~~, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., ~~56-7-1453, 56-7-1454, 56-7-1455, 56-7-1457~~, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a), and Omnibus Budget Reconciliation Act of 1990, Pub L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), and Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008), and Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015).*

**0780-01-58-.11 STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 2010 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY WITH AN EFFECTIVE DATE OF COVERAGE ON OR AFTER JUNE 1, 2010.**

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date of coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued with an effective date of coverage before June 1, 2010, remain subject to the requirements of T.C.A. Title 56, Chapter 7, Part 14 and all applicable benefit standards in Rules 0780-01-58-.07 and 0780-01-58-.08 of this Chapter.

- (1) (a) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic (core) benefits, as defined in Rule 0780-01-58-.09(2) of this Chapter.
- (b) If an issuer makes available any of the additional benefits described in Rule 0780-01-58-.09(3), or offers standardized benefit Plans K or L as described in subparagraphs (5)(h) and (i) of this Rule, then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic (core) benefits as described in subparagraph (1)(a), a policy form or certificate form containing either standardized benefit Plan C as described in subparagraph (5)(c), or standardized benefit Plan F as described in subparagraph (5)(e).
- (2) No groups, packages or combinations of Medicare supplement benefits other than those listed in this Rule shall be offered for sale in this state, except as may be permitted in Paragraph (6) and in Rule 0780-01-58-.~~42~~13 of this Chapter.
- (3) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in this ~~subsection~~ Rule and conform to the definitions in Rule 0780-01-58-.04 of this Chapter. Each benefit shall be structured in accordance with the format provided in Rules 0780-01-58-.09(2) and (3) of this Chapter; or, in the case of plans K or L, in subparagraphs (5)(h) or (i) and list the benefits in the order shown. For purposes of this Rule, "structure, language, and format" means style, arrangement and overall content of a benefit.
- (4) In addition to the benefit plan designations required in Paragraph (3), an issuer may use other designations to the extent permitted by law.
- (5) Make-up of 2010 Standardized Benefit Plans:
  - (a) Standardized Medicare supplement benefit Plan A shall include only the following: The basic (core) benefits as defined in Rule 0780-01-58-.09(2) of this Chapter.

- (b) Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in Rule 0780-01-58-.09(2) of this Chapter, plus one hundred percent (100%) of the Medicare Part A deductible as defined in Rule 0780-01-58-.09(3)(a) of this Chapter.
- (c) Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in Rule 0780-01-58-.09(2) of this Chapter, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in Rules 0780-01-58-.09(3)(a), (c), (d), and (f) of this Chapter, respectively.
- (d) Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefit as defined in Rule 0780-01-58-.09(2) of this Chapter, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in an foreign country as defined in Rules 0780-01-58-.09(3)(a), (c), and (f) of this Chapter, respectively.
- (e) Standardized Medicare supplement [regular] Plan F shall include only the following: The basic (core) benefit as defined in Rule 0780-01-58-.09(2) of this Chapter, plus one hundred percent (100%) of the Medicare Part A deductible, the skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Rules 0780-01-58-.09(3)(a), (c), (d), (e), and (f), respectively.
- (f) Standardized Medicare supplement Plan F ~~W~~with High Deductible shall include only the following: one hundred percent (100%) of covered expenses following the payment of the annual deductible set forth in part 2. below.
  1. The basic (core) benefit as defined in Rule 0780-01-58-.09(2) of this Chapter regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Rules 0780-01-58-.09(3)(a), (c), (d), (e), and (f) of this Chapter, respectively.
  2. The annual deductible in Plan F ~~W~~with High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by regular Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be one thousand five hundred dollars (\$1,500) and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve (12) month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars (\$10).
- (g) Standardized Medicare supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in Rule 0780-01-58-.09(2) of this Chapter regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Rules 0780-01-58-.09(3)(a), (c), (e), and (f) of this Chapter, respectively. Effective January 1, 2020, the standardized benefit plans described in Rule 0780-01-58-.12(1)(d) of this Chapter (Redesignated Plan G High Deductible) may be offered to any individual who was eligible for Medicare prior to January 1, 2020.

- (h) Standardized Medicare supplement Plan K is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:
1. Part A Hospital Coinsurance, sixty-first (61st) through ninetieth (90th) days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the sixty-first (61st) through the ninetieth (90th) day in any Medicare benefit period;
  2. Part A Hospital Coinsurance, ninety-first (91st) through one hundred fiftieth (150th) days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first (91st) through the one hundred fiftieth (150th) day in any Medicare benefit period;
  3. Part A Hospitalization After one hundred fifty (150) Days: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;
  4. Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in part 10.;
  5. Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the twenty-first (21st) day through the one hundredth (100th) day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in part 10.;
  6. Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in part 10.;
  7. Blood: Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in part 10.;
  8. Part B Cost Sharing: Except for coverage provided in part 9., coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in part 10.;
  9. Part B Preventive Services: Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and
  10. Cost Sharing After Out-of-Pocket Limits: Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of four thousand dollars (\$4000) in 2006, indexed each

year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

- (i) Standardized Medicare supplement Plan L is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:
    - 1. The benefits described in subparagraph (h), parts 1., 2., 3., and 9.;
    - 2. The benefit described in subparagraph (h), parts 4., 5., 6., 7., and 8., but substituting seventy-five percent (75%) for fifty percent (50%); and
    - 3. The benefit described in subparagraph (h), part 10., but substituting two thousand dollars (\$2000) for four thousand dollars (\$4000).
  - (j) Standardized Medicare supplement Plan M shall include only the following: The basic (core) benefit as defined in Rule 0780-01-58-.09(2) of this Chapter, plus fifty percent (50%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Rules 0780-01-58-.09(3)(b), (c), and (f) of this Chapter, respectively.
  - (k) Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in Rule 0780-01-58-.09(2) of this Chapter, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Rules 0780-01-58-.09(3)(a), (c), and (f) of this Chapter, respectively, with co-payments in the following amounts:
    - 1. the lesser of twenty dollars (\$20) or the Medicare Part B coinsurance or co-payment for each covered health care provider office visit, including visits to medical specialists; and
    - 2. the lesser of fifty dollars (\$50) or the Medicare Part B coinsurance or co-payment for each covered emergency room visit, however, this co-payment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.
- (6) New or Innovative Benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

**Authority:** T.C.A. §§ ~~56-1-704, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., 56-7-1453, 56-7-1454, 56-7-1455, 56-7-1457, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a)~~, and *Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), and Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008)*, and *Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015)*.

**0780-01-58-.12 STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 2020 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY ON OR AFTER JANUARY 1, 2020.**

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the following standards which are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of T.C.A. Title 56, Chapter 7, Part 14 and all applicable benefit standards in Rules 0780-01-58-.07 and 0780-01-58-.08 of this Chapter.

- (1) Benefit Requirements. The standards and requirements of Rule 0780-01-58-.11 shall apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions:
  - (a) Standardized Medicare supplement benefit Plan C is redesignated as Plan D and shall provide the benefits contained in Rule 0780-01-58-.11(5)(c) of this Chapter but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.
  - (b) Standardized Medicare supplement benefit Plan F is redesignated as Plan G and shall provide the benefits contained in Rule 0780-01-58-.11(5)(e) of this Chapter but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.
  - (c) Standardized Medicare supplement benefit plans C, F, and F with High Deductible may not be offered to individuals newly eligible for Medicare on or after January 1, 2020.
  - (d) Standardized Medicare supplement benefit Plan F with High Deductible is redesignated as Plan G with High Deductible and shall provide the benefits contained in Rule 0780-01-58-.11(5)(f) of this Chapter but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible; provided further that, the Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible.
  - (e) The reference to Plans C or F contained in Rule 0780-01-58-.11(1)(b) is deemed a reference to Plans D or G for purposes of this Rule.
- (2) Applicability to Certain Individuals. This Rule applies only to individuals that are newly eligible for Medicare on or after January 1, 2020:
  - (a) By reason of attaining the age of 65 on or after January 1, 2020; or
  - (b) By reason of entitlement to benefits under part A pursuant to Section 226(b) or 226A of the Social Security Act, or who are deemed to be eligible for benefits under Section 226(a) of the Social Security Act on or after January 1, 2020.
- (3) Guaranteed Issue for Eligible Persons. For purposes of Rule 0780-01-58-.15(5), in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare supplement policy C or F (including F with High Deductible) shall be deemed to be a reference to Medicare supplement policy D or G (including G with High Deductible), respectively, that meet the requirements of Rule 0780-01-58-.12.
- (4) Offer of Redesignated Plans to Individuals Other Than Newly Eligible. On or after January 1, 2020, the standardized benefit plans described in subparagraph (1)(d) above may be offered to any individual who was eligible for Medicare prior to January 1, 2020, in addition to the standardized plans described in Rule 0780-01-58-.11(5) of this Rule.

Authority: T.C.A. §§ 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a), and Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008) and Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015).

**0780-01-58-.4213 MEDICARE SELECT POLICIES AND CERTIFICATES.**

- (1) (a) This Rule shall apply to Medicare Select policies and certificates, as defined in this Rule.
  - (b) No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this Rule.
- (2) For the purposes of this Rule:
  - (a) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.
  - (b) "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.
  - (c) "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.
  - (d) "Medicare Select policy" or "Medicare Select certificate" mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.
  - (e) "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.
  - (f) "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.
  - (g) "Service area" means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare Select policy.
- (3) The commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this Rule and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, if the commissioner finds that the issuer has satisfied all of the requirements of this regulation-Chapter.
- (4) A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the commissioner.
- (5) A Medicare Select issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:
  - (a) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

1. Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.
  2. The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:
    - (i) To deliver adequately all services that are subject to a restricted network provision; or
    - (ii) To make appropriate referrals.
  3. There are written agreements with network providers describing specific responsibilities.
  4. Emergency care is available twenty-four (24) hours per day and seven (7) days per week.
  5. In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph part shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.
- (b) A statement or map providing a clear description of the service area.
  - (c) A description of the grievance procedure to be utilized.
  - (d) A description of the quality assurance program, including:
    1. The formal organizational structure;
    2. The written criteria for selection, retention and removal of network providers; and
    3. The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.
  - (e) A list and description, by specialty, of the network providers.
  - (f) Copies of the written information proposed to be used by the issuer to comply with Paragraph (9).
  - (g) Any other information requested by the commissioner.
- (6) (a) A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing the changes. Changes shall be considered approved by the commissioner after thirty (30) days unless specifically disapproved.
    - (b) An updated list of network providers shall be filed with the commissioner at least quarterly.
  - (7) A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

- (a) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and
  - (b) It is not reasonable to obtain services through a network provider.
- (8) A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.
- (9) A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:
- (a) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:
    - 1. Other Medicare supplement policies or certificates offered by the issuer; and
    - 2. Other Medicare Select policies or certificates.
  - (b) A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.
  - (c) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans K and L.
  - (d) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.
  - (e) A description of limitations on referrals to restricted network providers and to other providers.
  - (f) A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.
  - (g) A description of the Medicare Select issuer's quality assurance program and grievance procedure.
- (10) Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Paragraph (9) and that the applicant understands the restrictions of the Medicare Select policy or certificate.
- (11) A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.
- (a) The grievance procedure shall be described in the policy and certificates and in the outline of coverage.
  - (b) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.
  - (c) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

- (d) If a grievance is found to be valid, corrective action shall be taken promptly.
  - (e) All concerned parties shall be notified about the results of a grievance.
  - (f) The issuer shall report no later than each March 31st to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.
- (12) At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.
- (13) (a) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months.
- (b) For the purposes of this ~~subsection~~Paragraph, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this Subparagraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.
- (14) Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this Rule should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.
- (a) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.
- (b) For the purposes of this ~~subsection~~Paragraph, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this subparagraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.
- (15) A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

**Authority:** *T.C.A. §§ ~~56-1-701, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., 56-7-1453, 56-7-1454, 56-7-1455, 56-7-1457, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a), and Omnibus Budget Reconciliation Act of 1990, Pub L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), and Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008), and Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015).~~*

