Taro Health

Provider Manual

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Introduction to Taro Health

Taro Health (Taro Health, the Company, we, or our, as applicable) is a new carrier enrolling members offering ACA-compliant health insurance products for the individual and certain small group markets, available both on and off health exchanges.

Taro Health's mission is to provide affordable, high-quality, relationship-based health care. We are making thoughtful investments in an extraordinary primary care experience, developing processes to ensure provider empowerment, and building consumer-friendly technology to help guide our members to better outcomes and lower costs. By investing in and actively encouraging our members to engage with a primary care provider, we can help facilitate better health for our members.

Our Direct Primary Care (DPC) plan offerings are designed to provide and encourage increased utilization of primary care through an open access HMO structure, where the primary care provider (PCP) is typically a member's first point of contact for all health-related issues, but no referral is required to see a specialist. In our case, the PCP is specifically a local, community-based DPC provider who treats members with a style of care that promotes easy access to most healthcare needs built on trust and the doctor-patient relationship.

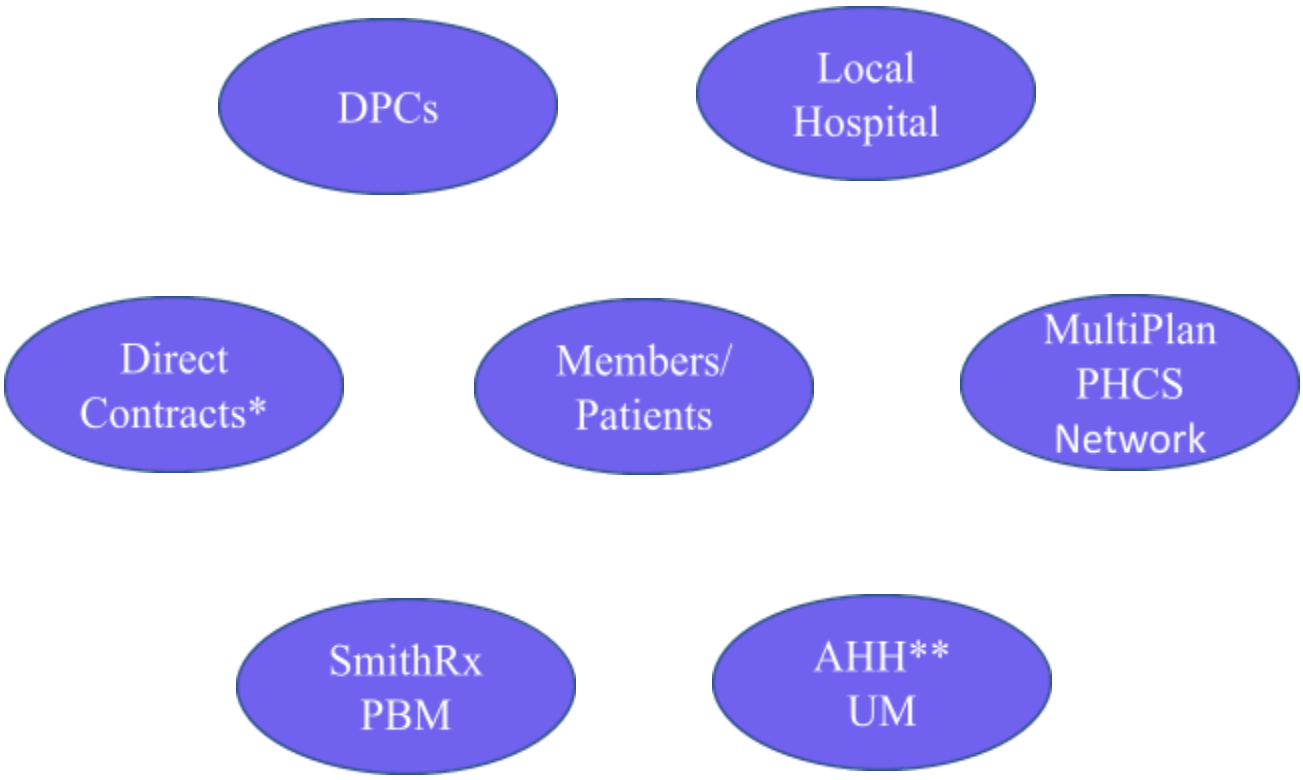
By simplifying and reducing the financial and administrative burdens of the traditional healthcare system for our members through the use of DPCs and other benefits, we will empower them to engage proactively in their healthcare needs. The DPC model, as opposed to traditional fee-for-service models, allows the DPC to build trusted relationships with their patients and become a natural navigator for additional care needed within the network. Therefore, we will not use a traditional gatekeeper model and require PCP referrals, as we anticipate that a member's active relationship and overall experience with their DPC will be welcomed and valued as a differentiated service.

