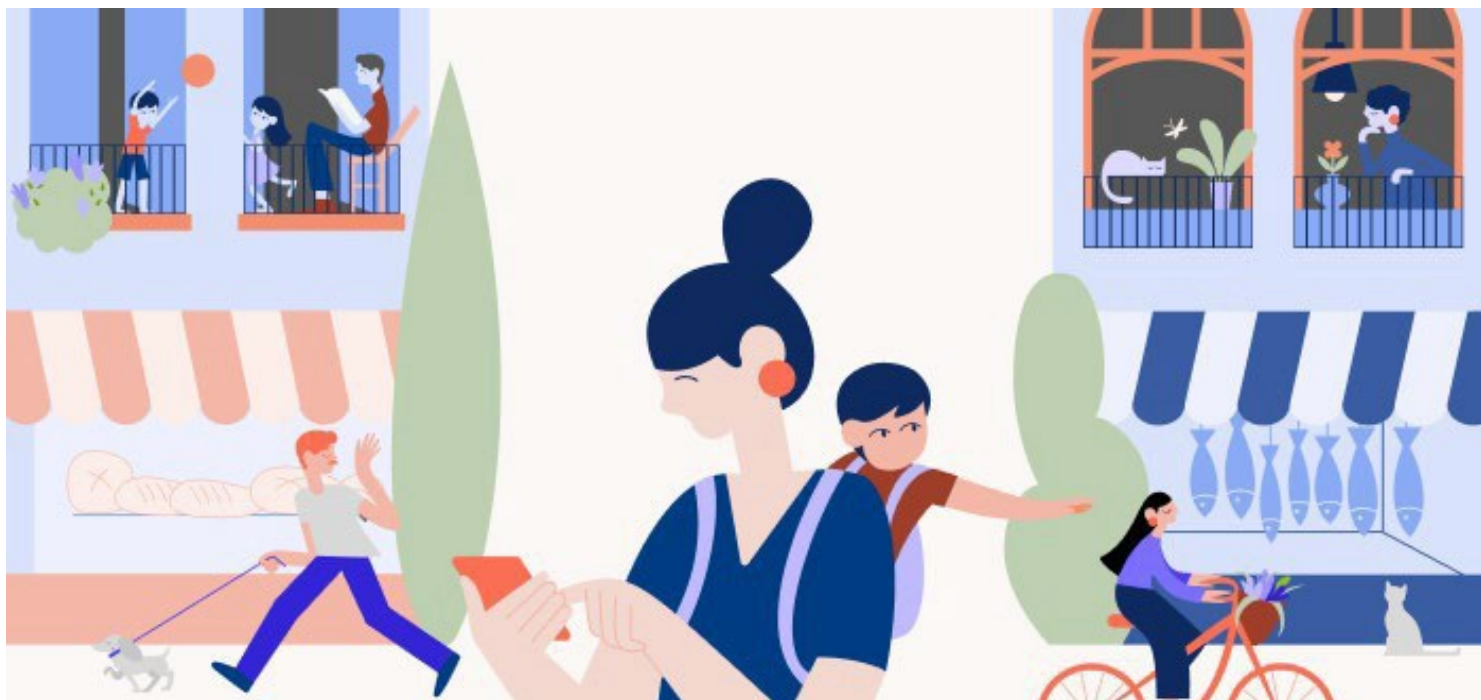




PROVIDER MANUAL

**Antidote Health Plan of Arizona, Inc.
Antidote Health Plan of Ohio, Inc.**



Effective Date: November 1, 2025

Antidote Health Plan
www.antidotehealth.com/provider.

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WELCOME

Welcome to Antidote Health Plan. We are delighted to have you as part of our dedicated network of top-tier physicians, hospitals, and healthcare professionals.

Antidote is a virtual first HMO that primarily focuses on enhancing our members' healthcare outcomes. Our approach addresses the unique needs of individuals prioritizing quality, efficiency, and convenience in their healthcare journey.

We are thrilled to have you as part of our unwavering commitment to reshaping the healthcare landscape. At the heart of Antidote Health lies a simple yet profound mission: to promote healthcare by making it both affordable and accessible, especially to communities and individuals who have traditionally lacked adequate access to quality medical services.

Our partnership with Quality Care Partners and its esteemed physicians, community leaders, local healthcare providers, and stakeholders forms a holistic ecosystem. This ecosystem addresses curative healthcare needs and emphasizes preventive measures, ensuring a well-rounded approach to an individual's well-being.

Welcome to the future of healthcare. Welcome to Antidote Health!

HOW TO USE THIS PROVIDER MANUAL

Antidote is committed to assisting its provider community by supporting their efforts to deliver well- coordinated and appropriate health care to our members. Antidote is also committed to disseminating comprehensive and timely information to its providers through this Provider Manual regarding Antidote's operations, policies, and procedures. Updates to the Provider Manual will be posted on our website at www.antidotehealth.com/provider.

Additionally, providers may be notified via bulletins and notices posted on the website and potentially on Explanation of Payment notices. Providers may contact Provider Services at 1-888-509-2688 to request a copy of the Provider Manual.

In accordance with the terms of your Participating Provider Agreement, providers are required to comply with the provisions of this manual.

NONDISCRIMINATION OF HEALTH CARE SERVICE DELIVERY

Antidote complies with the guidance set forth in the final rule for Section 1557 of the Affordable Care Act, which includes notification of nondiscrimination and instructions for accessing language services in all significant member materials and physical locations that serve our members.

All providers must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR).

Antidote requires providers to deliver services to Antidote members without regard to race, color, national origin, age, disability, or sex. Providers must not discriminate against members based on their payment status and cannot refuse to serve based on varying policy and practices and other criteria for the collecting of member financial responsibility from Antidote members.

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (Newborns' Act) enacted in 1996 provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth. Under the Newborns' Act, group health plans may not restrict benefits for mothers or newborns for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The 48-hour (or 96-hour) period starts at the time of delivery, unless a woman delivers outside of the hospital. In that case, the period begins at the time of the hospital admission. The attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier. The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours).

KEY CONTACTS & IMPORTANT PHONE NUMBERS

The following table includes several important telephone numbers and web addresses available to providers and their office staff. When calling, it is helpful to have the following information available:

- The provider's NPI number
- The practice Tax ID number
- The member's Antidote ID number

HEALTH PLAN INFORMATION		
Antidote Health Plan of Ohio, Inc. Antidote Health Plan of Arizona, Inc. Phone: 1-888-509-2688 TTY/TDD: 711 www.antidotehealth.com		
Department		Telephone/Web Address
Interpreter and Translation Services		1-888-623-3195
Provider Services - Claims Inquiries - Claims Payment - Disputes		1-888-509-2688 www.antidotehealth.com/provider 8:00a.m. – 5:00 p.m. (local time)
Medical Management - Inpatient, Outpatient, and Behavioral Health Prior Authorizations - Concurrent Review/Clinical Information - Case Management		
Member Services - Eligibility Verification - Member Grievance & Appeals		1-888-623-3195 www.antidotehealth.com/member 8:00a.m. – 8:00p.m. (local time)
Prescription Benefits Manager – Navitus Health Solutions		1-888-836-5146 www.antidotehealth.com/pharma Open 24/7/365
Suspected Fraud, Waste, and Abuse		1-866-256-2134

OVERVIEW OF OUR NETWORK

Antidote offers a network built to provide members with accessible, affordable, and convenient options for care. Our plans include Bronze, Silver, and Gold levels of coverage.

Antidote's network emphasizes licensed, board certified virtual first primary care providers (PCP) for members. Members can also select an in-person PCP by formally changing their PCP via Antidote's Customer Care Center at 1-888-623-3195 8:00 a.m. to 8:00 p.m. local time, Monday through Friday or via the member portal at www.antidotehealth.com/member.

Members can access Antidote's comprehensive network of in-person healthcare providers, facilities and hospitals for their healthcare needs if determined to be medically necessary by either their in-person PCP or an Antidote virtual first PCP. Antidote's plans are designed to offer members a unique type of coverage that reduces a member's out-of-pocket expenses if they consult with an Antidote virtual first PCP prior to seeking services. Antidote's plans and benefits vary, and there may be prior authorization requirements for certain types of care to be covered.

As a provider, it is important you confirm which plan a member has before extending care. This information is located on the member's ID card and can also be confirmed when verifying the member's eligibility.

PROVIDER PORTAL

Antidote offers a robust, provider portal with functionality that is critical to serving members and to ease administration of the Antidote plans for providers. The portal can be accessed at www.antidotehealth.com/provider.

Functionality

All users of the provider portal must complete a registration process. Once registered, providers may:

- Check eligibility
- View the specific benefits for a member
- Check member benefit limitations and usage
- Check authorization requirements
- Verify members remaining yearly deductible and amounts applied to plan out-of-pocket maximums

- View status of all claims that have been received, regardless of method of submission
- Submit authorizations and view the status of authorizations that have been submitted for members
- View and download explanations of payment (EOP)

Manage Account Access allows you to perform functions as an account manager such as adding portal accounts needed in your office.

For questions about the provider portal, contact **1-888-509-2688**.

Provider and Practitioner Rights at Antidote

Antidote is committed to ensuring fairness and transparency throughout our credentialing and network participation processes. We want to ensure all healthcare providers and practitioners understand their rights concerning the information we use and any decisions that may affect their participation with us.

Disclaimer

Providers agree that all health information, including that related to patient conditions, medical and pharmacy utilization available through the portals or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

CREDENTIALING & RECREDENTIALING

It is Antidote's policy to make every reasonable effort to ensure that the health care providers and practitioners who render services to Antidote's members undergo a credentialing and recredentialing process. The process involves completion of an application, primary source verification, medical malpractice review, and approval by the applicable Credentialing Committee or Chief Medical Officer or designee before a healthcare provider or practitioner can be listed in Antidote's Provider Directory and render services to Antidote's members.

The credentialing and recredentialing processes also exist to verify that health care providers and practitioners meet applicable governmental regulations and standards of the National Committee for Quality Assurance.

Antidote uses the standardized credentialing forms available on the website of the Council for Affordable Quality Health (CAQH) for healthcare providers practitioners. The following information must be on file:

- Signed attestation as to correctness and completeness, history of license, clinical privileges, disciplinary actions, and felony convictions, lack of current illegal substance use and alcohol abuse, mental and physical competence, and ability to perform essential functions with or without accommodation;
- Completed ownership and control disclosure form unless otherwise prohibited by state requirement;
- Current malpractice insurance policy face sheet, which includes insured dates and the amounts of coverage;
- Current Controlled Dangerous Substance (CDS) license, if applicable;
- Current Drug Enforcement Administration (DEA) registration certificate for the state in which the practitioner will see Antidote members;
- Completed and signed W-9 form (initial credentialing only);
- Current educational commission for foreign medical graduates (ECFMG) certificate, if applicable;
- Curriculum Vitae listing at a minimum, a five-year work history on the application with no unexplained gaps of employment over six months for initial applicants;
- Signed and dated release of information form not older than 120 days; and
- Current clinical laboratory improvement amendments (CLIA) certificate, if applicable.
- Signed attestation as to correctness and completeness, history of license, clinical privileges, disciplinary actions, and felony convictions, lack of current illegal substance use and alcohol abuse, mental and physical competence, and ability to perform essential functions with or without accommodation;
- Completed ownership and control disclosure form unless otherwise prohibited by state requirement;
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- Current educational commission for foreign medical graduates (ECFMG) certificate, if applicable;
- Curriculum Vitae listing at a minimum, a five-year work history on the application with no unexplained gaps of employment over six months for initial applicants;
- Signed and dated release of information form not older than 120 days; and
- Current clinical laboratory improvement amendments (CLIA) certificate, if applicable.

NOTE: To maintain a current profile and Provider Directory information, healthcare providers and practitioners are required to notify Antidote of any relevant changes to their credentialing information in a timely manner but in no event later than ten days from the date of the change.

Primary source verification of the following information submitted for credentialing and recredentialing will be completed:

- License through appropriate licensing agency;
- Board certification, or residency training, or professional education, where applicable;
- Malpractice claims and license agency actions through the National Practitioner Data Bank (NPDB); and
- Federal sanction activity, including Medicare/Medicaid services (Office of Inspector General).

For hospitals and ancillary facilities, a completed Facility Application and all supporting documentation as identified in the application must be received with the signed, completed application.

Once the clean application is received, the Credentialing Committee will usually render a decision on acceptance following its next regularly scheduled meeting in accordance with state and federal regulations.

Eligible Providers

All eligible providers are required to complete the credentialing process. All eligible providers must be recredentialed every 36 months. Credentialing, recredentialing, and on-going monitoring governs the participation of the following providers, including, but not limited to:

Medical	Behavioral Health (Mental Health and Substance Use)
Physicians (MD)	Physicians/Psychiatrists (MD)
Dentists (DDS)	Psychologists (PhD/PsyD, Certified or Licensed)
Oral Surgeons (DMD)	Doctors of Osteopathic Medicine (DO)

Medical	Behavioral Health (Mental Health and Substance Use)
Podiatrists (DPM)	Clinical Psychologists (licensed)
Doctors of Osteopathy (DO)	Licensed Clinical Social Workers (LCSW, State Certified)
Nurse Practitioners (NP)	Licensed Marriage & Family Therapists (LMFT)
Certified Nurse Practitioners (CNP)	Licensed Clinical Social Workers(LCSW)
Physician Assistants (PA)	Licensed Marriage Family Therapists (LMFT)
Certified Nurse Midwives (CNM)	Nurse Practitioner (NP)
Chiropractors (DC)	Medical Doctor (MD)
Doctors of Optometry (OD)	Licensed Professional Clinical Counselors (LPCC)
Acupuncturists (LAC)	Psychiatric Nurse Practitioners and Masters Level Clinical Nurse Specialists (Nationally or State Certified or Licensed)
Occupational Therapists (OT)	Occupational Therapists (OTR/L)
Physical Therapists (PT)	Addiction Medicine Specialists (ADM)
Speech Therapists (ST)	Other: Behavioral Health Care Specialists (Licensed, Certified or Registered by the State to Practice Independently)
Board Certified Behavior Analyst (BCBA)	
Clinical Nurse Specialists (CNS)	
Facilities	Facilities
Hospitals	Behavioral Health Facilities
Urgent Care Centers	
Freestanding Ambulatory Surgery Centers	
Diagnostic Imaging Facilities	
Durable Medical Equipment Companies	
Orthotic and Prosthetic Suppliers	
Outpatient Physical Therapy Centers	
Skilled Nursing Facilities	
Home Health Providers	
Audiologist (AUD)	
Advanced Practice Registered Nurse (APRN)	
Advanced Practice Nurse (APN)	
Advanced Nurse Practitioner (ANP)	
Registered Dietician (RD)	

Non-Registered CAQH Providers

PCPs cannot accept member assignments until they are fully credentialed.

Healthcare providers and practitioners should self-register with CAQH ProView at <https://proview.caqh.org>. CAQH will email a Welcome Kit with registration instructions. Healthcare providers and practitioners receive a personal CAQH Provider ID, allowing them to register on the CAQH website at proview.caqh.org and obtain immediate access to the ProView database via the Internet.

Once obtaining authenticating key information, healthcare providers and practitioners may create their own unique username and password.

Credentialing Committee

The Credentialing Committee, including the Chief Medical Officer or their physician designee, has the responsibility to establish and adopt necessary criteria for participation, termination, and direction of the credentialing procedures. Committee meetings are typically held at least monthly and more often as deemed necessary. Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to the Credentialing Committee's decision.

Antidote conducts healthcare providers and practitioners recredentialing at least every 36 months from the date of the initial credentialing decision or most recent recredentialing decision. The purpose of this process is to identify any changes in the healthcare provider's or practitioner's licensure, sanctions, certification, competence, or health status which may affect the healthcare provider's or practitioner's ability to perform services. This process includes all healthcare providers, practitioners, facilities, and ancillary providers previously credentialed and currently participating in the network.

In between credentialing cycles, performance monitoring activities occur on all healthcare providers and practitioners. Antidote reviews monthly reports released by both Federal and State entities to identify any healthcare providers and practitioners who have been newly sanctioned or excluded from participation in Medicare or Medicaid. Antidote also reviews member complaints and grievances against providers on an ongoing basis.

A provider's agreement may be terminated if at any time it is determined by the Credentialing Committee that credentialing requirements or standards are no longer being met.

Practitioner Right to Review and Correct Information

All healthcare providers and practitioners in the network have the right to review information obtained by Antidote to evaluate their credentialing and/or recredentialing application. This includes information obtained from any outside primary source, such as

the NPDB, CAQH, malpractice insurance carriers, and state licensing agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer review protected.

Healthcare providers and practitioners have the right to correct any erroneous information submitted by another party (other than references, personal recommendations, or other information that is peer review protected) in the event the provider believes any of the information used in the credentialing or recredentialing processes to be incorrect or should any information gathered as part of the primary source verification process differ from that submitted by the healthcare provider or practitioner.

Antidote will inform providers in cases where information obtained from primary sources varies from information provided by the healthcare provider or practitioner. To request release of such information, a written request must be submitted. Upon receipt of this information, the healthcare provider or practitioner will have 30 days from the initial notification to provide a written explanation detailing the error or the difference in information to the Credentialing Committee.

The Credentialing Committee will then include this information as part of the credentialing or recredentialing process. Antidote documents receipt of all corrections or additional information submitted by practitioners and includes this documentation in the practitioner's credentialing file for review by the Credentialing Committee.

Practitioner Right to Be Informed of Application Status

If you have applied to join Antidote's network, you have the right to be informed of the status of your application upon request.

The information Antidote will share includes information obtained from outside primary sources such as the National Practitioner Data Bank (NPDB), Council for Affordable Quality Healthcare (CAQH), malpractice insurance carriers, and state licensing agencies.

However, this right does not extend to reviewing references, personal recommendations, other information that is peer review protected, the checklist used to document verification dates and who completed the verifications or other sources of information that were obtained to meet verification requirements, or if federal or state law prohibits disclosure.

To obtain your application status, contact Antidote at **credentialing@antidotehealth.com** or **1-888-623-3195**.

Based on the method you request to obtain application status, Antidote will respond via email or telephone. Additionally, if information is missing from your application, you, or the individual you designate to submit your credentialing information, may receive email

inquiries from CAQH or Antidote's NCQA accredited Credentials Verification Organization (CVO), Medallion. It is your responsibility to ensure that you maintain an up-to-date CAQH profile, all required documents are uploaded and attested and authorize Antidote to access your profile.

Practitioner Right to Appeal or Reconsideration of Adverse Credentialing Decisions

If you are an existing provider and your continued participation is declined due to adverse credentialing determinations for reasons such as appropriateness of care or liability claims issues, you have the right to request an appeal of the decision. Appeal requests must be submitted in writing within 30 days from the date of Antidote's notice.

For new applicants who are declined participation, you may request a reconsideration within 30 days from the date of Antidote's notice. All written requests for appeal or reconsideration should include additional supporting documentation that supports your case for participation in the network.