**0780-01-58-.4314 OPEN ENROLLMENT.**

- (1) An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with the first day of the first month in which an individual is both sixty-five (65) years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this ~~subsection~~Paragraph without regard to age.
- (2)
  - (a) If an applicant qualifies under Paragraph (1) and submits an application during the time period referenced in Paragraph (1) and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition.
  - (b) If the applicant qualifies under Paragraph (1) and submits an application during the time period referenced in Paragraph (1) and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this ~~subsection~~Paragraph.
- (3) Except as provided in Paragraph (2) and Rules 0780-01-58-.4415 and .2526, Paragraph (1) of this Rule shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

**Authority:** *T.C.A. §§ 56-1-704, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., 56-7-1453, 56-7-1454, 56-7-1455, 56-7-1457, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a), and Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), and Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008), and Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015).*

**0780-01-58-.4415 GUARANTEED ISSUE FOR ELIGIBLE PERSONS.**

- (1) Guaranteed Issue.
  - (a) Eligible persons are those individuals described in Paragraph (2) who seek to enroll under the policy during the period specified in Paragraph (3), and who submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment with the application for a Medicare supplement policy.
  - (b) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in Paragraph (5) that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.
- (2) Eligible Persons. An eligible person is an individual described in any of the following subparagraphs:

- (a) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual;
- (b) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, and any of the following circumstances apply, or the individual is sixty-five (65) years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:
  - 1. The certification of the organization or plan has been terminated;
  - 2. The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;
  - 3. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856, or the plan is terminated for all individuals within a residence area;
  - 4. The individual demonstrates, in accordance with guidelines established by the Secretary, that:
    - (i) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or
    - (ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or
  - 5. The individual meets such other exceptional conditions as the Secretary may provide.
- (c) 1. The individual is enrolled with:
  - (i) An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost);
  - (ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;
  - (iii) An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or
  - (iv) An organization under a Medicare Select policy; and
- 2. The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under subparagraph (2)(b).

- (d) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:
    - 1. (i) Of the insolvency of the issuer or bankruptcy of the non-issuer organization; or
    - (ii) Of other involuntary termination of coverage or enrollment under the policy;
    - 2. The issuer of the policy substantially violated a material provision of the policy; or
    - 3. The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;
  - (e) 1. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act or a Medicare Select policy; and
  - 2. The subsequent enrollment under part 1. is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act); ~~or.~~
  - (f) The individual, upon first becoming eligible for benefits under part A of Medicare at age sixty-five (65), enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment.
  - (g) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in subparagraph (5)(d).
  - (h) The individual is enrolled under Title XIX of the Social Security Act (Medicaid) and the enrollment involuntarily ceases after the individual is sixty-five (65) years of age or older and eligible for and enrolled in Medicare Part B.
- (3) Guaranteed Issue Time Periods.
- (a) In the case of an individual described in subparagraph (2)(a), the guaranteed issue period begins on the later of: (i) the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or (ii) the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter;
  - (b) In the case of an individual described in subparagraphs (2)(b), (2)(c), (2)(e) or (2)(f) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated;
  - (c) In the case of an individual described in subparagraph (2)(d), part 1., the guaranteed issue period begins on the earlier of: (i) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if

any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage is terminated;

- (d) In the case of an individual described in subparagraph (2)(b), subparagraph (2)(d), part 2., subparagraph (2)(d), part 3., and subparagraphs (2)(e) or (2)(f) who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date;
  - (e) In the case of an individual described in subparagraph (2)(g), the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty- ~~(60)~~ day period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; ~~and~~
  - (f) In the case of an individual described in subparagraph (2)(h), the guaranteed issue period begins on the date that the individual receives notice of the involuntary disenrollment and ends on the date that is sixty-three (63) days after the date the coverage is terminated. The appropriate state disenrolling agency shall notify the individual no later than eight (8) calendar days after the effective date of involuntary disenrollment of his or her rights under this Rule and of the obligations of issuers of Medicare supplement policies under this Rule.;
  - (g) Those individuals who were involuntarily disenrolled from Medicaid in the period of June 1, 2009<sub>1</sub> through September 18, 2009<sub>1</sub> will have an open enrollment period of six (6) months after September 18, 2009<sub>1</sub> in which to purchase coverage; further, the issuer shall not consider the period of time between the date of involuntary disenrollment and September 18, 2009<sub>1</sub> to be a break in the period of continuous creditable coverage, and shall calculate the period of creditable coverage as though the individual were submitting an application on the actual date of disenrollment for purposes of excluding benefits on the basis of a preexisting condition. Those individuals who are involuntarily disenrolled after September 18, 2009<sub>1</sub> but before March 3, 2010, ~~the effective date of this Chapter~~ will have an open enrollment period of six (6) months after the effective date the applicable coverage terminated.; and
  - (h) In the case of an individual described in Paragraph (2) but not described in the preceding provisions of this ~~Subsection~~Paragraph, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date.
- (4) Extended Medigap Access for Interrupted Trial Periods.
- (a) In the case of an individual described in subparagraph (2)(e) or deemed to be so described, pursuant to this subparagraph, whose enrollment with an organization or provider described in subparagraph (2)(e), part 1. is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in subparagraph (2)(e);
  - (b) In the case of an individual described in subparagraph (2)(f) or deemed to be so described, pursuant to this subparagraph whose enrollment with a plan or in a program described in subparagraph (2)(f) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in subparagraph (2)(f); and

- (c) For purposes of subparagraphs (2)(e) and (2)(f), no enrollment of an individual with an organization or provider described in subparagraph (2)(e), part 1., or with a plan or in a program described in subparagraph (2)(f), may be deemed to be an initial enrollment under this subparagraph after the two (2) year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.
- (5) Products to Which Eligible Persons are Entitled. The Medicare supplement policy to which eligible persons are entitled under:
- (a) Subparagraphs (2)(a), (b), (c), (d), and (h) ~~is~~ are Medicare supplement ~~policy~~ policies which ~~has~~ have a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L offered by any issuer, after January 1, 2020, Plan A, B, D, G (including G with a high deductible), K or L offered by any issuer;
- (b) 1. Subject to subparagraph (2)(e), part 2. is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in subparagraph (a);
2. After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this subparagraph is:
- (i) The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or
- (ii) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K, or L policy that is offered by any issuer;
- (c) Subparagraph (2)(f) shall include any Medicare supplement policy offered by any issuer;
- (d) Subparagraph (2)(g) is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L, after January 1, 2020, Plan A, B, D, G (including G with a high deductible), K, or L and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.
- (6) Notification provisions.
- (a) At the time of an event described in Paragraph (2) because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Paragraph (1). Such notice shall be communicated contemporaneously with the notification of termination.
- (b) At the time of an event described in Paragraph (2) because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Paragraph (1). Such notice shall be communicated within ten (10) working days of the issuer receiving notification of disenrollment.
- (c) At the time of an event described in subparagraph (2)(h), no later than eight (8) calendar days after the effective date of involuntary disenrollment, the appropriate state disenrolling

agency shall notify the individual of his or her rights under this Rule and of the obligations of issuers of Medicare supplement policies under this Rule.

**Authority:** *T.C.A. §§ ~~56-1-701~~, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., ~~56-7-1453, 56-7-1454, 56-7-1455, 56-7-1457, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a)~~, and Omnibus Budget Reconciliation Act of 1990, Pub L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), and Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008), and Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015).*

#### **0780-01-58-.1516 STANDARDS FOR CLAIMS PAYMENT.**

- (1) An issuer shall comply with Ssection 1882(c)(3) of the Social Security Act (as enacted by Ssection 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by:
  - (a) Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;
  - (b) Notifying the participating physician or supplier and the beneficiary of the payment determination;
  - (c) Paying the participating physician or supplier directly;
  - (d) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;
  - (e) Paying user fees for claim notices that are transmitted electronically or otherwise; and
  - (f) Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.
- (2) Compliance with the requirements set forth in Paragraph (1) shall be certified on the Medicare supplement insurance experience reporting form.

**Authority:** *T.C.A. §§ ~~56-1-701~~, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., ~~56-7-1453, 56-7-1454, 56-7-1455, 56-7-1457, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a)~~, and Omnibus Budget Reconciliation Act of 1990, Pub L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), and Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008), and Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015).*

#### **0780-01-58-.1617 LOSS RATIO STANDARDS AND REFUND OR CREDIT OF PREMIUM.**

- (1) Loss Ratio Standards.
  - (a) 1. A Medicare Supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits, not including anticipated refunds or credits, provided under the policy form or certificate form:
    - (i) At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or

- (ii) At least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies;
- 2. Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:
  - (i) Home office and overhead costs;
  - (ii) Advertising costs;
  - (iii) Commissions and other acquisition costs;
  - (iv) Taxes;
  - (v) Capital costs;
  - (vi) Administrative costs; and
  - (vii) Claims processing costs.
- (b) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.
- (c) For purposes of applying subparagraph (1)(a) and Rule 0780-01-58-.4718(3)(c) only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising including both print and broadcast advertising shall be deemed to be individual policies.
- (d) For policies issued prior to July 1, 2009, expected claims in relation to premiums shall meet:
  - 1. The originally filed anticipated loss ratio when combined with the actual experience since inception;
  - 2. The appropriate loss ratio requirement from subparagraph (1)(a), part 1., subparts (i) and (ii) when combined with actual experience beginning with July 1, 2009 to date; and
  - 3. The appropriate loss ratio requirement from subparagraph (1)(a), part 1., subparts (i) and (ii) over the entire future period for which the rates are computed to provide coverage.
- (2) Refund or Credit Calculation.
  - (a) An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.
  - (b) If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit

calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

- (c) For the purposes of this section, policies or certificates issued prior to July 1, 2009, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after the July 1, 2009, date. The first report shall be due by May 31, 2011.
  - (d) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a *de minimis* level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for thirteen-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.
- (3) Annual filing of Premium Rates. An issuer of Medicare supplement policies and certificates issued before or after the effective date of this Chapter in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the commissioner, in accordance with the applicable filing procedures of this state:
- (a)
    - 1. Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing.
    - 2. An issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.
    - 3. If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this section.
  - (b) Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.
- (4) Public Hearings. The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form

issued before or after the effective date of this Chapter if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the commissioner.

**Authority:** *T.C.A. §§ ~~56-1-701~~, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., 56-7-1453, 56-7-1454, 56-7-1455, 56-7-1457, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a), and Omnibus Budget Reconciliation Act of 1990, Pub L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), and Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008), and Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015).*

#### **0780-01-58-.~~17~~18 FILING AND APPROVAL OF POLICIES AND CERTIFICATES AND PREMIUM RATES.**

- (1) An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner.
- (2) An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the commissioner in the state in which the policy or certificate was issued.
- (3) An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner.
- (4)
  - (a) Except as provided in subparagraph (b), an issuer shall not file for approval more than one (1) form of a policy or certificate of each type for each standard Medicare supplement benefit plan.
  - (b) An issuer may offer, with the approval of the commissioner, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one (1) for each of the following cases:
    1. The inclusion of new or innovative benefits;
    2. The addition of either direct response or agent marketing methods;
    3. The addition of either guaranteed issue or underwritten coverage; or
    4. The offering of coverage to individuals eligible for Medicare by reason of disability.
  - (c) For the purposes of this ~~section~~Rule, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.
- (5)
  - (a) Except as provided in ~~part 4.~~Rule 0780-01-58-.18(5)(a)1., an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this Chapter that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.
    1. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of

the notice by the commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this state.

2. An issuer that discontinues the availability of a policy form or certificate form pursuant to subparagraph ~~(5)(a)~~ Rule 0780-01-58-.18(5)(a)1 shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.
- (b) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection Rule.
- (c) A change in the rating structure or methodology shall be considered a discontinuance under subparagraph (a) unless the issuer complies with the following requirements:
  1. The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.
  2. The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential that is in the public interest.
- (6) (a) Except as provided in subparagraph (b), the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Rule 0780-1-58-.~~16~~17.
- (b) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.
- (7) The commissioner may approve "attained age" rate structures for Medicare supplement policies or certificates based upon a determination that the benefits provided in the policy are reasonable in relation to the premium charged.