Our DPC plan benefits feature:

- No cost for access to DPCs
- No copay for mental health visits
- No copay or low copay for preferred generic drugs
- Copays for specialists
- No cost or copays for lab services
- No cost or copays for x-rays and diagnostic imaging

The provider network structure surrounding our members to access care is summarized in the following diagram. It shows that we use the MultiPlan PHCS network for most of our specialists and free-standing facilities. We have direct contracts with local hospital systems where we operate for hospital and related services. The Company has certain directly contracted specialists and other providers complementary to the DPC network. More details on how to interact with our network partners is included in the following sections of the manual.

Taro Health Network Overview



* Providers that have signed contracts with Taro Health

** American Health Holdings

Use of MultiPlan PHCS Network

Taro Health has contracted with MultiPlan to access their Private Healthcare Systems (PHCS) network in the markets we operate in and nationally for emergent/ urgent care. Our members' ID cards display the MultiPlan PHCS logo. PCPs in the PHCS Network are excluded except for subscribers on our state and federal required plans.

MultiPlan maintains a provider portal and handbooks for professionals and facilities. MultiPlan's provider agreements refer to handbooks that provide detailed information covering a range of subjects such as reimbursement, credentialing and dispute resolution. You may also find it helpful to download a copy of MultiPlan's Quick Reference Guide, which gives answers to most service-related questions, and the Authorized Logo Guide.

MultiPlan Portal

https://www.multiplan.us/healthcare-providers

Pharmacy Benefits Manager

The Company uses SmithRx to manage our prescription drug benefits program including its drug formulary, utilization management (UM) programs including Step Therapy (ST) and Prior Authorization (PA), member cost reduction assistance and other related services. For further information you may contact SmithRx at (844) 512-3030. Their number is also on the back of your patient's ID card.

Taro Health has worked with SmithRx to manage requirements for coverage and limits for select prescription medications. These requirements and limits ensure that members use these medications in the most effective way. A team of practicing physicians and pharmacists developed these requirements and limits to help provide safe and quality coverage for our members. If you have any questions please contact SmithRx's Provider Help Desk at (844) 512-3030.

We encourage you to be proactive in determining whether the medications you are prescribing your Taro Health patients are subject to any of the following UM requirements. The Searchable Formulary Tool can be used to determine if the medication you are prescribing requires ST or PA. There are also printable files that identify medications requiring ST or PA.

Searchable Formulary Tool:

Maine Maine formulary

Oklahoma Oklahoma formula

Step Therapy

In some cases, SmithRx requires your patient to try another medication first to see if it has the desired outcome for their medical condition before another medication will be covered for that condition. For example, if Drug A and Drug B both treat your patient's medical condition, SmithRx may require the physician to prescribe Drug A first. If Drug A does not work as indicated, then coverage for Drug B will be authorized.

Prior Authorization

Certain medications require prior authorization which is noted in the formulary. As their physician, SmithRx requests that you go through the authorization process. SmithRx's Clinical Team reviews requests for these selected medications to help ensure appropriate and safe use of medications.

Prior Authorization Form:
https://s3.us-west-2.amazonaws.com/smithrx.com/docs/smithrx-prior-auth-form.pdf

Quantity Limits

For certain medications, SmithRx may limit the amount of the medication that will be covered per prescription or for a defined period. Amounts exceeding these limits will require additional review for coverage.

Appeal Process

SmithRx has an appeal process for physicians to request further review of a UM decision made on behalf of their patient. Please contact SmithRx's Provider Help Desk at (844) 512-3030 to begin an appeal. The appeal process uses the following levels of reviews:

- 1st level reviewed at SmithRx by clinical team
- 2nd level reviewed at SmithRx by clinical team
    - If denied, appeal determination is sent to Taro Health to determine if a 3rd level review is to be completed by an Independent Review Organization (IRO)
- 3rd level completed by IRO when requested by Taro Health

SmithRx Connect Program

SmithRx Connect can help patients and their doctors navigate DPC sources and support them throughout the process. As a result, patients will save money as many of these programs require little to no co-payment on their medication. SmithRx will also do most of the work!

