Medex Management System [MMS] – Booklet

Version 1.4.1 [29th June 2008]

Core Software Technologies ®
[CoreTech]

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Acknowledgements

Core Software Technologies (CoreTech) gratefully acknowledges the support of Medexa, which provides the business Know-How that made this product possible.

MMS product has been developed through merged cooperation between Medexa and CoreTech.

Medexa possesses a unique and wide knowledge and expertise extends of more than nine years in the health insurance field. In addition, Medexa continuously seeking to access and use latest technologies. Moreover Medexa is a global leader in their business field. Earlier Medexa's professional team founded several TPA companies and branches in the region, also produce a several TPA computer software's characterized by high technical abilities and continuity for several years. Medexa's key persons are:

- **Dr. Natheer Bate'** (share holder)

Dr. Natheer is the first creator of the health insurance management science in the Arab region. He is the author of profession rules. He participated in establishing number of TPA companies and Medexa was the latest company he has established with three branches in the Arab region.

Dr. Natheer (nazeer@medexa.net) at a glance

- Chairman and GM of Medexa and major shareholder since inception in 1999.
- Chairman of Jordan Association for Medical Insurance (JAMI).
- Chairman of Core Technologies software (CoreTech).
- Member of NatHealth's Board of directors, Deputy GM and operational manager since 1997 till the end of 1999.
- GM of Scientific Center for Health Insurance Management stating from 1991 till 1997.
- Health Insurance Consultant for Al-Nisr Al-Arabi Insurance Company since 1988 till 1991.
- Instructor and organizer of many Jordanian and Pan-Arab training seminars in topics related to the medical insurance industry.
- Consultant for five computer systems specialized in the health claim management.
- Patent for two claim management systems (Dynamic Health Insurance Administration Version I Registered No. [2001 – 4 – 833] and Dynamic Health Insurance Administration Version II Registered No. [2001 – 4 – 834]), which have been used by several well-known insurance and TPA companies.
- Specialist in medical international coding system

- Mr. Fadel Saleem Al Hardan

Mr. Fadel works in the TPA business field since the beginning of TPA in the Arab region. He gained experience in health insurance management since the beginning of his career. Moreover, he is one of few people who possess expertise in health insurance management and participated in the production of software applications to match the needs of health insurance management.

Mr. Fadel (fadel@medexa.net) at a glance

- ❖ B.Sc degree in Health Administration.
- ❖ Diploma is pharmacy science.
- ❖ Assistant GM in Medexa since 1999.
- ❖ Head of policy section in NatHealth Company since 1997 till Oct 1999.
- ❖ Claim supervisor in Scientific Center for Health Insurance Management since 1992 till 1997.
- ❖ Appliance for four claim management systems which have been used by many well-known insurance and TPA companies in Arab region.
- ❖ Possess unique ability to analyze data and delivery of a distinct to the project managers for the production of integrated system and distinct use of data base files (DBF).
- ❖ Participated in providing training sessions in health insurance system for MAGNET in 1996, Central Bank of Jordan in 1997, NatHealth in 2000, Medexa Oman in 2003 and Medexa Syria in 2006.
- ❖ Have training courses in (2000 through 2007) by General Arab Insurance Federation (improving employees' skills in health insurance sector).
- ❖ Giving lectures in e-health and claim management system

About

Core Software Technologies well known as CoreTech is a turnkey software and business solution provider. CoreTech established in 2005 to steers customers through the next generation of business innovation powered by technology with state-of-the-art software development and turnkey software solutions. CoreTech is specialized in the business process automation and solutions in the insurance and healthcare industries field.

For companies operating in the information age we help to leverage new technologies to competitive advantage. We deliver high impact and high value innovated solutions by bridging the gap between business and technology.

Strengths

- Deliver secure, reliable and scalable applications that help businesses excel in today's rapidly evolving economy.
- Gain client's satisfaction by fully understand and address our client's requirements within the minimal time-to-market.
- Assures a steady quality by guarantee high quality of our deliverables.
- Maintain continuous improvement by promoting a learning environment, and ensuring that our employees are exposed to, and trained on state-of-the-art technologies. Our software development process is continuously monitored and improved to maximize productivity.
- Utilize object-oriented analysis, design, and testing methodologies; ensure seamless integration and traceability between the project's requirements, design, development, quality assurance, and delivery.
- Match the most updated international codes and requirements.

