Important Notice for Maryland Plan Members/Enrollees Covered under Fully Insured Commercial Policies Issued in Maryland:
Referrals to Out-of-Network Providers 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 or your doctor can ask for a referral to 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 a referral to an out-of-network provider due to network inadequacy

To request a referral to an out-of-network provider, call the toll-free member phone number on your health plan ID card; for mental health and substance use disorder services, call the Mental Health phone number on your 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.

Referral requests will be reviewed in a timely manner, as appropriate for a member's condition. 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 to an out-of-network provider is not approved

If your request for a referral to an out-of-network provider is denied and you don't agree with our decision, you or your representative may request a **grievance review**. This is the process for asking us to reconsider a decision. The person who reviews your grievance will not be the person, or a subordinate of that person, who made the original decision.

A grievance request must be submitted within **180 days** from when you received the denial of your request for a referral to an out-of-network provider due to network inadequacy.

To submit a grievance, please provide the following information:

- A written grievance asking us to reconsider our decision
- The specific coverage 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:

Optum Appeals
PO Box 30512
Salt Lake City, UT 84130-0512
Fax: 1-855-312-1470

If more information is needed, we will notify you or your representative within 5 work days of receiving the grievance request. For emergency cases, we will verbally inform you if we need more information. If no additional information is available or is not submitted to Optum, a decision will be made on the available information.

The timeframe for Optum to review the grievance and make a decision depends on whether or not you have already received care from the out-of-network provider for whom you are requesting a referral to.

- **Prospective Denial:** If you have not yet received services from the out-of-network provider to

whom your request for a referral was denied, Optum will review the grievance and give you a decision no later than **30 work days** after the date on which the grievance was submitted. With written permission from you, or your representative, the time frame for Optum to respond can be extended up to 30 additional work days. Written notification of Optum's grievance decision will be sent to you, or your representative within 5 work 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 grievance review could seriously jeopardize the patient's life, health or ability to regain maximum function, we will give you a verbal decision within **24 hours** of receipt of the grievance request. A written notice of the decision will be provided to you or your representative within 1 day after the verbal grievance decision has been communicated. If we do not provide a grievance decision within 24 hours, you, or your representative, may file an adverse decision complaint directly with the Insurance Commissioner.

- **Retrospective Denial:** If you have already received services from the out-of-network provider to whom your request for referral was denied, Optum will review the grievance and give you a decision no later than **45 work days** from the date on which the grievance was submitted. Written notification of the grievance decision will be sent to you, or your representative within 5 work days after the grievance decision has been made. For questions, please call the number on your health plan ID card.