Reconsiderations will be reviewed by the Credentialing Committee at their next regularly scheduled meeting or no later than 60 days from the receipt of your additional documentation, in accordance with state and federal regulations.

Written requests to appeal or seek reconsideration of adverse credentialing decisions should be sent to the individual specified on your denial letter. All healthcare providers and practitioners who have applied to join have the right to be informed of the status of their application upon request.

To obtain application status, the healthcare provider or practitioner should contact **1-888-509-2688**.

PROVIDER ADMINISTRATION & ROLE OF THE PROVIDER

Provider Types That May Serve as PCPs

Providers who may serve as PCPs include:

- Internal Medicine
- Pediatrics
- General Medicine
- Family Practice
- Obstetrics/Gynecology
- Physician Assistants
- Nurse Practitioners

Member Panel Capacity

All PCPs have the right to state the number of members they are willing to accept into their panel. Antidote does not and is not permitted to guarantee that any provider will receive a certain number of members.

The PCP to member ratio shall not exceed the following limits:

Practitioner Type	Ratio
General/Family Practitioners	One per 2,000 members
Pediatricians	One per 2,000 members
Internists	One per 2,000 members

If a PCP has reached the capacity limit for their practice and wants to make a change to their open panel status, the PCP must notify Antidote 30 days in advance of their inability to accept additional members. Notification can be in writing or by calling the Provider Services Department at 1-888-509-2688. A PCP must not refuse new members into their panel unless the PCP has reached their specified capacity limit.

In the event an established patient becomes an Antidote member, that member will not be considered a new patient. Providers must not intentionally segregate members from fair treatment and covered services provided to other non-members.

Member Selection or Assignment of PCP

Antidote members will be assigned a virtual first PCP at the time of enrollment. Antidote members may also select an in-person PCP. In the event an Antidote member does not make a PCP choice, Antidote will usually select a PCP based on:

- Pregnant members are encouraged to select a pediatrician or other appropriate PCP for their newborn baby before the beginning of the last trimester of pregnancy. In the event the pregnant member does not select a PCP, Antidote will assign one for their newborn.
- The member may change their PCP at any time with the change becoming effective no later than the beginning of the month following the member's request for change. Members are advised to contact the Member Services Department at 1-888-509-2688 for further information.

Withdrawing from Caring for a Member

Providers may withdraw from caring for a member. Upon reasonable notice and after stabilization of the member's condition, the provider must send a certified letter to Antidote

Member Services detailing the intent to withdraw care. The letter must include information on the transfer of medical records as well as emergency and interim care.

PCP Coordination of Care to Specialists

When medically necessary care is needed beyond the scope of what the PCP can provide, PCPs are encouraged to initiate and coordinate the care members receive from specialist providers. Certain referrals to specialists require prior authorization. Healthcare providers and practitioners are required to use best efforts to refer members to network specialists. For assistance in identifying a network specialist, utilize the provider look up tool: antidotehealth.com/insurance/find-provider.

In accordance with federal and state law, providers are prohibited from making referrals for designated health services to healthcare providers with which the provider, the member, or a member of the provider's family or the member's family has a financial relationship.

Specialist Responsibilities

Specialist must communicate with the PCP regarding a member's treatment plan and referrals to other specialists. This allows the PCP to better coordinate the member's care and ensures that the PCP is aware of the additional service request. If a member is referred to a specialist by their virtual first PCP, the member's out-of-pocket expenses are reduced.

To ensure continuity and coordination of care for the member, every specialist must:

- Maintain contact and open communication with the member's referring PCP;
- Obtain authorization; from the Medical Management Department, if applicable, before providing services;
- Provide the referring PCP with consultation reports and other appropriate patient records within five business days of receipt of such reports or test results;
- Be available for or provide on-call coverage through another source 24 hours a day for management of patient care;
- Maintain the confidentiality of patient medical information; and
- Actively participate in and cooperate with all quality initiatives and programs.

APPOINTMENT AVAILABILITY & WAIT TIMES

Antidote follows the accessibility and appointment wait time requirements set forth by applicable regulatory and accrediting agencies. Antidote monitors participating provider compliance with these standards at least annually and will use the results of appointment standards monitoring to ensure adequate appointment availability and access to care and to reduce inappropriate emergency room utilization. The table below depicts the appointment availability for members:

Appointment Type	Access Standard
PCPs – Routine Visits	15 business days
Behavioral Health – Routine Visits	10 business days
Specialist Care – Non-urgent	30 business days
After Hours Care	Office number answered 24 hours a day, 7 days a week by answering service or instructions on how to reach a physician
Emergency Providers	24 hours a day, 7 days a week

The Centers for Medicare & Medicaid Services requires that Members seeking an appointment can schedule an appointment within the time frames set forth above 90% of the time.

Wait Time Standards for All Provider Types

It is recommended that office wait times do not exceed 30 minutes before an Antidote member is taken to the exam room.

Travel Distance and Access Standards

Antidote offers a comprehensive network of PCPs, specialist, hospitals, behavioral health care providers, diagnostic and ancillary services providers to ensure every member has access to covered services.

The travel distance and access standards that Antidote utilizes to monitor its network adequacy are in line with state, federal regulations, and accrediting agencies. For the standard specific to your specialty and county, contact the Provider Services Department at 1-888-509-2688.

Providers must offer and provide Antidote members appointments and wait times comparable to those offered and provided to other commercial members. Antidote routinely

monitors compliance with this requirement and may initiate corrective action, including suspension or termination, if there is a failure to comply with this requirement.

COVERING PROVIDERS

PCPs and specialist providers must arrange for coverage with another provider during scheduled or unscheduled time off. In the event of unscheduled time off, the provider must notify the Provider Services department of coverage arrangements as soon as possible.

For scheduled time off, the provider must notify the Provider Services department prior to the scheduled time off. The provider who engaged the covering provider must ensure that the covering physician has agreed to be compensated in accordance with the Antidote fee schedule in such provider's agreement.

Provider Phone Call Protocol

PCPs and specialists must:

- Answer the member's telephone inquiries on a timely basis
- Schedule appointments in accordance with appointment standards and guidelines set forth in this manual
- Schedule a series of appointments and follow-up appointments as appropriate for the member and in accordance with accepted practices for timely occurrence of follow-up appointments for all patients
- Identify and, when possible, reschedule cancelled and no-show appointments
- Identify member's special needs when scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or persons with cognitive impairments)
- Adhere to the following response times for telephone call-back wait times:
 - After hours for non-emergent, symptomatic issues: within 30 minutes
 - Same day for all other calls during normal office hours
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal office hours
- Have protocols in place to provide coverage in the event of a provider's absence
- Document after-hours calls in a written format in either the member's medical record or an after-hours call log and then transfer to the member's medical record

NOTE: If after-hours urgent or emergent care is needed, the PCP, specialist, or their designee should contact the urgent care center or emergency department to notify the facility of the patient's impending arrival. Antidote does not require prior authorization for care for an emergency medical condition.

Antidote will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement Program (QIP).

24- Hour Access to Providers

PCPs and specialists are required to maintain sufficient access to needed health care services on an ongoing basis and must ensure that such services are accessible to members as needed 24 hours a day, 365 days a year as follows:

- A provider's office phone must be answered during normal business hours; and
 - A member must be able to access their provider after normal business hours and on weekends; this may be accomplished through the following:
 - A covering physician;
 - An answering service;
 - A triage service or voicemail message that provides a second phone number that is answered; or
 - If the provider's practice includes a high population of Spanish speaking members, it is recommended that the message be recorded in both English and Spanish.
- Examples of unacceptable after-hours coverage include, but are not limited to:
 - Calls received after-hours are answered by a recording telling callers to leave a message;
 - Calls received after-hours are answered by a recording directing patients to go to an emergency room for any services needed; or
 - Not returning calls or responding to messages left by patients' after-hours within 30 minutes.

The selected method of 24-hour coverage chosen by the provider must connect the caller to someone who can render a clinical decision or reach the PCP or specialist for a clinical decision. Whenever possible, PCPs, specialists, or a covering professional must return the call within 30 minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number.

Antidote will monitor provider's compliance with this provision through scheduled and unscheduled visits and audits conducted by Antidote staff.

Hospital Responsibilities

Antidote has established a comprehensive network of hospitals to provide services to members. Hospital services and hospital-based providers must be qualified to provide services under the program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth by accrediting agencies, if any.

Hospitals must:

- Notify the PCP immediately or no later than the close of the next business day after the member's emergency room visit;
- Except for emergency stabilization services, obtain authorization for all inpatient and selected outpatient services listed in this manual. For assistance, call 1-888-509-2688 or visit www.antidotehealth.com/provider;
- Notify the Medical Management department by calling 1-888-509-2688 to notify Antidote of the ER admission within one business day; the information required includes the member's name, member ID, presenting symptoms/diagnosis, date of service, and member's phone number;
- Notify the Medical Management department of all newborn deliveries within one day of the delivery; and
- Adhere to the standards set forth in this manual for prior authorization requests

Provider Data Updates and Validation

Easy access to care for Antidote members is extremely important. When information regarding a healthcare provider or practitioner's address, office hours, specialty, phone number, hospital affiliations, or provider changes occur, it is the healthcare provider or practitioner's responsibility to timely notify Antidote. Antidote will quickly update its systems to ensure the most current information is accessible to members.

Antidote, and Antidote's contracted vendors, routinely perform audits of provider data. This may be done through outreach to confirm your practice information. Access to care is critical to ensuring the health and well-being of our members, and to provide reliable access to care, it is important to respond to the outreach. Without a response, we are unable to accurately make your information available to patients and you may be at risk of being removed from the Antidote's Provider Directory.

We need your support and participation in these efforts. The Centers for Medicare & Medicaid Services (CMS) may also audit provider directory data throughout the year. Notify your office personnel so they route these inquiries appropriately.

ANTIDOTE BENEFITS

Overview

Antidote's plans vary based the liability limits or cost share expenses to the member. The phrase "Metal Tiers" is used to categorize these limits. Under the Affordable Care Act (ACA), the Metal Tiers include Platinum, Gold, Silver, and Bronze. Antidote offers Gold, Silver and Bronze plans. Each plan is categorized within one of these "Metal Tiers." The tiers are based on the amount of member liability. For instance, at a Gold level, a member will pay higher premiums but will have lower out-of-pocket costs.

The essential health benefits (EHB) are the same within every plan Antidote offers. This means that every plan Antidote offers covers the minimum, comprehensive benefits as outlined in the ACA. The EHBs outlined in the Affordable Care Act are as follows:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including dental and vision care

Antidote covers services described in the Schedule of Benefits and Evidence of Coverage (EOC) for each Antidote plan. If there are questions regarding whether a service is considered a "covered service" or requires prior authorization, contact the Provider Services Department at **1-888-509-2688**.

Detailed information about benefits and services can be found in the current year EOC available at **antidotehealth.com/provider**.

Antidote's plans are marketed under the following names:

Metal Tiers	24/7	24/7 Complete
Gold	Antidote Gold 24/7 (Unlimited \$0 Virtual Urgent/PCP/Specialist/ Mental Health Visits + \$0 Select Rx) Antidote Gold Family First (24/7 Virtual Care + \$0 Select Rx)	Antidote Gold Cash Back (Unlimited \$0 Virtual PCP/Specialist/Mental Health Visits + \$0 Top Rx) Antidote Gold Family First Complete (24/7 Virtual Care + \$0 TopRx)
Silver	Antidote Silver 24/7 (Unlimited \$0 Virtual Urgent/PCP/Specialist/Mental Health Visits+ \$0 Select Rx) Antidote Silver Family First (24/7 Virtual Care + \$0 SelectRx)	Antidote Silver Cash Back (Unlimited \$0 Virtual PCP/Specialist/Mental Health Visits + \$0 Top Rx) Antidote Silver Family First Complete (24/7 Virtual Care+ \$0 TopRx)
Bronze	Antidote Bronze 24/7 (Unlimited \$0 Virtual Urgent/PCP/Specialist/Mental Health Visits+ \$0 Select Rx) Antidote Bronze Family First (24/7 Virtual Care+ \$0 SelectRx)	Antidote Bronze 24/7 Complete (Unlimited \$0 Virtual PCP/Specialist/Mental Health Visits + \$0 Top Rx) Antidote Bronze Family First Complete (24/7Virtual Care + \$0 TopRx)

There are also versions of these products with integrated adult dental plans.

The state standard plan designs are also available:

Metal Tiers	SafeGuard
Gold	Antidote Gold SafeGuard (\$0 Top Rx)
Silver	Antidote Silver SafeGuard (\$0 Top Rx)

Bronze	Antidote Bronze SafeGuard (\$0 Top Rx)
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Additional Benefit Information

Antidote offers HMO benefit plans in various geographic locations. Depending on the benefit plan, plans contain copays, coinsurance, and deductibles (cost shares). As stated elsewhere in this manual, cost shares may be collected at the time of service.

Members who are enrolled in HMO plans with Antidote must utilize in-network participating providers. Members and providers can identify other participating providers by visiting Antidote's website at www.antidotehealth.com and clicking on Find-A-Provider. When an out-of-network provider is utilized, except in the case of emergency services, the member will be 100% responsible for all charges.

Integrated Deductible Products

Antidote's plans contain an integrated deductible, meaning that the medical and prescription deductible are combined. In such plans, a member will reach the deductible first, then pay coinsurance until they reach the maximum out-of-pocket for their plan.

- Copays will be collected before the deductible for services that are not subject to the deductible.
- Other copays are subject to the deductible, and the copay will be collected only after the deductible is met.
- Services counting towards the integrated deductible include medical costs, physician services, hospital services, EHB covered services including pediatric dental and mental health services, and pharmacy benefits.
- Claims information including the accumulators will be displayed on the provider portal.

Maximum Out-of-Pocket Expenses

All Antidote plans contain a maximum out-of-pocket expense. Maximum out-of-pocket is the highest or total amount that must be paid by the member toward the cost of their health care (excluding premium payments). Maximum out-of-pocket costs can be determined by reviewing the member's EOC available at www.antidotehealth.com on the "Find Your Plan" page.

The rules regarding maximum out-of-pocket expenses are:

- A member will reach the deductible first and will continue to pay coinsurance and copays until they reach the maximum out-of-pocket for their plan.

- Copays will be collected before and after the deductible is met until the maximum out-of-pocket is met.
- Only medical and pediatric vision costs, if applicable, are applied to the deductible.
- All out-of-pocket costs, including copays, deductibles, and coinsurance apply to the maximum out-of-pocket, excluding premium payments.

COVERED SERVICES

Please visit the Antidote website for information on services, the member's coverage status and other information about obtaining services. Please refer to our website and the "Medical Management & Prior Authorization" section of this manual for more information about clinical determinations and prior authorization procedures.

Benefit Limits

In general, most benefit limits for services and procedures follow state and federal guidelines. Benefits limited to a certain number of visits per year are based on a calendar year (January through December). Please check to be sure the member has not already exhausted benefit limits before providing services by checking the provider portal or calling the Provider Services Department at 1-888-509-2688.

Preventive Services

Preventive care services are covered in accordance with the ACA. The ACA requires health plans (non- grandfathered) to cover certain identified services under the preventive care benefit without cost sharing to members (copayments, coinsurance amounts, and deductibles do not apply), when obtained from an in-network provider.

ACA required preventive care coverage includes:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by HRSA.

NOTE: The complete list of recommendations and guidelines can be found at:

<https://www.healthcare.gov/preventive-care-benefits>

Preventive benefits do not generally include services intended to treat an existing illness, injury, or condition. Benefits will be determined based on how the bill is submitted. Claims must be submitted with the appropriate diagnosis and/or procedure code to be paid at the 100% benefit level. If during a preventive care visit a member receives services to treat an existing illness, injury, or condition, the member may be required to pay a copayment, deductible and/or coinsurance for those covered non- preventive services.

For a listing of services that are covered at 100% and associated preventive benefits, visit www.antidotehealth.com/provider.

Notification of Pregnancy

Providers should notify Antidote immediately of any member who are expecting. We do not require that a physician or other healthcare provider obtain prior authorization for the delivery of the newborn. However, an inpatient stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require prior authorization. Refer to the Provider Authorization Guidelines in this manual if an authorization is required for additional services.

Notification of Pregnancy Surrogacy

Providers should notify Antidote immediately of any member intending to come into a contractual agreement or is expecting because of surrogacy. All pregnancy related services provided to a surrogate mother are not covered, including but not limited to charges related to the baby's birth, hospitalization, or care because of surrogacy. Please see the Antidote EOC for additional details.

Adding a Newborn or an Adopted Child

Coverage applicable for children will be provided for a newborn child or adopted child of an Antidote member from the moment of birth or moment of placement for adoptions if the eligible child is enrolled timely as specified in the member's EOC.

Non-Covered Services

Please refer to the member's EOC for a listing of non-covered (excluded) services. Visit www.antidotehealth.com to locate a member's EOC.

Transplant Services

Please refer to the member's EOC for a listing of covered and non-covered (excluded) services related to transplants.

Transplants are a covered benefit when a member is accepted as a transplant candidate. Prior authorization must be obtained before an evaluation for a transplant. We may require additional information such as testing and/or treatment before determining medical

necessity for the transplant benefit. Authorization must be obtained prior to performing any services related to the transplant surgery. Transplant services must meet medical criteria as set by Medical Management Policy.

Claims submission shall be followed related to transplant services is available to both the recipient and donor of a covered transplant as follows:

- If both the donor and recipient have coverage provided by the same insurer each will have their benefits paid by their own coverage program.
- If Antidote's member is the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this contract will be provided for both Antidote's member and the donor. In this case, payments made for the donor will be charged against the Antidote member's benefits.
- If Antidote's member is the donor for the transplant and no coverage is available to the member from any other source, the benefits under this contract will be provided for the member. No benefits will be provided for the recipient.
- If a lapse in coverage occurs due to non-payment of premium, no services related to transplants will be paid as a covered benefit.

For additional questions or information about Antidote's Prior Authorizations Guidelines, review the Medical Management section of this manual.

MEMBER BENEFITS, ELIGIBILITY, IDENTIFICATION & COST SHARE

Providers must verify benefits, eligibility, and a member's cost share each time an Antidote member is scheduled to receive services.

Member Benefits

In general, most benefit limits for services and procedures follow state and federal guidelines. Benefits limited to a certain number of visits per year are based on a calendar year (January through December).

In addition to verifying member benefits, eligibility and cost share, there may be further steps needed to help Antidote members maximize their benefit coverage before treatment is rendered. Prior authorization may be required before services are rendered.

Be sure the member has not already exhausted benefit limits before providing services by checking Antidote's provider portal or calling the Provider Services Department at **1-888-509-2688**.

Member Identification Card

All members will receive an Antidote member identification card.

Below is a sample member identification card. The ID card may vary due to the features of the health plan selected by the member.