Vision

CoreTech vision is to become a world-class software development and technology provider and to provide clients with innovated technical and business solutions by utilizing industry standards and technology.

Staff

CoreTech is powered by highly skilled professionals of professors, consultants, engineers, developers, executive equipped with the latest IT tools. CoreTech works round-the-clock to assure the timely delivery of your applications with the highest quality.

Preface

This document is intended to help you fully exploiting some of MMS most powerful features. This document helps you determining why you should choose MMS product. Use this document to help developing your strategy.

This document includes information to help you effectively understanding the product features, capabilities and functionalities. It contains information about the following:

- Technologies & Standards
- Platforms & Requirements
- Modules & Functionalities
- Reports & Data Mobility
- Integrations & Customization

About This Document

In this reference document there are six sections:

- The introduction section gives some background information about document purpose, audience, and product overview.
- The technology section gives information bout the product development language database and architecture of the product.
- The requirements section provides information about the platforms product operating on, operating system (OS) platforms and hardware required.
- The modules and functionality section explains the product modules available and their functionalities.
- The reports and data mobility section demonstrates the product reports and formats. In addition, it gives information about the different ways of how to extract the data.
- The integration section lists the integrated and future integrated system(s).

Executive Summary

Medical insurance industry is becoming increasingly complex and risk-ridden especially with the industry's growing variety of products and tremendous competition. MMS is a Core Software Technologies turnkey solution which presents a comprehensive, fully integrated medical insurance claim management system that caters to all the industry's requirements. It presents a scalable, dynamic and flexible approach to accommodate the rapid growth and constant changes in the parameters of medical insurance services. It has been designed according to the highest international standards and codes in the health care and insurance sectors.

MMS tailored to simplify processes within organizations, improve productivity, customer retention and reduce operational cost. MMS supports multiple insurance products and policies by facilitating the management of each medical insurance product, the creation of new insurance products and the support of re-insurance activities. The solution enables insurance companies to efficiently manage health care insurance activities, health care claims, and daily accounting activities.

MMS will minimize effort and time in creating, and managing new medical insurance products and services as well as enhance the capability of insurance business to respond to critical industry changes and growths. The package supports all the stages of the health care claim life cycle through a single and comprehensive solution. Within MMS solution package, organizations can create and manage their full suite of health care insurance products, in a dynamic and flexible manner for insurance industry needs.

MMS provides organizations (insurance and TPA) with management and automation for quotations, cover notes, policies, endorsements, renewal, claims, payments, recoveries, accounting transactions, etc.

MMS modules are created to save organizations time and money while introducing efficiency. The modules are suitable for a wide variety of applications, covering:

- Premium Calculation & Management
- Policy Management (Groups & Individuals)
- End-to-End Claim Management
- Flexible definitions
- Early alarms and detailed analysis
- Sophisticated Reporting Options
- Record & transactional data auditing
- Security & permissions management
- Financial management & calculations

Should keeping your expenses to minimal and raising your organization productivity and accuracy, then surly your choice is selecting CoreTech solutions.

Introduction

This section describes the reference document purpose, intended audience and briefly describes the product being introduced. It also lists all abbreviations and terms used in this document.

Purpose

The purpose of this reference document is to increase client's satisfaction by providing high-level information about the MMS product, product roadmap and future. In addition, to demonstrate the capabilities and features of the product which will moves companies to a competitive edge.

Audience

This document designed primarily to introduce the Medex Management System [MMS], and its functionality and capabilities, however this document also intended and aimed to decision makers whom interested in moving their insurance and/or TPA and/or TPA-like companies to a competitive edge. The reader expected to have knowledge of Health care Insurance Claim Management.

This document is not a tutorial and does not contain any procedural information. This document is intended for reference.