Access Plus Program

Many high-cost specialty medications can be accessed through Patient Assistance Programs. SmithRx will help patients navigate through the process while reducing out-of-pocket costs on the medications that work for them.

International Sourcing

Our contracted network of international pharmacies helps members obtain medications at a lower cost. The international network dispenses select medications from first-tier countries to ensure product purity and safety. If a patient is using a medication that qualifies, our team can work with them on the potential to source their medication internationally.

Low Cost Insulin program

The Diabetes Low Cost Insulin Program helps lower the cost of insulin at the pharmacy. Switching to generic and biosimilar insulin products, provides cost savings to your patient. Humalog is a rapid-acting insulin and is available in the generic formulation, Insulin lispro. A long-acting insulin, Insulin glargine-yfgn is a biosimilar to, and interchangeable with Lantus.

The Mark Cuban Cost Plus Drug Company

The Mark Cuban Cost Plus Drug Company (Cost Plus Drugs) is now part of theSmithRx pharmacy network! This expands access to more affordable prescription drugs for SmithRx members. To look for drugs on which savings might be possible, visit CostPlusDrugs.

We are here to help

The SmithRx Member Support Team is dedicated to connecting patients and doctors with the tools and resources needed to lower their out-of-pocket costs for medications. We can answer questions and support patients and doctors throughout the process. Our goal is to simplify pharmacy benefits and connect patients to savings on their prescriptions.

For questions about the SmithRx Connect program call (844) 454-5201 or email connect@smithrx.com

Direct Contracting with Taro Health

Taro Health welcomes inquiries from professional and facility-based providers to join our direct contracted network. Please contact us at support@tarohealth.com. The criteria we use to contract with and to credential providers is summarized in the following sections.

Criteria for Participation in the Taro Health Network

Taro Health follows applicable state guidelines on credentialing. In addition to those state requirements, Taro Health has established criteria and the sources used to verify these criteria for evaluation and selection of practitioners for participation in the Taro Health network. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the Taro Health network.

To remain eligible for participation, practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Taro Health.

Taro Health reserves the right to exercise discretion in applying any criteria and to exclude practitioners who do not meet the criteria. Taro Health may, after considering the recommendations of the Credentials Committee, waive any of the requirements for network participation established pursuant to these policies for good cause if it is determined that such waiver is necessary to meet the needs of Taro Health and the community it serves. The refusal of Taro Health to waive any requirement shall not entitle any practitioner to a hearing or any other rights to review.

Practitioners must meet the following criteria to be eligible to participate in the Taro Health network. If the practitioner fails to provide proof of meeting these criteria, the credentialing application will be deemed incomplete, and it will result in an administrative denial or termination from the Taro Health network.

Application for Initial Credentialing

In order to bill Taro for services rendered to Our members, a provider must be credentialed by Taro in accordance with this Policy. By applying to Taro for credentialing, the applicant attests to the correctness and completeness of all information furnished and consents to inspection of any records and documents that may be material to an evaluation of his or her qualifications.

Directly Contracted Provider Requirements

Providers contracting directly with Taro must provide the following information, which will be verified through our credentialing process as applicable:

- Professional License
- Drug Enforcement Administration Registration Number (DEA)
- Board Certification
- National Provider Data Bank (for Malpractice History)
- Licensure Actions
- Sanctions (OIG, GSA/SAM, Medicare Opt Out, State)
- Valid Malpractice Insurance
- Education and Training
- Work History (confirmation of no gaps > 6 months)
- Disclosure Questions (confirmation of favorable answers or an explanation)

Credentialing Process

Taro Health follows the regulatory requirements of the states in which we operate to initially and subsequently recredential network providers. We use a third party form for the primary source verification process for both professional and facility-based providers. A summary of the process is as follows:

1. Taro Health requires primary source verification for all credentials in the preceding list.
    a. Directly contracted physicians will undergo primary source verification by providing their NPI.
    b. Our third party firm will be the Credentials Verification Organization (CVO) that will conduct primary source verification.
2. Once the practitioner goes through primary source verification via Taro Health CVO or via provider CVO (i.e., when the provider or group verifies all of their MDs/DOs/PAs/NPs for us), Taro Health will enroll the practitioner into the Taro Health network.
3. For those primary source verified providers and practitioners who do not go through the Taro Health CVO CertifyOS, Taro Health will identify the provider organization as delegated credentialing oversight and will utilize our third party firm to perform audits on the providers and practitioners who enroll with Taro Health.