**Authority:** *T.C.A. §§ ~~56-1-701, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., 56-7-1453, 56-7-1454, 56-7-1455, 56-7-1457, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a), and Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), and Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008), and Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015).~~*

#### **0780-01-58-.~~18~~19 PERMITTED COMPENSATION ARRANGEMENTS.**

- (1) An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than ~~200~~two hundred percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.
- (2) The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five (5) renewal years.

- (3) No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.
- (4) For purposes of this sectionRule, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

**Authority:** *T.C.A. §§ ~~56-1-701~~, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., ~~56-7-1453, 56-7-1454, 56-7-1455, 56-7-1457, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a)~~, and Omnibus Budget Reconciliation Act of 1990, Pub L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), and Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008), and Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015).*

#### **0780-01-58-.4920 REQUIRED DISCLOSURE PROVISIONS.**

- (1) General Rules.
  - (a) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.
  - (b) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after the date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.
  - (c) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.
  - (d) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."
  - (e) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.
  - (f) 1. Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a *Guide to Health Insurance for People with Medicare* in the form developed jointly by the National Association of Insurance Commissioners and CMS and in a type size no smaller than twelve (12)

point type. Delivery of the *Guide* shall be made whether or not the policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this ~~regulation~~Chapter. Except in the case of direct response issuers, delivery of the *Guide* shall be made to the applicant at the time of application and acknowledgement of receipt of the *Guide* shall be obtained by the issuer. Direct response issuers shall deliver the *Guide* to the applicant upon request but not later than at the time the policy is delivered.

2. For the purposes of this ~~section~~Rule, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

(2) Notice Requirements.

- (a) As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the commissioner. The notice shall:

1. Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, and
2. Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

- (b) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

- (c) The notices shall not contain or be accompanied by any solicitation.

- (3) MMA Notice Requirements. Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

(4) Outline of Coverage Requirements for Medicare Supplement Policies.

- (a) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant; and

- (b) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name:

**NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.**<sup>21</sup>

- (c) The outline of coverage provided to applicants pursuant to this Paragraph ~~section~~consists of four (4) parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than twelve (12) point type. All plans shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be

prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

- (d) The following items shall be included in the outline of coverage in the order prescribed below:

**Benefit Chart of Medicare Supplement Plans Sold  
with an effective date of coverage on or After June 1, 2010**

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state. Plans E, H, I, and J are no longer available for sale. [This sentence shall not appear after June 1, 2011.]

**Basic Benefits:**

- **Hospitalization** –Part A coinsurance plus coverage for three hundred sixty-five (365) additional days after Medicare benefits end.
- **Medical Expenses** –Part B coinsurance (generally twenty percent (20%) of Medicare-approved expenses) or co-payments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or co-payments.
- **Blood** –First three (3) pints of blood each year.
- **Hospice**— Part A coinsurance

A	B	C	D	F	F*	G
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B coinsurance			
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible
		Part B Deductible		Part B Deductible		
				Part B Excess (100%)		Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency

\*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year ~~[\$2000]~~ deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed ~~[\$2000]~~. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

K	L	M	N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance; except up to \$20 copayment for office visit, and up to \$50 copayment for ER
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency

Out-of-pocket limit \$[46205120]; paid at 100% after limit reached	Out-of-pocket limit \$[23102560] ; paid at 100% after limit reached
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<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>F/F*</u>	<u>G</u>	<u>K</u>	<u>L</u>	<u>M</u>	<u>N</u>
Basic, Including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic including 100% Part B coinsurance except up to \$20 copayment for office visit and up to \$50 copayment for ER				
		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance			
	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible				
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit [\$5120]; paid at 100% after limit reached	Out-of-pocket limit [\$2560]; paid at 100% after limit reached		

**\*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2,200] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [\$2,200]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

**PREMIUM INFORMATION** [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

**DISCLOSURES** [Boldface Type]

Use this outline to compare benefits and premiums among policies.

~~This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010, have different benefits and premiums. Plans E, H, I, and J are no longer available for sale. [This paragraph shall not appear after June 1, 2011.]~~

**READ YOUR POLICY VERY CAREFULLY** [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

**RIGHT TO RETURN POLICY** [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within thirty (30) days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

**POLICY REPLACEMENT** [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

**NOTICE** [Boldface Type]

This policy may not fully cover all of your medical costs.

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]

[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

**COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]**

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four (4) plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this Chapter regulation. An issuer may use additional benefit plan designations on these charts pursuant to Rule 0780-1-58-.11(4) of this Chapter.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

**Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020**

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants **first (1st)** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G <sup>1</sup>	K	L	M	N	C	F <sup>1</sup>
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B Coinsurance or Copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply <sup>3</sup>	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in [2017] <sup>2</sup>					[\$5,120] <sup>2</sup>	[\$2,560] <sup>2</sup>				

<sup>1</sup> Plans F and G also have a high deductible option which require first paying a plan deductible of [\$2,200] before the plan begins to pay. Once the plan deductible is met, the plan pays one hundred percent (100%) of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

<sup>2</sup> Plans K and L pay one hundred percent (100%) of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

<sup>3</sup> Plan N pays one hundred percent (100%) of the Part B coinsurance, except for a co-payment of up to \$20 for some office visits and up to a fifty dollar (\$50) co-payment for emergency room visits that do not result in an inpatient admission.

**PLAN A**

**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

\* A benefit period begins on the first (1<sup>st</sup>) day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[4068\$1,316]	\$0	\$[4068\$1,316](Part A deductible)
61 <sup>st</sup> thru 90 <sup>th</sup> day	All but \$[267\$329] a day	\$[267\$329] a day	\$0
91 <sup>st</sup> day and after: —While using 60 lifetime reserve days	All but \$[534\$658] a day	\$[534\$658] a day	\$0
—Once lifetime reserve days are used:	\$0	100% of Medicare eligible expenses	\$0**
—Additional 365 days	\$0	\$0	All costs
—Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> thru 100 <sup>th</sup> day	All but \$[133.50\$164.50] a Day	\$0	Up to \$[133.50\$164.50] a day
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional three hundred sixty-five (365) days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN A**

**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

\* Once you have been billed \$[135\$183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES—</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as pPhysician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[135\$183] of Medicare Approved Amounts*	\$0	\$0	\$[135\$183] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$[135\$183] of Medicare Approved Amounts*	\$0	\$0	\$[135\$183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies —Durable medical equipment	100%	\$0	\$0
First \$[135\$183] of Medicare Approved Amounts*	\$0	\$0	\$[135\$183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**PLAN B**

**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

\* A benefit period begins on the first (1st) day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[4068\$1,316]	\$[4068\$1,316](Part A deductible)	\$0
61 <sup>st</sup> thru 90th day	All but \$[267\$329] a day	\$[267\$329] a day	\$0
91 <sup>st</sup> day and after: —While using 60 lifetime reserve days	All but \$[534\$658] a day	\$[534\$658] a day	\$0
—Once lifetime reserve days are used:	\$0	100% of Medicare eligible expenses	\$0**
—Additional 365 days	\$0	\$0	All costs
—Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> thru 100 <sup>th</sup> day	All but \$[133.50\$164.50] a day	\$0	Up to \$[133.50\$164.50] a day
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional three hundred sixty-five (365) days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN B**

**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

\* Once you have been billed \$[135\$183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES—</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, F First \$[135\$183] of Medicare Approved Amounts*	\$0	\$0	\$[135\$183] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$[135\$183] of Medicare Approved Amounts*	\$0	\$0	\$[135\$183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies  —Durable medical equipment	100%	\$0	\$0
First \$[135\$183] of Medicare Approved Amounts*	\$0	\$0	\$[135\$183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**PLAN C**

**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

\* A benefit period begins on the first (1st) day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[4068\$1,316]	\$[4068\$1,316](Part A deductible)	\$0
61 <sup>st</sup> thru 90th day	All but \$[267\$329] a day	\$[267\$329] a day	\$0
91 <sup>st</sup> day and after: —While using 60 lifetime reserve days	All but \$[534\$658] a day	\$[534\$658] a day	\$0
—Once lifetime reserve days are used:	\$0	100% of Medicare eligible expenses	\$0**
Additional 365 days —Beyond the additional 365 days	\$0	\$0	All costs

<p><b>SKILLED NURSING FACILITY CARE*</b>  You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</p> <p>First 20 days</p> <p>21<sup>st</sup> thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$<del>133.50</del>\$164.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$<del>133.50</del>\$164.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p><b>BLOOD</b></p> <p><b>First 3 pints</b></p> <p><b>Additional amounts</b></p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p><b>HOSPICE CARE</b></p> <p>You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	<p>All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care</p>	<p>Medicare co-payment/ coinsurance</p>	<p>\$0</p>

**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional three hundred sixty-five (365) days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN C**

**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

\* Once you have been billed \$[135\$183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES—</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[135\$183] of Medicare Approved Amounts*	\$0	\$[135\$183] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$[135\$183] of Medicare Approved Amounts*	\$0	\$[135\$183] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies  —Durable medical equipment	100%	\$0	\$0
First \$[ <del>135</del> \$183] of Medicare Approved Amounts*	\$0	\$[ <del>135</del> \$183](Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL—</b> NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

**PLAN D**

**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

\* A benefit period begins on the first (1st) day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1068\$1316]	\$[1068\$1316] (Part A deductible)	\$0
61st thru 90th day	All but \$[267\$329] a day	\$[267\$329] a day	\$0
91st day and after: —While using 60 lifetime reserve days	All but \$[534\$658] a day	\$[534\$658] a day \$0	\$0
—Once lifetime reserve days are used:	\$0	100% of Medicare eligible expenses	\$0**
Additional 365 days —Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[133.50\$164.50] a day	Up to \$[133.50\$164.50] a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	\$0

**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional three hundred sixty-five (365) days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN D**

**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

\* Once you have been billed \$[135\$183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES—</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[135\$183] of Medicare Approved Amounts*	\$0	\$0	\$[135\$183] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$[135\$183] of Medicare Approved Amounts*	\$0	\$0	\$[135\$183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PLAN D**  
**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies  —Durable medical equipment	100%	\$0	\$0
First \$[135\$183] of Medicare Approved Amounts*	\$0	\$0	\$[135\$183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL—NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

**PLAN F or HIGH DEDUCTIBLE PLAN F**

**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

- A benefit period begins on the first (1st) day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

**[\*\*This high deductible plan pays the same benefits as Plan F after ~~one has paid~~ you have paid a calendar year [\$2000,200] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$2000,200]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2000,200] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2000,200] DEDUCTIBLE,**] YOU PAY
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61st thru 90th day<sup>th</sup></p> <p>91st day and after: —While using 60</p> <p>Lifetime reserve days</p> <p>Once lifetime reserve days are used: —Additional 365 days</p> <p>Beyond the additional 365 days</p>	<p>All but \$[1068\$1,316]</p> <p>All but \$[267\$329] a day</p> <p>All but \$[534\$658] a day</p> <p>\$0</p> <p>\$0</p>	<p>\$[1068\$1,316] (Part A deductible)</p> <p>\$[267\$329] a day</p> <p>\$[534\$658] a day</p> <p>100% of Medicare eligible expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0***</p> <p>All costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101<sup>st</sup> day and after</p>	<p>All approved amounts</p> <p>All but \$[133.50\$164.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$[133.50\$164.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p><b>BLOOD</b> First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p><b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	<p>All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care</p>	<p>Medicare co-payment/coinsurance</p>	<p>\$0</p>

\*\*\* **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional three hundred sixty-five (365) days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN F or HIGH DEDUCTIBLE PLAN F**