Abbreviations & Terms

Lists all the terms and/or abbreviations used in this reference document

Term/Abbreviation	Description/Meaning
WHO	World Health Organization
FIC	Family of International Classifications
ICD	International Classification of Diseases
HCPCS	Health Common Procedure Coding System
ICHI	International Classification of Health Interventions
HBA	Human Body Anatomy
ATC	Anatomical Therapeutic Classification
GUI	Graphical User Interface
AHIMA	American Health Information Management Association
HIPAA	Health Insurance Portability and Accountability Act
HCFA	Health Care Financing Administration

Problem Statement

The insurance and TPA companies are interested to insure that their plans (Policy/Contract) at all times comply with the complex rules. That approach is increasingly desirable in the market as health care costs continue to increase. However modern claim management is facing number of facts that affects the continuity and growth of the organization such as:

- Business process involves too much paper work, (claims, endorsement, letters, etc), causing upheaval in the work and delay in answering clients.
- Companies depend primarily on its internal medical qualified staff such as (doctors, pharmacists, and assistant pharmacists) which leads to increase in administrative and salaries expenses.
- Companies use technical scrutiny of claims (Medical Factoid) to ensure reduction in health insurance cost for their clients.
- Companies requests pre-admission approvals and authorizations, this slows the treatment process.
- Diagnoses which determine the insurance coverage is important elements in a medical claim.
- Important elements of medical claims are the identification of the procedures to determine medical insurance coverage terms (covered procedure, utilization, agrees with patient specifications, etc).
- Fraud and medicines consumption are important problems facing insurance companies and TPAs.
- Health care claim management has a complex workflow. The process goes through many critical steps. TPA and insurance companies need to control all these steps and stages internally and externally.
- The expansion of medical providers adds more complexity to the managing process of health care claims. Nowadays medical providers have many branches in different areas and cities.
- TPA and Insurance companies have global existence and clients' world wide which necessitate software capabilities to deal with wide range of requirements and different conditions.

Product at a glance

Within any organization the effective use of resources are paramount to the development of profits and continued growth. Implementing a professional, flexible, and complete IT solution for process automation, that meets customer objectives, and requirements is a milestone.

- **MMS minimize the paper work** by storing a copy of all papers in particular files, thus can be viewed through the system at any time. You do not need to go back to the hard (paper) copy.
- **MMS reduces administrative costs** by the classified claim entry steps based on: secretary input step (which are 70% of the volume of work) and medical step (which constitute 30% of workload), accordingly company needs less number of medical staff to perform the functions. This will lead to reduction in expenditure.
- **MMS adopted international coding standards** and new ideas of managing health insurance. We classified the global dissection human body and linked each medical claim elements such as (ICD-10, HCPC, ICHI, ATC, Medication) with pathologist attendance. This is to ensure that each medical service received by patient is matched with the related medical case.
- **MMS integrates auto pre-approvals** functionality that receives admission request electronically through the Internet, then processes the admission request automatically without human intervention, except certain cases where human intervention is required, then sends answer automatically to the hospital.
- **MMS links dissection human body with all international coding standards and doctor specialties** to ensure that the treatment procedure does not contradict the patients' information such as age, gender, marital status, etc. as well as doctor specialty.
- **MMS complied with HCPC coding standards**, in addition the availability of more information related to the insurance coverage.
- **MMS complied with the WHO medicine specifications** to define full information for each medicine e.g. (gender, age, quantity, dosage form, diseases, side effects, firms, drug store…etc).Through this we have solved all health insurance problems related to medicines (indications & consumptions).
- **MMS built to address all stages and steps to manage claims with audit trial** to monitor these steps. All tasks in the workflow of the claim can be audited, reported, and monitored by the system.
- **MMS built to deal with different present and future medical providers types**, each one may have many parts with one or many branches in one or many cities or country, all consequences of this complexity have been addressed.
- **MMS been built to address any contract terms and conditions**. The flexibility of MMS Contract Module makes it able to deal with the final details of any contract.

Overview

The Medex Management System [MMS] is powerful turnkey health care claim management solution that allows TPA and insurance companies to setup and operate health care claim processing and management. Thanks to its fully customizable with amazing capabilities, MMS Position itself as one of the most comprehensive and cost-effective claim management software solutions available today. MMS empowers you with tools to manage your entire business from central and integrated interface.

MMS is health care claim management system reflects the automation requirements of the modern insurance industry. It is tailored to simplify processes within organizations, improve productivity, customer retention and reduce operational cost. MMS supports multiple insurance products by facilitating the management of each healthcare insurance product, the creation of new insurance products and the support of re-insurance activities. The solution enables TPA and insurance companies to efficiently manage health care insurance activities, health care claims, and daily accounting activities.

MMS is flexible enough to handle, manage and implements the new requirements in evolving rapidly changed environment in Insurance Industry, with minimal and/or no customization and/or costs.

