2026 Provider Manual

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

Effective Date: January 1, 2026

Antidote Health Plan
www.antidotehealth.com/provider

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Welcome to Antidote Health Plan

Welcome to Antidote Health Plan of Arizona and Ohio, Inc. 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.

How to Use This Provider Manual

This manual is your comprehensive guide to understanding Antidote's policies, procedures, and operational standards. It is designed to support your practice in delivering coordinated, compliant, and high-quality care to Antidote members.

Purpose

- To provide clear, actionable guidance on Antidote's expectations for providers.
- To ensure compliance with contractual, regulatory, and accreditation requirements, including NCQA standards.
- To serve as a reference for day-to-day administrative and clinical interactions with Antidote.

Navigation Tips

- Use the Table of Contents to locate specific topics quickly.
- Each section is organized by functional area (e.g., Credentialing, Claims, Medical Management).
- Hyperlinks are embedded throughout the digital version for easy access to referenced tools and resources.

Updates

- The manual is updated regularly to reflect changes in policy, regulation, and operational procedures.
- Updates will be posted at **http://www.antidotehealth.com/provider**
- Providers may also receive notifications via bulletins, Explanation of Payment (EOP) notices, or direct communications.

Compliance Reminder

As outlined in your Participating Provider Agreement, you are required to comply with the provisions of this manual. The participating provider agreement that is utilized for most of Ohio is held between Antidote and Quality Care Partners (QCP). The participation agreement held between the provider and QCP binds you to the Antidote product(s) participation. To the extent there is a conflict with your QCP contract and the Antidote Provider Manual, the Antidote Provider Manual takes precedence. If you have questions or need assistance, contact Provider Services at **1-888-509-2688**.

Nondiscrimination, Civil Rights, and Cultural Competency

Antidote Health Plan and its providers are committed to ensuring that all members receive services without discrimination. No individual shall be excluded from participation in, denied the benefits of, or subjected to discrimination under any program or activity on the basis of race, color, national origin, sex, age, disability, gender identity, sexual orientation, religion, or any other protected status.

Language Services

In accordance with Title VI of the Civil Rights Act, Section 1557 of the Affordable Care Act, and Executive Order 13166, Antidote provides language assistance services to individuals with Limited English Proficiency (LEP) at no cost.

These services are available at all points of contact and during all hours of operation.

Language services include:

- Telephonic interpretation
- Oral translation of written materials
- American Sign Language
- Auxiliary aids such as large print and braille
- Written translations of critical documents in prevalent non-English languages

Providers must not require members to provide their own interpreters or rely on unqualified staff or family members, except in emergencies or when specifically requested by the member under appropriate circumstances.

Americans with Disabilities Act (ADA) Compliance

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

Providers must ensure that their facilities and services comply with ADA standards and that no member is excluded or denied benefits due to disability.

Cultural Competency

- Facilitate access to cultural and linguistic services
- Provide care with consideration of members' race, ethnicity, language, and cultural background
- Participate in annual cultural competency training
- Develop treatment plans that reflect the member's cultural and personal context
- Ensure ADA compliance in all service settings

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 cesarean section.

The 48-hour (or 96-hour) period begins at the time of delivery, unless the delivery occurs outside of a hospital. In such cases, the period begins at the time of hospital admission. The attending provider may decide, after consulting with the mother, to discharge the mother and/or newborn earlier. However, the provider must not receive incentives or disincentives to discharge earlier than the federally protected timeframes.

Key Contacts and 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

Antidote Health Plan of Arizona, Inc. & Antidote Health Plan of Ohio, Inc. Phone: 1-888-509-2688 TTY/TDD: 711 www.antidotehealth.com		
Department	**Telephone/Web Address**	**Hours**
Interpreter and Translation Services	888-623-3195 (Member Services)	Free translation services are available to all Antidote members.
Provider Services • Benefit Verification • Claims Inquiries • Claims Payment Disputes • Credentialing Inquires • Network Status	1-888-509-2688 **www.antidotehealth.com/provider** Email: **Providers@antidotehealth.com**	Mon–Fri 8am–6pm ET
Medical Management • Adverse Determinants • Case Management • Concurrent Review/Clinical Information • Disease Management • Prior Authorizations: Inpatient, Outpatient and Behavioral Health Prior Authorization	1-888-509-2688 **medicalmgmt@antidotehealth.com**	Mon–Fri 8am–6pm ET
Member Services • Eligibility Verification • Member Grievance & Appeals	1-888-623-3195 **https://www.antidotehealth.com/member**	For questions about eligibility and claims and payments inquiries, please contact Member Services, **open daily from 8am-8pm ET.** For after-hours support, please leave a message and a member of our team will respond during business hours.
Prescription Benefits Manager- Navitus (PBM)	1-888-836-5146	24/7
PBM - Bank Identification Number	**Rx BIN:** 610602	
Suspected Fraud, Waste and Abuse	877-647-3335 **www.redflagreporting.com**	24/7
Medical Plan Claims Submission Payer ID	**AZ:** IHS05 **OH:** 89461	

Overview of Our Network

Antidote Health Plan of Arizona, Inc. and Antidote Health Plan of Ohio, Inc. offer a thoughtfully designed provider network that prioritizes accessibility, affordability, and convenience for our members. Our plans—available in Bronze, Silver, and Gold tiers—are structured to meet diverse healthcare needs while promoting cost-effective care delivery.

Antidote's network emphasizes virtual-first primary care providers (PCPs) who are licensed and board-certified. Members are initially assigned a virtual-first PCP upon enrollment but may opt to switch to an in-person PCP at any time. Changes can be made by contacting Antidote Member Services at **1-888-623-3195** (daily, 8am-8pm EST) or by visiting the Member Portal at **https://www.antidotehealth.com/for-members.**

Members also have access to Antidote's comprehensive network of in-person healthcare providers, facilities, and hospitals when medically necessary, as determined by either their in-person PCP or virtual-first PCP. To encourage coordinated care and reduce out-of-pocket expenses, Antidote's benefit structure rewards members who consult with their virtual-first PCP before seeking additional services.

Providers should verify a member's plan type before delivering care. This information is available on the member's ID card and can be confirmed through eligibility verification tools. Plan-specific benefits, prior authorization requirements, and coverage details are outlined in the plan documents available on the Antidote website at **https://www.antidotehealth.com/provider**.

Provider Portal

Release Date: *Coming Soon*

Antidote Health's Provider Portal is expected to launch in 2026. For provider resources, including case management referrals, PA requests, formulary lookup, and the Antidote Provider Directory, please refer to Antidote's Provider Resources at **http://www.antidotehealth.com/provider.**

Support

For questions or assistance with Antidote's provider resources, please contact Antidote Provider Services at **1-888-509-2688.**

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 and Recredentialing

Antidote Health Plan is committed to ensuring that all healthcare providers and practitioners rendering services to Antidote members undergo a thorough credentialing and recredentialing process. This process verifies compliance and applicable governmental regulations and NCQA standards.

Credentialing and recredentialing decisions will be made in accordance with NCQA standards.

Credentialing Requirements

All providers must complete the credentialing process prior to network participation. Antidote uses the standardized credentialing forms available on the website of the Council for Affordable Quality Health (CAQH) **https://www.caqh.org/providers for** healthcare providers practitioners.

The following information must be on file:

- Signed attestation regarding accuracy, licensure history, clinical privileges, disciplinary actions, felony convictions, substance use, mental and physical competence, and ability to perform essential functions.
- Ownership and control disclosure form (unless state law prohibits).
- Malpractice insurance face sheet with coverage details.
- DEA and CDS certificates (if applicable).
- W-9 form (initial credentialing only).
- ECFMG certificate (if applicable).
- Curriculum Vitae with five-year work history and no unexplained gaps over six months.
- Release of information form (signed and dated, not older than 120 days).
- CLIA certificate (if applicable).

Primary source verification will be conducted for:

- Licensure.
- Board certification or professional education.
- Malpractice history via NPDB.
- Federal sanctions (Medicare/Medicaid exclusions).

Facilities must submit a completed Facility Application with all supporting documentation.

Credentialing Committee

The Credentialing Committee, chaired by the Chief Medical Officer or designee, meets monthly or more frequently as needed. Failure to respond to requests for missing or expired information may result in termination of the application process prior to committee review.

Recredentialing

Recredentialing occurs every 36 months and includes:

- Review of licensure, sanctions, certifications, competence, and health status.
- Performance monitoring between cycles, including:
- Monthly federal/state sanction reports
- Exclusions and License status
- Member complaints and grievances
- Quality and utilization metrics

Providers may be terminated if credentialing standards are no longer met.

Eligible Providers

Medical	Behavioral Health (Mental Health and Substance Use)
Physicians (MD)	Physicians/Psychiatrists (MD)
Oral Surgeons (DMD)	Psychologists (PhD/PsyD, Certified or Licensed)
Podiatrists (DPM)	Doctor of Osteopathic Medicine (DO)
Doctors of Osteopathy (DO)	Clinical Psychologists (licensed)
Nurse Practitioners (NP)	Licensed Clinical Social Workers (LCSW, State Certified)
Certified Nurse Practitioners (CNP)	Licensed Marriage & Family Therapists (LMFT)
Physician Assistants (PA)	Licensed Professional Clinical Counselors (LPCC)
Certified Nurse Midwifes (CNM)	Psychiatric Nurse Practitioners and Masters Level Clinical Nurse Specialists (National or State Certified or Licensed)
Chiropractors (DC)	Occupational Therapists (OTR/L)
Doctor of Optometry (OD)	Addiction Medicine Specialists (ADM)
Acupuncturists (LAC)	Other: Behavioral Health Care Specialists (Licensed, Certified, or Registered by the State to Practice Independently)
Occupational Therapists (OT)	Board Certified Behavior Analyst (BCBA)
Physical Therapists (PT)	
Speech Therapists (ST)	
Medical	**Behavioral Health**
Home Health Providers	
Audiologist (AUD)	
Advanced Practice Registered Nurs (APRN)	
Advanced Practice Nurse (APN)	
Advanced Nurse Practitioner (ANP)	
Registered Dietician (RD)	
Clinical Nurse Specialists (CNS)	

Eligible Facilities

Facilities	Behavioral Health Facilities
Hospitals	Intensive Outpatient Programs (IOP)
Urgent Care Centers	Partial Hospital Programs
Freestanding Ambulatory Surgery Centers	Residential Programs
Diagnostic Imaging Facilities	Inpatient Programs
Durable Medical Equipment Companies	Ambulatory Detox Center
Orthotic and Prosthetic Suppliers	
Outpatient Physical Therapy Centers	
Skilled Nursing Facilities	
Home Health Agencies	

NOTE: Nurse Practitioners (NP), Physician Assistants (PA), Certified Nurse Midwives (CNM), Clinical Nurse Specialists (CNS), and other advanced practice providers may be credentialed as permitted by state law and Antidote Health Plan policy.

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.

Practitioner Rights 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.

Primary source verification for credentialing must be completed within 120 calendar days prior to the credentialing decision, in accordance with NCQA 2025 standards.