**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed \$[435183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[\*\*This high deductible plan pays the same benefits as Plan F after ~~one has paid~~ you have paid a calendar year ~~[\$2000,200]~~ deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are ~~[\$2000,200]~~. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2000,200] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2000,200] DEDUCTIBLE,**] YOU PAY
<b>MEDICAL EXPENSES -</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, Such as physician's Services, inpatient and Outpatient medical and Surgical services and Supplies, physical and Speech therapy, Diagnostic tests, Durable medical Equipment, First \$[435183] of Medicare Approved amounts*	\$0	\$[435183] (Part B deductible)	\$0
Remainder of Medicare Approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B excess charges</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$[435183] of Medicare Approved amounts*	\$0	All costs	\$0
Remainder of Medicare Approved amounts	\$0	\$[435183] (Part B deductible)	\$0
Remainder of Medicare Approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PLAN F or HIGH DEDUCTIBLE PLAN F**

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>AFTER YOU PAY \$[<del>\$2000,200</del>] DEDUCTIBLE,** PLAN PAYS</b>	<b>IN ADDITION TO \$[<del>\$2000,200</del>] DEDUCTIBLE,** YOU PAY</b>
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies  —Durable medical equipment	100%	\$0	\$0
First \$[ <del>135</del> \$183] of Medicare Approved Amounts*	\$0	\$[ <del>135</del> \$183] (Part B deductible)	\$0
Remainder of Medicare — Approved Amounts	80%	20%	\$0

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>AFTER YOU PAY \$[<del>\$2000,200</del>] DEDUCTIBLE,** PLAN PAYS</b>	<b>IN ADDITION TO \$[<del>\$2000,200</del>] DEDUCTIBLE,** YOU PAY</b>
<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b> Medically necessary Emergency care services Beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

**PLAN G or HIGH DEDUCTIBLE PLAN G**

**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

\* A benefit period begins on the first (1st) day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

[\*\*This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [\$2,200] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [\$2,200]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$2,200] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO [\$2,200] DEDUCTIBLE, **] YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day  91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$[1068\$1,316]  All but \$[267\$329] a day  All but \$[534\$658] a day  \$0  \$0	\$[1068\$1,316] (Part A deductible)  \$[267\$329] a day  \$[534\$658] a day  100% of Medicare eligible expenses  \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING            FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital First 20 days  21 <sup>st</sup> thru 100th day  101st day and after	All approved amounts  All but \$[133.50\$164.50] a day  \$0	\$0 Up to \$[133.50\$164.50] a day  \$0	\$0  \$0  All costs
<b>BLOOD</b> First 3 pints  Additional amounts	\$0  100%	3 pints  \$0	\$0  \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/ coinsurance for out- patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	\$0

\*\*\* **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional three hundred sixty-five (365) days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

### **PLAN G or HIGH DEDUCTIBLE PLAN G**

#### **MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

\* Once you have been billed \$~~133.50~~\$183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\* [\*\*This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [\$2,200] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [\$2,200]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY [\$2,200] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO [\$2,200] DEDUCTIBLE, **] YOU PAY
<b>MEDICAL EXPENSES—</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[135\$183] of Medicare  Approved Amounts*  Remainder of Medicare Approved Amounts	\$0      Generally 80%	\$0      Generally 20%	\$[135\$183] (Unless Part B deductible <u>has been</u> <u>met</u> )      \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	100%	All costs
<b>BLOOD</b> First 3 pints  Next \$[135\$183] of Medicare  Approved Amounts*  Remainder of Medicare Approved Amounts	\$0      \$0   80%	All costs      \$0   20%	\$0      \$[135\$183] (Unless Part B deductible <u>has been</u> <u>met</u> )   \$0
<b>CLINICAL LABORATORY            SERVICES—TESTS FOR            DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PLAN G or HIGH DEDUCTIBLE PLAN G**

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>[AFTER YOU PAY [\$2,200] DEDUCTIBLE, **] PLAN PAYS</b>	<b>[IN ADDITION TO [\$2,200] DEDUCTIBLE, **] YOU PAY</b>
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies  —Durable medical equipment	100%	\$0	\$0
First \$ <del>135</del> \$183 of Medicare Approved Amounts*	\$0	\$0	\$ <del>135</del> \$183 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>[AFTER YOU PAY [\$2,200] DEDUCTIBLE, **] PLAN PAYS</b>	<b>[IN ADDITION TO [\$2,200] DEDUCTIBLE, **] YOU PAY</b>
<b>FOREIGN TRAVEL—</b> NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maxi- mum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

## PLAN K

\* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[~~4,620~~\$5,120] each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare co-payment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

\*\* A benefit period begins on the first (1st) day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>HOSPITALIZATION**</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61 <sup>st</sup> thru 90th day  91st day and after:  —While using 60 lifetime reserve days  —Once lifetime reserve days are used: —Additional 365 days  —Beyond the additional 365 days	All but \$[ <del>1068</del> \$1,316]  All but \$[ <del>267</del> \$329] a day  All but \$[ <del>534</del> \$658] a day  \$0  \$0	\$[ <del>534</del> \$658](50% of Part A deductible)  \$[ <del>267</del> \$329] a day  \$[ <del>534</del> \$658] a day  100% of Medicare eligible expenses  \$0	\$[ <del>534</del> \$658](50% of Part A deductible)♦  \$0  \$0  \$0***  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days  21 <sup>st</sup> thru 100th day  101st day and after	All approved amounts All but \$[ <del>133.50</del> \$164.50] a day  \$0	\$0 Up to \$[ <del>66.75</del> \$82.25] a day  \$0	\$0 Up to \$[ <del>66.75</del> \$82.25] a day ♦  All costs
<b>BLOOD</b> First 3 pints  Additional amounts	\$0  100%	50%  \$0	50%♦  \$0
<b>HOSPICE CARE</b>  You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	50% of Co-payment/coinsurance	50% of Medicare Co-payment/coinsurance ♦

\*\*\* **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional three hundred sixty-five (365) days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN K**

**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

\* Once you have been billed \$[~~135~~\$183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>MEDICAL EXPENSES—</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[ <del>135</del> \$183] of Medicare Approved Amounts**** Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	\$0  Generally 80% or more of Medicare Approved Amounts  Generally 80%	\$0  Remainder of Medicare Approved Amounts  Generally 10%	\$[ <del>135</del> \$183] (Part B deductible)**** ♦ All costs above Medicare Approved Amounts  Generally 10% ♦
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [ <del>\$4620</del> \$5,120])*
<b>BLOOD</b> First 3 pints Next \$[ <del>135</del> \$183] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	\$0 \$0 Generally 80%	50% \$0 Generally 10%	50%♦ \$[ <del>135</del> \$183] (Part B deductible)**** ♦ Generally 10% ♦
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

\* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[4620\$5,120] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**PLAN K**  
**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[135\$183] of Medicare Approved Amounts*****	\$0	\$0	\$[135\$183] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	10%	10%♦

\*\*\*\*\*Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

**PLAN L**

\* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$~~2,340~~\$2,560 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays one hundred percent (100%) of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

\*\* A benefit period begins on the first (1st) day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>HOSPITALIZATION**</b> Semiprivate room and board, general nursing and miscellaneous services and supplies  First 60 days  61st thru 90th day  91st day and after: —While using 60 lifetime reserve days  —Once lifetime reserve days are used: —Additional 365 days  —Beyond the additional 365 days	All but \$ <del>1,068</del> <u>\$1,316</u>  All but \$ <del>267</del> <u>\$329</u> a day  All but \$ <del>534</del> <u>\$658</u> a day  \$0  \$0	\$ <del>808.50</del> <u>\$987</u> (75% of Part A deductible)  \$ <del>267</del> <u>\$329</u> a day  \$ <del>534</del> <u>\$658</u> a day  100% of Medicare eligible expenses  \$0	\$ <del>267</del> <u>\$329</u> (25% of Part A deductible)♦  \$0  \$0  \$0***  All costs
<b>SKILLED NURSING FACILITY CARE**</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital  First 20 days  21 <sup>st</sup> thru 100th day  101st day and after	All approved amounts  All but \$ <del>133.50</del> <u>\$164.50</u> a day  \$0	\$0  Up to \$ <del>100.13</del> <u>\$123.38</u> a day (75% of Part A Coinsurance)  \$0	\$0  Up to \$ <del>33.38</del> <u>\$41.13</u> a day (25% of Part A Coinsurance)♦  All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>BLOOD</b> First 3 pints	\$0	75%	25%♦
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	75% of co-payment/ coinsurance	25% of co-payment/ coinsurance ♦

\*\*\* **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional three hundred sixty-five (365) days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

#### PLAN L

#### MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

\*\*\*\* Once you have been billed \$[~~135~~\$183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>MEDICAL EXPENSES—</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[ <del>135</del> \$183] of Medicare Approved Amounts****	\$0	\$0	\$[ <del>135</del> \$183] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 80/75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [ \$2310 \$2,560 ])*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>BLOOD</b>			
First 3 pints	\$0	75%	25%♦
Next \$[135\$183] of Medicare Approved Amounts****	\$0	\$0	\$[135\$183] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

\* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[2310\$2,560] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**PLAN L**

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies —Durable medical equipment	100%	\$0	\$0
First \$[135\$183] of Medicare Approved Amounts****	\$0	\$0	\$[135\$183] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	15%	5% ♦

\*\*\*\*Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

**PLAN M**

**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

\* A benefit period begins on the first (1st) day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[4068\$1,316]	\$[534\$658](50% of Part A deductible)	\$[534\$658](50% of Part A deductible)
61 <sup>st</sup> thru 90th day	All but \$[267\$329] a day	\$[267\$329] a day	\$0
91 <sup>st</sup> day and after: —While using 60 lifetime reserve days	All but \$[534\$658] a day	\$[534\$658] a day	\$0
—Once lifetime reserve days are used: —Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> thru 100th day	All but \$[433.50\$164.50] a day	Up to \$[433.50\$164.50] a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	\$0

**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional three hundred sixty-five (365) days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN M**

**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

\* Once you have been billed \$[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES—</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment —First \$[183] of Medicare Approved Amounts*	\$0	\$0	\$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs

<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$[183] of Medicare Approved Amounts*	\$0	\$0	\$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b>			
MEDICARE APPROVED SERVICES	100%	\$0	\$0
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[183] of Medicare	\$0	\$0	\$[183] (Part B deductible)
First \$[183] of Medicare Approved Amounts*	\$0	\$0	\$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL—</b> NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

**PLAN N**

**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

\* A benefit period begins on the first (1st) day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[ <del>1068</del> \$1,316]	\$[ <del>1068</del> \$1,316](Part A deductible)	\$0
61 <sup>st</sup> thru 90th day	All but \$[ <del>267</del> \$329] a day	\$[ <del>267</del> \$329] a day	\$0
91 <sup>st</sup> day and after: —While using 60 lifetime reserve days	All but \$[ <del>534</del> \$658] a day	\$[ <del>534</del> \$658] a day	\$0
—Once lifetime reserve days are used: —Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> thru 100th day	All but \$[ <del>133.50</del> \$164.50] a day	Up to \$[ <del>133.50</del> \$164.50] a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	\$0

**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional three hundred sixty-five (365) days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN N**

**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

\* Once you have been billed \$[~~135~~\$183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES—</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[ <del>135</del> \$183] of Medicare			
Approved Amounts*	\$0	\$0	\$[ <del>135</del> \$183] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to [\$20] per office visit and up to [\$50] per emergency room visit. The co-payment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to [\$20] per office visit and up to [\$50] per emergency room visit. The co-payment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs

<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$[135\$183] of Medicare Approved Amounts*	\$0	\$0	\$[135\$183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b>			
MEDICARE APPROVED SERVICES	100%	\$0	\$0
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment	\$0	\$0	\$[135] (Part B deductible)
First \$[135\$183] of Medicare Approved Amounts*	\$0	\$0	[\$183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL—NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of	20% and amounts over the \$50,000 lifetime

(5) Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.

- (a) Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy, a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. § 1395 et seq.), disability income policy; or other policy identified in ~~Section 3B of this regulation~~ Rule 0780-01-58-.03(2), issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than twelve (12) point type and shall contain the following language:

“THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.”

