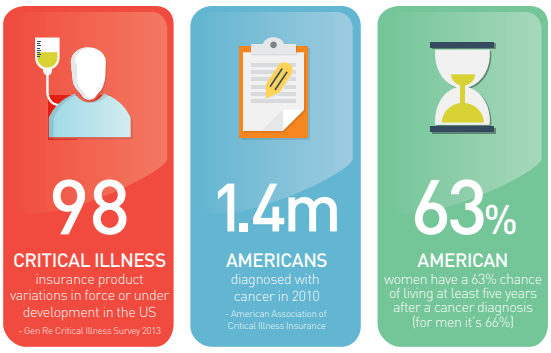
FINEOS Claims for Critical Illness

In North America, more people will experience a critical illness before they reach 75, than will die before that age. In the United Kingdom, one in five men and one in six women will experience a critical illness before their normal retirement age, so the need to respond rapidly to those covered by critical illness insurance is urgent. It is vital that critical illness carriers provide excellent customer service, a painless and fast claims process, and competitively priced, differentiated products.

FINEOS Claims for Critical Illness (CI) is the state-of-the-art technology solution for effectively managing CI and cancer insurance claims. The solution is successfully deployed at several FINEOS clients where it supports the end-to-end claims process for a range of operating models (typically dictated by the carrier's claims volumes) and product variations.

Traditionally, a claims system's capabilities have consisted solely of doing the mechanical efficiently and accurately. As you will see from the feature highlights here, the capabilities of FINEOS Claims for Critical Illness extend far beyond this.



Provide Superior Customer Service

It is almost impossible for an insurance carrier to provide excellent claims service when the tools of the job consist of multiple disparate systems, ad hoc spreadsheets and/or a partly paper-based claim file.

FINEOS Claims makes the electronic, single case file view of the claim a reality. This is achieved through an unparalleled breadth of in-built functionality. It includes CRM, workflow, external expense management, benefit calculations, and payments. It also has seamless system integrations with the carrier's enterprise document management and email systems. FINEOS Viewpoints allow for a comprehensive view of the same underlying data, providing the claimant with self-service capabilities, including:

- Claim submission
- Claim and payment status enquiry
- Ability to submit documents/scanned images
- Power to request updates to demographic, payment preference, and contact preference details

FINEOS Claims has a number of customer-centric, chronological views within its back-office solution. This facilitates one-click access to any prior claim information as well as rapid re-familiarization with recent communication threads on open claims. This is particularly applicable where the claimant has suffered a critical illness and concurrently filed for benefits under a CI, disability income, or hospital indemnity coverage.

A charge that is frequently leveled at many life and health insurance carriers is that they fail to keep the claimant informed during the initial claim-decision process. FINEOS Claims addresses this shortcoming through auto generated outbound communications via the claimant's preferred contact method (postal mail, email, secure message or SMS). Examples of these communications include:

- Acknowledging receipt of claim notification and advising expected decision timeframes
- Notification of name and direct contact details of claim specialist assigned to claim
- Notification that a payment has been issued and its salient payment details.

Positively Influence Claim Outcomes

Whether your claim handlers specialize in CI claims or also adjudicate life or disability claims, a key principle of sound risk management is that the aggregate complexity of each claim specialist's portfolio of claims is broadly consistent with their level of experience.

The FINEOS Claims Predictive Analytics module turns this principle from theory into reality. For example, the complexity score of a particular cancer claim can be designed to take into account factors such as:

- Whether a cancer in situ was pathologically or clinically diagnosed
- The types of medical reports submitted
- The insured's age, gender, and previous claims experience
- Coverage amount

Furthermore, this score can be configured to automatically re-assess as claim file development occurs.

FINEOS Claims provides claims managers with a dashboard indicating the aggregate complexity score of each claim specialist's caseload versus a pre-configured, expected value. An overburdened specialist can either be temporarily removed from round-robin assignment of new claims until their balance is redressed (a simple configuration task) or the claims manager can manually reassign their claims.

Work Smarter

Claims managers and supervisors are typically not armed with the tools that they need to gain a deep insight into the performance of operations they manage. There is a limit to the number of ad hoc requests that can be made to the data warehouse team when an emerging trend or operational issue is suspected. As a result, bottlenecks may go unnoticed until customer complaints start to flood in.

