Commercial Carrier Process to Request a Referral to a Specialist or NonPhysician Specialist
(Accurate as of August 1, 2022. Please check the MIA website for up-to-date information.)

Golden Rule Insurance Company

Consumer Contact Information	
Website	www.myuhone.com
Phone Number	Consumers can call 1-800-657-8205
Requesting a Referral	
Steps to request a non-panel (non-participating) provider specialist	Standing Referrals to SpecialistsYour plan may not require referrals. However, if you and your primary care physician have determined that seeking treatment for your condition requires that you need a standing referral to a specialist for treatment of a life threatening, degenerative, chronic, or disabling condition, call the toll-free member phone number on your health plan ID card for assistance in locating a network specialist. If you wish to have someone else represent you for this request, please tell us and we will send you the form needed to designate a representative. Standing Referrals for Pregnancy Your plan may not require referrals. However, if you are pregnant and would like to request a standing referral to an obstetrician for your primary care while pregnant and through the postpartum period, call the toll-free member phone number on your health plan ID card for assistance in locating a network obstetrician. If you wish to have someone else represent you for this request, please tell us and we will send you the form needed to designate a representative. Requests for an Exception to use an Out-of-Network Provider due to Network InadequacyIf you need covered health care services that are not available from a network provider—or access to a network provider would require unreasonable delay or travel—you, your doctor or a representative acting on your behalf can ask for an exception to use an out-of-network provider. If your request is approved, such services from the out-of-network provider will be covered at the network benefit level. How to request an exception to use an out-of-network provider To request an exception to use an out-of-network provider, call the toll-free member phone number on your health plan ID card. If you wish to have someone else represent you for this request, please tell us and we will send you the form needed to designate a representative. Exception requests will be reviewed and a determination will be made within 2 working days after receipt of all information needed to make a determination. Emergency cases: Please be sure to tell us if you have an emergency case where a health service is necessary to treat a condition or illness that, without medical attention, would seriously jeopardize the patient's life, health or ability to regain maximum function, or would cause the member to be in danger to self or others.
Review full referral request procedures	For Review full Referral Request Procedures: There are two ways to access the Referral Request Procedures: www.uhone.com/resources/find-a-doctor, click on Important Notices, scroll to Maryland, click on the link "Maryland Gap Referral and Appeal Review Process". The Notice was placed in this location to meet the regulation's requirements for the information to be available on the carrier's online directory. www.myuhone.com, scroll down to Important State Notices section, select Maryland from the drop down, click on the link contained in "For information on the Maryland Gap Referral and Appeal Review Process, please click here". This website is the member portal. The Company placed the Notice at this additional location so that the members would have additional access to it.

Carrier's timeline to grant or deny request	2 work days
Grievance process to appeal denial of a request	
How to file a grievance	If urgent call customer service at the phone number on the back of their ID card or write to Grievance Administrator PO Box 31371Salt Lake City, UT 84131-0371 Standard appeal fax: (801) 478-5463 Expedited (urgent) grievance fax: (866) 654-6323
Number of days for final grievance decisions	Prospective Denial: If you have not yet received services from the provider to whom your request for a referral was denied, a review will be completed and a written decision will be sent to you or your representative acting on your behalf, including a health care provider, no later than 30 calendar daysafter the date on which the appeal was submitted. If your denial is based on a service not being medically necessary, appropriate, or efficient, a written decision will be sent no later than 30 working daysafter the request for review. For emergency cases, where the medical condition is such that the time needed to complete a standard review could seriously jeopardize the patient's life, health or ability to regain maximum function, the decision will be made and communicated to the person filing the appeal within 72 hours of receipt of the request. If your denial is based on a service not being medically necessary, appropriate, or efficient, a decision will be verbally communicated within 24 hoursof receiving the request for review followed by a written notice of the decision within one day after the verbal communication was completed. Retrospective Denial: If you have already received services from the provider to whom your request for referral was denied, a review will be completed and a written decision will be sent to you or your representative acting on your behalf, including a health care provider, no later than 60 calendar daysfrom the date on which the appeal was submitted. If your denial is based on a service not being medically necessary, appropriate, or efficient, a written decision will be sent no later than 45 working daysafter the request for review.
Number of days/hours for emergency grievance decisions	For emergency cases, where the medical condition is such that the time needed to complete a standard review could seriously jeopardize the patient's life, health or ability to regain maximum function, the decision will be made and communicated to the person filing the appeal within 72 hours of receipt of the request. If your denial is based on a service not being medically necessary, appropriate, or efficient, a decision will be verbally communicated within 24 hoursof receiving the request for review followed by a written notice of the decision within one day after the verbal communication was completed.

Review full grievance process	For Review full Grievance Process: There are two ways to access the grievance process regarding a referral request denial: www.uhone.com/resources/find-a-doctor, click on Important Notices, scroll to Maryland, click on the link “Maryland Gap Referral and Appeal Review Process”. The Notice was placed in this location to meet the regulation’s requirements for the grievance process regarding this topic to be available on the carrier’s online directory. www.myuhone.com, scroll down to Important State Notices section, select Maryland from the drop down, click on the link contained in “For information on the Maryland Gap Referral and Appeal Review Process, please click here”. This website is the member portal. The Company placed the Notice at this additional location so that the members would have additional access to the grievance process regarding a referral request denial.