Important Notice for Maryland Plan Members
Golden Rule Insurance Company

Standing Referrals to Specialists

Your 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 Inadequacy

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.

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.

What to do if Your Request for Referral is not approved

If your request for a referral is denied and you don't agree with our decision, you or your representative acting on your behalf, including a health care provider, may request a review. The person who reviews your request will not be the person, or a subordinate of that person, who made the original decision.

A request for review must be submitted within **180 days** from when you received our denial.

To submit a request for review, please provide the following information:

- A written request asking us to reconsider our decision
- The specific decision you would like us to review
- An explanation of why the requested service should be considered for coverage
- Any additional information that supports your position
- A copy of the denial letter we sent you

Mail or fax this information to:

Grievance Administrator
PO Box 31371
Salt Lake City, UT 84131-0371
Standard appeal fax: (801) 478-5463
Expedited (urgent) grievance fax: (866) 654-6323

The timeframe for us to review your request for review and make a decision depends on whether or not you have already received care from the provider for whom you are requesting a referral to.

- **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 days** after 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 days** after 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 hours** of 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 days** from 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 days** after the request for review.

  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 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.

For questions, please call the toll-free member phone number on your health plan ID card.