Claims Submission, Appeals, Provider Call Center, and Portal

Claims Submission

Taro Health has retained Boon Chapman (Boon) to manage a provider call center, a portal for answering questions about claims status and related claims processing, among other services. Boon utilizes industry standard rules for editing claims coding and to determine whether additional information is needed to fully adjudicate and pay claims. Electronic payment is available if requested by providers.

Electronic submission of claims is the preferred method; however, paper claims may be submitted. For electronic submission, Boon uses Smart Data Solutions.

The electronic filing information to use is:

Taro Health Plan
EDI Payer ID: 74238

Paper claims submission address:

Taro Health Plan
PO Box 10110
Austin, TX 78766

Timely Filing of Claims

Providers should refer to their respective contracts for timely filing deadlines when submitting claims.

Unless a different timely filing deadline is specified in the contract, the timely filing deadlines for network and non-network providers to submit claims to Taro Health is 180 days from the date of service. If the medical service or treatment provided by the provider spans multiple dates (such as an inpatient stay), providers must submit claims to Taro Health within 180 days from the last date of service listed on the claim.

If a claim is not submitted within 180 days from the date of service, the claim will be denied as untimely and no reimbursement will be paid by Taro Health.

If additional information is required to adjudicate and pay a claim, Boon will deny the claim and indicate with denial codes what additional information is required. Their policy is to make a minimum of three attempts to obtain the information from the submitting provider. Information submitted timely will be considered.

The following are some of the most common reasons documentation may be required from a provider:

- Itemized Bill
  - Verify line item services for a UB claim. Usually this is required when all services were not authorized or if services may be questionable.
- Medical Records
  - Verify medical necessity of services when a prior authorization is not complete, or that American Health Holdings was not contacted to precertify a procedure (see following section for Utilization Management and Medical Policy.)
- Operative Report
  - Verify surgeon, assistant surgeon or co-surgeon and can also help identify the services and patient's condition at the time of the procedure.
- Corrected Billing
  - When invalid codes or missing information such as modifiers or inappropriate coding is identified by Boon's editing system.

Appeals of Claims Payment

If you believe a claim has been paid or denied in error, Boon has a process for you to follow to appeal the outcome of that claim.

For claims denied for a **Not Medically Necessary Procedure,** please submit those appeals to American Health Holdings as noted in the following Utilization Management and Medical Policy section.

Submit written appeals within 180 days from adverse benefit determination. Second level appeals must be submitted within 60 days from a first level appeal determination. Submit appeals to:

Taro Health Plan
PO Box 10110
Austin, TX 78766

Once the appeal letter has been received, Boon will:

- Within three business days, confirm receipt, address and phone #;
- Notify provider of delays in missing information needed to complete review of appeal;
- Make a decision within 30 business days of receipt of all necessary information and will include:
  - Statement of reviewer's understanding of appeal;
  - Reviewer's decision;
  - Criteria referenced in review determination; and
  - Notice of provider's rights.

For questions regarding the appeals process, or appeal status, contact Provider Services at: (833) 928-0574.

Provider Call Center and Portal

Boon has a provider services line as well as a portal hosted by Health*X*. The phone number for the provider services line is:

(833) 928-0574
Hours of operation are 8:00 AM to 5:30 PM CT

Link to provider portal
https://providerportal.tarohealth.com

Utilization Management and Medical Policy

Taro Health coordinates utilization management and the related medical policies with American Health Holdings (AHH). AHH uses Milliman Care Guidelines (MCG) which are an industry-leading, evidence-based comprehensive set of care guidelines. MCG assists with our precertification or prenotification process required for certain medical procedures and services. Evidence-based care guidelines from MCG help us to provide the right care in the right setting for the best health outcomes of your patients and our members. Those medical procedures or services requiring either precertification or prenotification are in Appendix A accompanying this manual.

We encourage you to call the AHH phone number, (833) 462-0088, on the back of your patient's ID card to speak with one of their representatives to ensure that the precertification or prenotification process is smooth, and there is no interruption in your patient's care.

Alternatively, you may use AHH's online system (www.getprecert.com) to provide the required information.

