§ 4910. Right to external appeal established. 1. There is hereby established an enrollee's right to an external appeal of a final adverse determination by a health care plan.

2. An enrollee, the enrollee's designee and, in connection with concurrent and retrospective adverse determinations, an enrollee's health care provider, shall have the right to request an external appeal when:

(a) (i) the enrollee has had coverage of a 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 commissioner in consultation with the superintendent of financial services, and

(ii) the health care plan has rendered a final adverse determination with respect to such health care service or both the plan and the enrollee have jointly agreed to waive any internal appeal, or the enrollee 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

(b) (i) the enrollee 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 enrollee have jointly agreed to waive any internal appeal, or the enrollee is deemed to have exhausted or is not required to complete any internal appeal pursuant to section 2719 of the federal Public Health Service Act, 42 U.S.C. § 300gg-19, and

(ii) the enrollee's attending physician has certified that the enrollee 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

(iii) the enrollee'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 enrollee'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 (b) of subdivision five of section forty-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 enrollee than any covered standard health service or procedure or, in the case of a rare disease, based on the physician's certification required by subdivision seven-g of section forty-nine hundred of this article and such other evidence as the enrollee, the enrollee's designee or the enrollee's attending physician may present, that the requested health service or procedure is likely to benefit the enrollee in the treatment of the enrollee's rare disease and that such benefit to the enrollee outweighs the risks of such health service or procedure; or (b) a clinical trial for which the enrollee 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

(iv) 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

(c)(i) the enrollee has had coverage of the health service (other than a clinical trial to which paragraph (b) of this subdivision 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 health service 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 enrollee have jointly agreed to waive any internal appeal; and

(ii) the enrollee'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 enrollee for the

health service sought, certifies that the out-of-network health service is materially different than the alternate recommended in-network service, and recommends a health care 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.

(d)(i) The enrollee 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 enrollee, and who is able to provide the requested health service.

(ii) The enrollee'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 enrollee 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 enrollee, and recommends an out-of-network provider with the appropriate training and experience to meet the particular health care needs of an enrollee, and who is able to provide the requested health service.

3. (a) The health care plan may charge the enrollee a fee of up to twenty-five dollars per external appeal with an annual limit on filing fees for an enrollee 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 enrollee. 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 this chapter. Notwithstanding the foregoing, the health plan shall not require the enrollee to pay any such fee if such fee shall pose a hardship to the enrollee as determined by the plan.

(b) The health care plan may charge the enrollee's health care

provider a fee of up to fifty dollars per external appeal, other than for an external appeal requested pursuant to paragraph (b) or (c) of subdivision four of section forty-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 enrollee's health care provider.

4. 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 denials shall be binding on the enrollee and the insurer and shall supersede any determinations rendered pursuant to this title.