Commercial Carrier Process to Request a Referral to a Specialist or NonPhysician Specialist (Accurate as of January 6, 2023. Please check the MIA website for up-to-date information.)	
Golden Rule Insurance Company	
Consumer Contact	
Website	www.myuhone.com
Phone Number	1-800-657-8205
Requesting a Referral	
Steps to request a non-panel (non-participating) provider specialist	If 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. 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.
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 Process 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 Process at this additional location so that the members would have additional access to it.
Carrier's timeline to grant or deny request	Exception request for non-emergency medical care determinations will be made within 2 working days after receipt of all information needed to make a determination. Exception request for emergency medical care determinations will be made within 2 hours after receipt of all information needed to make a determination.
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 31371 Salt Lake City, UT 84131-0371 Standard fax: (801) 478-5463 Expedited (urgent) 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 no later than 30 working days after the date on which the grievance was submitted. With written permission from you, your health care provider, or a representative acting on your behalf, the time frame for us to respond can be extended up to 30 additional working days. Written notification of our grievance decision will be sent to you, your health care provider, and any representative acting on your behalf within five working days after the grievance decision has been made. 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 24 hours of receipt of the grievance request. A written notice of the grievance decision will be provided to you, your health care provider, and any representative acting on your behalf 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 no later than 45 working days from the date on which the grievance was submitted. Written notification of our grievance decision will be sent to you, your health care provider, and any representative acting on your behalf within five working days after the grievance decision has been made. Note: Timeframes for resolving disputes may be subject to federal requirements. We will adhere to whichever results in completion of the dispute sooner. Federal law requires that a grievance decision for a prospective denial be made within 30 days after receipt of a request for review and within 60 days after receipt of a request for review of a retrospective denial.
Number of days/hours for emergency grievance decisions	24 hours

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 Process 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 Process at this additional location so that the members would have additional access to the grievance process regarding a referral request denial.