- No login account is required to use the site
- Data is secure and encrypted
- Simple, step-by-step process. Please have the following information available for entering:
    - Member identification number
    - Patient's full name, address, and phone number
    - Diagnosis code(s)
    - CPT codes (if applicable)
    - Admitting/ ordering physician's full name, address, phone number and tax ID
    - Facility name, address, phone number and tax ID
- AHH will review the request
- If more information is required, an Intake Coordinator will contact you to complete the case
- When a decision is reached, a Utilization Management nurse will contact you via fax

Outside of state regulations, Taro Health's standard turnaround time for an initial admission is 72 hours once a complete request is received, inpatient concurrent review is one day if clinical details are submitted greater than 24 hours prior to the expected discharge date or 72 hours if clinical details are received fewer than 24 hours of discharge date.

AHH offers a reconsideration or peer-to-peer review process for pre-service precertification if a non-certification determination is made on the initial review. The attending physician or ordering provider may provide additional information or speak with the Physician Reviewer who made the non-certification determination, they may request either Reconsideration by submitting additional clinical information or a Peer–to-Peer Discussion contact information to schedule provided in denial notice, but not within 10 business days of notification. Once this time has been exhausted, reviews will follow the appeals process.

Notification of Member Admission

AHH should be notified of a Taro Health member being admitted within the following timeframes:

- Elective admissions: 48 hours
- Emergent admissions: Two business days

Appeals of Utilization Review Decisions

AHH has an appeals process for physicians to request further review of UM decisions made on behalf of their patients. Please contact the AHH provider helpdesk at (866) 888-1500 to begin an appeal. The appeals process uses the following levels of reviews:

- 1st level reviewed at AHH by clinical team
- 2nd level reviewed at AHH by clinical team
    - If denied, appeal determination is sent to Taro Health to determine if a 3rd level review is to be completed by an IRO
- 3rd level completed by IRO when requested by Taro Health

Quality of Care Initiatives

Taro Health's goals as a health plan include the monitoring of the care our members receive to ensure the care they need is delivered in the most appropriate setting and with an exceptional patient experience with quality and appropriate outcomes. This is the reason we chose to focus on extraordinary primary care services as the cornerstone of our health plan. In order to know that this is occurring, Taro Health will use healthcare measures to access the clinical quality and adequacy of their care. An example of such measures is the Healthcare Effectiveness Data and Information Set (HEDIS) created by the National Committee for Quality (NCQA).

These measures were developed to assess the clinical quality performance of health plans. They cover many aspects of healthcare including preventive care, management of physical and mental health conditions, access and availability of care, patient experience, utilization, and resource use.

Analysis of HEDIS-type data helps to identify gaps in care. This is particularly important for preventive care and chronic populations with disease states such as diabetes, cardiovascular disease, and patients with lung disease. Such measures lead to the identification of at-risk pediatric populations who fail to complete preventive care such as immunizations, dental and well-child care.

Taro Health will develop quality-of-care initiatives to address these gaps in care. We plan to work with our network of providers when such gaps are identified to make them aware of the care that is needed by our members and your patients. This could be in the form of direct contact such as outreach by phone or a letter accompanying a list of patients and the indicated care that is needed. We hope to gain the cooperation from our providers to ensure that we facilitate the total care that our members need.

Review of Medical Records

From time to time we may need to review, audit, and duplicate data and other records maintained on our members, including medical records or other records relating to billing, payment, and assignment, to the extent permitted by state and federal law. We wish to conduct such reviews or audits in a cooperative manner such that your operations are not disrupted in any material way.

Taro Health will need access at reasonable times upon proper notification and discussion to your books, records and papers relating to the services you have provided to our members, to the cost thereof, and to payments that you have received from Taro Health members or others on their behalf.

In conjunction with the above sections, we expect you to provide the same access to data and records to any state or federal government officials entitled to such access by law and shall reasonably comply with any requests issued by government officials in connection with any audit or investigation.

The records for Taro Health patients and related claims records should be maintained at least ten years from the date of service. Your books, documents, and records should be maintained in accordance with the general standards applicable to such book, document or record-keeping and should be maintained during any audit or investigation by government officials.

For more specific information about the above reviews or audits of your records, please refer to the contract that you signed with us. Nothing in this manual is intended to be in conflict with the rights that Taro Health has per our contract.

Risk Adjustment

Diagnosis Code Requirements

As a participating Qualified Health Plan under the Affordable Care Act, Taro Health is subject to a Risk Adjustment program administered by CMS. In a risk adjustment program, a patient gets a risk score based on demographics, such as age and gender, as well as health status. ICD-10-CM codes, which represent a patient's diagnosis, provide data about health status and, therefore, the expected outcomes and costs of care. The role of ICD-10-CM codes makes proper documentation and reporting of diagnoses essential to the success of the CMS risk adjustment program. Keep in mind that what might be "good enough" to establish medical necessity on a fee-for-service claim may not be specific enough for accurate risk score calculation based on Hierarchical Condition Categories (HCC).