> **AZ Providers:** In accordance with Arizona Revised Statutes SB 1291, Antidote Health Plan will complete credentialing within 60 calendar days of receiving a complete application.
>
> **Ohio Providers:** Credentialing is conducted in accordance with Ohio Administrative Code 5160-26-05 and 5160-1-17.7, as well as NCQA standards.

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. All updates to provider credentialing files will be documented and tracked to ensure information integrity and compliance with NCQA standards.

Right to Be Informed of Credentialing 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 call Member Services at 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.

Right to Appeal or Reconsider Adverse Credentialing Decision

Applicants who are existing providers and who are declined continued participation due to adverse credentialing determinations (for reasons such as appropriateness of care or liability claims issues) have the right to request an appeal of the decision. Requests for an appeal must be made in writing within 30 days of the date of the notice.

New applicants who are declined participation may request a reconsideration within 30 days from the date of the notice. All written requests should include additional supporting documentation in favor of the applicant's appeal or reconsideration for participation in the network.

Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting and/or no later than 60 days from the
receipt of the additional documentation in accordance with state and federal regulations. Written requests to appeal or reconsideration of adverse credentialing decisions should be sent to the attention of the individual included on the denial letter.

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.

Provider Administration and the Role of the Provider

Antidote Health Plan outlines clear expectations for provider administration and the role of Primary Care Providers (PCPs) in delivering coordinated, accessible, and high-quality care to members. The following section details PCP eligibility, responsibilities, and operational standards.

For the purposes of this manual, a Primary Care Provider (PCP) may be a physician (MD/DO), nurse practitioner (NP), or physician assistant (PA) who is licensed/certified and credentialed to provide primary care services in accordance with state law and Antidote Health Plan policy.

PCP Eligibility Comparison: Ohio vs. Arizona

Specialty	Ohio PCP Eligibility	Arizona PCP Eligibility
Internal Medicine	Yes	Yes
Family Practice	Yes	Yes
General Practice	Yes	Yes
Pediatrics	Yes	Yes
Nurse Practitioner (NP)	Yes (If certified and within scope)	Yes (If certified and within scope)
Physician Assistant (PA)	Yes (If certified and within scope)	Yes (If certified and within scope)

PCP Panel Capacity

All references to “PCP” in this section include physicians, nurse practitioners, physician assistants, and certified nurse midwives acting within their scope of practice and as permitted by state law and Antidote credentialing policies.

PCPs may define the number of members they are willing to accept into their panel. Antidote does not and is not permitted to guarantee member assignments.

The following ratios apply:

Practitioner Type	Maximum Ratio
General/Family Practitioners	1 per 2,000 members
Pediatricians	1 per 2,000 members
Internists	1 per 2,000 members

PCPs must notify Antidote at least 30 days in advance if they intend to close their panel due to reaching capacity. Notification may be submitted in writing or by contacting Provider Services at 1-888-509-2688. PCPs may not refuse new members unless their panel is officially closed.

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 and Assignment of PCP

All references to "PCP" in this section include physicians, nurse practitioners, physician assistants, and certified nurse midwives acting within their scope of practice and as permitted by state law and Antidote credentialing policies.

Members are assigned a virtual PCP upon enrollment and may select an in-person PCP at any time. If no selection is made, Antidote may assign a PCP based on geographic and specialty appropriateness. Pregnant members are encouraged to select a PCP for their newborn prior to the third trimester. 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 1-888-623-3195 (daily, 8am-8pm EST) for further information. PCP changes are effective the first day of the following month after the request is received.

Withdrawing from Member Care

Providers may withdraw from caring for a member with reasonable notice and after stabilization of the member's condition. A certified letter must be sent to Antidote Member Services detailing the withdrawal, including medical record transfer and interim care arrangements.

PCP Coordination of Care

All references to "PCP" in this section include physicians, nurse practitioners, physician assistants, and certified nurse midwives acting within their scope of practice and as permitted by state law and Antidote credentialing policies.

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. Members may self-refer to a specialist and that specialist may require a referral from their PCP.

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 Standards

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.

Appointment Type	Access Standard
PCP – Routine Visit	Within 14 business days
Behavioral Health – Routine Visit	Within 10 business days
Specialist – Non-urgent Visit	Within 14 business days
After-Hours Care	24/7 access via answering service
Emergency Services	24/7 availability

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 compliance 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 with 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. For scheduled time off, providers must notify the Provider Services department prior to the absence. In the event of unscheduled time off, notification must be made as soon as possible.

The provider engaging the covering provider must ensure that the covering physician agrees to compensation in accordance with the Antidote fee schedule outlined in the provider's agreement.

Provider Phone Call Protocol

PCPs and specialists must adhere to the following protocols regarding member telephone inquiries and appointment scheduling:

- Answer member telephone inquiries in a timely manner
- Schedule appointments per standards and guidelines in this manual
- Schedule series and follow-up appointments as medically appropriately
- Identify and reschedule cancelled and no-show appointments
- Identify special needs during scheduling (e.g., wheelchair, language interpretation, cognitive impairments)
- Respond to non-emergent symptomatic issues after hours within 30 minutes
- Respond to all other calls during normal hours on the same day
- Provide for availability of professional and support personnel during office hours
- Maintain protocols for coverage during provider absence
- Document after-hours calls in the member's medical record or call log

NOTE: For urgent or emergent after-hours care, the PCP, specialist, or designee should notify the urgent care center or emergency department of the patient's impending arrival. Prior authorization is not required for emergency medical conditions.

24-Hour Access to Providers

PCPs and specialists must ensure 24/7 access to healthcare services. Office phones must be answered during business hours, and after-hours access must be available through one of the following methods:

- A covering physician
- An answering service
- A triage service or voicemail with a secondary answered number
- Bilingual voicemail messages for practices with high concentrations of non-English speaking members, i.e.: Spanish-speaking populations.

Unacceptable after-hours coverage includes:

- Recordings asking callers to leave a message
- Recordings directing patients to the emergency room for all services
- Failure to return calls

The selected method must connect the caller to someone capable of rendering a clinical decision or reaching the provider. After-hours coverage must be accessible via the office's daytime phone number. Antidote monitors compliance through scheduled and unscheduled audits.

Hospital Responsibilities

Antidote's hospital network must comply with state and federal laws and accrediting agency requirements.

Hospital responsibilities include:

- Notify the PCP immediately or by the next business day following an ER visit
- Obtain authorization for inpatient and selected outpatient services
- Notify Medical Management of ER admissions within one business day
- Notify Medical Management of newborn deliveries within one business day
- Adhere to prior authorization standards outlined in this manual

Provider Data Updates and Validation

Providers must promptly notify Antidote of changes to address, office hours, specialty, phone number, hospital affiliations, or other relevant data. Antidote updates systems to ensure accurate member access. Routine audits may be conducted by Antidote or contracted vendors. Providers must respond to outreach to avoid removal from the Provider Directory. CMS may also audit provider directory data throughout the year.

Antidote Benefits

Overview

Antidote Health Plan offers HMO benefit plans across multiple geographic regions, including Ohio and Arizona. All plans comply with applicable federal and state regulations, including the Affordable Care Act (ACA), and are designed to provide members with accessible, affordable, and comprehensive healthcare coverage.

Plans are categorized into Metal Tiers—Gold, Silver, and Bronze—based on member cost-sharing liability. Higher-tier plans (e.g., Gold) feature higher premiums but lower out-of-pocket costs.

Each plan includes the same Essential Health Benefits (EHBs) as mandated by the ACA:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- 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's plans are marketed under various product names, including "Complete," "Elite," and "SafeGuard" versions. Some plans also include integrated adult dental coverage.

Integrated Deductible Products

Antidote plans feature integrated deductibles, meaning medical and pharmacy deductibles are combined. Members must meet the deductible before coinsurance applies.

Key points include:

- Copays for services not subject to the deductible are collected at the time of service.
- Copays for services subject to the deductible are collected only after the deductible is met.
- Services contributing to the deductible include physician visits, hospital services, Essential Health Benefits (EHB)-covered services (e.g., pediatric dental, mental health), and pharmacy benefits.
- For deductible and out-of-pocket accumulators, please contact Provider Services at 1-888-2688.

Maximum Out-of-Pocket (MOOP) Expenses

Each Antidote plan includes a defined maximum out-of-pocket (MOOP) expense, which represents the total amount a member must pay for covered services in a plan year, excluding premiums. Once the MOOP is reached, Antidote covers 100% of eligible services.

MOOP includes:	MOOP does not include:
• Deductibles • Coinsurance • Copayments	• Premium payments • Out-of-network cost-sharing (except for emergency services and certain ancillary services) • Non-covered services or services exceeding benefit limits

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.

State-Specific Differences

Ohio:

- Coverage is governed by the Ohio Department of Insurance.
- Grace periods vary based on subsidy status:
  - 31 days for unsubsidized members
  - 3 months for subsidized members
- Out-of-network services are generally not covered unless preauthorized
- Emergency services are covered at both network and out-of-network facilities until the member can be safely transferred.
- Urgent care services are covered at network level when accessed at freestanding urgent care centers or when temporarily outside the service area.
- Ohio Revised Code § 3902.51 and the Federal No Surprises Act protect members from balance billing for emergency services and certain ancillary services.

Arizona:

- Coverage is governed by Arizona Revised Statutes and the Department of Insurance and Financial Institutions.
- Grace periods vary based on subsidy status:
  - 31 days for unsubsidized members
  - 3 months for subsidized members
- Group plans have specific termination and continuation provisions.
- Urgent care services are covered at network level when accessed at freestanding urgent care centers or when temporarily outside the service area.
- Emergency services are covered at both network and out-of-network facilities until the member can be safely transferred.