- (b) Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in subparagraph (4)(a) shall disclose, using the applicable statement in Appendix C, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

**Authority:** *T.C.A. §§ ~~56-1-701, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., 56-7-1453, 56-7-1454, 56-7-1455, 56-7-1457, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a), and Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), and Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008), and Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015).~~*

**0780-01-58-.2021 REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE.**

- (1) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare supplement, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

**[Statements]**

- (1) You do not need more than one (1) Medicare supplement policy.
- (2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- (3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- (4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for twenty-four (24) months. You must request this suspension within ninety (90) days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within ninety (90) days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

- (5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within ninety (90) days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- (6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

**[Questions]**

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS. [Please mark Yes or No below with an "X"]

To the best of your knowledge,

- (1) (a) Did you turn age sixty-five (65) in the last six (6) months? Yes \_\_\_ No \_\_\_
- (b) Did you enroll in Medicare Part B in the last six (6) months? Yes \_\_\_ No \_\_\_
- (c) If yes, what is the effective date? \_\_\_\_\_
- (2) Are you covered for medical assistance through the state Medicaid program?

[NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]

Yes \_\_\_ No \_\_\_

If yes,

If yes,

- (a) Will Medicaid pay your premiums for this Medicare supplement policy? Yes \_\_\_  
Yes \_\_\_ No \_\_\_
- (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?  
Yes \_\_\_ No \_\_\_

- (3) (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START / / END / /

- (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Yes \_\_\_ No \_\_\_

- (c) Was this your first time in this type of Medicare plan? Yes \_\_\_ No \_\_\_

- (d) Did you drop a Medicare supplement policy to enroll in the Medicare plan? Yes \_\_\_ No \_\_\_

- (4) (a) Do you have another Medicare supplement policy in force?

Yes \_\_\_ No \_\_\_

- (b) If so, with what company, and what plan do you have [optional for Direct Mailers]?

\_\_\_\_\_

- (c) If so, do you intend to replace your current Medicare supplement policy with this policy?

Yes \_\_\_ No \_\_\_

- (5) Have you had coverage under any other health insurance within the past sixty-three (63) days? (For example, an employer, union, or individual plan)

Yes \_\_\_ No \_\_\_

- (a) If so, with what company and what kind of policy?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- (b) What are your dates of coverage under the other policy?

START \_\_/\_\_/\_\_ END \_\_/\_\_/\_\_

(If you are still covered under the other policy, leave "END" blank.)"  
[end of questions in form]

- (2) Agents shall list any other health insurance policies they have sold to the applicant.
  - (a) List policies sold which are still in force.
  - (b) List policies sold in the past five (5) years that are no longer in force.
- (3) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.
- (4) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One (1) copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.
- (5) The notice required by Paragraph (4) for an issuer shall be provided in substantially the following form in no less than twelve (12) point type:

**NOTICE TO APPLICANT REGARDING ~~REPLACEMENT~~ REPLACEMENT  
OF MEDICARE SUPPLEMENT INSURANCE  
OR MEDICARE ADVANTAGE**

[Insurance company's name and address]

**SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.**

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

**STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:**

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one (1)):

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.

\_\_\_\_\_ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

\_\_\_\_\_ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.  
[optional only for Direct Mailers. ]

\_\_\_\_\_ Other. (please specify) \_\_\_\_\_

1. **Note:** If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

\_\_\_\_\_ (Signature of Agent, Broker or  
Other Representative)\*

[Typed Name and Address of Issuer, Agent or Broker]

\_\_\_\_\_  
(Applicant's Signature)

\_\_\_\_\_  
(Date)

\*Signature not required for direct response sales.

- (6) Paragraphs 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

**Authority:** *T.C.A. §§ ~~56-1-701~~, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., ~~56-7-1453, 56-7-1454, 56-7-1455, 56-7-1457, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a)~~, and Omnibus Budget Reconciliation Act of 1990, Pub L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), ~~and Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008)~~, and Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015).*

## **0780-01-58-.2122 FILING REQUIREMENTS FOR ADVERTISING.**

An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the ~~Commissioner of Commerce and Insurance of this state for review or approval by the commissioner~~ to the extent it may be required under state law.

**Authority:** ~~T.C.A. §§ 56-1-701, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., 56-7-1453, 56-7-1454, 56-7-1455, 56-7-1457, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a), and Omnibus Budget Reconciliation Act of 1990, Pub L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), and Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008), and Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015).~~

## **0780-01-58-.2223 STANDARDS FOR MARKETING.**

- (1) An issuer, directly or through its producers, shall:
  - (a) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.
  - (b) Establish marketing procedures to assure excessive insurance is not sold or issued.
  - (c) Display prominently by type, stamp or other appropriate means, on the first page of the policy the following:

**“Notice to buyer: This policy may not cover all of your medical expenses.”**
  - (d) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.
  - (e) Establish auditable procedures for verifying compliance with this Paragraph.
- (2) In addition to the practices prohibited in T.C.A. §§ 56-8-101, *et seq.*, the following acts and practices are prohibited:
  - (a) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy or to take out a policy of insurance with another insurer.
  - (b) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.
  - (c) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.
- (3) The terms “Medicare Supplement,” “Medigap,” “Medicare Wrap-Around” and words of similar import shall not be used unless the policy is issued in compliance with this Chapter.

**Authority:** ~~T.C.A. §§ 56-1-701, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., 56-7-1453, 56-7-1454, 56-7-1455, 56-7-1457, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a), and Omnibus Budget Reconciliation Act of 1990, Pub L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), and Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008), and Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015).~~

**0780-01-58-.2324 APPROPRIATENESS OF RECOMMENDED PURCHASE AND EXCESSIVE INSURANCE.**

- (1) In recommending the purchase or replacement of any Medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.
- (2) Any sale of a Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is prohibited.
- (3) An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

**Authority:** *T.C.A. §§ ~~56-1-701~~, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., ~~56-7-1453~~, ~~56-7-1454~~, ~~56-7-1455~~, ~~56-7-1457~~, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a), and Omnibus Budget Reconciliation Act of 1990, Pub L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), and Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008), and Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015).*

**0780-01-58-.2425 REPORTING OF MULTIPLE POLICIES.**

- (1) On or before March 1 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate:
  - (a) Policy and certificate number; and
  - (b) Date of issuance.
- (2) The items set forth above must be grouped by individual policyholder.

**Authority:** *T.C.A. §§ ~~56-1-701~~, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., ~~56-7-1453~~, ~~56-7-1454~~, ~~56-7-1455~~, ~~56-7-1457~~, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a), and Omnibus Budget Reconciliation Act of 1990, Pub L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), and Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008), and Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015).*

**0780-01-58-.2526 PROHIBITION AGAINST PREEXISTING CONDITIONS, WAITING PERIODS, ELIMINATION PERIODS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES.**

- (1) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate for similar benefits to the extent such time was spent under the original policy.
- (2) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods for benefits similar to those contained in the original policy or certificate.

**Authority:** *T.C.A. §§ ~~56-1-701~~, ~~56-2-301~~, 56-6-112, 56-6-124(a), 56-7-1401 et seq., ~~56-7-1453~~, ~~56-7-1454~~, ~~56-7-1455~~, ~~56-7-1457~~, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a), and Omnibus Budget Reconciliation Act of 1990, Pub L. No. 101-508, (1990), Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008), and Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008), and Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015).*

**0780-01-58-.2627 PROHIBITION AGAINST USE OF GENETIC INFORMATION AND REQUESTS FOR GENETIC TESTING.**

This Rule Section applies to all policies with policy years beginning on or after May 21, 2009.

- (1) An issuer of a Medicare supplement policy or certificate:
  - (a) Shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a pre-existing condition) on the basis of the genetic information with respect to such individual; and
  - (b) Shall not discriminate in the pricing of the policy or certificate, including the adjustment of premium rates, of an individual on the basis of the genetic information with respect to such individual.
- (2) Nothing in Paragraph (1) shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from:
  - (a) Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or
  - (b) Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group).
- (3) An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.
- (4) Rule Paragraph (3) shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under part C of title XI and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) and consistent with Paragraph (1).
- (5) For purposes of carrying out Paragraph (4), an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.
- (6) Notwithstanding Paragraph (3), an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:
  - (a) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.
  - (b) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that—:
    1. compliance with the request is voluntary; and
    2. non-compliance will have no effect on enrollment status or premium or contribution amounts.
  - (c) No genetic information collected or acquired under this Paragraph shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.

- (d) The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this Paragraph, including a description of the activities conducted.
  - (e) The issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this Paragraph.
- (7) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.
  - (8) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.
  - (9) If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of Paragraph (8) if such request, requirement, or purchase is not in violation of Paragraph (7).
  - (10) For the purposes of this Rule only:
    - (a) "Issuer of a Medicare supplement policy or certificate" includes a third-party administrator, or other person acting for or on behalf of such issuer.
    - (b) "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.
    - (c) "Genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual.
    - (d) "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.
    - (e) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.
    - (f) "Underwriting purposes" means,
      1. ~~r~~Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;
      2. ~~t~~The computation of premium or contribution amounts under the policy;
      3. ~~t~~The application of any pre-existing condition exclusion under the policy; and
      4. eOther activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

**Authority:** T.C.A. §§ ~~56-1-701, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., 56-7-1453, 56-7-1454, 56-7-1455, 56-7-1457, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a)~~, and *Omnibus Budget Reconciliation Act of 1990, Pub L. No. 101-508, (1990)*, *Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008)*, and *Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008)*, and *Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015)*.

**0780-01-58-.2728 SEVERABILITY.**

If any provision of this Chapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Chapter and the application of such provision to other persons or circumstances shall not be affected thereby.

**Authority:** T.C.A. §§ ~~56-1-701, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., 56-7-1453, 56-7-1454, 56-7-1455, 56-7-1457, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a)~~, and *Omnibus Budget Reconciliation Act of 1990, Pub L. No. 101-508, (1990)*, *Genetic Information Non Discrimination Act, Pub. L. No.: 110-233 (2008)*, and *Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008)*, and *Medicare Access and CHIP Reauthorization Act, Pub. L. No: 114-10 (2015)*.

**0780-01-58-.28 EFFECTIVE DATE.**

The effective date of this Chapter shall be as set forth below.

**Authority:** T.C.A. §§ ~~56-1-701, 56-2-301, 56-6-112, 56-6-124(a), 56-7-1401 et seq., 56-7-1453, 56-7-1454, 56-7-1455, 56-7-1457, 56-7-1501 et seq., 56-7-1503, 56-7-1504, 56-7-1505, 56-7-1507, and 56-32-118(a)~~, and *Omnibus Budget Reconciliation Act of 1990, Pub L. No. 101-508, (1990)*, *Genetic Information Non Discrimination Act, Pub, L. No.: 110-233 (2008)*, and *Medicare Improvements for Patients and Providers Act, Pub. L. No.: 110-275 (2008)*.

MEDICARE SUPPLEMENT REFUND CALCULATION FORM  
FOR CALENDAR YEAR \_\_\_\_\_

TYPE<sup>1</sup> \_\_\_\_\_ SMSBP<sup>2</sup> \_\_\_\_\_  
 For the State of \_\_\_\_\_ Company Name \_\_\_\_\_  
 NAIC Group Code \_\_\_\_\_ NAIC Company Code \_\_\_\_\_  
 Address \_\_\_\_\_ Person Completing Exhibit \_\_\_\_\_  
 Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

Line		(a) Earned Premium <sup>3</sup>	(b) Incurred Claims <sup>4</sup>
1.	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues <sup>5</sup>		
	c. Net (for reporting purposes = 1a-1b)		
2.	Past Years' Experience (all policy years)		
3.	Total Experience (Net Current Year + Past Year)		
4.	Refunds Last Year (Excluding Interest)		
5.	Previous Since Inception (Excluding Interest)		
6.	Refunds Since Inception (Excluding Interest)		
7.	Benchmark Ratio Since Inception ( <i>see worksheet for Ratio 1</i> )		
8.	Experienced Ratio Since Inception ( <i>Ratio 2</i> ) $\frac{\text{Total Actual Incurred Claims (line 3, col. b)}}{\text{Total Earned Prem. (line 3, col. a) - Refunds Since Inception (line 6)}}$		
9.	Life Years Exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.		
10.	Tolerance Permitted (obtained from credibility table)		

**Medicare Supplement Credibility Table**

Life Years Exposed	
Since Inception	Tolerance
10,000 +	0.0%
5,000 -9,999	5.0%
2,500 -4,999	7.5%
1,000 -2,499	10.0%
500 - 999	15.0%
If less than 500, no credibility.	