ANTIDO+ ODI QCP
Membership Card

Member ID: **[A-00-123-456-01]**
Member Name: **[John Doe]**

Issuer: [Antidote Health Plan of Ohio, Inc.]
Plan: [Silver Family First 2024 On Exchange]
Effective Date: [Jan 1, 2024]

Visit	Antidote	With Antidote	QCP
Copay	Provider	Referral	Provider
PCP	[\$0]	[\$0]	[\$30]
Specialist	[\$0]	[\$15]	[\$60]
Mental Health	[\$0]	[\$15]	[\$30]



Download App
for 24/7 Care

RxGroup: **610610**
RxBIN: **XYZA10**
RxPCN: **STK111**

Ded IND/FAM:
[\$5000 / \$10000]
OOPM IND/FAM:
[\$9000 / \$18000]

This card is issued to Antidote Health members for identification purposes only. The provisions of health plan benefits are subject to the terms and conditions of the Evidence of Coverage. Your health benefit plan is subject to sections 3902.50 through 3902.54 of the Ohio Revised Code.

Members: Antidote Health Plan is here to help you. To schedule an appointment, refill a prescription, check benefits, view claims, find a provider, ask questions, and more:
24/7 Access Online – www.antidotehealth.com/member
24/7 Access Member Services – 1-888-623-3195; TTY 711
In an emergency, call 911 or go to the emergency room

Providers: This card does not guarantee coverage. To verify coverage, obtain prior authorization, check eligibility, find network providers, and see all preauthorization requirements, visit www.antidotehealth.com/provider, or call (1-800-123-4596)

Pharmacy: Call 888-838-5148 or www.antidotehealth.com/pharma
Ohio EDI claims: Payer ID – 89481
Ohio Paper claims: PO Box 595 Arnold, MD 21012



NOTE: Presentation of a member ID card is not a guarantee of eligibility. Providers must always verify eligibility on the same day services are required.

Preferred Method to Verify Member Benefits, Eligibility, and Cost Share

To verify member benefits, eligibility, and cost share information, the preferred method is the Antidote provider portal found at www.antidotehealth.com/provider.

Using the portal, any registered provider can quickly check member eligibility, benefits, and cost share information. An eligibility search can be performed using first name, last name, and date of birth, or by member ID. Eligibility and cost share information loaded onto this website is obtained from and reflective of all changes made within the last 24 hours.

Other Methods to Verify Member Benefits, Eligibility and Cost Share	
Provider Services at 1-888-509-2688	Follow the menu prompts to speak to a Provider Services Representative to verify eligibility before rendering services. Provider Services will require the member’s name or member ID number and date of birth to verify eligibility.

Importance of Verifying Member Benefits, Eligibility, and Cost Share Benefit Design

To accurately collect a member's cost share (coinsurance, copays, and deductibles), providers must know the benefit design. A member cost-sharing level and copayment is based on the member's health plan. You can collect the copayment amounts from the member at the time of service.

The provider portal found at www.antidotehealth.com/provider provides the information needed.

Premium Grace Period for Members Receiving Advanced Premium Tax Credits (APTCs)

A provision of the ACA requires that Antidote allow members receiving Advance Premium Tax Credits (APTC) a three-month grace period to pay premiums before coverage is terminated.

Members for whom Antidote is not receiving an APTC will have a grace period of 30 days.

MEDICAL MANAGEMENT

The components of Antidote's Medical Management program are Utilization Management, Care Management and Concurrent Review, Health Management and Behavioral Health. These components are discussed below.

Utilization Management

Antidote is committed to providing members with comprehensive medical and behavioral health services that are appropriate, timely, effective, and medically necessary. Antidote focuses on optimizing each member's health status, sense of well-being, productivity, and access to appropriate health care while at the same time actively managing cost trends. Antidote's Utilization Management (UM) Program is an important element to fulfilling this commitment.

Antidote is also committed to ensuring that all participating practitioners have access to the criteria used for Utilization Management (UM) decisions. Practitioners are informed annually through the Provider Manual that UM criteria are available upon request. Antidote's written UM decision-making criteria are available to its practitioners upon request. Practitioners may obtain the most recent UM criteria through various channels, including mail, fax, or email. For practitioners without fax, email, or internet access, the criteria are routinely mailed. Criteria can also be requested upon request by telephone.

Key aspects of the UM Program are medical necessity, appropriateness, availability, and accessibility of health services. Utilization Management is an on-going process of assessing, planning, organizing, directing, coordinating, monitoring, and evaluating the utilization of health care services for Antidote's members.

The objectives of the UM Program are to:

- Assure that physical and behavioral health care services are consistent with accepted medical practice and community standards of care.
- Oversee the UM Program to ensure its administration is in a manner that facilitates efficient member care and access and promotes fair and consistent decision-making.
- Monitor provider and practitioner practice patterns to identify opportunities for improving the delivery of care to Antidote's members.
- Identify and refer members who would benefit from case management.
- Educate members and healthcare providers and practitioners about the UM Program, UM processes, and review criteria.

Healthcare providers and practitioners are required to participate in and observe the protocols of Antidote's UM program for health care services rendered to members. Utilization Management includes, but is not limited to, precertification (also known as prospective review or prior authorization), concurrent review, and retrospective review.

Antidote does not reward providers, employees who perform utilization reviews, or other individuals for issuing denials of authorization. Neither network inclusion nor hiring and firing practices influence the likelihood or perceived likelihood for an individual to deny or approve coverage. There are no financial incentives to deny care or encourage decisions that result in underutilization.

Prior authorization or prospective review is the request to the UM Department for approval of certain services before the service is rendered. Authorization must be obtained prior to the delivery of certain elective and scheduled services. For more information regarding the elective or scheduled services that require prior authorization, visit www.antidotehealth.com/provider or review the Prior Authorization guidelines below. Failure to obtain authorization will result in denial of coverage.

To initiate the precertification process, contact **1-740-647-4140** or complete the on-line Authorization Request Form available at **www.antidotehealth.com/provider**.

Utilization Management Determination Timeframes

Authorization decisions are made as expeditiously as possible. Below is a list of specific timeframes utilized by Antidote. In some cases, it may be necessary for an extension to

extend the timeframe below. You will be notified if an extension is necessary. Please contact Antidote if you would like a copy of the policy for UM timeframes.

Type	Timeframe
Prospective/Urgent	Within 48 hours of receipt of all information needed to complete the review. If all information is not received by the end of the 48 hours, a determination will be made based on available information.
Prospective/Non-urgent	Within 10 business days of receipt of all information needed to complete the review. If all information is not received by the 14th day of the request a determination will be made based on available information.
Concurrent/Urgent	1 day extension: A onetime extension may be granted up to 72 hours. If all information is not received by the end of the 72 hours, a determination will be made based on available information.
Concurrent/Non-urgent	1 day extension: A onetime extension may be granted up to 72 hours. If all information is not received by the end of the 72 hours, a determination will be made based on available information.
Retrospective	30 days

Medically Necessary

Medically Necessary means any medical service, supply, or treatment authorized by a healthcare provider or practitioner to diagnose and treat a member's illness or injury which:

- Is consistent with the symptoms or diagnosis;
- Is provided according to generally accepted medical practice standards;
- Is not custodial care;
- Is not solely for the convenience of the healthcare provider, practitioner or the member;
- Is not experimental or investigational;
- Is provided in the most cost-effective care facility or setting;
- Does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment; and
- When specifically applied to a hospital confinement, it means that the diagnosis and treatment of the medical symptoms or conditions cannot be safely provided as an outpatient.

Antidote has adopted the following utilization review criteria to determine whether services are medically necessary services for purposes of plan benefits:

Services	Criteria
Medical Services	Milliman Care Guidelines® Adult, Clinical Policies and Pediatric Guidelines and internally developed criteria by Antidote health care professionals and related specialists. More information is available at www.careguidelines.com .
Substance Use Disorder Services	American Society for Addiction Medicine (ASAM) Patient Placement Criteria. The criteria are available at www.asam.org .
Behavioral Health Services	Milliman Care Guidelines® Behavioral Health Criteria (Adult and Geriatric or Child and Adolescent Psychiatry) and internally developed criteria by Antidote behavioral health care professionals and related specialists. More information is available at www.careguidelines.com .
Cancer Services	The National Comprehensive Cancer Network® guidelines and internally developed criteria by Antidote health care professionals and related specialists. More information is available at www.nccn.org .

Antidote's Chief Medical Officer, or other health care professionals who has the appropriate clinical expertise in treating a member's condition or disease, reviews all potential adverse determinations and will decide in accordance with currently accepted medical or health care practices, considering special circumstances of each case that may require deviation from the criteria as mentioned above.

Providers may obtain the criteria used to make a specific adverse determination or discuss any adverse decisions with an Antidote physician or other appropriate reviewer at the time of the notification to the requesting provider by contacting the Medical Management

Department at **1-888-509-2688**. An Antidote Care Manager may also be involved to assist in the coordination of communication.

Members or healthcare professionals, with the member's consent in Ohio and without the member's consent in Arizona, may request an appeal related to a medical necessity decision made during the authorization or concurrent review process via facsimile at **1-740-647-4140** or in writing to:

**Antidote Health Plan
Attention: Appeals and Grievances Department
434 Main Street
Zanesville, OH 43701**

CARE MANAGEMENT & CONCURRENT REVIEW

Care Management

Care management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet a member's health needs, using communication and available resources to promote quality, cost effective outcomes. Care management is member- centered, goal-oriented, culturally relevant, and logically managed processes to help ensure that a member receives needed services in a supportive, effective, efficient, timely, and cost-effective manner.

Care management empowers members to be appropriate users of healthcare by providing the tools and resources needed for lifestyle, health, and healthcare self-management. Care Managers support early identification of health issues and encourage members to take an active and informed role in their healthcare decisions.

In partnership with Antidote providers, Antidote continually seeks to improve the health and well-being of our members by:

- Promoting wellness, disease prevention and improve quality of life, functional status, and overall health;
- Providing access to culturally diverse comprehensive health services;
- Educating and assisting members, their families, and caregivers to navigate the health care system reducing fragmentation in the services to be delivered, and to better understand their individual and/or family health care benefits;
- Enabling members to play an active role in their health care;
- Delivering services with responsibility and respect and empathy;
- Identifying at-risk members that can benefit from case management;
- Providing seamless care coordination and safe transitions of care;

- Reducing preventable costs associated with hospital readmissions and frequent emergency visits;
- Facilitating communication among the member, their families and caregivers, health care providers, the community, and Antidote to enhance cooperation while planning for and meeting the health care needs of the member; and
- Increasing member and provider satisfaction through the collaboration, coordination, and management of health care resources.

The Care Management team supports physicians by tracking compliance with the care management plan and facilitating communication between the PCP, member, managing physician, and the Care Management team. The Care Manager also facilitates referrals and links to community providers.

The managing physician maintains responsibility for the member's ongoing care needs. The Care Manager will contact the PCP and/or managing physician if the member is not following the plan of care or requires additional services.

Antidote provides individual care management services for members who have high-risk, high- cost, complex, or catastrophic conditions. The Care Manager will work with all involved providers to coordinate care and provide referral assistance and other care coordination as required.

The following conditions and/or diagnoses are examples of appropriate referrals:

Conditions/Diagnoses	
Addiction	High Blood Pressure
Adults or Children with Serious or Complex Medical Needs	Long Hospital Stay (> 5 days)
Asthma	Medication Noncompliance
At Risk Pregnancies and Post-natal Care	Missed Follow-up Visits
Cancer	Multi-trauma Cases
CHF	Multiple ER Visits
COPD	Multiple hospital stays
CRF	New Stress on Family (i.e., unemployment, deployment, etc.)
Diabetes	Post Admission Rehabilitation
Dialysis	Seniors
Drug or Alcohol Abuse	Social Issues (social isolation, hunger housing, domestic violence)

Eating Disorders	Special Needs
End of Life Care	Transgender Case Management
Functional Limitations	Transplant Patient
Heart Problems	

Telephonic care management by registered nurses, licensed mental health professionals and social services specialists as well as Marketplace Coordinators is available. Care Managers work with the member to create a customizable plan of care to promote healthcare as well as adherence to the care management plans. Care Managers will coordinate with physicians, as needed, to develop and maintain a plan of care to meet the needs of all involved.

All Antidote members with identified needs are assessed for care management enrollment. Members with needs may be identified via referrals from other Antidote staff members, via hospital census, via direct referral from providers, via self-referral, or referral from other providers. To refer an Antidote member to a Care Manager, call **1-888-258-7621**.

A Care Management Referral Form is available at www.antidotehealth.com/provider.

Complex Care Management

Antidote provides Complex Case Management (CCM) services intended to coordinate care and resources for our highest-risk members managing complex conditions. Antidote maintain multiple avenues for members to be considered for these necessary services. These access points include referrals generated internally through the Medical Management program or initiated externally by a Discharge Planner.

Importantly, referrals from practitioners is a recognized pathway for initiating consideration for CCM services. Antidote communicates to members and practitioners the multiple referral options available for Complex Case Management services at least annually and whenever updates occur.

Furthermore, members or their caregivers are empowered to submit a referral directly. The organization considers CCM an opt-out program, affirming that all members deemed eligible have the right to participate or decline participation in the program. The establishment of these diverse referral avenues ensures that the time between identifying a member's clinical or social needs and the delivery of complex case management services is minimized.

Antidote's referral form is located at **<https://www.antidotehealth.com/for-providers>**. A referral can also be initiated by contacting **1-740-647-4140**.

Concurrent Review

A concurrent review of the medical necessity and appropriateness of care of an inpatient stay is conducted to determine if additional services, beyond those originally approved are warranted. All continued stay requests are reviewed utilizing appropriate decision protocols, which are based on reasonable medical evidence.

The Medical Management Department will concurrently review the treatment and status of all members who are inpatient through contact with the hospital's Utilization and Discharge Planning Departments and when necessary, the member's attending physician. An inpatient stay will be reviewed as indicated by the member's diagnosis and response to treatment. The review will include evaluation of the member's status, proposed plan of care, discharge plans, and subsequent diagnostic testing or procedures.

Health Management

Health management is the concept of reducing health care costs and improving quality of life for individuals with a chronic condition through ongoing integrated care. Health management supports the physician or practitioner/patient relationship and plan of care; it emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

Antidote's Health Information Survey

Antidote members are requested to complete a Health Information Survey upon enrollment. Antidote utilizes the information to better understand the member's health care needs to provide customized, educational information and services specific to their needs. Antidote members can login to their account at Antidote to complete the health survey.

Antidote's MVP Rewards Program

The MVP rewards program gives members the opportunity to earn reward dollars for taking charge of their health. This program provides incentives when they take advantage of their preventive care benefits by helping them earn reward dollars.

When members take an active role in their healthcare, you can help them experience healthier outcomes. Members earn MVP rewards by completing healthy behaviors.

Examples include:

- Completing their Health Information Survey, which verifies demographic information and health information

- Getting their annual wellness exam

PRIOR AUTHORIZATIONS

Services Requiring Prior Authorization

The following Prior Authorization Grid reflects services that require prior authorization and is not intended to be a comprehensive list of covered services. Providers should refer to the appropriate EOC available online at **www.antidotehealth.com** for a complete list of covered benefits.

Category of Service	Services Requiring Prior Authorization
Behavioral Health	• All Admissions for: • Acute Inpatient Psychiatric • Partial Hospitalization Programs (PHP) • Residential Mental Health • Substance Use Disorder, including Detoxification • Applied Behavior Analysis (ABA) Services • Electroconvulsive Therapy (ECT) • Intensive Outpatient Program (IOP) • Psychological Testing • Psycho-diagnostic Evaluation • Psychotherapy Treatment • Office-based Opioid Treatment and Withdrawal Management • Transcranial Magnetic Stimulation (rTMS) • Vagus Stimulation Treatments
Diagnostic Imaging	• Computerized Tomography Scans (CT) • Magnetic Resonance Angiography (MRA) • Magnetic Resonance Imaging (MRI) • Nuclear Cardiology Procedures (e.g., Stress Tests/ Treadmill) • Positron-Emission Tomography (PET/PET-CT) • Single-Photon Emission Computerized Tomography (SPECT) • Ultrasounds - Level II

Durable Medical Equipment (DME), Medical Equipment and Supplies	• All DME, Medical Equipment and Supplies with a cost greater than \$500.00
Experimental/Investigational Treatment, Procedures and Drugs	• Clinical Trials • Investigational and Experimental Drug Therapies • Experimental Procedures • New Technologies non-FDA approved for use (e.g., Robotic Surgery) • Non-FDA approved and/or off-label use
Home Health/Hospice	• All Home Health Services (Registered Nurse, Physical, Speech and Occupational Therapists, Home Health Aides, etc.) • Home Intravenous (IV) Infusions • Hospice Services • PT/ OT/ Speech Therapy - PA required after 12th visit

Category of Service	Services Requiring Prior Authorization
Inpatient Admissions	• All Elective Inpatient Admissions and Admissions via ED to: • Acute Care Hospitals • Long Term Acute Care Hospital (LTACH) • Extended Care Facility (ECF) • Rehabilitation and Therapy Services: • Acute Inpatient Rehabilitation or Acute Rehabilitation Unit (AIR/ARU) • Skilled Nursing Facilities (SNF) • Subacute Nursing Facilities
Medications	• Infusion Services • Injections (Including J Codes and Q Codes, but excluding Immunizations) >\$500 • Non-Formulary Prescription Drugs • Physician Administered Drugs (PADS)
Non-Contracted Providers/Out of Network	• All Non-Urgent/Non-Emergent Medical or Behavioral Health Services rendered by Non-Contracted Providers

Outpatient Services and Procedures	• Acupuncture Services • All Outpatient Procedures (e.g., Amniocentesis, Nerve Conduction Studies, Varicose Vein Treatment Performed Outside of a Physician's Office, Endoscopy and Colonoscopy) • All Outpatient Surgery (e.g., Cataract Surgery, Tonsillectomy, Abdominoplasty, Panniculectomy, Breast Reduction and Augmentation Surgery) • Automated External Defibrillator (AED), Holter, Mobile Cardiac Telemetry Monitoring Services • CAR T-cell Therapy • Cardiac and Pulmonary Rehabilitation • Chemotherapy and Radiation Treatment (e.g., Brachytherapy, Neutron Beam therapy, Proton Beam Therapy, Intensity-modulated Radiation Therapy (IMRT), Stereotactic Body Radiation Therapy (SBRT), Stereotactic radiosurgery (SRS), Gamma-ray and CyberKnife) • Chiropractic Services - PA required after 12th visit • Dental Surgery, Dental Anesthesiology Service, Jaw Surgery and Orthognathic Procedures • Dialysis: All hemodialysis and peritoneal, continuous ambulatory peritoneal dialysis (CAPD), automated peritoneal dialysis (APD), Continuous cycling peritoneal dialysis (CCPD). • Gender Affirming Therapy and Surgery • Genetic Testing and Counseling (see Appendix A) • Hyperbaric Oxygen Therapy • Infertility Services • Neuropsychological testing • Non-routine Laboratory, Ultrasound and Radiology Services • Outpatient Therapies (Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST)) - PA required after 12th visit • Pain Management Services • Palliative Care Services • Reconstructive Procedures • Second Opinions • Sleep Studies
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	• Spinal Procedures, including all Injections • Surgical Implants (e.g., Pacemaker, Baclofen Pump, Neuro and Spinal Cord Stimulators, Cochlear Auditory Implant) • Temporomandibular Disorder (TMJ) Treatment • Unclassified Procedures • Ventricular Assist Device •
Post Stabilization	• Inpatient Admission following Stabilization of an Emergency Medical Condition¹
Prescription Medications	• Refer to the Antidote Health Formulary available at: https://www.antidotehealth.com to determine which prescription medications require Prior Authorization
Therapies (Home and Inpatient)	• All Physiological, Occupational and Speech Therapies, including: • Shockwave Therapy • Vestibular Therapy • Lymphatic Therapy • Respiratory Therapy • Urogynecological Therapy • Neurophysiological • Anorectal Rehabilitation
Weight Reduction	• All Bariatric Surgeries and Procedures
Transplants	• All Transplants and Related Services
Transportation: Non-Emergency Medical Transport	• Non-Emergency Medical Transport (NEMT) (including Fixed- Wing Air Transport)
Other	• All Non-urgent/Non-emergent Services Performed outside the Service Area • All Non-covered Services • Any Service that Exceeds the Benefit Limit