Antidote PY 2026 Offerings by Metal Tier

Metal Tier	Complete	Elite	Standard
Bronze	• Bronze Complete $0 Tier-1 PCP, $0 Antidote 24/7 Virtual PCP/Urg/Chronic Care, $0 Core Rx • Bronze Complete+Dental $0 Tier-1 PCP, $0 Antidote 24/7 Virtual PCP/Urg/Chronic Care, $0 Core Rx	• Bronze Elite $0 Tier-1 PCP, $0 Antidote 24/7 Virtual PCP/Urg/Chronic Care/Referred Labs, $0 Advanced Rx • Bronze Elite+Dental $0 Tier-1 PCP, $0 Antidote 24/7 Virtual PCP/Urg/Chronic Care/Referred Labs, $0 Advanced Rx	Bronze Standard
Silver	• Silver Complete $0 Tier-1 PCP, $0 Antidote 24/7 Virtual PCP/Urg/Chronic Care, $0 Core Rx • Silver Complete+Dental $0 Tier-1 PCP, $0 Antidote 24/7 Virtual PCP/Urg/Chronic Care, $0 Core Rx	• Silver Elite $0 Tier-1 PCP, $0 Antidote 24/7 Virtual PCP/Urg/Chronic Care/Referred Labs, $0 Advanced Rx • Silver Elite+Dental $0 Tier-1 PCP, $0 Antidote 24/7 Virtual PCP/Urg/Chronic Care/Referred Labs, $0 Advanced Rx	Silver Standard
Gold	• Gold Complete $0 Tier-1 PCP, $0 Antidote 24/7 Virtual PCP/Urg/Chronic Care, $0 Core Rx • Gold Complete+Dental $0 Tier-1 PCP, $0 Antidote 24/7 Virtual PCP/Urg/Chronic Care, $0 Core Rx	• Gold Elite $0 Tier-1 PCP, $0 Antidote 24/7 Virtual PCP/Urg/Chronic Care/Referred Labs, $0 Advanced Rx • Gold Elite+Dental $0 Tier-1 PCP, $0 Antidote 24/7 Virtual PCP/Urg/Chronic Care/Referred Labs, $0 Advanced Rx	Gold Standard
Platinum	***Only Available in Arizona*** • Platinum Complete $0 Tier-1 PCP, $0 Antidote 24/7 Virtual PCP/Urg/Chronic Care, $0 Core Rx • Platinum Complete+Dental $0 Tier-1 PCP, $0 Antidote 24/7 Virtual PCP/Urg/Chronic Care, $0 Core Rx	***Only Available in Arizona*** • Platinum Elite $0 Tier-1 PCP, $0 Antidote 24/7 Virtual PCP/Urg/Chronic Care/Referred Labs, $0 Advanced Rx • Platinum Elite+Dental $0 Tier-1 PCP, $0 Antidote 24/7 Virtual PCP/Urg/Chronic Care/Referred Labs, $0 Advanced Rx	
Catastrophic	Catastrophic Standard		

Member Benefits, Eligibility, Identification and Cost Share

Member Benefits

Antidote Health Plan benefits are structured according to federal and state regulations. Most benefit limits are based on a calendar year (January through December). Providers must confirm that members have not exhausted benefit limits before rendering services. This can be done via the Antidote provider portal or by contacting Provider Services at **1-888-509-2688.**

Benefit coverage includes inpatient hospital services, outpatient care, preventive services, prescription drugs, and extended care. Extended care may include skilled nursing facility care, rehabilitation services, and home health care, as specified in the member's plan documents. All services must be medically necessary and meet Antidote's clinical criteria. Prior authorization may be required for certain services before treatment is rendered.

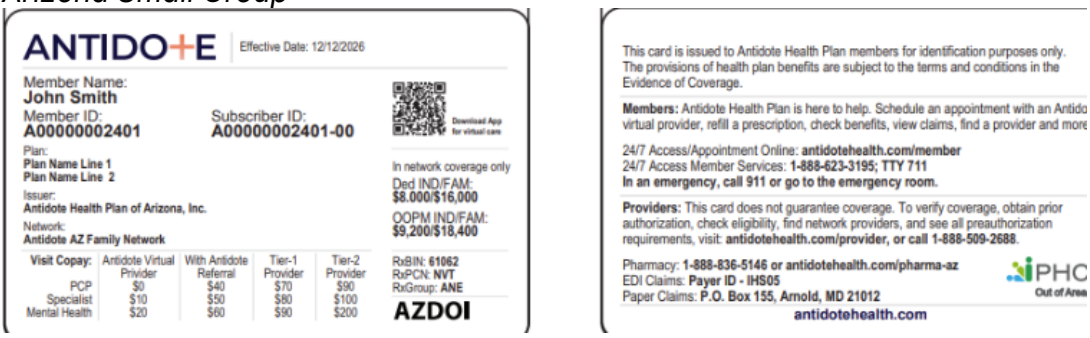
Member Identification Card

All members receive an Antidote identification card upon enrollment. The ID card includes the member's name, ID number, and plan details. Providers must request and verify the ID card at each visit.

NOTE: Presentation of the card is not a guarantee of eligibility; verification must be completed on the date of service.

Sample IDs – Arizona

Arizona Small Group



AZ Marketplace Complete-Elite – Maricopa and Pima

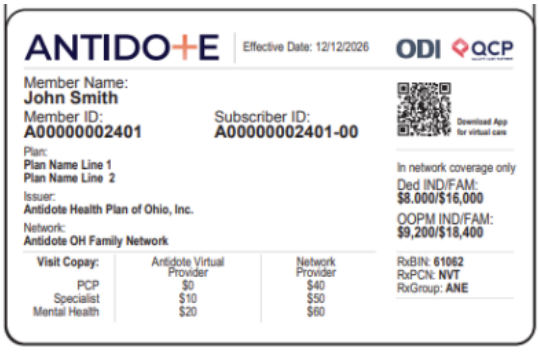
AZ Marketplace Complete – Pinal Only

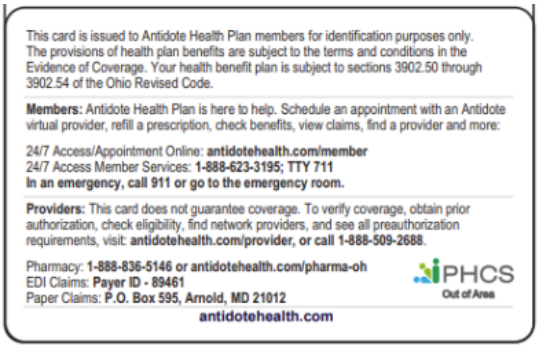
AZ Catastrophic

Sample IDs - Ohio

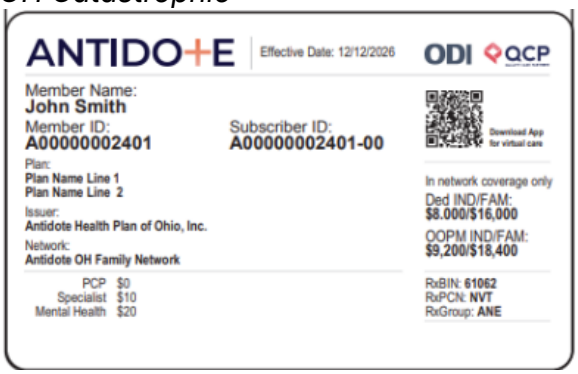
OH Complete-Elite

OH Standard





OH Catastrophic



OH Standard

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

Verification is available by calling Provider Services at **1-888-509-2688.** Representatives will require the member's name or ID number and date of birth.

Importance of Verifying Member Benefits, Eligibility, and Cost Share

To accurately collect coinsurance, copayments, and deductibles, providers must understand the member's benefit design. Cost-sharing amounts vary by plan and must be collected at the time of service. The provider portal offers real-time access to this information.

Premium Grace Periods

Antidote complies with ACA provisions regarding premium grace periods:

- Members receiving Advance Premium Tax Credits (APTCs) are allowed a 90-day grace period before coverage is terminated.
- Members not receiving APTCs have a 31-day grace period.

Eligibility and Enrollment

Eligibility is determined by the Health Insurance Marketplace Enrollment Entity. Members must reside in the service area and meet enrollment criteria. Dependents may be added through qualifying events such as birth, adoption, or marriage. Coverage begins on the effective date specified by the enrollment entity and upon receipt of premium payment.

- Eligibility and benefits are provided without regard to race, color, national origin, sex, age, or disability, in accordance with federal and state law.
- Special Enrollment Periods (SEPs) allow members to enroll outside of open enrollment due to qualifying life events. SEPs are administered in accordance with CMS and state Marketplace rules. These include loss of coverage, birth or adoption of a child, marriage, or relocation.

Members have 60 days to report the event and enroll.

Cost Share Components

Antidote plans include the following cost-sharing elements:

- **Deductibles:** Members must meet the deductible before Antidote pays for covered services. Individual and family deductibles apply. Once the family deductible is met, no further deductible is required for any member for the remainder of the plan year.
- **Copayments:** Fixed dollar amounts paid by the member at the time of service. These may vary by service type and are listed in the Schedule of Benefits. For specific copayment and coinsurance amounts, refer to the member's Schedule of Benefits.
- **Coinsurance:** A percentage of the allowed amount for covered services that the member must pay after the deductible is met. Antidote pays the remaining percentage.
- **Maximum Out-of-Pocket (MOOP):** The total amount a member must pay in a plan year for covered services. Once the MOOP is reached, Antidote pays 100% of covered services for the remainder of the year. MOOP excludes premiums and non-covered services.

Covered Services

Antidote Health Plan provides coverage for a broad range of medically necessary services across all product tiers. Covered services must be rendered by in-network providers unless otherwise authorized and must meet applicable clinical criteria, utilization review standards, and regulatory requirements.

Providers are responsible for verifying benefit eligibility and obtaining prior authorization where required. Please refer to our website and the "Medical Management and Prior Authorization" section of this manual for more information about clinical determinations and prior authorization procedures.

Benefit Limits

Most benefit limits for services and procedures follow state and federal guidelines and are based on a calendar year (January through December). Limits may apply to services such as therapy visits, diagnostic procedures, or habilitative treatments. Providers must verify whether a member has exhausted benefit limits before rendering services by contacting Provider Services at **1-888-509-2688.**

Preventive Services

Preventive care services are covered in accordance with the Affordable Care Act (ACA) and are exempt from cost-sharing when provided by in-network providers.

These services include:

- USPSTF "A" and "B" rated services: Evidence-based screenings and interventions for adults and children.
- Immunizations: Recommended by the Advisory Committee on Immunization Practices (ACIP) for all age groups.
- Health Resources and Services Administration-recommended screenings:
    - For infants, children, and adolescents: developmental screenings, autism assessments, vision and hearing tests, lead and iron deficiency screenings, and immunizations.
    - For women: cervical cancer screening, BRCA counseling, gestational diabetes screening, breastfeeding support, and contraceptive counseling.
- Tobacco cessation: Includes up to two cessation attempts per year, four counseling sessions per attempt, and FDA-approved medications without prior authorization.
- Breastfeeding support: Includes one breast pump per pregnancy and lactation counseling.
- Wellness visits: Annual exams and screenings to maintain health and prevent disease.

NOTE: The complete list of recommendations and guidelines can be found at: **www.healthcare.gov/preventive-care-benefits**

Preventive services must be billed with appropriate diagnosis and procedure codes to qualify for full coverage. If non-preventive services are rendered during a preventive visit, applicable copayments, coinsurance, and deductibles may apply. For a listing of services that are covered at 100% and associated preventive benefits, visit **www.antidotehealth.com/provider.**

Notification of Pregnancy

Notify Antidote as early as possible when a member is pregnant for care coordination. No prior authorization is required for routine labor and delivery. Authorization may be required for inpatient stays that extend beyond 48 hours (vaginal) or 96 hours (cesarean) due to clinical need. Postpartum follow-up is based on clinical indication and may include maternal/newborn assessment, feeding support, and newborn screening.

Notification of Surrogacy

Providers should notify Antidote if a member is involved in a surrogacy arrangement. All pregnancy-related services provided to a surrogate mother are excluded from coverage, including delivery, hospitalization, and newborn care. This applies to both covered and non-covered individuals serving as surrogates.

Adding a Newborn or Adopted Child

Coverage for newborns and adopted children begins at birth or placement, respectively, provided the child is enrolled within the timeframe specified in the member's EOC.