Innovations

The MMS is recognized as the first system in the regions conforms to and implements the latest International Classification of Dieses (ICD-10), Human Body Anatomy, Health Common Procedure Coding System (HCPCS) as well as Drugs information according to Anatomical Therapeutic Classification (ATC), Integrated together in the re-engineered medical factoid checking engine.

Technology

This section describes the technologies used to develop and implement the MMS product

Architecture

The system is developed based on oracle technologies. The system architecture is designed to compliant with the best oracle practice software architecture and development guidelines to operate on the Client/Server and 3-tier (Web Enabled) architecture concepts using WAN and/or LAN communication networks. The product can operate on multi-OS platforms such as Microsoft windows, UNIX, and Solaris.

Database

The system is using Oracle Database Server 9i Release 2 (9.2.0.1.0), in addition to that the system can be deployed and operate on later versions of Oracle database server such as Oracle Database Server 10g Release 1 and Release 2, and Oracle database Server 11g.

Performance & Availability

MMS is recognized as the first system of its kind that accomplished the high-availability, high-liability, high-response, and zero-down time, by handling large volume of transactions in fast, efficient, and accurate manner.

Interface

To insure that the product is supporting wide range of clients, the system is designed and developed using Oracle Developer 6i Patch 16. However the system will be converted later on and migrated to Oracle Developer Suite 10g Release 2 (10.1.2.0.2).

Why Oracle?

Oracle is worldwide popular technology and can be found in almost all industries, due to the fact that Oracle provides:

Scalability and Performance

- Concurrency
- Read Consistency
- Locking Mechanisms
- Quiescence Database
- RAC
- Portability

Manageability

- Self managing database
- OEM
- SQL*Plus
- ASM
- Scheduler
- Resource Manager

Easy Backup and Recovery
High availability

Business Intelligence

- Data Warehousing
- ETL
- Materialized views
- Bitmap indexes
- Table compression
- Parallel Execution
- Analytic SQL
- OLAP
- Data mining
- Partitioning

Content Management

- XML
- LOB
- Oracle Text
- Oracle Ultra Search
- Oracle interMedia
- Oracle Spatial

Highest Security ever
Data integrity/Triggers

- Integrity constraints
- Triggers
-

Information Integration Features

- Distributes SQL
- Oracle Streams

Many programming languages
Integration or handling

- Java
- PL/SQL
- COBOL
- C
- And more.

Also using a 4GL in development will provides follows:

- Database query languages.
- Report Generators.
- Data manipulation, analysis and reporting languages.
- Data-stream languages.
- Database driven GUI application development.
- Screen painters and generators.
- GUI creators.
- Web development languages.

Requirements

This section describes the system requirements [Server side and Client Side] and OS platforms in order to implement and operate the MMS product.

Server Requirements

The following tables list the minimum hardware and software requirements for running the MMS on server side.

Hardware Component Requirements

Computer	Intel or compatible Pentium IV Xeon or higher processor minimum; 1.1 GHz or higher (Strongly Recommended)
Memory (RAM)	4GB or more recommended
Hard Disk Space	10 GB or more recommended; actual requirements depend on your system configuration.
Monitor	Super VGA (1,024x768) or higher resolution
CD-ROM	Required for DVD and/or CD installation

Software Component Requirements

Operating System	Windows Server 2000, Enterprise Edition Windows Server 2003, Enterprise Edition UNIX
Database	Oracle Database Server 9i Release 2 or Later
Application Server	Oracle Application Server 10g Release 2*

* Required for 3-Tier Architecture

Client Requirements

The following tables list the minimum hardware and software requirements for running the MMS on client side.

Hardware component Requirements

Computer	Intel Pentium/Celeron family or compatible Pentium III Xeon or higher processor minimum; 1.1 GHz or higher recommended
Memory (RAM)	512 MB or more recommended
Hard Disk Space	1 GB or more recommended; actual requirements depend on your system configuration.
Monitor	Super VGA (1,024x768) or higher resolution
Pointing Device	Microsoft Mouse or Compatible pointing device
CD-ROM	Required for DVD and/or CD installation

Software Components Requirements

Operating System	Windows XP Professional Service Pack 2
Runtime	Oracle Developer 6i Oracle Developer Suite 9i Release 2* Oracle Developer Suite 10g Release 2*
Browser	Microsoft Internet Explorer 6.0 or Later (Other Internet Browser Compatible)
Java	Oracle JInitiator*