Appendix A
Genetic Testing Requiring Prior Authorization

CPT Code	CPT Description
81162	Comprehensive analysis of BRCA1 and BRCA2 genes, including full sequencing and large rearrangement detection for hereditary breast and ovarian cancer risk.
81201	Full gene sequence analysis of the APC gene to diagnose familial adenomatous polyposis (FAP) and attenuated FAP.
81203	Analysis of APC gene for duplication and deletion variants, used in diagnosing FAP and assessing genetic predisposition to colorectal cancer.
81206	BCR/ABL1 translocation analysis targeting the major breakpoint, used in diagnosing chronic myelogenous leukemia (CML).
81207	BCR/ABL1 translocation analysis targeting the minor breakpoint, relevant for CML and acute lymphoblastic leukemia (ALL).
81210	Genetic analysis of the BRAF gene for common variants, especially V600E, used in cancer diagnostics like melanoma and colorectal cancer.
81212	BRCA1 and BRCA2 variant analysis for 185delAG, 5385insC, and 6174delT mutations, commonly used in hereditary cancer risk assessment.
81219	Analysis of CALR gene exon 9 variants, used in diagnosing myeloproliferative disorders like essential thrombocythemia and primary myelofibrosis.
81220	CFTR gene analysis for common variants associated with cystic fibrosis, often used in prenatal and carrier screening.
81229	Genome-wide cytogenomic analysis using CGH microarray to detect copy number variants and SNPs, used for evaluating developmental delays and congenital anomalies.
81240	Genetic analysis of the F2 (prothrombin) gene for the 20210G>A variant, used to assess risk for hereditary hypercoagulability (e.g., deep vein thrombosis).
81241	Genetic analysis of the F5 (Factor V) gene for the Leiden variant, associated with increased risk of thrombosis and hereditary hypercoagulability.
81259	Full gene sequence analysis of HBA1 and HBA2 genes, used to diagnose alpha thalassemia and other hemoglobinopathies.
81403	Level 4 molecular pathology procedure for moderate complexity genetic tests, including mutation scanning and sequencing of 2–5

CPT Code	CPT Description
	exons.
81404	Level 5 molecular pathology procedure for dynamic mutation disorders and sequencing of 6–10 exons, used in diagnosing muscular dystrophies, metabolic, and renal disorders.
81405	Level 6 molecular pathology procedure for 6–10 exon sequencing or 11–25 exon scanning, used in diagnosing cardiomyopathies, metabolic, and neurological disorders.
81406	Level 7 molecular pathology procedure for 11–25 exon sequencing or 26–50 exon scanning, used in diagnosing complex genetic disorders.
81407	Level 8 molecular pathology procedure for 26–50 exon sequencing, used in multi-gene analysis for hereditary conditions.
81408	Level 9 molecular pathology procedure for >50 exon sequencing in a single gene, used in diagnosing rare and complex genetic disorders like Stargardt disease and Usher syndrome.
81412	Genomic sequence analysis panel for Ashkenazi Jewish-associated disorders, testing at least nine genes including CFTR, HEXA, GBA, etc.
81420	Genomic sequence analysis panel for fetal chromosomal aneuploidy using cell-free fetal DNA in maternal blood. Screens for trisomy 13, 18, and 21 (e.g., Down syndrome) in a non-invasive prenatal test (NIPT).
81432	Genomic sequence analysis panel for hereditary breast cancer-related disorders, analyzing 5 or more genes including BRCA1/2, MLH1, MSH2, etc., for sequence and copy number variants.
81433	Duplication/deletion analysis panel for hereditary breast cancer-related disorders, focusing on genes like BRCA1, BRCA2, MLH1, MSH2, STK11.
81435	Genomic sequence analysis panel for hereditary colon cancer syndromes (e.g., Lynch syndrome), analyzing 5 or more genes for sequence and copy number variants.
81437	Genomic sequence analysis panel for hereditary neuroendocrine tumor disorders, including genes related to medullary thyroid carcinoma, pheochromocytoma, etc.
81438	Duplication/deletion analysis panel for hereditary neuroendocrine tumor disorders, targeting genes like SDHB, SDHC, SDHD, and VHL.
81443	Genomic sequence analysis panel for severe inherited conditions, sequencing 15 or more genes (e.g., CFTR, GAA, HBB), often used in Ashkenazi Jewish carrier screening.
81445	Genomic sequence analysis panel for solid organ neoplasms, analyzing 5–50 genes for DNA/RNA alterations in tumor specimens.

CPT Code	CPT Description
81450	Genomic sequence analysis panel for hematolymphoid neoplasms, analyzing 5–50 genes in blood or bone marrow for DNA/RNA alterations.
81479	Unlisted molecular pathology procedure. Used when no specific CPT code exists for a novel or unique molecular test. Requires detailed documentation.

¹ Network providers should refer to their provider agreement for specific contractual requirements. Generally, notification is required with 48 hours of an emergency admission.

Prior Authorization is not required for the following services:

Category of Service	Services NOT Requiring Prior Authorization
Behavioral Health	Behavioral Health Counseling and Therapy Services, including: • Family • Couple • Group • Telebehavioral Health Services
Hydration	Performed in Conjunction with a Service Requiring Prior Authorization (e.g., Chemotherapy)
Immunizations/Vaccinations	Performed at an Antidote Contracted Pharmacy Information about Antidote's Contracted Pharmacy Network is located at https://www.antidotehealth.com/pharma
Routine Services	Routine Laboratory Tests, Ultrasound and X-rays Performed in Conjunction with a Service not Requiring Prior Authorization
Testing	• Fetal Non-stress Testing • HIV Testing
Transportation	Emergency Medical Transportation
Urgent Care	Telehealth for Urgent Care Services
Other	Family Planning Services

It is the responsibility of the facility in coordination with the rendering healthcare provider or practitioner to ensure that an authorization has been obtained for all inpatient and selected

outpatient services, except for emergency stabilization services. All inpatient admissions require prior authorization.

Any anesthesiology, pathology, radiology, or hospitalist services related to a procedure or hospital stay requiring a prior authorization will be considered downstream and will not require a separate prior authorization.

Services related to an authorization denial will result in denial of all associated claims.

Timeframes for Prior Authorization Requests and Notifications

The following time frames are required of the ordering provider for prior authorization and notification:

Service Type	Timeframe
Scheduled admissions	Prior Authorization required 5 days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required 10 days prior to the elective outpatient service date
Emergent inpatient admissions	Notification one business day
Observation – 48 hours or less	Notification within 24 hours for non-participating providers
Observation – greater than 48 hours	Requires inpatient prior authorization within 1 business day
Maternity admissions	Notification within 1 day
Newborn admissions	Notification within 1 day
Neonatal Intensive Care Unit (NICU) admissions	Notification within 1 day
Outpatient Dialysis	Notification within 1 day
Organ transplant initial evaluation	Prior Authorization required at least 30 days prior to the initial evaluation for organ transplant services.
Clinical trials services	Prior Authorization required at least 30 days prior to receiving clinical trial services.

Procedure for Requesting Prior Authorizations for Medical and Behavioral Health Services

The preferred method for submitting authorizations is through the provider portal at www.antidotehealth.com/provider. The provider must be a registered user. If the provider is not already a registered user on the provider portal and needs assistance or training on submitting prior authorizations, the provider should contact the Provider Services Department at **1-888-509-2688**.

The requesting or rendering provider must provide the following information to request prior authorization (regardless of the method utilized):

- Member's name, date of birth and Antidote ID number
- Provider's Tax ID, NPI number, taxonomy code, name, and telephone number
- Facility name if the request is for an inpatient admission or outpatient facility services
- Provider location if the request is for an ambulatory or office procedure
- The procedure code(s)
- Relevant clinical information (e.g., past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Admission date or proposed surgery date if the request is for a surgical procedure
- Discharge plans
- For obstetrical admissions, the date and method of delivery, targeted admission date, and information related to the newborn or neonate

NOTE: If the procedure codes submitted at the time of authorization differ from the services performed, it is required within 72 hours or prior to the time the claim is submitted that Medical Management is notified to update the authorization. Failure to timely notify the Medical Management Department at **1-888-509-2688** may result in a claim denials.

Second Opinion

Members or a healthcare provider or practitioner with the member's consent may request and receive a second opinion from a qualified professional within the Antidote network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out-of-network provider only upon receiving a prior authorization from the UM Department.

Preventive Health Care

Antidote is committed to the promotion of the lifelong benefits of preventive care. Members may see a network provider, who is contracted with Antidote to provide health care services directly, without prior authorization for:

- Medically necessary maternity care;
- Preventive care (well care) and general examinations;
- Gynecological care; or
- Follow-up visits for the above services.

A complete list of preventive health care services is available at www.antidotehealth.com/provider.

If the member's health care provider diagnoses a condition that requires a prior authorization to other specialists or hospitalization, prior authorization must be obtained in accordance with Antidote's prior authorization requirements.

Retrospective Review

Retrospective review is an initial review of services after services have been provided to a member. A retrospective review involves the evaluation of clinical records to determine the appropriateness and necessity of rendered care where notification was not received prior to services being rendered.

All requests for services are reviewed utilizing appropriate decision protocols, which are based on reasonable medical evidence. A retrospective review may occur when authorization or timely notification to Antidote was not obtained due to extenuating circumstances (i.e., member was unconscious at presentation, member did not have their Antidote ID card or otherwise indicated other coverage, services authorized by another payer that subsequently determined the individual was not eligible at the time of service).

Requests for retrospective review must be submitted promptly.

Emergency Care

Emergency care means medical services provided after the sudden or unexpected onset of a medical condition manifesting itself by acute symptoms, including injury caused by an accident, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:

- The patient's life or health would be placed in serious jeopardy;
- Vital bodily functions would be seriously impaired; and
- There would be serious and permanent dysfunction of a bodily organ or part.

Authorization of all admissions following an emergency room visit is usually required within forty-eight (48) hours after the admission unless otherwise set forth in the provider agreement.

PHARMACY

The pharmacy benefits for Antidote members vary based on their plan. Information regarding the member's pharmacy coverage can be found at www.antidotehealth.com/provider.

Additional resources are available at www.antidotehealth.com/pharma and include, for example, the Antidote Formulary, retail pharmacy locator, mail order pharmacy information and the Prior Authorization/Formulary Exception Request form.

The Antidote Formulary is designed to assist contracted prescribing practitioners with selecting the most clinically and cost-effective medications available. Antidote ensures that all prescribing practitioners receive critical information regarding our pharmaceutical management procedures annually and after updates.

We communicate a detailed list of pharmaceuticals, including any restrictions and preferences, as well as an explanation of any applicable limits or quotas. Antidote communicates the formulary and pharmaceutical management procedures to prescribing practitioners and members at least annually and whenever changes occur.

This information is communicated in Antidote's Formulary or Medication List, which is available at www.antidotehealth.com/pharma. The Medication List explicitly outlines how to use the pharmaceutical management procedures, covering Antidote's processes for generic substitution, therapeutic interchange, and step-therapy protocols.

Furthermore, information about what is necessary to support an exception request (referred to as a Prior Authorization/Formulary Exception Request) for pharmaceuticals is available on our website at <https://www.antidotehealth.com/for-providers>. This information is also distributed through methods such as mail, fax, or email upon request.

NOTE: Antidote may limit communications of updates to changes to the Formulary/Medication List that result in restrictions or replacements ("negative" formulary changes) and target only affected practitioners.

The Formulary provides instruction on the following:

- Which drugs are covered, including restrictions, prior authorization requirements, and limitations;
- The pharmacy management program requirements and procedures;
- An explanation of limits and quotas;
- How prescribing providers can make an exception request; and
- How Antidote conducts generic substitution, therapeutic interchange, and step-therapy.

The Antidote formulary does not:

- Require or prohibit the prescribing or dispensing of any medication;
- Substitute for the professional judgment of the physician or pharmacist; or
- Relieve the physician or pharmacist of any obligation to the member.

CLAIMS

The appropriate CMS billing form is required for paper and electronic data interchange (EDI) claim submissions. The CMS billing forms are CMS 1450 for facilities and CMS 1500 for professionals. Antidote follows the CMS billing requirements for paper and EDI. Antidote is required by state and federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements to ensure timely processing of claims and to avoid unnecessary rejections or denials.

Verification Procedures

All claims filed with Antidote are subject to verification procedures. These include, but are not limited to, verification of the following:

- All required fields are completed on an original CMS 1500 Claim Form, CMS 1450 (UB-04) Claim Form, or EDI electronic claim format.
- All claim submissions are subject to 5010 validation procedures based on CMS Industry Standards.
- Member ID and date of birth combination must exactly match a participating Antidote member.
- Taxonomy codes are required.
 - All Diagnosis, Procedure, Modifier, Location (Place of Service), Revenue, Type of Admission, and Source of Admission codes are valid for:
 - Date of Service
 - Provider Type and/or provider specialty billing
 - Age and/or sex for the date of service billed
 - Bill type
- All Diagnosis Codes are to their highest number of digits available.

- National Drug Code (NDC) is billed in the appropriate field on all claim forms when applicable. This includes the quantity and type. Type is limited to the list below
 - F2 – International Unit
 - GR – Gram
 - ME – Milligram
 - ML – Milliliter
 - UN – Unit
- Principal diagnosis billed reflects an allowed principal diagnosis as defined in the volume of ICD- 10-CM for the date of service billed.
 - For a CMS 1500 Claim Form, this criterion looks at all procedure codes billed and the diagnosis they are pointing to. If a procedure points to the diagnosis as primary, and that code is not valid as a primary diagnosis code, that service line will deny.
 - All inpatient facilities are required to submit a Present on Admission (POA) Indicator. Claims will be denied (or rejected) if the POA indicator is missing. Please reference the CMS Billing Guidelines regarding POA for more information and for excluded facility types. Valid 5010 POA codes are:
 - N – No
 - U – Unknown
 - W- Not Applicable
 - Y – Yes
- Member is eligible for services under Antidote during the time in which services were provided.
- Services are provided by a participating provider, or if provided by an “out of network” provider, authorization is received to provide services to the eligible member. (Excludes services by an “out of network” provider for an emergency medical condition; however, authorization requirements apply for post-stabilization services.)
- An authorization is given for services that require prior authorization by Antidote.
- Third party coverage is clearly identified, and appropriate COB information is included with the claim submission.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service. The service provided is a covered benefit under the member’s contract on the date of service and prior authorization processes were followed.
- Payment for services is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in this manual

Clean Claim Definition

A clean claim means a claim for payment of health care expenses that is submitted on a CMS 1500 or a CMS 1450 (UB04) claim form, in a format required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) with all required fields completed in accordance with Antidote's claim filing requirements.

Non-clean Claim Definition

A clean claim shall not include a claim:

- That contains invalid or missing data elements, a claim that has been suspended to get more information from the provider, or a claim that requires manual intervention/processing; or
- For which Antidote requires additional information to resolve the claim.

Rejections vs. Denials Rejection

A rejection is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. Rejections do not enter Antidote's claims adjudication system. There is no Explanation of Payment (EOP) for these claims. The provider receives a letter or a rejection report if the claim is submitted electronically. If a claim is rejected, the identified issue must be corrected, and the claim resubmitted as an original claim.

Denial

If all edits pass and the claim is accepted, it is entered into the system for processing. A denial is defined as a claim that passes edits and is entered into the system but is billed with invalid or inappropriate information causing the claim to deny. In this case, an EOP is sent that includes the denial reason.

Timely Filing ²

Initial Claims		Reconsiderations or Claim Dispute/Appeals		Coordination of Benefits	
Calendar Days					
Par	Non-Par	Par	Non-Par	Par	Non-Par
180 days	90 days	180 days	90 days	90 days from the primary payers EOP date to the date received	90 days from the primary payers EOP date to the date received

² The timely filing days set forth herein shall apply unless otherwise indicated in provider's agreement.

- Initial Claims - Days are calculated from the date of service (DOS) to the date received by Antidote or from the Explanation of Payment (EOP) date. For observation and inpatient stays, the date is calculated from the date of discharge.
- Claims Dispute/Appeals - Days are calculated from the date of the EOP issued by Antidote to the date received.
- Coordination of Benefits - Days are calculated from the date of the EOP from the primary payers to the date received.

Refunds and Overpayments

Antidote routinely audits all claims for payment errors. Claims identified as underpaid or overpaid will be reprocessed appropriately. Providers are responsible for reporting overpayments or improper payments to Antidote. Providers have the option of requesting future offsets to payments or may mail refunds and overpayments, along with supporting documentation (copy of the remittance advice along with affected claims identified), to the following address:

**Antidote Health Plan
P.O. Box 39638
Solon, OH 44139**

Who Can File Claims?

All providers who have rendered services for Antidote members can file claims. It is important that providers ensure Antidote has accurate and complete information on file. Please confirm with the Provider Services Department that the following information is current in our files:

- Provider Name (as noted on current W-9);
- National Provider Identifier (NPI);
- Group NPI;
- Tax Identification Number (TIN);
- Taxonomy code;
- Physical location address (as noted on current W-9); and
- Billing name and address (as noted on current W-9).

Antidote recommends that providers notify Antidote 30-60 days in advance of changes pertaining to billing information. If the billing information change affects the address to which the end of year 1099 IRS form is mailed, a new W-9 form is required. Changes to a provider's TIN and/or address are NOT acceptable when conveyed via a claim form or a 277 electronic file.

Claims for billable services provided to Antidote members must be submitted by the provider who performed the services or by the provider's authorized billing vendor.

Electronic Claims Submission

Providers are encouraged to participate in Antidote's Electronic Claims/Encounter Filing Program through Centene. Antidote has the capability to receive an ANSI XS12N 837 professional, institutional, or encounter transaction. In addition, Antidote has the capability to generate an ANSI X12N 835 electronic remittance advice/EOP. For more information on electronic filing, call 740-455-5199.

Antidote Health Plan

Providers who bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims. Providers who bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports.

Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Antidote can receive coordination of benefits (COB or secondary) claims electronically. Antidote follows the 5010 X12 HIPAA Companion Guides for requirements on submission of COB data.

Antidote's Payer ID in Ohio is 89461.

Antidote's Payer ID in Arizona is IHS05.

Antidote uses ClaimsBridge as its clearinghouse in Arizona and Ohio.

Specific Data Record Requirements

Claims transmitted electronically must contain all the required data of the X12 5010 Companion Guides. Please contact the clearinghouse you intend to use and ask if they have additional data record requirements.

Electronic Claim Flow Description & Important General Information

To send claims electronically to Antidote, all EDI claims must be forwarded ClaimsBridge. Complete this via a direct submission to ClaimsBridge or through another EDI clearinghouse.

Once ClaimsBridge receives the transmitted claims, they are validated against their proprietary specifications and plan-specific requirements. Claims not meeting the requirements are immediately rejected and sent back to the sender via a clearinghouse error report. It is very important to review this error report daily to identify any claims that were not transmitted to Antidote. The name of this report can vary based upon the provider's contract with their intermediate EDI clearinghouse.

Accepted claims are passed to Antidote, and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to Antidote by ClaimsBridge are validated against provider and member eligibility records. Claims that do not meet provider and/or member eligibility requirements are rejected and sent back daily. ClaimsBridge in turn forwards the rejection back to its trading partner (the intermediate EDI clearinghouse or provider). It is very important to review this report daily. The report shows rejected claims. These claims must be reviewed and corrected timely. Claims passing eligibility requirements are then passed to the claim processing queues.

Providers are responsible for verification of EDI claims receipts. Acknowledgements for accepted or rejected claims received from ClaimsBridge must be reviewed and validated against transmittal records daily.

Since ClaimsBridge returns acceptance reports directly to the sender, submitted claims not accepted by ClaimsBridge are not transmitted to Antidote.

If you would like assistance in resolving submission issues reflected on either the acceptance or claim status reports, please contact your clearinghouse or vendor Customer Service Department.

Rejected electronic claims may be resubmitted electronically once the error has been corrected. Be sure to submit the rejected claim as an original claim.

Invalid Electronic Claim Record Rejections/Denials

All claim records sent to Antidote first must pass the clearinghouse proprietary edits and plan specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received by Antidote. In these cases, the claim must be corrected and re-submitted within the required filing deadline as previously mentioned in the Timely Filing section of this manual. It is important that you review the acceptance or claim status reports received from the clearinghouse to identify and re-submit these claims accurately.

Exclusions

The following inpatient and outpatient claim types are excluded from EDI submission options and must be filed on paper:

- Claims requiring supporting documentation or attachments (e.g., consent forms)
NOTE: COB claims can be filed electronically.
- Medical records to support billing miscellaneous codes.
- Claims for services that are reimbursed based on purchase price (e.g., custom DME, prosthetics). **NOTE:** Provider is required to submit the invoice with the claim.
- Claims for services requiring clinical review (e.g., complicated, or unusual procedure).

NOTE: Provider is required to submit medical records with the claim.

- Claim for services requiring documentation and a Certificate of Medical Necessity (e.g., oxygen, motorized wheelchairs).

Paper Claim Submission

The mailing address for first time claims (medical and behavioral health) corrected claims and requests for reconsideration:

For Ohio Paper Claim Submission:

Antidote Health Plan of Ohio, Inc.
P.O. Box 595
Arnold, MD 21012

For Arizona Paper Claim Submission:

Antidote Health Plan of Arizona, Inc.
P.O. Box 155
Arnold, MD 21012

The mailing address for claim disputes/appeals (medical and behavioral health) for Ohio and Arizona is:

Antidote Health Plan
Attention: Claim Disputes Department
P.O. Box 39638
Solon, OH 44139
Fax: 1-216-504-9561

Antidote encourages all providers to submit claims electronically. Paper submissions are subject to the same edits as electronic and web submissions.

All paper claims must pass specific edits prior to acceptance. Claim that do not pass these edits are invalid and will be rejected. If a paper claim has been rejected, the provider must correct the error and resubmit the paper claim as an original claim. If the paper claim passes the specific edits and is denied after acceptance, the provider should submit the denial letter with the corrected claim.

Acceptable Forms

Antidote only accepts the CMS 1500 (02/12) and CMS 1450 (UB-04) paper claim forms. Other claim form types will be rejected and returned to the provider.

Professional providers and medical suppliers complete the CMS 1500 (02/12) Claim Form and institutional providers complete the CMS 1450 (UB-04) Claim Form.

Antidote does not supply claim forms to providers. Providers should purchase them from a supplier of their choice. All paper claim forms must be typed with either 10- or 12-point Times New Roman font and on the required original red and white version to ensure clean acceptance and processing. Black and white forms, handwritten and nonstandard forms will be rejected and returned to provider. To reduce document handling time, do not use highlights, italics, bold text, or staples for multiple page submissions.

If you have questions regarding what type of form to complete, contact the Provider Services Department at **1-888-509-2688**.

Important Steps to Successful Submission of Paper Claims

- Providers must file claims using standard claims forms (CMS 1450 (UB-04) for hospitals and facilities; CMS 1500 for physicians or practitioners).
- Complete all required fields on an original, red CMS 1500 (Version 02/12) or CMS 1450 (UB-04) Claim Form. **NOTE:** Non-red, nonstandard, and handwritten claim forms will be rejected back to the provider.
- Enter the provider's NPI number in the "Rendering Provider ID#" section of the CMS 1500 form (see box 24J).
- Providers must include their taxonomy code and corresponding ID qualifier in this section for correct processing of claims.
- Ensure all Diagnosis Codes, Procedure Codes, Modifier, Location (Place of Service); Type of Bill, Type of Admission, and Source of Admission Codes are valid for the date of service.
- Ensure all Diagnosis and Procedure Codes are appropriate for the age of sex of the member.
- Ensure all Diagnosis Codes are coded to their highest number of digits available.
- Ensure the Antidote member is eligible for services during the time in which services were provided.
- Ensure the provider receives prior authorization to provide services to the eligible member, when appropriate.
- Ensure an authorization is given for services that require prior authorization by Antidote.
- Providers billing CLIA services on a CMS 1500 paper form must enter the CLIA number in Box 23 of the CMS 1500 form.

Claims missing the necessary requirements are not considered "clean claims" and will be returned to providers with a written notice describing the reason for return.

Corrected Claims, Requests for Reconsideration or Claim Disputes

All requests for corrected claims, reconsiderations, or claim disputes must be received within 180 days from the date of the original explanation of payment or denial. Prior processing will be upheld for corrected claims or provider claims requests for reconsideration or disputes/appeals received outside of the 180-day timeframe, unless a qualifying, extenuating circumstance is offered, and appropriate documentation is provided to support the qualifying circumstance.

Qualifying circumstances include:

- A catastrophic event that substantially interferes with normal business operation of the provider, or damage or destruction of the provider's business office or records by a natural disaster, mechanical, administrative delays, or errors by Antidote or the Federal and/or State regulatory body.
- The member was eligible; however, the provider was unaware that the member was eligible for services at the time services were rendered. Consideration is granted in this situation only if all the following conditions are met:
 - The provider's records document that the member refused or was physically unable to provide their ID Card or information;
 - The provider can substantiate that they continually pursued reimbursement from the patient until eligibility was discovered; and
 - The provider has not filed a claim for this member prior to the filing of the claim under review.

Relevant Claim Definitions

- Corrected claim – A provider is changing the original claim.
- Request for reconsideration – A provider disagrees with the original claim outcome (payment amount, denial reason, etc.).
- Claim dispute/appeal – A provider disagrees with the outcome of the request for reconsideration.

Corrected Claims

- Corrected claims must clearly indicate they are corrected in one of the following ways:
 - Submit a corrected claim electronically via a clearinghouse.
 - Institutional Claims (UB): Field CLM05-3=7 and Ref*8 = Original Claim Number
 - Professional Claims (CMS): Field CLM05-3=7 and REF*8 = Original Claim Number

Submit a corrected paper claim to:

For Ohio Paper Claim Submission:

Antidote Health Plan of Ohio, Inc.
P.O. Box 595
Arnold, MD 21012

For Arizona Paper Claim Submission:

Antidote Health Plan of Arizona, Inc.
P.O. Box 155
Arnold, MD 21012

- Upon submission of a corrected paper claim, the original claim number must be typed in field 22 (CMS 1500) and in field 64 CMS 1450 (UB-04) with the corresponding frequency codes in field 22 of the CMS 1500 and in field 4 of the CMS 1450 (UB-04) form.
- Corrected claims must be submitted on standard red and white forms. Handwritten corrected claims will be rejected.

Request for Reconsideration

A request for reconsideration is a communication from the provider about a disagreement with the way a claim was processed. Generally, medical records are not required for a request for reconsideration. However, if the request for reconsideration is related to a code audit, code edit, or authorization denial, medical records must accompany the request for reconsideration. If the medical records are not received, the original denial will be upheld.

Reconsiderations may be submitted in the following ways:

- Providers may elect to call to the Provider Services Department at 1-888-509-2688. This method is for requests for reconsideration that do not require submission of supporting or additional information. An example of this is when a provider believes a particular service should be reimbursed at a particular rate, but the payment amount did not reflect that rate.
- Providers may send a written letter that includes a detailed description of the reason for the request. To ensure timely processing, the letter must include sufficient identifying information, which includes, at a minimum, the member's name, member's ID number, member's date of birth, date of service, total claim amount billed, provider name, original EOP and/or the original claim number and claim amount paid.
- It is not necessary to attach a copy of the submitted claim.

For Arizona and Ohio, written requests for reconsideration and any applicable attachments must be mailed to:

Antidote Health Plan

Attention: Claim Disputes Department
P.O. Box 39638
Solon, OH 44139

When the request for reconsideration results in an overturn of the original decision, the provider will receive a revised EOP.

Claim Dispute

A claim dispute should be used only when a provider has received an unsatisfactory response to a request for reconsideration. If a dispute form is submitted and a reconsideration request is not located in our system, this will be considered a reconsideration and treated as outlined above.

Arizona and Ohio claim disputes must be submitted on a Provider Dispute Form found at antidotehealth.com/provider. The Provider Dispute Form must be completed in its entirety. Mail completed claim dispute/appeal forms to:

Antidote Health Plan
Attention: Claim Disputes Department
P.O. Box 39638
Solon, OH 44139

A claim dispute or appeal will be resolved within 30 calendar days. The provider will receive a written letter detailing the decision to overturn or uphold the original decision. If the original decision is upheld, the letter will include the rationale for upholding the decision. Disputed claims are resolved to a paid or denied status in accordance with state law and regulation.

RISK ADJUSTMENT & CORRECT CODING

Whether a payer is selling off- or on-Exchange, risk adjustment is a critical element of the ACA that helps ensure the long-term viability of the Health Insurance Marketplace. Accurate risk adjustment calculation requires accuracy and specificity in diagnostic coding. Providers should always document and code according to CMS regulations and follow all applicable coding guidelines for ICD-10-CM, CPT, and HCPCS code sets, as amended.

Providers should note the following guidelines:

- Code all diagnoses to the highest level of specificity, which means assigning the most precise ICD diagnosis code that most fully describes the symptom(s) or diagnosis(ses) in the medical record;
- Ensure medical record documentation is clear, concise, consistent, complete, legible, and meets CMS signature guidelines;
- Submit claims information in a timely, accurate and complete manner;
- Provide medical records as requested by Antidote or its designated vendor in a timely manner; and
- Ensure coding staff are aware of the importance of proper coding.

Accurate and thorough coding is imperative to Antidote's ability to manage members and comply with Risk Adjustment Data Validation audit requirements. Claims submitted with inaccurate or incomplete data will often require retrospective chart review.

CODE EDITING

Antidote uses HIPAA-compliant code auditing software to improve accuracy and efficiency in claims processing, payment, and reporting. The software detects and documents coding errors on provider claims prior to payment by analyzing CPT, HCPCS, ICD-10, modifier, and place of service codes against correct coding guidelines.

While code auditing software is a useful tool to ensure provider compliance with correct coding, it will not wholly evaluate all clinical scenarios. Accordingly, exceptions to general correct coding principles may be required to ensure adherence to health plan policies and to facilitate accurate claims reimbursement.

Antidote may request medical records or other documentation to verify that all procedures and/or services billed are properly supported in accordance with correct coding guidelines.

Edit Sources

The claims editing software contains a comprehensive set of rules addressing coding inaccuracies such as: unbundling, frequency limitations, fragmentation, up coding, duplication, invalid codes, mutually exclusive procedures, and other coding inconsistencies.

Each rule is linked to a generally accepted coding principle. Guidance surrounding the most likely clinical scenario is applied. This information is provided by clinical consultants, health plan medical directors, current research, etc.

The following sources are utilized in determining correct coding guidelines for the software:

- CMS's National Correct Coding Initiative (NCCI) Policy Manual and Claims Processing Manual guidelines as well as current Procedure-to-Procedure and Medically Unlikely edit tables;
- American Medical Association (CPT, HCPCS, and ICD-10 guidelines and publications including CPT manual, AMA website, CPT Assistant, CPT Insider's View, etc.);
- CMS coding resources such as National Physician Fee Schedule, Provider Benefit Manual, Medicare Learning Network®, etc.; and
- Antidote policies and provider contract considerations.

Code Editing and the Claims Adjudication Cycle

Each service line on a claim is processed through the code editing rules engine and evaluated for correct coding. As part of this evaluation, the claim is analyzed against other codes billed on the same claim as well as previously paid claims found in the member and provider's history. Depending upon the code edit applied, the software will make the following recommendations:

Deny: Code editing rule recommends the denial of a claim line. The appropriate explanation code is documented on the provider's EOP along with reconsideration/appeal instructions.

Pend: Code editing recommends that the service line pend for clinical review and validation. This review may result in a pay or deny recommendation. The decision is documented on the provider's EOP along with reconsideration/appeal instructions.

Replace and Pay: Code editing recommends the denial of a service line, and a new line is added and paid. In this scenario, the original service line is left unchanged on the claim and a new line is added to reflect the software recommendations. For example, an incorrect CPT code is billed for the member's age. The software will deny the original service line billed by the provider and add a new service line with the correct CPT code, resulting in a paid service line. This action does not alter or change the provider's billing, as the original billing remains on the claim.

Claim Reconsiderations Related to Code Editing and Editing

Claims reconsiderations resulting from claim-editing are handled per the provider claims dispute process outlined in this manual. When submitting claims reconsiderations, please submit medical records, invoices, and all related information to assist with the appeals review.

If you disagree with a code edit or edit and request claim reconsideration, you must submit medical documentation (medical records) related to the reconsideration. If medical documentation is not received, the original code-edit(s) will be upheld.

THIRD PARTY LIABILITY

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured, or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program that is or may be liable to pay all or part of the health care expenses of the member.

BILLING THE MEMBER

Covered Services

Antidote providers are prohibited from billing the member for any covered services except for copayments, coinsurance, and deductibles.

- Copayments, coinsurance, and any unpaid portion of a deductible may be collected from the member at the time of service.
- If the amount collected from the member is higher than the actual amount owed upon claim adjudication, the provider must reimburse the member the overpaid amount within 45 days.

For members who are in a suspended status and seeking services from providers:

- Providers may advise the member that services may not be delivered because the member is in a suspended status. The member's status must be verified through the provider portal or by calling the Provider Services Department at 1-888-509-2688.
- Should a provider make the decision to render services, the provider may collect from the member. Providers must submit a claim to Antidote.
- If the member subsequently pays their premium and is removed from a suspended status, claims will be adjudicated by Antidote. The provider would then be responsible to reconcile the payment received from the member and the payment received from Antidote. The provider may then bill the member for an underpayment or return to the member any overpayment.
- If the member does not pay their premium and is terminated from their Antidote plan, providers may bill the member for their full billed charges.
- Out-of-network providers may be limited by state or other regulations when balance billing members for amounts not considered to be copayments, coinsurance, or deductible.

Non-Covered Services

Contracted providers may only bill Antidote members for non-covered services if the member and provider both sign an agreement outlining the member's responsibility to pay prior to the services being rendered. The agreement must be specific to the services being rendered and clearly state:

- The specific service(s) to be provided;

- A statement that the service is not covered by Antidote;
- A statement that the member chooses to receive and pay for the specific service; and
- The member is not obligated to pay for the service if it is later found that service was covered by Antidote at the time it was provided, even if Antidote did not pay the provider for the service because the provider did not comply with Antidote's requirements.

Billing for "No-Shows"

Providers may bill the member a reasonable and customary fee for missing an appointment when the member does not call-in advance to cancel the appointment. The "no show" appointment must be documented in the medical record.

Failure to Obtain Authorization

Providers may not bill members for services when the provider fails to obtain an authorization and the claim is denied by Antidote.

No Balance Billing

Payments made by Antidote to providers less any copays, coinsurance, or deductibles which are the financial responsibility of the member, will be considered payment in full. Providers may not seek payment from Antidote members for the difference between the billed charges and the contracted rate paid by Antidote.

Interim Billing

Antidote does not accept interim billing for estimated monies owed to participating and out-of-network facilities. Claims processing will begin upon receipt of the final bill for services rendered for inpatient hospital and skilled nursing stays.

COMPLAINT PROCESS

Complaint or Grievance

A complaint or grievance is a verbal or written expression by a provider which indicates dissatisfaction or dispute with Antidote's policies, procedure, or any aspect of Antidote's functions. Antidote logs and tracks all complaints or grievances whether received verbally or in writing. A provider has 180 calendar days from the date of the incident, such as the original EOP date, to file a complaint or grievance. After a complete review, Antidote will provide a written notice to the provider within 30 calendar days from the received date of Antidote's decision. If the complaint or grievance is related to claims payment, the provider must follow the process for claim reconsideration or claim dispute as noted in the Claims section of this manual prior to filing a complaint.

Provider Complaint/Grievance and Appeal Process

Claim complaints must follow the claim dispute process and then the complaint process below. Medical necessity and authorization denials are handled in the Appeal process set forth below. Please note that claim payments are not appealable. Arizona and Ohio claim complaints must be handled via the claim dispute and complaint process.

Claim disputes may be mailed to:

Antidote Health Plan
Attention: Claim Disputes Department
P.O. Box 39638
Solon, OH 44139

Member Complaint or Grievance and Appeal Process

To ensure Antidote member's rights are protected, Antidote members are entitled to a complaint or grievance and appeals process. The procedures for filing a complaint or grievance and appeal are outlined in the Antidote member's EOC.

If a member is displeased with any aspect of services rendered:

- The member should contact the Member Services Department at 1-888-623-3195.
- If the member continues to be dissatisfied, they may file a formal complaint or grievance.
- Depending on the nature of the complaint or grievance, the member will be offered the right to appeal the decision. At the conclusion of this formalized process, the member will receive written confirmation of the determination. Antidote will complete the appeal process in the timeframes as specified in rules and regulation.
- The member has the right to appeal to an external independent review organization.
- A member may designate in writing to Antidote that a provider is acting on behalf of the member regarding the complaint or grievance and appeal process.