For adopted children, birth-related expenses may be covered if:

- The child is legally adopted within one year of birth.
- The member is legally obligated to pay for the birth.
- Notification is made within 60 days of adoption approval.

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 is required before evaluation and surgery.

Transplant services must meet medical necessity criteria and may include:

- Pre-transplant evaluations
- Organ procurement
- Post-transplant care

Claims submission rules 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.

Non-Covered Services

The following services are not covered under Antidote plans:

- Surrogacy-related services for both covered and non-covered individuals
- Cosmetic procedures (unless medically necessary)
- Reversal of sterilization
- Non-therapeutic abortion
- Experimental or investigational treatments
- Alternative therapies (e.g., acupuncture, massage, aromatherapy)
- Services rendered outside the U.S. (except emergency care)
- Educational, custodial, or domiciliary care
- Bariatric surgery (unless medically necessary and preauthorized)
- Eye surgery for refractive errors (e.g., LASIK)
- Dental services not listed as covered
- Services not ordered by a physician or not medically necessary
- Services performed by immediate family members
- Services provided free of charge or for which the member has no financial obligation

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.

Medical Management

Antidote Health's Medical Management program is a coordinated, evidence-based approach to ensure members receive medically necessary, timely and cost-effective care. This program is administered by Quality Care Partners (QCP).

The program integrates:

1. Utilization Management (UM)
2. Care Management (CM)
3. Health Management (HM)
4. Behavioral Health Management

These processes support appropriate use of services, improved health outcomes and a better provider and member experience. If a state, federal or contract requirement is more stringent than what is described in this section, Antidote will follow the stricter requirement.

Utilization Management (UM)

The UM Program ensures that medical and behavioral health services provided to members are:

- Medically necessary,
- Provided in the most appropriate setting,
- Consistent with recognized standards of care, and
- Delivered in a timely manner.

UM activities include prior authorization (precertification), concurrent review and retrospective review. Antidote Health does not use financial incentives to encourage denials or underutilization. There are no rewards tied to issuing adverse determinations.

UM Criteria Availability

Antidote Health makes its UM decision-making criteria available to all contracted and non-contracted practitioners upon request. Criteria may be requested by phone, mail, fax or email and will be mailed if electronic methods are not available.

- Medical Management Department: delegated to Quality Care Partners (QCP). Call 888-509-2688, option 4.

Practitioners may also request the specific criteria used for a particular determination or speak with an Antidote physician or other appropriate reviewer. A Care Manager may assist in coordinating these discussions.

Clinical Review and Adverse Determinations

All potential adverse determinations are reviewed by the Chief Medical Officer or another licensed health care professional with the appropriate clinical expertise for the condition under review. Decisions are based on nationally accepted standards of medical practice and may take into account the member's individual clinical circumstances when those circumstances are not fully addressed in written criteria.

UM Decision Timeframes

Antidote strives to meet or exceed federal on/off exchange requirements. Antidote may apply shorter (stricter) timeframes than the federal minimums.

Review Type	Determination Timeframe	Notification Timeframe
Urgent (expedited) prior authorization	As soon as possible, plan standard is ≤ 48 hours of receipt*	Within the same 48-hour period
Standard (non-urgent) prior authorization	Within 7 calendar days of receipt*	Within 7 calendar days
Concurrent review (inpatient/ongoing care)	Urgent: within 24 hours of receipt of needed clinicals; otherwise within 72 hours	Same as determination
Post-service (retrospective) review	Within 30 calendar days of receipt	Within 5 business days

*If state or federal requirements differ, Antidote will follow applicable law. When multiple standards apply to the same request, Antidote will apply the shorter (more stringent) decision timeframe, unless a provider agreement or regulatory requirement specifies otherwise.

Concurrent Review (Inpatient/Ongoing Care)

Concurrent review is the ongoing evaluation of medical necessity, level of care and discharge planning while a member is in an inpatient or other facility-based setting. The purpose is to ensure that continued services remain appropriate and that the member is transitioned to the most appropriate setting when clinically indicated.

Process

- Antidote requests clinical updates from the facility at intervals based on the member's condition, the applicable clinical criteria and regulatory requirements.
- Continued stay decisions are made using nationally accepted criteria and the member's current clinical status.
- Discharge planning is addressed early and updated throughout the stay.
- When clinical information is insufficient, Antidote will request additional information and give the facility an opportunity to supply it.

Timeframes

- Urgent/acute continued stay: determination as soon as the needed clinical information is received, generally within 24 hours, and no later than 72 hours.
- Notification to the facility occurs at the same time as the determination.

Adverse decisions

- Any potential denial or reduction in services is reviewed by a physician or other appropriate licensed health care professional.
- The facility and attending provider may speak with the Antidote reviewer to discuss the case and provide additional information.

Appeals

Antidote offers both expedited and standard appeals. All medical necessity appeals are reviewed by licensed health professionals in accordance with applicable state requirements and NCQA standards.

- Ohio: A health care professional may appeal on the member's behalf with the member's consent.
- Arizona: A health care professional may appeal on the member's behalf without the member's consent.

Appeals may be requested verbally, electronically, or in writing.

Phone	740-455-5199
Fax	740-455- 8817
Mail medical necessity appeals to:	Antidote Health Plan Attn: QCP Appeals and Grievances Department 434 Main Street FL 3 Zanesville, OH 43701

Prior Authorization (PA) Requirements

Certain elective and scheduled services require prior authorization before they are rendered.

Failure to obtain PA when required will result in denial of coverage and denial of associated claims.

- The facility and the rendering provider are responsible for verifying PA requirements and obtaining authorization for all inpatient services and selected outpatient services, except for emergency stabilization services.
- Services that are ancillary to an approved admission or procedure (such as anesthesiology, pathology, radiology or hospitalist services) are considered dependent on the original authorization and generally do not require a separate PA.
- The most current PA requirements are posted on the Antidote Provider Portal and take precedence over the manual.

The list of services requiring PA is subject to change. **2026 PA Guidelines** are available at **https://www.antidotehealth.com/providers** under "Provider Resources."

Prior Authorization Grid (Representative)

The services below require prior authorization. This list is a summary and is subject to change. Providers must verify current requirements on the Antidote Provider Portal or by contacting QCP Medical Management Department at **740-455-5199.**

Category of Service	Requires Prior Authorization For
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 Professional E/M services in hospital, observation, and ED settings, and routine outpatient psychotherapy (90791, 90792, 90832–90840) do not require prior authorization. Authorization applies to the facility level of care (e.g., inpatient psych, PHP, IOP) and to designated behavioral health procedures per policy.
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	Equipment > $500
Experimental/ Investigational	• 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	Requires Prior Authorization For
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 (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	• 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 (see Appendix A) and Counseling • 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 • Reconstructive Procedures • Sleep Studies • 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

Category of Service	Requires Prior Authorization For
Post Stabilization	• Inpatient Admission following Stabilization of an Emergency Condition
Prescription Medications	• Refer to the Antidote Health Formulary available at: **https://www.antidotehealth.com/insurance/formulary-info** to determine which prescription medications require Prior Authorization. For information on requesting formulary exception, please refer to the 'Formulary Exception Process" subsection in the Pharmacy Section of this manual.
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

Provider Submission Timeframes

These timeframes support timely review and care coordination. If a state, federal or contract requirement is more stringent, the stricter requirement applies.

Service Type	Provider Action/Required Timeframe
Scheduled (elective) inpatient admissions	Submit PA at least 5 days before the scheduled admission
Elective outpatient services/procedures	Submit PA at least 10 days before the service date
Emergent inpatient admissions	Notify the plan within 1 business day of admission. Emergency services are not delayed for PA.
Observation ≤ 48 hours (non-par providers)	Notify Antidote within 24 hours
Service Type	**Provider Action/Required Timeframe**
Observation > 48 hours	If member remains in observation >48 hours, submit/convert to inpatient PA by the next business day.
Maternity admissions (Routine Delivery)	Notify within 1 day after delivery. PA is not required for routine vaginal or C-section delivery, but notification supports newborn linkage.
Newborn admissions	Notify within 1 day and submit clinicals/PA if the newborn requires an ongoing inpatient or NICU level of care.
NICU admissions	Notify within 1 day and submit clinical documentation for concurrent review
Outpatient dialysis	Notify Antidote within 1 day of initiation
Organ transplant initial evaluation	Submit PA at least 30 days before the evaluation
Clinical trial services	Submit PA at least 30 days before services begin

Submission Process

Preferred method:
PA request forms are available at **www.antidotehealth.com/provider** under "Provider Resources." For registration or training, contact Provider Services at **1-888-509-2688**.

Required information:

- Member name, date of birth, Antidote member ID
- Rendering/billing provider NPI and tax ID, and contact information
- Procedure/CPT/HCPCS codes and clinical rationale
- Admission/surgery/service date
- Discharge plans, if known
- For OB: delivery method and newborn details, if applicable

Code changes:
If the services performed differ from the services authorized, notify Medical Management at **1-888-509-2688** within 72 hours or before a claim submission so the authorization can be updated. Failure to notify may result in claim denial.

Emergency Admissions Notification

For admissions that occur following an emergency room visit, the hospital must notify Antidote Health of the admission within 1 business day, unless a shorter or different timeframe is specified in the provider agreement or required by state regulation.

Second Opinions

Members, or a treating provider with the member's consent, may request a second opinion from an in-network qualified practitioner. If an appropriate practitioner is not available in network, Antidote may authorize an out-of-network second opinion with prior authorization from Utilization Management.

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 (e.g., 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).

In the event authorization was not requested prior to services being rendered, a retrospective or post-service claim denial review may be requested by submitting a Provider Dispute Form. Requests for retrospective review must be submitted within 30 days of the date of Antidote's claim denial.

The Provider Dispute Form is available at **www.antidotehealth.com/providers** in the under "Provider Resources" or by calling Antidote Provider Services at **1-888-509-2688**.

Complete the form in its entirety. In the section entitled "Dispute Type" indicate that a retrospective/post-service authorization/claim denial review is requested. Include relevant clinical documentation and a description of the extenuating circumstances to enable Antidote to promptly respond to the dispute.

Submit the completed Provider Dispute Form with the supporting documentation to:

Antidote Health Plan
Attn: Claim Disputes Department
P.O. Box 24082
Newark, NJ 07101

Forms may also be faxed to: **1-888-396-8939.**

After a thorough review of the documentation submitted with the dispute, a formal written notice of Antidote's final determination will be mailed. Antidote's decision is final.

It is important to note that state regulations bar providers from balance billing members for services denied by the health plan, including those services denied due to a provider's failure to obtain a prior authorization. A post-service denial is based on a failure to meet contractually agreed upon utilization management program requirements. A provider's failure to obtain an authorization in advance of services being rendered does not make the services non-covered and thereby subject to financial liability by the Antidote member.

Emergency Care

Emergency services do not require prior authorization.

Definition:
Emergency care is care for a sudden and unexpected condition that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect to result in:

- Placing the member's health (or the health of an unborn child) in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part.

Admissions following emergency department care must be reported to Antidote within 48 hours or the next business day, unless a different timeframe is specified in the provider agreement.