- 
- 1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
  - 2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
  - 3 Includes Modal Loadings and Fees Charged
  - 4 Excludes Active Life Reserves
  - 5 This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

**MEDICARE SUPPLEMENT REFUND CALCULATION FORM  
FOR CALENDAR YEAR \_\_\_\_\_**

TYPE <sup>1</sup> _____	SMSBP <sup>2</sup> _____
For the State of _____	Company Name _____
NAIC Group Code _____	NAIC Company Code _____
Address _____	Person Completing Exhibit _____
Title _____	Telephone Number _____

11.	Adjustment to Incurred Claims for Credibility	
	Ratio 3 = Ratio 2 + Tolerance	

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.  
If Ratio 3 is less than the Benchmark Ratio, then proceed.

12.	Adjusted Incurred Claims	
	[Total Earned Premiums (line 3, col. a)–Refunds Since Inception (line 6)] x Ratio 3 (line 11)	
13.	Refund =	
	Total Earned Premiums (line 3, col. a)–Refunds Since Inception (line 6) –[Adjusted Incurred Claims (line 12)/Benchmark Ratio (Ratio 1)]	

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name - Please Type

\_\_\_\_\_  
Title - Please Type

\_\_\_\_\_  
Date

REPORTING FORM FOR THE CALCULATION OF BENCHMARK  
RATIO SINCE INCEPTION FOR GROUP POLICIES  
FOR CALENDAR YEAR \_\_\_\_\_

TYPE<sup>1</sup> \_\_\_\_\_ **SMSBP<sup>2</sup>** \_\_\_\_\_  
 For the State of \_\_\_\_\_ Company Name \_\_\_\_\_  
 NAIC Group Code \_\_\_\_\_ NAIC Company Code \_\_\_\_\_  
 Address \_\_\_\_\_ Person Completing Exhibit \_\_\_\_\_  
 Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

(a) <sup>3</sup>	(b) <sup>4</sup>	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o) <sup>5</sup>
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15+ <sup>6</sup>		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception:  $(l + n)/(k + m)$ : \_\_\_\_\_

<sup>1</sup> Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

<sup>2</sup> "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.

<sup>3</sup> Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.).

<sup>4</sup> For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

<sup>5</sup> These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

<sup>6</sup> To include the earned premium for all years prior to as well as the 15<sup>th</sup> year prior to the current year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK  
RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES  
FOR CALENDAR YEAR \_\_\_\_\_

TYPE<sup>1</sup> \_\_\_\_\_ SMSBP<sup>2</sup> \_\_\_\_\_  
 For the State of \_\_\_\_\_ Company Name \_\_\_\_\_  
 NAIC Group Code \_\_\_\_\_ NAIC Company Code \_\_\_\_\_  
 Address \_\_\_\_\_ Person Completing Exhibit \_\_\_\_\_  
 Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

(a) <sup>3</sup>	(b) <sup>4</sup>	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o) <sup>5</sup>
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15+ <sup>6</sup>		4.175		0.493		8.684		0.725		0.77
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception:  $(l + n)/(k + m)$ : \_\_\_\_\_

- <sup>1</sup> Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
- <sup>2</sup> "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
- <sup>3</sup> Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.).
- <sup>4</sup> For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
- <sup>5</sup> These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.
- <sup>6</sup> To include the earned premium for all years prior to as well as the 15<sup>th</sup> year prior to the current year.

**APPENDIX B**

**FORM FOR REPORTING  
MEDICARE SUPPLEMENT POLICIES**

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_

Due March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name and Title (please type)

\_\_\_\_\_  
Date

## APPENDIX C

### DISCLOSURE STATEMENTS

#### **Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare**

1. Section 1882 (d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.
2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).
3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.
4. Property/casualty and life insurance policies are not considered health insurance.
5. Disability income policies are not considered to provide benefits that duplicate Medicare.
6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
7. The federal law does not preempt state laws that are more stringent than the federal requirements.
8. The federal law does not preempt existing state form filing requirements.
9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

**This is not Medicare Supplement Insurance**

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits when it pays:**

- hospital or medical expenses up to the maximum stated in the policy

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

**Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that provide benefits for specified limited services.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

**This is not Medicare Supplement Insurance**

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits when:**

- any of the services covered by the policy are also covered by Medicare

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

**Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

**This is not Medicare Supplement Insurance**

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits when it pays:**

- hospital or medical expenses up to the maximum stated in the policy

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

**Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

**This is not Medicare Supplement Insurance**

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

**Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

**This is not Medicare Supplement Insurance**

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits when:**

- any expenses or services covered by the policy are also covered by Medicare

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- hospice
- other approved items and services

**Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

**This is not Medicare Supplement Insurance**

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits when:**

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization
- physician services
- hospice care
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items & services

**Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

**This is not Medicare Supplement Insurance**

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits when it pays:**

- the benefits stated in the policy and coverage for the same event is provided by Medicare

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

**Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

**Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

**Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.**

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

**Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

**Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

**Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

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[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

**Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization
- physician services
- hospice care
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items & services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

**Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or your state [health] insurance [assistance] program [SHIP].

**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

Board Member	Aye	No	Abstain	Absent	Signature (if required)
N/A					

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Commissioner (board/commission/ other authority) on 11/11/18 (mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 07/24/2018

Rulemaking Hearing(s) Conducted on: (add more dates). 9/14/2018



Date: 11/11/18

Signature: Julie Mix McPeak

Name of Officer: Julie Mix McPeak

Title of Officer: Commissioner

Subscribed and sworn to before me on: 11/11/18

Notary Public Signature: Denise M Lewis

My commission expires on: 1/15/20

Agency/Board/Commission: Tennessee Department of Commerce & Insurance

Rule Chapter Number(s): 0780-01-58

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slattery III  
Herbert H. Slattery III  
Attorney General and Reporter  
11/19/2018  
Date

**Department of State Use Only**

RECEIVED  
2018 NOV 20 PM 1:2  
SECRETARY OF STATE  
PUBLICATIONS

Filed with the Department of State on: 11/20/18

Effective on: 2/18/19

Tre Hargett  
Tre Hargett  
Secretary of State

## **G.O.C. STAFF RULE ABSTRACT**

**DEPARTMENT:** Department of Health

**DIVISION:** Board of Dietitians/Nutritionist Examiners

**SUBJECT:** Renewal Fee Decrease

**STATUTORY AUTHORITY:** Tennessee Code Annotated, Section 63-25-107

**EFFECTIVE DATES:** February 19, 2019 through June 30, 2019

**FISCAL IMPACT:** Minimal

**STAFF RULE ABSTRACT:** The amendment to Rule 0470-01-.06 decreases the biennial renewal fee for Dietitians/Nutritionists from \$90.00 to \$70.00.

**Public Hearing Comments**

One copy of a document that satisfies T.C.A. § 4-5-222 must accompany the filing.

There were no public comments, either written or oral.

## Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process, all agencies shall conduct a review of whether a proposed rule or rule affects small business.

**(1) The extent to which the rule or rules may overlap, duplicate, or conflict with other federal, state, and local governmental rules.**

This rule amendment does not overlap, duplicate, or conflict with other federal, state, and local government rules.

**(2) Clarity, conciseness, and lack of ambiguity in the rule or rules.**

This rule amendment is established with clarity, conciseness, and lack of ambiguity.

**(3) The establishment of flexible compliance and/or reporting requirements for small businesses.**

This rule amendment does not contain reporting requirements.

**(4) The establishment of friendly schedules or deadlines for compliance and/or reporting requirements for small businesses.**

This rule amendment does not contain reporting requirements.

**(5) The consolidation or simplification of compliance or reporting requirements for small businesses.**

This rule amendment does not contain reporting requirements.

**(6) The establishment of performance standards for small businesses as opposed to design or operational standards required in the proposed rule.**

This rule amendment does not establish performance standards for small businesses as opposed to design or operational standards required for the proposed rule.

**(7) The unnecessary creation of entry barriers or other effects that stifle entrepreneurial activity, curb innovation, or increase costs.**

This rule amendment does not create unnecessary barriers or other effects that stifle entrepreneurial activity, curb innovation, or increase costs.

STATEMENT OF ECONOMIC IMPACT TO SMALL BUSINESSES

**Name of Board, Committee or Council:** Board of Dietitian/Nutritionist Examiners

**Rulemaking hearing date:** August 31, 2018

- 1. Type or types of small business and an identification and estimate of the number of small businesses subject to the proposed rule that would bear the cost of, and/or directly benefit from the proposed rule:**

Dietitians/Nutritionists, as well as those that employ them will be affected. These groups will benefit from the fee reductions. Currently, there are one thousand seven hundred and seventy-two (1,772) Dietitians/Nutritionists.

- 2. Projected reporting, recordkeeping and other administrative costs required for compliance with the proposed rule, including the type of professional skills necessary for preparation of the report or record:**

These proposed rule amendments will not affect reporting or recordkeeping and do not involve administrative costs.

- 3. Statement of the probable effect on impacted small businesses and consumers:**

The Board does not anticipate that there will be any adverse impacts to small businesses as small businesses could benefit from the fee reduction and consolidations. These proposed rule amendments should not have any impact on consumers.

- 4. Description of any less burdensome, less intrusive or less costly alternative methods of achieving the purpose and/or objectives of the proposed rule that may exist, and to what extent, such alternative means might be less burdensome to small business:**

There are no less burdensome, less intrusive or less costly methods of achieving the purpose and/or objectives of the proposed rule amendments. On the contrary, these rule amendments could have a positive impact on business.

- 5. Comparison of the proposed rule with any federal or state counterparts:**

Federal: None.

State: Many Health Related Boards in Tennessee currently operating at a surplus are reducing some licensure fees including the Board of Respiratory Care, the Board of Medical Examiners Committee on Physician Assistants, and the Board of Examiners in Psychology.

- 6. Analysis of the effect of the possible exemption of small businesses from all or any part of the requirements contained in the proposed rule.**

These proposed rule amendments do not provide exemptions for small businesses.

### **Impact on Local Governments**

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 “any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments.” (See Public Chapter Number 1070 (<http://publications.tnsosfiles.com/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

The proposed rule amendments should not have a financial impact on local governments.

**Additional Information Required by Joint Government Operations Committee**

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

The amendment to Rule 0470-01-.06 decreases the biennial renewal fee for Dietitians/Nutritionists from \$90.00 to \$70.00.

- (B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

Tenn. Code Ann. § 63-25-107.

- (C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

Dietitians/Nutritionists, as well as those that employ them will be affected. These groups will benefit from the fee reductions.

- (D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule or the necessity to promulgate the rule;

None.

- (E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

These rules should not result in any increase or decrease in state or local government revenues or expenditures.

- (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

T. Eric Winters, Assistant General Counsel, Department of Health.

- (G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

T. Eric Winters, Assistant General Counsel, Department of Health.

- (H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

Department of Health, Office of General Counsel, 665 Mainstream Drive, Nashville, 37243, (615)741-1611, Eric.Winters@tn.gov.

- (I) Any additional information relevant to the rule proposed for continuation that the committee requests.

None.