Member Appeals

Pre-service member appeals must follow the appeal process below. A member must designate in writing for a provider to act on behalf of the member regarding the appeal process.

An appeal is the mechanism which allows providers the right to appeal actions of Antidote such as a prior authorization denial, or if the member is aggrieved by any rule, policy, procedure, or decision made by Antidote.

A member has 180 calendar days from Antidote's notice of action to file the appeal. Antidote shall acknowledge receipt of each appeal within 10 business days after receiving an appeal. Antidote shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires, but shall not exceed 30 calendar days from the date Antidote receives the appeal.

Antidote may extend the timeframe for resolution of the appeal up to 14 calendar days if the member requests the extension or Antidote demonstrates that there is a need for additional information and how the delay is in the member's best interest. For any extension not requested by the member, Antidote shall provide written notice to the member for the delay.

Expedited appeals may be filed with Antidote if the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a provider that requests an expedited resolution or supports a member's appeal. In instances where the member's request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.

Decisions for expedited appeals are issued as expeditiously as the member's health condition requires, not exceeding 72 hours from the initial receipt of the appeal. Antidote may extend this timeframe by up to an additional 14 calendar days if the member requests the extension or if Antidote provides satisfactory evidence that a delay in rendering the decision is in the member's best interest.

Providers may also invoke any remedies as set forth in their provider agreement.

The mailing address for Arizona and Ohio non-claim related provider grievances and appeals is:

Antidote Health Plan
Attention: Appeals and Grievances Department
434 Main Street
Zanesville, OH 43701

Arizona and Ohio non-claim related member complaints, grievances or appeals are mailed to:

Antidote Health Plan
Attention: Member Complaint, Grievance and Appeals Department
P.O. Box 39638
Solon, OH 44139

FRAUD, WASTE & ABUSE

Antidote takes the detection, investigation, and prosecution of fraud and abuse very seriously and through its third party administrator, Solidarity Health Networks has a Fraud, Waste, and Abuse (FWA) program that complies with the federal and state laws. Solidarity Health Networks performs audits, which may result in taking actions against providers who commit fraud, waste, and/or abuse.

These actions include but are not limited to:

- Remedial education and training to prevent the billing irregularity;
- More stringent utilization review;
- Recoupment of previously paid monies;
- Termination of provider agreement or other contractual arrangement;
- Civil and/or criminal prosecution; and
- Implementation of a corrective action plan (CAP).

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our confidential and anonymous Reporting Hotline at 1-877-647-3335. Anonymous, safe and secure reporting is available 24/7.

To file a report:

- Toll-free telephone: 877-647-3335
- Website: <https://www.redflagreporting.com>
- Text: 234-231-9005 Fax: 330-572-8146
- Email: redflag@redflagreporting.com
- Mail: Red Flag Reporting, PO Box 4230, Akron, OH 44321

Antidote takes all reports of potential fraud, waste, or abuse very seriously and investigates all reported issues.

FWA Program Compliance Authority and Responsibility

Antidote's Chief Legal and Compliance Officer has overall responsibility, authority, and oversight of the provisions of the compliance program.

Participating providers must cooperate fully in making personnel and/or subcontractor personnel available for in-person interviews, consultations, or such other activities, including investigations and production of medical records deemed necessary by Antidote. If the provider fails to respond to the second and final request for medical records, or if services for which claims have been paid are not documented in the medical record, Antidote will recover all amounts paid for the services in question.

False Claims Act

The False Claims Act establishes liability when any person or entity improperly receives or avoids payment to the federal government. The Act prohibits:

- Knowingly presenting, or causing to be presented a false claim for payment or approval;
- Knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim;
- Conspiring to commit any violation of the False Claims Act;
- Falsely certifying the type or amount of property to be used by the federal government;
- Certifying receipt of property on a document without completely knowing that the information is true;
- Knowingly buying government property from an unauthorized officer of the federal government; and
- Knowingly making, using, or causing to be made or used a false record to avoid or decrease an obligation to pay or transmit property to the federal government.

For more information regarding the False Claims act, please visit www.cms.hhs.gov.

MEMBER RIGHTS & RESPONSIBILITIES

Member Rights

Providers must comply with the rights of members as set forth below:

- To receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- To be treated with respect and recognition of their dignity and their right to privacy.
- To participate with practitioners in making decisions about their health care.
- To a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- To voice complaints or appeals about the organization or the care it provides.
- To make recommendations regarding the organization's member rights and responsibilities policy.
- To have access to a current list of network providers. Additionally, a member may access information on network providers' education, training, and practice.
- To select a health plan or switch health plans, within the guidelines, without any threats or harassment.
- To receive information in a different format in compliance with the Americans with Disabilities Act if the member has a disability.

- To select a primary care provider within the network. The member has the right to change their primary care provider or request information on network providers close to their home or work.
- To know the name and job title of people providing care to the member. The member also has the right to know which physician is their primary care provider.
- To a second opinion by a network physician, at no cost to the member, if the member believes that the network provider is not authorizing the requested care, or if the member wants more information about their treatment.
- To privacy of their personal health information, consistent with state and federal laws, and Antidote policies.
- To be kept informed of covered and non-covered services, program changes, how to access services, primary care provider assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and other Antidote rules and guidelines. Antidote will notify members at least 60 days before the effective date of the modifications.
- To have adequate access to qualified medical practitioners and treatment or services regardless of age, race, creed, sex, sexual orientation, national origin, or religion. Sex discrimination includes, but is not limited to, discrimination based on pregnancy, gender identity and sex stereotyping.
- To have access to an interpreter when the member does not speak or understand the language of the area.
- To execute an advance directive for health care decisions. An advance directive will assist the primary care provider and other providers to understand the member's wishes about the member's health care. The advance directive will not take away the member's right to make their own decisions. Examples of advance directives include:
 - Living Will
 - Health Care Power of Attorney
 - "Do Not Resuscitate" Orders
 - Members also have the right to refuse to make advance directives.
 - Members may not be discriminated against for not having an advance directive.

Member Responsibilities

- To supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- To follow plans and instructions for care that they have agreed to with their practitioners.
- To understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- To treat all health care professionals and staff with courtesy and respect.

- To show their I.D. card and keep scheduled appointments with their provider and call the provider's office during office hours whenever possible if the member has a delay or cancellation.
- To know the name of their assigned primary care provider. The member should establish a relationship with their primary care provider. The member may change their primary care provider verbally or in writing by contacting the Antidote Member Services Department.
- To follow all health benefit plan guidelines, provisions, policies, and procedures.
- To use any emergency room only when they think they have a medical emergency. For all other care, the member should seek care at an urgent care center, Antidote telehealth or call their PCP.
- To give all information about any other medical coverage they have at the time of enrollment. If, at any time, the member gains other medical coverage besides Antidote coverage, the member must provide this information to Antidote.
- To pay their monthly premium, all deductible amounts, copayment amounts, or cost-sharing percentages at the time of service.

PROVIDER RIGHTS & RESPONSIBILITIES

Antidote is committed to ensuring fairness and transparency throughout our credentialing and network participation processes. We want to ensure all healthcare providers and practitioners understand their rights concerning the information we use and any decisions that may affect their participation with us.

Provider Rights

- To be treated by their patients who are Antidote members and other healthcare workers with dignity and respect.
- To receive accurate and complete information and medical histories for members' care.
- To have their patients, who are Antidote members, act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly.
- To expect other network providers to act as partners in members' treatment plans.
- To expect members to follow their health care instructions and directions, such as taking the right amount of medication at the right times.
- To make a complaint or file an appeal against Antidote and/or a member.
- To file a grievance on behalf of a member, with the member's consent.
- To have access to information about Antidote quality improvement programs, including program goals, processes, and outcomes that relate to member care and services.
- To contact Provider Services with any questions, comments, or problems.
- To collaborate with other health care professionals who are involved in the care of members.

- To not be excluded, penalized, or terminated from participating with Antidote for having developed or accumulated a substantial number of patients in Antidote with high-cost medical conditions.
- To collect member copays, coinsurance, and deductibles at the time of the service.

Provider Responsibilities

Providers must comply with each of the items listed below.

- To help or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
 - Recommend new or experimental treatments,
 - Provide information regarding the nature of treatment options,
 - Provide information about the availability of alternative treatment options, therapies, consultations, or tests, including those that may be self-administered,
 - Be informed of risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options.
- To treat members with fairness, dignity, and respect.
- To not discriminate against members based on race, color, gender, national origin, limited language proficiency, religion, age, health status, existence of a pre-existing mental or physical disability/condition including pregnancy and/or hospitalization, the expectation for frequent or high-cost care.
- To maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
- To give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice and scope of service.
- To provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA.
- To allow members to request restriction on the use and disclosure of their personal health information.
- To provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records.
- To provide clear and complete information to members - in a language they can understand about their health condition and treatment, regardless of cost or benefit coverage, and allow member participation in the decision-making process.
- To tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment.

- To allow a member who refuses or requests to stop treatment the right to do so, if the member understands that by refusing or stopping treatment the condition may worsen or be fatal.
- To respect members' advance directives and include these documents in their medical record.
- To allow members to appoint a parent/guardian, family member, or other representative if they can't fully participate in their treatment decisions.
- To allow members to obtain a second opinion, and answer members' questions about how to access health care services appropriately.
- To follow all state and federal laws and regulations related to patient care and rights.
- To participate in Antidote data collection initiatives, such as HEDIS® and other contractual or regulatory programs and allow use of provider performance data.
- To review clinical practice guidelines distributed by Antidote.
- To comply with the Antidote Medical Management program as outlined herein.
- To disclose overpayments or improper payments to Antidote.
- To provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.
- To obtain and report to Antidote information regarding other insurance coverage the member has or may have.
- To give Antidote timely, written notice if provider is leaving/closing a practice.
- To contact Antidote to verify member eligibility and benefits, if appropriate.
- To invite member participation in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible.
- To provide members with information regarding office location, hours of operation, accessibility, and translation services.
- To object to providing relevant or medically necessary services based on the provider's moral or religious beliefs or other similar grounds.
- To provide hours of operation to Antidote members which are no less than those offered to other commercial members.

CULTURAL COMPETENCY

Antidote views cultural competency as the measure of a person or organization's willingness and ability to learn about, understand, and provide excellent customer service across all segments of the population. It is the active implementation of a system-wide philosophy that values differences among individuals and is responsive to diversity at all levels in the community and within an organization and at all service levels the organization engages in outside of the organization.

A sincere and successful cultural competency program is evolutionary and ever-changing to address the continual changes occurring within communities and families. In the context of health care delivery, cultural competency is the promotion of sensitivity to the needs of patients and incorporates cultural considerations that include, but are not limited to the following: race, ethnicity, primary language, age, geographic location, gender identity, sexual orientation, English proficiency, physical abilities/limitations, spiritual beliefs and practices, economic status, family roles, literacy, diverse populations.

It accommodates the patient's culturally based attitudes, beliefs and needs within the framework of access to health care services and the development of diagnostic and treatment plans and communication methods to fully support the delivery of competent care to the patient. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions, and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

Antidote is committed to the development, strengthening, and sustaining of healthy provider-member relationships. Members are entitled to dignified, appropriate care. A provider's services should meet the unique needs of every member regardless of race, ethnicity, culture, language proficiency, or disability. In all interactions, providers are expected to act in a manner that is sensitive to the ways in which the member experiences the world. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care.

Providers must:

- Facilitate member access to Cultural and Linguistic Services, including Informing members of their right to access free, quality medical interpreters, and signers, accessible transportation, and TDD/TTY services. To support informing members of their right to access free language services, it is recommended that providers post nondiscrimination notices and language assistance taglines in lobbies and on websites. Language assistance taglines notify individuals of the availability of language assistance in the top 15 languages utilized.

- Provide medical care with consideration of the members' primary language, race ethnicity and culture.
- Participate in cultural competency training annually and ensure that office staff routinely interacting with members have also been given the opportunity to participate in, and have participated in, cultural competency training.
- Ensure that treatment plans are developed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, gender identity, sexual orientation, and other characteristics that may influence the member's perspective on health care.
- Ensure an appropriate mechanism is established to fulfill the provider's obligations under the Americans with Disabilities Act including that all facilities providing services to members must be accessible to persons with disabilities. Additionally, no member with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public facility, or be subjected to discrimination by any such facility.

Antidote expects providers to treat members without regard to race, color, creed, sex, gender identity, religion, age, national origin ancestry, marital status, sexual orientation, health status, income status, program membership, physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- Denying a member, a covered service or availability of a facility; and
- Providing an Antidote member a covered service that is different or in a different manner, or at a different time or at a different location than to other "public" or private pay members (examples: separate waiting rooms, delayed appointment times).

Language Services

In accordance with Title VI of the Civil Rights Act, Prohibition against national Origin Discriminations, the President's Executive Order 131166, section 1557 of the Patient Protection and Affordable care Act, Antidote and its providers must make language assistance available to persons with Limited English Proficiency (LEP) at all points of contact during all hours of operation. Language services are available at no cost to Antidote members and providers without unreasonable delay at all medical points of contact. The member has the right to file a complaint or grievance if cultural and linguistic needs are not met.

Language services include, but are not limited to:

- Telephonic interpretation;
- Oral translation (reading of English material in a members preferred language);
- American Sign language;
- Auxiliary aids including alternate formats such as large print and braille; and

- Written translations for materials that are critical for obtaining health insurance coverage and access to health care services in non-English prevalent languages.

Information is deemed to be critical for obtaining health insurance coverage or access to health care services if the material is required by law or regulation to provide the document to an individual.

To obtain language services for a member, contact Antidote as soon as possible, or at least 5 business days before the appointment. All providers (medical, behavioral, pharmacy, etc.) can request language services by calling Antidote at **1-866-256-2134 or TTY 711**.

Restrictions Related to Interpretation or Facilitation of Communication

- Providers may not request or require an individual with LEP to provide their own interpreter.
- Providers may not rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with LEP.
- Providers may not use an accompanying adult or minor child to interpreter or facilitate communication.

Exceptions to these expectations include:

- In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with LEP immediately available.
- Accompanying adults (minors are excluded) where the individual with LEP specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances for minimal needs.

Providers are encouraged to document in the member's medical record any member denial of professional interpreters and the circumstances that resulted in the use of a minor or accompanying adult as an interpreter.

AMERICANS WITH DISABILITIES ACT (ADA)

Antidote is committed to providing equal access to quality health care and services that are physically and programmatically accessible for members living with disabilities.

Antidote encourages providers to establish policies and practices that are part of the delivery of healthcare so members with disabilities receive the same quality of care as other persons.

General Requirements

General prohibitions against discrimination.

- No qualified individual with a disability shall, based on disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity.
- A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, based on disability:
 - Deny a qualified individual with a disability the opportunity to participate in or benefit from the aid, benefit, or service;
 - Afford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded to others;
 - Provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;
 - Provide different or separate aids, benefits, or services to individuals with disabilities or to any class of individuals with disabilities than is provided to others unless such action is necessary to provide qualified individuals with disabilities with aids, benefits, or services that are as effective as those provided to others;
 - Aid or perpetuate discrimination against a qualified individual with a disability by providing significant assistance to an agency, organization, or person that discriminates based on disability in providing any aid, benefit, or service to beneficiaries of the public entity's program;
 - Deny a qualified individual with a disability the opportunity to participate as a member of planning or advisory boards; or
 - Otherwise limit a qualified individual with a disability in the enjoyment of any right, privilege, Antidote, or opportunity enjoyed by others receiving the aid, benefit, or service.
- A public entity may not deny a qualified individual with a disability the opportunity to participate in services, programs, or activities that are not separate or different, despite the existence of permissibly separate or different programs or activities.
- A public entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration:
 - That have the effect of subjecting qualified individuals with disabilities to discrimination based on disability;

- That have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities; or
 - That perpetuate the discrimination of another public entity if both public entities are subject to common administrative control and are agencies of the same state.
- A public entity may not, in determining the site or location of a facility, make selections:
 - That have the effect of excluding individuals with disabilities from, denying them the benefits of, or otherwise subjecting them to discrimination; or
 - That have the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the service, program, or activity with respect to individuals with disabilities.
- A public entity, in the selection of procurement contractors, may not use criteria that subject qualified individuals with disabilities to discrimination based on disability.
- A public entity may not administer a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination based on disability, nor may a public entity establish requirements for the programs or activities of licensees or certified entities that subject qualified individuals with disabilities to discrimination based on disability. The programs or activities of entities that are licensed or certified by a public entity are not, themselves, covered by this part.
- A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination based on disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.
- A public entity shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered.
 - Nothing in this part prohibits a public entity from providing benefits, services, or advantages to individuals with disabilities, or to a particular class of individuals with disabilities beyond those required by this part.
- A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.
 - Nothing in this part shall be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or

benefit provided under the ADA or this part which such individual chooses not to accept.

- Nothing in the Act or this part authorizes the representative or guardian of an individual with a disability to decline food, water, medical treatment, or medical services for that individual.
- A public entity may not place a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids or program accessibility, that are required to provide that individual or group with the nondiscriminatory treatment required by the Act or this part.
- A public entity shall not exclude or otherwise deny equal services, programs, or activities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.
- Providers must ensure their websites meet compliance with Section 508 Accessibility Standards. Section 508 is a federal law that requires agencies to provide people with disabilities equal access to electronic information and data comparable to those who do not have disabilities.

QUALITY IMPROVEMENT PLAN

Overview

Antidote's culture, systems, and processes are structured around its mission to improve the health of all enrolled members through a proactive, data-driven approach to improving the quality of care and services. Antidote uses a systematic approach to quality improvement initiatives applying reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of healthcare provided to all members.

This system provides a continuous cycle for assessing the level of care and service among health plan initiatives, including preventive health, acute and chronic care, behavioral health, over- and under- utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and resources to support the interventions.

Quality Management Program Structure

The Antidote Board of Directors has the ultimate oversight for the care and service provided to members. The Board of Directors oversees the Quality Management (QM) Program and has various committees to monitor the QM Program. The scope of the QM Program is comprehensive and addresses both the level of clinical care and the level of service provided to Antidote members. The QM Program incorporates all demographic groups and ages, benefit packages, care settings, providers, and services in quality improvement activities. This includes services for the following: preventive care, primary care, specialty care, acute care, short-term care, long-term care, ancillary services, and operations.

The QM Program's purpose is to:

- Enhance and improve quality of care;
- Provide oversight and direction regarding policies, procedures, and protocols for member care and services; and
- Offer guidelines based on recommendations for appropriateness of care and services.

This is accomplished through a comprehensive, Antidote-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems; the identification of opportunities to improve member outcomes; and the education of members, providers, and staff regarding for example quality improvement, utilization management, pharmacy and credentialing/recredentialing programs and practices.

QUALITY IMPROVEMENT PROJECTS

Antidote develops Quality Improvement Projects (QIPs) as part of its assessment and implementation of continuous quality improvement. QIPs based on demonstration of need and relevance to the population served. QIPs may also be created in response to identified problems, gaps, performance issues, accreditation requirements, or other performance initiatives. QIP selection can be based on the analysis of administrative and clinical data and/or input from stakeholders.