Care Management

Antidote Health operates a Care Management program to help members with complex, high-risk or high-cost needs get the right services at the right time. The program is member-centered and focuses on assessment, planning, coordination and follow-up to support safe, cost-effective care.

PCPs are expected to coordinate and triage urgent, ongoing and routine needs within required timeframes, including those established under Ohio regulations.

Program objectives:

- Promote wellness, prevention and improved quality of life.
- Increase access to comprehensive and culturally responsive services.
- Educate members, families and caregivers about conditions, benefits and available resources.
- Reduce fragmentation of care and support safe transitions.
- Reduce preventable utilization such as avoidable ED visits and hospital readmissions.
- Improve communication among members, caregivers, providers and Antidote.
- Improve member and provider satisfaction.

Care Manager activities may include:

- Monitoring and supporting adherence to individualized care plans.
- Coordinating with PCPs, specialists, facilities and behavioral health providers.
- Initiating referrals and linking members to community and social services.
- Notifying providers when members need additional services or are not engaging in recommended care.

Eligibility and Referral Sources

Members may be identified for Care Management through:

- internal sources (UM/medical management, inpatient/ED census, transition-of-care reports, risk stratification tools),
- external referrals (providers, facilities, community agencies, caregivers), and
- member or caregiver self-referral.

All referrals are reviewed by Care Management to confirm eligibility and determine the appropriate level of service.

To refer a member, providers may:

- Call 1-888-258-7621, or
- Submit a **Care Management Referral Form**, available at **www.antidotehealth.com/providers.**

Conditions Appropriate for Care Management Referral

Medical/Behavioral Health Conditions	Utilization, Adherence or Social Triggers
• Substance use disorder/addiction • Asthma or other chronic pulmonary conditions • Cancer • CHF, COPD or chronic renal failure • Diabetes, including members receiving dialysis • Eating disorders • End-of-life or palliative care needs • Significant functional limitations or disability • Cardiac/heart disease • At-risk or high-risk pregnancies • Transplant candidates or post-transplant members • Behavioral health conditions that affect treatment adherence or safety	• Medication nonadherence/noncompliance • Multiple or avoidable ED or inpatient admissions • Missed or frequent no-show/follow-up appointments • Recent discharge from inpatient, SNF, rehab or other post-acute settings • Social isolation or unstable/unsafe housing • Unemployment or other significant psychosocial stressors • Older adults or members with special needs who require coordination • Members seeking or receiving gender-affirming services who would benefit from coordination

Providers may refer any member they believe would benefit from additional assessment, coordination or linkage to community resources.

Complex Care Management (CCM)

Complex Care Management is available for members with the highest level of medical, behavioral or social risk, such as multiple comorbidities, frequent hospitalizations or significant barriers to care.

Members may be referred to CCM through internal sources, treating practitioners, facilities/discharge planners or self-referral. Antidote informs members and providers of CCM referral options at least annually and when processes change.
Eligible members are contacted and offered enrollment. Members may decline services at any time.

- **CCM Referrals: https://www.antidotehealth.com/providers**
- **CCM Phone Referral:** 1-888-258-7621

Health Management

Antidote Health offers Health Management services for members with chronic or emerging conditions.

The program:

- supports the member–provider relationship,
- emphasizes prevention of exacerbation and complications,
- uses evidence-based practice guidelines, and
- monitors outcomes to improve clinical, functional and cost results.

Health Information Survey

At enrollment, members are encouraged to complete the Health Information Survey through their online account at **https://www.antidotehealth.com**. The survey helps identify health risks and service needs so outreach and educational materials can be targeted.

MVP Rewards Program

Antidote's MVP Rewards Program encourages members to use preventive services by offering rewards for completing certain activities, such as:

- completing the Health Information Survey, and
- receiving an annual wellness exam.

Program terms and eligible activities are subject to change and are posted in member materials.

Appendix I: Genetic and Molecular Testing Requiring Prior Authorization

Certain genetic, molecular and proprietary laboratory tests require prior authorization (PA) due to clinical complexity, cost or plan policy. Providers must obtain PA before the test is performed. Coverage is subject to the member's benefits and applicable medical necessity criteria.

Because CPT/PLA codes and test panels change frequently, providers should confirm current PA requirements on the Antidote Provider Portal or by contacting Medical Management. Unlisted or novel codes (for example, 81479 or 0345U) must be submitted with supporting clinical documentation.

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).

CPT Code	CPT Description
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 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.
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.
0345U	a proprietary laboratory analysis of 15 genes to help guide the management of mental health conditions

Appendix II: Services Not Requiring Prior Authorization

The services listed in this appendix are generally exempt from PA when:

1. Billed by a participating provider,
2. Covered under the member's benefit plan, and
3. Within benefit limits.

This list is a summary and subject to change. Providers should confirm requirements on the Provider Portal if there is any uncertainty.

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
Routine Services	Routine Laboratory Tests (except Genetic Tests reflected on Appendix I) Ultrasound (except for Ultrasounds - Level II or Greater than Two Ultrasounds per Pregnancy)
Testing	Fetal Non-stress Testing HIV Testing
Transportation	Emergency Medical Transportation
Urgent Care	Telehealth for Urgent Care Services
Other	Family Planning Services

Risk Adjustment and Correct Coding

Risk adjustment is a foundational component of the Affordable Care Act (ACA), designed to promote equity and sustainability across the Health Insurance Marketplace.

Whether operating on-or-off-Exchange, Antidote relies on accurate risk adjustment to ensure appropriate resource allocation and regulatory compliance.

To support this, providers must adhere to the following documentation and coding standards:

- Code to the highest level of specificity: Assign the most precise ICD-10-CM diagnosis codes that fully reflect the member's condition(s) as documented in the medical record.
- Ensure documentation integrity: Medical records must be clear, concise, consistent, complete, legible, and compliant with CMS signature requirements. Timely and complete claims submission:
- Submit all claims with accurate and complete data to avoid delays or retrospective chart reviews.
- Respond to medical record requests: Provide requested documentation to Antidote or its designated vendor promptly.
- Educate coding staff: Ensure all coding personnel understand the importance of correct coding practices and their impact on risk adjustment.

Accurate and thorough coding is essential to Antidote's ability to manage member care effectively and meet Risk Adjustment Data Validation (RADV) audit standards. Incomplete or inaccurate claims may trigger retrospective reviews and impact reimbursement.

Pharmacy

Antidote Health Plan offers pharmacy benefits that vary by member plan.

Providers are encouraged to verify a member's specific pharmacy coverage at **antidotehealth.com/pharma**

Additional pharmacy-related resources are available on the Antidote website, including:

- The Antidote Formulary (Medication List)
- Retail pharmacy locator
- Mail order pharmacy services
- Prior Authorization/Formulary Exception Request forms

Antidote Formulary Overview

The Antidote Formulary is a clinical and cost-effective guide to assist contracted prescribers in selecting appropriate medications.

It includes:

- A comprehensive list of covered drugs, including any applicable restrictions, prior authorization requirements, and limitations
- Pharmacy management program requirements and procedures
- Information on quantity limits and dosage quotas
- Step-by-step instructions for submitting formulary exception or prior authorization requests
- Policies on generic substitution, therapeutic interchange, and step therapy protocols

The formulary is reviewed and updated regularly. Prescribing providers and members are notified of changes at least annually and when significant updates occur. Negative formulary changes (e.g., drug removals or added restrictions) are communicated directly to affected providers.

Prescriber Responsibilities

Prescribers are expected to:

- Use the Antidote Formulary as a reference when prescribing medications
- Submit prior authorization or formulary exception requests when required
- Stay informed of formulary updates and pharmaceutical management procedures
- Exercise professional judgment in all prescribing decisions

The formulary does not:

- Mandate or prohibit the prescribing or dispensing of any medication
- Replace the clinical judgment of the provider or pharmacist
- Relieve providers of their professional obligations to members

Prior Authorization for Medications

Certain medications require prior authorization before dispensing.

These include:

- Infusion services
- Injections (excluding immunizations)
- Non-formulary prescription drugs
- Physician-administered drugs (PADS)

To determine if a medication requires prior authorization, consult the Antidote Formulary or contact the Utilization Management Department. Providers may submit requests via the online Authorization Request Form or by contacting Provider Services.

Formulary Exception Process (Arizona & Ohio)

Providers and members in Arizona and Ohio may request a formulary exception for a non-formulary drug or to waive a utilization management requirement (such as step therapy, prior authorization, or quantity limits). Exception requests may be submitted using the Medication Request Form, and fax.

The request must include clinical documentation supporting the medical necessity of the non-formulary drug, including evidence of failure, contraindication, or intolerance to formulary alternatives.

Standard exception requests will be reviewed and a decision provided within 72 hours. Expedited requests, for urgent medical needs, will be reviewed and a decision provided within 24 hours. If an exception request is denied, providers and members may appeal the decision. If the appeal is denied, the case may be submitted for external review by an independent review organization, whose decision is binding.

In Arizona, if a member is renewing coverage and has been previously approved for a non-formulary drug, the exception will be granted if the provider certifies that formulary alternatives are not appropriate and the member has had a positive outcome on the requested drug. In both states, the process is compliant with all applicable state and federal requirements.

Member Rights and Responsibilities

Member Rights

- To receive information about Antidote Health Plan, its services, practitioners, providers, and member rights and responsibilities.
- To be treated with respect and recognition of dignity and privacy.
- To be treated with respect and recognition of dignity and privacy, and to be free from any restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- 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 make recommendations regarding the organization's Member Rights and Responsibilities Policy and participate in advisory committees or feedback forums to influence policy and governance.
- To have access to a current list of Network Providers, including information on education, training, practice, and any provider incentive plans that may affect referral services.
- To receive information in alternative formats in compliance with the Americans with Disabilities Act.
- To receive information in alternative formats in compliance with the Americans with Disabilities Act, including Braille, large print, audio, and other formats as needed.
- To know the name and job title of people providing care.
- To a second opinion by a network physician at no cost.
- To privacy of personal health information, consistent with state and federal laws and Antidote policies.
- To privacy of personal health information, consistent with state and federal laws and Antidote policies, and to request access to their medical records annually at no cost. Requests will be fulfilled within 30 days, or a written denial will be provided within 60 days.
- To adequate access to qualified medical practitioners and services regardless of age, race, creed, sex, sexual orientation, national origin, or religion.
- To access interpreter services when language barriers exist.
- To access interpreter services for all languages at no cost, regardless of language barriers.
- 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
- To continuity of care during provider transitions when medically necessary.
- To authorization for out-of-network care when no qualified network provider is available.
- To appeal coverage rescissions and benefit denials through internal and external review processes.

Member Responsibilities

Note: Member rights and grievance procedures should be posted in all service locations and available upon request

- To follow agreed-upon treatment plans and provider instructions.
- To understand their health problems and participate in developing mutually agreed upon treatment goals.
- To treat all health care professionals and staff with courtesy and respect.
- To treat all health care professionals and staff with courtesy and respect, and to be protected from any form of abuse, neglect, or harassment.
- To establish and maintain a relationship with their assigned PCP and notify Antidote of changes.
- To establish and maintain a relationship with their assigned PCP and notify Antidote of changes. Members may designate and receive visitors and may withdraw or deny consent for visitors at any time.
- To use emergency services 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 provide information about other medical coverage at enrollment and when coverage changes.
- To pay monthly premiums, deductibles, copayments, and cost-sharing amounts at the time of service

Provider Rights and 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.