**Department of State**  
**Division of Publications**  
 312 Rosa L. Parks Ave., 8th Floor, Snodgrass/TN Tower  
 Nashville, TN 37243  
 Phone: 615-741-2650  
 Email: [publications.information@tn.gov](mailto:publications.information@tn.gov)

**For Department of State Use Only**

Sequence Number: 11-17-18  
 Rule ID(s): 7493  
 File Date: 11/21/18  
 Effective Date: 1/19/19

# Rulemaking Hearing Rule(s) Filing Form

*Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).*

*Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).*

**Agency/Board/Commission:** Tennessee Board of Dietitian/Nutritionist Examiners  
**Division:**  
**Contact Person:** T. Eric Winters, Assistant General Counsel  
**Address:** 665 Mainstream Drive, Nashville, Tennessee  
**Zip:** 37243  
**Phone:** (615) 741-1611  
**Email:** [Eric.Winters@tn.gov](mailto:Eric.Winters@tn.gov)

**Revision Type (check all that apply):**

- Amendment  
 New  
 Repeal

**Rule(s)** (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please make sure that ALL new rule and repealed rule numbers are listed in the chart below. Please enter only ONE Rule Number/Rule Title per row)

Chapter Number	Chapter Title
0470-01	General Rules and Regulations
Rule Number	Rule Title
0470-01-.06	Fees

(Rule 0470-1-.05, continued)

- (10) An applicant shall cause to be submitted to the Board's administrative office directly from the vendor identified in the Board's licensure application materials, the result of a criminal background check.
- (11) If an applicant holds or has ever held a certificate or license to practice as a dietitian/nutritionist in any other state, the applicant shall cause to be submitted the equivalent of a Tennessee Certificate of Endorsement from each such licensing board which indicates the applicant holds or held an active certificate or license and whether it is in good standing presently or was at the time it became inactive.
- (12) When necessary, all required documents shall be translated into English and such translation and original document certified as to authenticity by the issuing source. Both versions must be submitted.
- (13) Personal resumes are not acceptable and will not be reviewed.
- (14) Application review and licensure decisions shall be governed by rule 0470-1-.07.
- (15) The burden is on the applicant to prove by a preponderance of the evidence that his course work, supervision, and experience are equivalent to the board's requirements.
- (16) The initial license fee must be received in the Board's administrative office on or before the 30th day from receipt of notification that the fee is due. Failure to comply will result in the application file being closed.
- (17) A license will be issued after all requirements, including payment of an initial license fee pursuant to rule 0470-1.06, have been met.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 63-25-107, 63-25-108, 63-25-109, 63-25-110, and 63-25-111.  
**Administrative History:** Original rule filed December 18, 1995; effective March 1, 1996. Amendment filed September 17, 1998; effective December 1, 1998. Amendment filed September 5, 2002; effective November 19, 2002. Amendment filed March 17, 2006; effective May 31, 2006.

**0470-1-.06 FEES.**

- (1) The fees are as follows:
  - (a) Application fee - A fee to be paid by all applicants. It must be paid each time an application for licensure is filed.
  - (b) Endorsement/Verification - A fee paid whenever a licensee requests the board endorse him to another state or whenever a request is made to verify a license.
  - (c) Late Renewal fee - A nonrefundable fee to be paid when an individual fails to timely renew his license.
  - (d) License fee - A fee to be paid by all applicants who have been approved for licensure prior to the issuance initial of the license. (Not to be confused with any professional association registration fees.)
  - (e) Reinstatement fee - A fee to be paid each time an individual requests to reinstate his license.
  - (f) Renewal fee - A fee to be paid by all licensees at the expiration of the license. This fee also applies to individuals who reactivate a retired or lapsed license.

(Rule 0470-1-.06, continued)

- (g) Replacement License Fee - A fee to be paid when an individual requests a replacement for a lost or destroyed "artistically designed" license.
- (h) State Regulatory Fee - To be paid by all individuals at the time of application and with each renewal application.
- (i) Temporary Permit Fee - A fee to be paid when an applicant requests a temporary permit pursuant to T.C.A. § 63-25-109.
- (2) All fees shall be established, reviewed, and changed by the board.
- (3) All fees must be submitted to the board administrative office by certified or personal check or money order. Checks or money orders are to be made payable to the Board of Dietitian/Nutritionist Examiners.
- (4) Fee Schedule
- | Amount                            | Amount              |
|-----------------------------------|---------------------|
| (a) Application                   | \$ 75.00            |
| (b) Endorsement/Verification      | \$ 20.00            |
| (c) Late Renewal                  | \$100.00            |
| (d) License - Initial             | \$ 55.00            |
| (e) Reinstatement                 | \$ 90.00            |
| <del>(f) Renewal - Biennial</del> | <del>\$ 90.00</del> |
| (f) Renewal - Biennial            | \$ 70.00            |
| (g) Replacement License           | \$ 25.00            |
| (h) State Regulatory-Biennial     | \$ 10.00            |
| (i) Temporary Permit              | \$ 5.00             |
- (5) All fees except the initial license fee will be nonrefundable. The initial license will be refunded if the license fee has been paid at the time of application and the individual's application is denied.

**Authority:** T.C.A. §§4-3-1011, 4-5-202, 4-5-204, 63-1-106, 63-1-118, 63-25-107, 63-25-109, 63-25-111, 63-25-112, and 63-25-113. **Administrative History:** Original rule filed December 18, 1995; effective March 1, 1996. Amendment filed September 17, 1998; effective December 1, 1998. Amendment filed September 9, 1999; effective November 22, 1999. Amendment filed May 2, 2005; effective July 16, 2005.

#### 0470-1-.07 APPLICATION REVIEW, APPROVAL, AND DENIAL.

- (1) An application packet shall be requested from the board's administrative office.
- (2) Applications for licensure will be accepted throughout the year and files which are completed on or before the 30th day prior to the meeting will be ordinarily processed at the next board meeting scheduled for the purpose of reviewing files.

\* If a roll-call vote was necessary, the vote by the Agency on these rulemaking hearing rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)
Jamie L. Bailey	X				
Queen Esther Cox	X				
Vacant					
James B. Burkard	X				
Linda Y. Hankins	X				
Vacant					

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Tennessee Board of Dietitian/Nutritionist Examiners (board/commission/ other authority) on 08/31/2018 (mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 03/13/18 (mm/dd/yy)

Rulemaking Hearing(s) Conducted on: (add more dates). 08/31/18 (mm/dd/yy)

Date: 8/31/18

Signature: Eric Winters

Name of Officer: T. Eric Winters

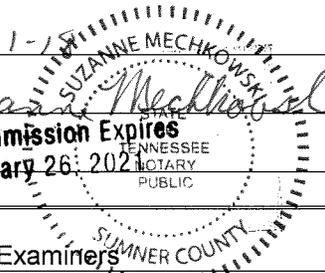
Assistant General Counsel

Title of Officer: Department of Health

Subscribed and sworn to before me on: 8-31-18

Notary Public Signature: Suzanne Mechkowsky

My commission expires on: January 26, 2021



Agency/Board/Commission: Tennessee Board of Dietitian/Nutritionist Examiners

Rule Chapter Number(s): 0470-01-.06

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slater III

Herbert H. Slater III  
Attorney General and Reporter

11/15/2018

Date



**G.O.C. STAFF RULE ABSTRACT**

DEPARTMENT: Labor and Workforce Development

DIVISION: Legal

SUBJECT: Inspection and Copies of Public Records

STATUTORY AUTHORITY: Tennessee Code Annotated, Section 10-7-503(g)(2)

EFFECTIVE DATES: February 6, 2019 through June 30, 2019

FISCAL IMPACT: Minimal

STAFF RULE ABSTRACT: This proposed rule brings departmental regulations within current law regarding open records.

## **Regulatory Flexibility Addendum**

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process, all agencies shall conduct a review of whether a proposed rule or rule affects small business.

These rule revisions will not adversely affect small business. These rule revisions are required by statute.

## **Impact on Local Governments**

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 “any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments.” (See Public Chapter Number 1070 (<http://publications.tnsosfiles.com/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

These rule revisions will not impact local governments.

**Additional Information Required by Joint Government Operations Committee**

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

These rule revisions are submitted to bring departmental regulations within current law re: open records.

- (B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

T.C.A. § 10-7-503(g)(2)

- (C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

Citizens of Tennessee who wish to obtain official records of the Tennessee Department of Labor & Workforce Development.

- (D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule or the necessity to promulgate the rule;

None known.

- (E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

Not applicable. No foreseeable change in revenue or expenditure.

- (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

TDLWD Legal Division

- (G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Chance Deason and/or Daniel Bailey

- (H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

202 French Landing Drive, Nashville TN, 37243

- (I) Any additional information relevant to the rule proposed for continuation that the committee requests.

Any additional information that the Committee requires will be provided.

**Department of State  
Division of Publications**

312 Rosa L. Parks Ave., 8th Floor, Snodgrass/TN Tower  
Nashville, TN 37243  
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**For Department of State Use Only**

Sequence Number: 11-06-18  
Rule ID(s): 7263  
File Date: 11/8/18  
Effective Date: 2/6/19

## Proposed Rule(s) Filing Form

*Proposed rules are submitted pursuant to Tenn. Code Ann. §§ 4-5-202, 4-5-207, and 4-5-229 in lieu of a rulemaking hearing. It is the intent of the Agency to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within ninety (90) days of the filing of the proposed rule with the Secretary of State. To be effective, the petition must be filed with the Agency and be signed by ten (10) persons who will be affected by the amendments, or submitted by a municipality which will be affected by the amendments, or an association of ten (10) or more members, or any standing committee of the General Assembly. The agency shall forward such petition to the Secretary of State.*

*Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).*

**Agency/Board/Commission:** Labor & Workforce Development  
**Division:** Legal  
**Contact Person:** Chance Deason  
**Address:** 220 French Landing Drive, 4A Nashville TN.  
**Zip:** 37243  
**Phone:** 615-532-6699  
**Email:** [Chance.deason@tn.gov](mailto:Chance.deason@tn.gov)

**Revision Type (check all that apply):**

- Amendment  
 New  
 Repeal

**Rule(s)** (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please make sure that **ALL** new rule and repealed rule numbers are listed in the chart below. Please enter only **ONE** Rule Number/Rule Title per row)

Chapter Number	Chapter Title
0800-08	Inspection and Copies of Public Records
Rule Number	Rule Title
0800-08-01-.01	Purpose and Scope
0800-08-01-.02	Definitions
0800-08-01-.03	Inspection of Records
0800-08-01-.04	Copies of Records
0800-08-01-.05	Fees and Charges and Procedures for Billing and Payment
0800-08-01-.06	Inspection of Records
0800-08-01-.07	Copies of Records

Chapter Number	Chapter Title

Place substance of rules and other info here. Please be sure to include a detailed explanation of the changes

Rules of  
the  
Tennessee Department of Labor and Workforce Development

Chapter 0800-08-01  
Charges for Copies of Public Records

Inspection and Copies of Public Records

Table of Contents

0800-08-01-.01	Purpose and Scope	0800-08-01-.05	Inspection of Records
0800-08-01-.02	Definitions	0800-08-01-.06	Copies of Records
0800-08-01-.03	Charges for Copies Requesting Access to Public Records	0800-08-01-.07	Fees and Charges and Procedures for Billing and Payment
0800-08-01-.04	Responding to Public Records Requests		

**0800-08-01-.01 Purpose and Scope.**

- (1) ~~The purpose of this chapter is to implement provisions contained in the amendments to Tennessee Code Annotated § 10-7-503 establishing a schedule which a records custodian may use as a guideline to charge a citizen requesting copies of public records pursuant to the Tennessee Public Records Act, Tennessee Code Annotated §§ 10-7-501 et seq.~~

Pursuant to Tenn. Code Ann. § 10-7-503(g), the following rules regarding public records for the Tennessee Department of Labor & Workforce Development are adopted to provide economical and efficient access to public records as provided under the Tennessee Public Records Act ("TPRA") in Tenn. Code Ann. § 10-7-501, et seq.

- (2) ~~This chapter applies to charges for public records released by all agencies within the Department of Labor and Workforce Development except for records of the Division of Employment Security as described in Tennessee Code Annotated § 50-7-701(d).~~

The TPRA provides that all state, county and municipal records shall, at all times during business hours, be open for personal inspection by any citizen of this state, and those in charge of the records shall not refuse such right of inspection to any citizen, unless otherwise provided by state law. See Tenn. Code Ann. § 10-7-503(a)(2)(A). Accordingly, the public records of the Tennessee Department of Labor & Workforce Development are presumed to be open for inspection unless otherwise provided by law.

