§ 4910. Right to external appeal established. (a) There is hereby established an insured's right to an external appeal of a final adverse determination by a health plan.

(b) An insured, the insured's designee and, in connection with concurrent and retrospective adverse determinations, an insured's health care provider, shall have the right to request an external appeal when:

(1) (A) the insured has had coverage of the health care service, which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, pursuant to title one of this article on the grounds that such health care service does not meet the health care plan's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or other ground consistent with 42 U.S.C. § 300gg-19 as determined by the superintendent, and

(B) the health care plan has rendered a final adverse determination with respect to such health care service or both the plan and the insured have jointly agreed to waive any internal appeal, or the insured is deemed to have exhausted or is not required to complete any internal appeal pursuant to section 2719 of the Public Health Service Act, 42 U.S.C. § 300gg-19; or

(2) (A) the insured has had coverage of a health care service denied on the basis that such service is experimental or investigational, and such denial has been upheld on appeal under title one of this article, or both the plan and the insured have jointly agreed to waive any internal appeal, or the insured is deemed to have exhausted or is not required to complete any internal appeal pursuant to section 2719 of the Public Health Service Act, 42 U.S.C. § 300gg-19, and

(B) the insured's attending physician has certified that the insured has a condition or disease (a) for which standard health services or procedures have been ineffective or would be medically inappropriate, or (b) for which there does not exist a more beneficial standard health service or procedure covered by the health care plan, or (c) for which there exists a clinical trial or rare disease treatment, and

(C) the insured's attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the insured's condition or disease, must have recommended either (a) a health service or procedure

(including a pharmaceutical product within the meaning of subparagraph (B) of paragraph two of subsection (e) of section four thousand nine hundred of this article) that, based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the insured than any covered standard health service or procedure or, in the case of a rare disease, based on the physician's certification required by subsection (g-7) of section four thousand nine hundred of this article and such other evidence as the insured, the insured's designee or the insured's attending physician may present, that the requested health service or procedure is likely to benefit the insured in the treatment of the insured's rare disease and that such benefit to the insured outweighs the risks of such health service or procedure; or (b) a clinical trial for which the insured is eligible. Any physician certification provided under this section shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation, and

(D) the specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for the health care plan's determination that the health service or procedure is experimental or investigational; or

(3)(A) the insured has had coverage of the health service (other than a clinical trial to which paragraph two of this subsection shall apply), which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, pursuant to title one of this article on the grounds that such health service is out-of-network and an alternate recommended treatment is available in-network, and the health plan has rendered a final adverse determination with respect to an out-of-network denial or both the health plan and the insured have jointly agreed to waive any internal appeal; and

(B) the insured's attending physician, who shall be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the insured for the health service sought, certifies that the out-of-network health service is materially different than the alternate recommended in-network health service, and recommends a health service that, based on two documents from the available medical and scientific evidence, is likely to be more

clinically beneficial than the alternate recommended in-network treatment and the adverse risk of the requested health service would likely not be substantially increased over the alternate recommended in-network health service.

(4)(A) The insured has had an out-of-network referral denied on the grounds that the health care plan has a health care provider in the in-network benefits portion of its network with appropriate training and experience to meet the particular health care needs of an insured, and who is able to provide the requested health service.

(B) The insured's attending physician, who shall be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the insured for the health service sought, certifies that the in-network health care provider or providers recommended by the health care plan do not have the appropriate training and experience to meet the particular health care needs of an insured, and recommends an out-of-network provider with the appropriate training and experience to meet the particular health care needs of an insured, and who is able to provide the requested health service.

(c) (1) The health care plan may charge the insured a fee of up to twenty-five dollars per external appeal with an annual limit on filing fees for an insured not to exceed seventy-five dollars within a single plan year; provided that, in the event the external appeal agent overturns the final adverse determination of the plan, such fee shall be refunded to the insured. Notwithstanding the foregoing, the health plan shall not require the enrollee to pay any such fee if the enrollee is a recipient of medical assistance or is covered by a policy pursuant to title one-A of article twenty-five of the public health law. Notwithstanding the foregoing, the health plan shall not require the insured to pay any such fee if such fee shall pose a hardship to the insured as determined by the plan.

(2) The health care plan may charge the insured's health care provider a fee of up to fifty dollars per external appeal, other than for an external appeal requested pursuant to paragraph two or three of subsection (d) of section four thousand nine hundred fourteen of this article; provided that, in the event the external appeal agent overturns the final adverse determination of the plan, such fee shall be refunded

to the insured's health care provider.

(d) An enrollee covered under the Medicare or Medicaid program may appeal the denial of a health care service pursuant to the provisions of this title, provided, however, that any determination rendered concerning such denial pursuant to existing federal and state law relating to the Medicare or Medicaid program or pursuant to federal law enacted subsequent to the effective date of this title and providing for an external appeal process for such denial shall be binding on the enrollee and the insurer and shall supersede any determinations rendered pursuant to this title.