Third-Party Liability Rights

Arizona Providers

In accordance with Arizona law (A.R.S. § 33-931 et seq.), providers in the Antidote Health Plan network have the right to assert a medical lien for the reasonable and customary charges of care provided to a member who has suffered injuries due to the negligence or wrongful act of a third party.

This right allows providers to seek payment directly from any third-party settlement, judgment, or award obtained by the member, subject to the following conditions:

- The lien applies only to proceeds from third-party liability claims and does not attach to health insurance, medical payments coverage, or uninsured/underinsured motorist benefits.
- Providers must properly file the lien in accordance with Arizona statutory requirements, including timely recording in the county where services were rendered.
- One-third of any third-party recovery is exempt from lien enforcement unless the member and provider agree in writing to waive this protection.
- Any compromise or settlement of a lien must be fair and equitable to all parties, considering the nature of the member's injuries, customary charges, and the total amount recovered.
- Providers may not pursue direct collection from the member for amounts subject to a valid lien, except as permitted by law.

Antidote Health Plan supports providers in exercising these rights and will cooperate in providing necessary information to facilitate the lien process, consistent with applicable state and federal regulations.

Ohio Providers

Healthcare providers in Ohio may assert rights to recover the cost of medical services from third-party settlements or judgments when treating patients injured due to another party's negligence. These rights are governed by a combination of Ohio Revised Code (ORC) and Ohio Administrative Code (OAC) provisions.

Medical Liens in Personal Injury Cases:

- Providers such as hospitals, physicians, and rehabilitation centers may place medical liens on personal injury settlements or judgments to ensure reimbursement for services rendered.
- These liens are legal claims against the injured party's recovery and must be properly documented and filed.

Liens may be asserted by medical providers for unpaid bills, health insurance companies seeking reimbursement, Medicaid and Medicare programs, and child support enforcement agencies. Antidote Health Plan supports Ohio providers in exercising these rights and will cooperate in providing necessary information to facilitate the lien and recovery process, consistent with applicable state and federal regulations.

Providers Right to Review and Correct Credentialing Information

All healthcare providers and practitioners in our network have the right to review information Antidote obtains to evaluate your credentialing and/or recredentialing application. This includes data gathered from external 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, or other information protected by peer review.

Primary source verification for credentialing must be completed within 120 calendar days prior to the credentialing decision, in accordance with NCQA 2025 standards.

You also have the right to correct any erroneous information submitted by another party, excluding references, personal recommendations, or peer-review protected material. If information obtained from primary sources differs from what you submitted, Antidote will inform you. To request the release of such information, you must submit a written request.

Once you receive this information, you will have 30 days from the initial notification to provide a written explanation detailing the error or difference in information to our Credentialing Committee. The Credentialing Committee will then include this explanation as part of the credentialing or recredentialing process. We will document receipt of the corrected information in your credentialing file.

All updates to provider credentialing files will be documented and tracked to ensure information integrity and compliance with NCQA standards.

AZ Providers

In accordance with Arizona Revised Statutes SB 1291, Antidote Health Plan will complete credentialing within 60 calendar days of receiving a complete application.

Providers Right to Be Informed of Credentialing Application Status

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

Credentialing applications shall include optional questions regarding provider race, ethnicity, and language capabilities. Responses are voluntary and will not be used for discriminatory purposes.

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 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.

Providers Right to Appeal or Reconsider 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. Providers will be notified of credentialing and recredentialing decisions within 30 calendar days of the final determination.

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.

Claims

Antidote Health Plan requires providers to submit claims using the appropriate CMS billing forms: CMS 1500 for professional services and CMS 1450 (UB-04) for institutional services. All claims must comply with CMS billing requirements and HIPAA standards. Claims must be complete, accurate, and submitted within the designated timeframes to ensure timely adjudication and payment.

Verification Procedures

- Completion of all required fields on CMS 1500, CMS 1450, or EDI formats.
- Validation under CMS 5010 standards.
- Accurate member ID and date of birth matching.
- Inclusion of taxonomy codes.
- Valid diagnosis, procedure, modifier, and place of service codes.
- National Drug Code (NDC) entries when applicable.
- Present on Admission (POA) indicators for inpatient claims.
- Confirmation of member eligibility and provider authorization status.

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.

Clean vs. Non-Clean Claims

- **Clean Claim:** A claim submitted in the correct format with all required data elements, ready for adjudication without manual intervention.
- **Non-Clean Claim:** A claim missing required data or requiring additional information or manual review.

Rejections and Denials

- **Rejection:** A claim that fails initial system edits and is not entered into the adjudication system. No EOP is issued.
- **Denial:** A claim that passes edits but is denied due to billing errors or policy violations. An EOP is issued with denial reasons.

Timely Filing Requirements

Claim Type	Participating Providers	Non-Participating Providers
Initial Claims	180 days	90 days
Reconsiderations/Appeals	180 days	90 days
Coordination of Benefits (COB)	90 days from primary payer's EOP date	90 days from primary payer's EOP date

Note: Days are calculated from the date of service or discharge (for inpatient stays) to the date received by Antidote. The timely filing days set forth herein shall apply unless otherwise indicated in the provider's agreement.

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

Antidote supports ANSI X12N 837 transactions and 835 electronic remittance advice. Claims must be submitted via ClaimsBridge (AZ and OH).

Providers must monitor error reports and resubmit corrected claims promptly.

AZ Payer ID:	**OH Payer ID:**
IHS05	89461

Specific Data Record Requirements

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

Electronic Claim Flow Description and Important General Information

To send claims electronically to Antidote, follow the submission EDI address located on the Member's ID card. Antidote utilizes ClaimsBridge, Innovative Health Services for acceptance of claims from provider clearinghouse

Antidote will validate against 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.

Claim Acceptance and Processing
When claims are accepted, ClaimsBridge immediately returns an acceptance report to the sender and forwards the claims to Antidote for processing.

Eligibility Validation
Both ClaimsBridge and Antidote validate all forwarded claims against member eligibility records. Claims that meet eligibility requirements move to the claim processing queue.

Rejected Claims
Claims that fail eligibility validation are rejected daily by ClaimsBridge or Antidote and returned to the submitting party (either the intermediate EDI clearinghouse or the provider).

Provider Responsibilities
Providers are responsible for:

- Verifying EDI claim receipts daily
- Reviewing acceptance and rejection acknowledgements from ClaimsBridge
- Validating acknowledgements against their transmittal records

Important Notes

- Claims not accepted by ClaimsBridge are never transmitted to Antidote
- For help resolving submission issues, contact your clearinghouse or vendor's Customer Service Department
- Rejected claims may be resubmitted electronically after correction but must be submitted as original claims (not corrections).

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.

Rejected claims 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 to the address printed on the Member’s ID card:

- 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).

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

Claims Payment

Antidote uses ECHO to process electronic payments in September 2026. In addition, ECHO conducts Antidote's 1099 processing and reporting.

All Paper Checks and Mailed payments will no longer be supported. ECHO will support electronic payment systems (EPP) (e.g., Automated Clearinghouse (ACH), Electronic Funds Transfer (EFT), Virtual Card Payment (VCP)). Providers must log into the ECHO portal and select a payment method. Failure to do so results in a virtual card and a fee.

Read more about payment options and actions you need to take in this Echo bulletin: https://storage.googleapis.com/antidote-public-assets/dropbox/provider-echo-bulletin-september-2026.pdf.

Paper Claims Submission

Paper claims must be typed in Times New Roman (10 or 12 pt) on red CMS forms. Handwritten or black-and-white forms are rejected.

AZ Mailing Address

First-time and corrected claims	Disputes/Appeals
P.O. Box 155 Arnold, MD 21012	PO Box 24082 Newark, NJ 07101

OH Mailing Address

First-time and corrected claims	Disputes/Appeals
P.O. Box 595 Arnold, MD 21012	PO Box 24082 Newark, NJ 07101

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.

Corrected Claims, Reconsiderations, and 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.

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:	**For Arizona Paper Claim Submission**:
Antidote Health Plan of Ohio, Inc. P.O. Box 595 Arnold, MD 21012	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
PO Box 24082
Newark, NJ 07101

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 **www.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
PO Box 24082
Newark, NJ 07101

A claim dispute or appeal will be resolved within 30 calendar days of receipt. 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.

Refunds and Overpayments

Providers must report overpayments and may request offsets or submit refunds with documentation.

Refunds for Arizona and Ohio should be mailed to:

Antidote Health Plan
PO Box 24082
Newark, NJ 07101

Billing the Member

Providers may only bill members for:

- Copayments, coinsurance, and deductibles.
- Non-covered services with signed agreements.
- Missed appointments (documented).
- Services rendered during suspended status (with reconciliation if coverage resumes).

Balance billing is prohibited for covered services beyond member cost-share.

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.

Code Editing and Adjudication

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
- 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
- American Medical Association (CPT, HCPCS, and ICD-10 guidelines and publications)
- CMS coding resources such as National Physician Fee Schedule, Provider Benefit Manual, Medicare Learning Network®
- Antidote 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.
- Replace and Pay: Code editing recommends the denial of a service line, and a new line is added and paid. The original service line is left unchanged on the claim and a new line is added to reflect the software recommendations.

Claim Reconsiderations Related to Code 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.

Appendix III: Reimbursement Policies

Antidote Health Plan uses Medicare reimbursement methodologies and CMS guidelines as a reference for payment policy, except where superseded by applicable federal or state law, including but not limited to Arizona Revised Statutes (A.R.S.) and Ohio Revised Code (ORC), or by specific plan requirements. All reimbursement policies must comply with NCQA standards.

Admissions for Same or Related Diagnoses (30-Day Readmission Rule)

Inpatient admissions for the same or a related diagnosis occurring within 30 days following a discharge may be considered part of the previous admission and not separately reimbursable, but only when clinically related and not separately authorized. Each case will be reviewed based on medical necessity and authorization status.

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
Payment will be made to the appropriate billing provider based on service documentation, place of service, and rendering provider NPI, not billing order.

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.
- Payment will be made to the appropriate billing provider based on service documentation, place of service, and rendering provider NPI, not billing order.

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.

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.

Lesser Of Language
Antidote plan benefit is limited to the lesser of the provider’s billed charges or the contracted rate unless otherwise specified in the provider agreement between the applicable network and the provider.

Multiple Procedure Rules for Surgery and Endoscopic
Antidote applies the then standard CMS Multiple Procedure Payment Reduction to the practice expense (PE) portion of therapy services when more than one unit or procedure is billed for the same patient on the same day.