- At any given time, Antidote maintains no less than two QIPs that address opportunities for error reduction or performance improvement.
- At least one of the two QIPs must address consumer safety or improved outcomes for the population served.
- Representation of the Credentialing, Utilization Management and Regulatory Compliance committee shall approve QIPs.
- For each QIP, Antidote will:
 - Establish measurable goals for quality improvement;
 - Establish projected time frames for meeting goals for quality improvement;

- Design and implement strategies to improve performance;
- Conduct quantifiable measurements of baseline level of performance and subsequent level of performance at least annually;
- Document changes or improvements relative to the baseline measurement; and
- Conduct a barrier analysis if the performance goals are not met.

KEY PERFORMANCE INDICATORS

Antidote has developed standardized performance measures that are clearly defined, objective, measurable, and allow tracking over time. Antidote conducts ongoing monitoring of these key performance indicators (KPIs) to assure that the organization is meeting and maintaining identified performance benchmarks. KPIs are reported to the appropriate committee(s) quarterly. Monitoring of the designated KPIs is conducted monthly. Performance issues identified are subject to corrective action.

Practitioner Involvement

Antidote requires all healthcare providers and practitioners to cooperate with quality improvement activities to improve the quality of care and services and member experience. Cooperation includes allowing Antidote to collect, use and evaluate healthcare provider and practitioner performance data to ensure success of Antidote's QM Program. Antidote may use practitioner performance data for quality improvement activities.

Healthcare providers and practitioners are encouraged to participate in quality improvement activities to improve the quality of care and services and member experience. Healthcare providers and practitioners are integral to the success of the QM Program. Involvement in various levels of the process is highly encouraged through network provider representation. Antidote encourages primary care and behavioral health representation on quality committees.

Quality Assessment and Performance Improvement Program Scope and Goals

The Antidote QM Program scope encompasses meaningful interventions in the following areas:

- Acute and chronic care management
- Behavioral health care
- Compliance with member confidentiality laws and regulations (HIPAA)
- Compliance with preventive health guidelines and clinical practice guidelines
- Continuity and coordination of care
- Delegated entity oversight
- Employee and provider cultural competency
- Member enrollment and disenrollment
- Member experience, including complaints, grievances, and appeals

- Patient safety
- PCP changes
- Pharmacy
- Provider and Antidote after-hours telephone accessibility
- Provider appointment availability
- Provider reconsiderations and disputes
- Provider network adequacy and capacity
- Provider experience
- Selection and retention of providers (credentialing and recredentialing)
- Utilization of services, including under-and over-utilization
- CAHPS surveys and HEDIS® results
- To achieve maintain National Committee for Quality Assurance (NCQA) health plan accreditation
- To monitor for ongoing compliance with regulatory and NCQA

Preventive Guidelines

Evidence-based preventive health guidelines are available to assist providers in making decisions regarding health care in specific clinical situations. Guidelines are adopted from national recognized sources, in consultation with network providers (including behavioral health as indicated) and based on the health needs and opportunities for improvement identified as part of the QM Program, valid and reliable clinical evidence, or a consensus of health care professionals in the field and needs of the members.

Preventive health guidelines are reviewed annually and updated upon significant new scientific evidence or change in national standards. Antidote makes all current preventive health available online at www.antidotehealth.com/provider.

Quality Rating System

Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS® is a set of standardized performance measures developed by NCQA, which allows comparison across health plans. HEDIS® gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences.

HEDIS® rates are becoming more and more important, not only to Antidote, but to the providers. The aggregated HEDIS® rates are used to evaluate the effectiveness of a health plan's ability to demonstrate the clinical management of its members. Physician-specific scores are used as evidence of preventive care delivery in PCP practices.

HEDIS® Rate Calculations

HEDIS® rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Measures typically calculated using administrative data include annual mammogram, annual chlamydia screening, appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and behavioral health services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of medical records to extract data regarding services rendered but not reported to Antidote through claims. Accurate and timely claims and submission using appropriate CPT, ICD-10, and HCPCS codes can reduce the necessity of medical record reviews. HEDIS® measures typically requiring medical record review include childhood immunizations, well child visits, diabetic HbA1c values, LDL, eye exam and nephropathy, controlling high-blood pressure, cervical cancer screening, and prenatal care and postpartum care.

Who Conducts Medical Record Reviews (MRR) for HEDIS®?

Antidote has contracted with an independent national MRR vendor to conduct the HEDIS® MRR on its behalf. Medical record review audits for HEDIS® are conducted on an ongoing basis with a particular focus from January through May each year. At that time, a sample of your member's medical records may be selected for review. If so, you will receive a call and/or a letter from a MRR representative. Prompt cooperation is expected and appreciated. To facilitate the collection process, ensure chart documentation reflects all services provided. Keep accurate medical record documentation of each member service and document conversations.

Sharing of protected health information (PHI) used or disclosed for purposes of treatment, payment, or health care operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member. Antidote's MRR vendor will sign a HIPAA compliant Business Associate Agreement with Antidote, which allows them to collect PHI.

REGULATORY MATTERS

Medical Records

Antidote providers must keep accurate and complete patient medical records which are consistent with 45 CFR 156, financial, and other records pertinent to Antidote members. Such records enable providers to render the most appropriate level of health care service to members. They will also enable Antidote to review the level and appropriateness of the services rendered. To ensure the member's privacy, medical records should be kept in a secure location. Antidote requires providers to maintain all records for members for at least 10 years after the final date of service unless a longer period is required by applicable state law.

Required Information

To be considered a complete and comprehensive medical record, the member's medical record (file) should include, at a minimum: provider notes regarding examinations, office visits, referrals made, tests ordered, and results of diagnostic tests ordered (i.e., x-rays, laboratory tests). Medical records should be accessible at the site of the member's participating PCP. All medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, should be documented, and prepared in accordance with all applicable state rules and regulations and signed by the medical professional rendering the services.

Providers must maintain complete medical records for members in accordance with the standards set forth below:

- Member's name, and/or medical record number must be on all chart pages.
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.).
- Prominent notation of any spoken language translation or communication assistance must be included.
- All entries must be legible and maintained in detail.
- All entries must be dated and signed or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented. An up-to-date immunization record is established for pediatric members, or an appropriate history is made in chart for adults.
- Evidence that preventive screening and services are offered in accordance with Antidote practice guidelines.
- Appropriate subjective and objective information pertinent to the member's presenting complaints is documented in the history and physical.
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER

encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.

- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.
- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed, including instructions to the member.
- Documentation of prenatal risk assessment for pregnant members or infant risk assessment for newborns.
- Signed and dated required consent forms are included.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate are documented.
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the primary care provider (PCP) to signify review.
- Referrals to specialists and ancillary providers are documented, including follow up of outcomes and summaries of treatment rendered elsewhere, including family planning services, preventive services, and services for the treatment of sexually transmitted diseases.
- Health teaching and/or counseling is documented.
- For members 10 years and over, appropriate notations concerning use of tobacco, alcohol, and substance use (for members seen three or more times substance abuse history should be queried).
- Documentation of failure to keep an appointment.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months, or as needed.
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem.
- Confidentiality of member information and records are protected.
- Evidence that an advance directive has been offered to adults 18 years of age and older.

Access to Records and Audits by Antidote

Subject only to applicable state and federal confidentiality or privacy laws, the provider shall permit Antidote or its designated representative, such as MRR representative, access to provider's records, at provider's place of business in the state during normal business hours, or remote access of such records, to audit, inspect, review, perform chart reviews, and duplicate such records. If performed on site, access to records for the purpose of an audit shall be scheduled at mutually agreed upon times, upon at least 30 business days prior written notice by Antidote or its designated representative, but not more than 60 days following such written notice.

Electronic Medical Record Access

Providers will grant Antidote or its delegate access to the provider's Electronic Medical Record (EMR) system to effectively case manage members and capture medical record data for risk adjustment and quality reporting. There will be no other fees charged to Antidote for this access.

Medical Records Release

All member medical records are confidential and must not be released without the written authorization of the member or their parent/legal guardian, in accordance with state and federal law and regulation. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need-to-know basis.

All release of specific clinical or medical records for substance use disorders must meet federal guidelines at 42 CFR Part 2 and any applicable state laws.

Medical Records Transfer for New Members

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned Antidote members. If the member or member's parent/legal guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers, then this should also be noted in the medical record.

Federal and State Laws Governing the Release of Information

The release of certain information is governed by a myriad of federal and/or state laws.

These laws often place restrictions on how specific types of information may be disclosed, including, but not limited to, behavioral health, alcohol /substance abuse treatment, and communicable disease records.

For example, HIPAA requires that covered entities, such as health plans and providers, release protected health information only when permitted under the law, such as for treatment, payment, and operations activities, including care management and coordination.

However, a different set of federal rules place more stringent restrictions on the use and disclosure of alcohol and substance abuse treatment records (42 CFR Part 2 or "Part 2"). These records generally may not be released without consent from the individual whose information is subject to the release.

Still other laws at the state level place further restrictions on the release of certain information, such as behavioral health, communicable disease, etc. Contracted providers are independently obligated to know, understand, and comply with these laws.

Antidote takes privacy and confidentiality seriously. Contact Antidote's Chief Legal and Compliance Officer by phone at 1-888-623-3195 or in writing with any questions about Antidote's privacy practices.

Antidote Health Plan
Attention: Chief Legal and Compliance Officer
1460 Broadway
New York, NY 10036

Appendix I: Reimbursement Policies

Generally, Antidote follows Medicare reimbursement policies.

Instances that vary from Medicare include:

Admissions for Same or Related Diagnoses

Inpatient admissions for the same or a related diagnoses occurring within 30 days following a discharge in connection with a previous admission shall be considered part of the previous admission and are not separately reimbursable.

Calculating Anesthesia

Anesthesia time is defined as the period during which an anesthesia provider is present with the patient. It starts when the anesthesia provider begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia provider is no longer furnishing anesthesia services to the patient, when for example, the patient is placed safely under postoperative care. Anesthesia time is a continuous time from the start of anesthesia to the end of an anesthesia service.

Certified Nurse Midwife (CNM) Rules

Payment for CNM services is made at 100% of the contracted rate.

EKG Payment

EKG Interpretation is separately billable and payable from the actual test. However, the first provider to bill receives payment for services.

Physician Site/Place of Service (POS)

Physicians will be paid at the physician rate only at the following sites/place of service:

- Office (11)
- Home (12)
- Assisted Living Facility (13)
- Mobile Unit (15)
- Walk in Retail Health Clinic (17)
- Urgent Care Facility (20)
- Birthing Center (25)
- Nursing Facility (32)
- Skilled Nursing Facility (31)
- Independent Clinic (49)
- Federally Qualified Health Center (50)
- Intermediate Care Facility (54)
- Residential Substance Abuse Treatment Facility (55)
- Non-residential Substance Abuse Treatment Facility (57)
- Non-residential Opioid Treatment Facility (58)

- End Stage Renal Disease Treatment Facility (65)
- Public Health Clinic (71)
- Rural Health Center (72)
- Tribal 638 Free-standing Facility (07)
- Other POS (99)

Diagnostic Testing of Implants

Charges and payments for diagnostic testing of implants following surgery is not included in the global fee for surgery and is reimbursable if the testing is outside the global timeframe. If it is inside the global timeframe, it is not reimbursable.

Hospital-Acquired Conditions and Provider Preventable Conditions

Payment to a provider shall comply with state and federal laws requiring reduction of payment or non- payment to a provider for “hospital- acquired conditions” and for “provider preventable conditions” as such terms (or the reasonable equivalents thereof) are defined under applicable state and federal laws.

Lesser Of Language

Pay provider the lesser of the provider’s billed charges or the contracted rate.

Multiple Procedure Rules for Surgery and Endoscopic

Where multiple outpatient surgical or scope procedures are performed on a member during a single occasion of surgery, reimbursement will be as follows:

- The procedure for which the allowed amount is greatest will be reimbursed at 100%.
- The procedures with second and third greatest allowed amounts will each be reimbursed at 50%.
- Any additional procedures will not be eligible for reimbursement.

Multiple Procedure Rules for Radiology

Multiple procedure radiology codes follow Multiple Procedure discount rules: 100%/50%/50%, max three radiology codes.

Physician Assistant (PA) Payment Rules

Physician assistant services are paid at 85% of what a physician is paid under the Antidote Physician Fee Schedule.

PA services furnished during a global surgical period shall be paid at 85% of what a physician is paid under the Antidote Physician Fee Schedule.

PA assistant-at-surgery services shall be paid at 85% of what a physician is paid under the Medicare.

Physician Fee Schedule. Since physicians are paid at 16% of the surgical payment amount under the Medicare Physician Fee Schedule for assistant-at-surgery services, the actual payment amount that PAs receive for assistant-at-surgery services is 13.6% of the amount paid to physicians. The AS modifier must be used.

Provider-Based Billing

Provider-based billing will not be reimbursed as it is included as part of the compensation for professional fees. Neither Antidote nor the member shall be responsible for such provider-based billing. Provider-based billing is the amount charged by a clinic or facility as a technical component, or for overhead, in connection with professional services rendered in a clinic or facility and includes but is not limited to services billed using Revenue Codes 510-519.

Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS) Payment Rules

In general, NPs and CNSs are paid for covered services at 85% of what a physician is paid under the Antidote Physician Fee Schedule.

Surgical Physician Payment Rules

For surgeries billed with either modifier 54, 55, 56, or 78, pay the appropriate percentage of the fee schedule payment as identified by the modifier and procedure code used.

Incomplete Colonoscopy Rule

Incomplete colonoscopies should be billed with CPT 45378 and modifier 53. This will pay 25% of the fee schedule rate for the incomplete procedures. The rest of the claim pays according to the fee schedule.

Injection Services

Injection service codes must pay separately if no other physician service is paid and when not billed with office visit. If an office visit is billed, then no injection is payable because it is covered in the office charge.

Unpriced Codes

If the CMS/Medicare does not contain a published fee amount, an alternate “gap fill” source is utilized to determine the fee amount. Unlisted codes are subject to the code edit and audit process and require submission of medical records.

Rental or Purchase Decisions

Rental or purchase decisions are made at the discretion of Medical Management.

Payment for Capped Rental Items during Period of Continuous Use

When no purchase options have been exercised, rental payments may not exceed a period of continuous use of longer than 13 months. For the month of death or discontinuance of use, the full month rental is paid. After 13 months of rental have been paid, the supplier must continue to provide the item without any charge, other than for the maintenance and servicing fees until medical necessity ends or Antidote coverage ceases. For this purpose, unless there is a break in need for at least 60 days, medical necessity is presumed to continue. Any lapse greater than 60 days triggers a new medical necessity review.

If the beneficiary changes suppliers during or after the 13-month rental period, this does not result in a new rental episode. The supplier that provides the item in the 13th month of the rental period is responsible for supplying the equipment and for maintenance and servicing after the 13-month period. If the supplier changes after the 10th month, there is no purchase option.

Percutaneous Electrical Nerve Stimulator (PENS) Rent Status While Hospitalized

An entire month's rent may not be paid when a patient is hospitalized during the month. The rent will be prorated to allow for the time not hospitalized.

Transcutaneous Electrical Nerve Stimulator (TENS)

To permit an attending physician time to determine whether the purchase of a TENS is medically appropriate for a particular patient, ten percent of the purchase price of the item is paid for each of two months. The purchase price and payment for maintenance and servicing are determined under the same rules as any other frequently purchased item. There is a reduction in the allowed amount for purchase due to the two months rental.

APPENDIX II: ARIZONA STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by state or federal law to be included in the Participating Practitioner's or Participating Provider's agreement with the health care services organization (HCSO).

AZ – 1 Member Hold Harmless. If the health care services organization (HCSO) fails to pay for any Covered Services as provided in a Member's Benefit Plan, the Member is not liable to Participating Practitioners or Participating Providers for any amounts owed by HCSO and Participating Practitioners and Participating Providers shall not bill or otherwise attempt to collect from the Member the amount owed by HCSO in accordance with Ariz. Rev. Stat. § 20-1072. Participating Practitioners and Participating Providers shall not maintain an action at law against a Member to collect any amounts owed by HCSO for which the Member is not liable to Participating Practitioners and Participating Providers pursuant to Ariz. Rev. Stat. § 20-1072. Participating Practitioners and Participating Providers may not charge a Member more than the amount Provider has contracted with Antidote to charge Members.

AZ – 2 Member Appeal. Appeal shall have the meaning set forth in Ariz. Rev. Stat. §20-2501, and Ariz. Rev. Stat. § 20-2530 et seq.

AZ – 3 Emergency Services. Per Ariz. Rev. Stat. § 20-2081, Emergency services are health care services provided to a Member in a licensed hospital emergency facility by a Practitioner after the onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

- Serious jeopardy to the Member's health, including mental health.
- Serious impairment to a bodily function of the patient.
- Serious dysfunction of any bodily organ or part of the Member.
- Harm to the Member or others.

AZ – 4 Freedom of Choice. HCSO and Participating Practitioners shall adhere to "Freedom of Choice" statutes requiring that HCSO reimburse health services covered by Benefit Plans without designating the specific type of licensed health professional to perform the service. In accordance with Ariz. Rev. Stat. § 20-841, HCSO shall reimburse charges for reasonable and necessary Covered Services provided by any Participating Practitioners licensed pursuant to Ariz. Rev. Stat. Title 32, Chapter 8 (chiropractors), Chapter 9 (physicians), or Chapter 17 (osteopathic physicians), if the services are within the lawful scope of practice of the Participating Practitioner, regardless of the nomenclature used to describe the condition, complaint or service.

AZ – 5 Treatment Discussions. HCSO shall not restrict or prohibit a Participating Practitioner's or Participating Provider's good faith communications with the Participating Practitioner's or Participating Provider's Members concerning any such Member's health care or medical needs, treatment options, health care risks or benefits. HCSO shall not terminate or refuse to renew a Participating Provider's or Participating Practitioner's participation in HCSO's network, solely because the Participating Practitioner or Participating Provider in good faith does any of the following: (a) advocates in private or in public on behalf of a Member; (b) assists a Member in seeking reconsideration of a decision made by HCSO to deny coverage for a health care service; or (c) reports a violation of law to an appropriate authority, in accordance with Ariz. Rev. Stat. § 20-118; § 20-1061.

AZ – 6 Provider Directories and Demographic Reports. Participating Practitioners and Participating Providers shall furnish HCSO with the necessary information for HCSO to maintain a provider directory that includes a list of Participating Practitioners and Participating Providers available to Members and to provide demographic information reports in accordance with Ariz. Admin. Code R20-6-1912 and R20-6-1913.

AZ – 7 Uniform Billing. To the extent Participating Provider operates a hospital which is subject to the uniform billing requirements of Ariz. Rev. Stat. § 36-125.05, HCSO shall accept such billing as its principal billing format, in accordance with Ariz. Rev. Stat. 36-125.07. To the extent Participating Provider is a hospital and HCSO requires the submission of supplemental information to substantiate billing for emergency services, HCSO shall pay the reasonable cost to the hospital of reproducing such supplemental information that shall be related solely to emergency services.