- (3) Designated personnel of the Tennessee Department of Labor & Workforce Development shall promptly provide access and assistance to persons properly requesting to inspect or receive copies of public records. No provisions of these rules shall be used to hinder access to open public records. However, the integrity and organization of public records, as well as the efficient and safe operation of the Tennessee Department of Labor & Workforce Development shall be protected as provided by current law. Questions regarding public record requests should be addressed to the Records Custodian for the Tennessee Department of Labor & Workforce Development.

*Authority: 2008 Tennessee Public Acts Chapter 1179, T.C.A. § 4-3-1411, T.C.A. § 10-7-506 and T.C.A. § 50-7-701. Administrative History: Public necessity rule filed November 12, 2008; effective through April 26, 2009. Public necessity rule filed November 12, 2008 and effective through April 26, 2009 expired effective April 27, 2009. Original rule filed December 11, 2008; effective April 30, 2009.*

*Authority: T.C.A. §§ 10-7-501, 10-7-503.*

0800-08-01-.02 Definitions. As used in this chapter unless the context clearly otherwise requires:

- (1) "Commissioner" means the Commissioner of Labor and Workforce Development.  
"TDLWD" means the State of Tennessee, Tennessee Department of Labor & Workforce Development.
- (2) "OORC" means the Office of Open Records Counsel.
- (3) "Public Record" means all documents, papers, letters, maps, books, photographs, microfilms, electronic data processing files and output, films, sound recordings, or other material, regardless of physical form or characteristics made or received pursuant to law or ordinance or in connection with the transaction of official business by this agency.  
"Public Records" or "Records" means all documents, papers, letters, maps, books, photographs, microfilms, electronic data processing files and output, films, sound recordings, or other material, regardless of physical form or characteristics, made or received pursuant to law or ordinance or in connection with the transaction of official business by any governmental agency provided under the Tennessee Public Records Act ("TPRA") in Tenn. Code Ann. § 10-7-501, et seq. See Tenn. Code Ann. § 10-7-503(a)(1)(A).
- (4) "Records Custodian" means the individual(s) responsible for the production and release of public records within each operating section of the Department.  
"Public Records Request Coordinator" means the person designated by the TDLWD to facilitate timely responses to public records requests.
- (5) "Requestor" means a citizen of Tennessee seeking access to a public record, whether it is for inspection or duplication.
- (6) "Tennessee Public Records Act" or "TPRA" means the State law codified in T.C.A. § 10-7-501, et seq., regarding access to public records.

*Authority: 2008 Tennessee Public Acts chapter 1179, T.C.A. § 10-7-506 and T.C.A. § 4-3-1411. Administrative History: Public necessity rule filed November 12, 2008; effective through April 26, 2009. Public necessity rule filed November 12, 2008 and effective through April 26, 2009 expired effective April 27, 2009. Original rule filed December 11, 2008; effective April 30, 2009.*

Authority: T.C.A. §§ 10-7-501, 10-7-503.

0800-08-01-.03 Charging for Copies of Public Records.  
Requesting Access to Public Records

- (1) Charges for copies of public records released by the Department of Labor and Workforce Development under the authority of the Commissioner will be assessed in accordance with the current OORC Schedule of Reasonable Charges for Public Records or in accordance with the provisions contained in Title 20 Code of Federal Regulations, part 603.8(d) for copies of public records released by the Division of Employment Security.

Public record requests shall be made to the Public Records Request Coordinator ("PRRC") or his/her designee in order to ensure public record requests are routed to the appropriate records custodian and fulfilled in a timely manner.

(Rule 0800-08-01-.03, continued)

- (2) Any charges incurred in the production of copies not specifically listed or in excess of the amounts specified in the Schedule of Reasonable Charges must be documented by the Records Custodian to justify the extra charge(s).

Requests for inspection only may be made orally or in writing. The PRRC should request an email or mailing address from the requestor for providing any written communication required under the TPRA.

- (3) Charges may be reduced or waived at the discretion of the Commissioner. Appropriate documentation must be submitted by the Records Custodian when a reduction or waiver of the charges is requested.

Requests for inspection or duplication of public records may be made orally or in writing at 220 French Landing Drive, 4-A, Nashville TN, 37243 or by email to: [TDLWD.PublicRecords@tn.gov](mailto:TDLWD.PublicRecords@tn.gov).

- (4) Delivery and/or shipping costs incurred may be included in the total amount charged for the records release if appropriate.

Proof of Tennessee citizenship by presentation of a valid Tennessee driver's license or alternative State of Tennessee issued ID is required as a condition to inspect or receive copies of public records.

- (5) Payment must be made in advance in the form of a check or money order made payable to the "Treasurer, State of Tennessee".

*Authority: 2008 Tennessee Public Acts chapter 1179, T.C.A. § 4-3-1411, T.C.A. § 10-7-506 and T.C.A. § 50-7-701. Administrative History: Public necessity rule filed November 12, 2008; effective through April 26, 2009. Public necessity rule filed November 12, 2008 and effective through April 26, 2009 expired effective April 27, 2009. Original rule filed December 11, 2008; effective April 30, 2009.*

*Authority: T.C.A. § 10-7-503*

0800-08-01-.04 Responding to Public Records Requests

- (1) The "PRRC" and Records Custodian shall review public record requests and make an initial determination of the following:

- (a) If the requestor provided evidence of Tennessee citizenship;
- (b) If the records requested are described with sufficient specificity to identify them; and
- (c) If the Tennessee Department of Labor & Workforce Development is the custodian of the records.

- (2) The "PRRC" and/or Records Custodian shall acknowledge receipt of the request and take any of the following appropriate action(s):

- (a) Advise the requestor of these Rules and the elections made regarding:

1. Proof of Tennessee citizenship;

(Rule 0800-08-01-.04, continued)

- 2. Form(s) required for copies;
- 3. Fees; and
- 4. Aggregation of multiple or frequent requests.

(b) If appropriate, deny the request, providing the appropriate ground such as one of the following:

- 1. The requestor is not, or has not presented evidence of being, a Tennessee citizen;
- 2. The request lacks specificity;
- 3. An exemption makes the record not subject to disclosure under the TPRA (absent any required signed authorization, subpoena or court order issued by a state or federal court);
- 4. The Tennessee Department of Labor & Workforce Development is not the custodian of the requested records;
- 5. The records do not exist.

(c) If appropriate, contact the requestor to see if the request can be narrowed.

(d) Forward the records request to the appropriate records custodian in the TDLWD.

(e) If requested records are in the custody of a different governmental entity, and the PRRC knows the correct governmental entity, advise the requestor of the correct governmental entity for that entity if known.

- (3) Upon receiving a valid public records request, a records custodian shall promptly make requested public records available in accordance with T.C.A. § 10-7-503. If the records custodian is uncertain that an applicable exemption applies, the custodian may consult with the TDLWD's Attorneys or the OORC.
- (4) If not practicable to timely provide requested records then a records custodian shall notify the requestor that additional time will be necessary.
- (5) If a records custodian denies a public record request, he or she shall deny the request in writing as provided herein.
- (6) If a records custodian reasonably determines production of records should be segmented because the records request is for a large volume of records, or additional time is necessary to prepare the records for access, the records custodian shall notify the requestor that production of the records will be in segments and that a records production schedule will be provided as expeditiously as practicable. If appropriate, the records custodian should contact the requestor to see if the request can be narrowed.
- (7) Redaction: If a record contains confidential information or information that is not open for public inspection, the records custodian shall prepare a redacted copy prior to providing access. If questions arise concerning redaction, the records custodian should coordinate with

(Rule 0800-08-01-.04, continued)

counsel or other appropriate parties regarding review and redaction of records. The records custodian may also consult with the OORC or with the Office of Attorney General and Reporter.

Authority: T.C.A. §10-7-503.

#### 0800-08-01-.05 Inspection of Records

- (1) There shall be no charge for inspection of open public records.
- (2) The location for inspection of records within the offices of the Tennessee Department of Labor & Workforce Development should be determined by the records custodian.
- (3) A records custodian may require an appointment for inspection and shall be present during the inspection process.

Authority: T.C.A. § 10-7-503.

#### 0800-08-01-.06 Copies of Records

- (1) A records custodian shall respond to a public record request for copies in the most economic and efficient manner practicable.
- (2) Copies will be available for pickup at a location specified by the PRRC or records custodian, or may be delivered to the mailing address specified by the requestor.
- (3) If a Requestor desires to use personal equipment to make copies, or images, of records that need redaction by TDLWD staff, applicable fees and charges will be collected by TDLWD prior to the copies or images being made by Requestor.

Authority: T.C.A. § 10-7-503.

#### 0800-08-01-.07 Fees and Charges and Procedures for Billing and Payment

- (1) Records custodians shall provide requestors with an itemized estimate of the charges prior to producing copies of records and may require pre-payment of such charges before producing requested records.
- (2) Fees and charges for copies are as follows:
  - (a) Fees and charges for copies will be in accordance with the OORC Schedule of Reasonable Charges:
    1. \$0.15 per page for 8 x 11- and 8 ½ x 14 black and white copies.
    2. \$0.50 per page for 8 x 11- and 8 ½ x 14 color copies.
    3. Labor at the hourly wage of the employee(s) reasonably necessary to produce the requested information when time exceeds 1 hour.

(Rule 0800-08-01-.07, continued)

4. If an outside vendor is used, the actual costs assessed by the vendor.
5. For storage devices, such as flash drives, and other office items, the cost incurred by the TDLWD.

(b) If the fees and charges noted herein shall conflict with the OORC Schedule of Reasonable Charges, the OORC Schedule of Reasonable Charges shall control.

- (3) Payments of fees for records shall be made by check or money order payable to the State of Tennessee, Tennessee Department of Labor & Workforce Development. Payment in cash will not be accepted. Payment is due upon production of the requested material. Requestors will not be entitled to receive additional records until all payments for records provided within the previous sixty (60) days have been received.
- (4) Payment in advance may be required when costs are estimated to exceed \$50.00 or an outstanding balance exceeds \$100.00.
- (5) If the copies of the requested records are delivered by mail, the costs of standard delivery, including postage, shall be included in the copy charge. Any charges for non-standard delivery shall be borne by the requesting party.
- (6) Unless otherwise agreed, TDLWD will not aggregate record requests in accordance with the Frequent and Multiple Request Policy promulgated by the OORC when more than (4) requests are received within a calendar month (either from a single individual or a group of individuals deemed working in concert).

Authority: T.C.A. § 10-7-503 & T.C.A. § 10-7-506(a).

\* If a roll-call vote was necessary, the vote by the Agency on these rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)

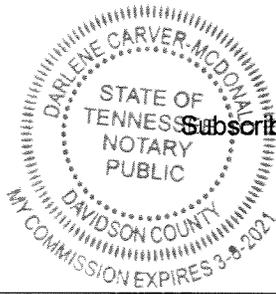
I certify that this is an accurate and complete copy of proposed rules, lawfully promulgated and adopted by the Commissioner of Labor & Workforce Development on 10/01/2018, and is in compliance with the provisions of T.C.A. § 4-5-222. The Secretary of State is hereby instructed that, in the absence of a petition for proposed rules being filed under the conditions set out herein and in the locations described, he is to treat the proposed rules as being placed on file in his office as rules at the expiration of ninety (90) days of the filing of the proposed rule with the Secretary of State.

Date: 10/23/2018

Signature: *Chance H. Deason*

Name of Officer: Chance H. Deason

Title of Officer: General Counsel



Subscribed and sworn to before me on: October 23, 2018

Notary Public Signature: *Darlene Carver-McDonald*

My commission expires on: March 8, 2021

Agency/Board/Commission: \_\_\_\_\_

Rule Chapter Number(s): \_\_\_\_\_

All proposed rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

*Herbert H. Slatery III*  
 Herbert H. Slatery III  
 Attorney General and Reporter  
11/1/2018  
 Date

**Department of State Use Only**

113 CR 1-18  
 2018 NOV -8 PM 12:44  
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Filed with the Department of State on: 11/8/18

Effective on: 2/6/19

*Tre Hargett*  
 Tre Hargett  
 Secretary of State