- Applies to physical therapy, occupational therapy, and speech therapy
- Applies to multiple units of the same timed code
- Applies to multiple different therapy codes
- Only the first (highest-valued) code is paid at 100% of PE
- All additional codes/units have reduced PE payment

Unless otherwise specified in your contract, Antidote applies the Medicare Ambulatory Surgical Center (ASC) Payment System or the Hospital Outpatient Prospective Payment System (OPPS) rules during the adjudication and payment process.

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

Unless otherwise specified in your contract**,** Antidote applies Multiple Procedure Payment Reductions (MPPR) to Ambulatory (Outpatient) radiology procedures. The Hospital Outpatient Prospective Payment System (OPPS) applies for radiology services performed in a hospital outpatient department.

For physician's offices, freestanding imaging or radiation oncology centers, or other non-hospital settings payment is made according to the Medicare Physician Fee Schedule (MPFS).

Multiple procedure radiology codes follow Multiple Procedure discount rules:

- 100%/50%/50%, max three radiology codes.
- Site/Place of Service (POS) differential is applied

Physician Site/Place of Service (POS)

Providers will be paid at the professional contracted 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)

Non-Physician Practitioner (NPP) Payment Rules
Unless otherwise specified in your contract, Antidote follows the then-current CMS payment rules applicable to each non-physician practitioner type.

Physician Assistant (PA) Payment Rules
Unless otherwise specified in your contract, Antidote follows the then-current CMS payment rules applicable to each non-physician practitioner type.

Provider-Based Billing

Clinic & Freestanding Clinic Facility Fees (Revenue Codes 51X & 52X)
Unless otherwise specified in your contract, services rendered in an office or clinic setting that do not require a facility level of care are reimbursed assuming that the associated professional services are global and inclusive of administrative, overhead, and routine clinic operating costs.

Non-Payable Revenue Code Series
51X – Clinic (e.g., 510 General, 511 Chronic Pain Center, 512 Dental, 513 Psychiatric, 514 OB/GYN, 515 Pediatric, 516 Urgent Care, 517 Family Practice, 519 Other)

52X – Freestanding Clinic (e.g., 520 General, 521 Rural Health Clinic, 523 Family Practice Clinic – Freestanding)

Rationale
Professional fee schedules for office/clinic sites account for use of space, staff, supplies, and other routine overhead. Separate facility fees for these encounters are bundled into the professional reimbursement and are not separately payable.

Exceptions
1. The setting is a CMS-recognized outpatient department or other facility that meets applicable provider-based and licensure requirements; and
2. The service requires documented facility-level equipment, monitoring, or staffing beyond a typical physician office; and
3. The provider is contracted as a facility and meets Antidote’s billing and documentation requirements.

Claims Processing & Denials
Claims or claim lines with RC 51X/52X that do not meet the exception criteria will be denied as not separately payable. All other covered, properly coded services on the claim will be adjudicated per yours participation agreement and applicable fee schedules.

Appeals Documentation
Appeals must include evidence that a facility level of care was required and that the site meets facility recognition/registration criteria (e.g., Hospital Outpatient Department registration, resources used, monitoring/recovery, equipment). Absence of such documentation will result in the original denial being upheld.

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.

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.

Durable Medical Equipment (DME) and Rental Items
Rental or purchase determinations will follow documented Medical Management criteria, applicable benefit plan language, and state notice requirements. Rental periods and ownership transitions are subject to member plan benefits, prior authorization, and applicable state notification requirements.

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.

For questions regarding reimbursement, providers may contact Antidote Provider Services at **1-800-509-2688.**

Third Party Liability

Third Party Liability (TPL) refers to any other health insurance plan or carrier—including individual, group, employer-related, self-insured, self-funded, commercial carriers, automobile insurance, and workers' compensation—that may be responsible for covering all or part of a member's health care expenses.

Antidote requires providers to:

- Identify and report TPL: Providers must notify Antidote when they become aware of any third-party coverage that may apply to a member's care.
- Claims must be submitted with appropriate coordination of benefits (COB) documentation when TPL is involved. Acceptable COB documentation includes the primary payer's Explanation of Benefits (EOB), Coordination of Benefits (COB) document, or other evidence of adjudication.
- Avoid duplicate billing: Providers must not bill Antidote for services already paid or payable by another carrier.
- Support subrogation efforts: Providers must cooperate with Antidote's efforts to recover costs from liable third parties when applicable.

Proper handling of TPL ensures compliance with regulatory requirements and supports accurate claims adjudication.

Cultural Competency

Antidote Health Plan is committed to the development, strengthening, and sustaining of healthy provider-member relationships. Members are entitled to dignified, appropriate care.

A provider's services must 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, signers, accessible transportation, and TDD/TTY services.
- Post nondiscrimination notices and language assistance taglines in lobbies and on websites. Language assistance taglines must reflect the top 15 languages utilized by members.
- Provide medical care with consideration of the member's 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.

- Develop treatment plans that reflect 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.
- Establish mechanisms to fulfill obligations under the Americans with Disabilities Act, including ensuring that all facilities providing services to members are accessible to persons with disabilities.
- 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, or physical or behavioral disabilities except where medically indicated.

Cultural Competency

- Facilitate access to cultural and linguistic services
- Provide care with consideration of members' race, ethnicity, language, and cultural background
- Participate in annual cultural competency training
- Develop treatment plans that reflect the member's cultural and personal context
- Ensure ADA compliance in all service settings

Language Services

In accordance with Title VI of the Civil Rights Act, Executive Order 13166, and Section 1557 of the 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.

Language services include:

- Telephonic interpretation
- Oral translation (reading of English material in a member's preferred language)
- American Sign Language
- Auxiliary aids including alternate formats such as large print and braille
- Written translations for materials critical to obtaining health insurance coverage and access to health care services in non-English prevalent languages

Providers may not:

- Require individuals with LEP to provide their own interpreter
- Rely on unqualified staff or minors to interpret or facilitate communication

Exceptions apply only in emergencies or when the member explicitly requests an accompanying adult to interpret. Providers must document any member denial of professional interpreters and the circumstances that resulted in the use of a minor or accompanying adult.

To obtain language services, providers should contact Antidote at least five business days before the appointment at **1-866-256-2134** or TTY 711.

Communication and Accessibility

Providers must:

- Offer qualified sign language interpreters and written materials in accessible formats (e.g., large print, audio, electronic).
- Ensure that all facilities are accessible to persons with disabilities.
- Avoid discriminatory practices in the delivery of services, including separate waiting rooms or delayed appointment times.

Antidote expects providers to treat all members equitably and to uphold the principles of dignity, respect, and inclusion in every aspect of care delivery.

Americans with Disabilities Act (ADA)

Antidote Health Plan is committed to providing equal access to quality health care and services that are physically and programmatically accessible for members living with disabilities. Providers are expected to establish policies and practices that ensure members with disabilities receive the same quality of care as other persons.

General Requirements

Providers must comply with the following:

- No qualified individual with a disability shall be excluded from participation in or denied the benefits of services, programs, or activities, or be subjected to discrimination.

Providers may not:

- Deny participation or benefits based on disability
- Provide unequal or ineffective services
- Aid discriminatory entities
- Use discriminatory criteria in site selection, procurement, licensing, or certification
- Impose surcharges for accessibility accommodations
- Exclude individuals due to association with someone who has a disability
- Providers must make reasonable modifications in policies, practices, or procedures when necessary to avoid discrimination unless such modifications would fundamentally alter the nature of the service.
- Providers must not apply eligibility criteria that screen out individuals with disabilities unless necessary for the provision of the service.
- Services must be administered in the most integrated setting appropriate to the needs of qualified individuals with disabilities.
- Providers must ensure their websites meet compliance with Section 508 Accessibility Standards.

Nondiscrimination, Civil Rights, and Cultural Competency

Antidote Health Plan and its providers are committed to ensuring that all members receive services without discrimination. No individual shall be excluded from participation in, denied the benefits of, or subjected to discrimination under any program or activity on the basis of race, color, national origin, sex, age, disability, gender identity, sexual orientation, religion, or any other protected status.

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 cesarean section.

The 48-hour (or 96-hour) period begins at the time of delivery, unless the delivery occurs outside of a hospital. In such cases, the period begins at the time of hospital admission. The attending provider may decide, after consulting with the mother, to discharge the mother and/or newborn earlier. However, the provider must not receive incentives or disincentives to discharge earlier than the federally protected time frames.

Billing the Member

Covered Services

Providers may only bill members for covered services under the following conditions:

- Cost-Sharing Obligations: Providers may collect copayments, coinsurance, and deductibles at the time of service. These amounts must align with the member's benefit plan and be verified prior to collection.
- Overpayment Reconciliation: If the amount collected from the member exceeds the adjudicated member responsibility (including copayments, coinsurance, deductibles, fee schedule adjustments, or retroactive changes), the provider must issue a refund within 45 calendar days of claim adjudication. Overpayment is defined as any amount collected from the member that exceeds the final member responsibility determined by Antidote after claim processing. If required by state law, interest may be owed on late refunds.

Suspended Member Status

Providers must verify member eligibility through the Provider Portal or by contacting Provider Services.

If a member is in suspended status, providers may:

- Decline to render services.
- Render services and collect payment but must submit a claim to Antidote.
- If the member reinstates coverage, Antidote will adjudicate the claim and the provider must reconcile any payment differences.
- If the member is terminated, providers may bill the member for the full billed charges.
- State and federal laws—including Arizona Revised Statutes § 20-1072, Ohio Revised Code § 3902.51, and the Federal No Surprises Act—limit or prohibit certain out-of-network providers from balance billing members for amounts beyond copayments, coinsurance, or deductibles, especially for emergency and certain covered services.

Non-Covered Services

Contracted providers may bill members for non-covered services only when a written agreement is signed by both the provider and the member prior to service.

The agreement must include:

- A detailed description of the service(s).
- A statement that the service is not covered by Antidote.
- A declaration that the member elects to receive and pay for the service.
- A clause stating the member is not responsible for payment if the service is later deemed covered and the provider failed to follow Antidote's requirements.

No-Show Charges
Providers may charge a reasonable and customary fee for missed appointments when the member fails to cancel in advance. The missed appointment must be documented in the medical record.

Authorization Failures
Providers may not bill members for services denied due to failure to obtain required prior authorization. This includes services rendered without approval when authorization was mandated by the plan.

No Balance Billing
Antidote's payment to providers, minus applicable member cost-sharing, constitutes payment in full. Providers may not bill members for the difference between billed charges and the contracted rate. This applies to all in-network providers and is reinforced by Arizona's "Hold Harmless" provision.

Interim Billing
Antidote does not accept interim billing for estimated monies owed to participating and out-of-network facilities. For inpatient hospital and skilled nursing stays, providers should submit a final bill after the member is discharged or the course of care is completed. Claims processing will begin upon receipt of the final bill. For stays spanning multiple months, providers may submit the final bill at the end of each continuous period of care or upon discharge, in accordance with standard industry practice and applicable state law. Interim bills submitted prior to discharge will not be processed.