AZ – 8 Prompt Claim Payments. HCSO and Participating Practitioners and Participating Providers shall adhere to Arizona's prompt claim payment statutes, Ariz. Rev. Stat. § 20-3102. A "clean claim" means a written or electronic claim for health care services or benefits that may be processed without obtaining additional information, including coordination of benefits information, from Participating Practitioners and Participating Providers, another health care Practitioner or Provider, the Member or a third party, except in cases of fraud.

The term "adjudicate" for purposes of this section means HCSO's decision to deny or pay a claim, in whole or in part, including the decision as to how much to pay. Unless otherwise agreed, HCSO shall adjudicate clean claims within thirty (30) days after HCSO receives a clean claim, in accordance with Ariz. Rev. Stat. § 20-3102. Unless otherwise agreed, HCSO shall pay the approved portion of any clean claim within thirty (30) days after the claim is adjudicated. If the claim is not paid within thirty (30) days from the date of adjudication or within the time period agreed to by the parties, HCSO shall pay interest on the claim at a rate that is allowed under Arizona law (Ariz. Rev. Stat. § 20-3102(A)). Interest shall be calculated beginning on the date that the payment to the health care provider is due.

If a claim is not a clean claim and HCSO requires additional information to adjudicate the claim, HCSO shall send a written request for additional information to Practitioner or Provider within thirty (30) days after HCSO receives the claim. HCSO shall notify Practitioner or Provider of all the specific reasons for the delay in adjudicating the claim. HCSO shall not request information from Practitioner or Provider that does not apply to the medical condition at issue for the purposes of adjudicating a clean claim. HCSO may only request that Practitioner or Provider resubmit claim information that Practitioner or Provider previously provided to HCSO if HCSO has a reasonable justification to request the resubmission and the purpose of the request is not to delay the payment of the claim. HCSO shall record the date it receives additional information and shall adjudicate the claim within thirty (30) days of receiving the additional information. HCSO shall pay the approved portion of the adjudicated claim within thirty (30) days from the date of adjudication or within the time frame agreed to by the parties. If the claim, supplemented by the additional information, is not paid within thirty (30) days from the date of adjudication, HCSO shall pay interest on the claim at a rate that is equal to the legal rate specified in Ariz. Rev. Stat. § 20-3102(A).

AZ – 9 Retroactive Adjustment of Claims. Unless otherwise agreed, neither HCSO nor Participating Practitioner or Participating Provider shall adjust or request adjustment of the payment or denial of a claim more than one year after HCSO has paid or denied that claim. If the parties agree on a different length of time to adjust or request adjustment of the payment of a claim, both parties shall have the same length of time to do so. If the claim is adjusted, neither HCSO nor Participating Practitioner or Participating Provider shall owe interest on the overpayment or the underpayment resulting from the adjustment, as long as the adjusted payment is made or recoupment taken within thirty (30) days of the date of the adjudication of the claim adjustment. The time limitations set forth in this paragraph do not apply in cases of fraud. (Ariz. Rev. Stat. § 20-3102)

AZ – 10 Claims Grievance Reporting. HCSO and Participating Practitioner or Participating Provider shall resolve payment disputes and other contractual grievances as set forth in the Agreement. The parties acknowledge that the process set forth in the Agreement constitutes the internal system of resolving payment disputes and other contractual grievances required by Ariz. Rev. Stat. § 20-3102(F).

HCSO and Participating Practitioner or Participating Provider agree that, in accordance with Ariz. Rev. Stat. § 20-3102(F), HCSO may disclose to the Arizona Department of Insurance Director a summary of any grievances submitted by Participating Practitioner or Participating Provider on a semiannual basis, including the name and identification number(s) of Practitioner or Provider, the type of grievance, the date HCSO received the grievance, and the date the grievance was resolved.

AZ – 11 Provider Incentives. HCSOP shall not offer any type of financial incentive plan which provides a specific payment made to or withheld from Participating Practitioners or Participating

Providers as an inducement to deny, reduce, limit, or delay medically necessary care that is a Covered Service in accordance with Ariz. Rev. Stat. § 20-1061.

AZ – 12 Subrogation. Subrogation of recovery against a third-party for bodily injury is not permitted by Arizona case law since this is the legal equivalent of an assignment of the insured's cause of action against a third-party tortfeasor, which is not assignable in law. Allstate Ins. Co. v. Druke, 118 Ariz. 301, 576 P.2d 489 (1978).

AZ – 13 Utilization Review. In accordance with Ariz. Rev. Stat. Title 20, Chapter 15, to the extent HCSO has adopted a utilization review plan including written utilization review standards and criteria to assess requested medical or health care services or claims for medical and health care services, as well as processes for the review, reconsideration, and appeal of denials of requested medical or health care services or claims for medical and health care services. HCSO and Participating Practitioners and Participating Providers agree that decisions regarding approval or denial of medical or health care services or claims for medical and health care services shall be governed by the most recent utilization review system plan filed with the Director of the Arizona Department of Insurance in accordance with Ariz. Rev. Stat. § 20-2532. The most current utilization review plan shall be made available upon request. HCSO and Participating Practitioner or Participating Provider acknowledge that the utilization review plan may be changed subject to the requirements of Ariz. Rev. Stat. Title 20, Chapter 15. Participating Practitioner or Participating Provider agrees to fully cooperate and provide information to HCSO or its designated utilization review agent in a complete and timely a manner to allow HCSO or its authorized utilization review agent to investigate, evaluate and form a reasonable basis for utilization decisions concerning requested medical or health care services or claims for medical and health care services of Members. To the extent HCSO provides a Member's treating Participating Practitioner or Participating Provider a form statement concerning the Member's right to appeal a denial, Participating Practitioner or Participating Provider shall notify the Member of the Member's right to appeal, in accordance with Ariz. Rev. Stat. § 20-2533.

AZ – 14 Prior Authorization. To the extent HCSO establishes a prior authorization requirement for any of its Benefit Plans pursuant to Ariz. Rev. Stat. Title 20, Chapter 15, Participating Practitioners or Participating Providers shall fully cooperate and provide information to HCSO or its designated utilization review agent in a complete and timely manner to allow HCSO or its authorized review agent to investigate, evaluate and form a reasonable basis for prior authorization decisions.

AZ – 15 Network Access Standards. Participating Practitioners and Participating Providers agree to cooperate with HCSO to maintain the following standards to provide Members access to Covered Services, in accordance with Ariz. Admin. Code R20-1914:

- For preventive care services from a contracted PCP, an appointment date within 60 days of the Member's request, or sooner if necessary, for the Member to be immunized on schedule.
- For routine-care services from a contracted PCP, an appointment date within 15 days of the Member's request to the Practitioner or sooner if medically necessary.
- For specialty care services from a Participating Practitioner, an appointment date within 60 days of the Member's request or sooner if medically necessary.
- In-area urgent care services from a Participating Practitioner seven days per week.
- Timely non-emergency inpatient care services from a Participating Provider.
- Timely services from a Participating Practitioner in a contracted facility including inpatient emergency care.
- Services from an ancillary Participating Practitioner or Participating Provider during normal business hours, or sooner if medically necessary.

AZ – 16 Provider Credentialing. HCSO shall credential Participating Practitioners and Participating Providers in accordance with the procedures and timelines provided in Ariz. Rev. Stat. Title 20, Chapter 27.

AZ – 17 Primary Care Physician or Practitioner means a (i) physician who is a family practitioner, general practitioner, pediatrician, general internist, obstetrician, or gynecologist; (ii) a nurse practitioner or certified nurse who is certified pursuant to Ariz. Rev. Stat. Title 32, Chapter 15.; or (iii) a physician assistant who is licensed pursuant to title 32, chapter 25 as per Ariz. Rev. Stat. § 36-2901.

AZ – 18 Member Continuity of Care After Provider Termination. HCSO shall allow any Member receiving healthcare from a Participating Practitioner or Participating Provider who is terminated from HCSO's network (except for reasons of the Participating Practitioner's or Participating Provider's medical incompetence or unprofessional conduct), on written request of the Member to HCSO, to continue an active course of treatment with that Practitioner or Provider during a transitional period if the conditions provided by Ariz. Rev. Stat. § 20-1057.04 are satisfied.

AZ – 10 Member Continuity of Care After Insolvency. Participating Practitioners and Participating Providers shall provide Covered Services to Members at the same rates and subject to the same terms and conditions established in the Agreement for the duration of the period after HCSO is declared insolvent, until the earliest of the following: (a) a determination by the court that the insolvent HCSO cannot provide adequate assurance it shall be able to pay Participating Practitioners' and Participating Providers' claims for Covered Services that were rendered after HCSO is declared insolvent; (b) a determination by the court that insolvent HCSO is unable to pay Participating Practitioners' and Participating Providers' claims for Covered Services that were rendered after HCSO is declared insolvent; (c) a determination by the court that continuation of the Agreement would constitute undue hardship to Participating Practitioners and Participating Providers; or (d) a determination by the court that HCSO has satisfied its

obligations to all Members under the applicable Benefit Plans, in accordance with Ariz. Rev. Stat. § 20-1074(B)).

AZ – 20 Maternity and Post-delivery Care. HCSO shall not penalize or reduce or limit reimbursement to Participating Provider, or its employees and agents, because Participating Provider, or its employee or agents: (1) allows a mother and newly born baby a hospital stay of not less than forty-eight (48) hours in connection with childbirth for the mother or newborn child following a normal vaginal delivery or a hospital stay of not less than ninety-six (96) hours in connection with childbirth for the mother or newborn child following a cesarean section. HCSO is not providing, and shall not provide, Participating Provider, or its employees or agents, monetary or other incentives to induce Participating Provider, or its employees or agents, to cause early discharge of a Member as set forth in this paragraph or otherwise provide care inconsistent with Ariz. Rev. Stat. 20-1342(12)(B). Nothing in this paragraph prevents HCSO from negotiating the level and type of reimbursement with Participating Provider for post-partum care.

AZ – 21 Dental Services. To the extent that HCSO offers reimbursement or coverage to Members for dental services and Participating Practitioners or Participating Providers provide dental services to a Member under this Agreement, HCSO shall not limit the fee or reimbursement that Participating Practitioners and Participating Providers may charge to a Member for dental services unless those dental services are Covered Services, in accordance with Ariz. Rev. Stat. § 20-1057.12.

AZ – 22 Limitations on Disclosure of HIV Information. HCSO shall not disclose to Participating Practitioners and Participating Providers any confidential HIV-related information unless such disclosure is authorized in writing pursuant to a release as set forth in Ariz. Rev. Stat. § 20-448.01 and Ariz. Admin. Code R20-6-1204 or as otherwise required by law. Participating Practitioners and Participating Providers shall not disclose and shall take all reasonable measures to avoid disclosure of any confidential HIV-related information provided to Participating Practitioners and Participating Providers by HCSO to any other person except as allowed under Ariz. Rev. Stat. § 20-448.01. “Confidential HIV-related information” means information concerning whether a person has had an HIV-related test or has HIV infection, HIV-related illness or acquired immune deficiency syndrome and includes information which identifies or reasonably permits identification of that person or the person’s contacts.

AZ – 23 Telemedicine Services. To the extent that Participating Practitioners and Participating Providers provide any telemedicine services to Members within the scope of Ariz. Rev. Stat. § 20-1057.13, Participating Practitioners and Participating Providers shall ensure that all such services provided through telemedicine or resulting from a telemedicine consultation shall comply with Arizona licensure requirements, accreditation standards and any practice guidelines of a national association of medical professionals promoting access to medical care for

consumers via telecommunications technology or other qualified medical professional societies to ensure quality of care, in accordance with Ariz. Rev. Stat. § 20-1057.13.

AZ – 24 Familial Relationships. HCSO shall provide coverage for lawful health care services that are provided by a Participating Practitioner to a Member regardless of the familial relationship of the Participating Practitioner to the Member if the health care service would be covered were it provided to a Member who was not related to the Participating Practitioner. Nothing in this section of the Exhibit limits the right or authority of HCSO to limit coverage to Practitioners who are contracted or otherwise part of HCSO' network, in accordance with Ariz. Rev. Stat. § 20-1057.17.

APPENDIX III: OHIO STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by state or federal law to be included in the provider's agreement.

OH-1 Services. The Provider Manual describes (a) the specific health care services for which each Participating Provider is responsible, including limitations or conditions on such services (if any); (b) the rights and responsibilities of Health Plan and a Payor, and of the Participating Providers, with respect to administrative policies and programs, including, but not limited to, payments systems, utilization review, quality assurance, assessment, and improvement programs, credentialing, confidentiality requirements, and any applicable federal or state programs; and (c) the specifics of any obligation on a Participating Provider that is a primary care provider to provide, or to arrange for the provision of, Covered Services twenty-four (24) hours per day, seven (7) days per week. The procedures for the resolution of disputes arising out of the Agreement are sent forth in the Agreement or Provider Manual. (OHIO REV. CODE §§ 1751.13(C)(1); 1751.13(C)(4); 1751.13(C)(10); 1751.13(C)(11))

OH-2 Covered Person Hold Harmless. Each Participating Provider agrees that in no event, including but not limited to nonpayment by Health Plan or the Payor, insolvency of Health Plan or the Payor, or breach of the Agreement, shall the Participating Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a Covered Person or person to whom health care services have been provided, or person acting on behalf of the Covered Person, for Covered Services provided pursuant to the Agreement. This does not prohibit the Participating Provider from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against Health Plan, the Payor, or their respective successors. This Section shall survive the termination of the Agreement with respect to Covered Services provided under the Agreement during the time the Agreement was in effect, regardless of the reason for the termination, including the insolvency of the Payor. (OHIO REV. CODE §§ 1751.13(C)(2); 1751.13(C)(12); 1751.60(C))

OH-3 Continuity of Care. Each Participating Provider shall continue to provide Covered Services to patients that were Covered Persons under the Agreement in the event of Health Plan's or the Payor's insolvency or discontinuance of operations. Each Participating Provider shall continue to provide Covered Services to patients that were Covered Persons under the Agreement as needed to complete any Medically Necessary procedures commenced but unfinished at the time of Health Plan's or the Payor's insolvency or discontinuance of operations. The completion of a Medically Necessary procedure shall include the rendering of all Covered Services that constitute Medically Necessary follow-up care for that procedure. The foregoing does not require the Participating Provider to continue to provide any Covered Service after the occurrence of any of the following: (a) the end of the thirty-day period following the entry of a

liquidation order under Chapter 3903 of the Ohio Revised Code; (b) the end of the Covered Person's period of coverage for a contractual prepayment or premium; (c) the Covered Person obtains equivalent coverage with another health insuring corporation or insurer, or the Covered Person's employer obtains such coverage for the Covered Person; (d) the Covered Person or the Covered Person's employer terminates coverage under the Coverage Agreement or Payor Contract; (e) a liquidator effects a transfer of Health Plan's or the Payor's obligations under the contract under Section 3903.21(A)(8) of the Ohio Revised Code. (OHIO REV. CODE § 1751.13(C)(3))

OH-4 Records. Each Participating Provider shall keep confidential and make available those health records maintained by the Participating Provider to monitor and evaluate the quality of care, to conduct evaluations and audits, and to determine on a concurrent or retrospective basis the necessity of and appropriateness of health care services provided to Covered Persons. Each Participating Provider shall make these health records available to appropriate State and federal authorities involved in assessing the quality of care or in investigating the grievances or complaints of Covered Persons. Each Participating Provider shall comply with applicable State and federal laws related to the confidentiality of medical or health records. (OHIO REV. CODE § 1751.13(C)(5))

OH-5 Assignment. The contractual rights and responsibilities under the Agreement may not be assigned or delegated by the Participating Provider without the prior written consent of Health Plan. (OHIO REV. CODE § 1751.13(C)(6))

OH-6 Insurance. Each Participating Provider shall maintain adequate professional liability and malpractice insurance and shall notify Health Plan not more than ten (10) days after the Participating Provider's receipt of notice of any reduction or cancellation of such coverage. (OHIO REV. CODE § 1751.13(C)(7))

OH-7 Covered Person Rights. Each Participating Provider shall observe, protect, and promote the rights of Covered Persons as patients. Each Participating Provider shall provide health care services without discrimination based on a patient's participation in the health care plan, age, sex, ethnicity, religion, sexual orientation, health status, or disability, and without regard to the source of payments made for health care services rendered to a patient. This requirement shall not apply to circumstances when the Participating Provider appropriately does not render services due to limitations arising from the Participating Provider's lack of training experience, or skill, or due to licensing restrictions. (OHIO REV. CODE §§ 1751.13(C)(8); 1751.13(C)(9))

OH-8 Definitions. The terms used in the Agreement and defined by Chapter 1751 of the Ohio Revised Code are to be construed when used in the Agreement in a manner consistent with those statutory definitions (OHIO REV. CODE § 1751.13(C)(13))

OH-9 Payor's Role. Each Participating Provider acknowledges that the Payor is a third-party beneficiary to the Agreement, and that each Payor retains the right to approve or disapprove the participation of the Participating Provider with respect to any provider panel or network available for a particular Coverage Agreement. (OHIO REV. CODE § 1751.13(F))

OH-10 Oversight. Each Participating Provider acknowledges Health Plan's statutory responsibility to monitor and oversee the offering of Covered Services to Covered Persons. (OHIO REV. CODE § 1751.13(G))

OH-11 Third Party Access. The Agreement applies to network rental arrangements. One purpose of the Agreement is selling, renting or giving Health Plan rights to the services of the Participating Provider, including other preferred provider organizations, and the third party accessing the Participating Provider's services is any of the following: (i) a Payor or a third-party administrator or other entity responsible for administering claims on behalf of the Payor; (ii) a preferred provider organization or preferred provider network that receives access to the Participating Provider's services pursuant to an arrangement with the preferred provider organization or preferred provider network in a contract with the Participating Provider that is in compliance with Ohio Rev. Code § 3963.02(A)(1)(c), and is required to comply with all of the terms, conditions, and affirmative obligations to which the originally contracted primary participating provider network is bound under its contract with the Participating Provider, including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement; (iii) an entity that is engaged in the business of providing electronic claims transport between Health Plan and the Payor or third-party administrator and complies with all of the applicable terms, conditions, and affirmative obligations of Health Plan's contract with the Participating Provider including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement; (iv) an employer or other entity providing coverage for health care services to its employees or members, and that employer or entity has a contract with Health Plan or its Affiliate for the administration or processing of claims for payment for services provided pursuant to the Agreement with the Participating Provider; or (v) an entity that is an Affiliate or subsidiary of Health Plan or is providing administrative services to, or receiving administrative services from, Health Plan or an Affiliate or subsidiary of Health Plan. (OHIO REV. CODE § 3963.02)

OH-12 Summary Disclosure Form. The summary disclosure form, attached hereto as Schedule A-1, is incorporated herein by this reference. (OHIO REV. CODE § 3963.03)