[Tenn. Code Ann. § 56-7-120.]

§ 56-7-120. Assignment of benefits: General Provisions

(a)(1) Notwithstanding any law to the contrary, if a policy of insurance issued in this state provides for coverage of health care rendered by a healthcare provider covered under title 63, the insured or other persons entitled to benefits under the policy are entitled to assign their benefits to the healthcare provider and such rights must be stated clearly in the policy. Notice of the assignment must be in writing to the insurer in order to be effective unless otherwise stated in the policy.

(2) If a property and casualty insurance policy includes a specified medical expense benefit payable without regard to fault, but does not permit assignment of the benefit, the insurer must establish a process that, when requested by the insured, the insurer must disburse funds in the names of the insured and the healthcare provider as joint payees. Disbursement is subject to the terms and conditions under the issued policy.

(b) As used in this section:

(1) "Emergency medical services" means the services used in responding to the perceived individual need for immediate medical care in order to prevent loss of life or aggravation of physiological or psychological illness or injury;

(2) "Health insurance coverage":

(A) Means benefits consisting of medical care, provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care, under any policy, certificate or agreement offered by a health insurance entity; and

(B) Does not include policies or certificates covering only accident, credit, disability income, long-term care, hospital indemnity, medicare supplement as defined in 42 U.S.C. § 1395ss(g)(1), specified disease, other limited benefit health insurance, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that are statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

(3) "Healthcare facility" means a hospital as defined in title 68, chapter 11, part 2, or an ambulatory surgical treatment center as defined in title 68, chapter 11, part 2;

(4) "Healthcare provider" means any doctor of medicine, osteopathy, dentistry, chiropractic, podiatry, or optometry; a pharmacist or pharmacy; a hospital; home health agency; an entity providing infusion therapy services; or an entity providing medical equipment services;

(5) "Insured" or "covered person" means a person on whose behalf a health insurance entity offering health insurance coverage is obligated to pay benefits or provide services; and

(6) "Stabilized" means the insured is no longer in need of emergency medical services.

(c)(1) For purposes of this subsection (c):

(A) "**In-network** healthcare facility" means a **hospital** or ambulatory treatment surgical center licensed under title 68, chapter 11, part 2 that has a current contract **provider** agreement with the insured's insurer; and

(B) "**Out-of-network** facility-based **physician**" means a **physician**:

(i) To whom a participating healthcare facility has granted clinical privileges;

(ii) Who provides services to patients of the participating healthcare facility pursuant to those clinical privileges; and

(iii) Who does not have a current contract or provider agreement with the insured's insurer.

(2) An insured's assignment of benefits, pursuant to subsection (a), may be disregarded by an insurer if:

(A) The assignment of benefits is to an **out-of-network** facility-based **physician**; and

(B) The following conditions are not satisfied:

(i) The healthcare facility provides written notice to the insured, or the insured's personal representative, that includes the following:

(*a*) A statement that the **out-of-network** facility-based **physician** may not have a current contract **provider** agreement with the insured's insurer;

(b) A statement that the insured agrees to receive medical services by an **out-of-network** healthcare **provider** and will receive a bill for one hundred percent (100%) of billed charges for the amount unpaid by the insured's insurer;

(c) The estimated amount that the facility will charge the insured for items and services provided by the facility in accordance with the insured's health benefits coverage for the items and services; and

(d) A listing of anesthesiologists, radiologists, emergency room physicians, and pathologists or the groups of such physicians with which the facility has contracted, including the physician or group name, phone number, and website;

(ii) The insured signs the written notice, acknowledging agreement to receive medical services by an out-of-network provider; and

(iii) The written notice includes the following statement:

The physicians and other providers that may treat the patient at this facility may not be employed by this facility and may not participate in the patient's insurance network.

Anesthesiologists, radiologists, emergency room physicians, and pathologists are not employed by this facility. Services provided by those specialists, among others, will be billed separately.

Before receiving services, the patient should check with his or her insurance carrier to find out if the patient's providers are in-network. Otherwise, the patient may be at risk of higher out-of-network charges.

(d)(1) The written notice required by subdivision (c)(2)(B) must be provided to the insured, or the insured's personal representative, prior to when the insured first receives services from the out-of-network facility-based physician. If the insured is receiving medical services through a hospital emergency department or is

incapacitated or unconscious at the time of receiving services, the written notice is not required until the insured is stabilized.

(2) The failure of the healthcare facility to provide the notice required by subdivision (c)(2)(B) does not give rise to any right of indemnification or private cause of action against the healthcare facility by an out-of-network facility-based physician for an insurer's disregard of an insured's assignment of benefits unless:

(A) The healthcare facility's failure to provide the written notice is due to willful or wanton misconduct of an agent of the healthcare facility; and

(B) The out-of-network facility-based physician provides the insured a billing statement that:

(i) Contains an itemized listing of the services and supplies provided along with the dates when the services and supplies were provided;

(ii) Contains a conspicuous, plain language explanation that:

(*a*) The out-of-network facility-based physician does not have a current contract provider agreement with the insured's insurer; and

(*b*) The insurer has paid a rate, as determined by the insurer, that is below the out-of-network facility-based physician'sbilled amount;

(iii) Contains a telephone number to call to discuss the billing statement; provide an explanation of any acronyms, abbreviations, and numbers used on the statement; or discuss any payment issues;

(iv) Contains a statement that the insured may call the telephone number described in subdivision (d)(2)(B)(iii) to discuss alternative payment arrangements;

(v) For billing statements that total an amount greater than two hundred dollars ($200), over any applicable copayments, coinsurance or deductibles, states, in plain language, that if the insured finalizes a payment plan agreement within forty-five (45) days of receiving the first billing statement and substantially complies with the agreement, the out-of-networkfacility-based physician shall not furnish adverse information to a consumer reporting agency regarding an amount owed by the insured. For purposes of this subdivision (d)(2)(B)(v), a patient is considered out of substantial compliance with the payment plan agreement if the payments are not made in compliance with the agreement for a period of forty-five (45) days; and

(vi) Contains a telephone number for the department and a clear and concise statement that the insured may call the department to complain about any out-of-network charges.

(3) Nothing in this subsection (d) applies to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, or other limited benefit hospital insurance policies.