* Required for 3-Tier Architecture

Modules & Functionalities

This section describes the system modules functionalities and capabilities; the major MMS functionality is to perform Health care Claim Management. MMS armed with flexible modules integrated together to manage, and process TPA and insurance business processes, claim validation and management. The MMS main modules are:

- Setup Module
- Security Module
- Definitions Module
- Insurance Parties' Module
- Insured Parties' Module
- Medical Provider's Module
- Family of International Classifications Module (WHO-FIC)
- Drugs/Medicines Module
- Treaties Module
- Contracts Module
- Claims & Batches Module
- Pre-Authorization & Admission Module
- Document Archiving Module
- Pricing Module
- Financial Module

General

The product design and layout will adopted the best GUI look & feel practice techniques such as using standardized layout components (navigation, colors, buttons, fields, etc). Colors are comfortable to the end-user. The product user interface language is bilingual and can be changed on the fly with one-click button. In addition a guarantee of minimum five different ways of information searches from any where. On the fly one-click help information. MMS also includes:

- Auto names translation (human names) based on gender.
- Auto data fill (during data entry) wherever applicable.
- Bi-Lingual Data & Interface.

The information herein are listed for identification only, more functionalities are available for each module.

Setup Module

The setup module is designed to facilitate and administrate the feature reach MMS product; it allows the system administrator to dynamically define and maintain system preferences, system main components, interface languages (dynamic labeling/prompts), interface optional and mandatory information, system messages and alerts text information, names dictionary, and end-user main menu organization and structure. The setup module gives the administrator the ability to easily and efficiently navigate and administrate the system.

Security Module

The security module is designed to maximize the security level in flexible and dynamic manner by allowing the definition of several levels of permissions. The security protection provided by system is designed up-to field level. The security module allows to (but not limited to) dynamically define and/or maintain different types of access privileges, user's groups, user's group's access privileges rights up-to field level, end-user access privileges rights and exceptional access up-to field level. This module generates auditing information by date/time, user, transaction type, etc. The module is supporting unlimited number of end-users definition. In addition, administrator may control toolbar for each user. Moreover the administrator can hide/show information for any screen on any user and/or group.

Definitions Module

The definitions module is designed to dynamically define various business terms and information required to standardized the system information, minimize data entry and allows the system to act according to the selected define values, which will resulted in minimizing data entry spelling errors. In addition, it gives the power to dynamically define many business terms and their actions which will complain and apply with the adaptability of rabidly changed environments and business rules.

The definition module allows to (but not limited to) dynamically define different gender types, regions and country information, Insurance classes, medical provider types, doctor specialties, occupations, bands information, formal titles, educational titles, marital statuses, subscriber family relations, etc.

Insurance Parties Module

The insurance parties' module is designed to dynamically define various insurance parties' information and branches such as re-insurer, risk carriers (insurance, self-funded), brokers, fund-management companies, which will integrate to verify and validate claim processing information and generates settlements reports to be sent to the concerned parties. In addition, the insurance parties' module is capable to define and support insurance party alliance.

Insured Parties Module

The insured parties' module is designed to dynamically define and harvest insured parties' information such as subscribers and insured groups; the module is capable to define unlimited numbers of subscribers and insured groups. The module is capable to store historical information. The module is capable to handle all subscribers' types (head of families and dependents). Intelligent features have been added to the module to minimize the data entry by allowing the module to automatically populate known information such as gender and title. This information maybe populated automatically by identifying the subscriber name. Maintains subscriber medical history and identifies chronic and un-repeated HCPCS and ICD. Insured parties' module links the insured group with subscribers.

Medical Providers Module

The medical providers' module is designed to dynamically define various medical providers and branches such as hospital, clinic, medical center, and pharmacy, etc. the module is integrated to the verifying and validating claim processing information and generate settlements reports to be sent to the concerned parties.

The module allows the system to manage and register different medical providers in terms of branches, parts, working hours, etc. This functionality allows an easy preparation to print the medical provider network booklet. Also, the module is allowing user's to freely define multiple medical provider networks (private and public). Moreover, medical provider types are dynamically defined in the system.