FINEOS Claims Business Analyzer empowers managers and supervisors to self-sufficiently monitor all aspects of their claims operations without any database SQL skills or recourse to the data warehouse team. The module consists of a suite of dashboards and reports with in-depth slicing and dicing, trend analysis, and comparison capability. It covers all aspects of the claims operation, including:

- Incidence of new claim submissions, the channels through which they are being reported, and claim filing time lags (versus date of diagnosis)
- Claim approval rates at claim office, claim team, and claim specialist level
- Initial claim decision durations, both at aggregate level and broken down by various handovers, that occur during the process
- Specific amount spent on benefit payments and external investigative services
- Incidence of appealed decisions, appeal processing durations, and the percentage of decisions overturned
- Incidence of claim referrals to internal medical staff

> **"We believe we now have the platform for a best-in-class solution that supports our growing lines of business, positions us to deliver a more efficient claims process and maintains the exceptional levels of service that Mutual of Omaha customers have come to expect."**
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> *- Kathy Brown, Director of Group Insurance Claims, Mutual of Omaha*

Features at a Glance

Claims

Notification: First Report of Injury/Illness

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- Multi-channel, multi-source
- Scripted, rules-driven claim intake
  - Reflexive presentation of market-standard questions tailored for both paper and telephonic notifications. Can be configured to suit corporate, resource, group-specific, and unique servicing needs
  - Configurable scripting to guide call center and/or intake staff
- Secure online submission via optional self-service portal eliminates re-keying of data required by back office
- Robust FMLA integration

Initial Assessment and Assignment

- Integrated policy and benefit information
  - Via administration system adapter/loader
  - Via Plan Manager component that enables full definition of policies, plans, and benefits
- Rules-driven claim assignment
  - Via geography, condition code, analyst skill level, dollar-value, or any other parameter or combination thereof
  - Assign claim tasks in parallel to multiple users while maintaining a singular claim owner
- Detailed medical coding including diagnosis and treatment
- Automated eligibility determination to expedite/remove human error

Compliance / Best Practice

- Processes to manage ERISA and Unfair Claim Practice statutes
- HIPAA compliance (securing medical data, masking claimant details, tagging and identifying authorized representatives)
- Claim file auto assembly (for print, PDF, other) to handle freedom of information/legal requests
- ACORD compliant interfaces
- Synergy with reserving and ICOS systems
- Change history fully audited and visible via the user interface screens when required

Investigation and Fraud Detection

- Rules-driven alerts for when investigation should be considered (e.g. non-disclosure, pre-existing conditions)
- Complete audit trail and history of prior claims
- Ability to score claims to assist analyst in applying optimum case management techniques

Customer Service

- Single view of customer
- Unified claim relationships view with case and party maps
- Newsfeed view which quickly presents all correspondence, calls, workflow, process stage gates, claim status changes, etc., associated with a claim in chronological order and advanced filtering capability for quick assimilation of all activity within a period or over the life of a claim
- Employer organization structure
- Correspondence automatically generated (real-time or batch) with pre-population of claim information, claim handler details including signature
- Email integration (MS Outlook, Lotus Notes) – inbound/outbound emails seamless integration including documents upload/case and party linkage facility
- MS Sharepoint integration
- SMS enabled
- Mobile and tablet devices ready

Comprehensive Payments Management

- Detailed calculation trail for all payment lines items for explanation / audit purposes
- Configurable offsets and deductions calculations
- Configurable user payment authority limits and based on total claim value (all benefits)
- Percent of random claims audited adjustable by supervisor based on analyst experience level

Reporting and Insight

- Over forty real-time reports covering all financial and operational aspects of the claims function;
  - Single view of all stage gates/workflow within claim decision
  - Fulfill group SLAs
- Dashboard style, graphical reports and KPIs with ability to drill in to individual claims for better management and decision making
- Reporting views for plugging into any external reporting tool
- Unique Process Analyzer heat map that enables workflow optimization by streamlining rarely used paths and identifying/correcting process bottlenecks

Usability

- Ability to manage multi-benefit and make multiple policy claims within a single electronic claim file
- Graphical timeline depicting all history of a claim in an easy to navigate fashion
- Single newsfeed view of all claim activity within a period of over the life of a claim
- Every widget, tab, and screen can be downloaded into Excel or PDF
- Keyword accelerators for heads down keyboarding for repetitive tasks
- ADA-compliant for visually impaired and disabled
- Alerts banner making open case validations and prompts clearly viewable and actionable upon entry to a case
- Robust, configurable and graphical workflow engine that underlies the entire solution
- Ability to restrict activity based on role and security profile (secured actions)
- HTML5 ensures the smoothest navigation experience
- Unlimited browser tabs for complex case reference
- Convenient "Recent Cases" menu for back and forth toggling
- Collapsible summary panel for always available case summary and participant information

Technology

- Web and rules-based JEE and service oriented architecture
- Multi-platform
- Multi-device (computer, tablet, smart phone)
- Multilingual, multi-currency

FINEOS is the #1 provider of group and individual claims software solutions for the global Life and Health insurance industry. FINEOS Claims is the only solution deployed globally that supports the processing of Disability, Life and Waiver claims on a single platform. FINEOS Claims is the solution of choice at six of the top twenty Life and Health insurance carriers in the US.

To find out more about **FINEOS Claims for Critical Illness** or to request a demo, please contact us at **info@FINEOS.com**.

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