Contact Information
For questions regarding billing policies or claims:

Provider Services	1-888-509-2688
Claims Submission Portal	https://www.antidotehealth.com/providers
Email Support	providers@antidotehealth.com
Mailing Address	Antidote Health Plan Provider Services Department PO Box 24082 Newark, NJ 07101

Complaint Process

Complaints and Grievances

A complaint or grievance is a verbal or written expression by a provider indicating dissatisfaction with Antidote's policies, procedures, or operations. All complaints are logged and tracked, whether received verbally or in writing.

Providers have 180 calendar days from the date of the incident (e.g., Explanation of Payment [EOP] date) to file a complaint or grievance. Antidote will conduct a full review and issue a written decision within 30 calendar days of receipt.

If the issue relates to claims payment, providers must first follow the claim reconsideration and claim dispute process outlined in the Claims section before submitting a complaint.

Provider Complaints or Grievances and Appeals

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
Attn: Claim Disputes Department
PO Box 24082
Newark, NJ 07101

Providers may invoke remedies outlined in their provider agreement.

Member Complaints or Grievances and Appeals

Members may file complaints or grievances regarding any aspect of care or service. The process is outlined in the member's Evidence of Coverage (EOC). EOC can be found on the Antidote website: **https://www.antidotehealth.com/plan-docs**

Members may:

- Contact Member Services at 1-888-623-3195
- File a formal complaint or grievance
- Appeal decisions as appropriate
- Designate a provider to act on their behalf in writing
- Request an external independent review

Antidote will resolve member appeals within 30 calendar days, or 72 hours for expedited cases. Extensions may be granted per regulatory guidelines.

Mailing Addresses

Medical Review/Utilization Management Decision Complaints and Appeals	Antidote Health Plan Attention: Appeals and Grievances Department 434 Main Street Zanesville, OH 43701
Claim Disputes, Benefit determinations, and Reconsiderations	Antidote Health Plan Attention: Claim Disputes Department PO Box 24082 Newark, NJ 07101

Fraud, Waste and Abuse (FWA)

Antidote Health Plan is committed to preventing, detecting, and resolving fraud, waste, and abuse (FWA) across all aspects of its operations. In collaboration with our Third Party Administrator, Solidarity Health Networks, we have developed a comprehensive FWA Program that aligns with applicable federal and state laws, including:

Federal False Claims Act (31 U.S.C. §§ 3729–3733): Prohibits knowingly submitting false claims for payment to the government, including making false records or statements, conspiring to defraud, or improperly avoiding payment obligations. Violations may result in significant civil penalties and treble damages.

Ohio Revised Code § 2913.40 – Medicaid Fraud: Prohibits providers from making false or misleading statements to obtain Medicaid reimbursement, charging unauthorized fees, or accepting kickbacks in connection with Medicaid services.

Arizona Revised Statutes § 20-466 et seq. – Insurance Fraud: Establishes a fraud unit within the Department of Insurance and Financial Institutions to investigate fraudulent acts against insurers. The statute empowers investigators with law enforcement authority and outlines procedures for evidence collection and confidentiality.
Providers are expected to comply fully with these laws and cooperate with any investigations or audits related to FWA. Failure to do so may result in disciplinary action, termination of provider agreements, and legal consequences.

Definition of Fraud, Waste, and Abuse (FWA)

- Fraud: An intentional act of deception, misrepresentation, or concealment to gain something of value.
- Waste: Overutilization of services or practices that result in unnecessary costs.
- Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, resulting in unnecessary costs or reimbursement for services not medically necessary.

Provider Responsibilities

Participating providers are required to:

- Comply with all applicable federal and state FWA laws and regulations.
- Cooperate fully with Antidote's FWA investigations, audits, and corrective actions.
- Maintain accurate and complete documentation to support all billed services.
- Respond promptly to requests for medical records or other documentation.
- Report suspected FWA activities involving members, providers, or employees.

Failure to comply may result in:

- Remedial education or training
- Enhanced utilization review Recovery of overpayments
- Termination of provider agreements
- Referral to law enforcement or regulatory agencies

Reporting Suspected FWA

Antidote encourages all providers, staff, and members to report suspected FWA. Reports may be made confidentially and anonymously 24/7 through the following channels:

Toll-Free Hotline	1-877-647-3335
Website	https://www.redflagreporting.com
Text	RFR to 234-231-9005
Fax	330-572-8146
Email	redflag@redflagreporting.com
Mail	Red Flag Reporting PO Box 4230, Akron, OH 44321

All reports are taken seriously and investigated thoroughly. Retaliation against individuals who report in good faith is strictly prohibited.

FWA Program Oversight

Antidote's Chief Legal and Compliance Officer holds ultimate responsibility for the FWA Program, including:

- Oversight of investigations and audits
- Implementation of corrective action plans
- Coordination with regulatory and law enforcement agencies
- Ensuring compliance with NCQA standards and CMS requirements

False Claims Act Compliance

Under the Federal False Claims Act, providers may be held liable for knowingly:

- Submitting false or fraudulent claims for payment
- Making false statements to obtain payment
- Concealing or avoiding obligations to pay the government

Violations may result in significant civil penalties, including treble damages and exclusion from federal healthcare programs. For more information, visit **http://www.cms.hhs.gov**

Quality Improvement

Quality Improvement Program

Antidote Health Plan is committed to improving the health of its members through a proactive, data-driven Quality Management (QM) Program. This program applies systematic methods for monitoring, analysis, evaluation, and improvement across all care and service domains. It encompasses preventive health, acute and chronic care, behavioral health, utilization, continuity and coordination of care, patient safety, and administrative services.

Quality Management Program Structure

The Antidote Board of Directors oversees the QM Program through various committees. The program addresses clinical care and service quality across all demographics, benefit packages, care settings, and provider types. It includes preventive, primary, specialty, acute, long-term, ancillary, and operational services.

The QM Program aims to:

- Enhance and improve quality of care
- Provide oversight for policies and protocols
- Offer guidelines for appropriateness of care and services

Quality Improvement Projects (QIPs)

Antidote maintains at least two QIPs at all times, one of which must address consumer safety or improved outcomes. QIPs are selected based on data analysis, stakeholder input, and performance gaps.

Each QIP includes:

- Measurable goals
- Projected timeframes
- Improvement strategies
- Baseline and follow-up performance measurements
- Documentation of changes
- Barrier analysis if goals are unmet

Key Performance Indicators (KPIs)

Antidote uses standardized, objective, and measurable KPIs to monitor performance. KPIs are reviewed monthly and reported quarterly to relevant committees. Corrective actions are initiated for performance issues.

Practitioner Involvement

All providers are encouraged to participate in quality improvement activities. This includes sharing performance data, participating in committees, and supporting initiatives. Primary care and behavioral health providers are encouraged to serve 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
- Primary Care Provider 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

Antidote adopts evidence-based preventive health guidelines from nationally recognized sources. These guidelines are reviewed annually and updated as needed. They are available online at **http://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.

NCQA and State Compliance

This section aligns with NCQA standards including QI 1–4, UM 4–6, CR 3–4, and QI 3. It supports accreditation goals and regulatory compliance through structured monitoring and improvement activities.

It also reflects Ohio Revised Code and Arizona Administrative Code requirements for quality oversight, preventive care, and member safety.

For assistance, contact Antidote Provider Services at **1-800-509-2688.**

Regulatory Matters

Antidote Health Plan is committed to full compliance with all applicable federal, state, and accreditation requirements. Participating providers are expected to understand and adhere to the regulatory provisions outlined below, which reflect mandates from the National Committee for Quality Assurance (NCQA), the Arizona Revised Statutes (A.R.S.), and the Ohio Revised Code (ORC).

Documentation Standards

Providers must maintain comprehensive, legible, and timely medical records that include:

- Evidence of preventive screenings and services per Antidote guidelines.
- Complete history and physical documentation relevant to the member's presenting complaint.
- Past medical history for members seen three or more times, including serious illnesses, surgeries, ER visits, and prenatal/birth history for pediatric members.
- Working diagnosis consistent with clinical findings.
- Treatment plans appropriate to the diagnosis, including prescribed therapies and medications.
- Documentation of prenatal and infant risk assessments.
- Signed and dated consent forms.
- Follow-up on unresolved issues from prior visits.
- Documentation of lab/imaging orders and follow-up on abnormal results.
- Referrals and outcomes from specialists and ancillary providers.
- Health education and counseling notes.
- Substance use history for members age 10 and older.
- Notation of missed appointments and follow-up plans.
- Evidence that care decisions do not place members at inappropriate risk.
- Documentation of advance directives offered to members age 18 and older.
- Protection of member confidentiality in accordance with HIPAA and 42 CFR Part 2

Access to Records and Audits

Subject to applicable privacy laws, providers must grant Antidote or its designated representatives access to medical records for audits, chart reviews, and quality assessments. On-site audits require a minimum of 30 business days' notice and must occur within 60 days of notification. Remote access may be requested for risk adjustment and quality reporting purposes. No fees shall be charged to Antidote for EMR access.

Medical Records Release and Transfer

Medical records may only be released with written authorization from the member or legal guardian. Releases must comply with federal and state laws, including HIPAA and 42 CFR Part 2. PCPs must document efforts to obtain historical records for newly assigned members. If records cannot be obtained, this must be noted in the member's chart.

Compliance with Federal and State Laws

Providers must comply with all applicable laws governing the release of sensitive information, including:

- Behavioral health and substance use disorder records (42 CFR Part 2).
- Communicable disease records.
- HIV-related information (A.R.S. § 20-448.01 and R20-6-1204).
- Emergency services access (A.R.S. § 20-2081).
- Freedom of choice in provider selection (A.R.S. § 20-841).
- Telemedicine standards (A.R.S. § 20-1057.13).
- Prompt payment of clean claims (A.R.S. § 20-3102).
- Continuity of care after provider termination or insolvency (A.R.S. § 20-1057.04, § 20-1074(B); ORC § 1751.13(C)(3)).
- Member hold harmless protections (A.R.S. § 20-1072; ORC § 1751.13(C)(2)).
- Non-discrimination in service delivery (ORC § 1751.13(C)(8)).

Regulatory Oversight and Provider Responsibilities

Providers must:

- Maintain professional liability insurance and notify Antidote of any changes (ORC § 1751.13(C)(7)).
- Cooperate with audits and investigations by Antidote and regulatory agencies.
- Ensure timely access to care and compliance with appointment availability standards (NCQA UM 5, QI 3).
- Participate in credentialing and recredentialing processes per NCQA CR 3–4 and state law.
- Protect member rights and confidentiality in all interactions.

For questions regarding regulatory compliance, providers may contact Antidote Provider Services at **1-800-509-2688**.

Appendix IV: Arizona Mandated 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:

A. Serious jeopardy to the Member's health, including mental health.
B. Serious impairment to a bodily function of the patient.
C. Serious dysfunction of any bodily organ or part of the Member.
D. 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.

A. 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.
B. 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:

A. 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.
B. 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.

C. For specialty care services from a Participating Practitioner, an appointment date within 60 days of the Member's request or sooner if medically necessary.
D. In-area urgent care services from a Participating Practitioner seven days per week.
E. Timely non-emergency inpatient care services from a Participating Provider.
F. 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 – 19 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 <u>Familial Relationships</u>. 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 V: Ohio Mandated 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)