WHO - Family of International Classifications Module

The medical information module is designed to conform to the WHO International Classifications Standards. These standards will be used in the claim processing engine to validate the claim medical information with the medical factoid in various levels (types). However, the ICD-10 is designed to support the different types of ICD-10 releases such as ICD-10-DM and ICD-10-AM. Also the mapping of ICD-9 is also available in the system.

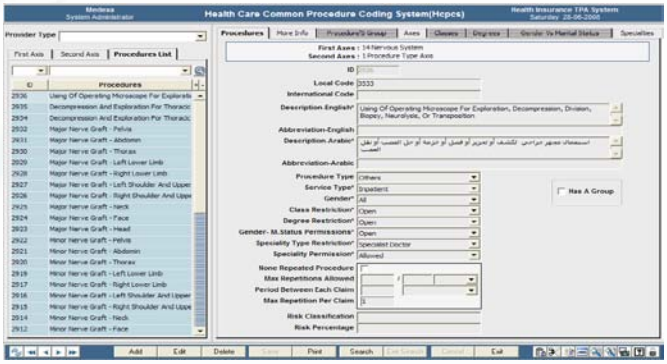
The WHO Family of International Classifications coding systems incorporated to the system is as follows:

- International Classifications of Diseases 10 (ICD-10).
- International Classification of Health Interventions (ICHI).
- Anatomical Therapeutic Classification (ATC).

Other international association coding systems are:

- Human Body Anatomy (HBA).
- Health Care Common Procedure Coding System (HCPCS).

The WHO Family of International Classifications module allows to (but not limited to) define and/or maintain the complete International Classification of diseases (ICD-10) information. The WHO Family of International Classifications determines the gender, marital status, doctor specialty, chronics, clinically identifying ICD… etc. It also determines the related Human Body Anatomy for each defined ICD, related procedural Type Axis and related Health Care Common Procedure Coding System (HCPCS) information. It defines service types, gender, marital status, and doctor specialty, repeated and non-repeated procedures, with/without condition(s). Bellow is a screenshot of the HCPCS screen used to define HCPCS information and define the rules and conditions such as medical provider type, axes categories… etc.



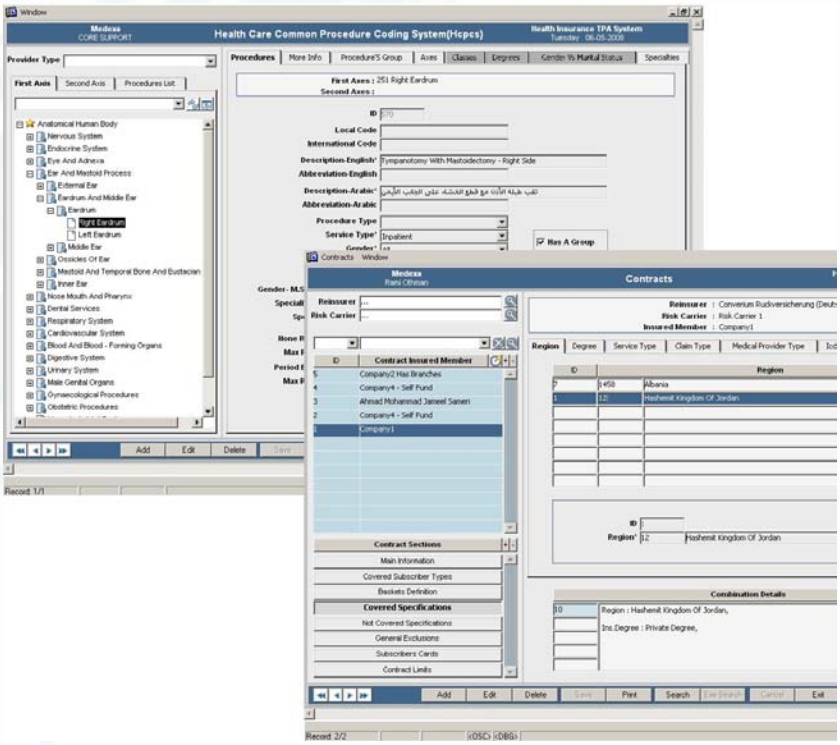
Also the Anatomical Therapeutic Classification (ATC) has been integrated to the system that categorizes the drugs and medicines; the ATC allows the user to determine the doctor specialty, Procedure Axes Level Information, group of HCPCS and/or ICD based on Medical provider types.