In order to ensure claims that we report to CMS are as accurate and complete as permitted, we will be electronically reviewing medical and pharmacy claims for gaps in HCC codes. One key element of our reviews will be the ICD-10 diagnosis codes associated with each CPT procedure code on your claims. In general, this means that you should identify the four most important or serious conditions or diagnoses that a procedure is intended to treat, which should be listed in order of severity and specifically related to the procedure code to which they are pointed.

Access and Review of Medical Records

The extent to which you pay attention to detail in your claims will help obviate the need for us to perform medical records reviews later to ensure that your claims fully capture the overall health status of your patients and our members.

Appendix A

Precertification List

Precertification is a determination of medical necessity only and does not involve matters of claim payment, eligibility, coverage, or the type and/ or availability of benefits.

Precertification for Inpatient and Outpatient procedures that could be considered Experimental/ Investigational is required.

All Inpatient Admissions

- **Prenotification for:**
  - Obstetric – Prenotification only (precertification only required if days exceed federal mandate)
- **Precertification for:**
  - Acute
  - Long-Term Acute Care
  - Rehabilitation
  - Mental Health/ Substance Use Disorder
  - Transplant
  - Skilled Nursing Facility
  - Residential Treatment Facility

Outpatient and Physician – Surgery

- **Prenotification for:**
  - Biopsies (excluding skin)
  - Vascular Access Devices for the Infusion of Chemotherapy (e.g., PICC and Central Lines)
  - Thyroidectomy, Partial or Complete
  - Open Prostatectomy
  - Creation and Revision of Arteriovenous Fistula (AV Fistula) or Vessel-to-Vessel Cannula for Dialysis
  - Oophorectomy, unilateral and bilateral

- **Precertification for:**
    - Back Surgeries and hardware related to surgery
    - Osteochondral Allograft, knee
    - Hysterectomy (including prophylactic)
    - Autologous chondrocyte implantation, Carticel
    - Transplant (excluding cornea)
    - Balloon sinuplasty
    - Sleep apnea-related surgeries, limited to:
        - Radiofrequency ablation (Coblation, Somnoplasty)
        - Uvulopalatopharyngoplasty (UPPP) (including laser-assisted procedures)
    - Potentially Cosmetic Procedures, including but not limited to:
        - Abdominoplasty
        - Blepharoplasty
        - Cervicoplasty (neck lift)
        - Facial skin lesions (Photo therapy, laser therapy - excluding MOHS)
        - Hernia repair, abdominal and incisional (only when associated with a cosmetic procedure)
        - IDET (thermal intradiscal procedures)
        - Liposuction/ lipectomy
        - Mammoplasty, augmentation and reduction (including removal of implant)
        - Mastectomy (including gynecomastia and prophylactic)
        - Morbid obesity procedures
        - Orthognathic procedures (e.g., Genioplasty, LeFort osteotomy, Mandibular ORIF, TMJ)
        - Otoplasty
        - Panniculectomy
        - Rhinoplasty
        - Rhytidectomy
        - Scar revisions
        - Septoplasty
        - Varicose vein surgery/ sclerotherapy

Outpatient and Physician – Diagnostic Services

- **Prenotification for:**
    - CT for non-orthopedic (CTs for orthopedic do not require prenotification)
    - MRI for non-orthopedic (MRIs for orthopedic do not require prenotification)
- **Precertification for:**
    - PET
    - Capsule endoscopy
    - Genetic Testing (including BRCA)
    - Sleep Study

Outpatient and Physician – Continuing Care Services

- **Prenotification for:**
  - Dialysis
- **Precertification for:**
  - Chemotherapy (including oral)
  - Radiation Therapy
  - Oncology and transplant-related injections, infusions and treatments (e.g., CAR-T, endocrine and immunotherapy), excluding supportive drugs (e.g., antiemetic and antihistamine)
  - Hyperbaric Oxygen
  - Home Health Care
  - Durable Medical Equipment, limited to electric/ motorized scooters or wheelchairs and pneumatic compression devices

Specialty Pharmacy Program

Precertification for specialty medications is reviewed by SmithRx, the Company's PBM. Please see the above section for contact and administrative procedures with SmithRx. Their phone number is also listed on the back of your patient's ID card.