Contracts Module

The contract module is designed in unique, professional and state-of-the-art manners to handle all types, aspects and exception, rules, and condition definitions in the Insurance world (to some extend). The contract module leverages the contract types, premiums, subscriber types, subscribers, coverage conditions and limits, all integrated to perform policy, subscriber and claim management, in addition to the premium installments management.

The contract module allows to (but not limited to) define and/or maintain coverage conditions and exceptions, subscriber types, contract Types (individual and groups), unlimited number of conditions and rules, manage contract premium and subscriber premium installments, and calculations, limits information of all types (deductibles, co-payments, etc), insurance card management, multi-type billing information, and controlling services cost and limit.

The contract module has the capabilities to define a policy with one-click, by selecting the contract template from the treaties. The contract module allows handling multi-risk carriers, multi-insured groups from within a single policy, and also can handle self-fund insured groups. The contract module has an auto alerting capabilities for policy renewal, and risky policy.

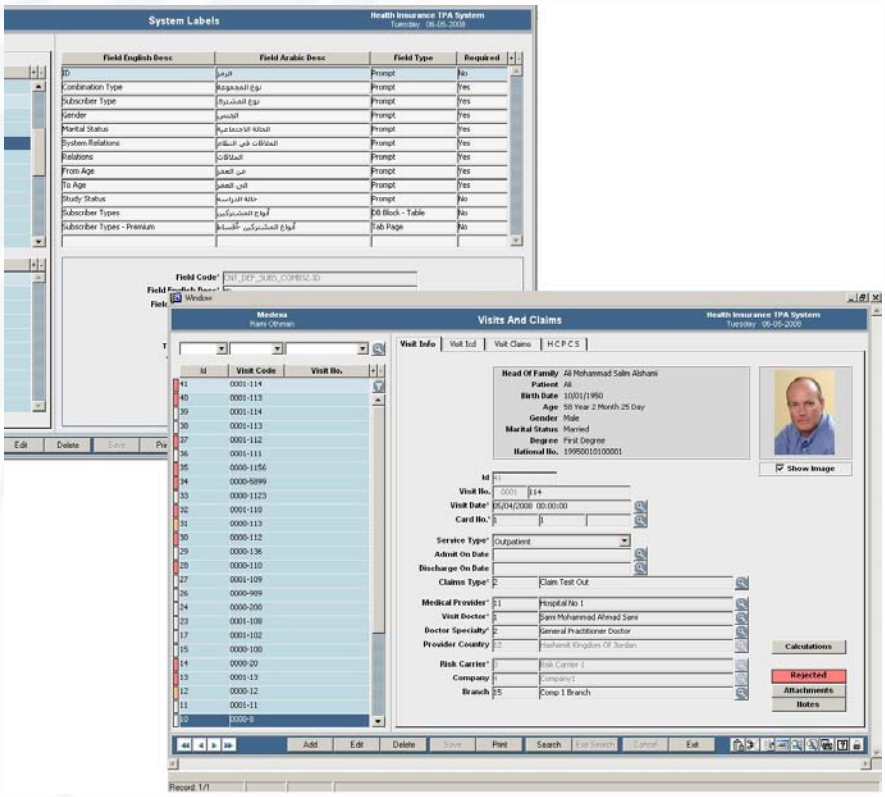


Claims & Batches Module

The claims and batches module is designed to support unlimited number of claims, claim's types, and medical provider types, etc. The claims and batches module allows to (but not limited to), perform online and offline claim data entry, claims are categorized based on risk-carrier, batches and shipments.

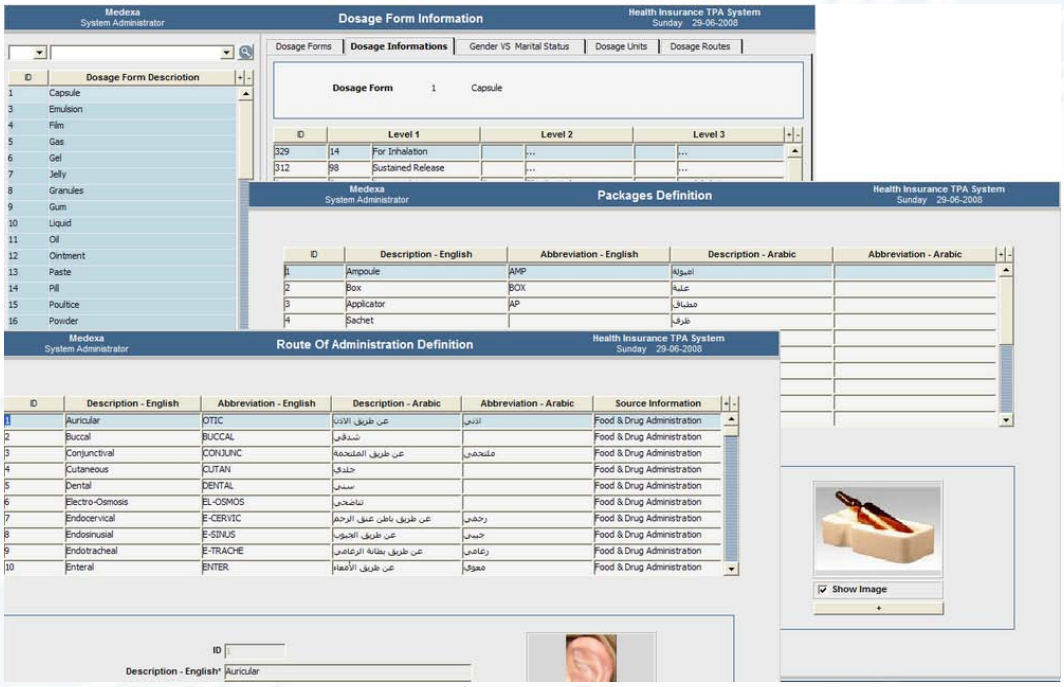
The module is armed with a new re-engineered validation and verification process engine that will validate and verify claims and visits information against policy rules, medical factoid, subscriber information, etc. Also the system will request doctors to audit the claims information and also provide his/her feedback. If results are identified as matched then the system will register such information to be used later by the validation and verification process engine in order perform an auto approval which will minimize the manual process. Vise versa mismatch results will indicate that one of the pre-defined information is mistakenly entered and needs to be corrected.

The manual claim entry is automatically populating and identifying most of the information being entered. That will raise the user productivity. Also the claim summarized information, such as status, total cost, rejected amount, etc. are populated.



Drugs/Medicines Module

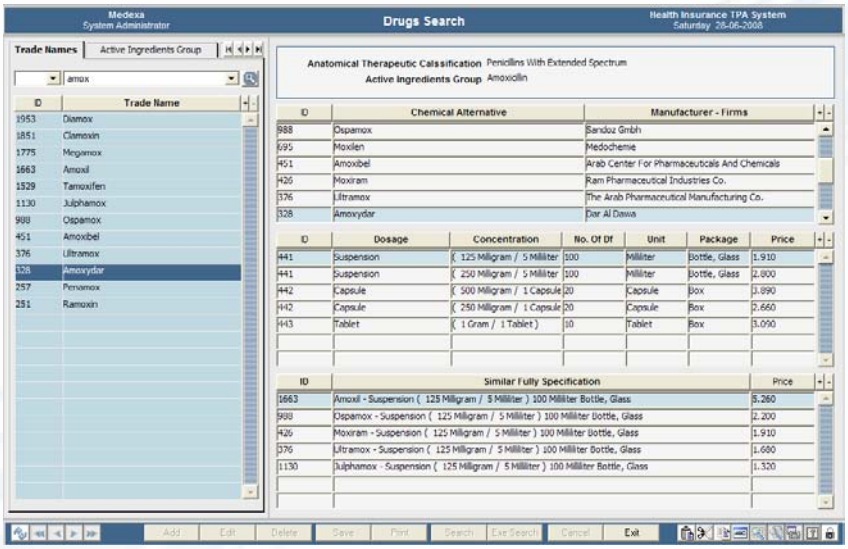
The drugs/medicines module is designed to capture all drugs information such as route of administration, concentrations, dosage forms, dosage frequency, packages, units, and active ingredients and group of active ingredients, DRG and TQ drug information, manufacturer and drug stores, trade names, and an advance drug search capabilities. Bellow is a figure of some of the drug module.



The drug information can be restricted on specific subscribers by identifying and defining the age, gender, marital status, ICD, contradictions, etc. up-to the trade name package.

In addition to all above also drugs information has been designed to complain with the Anatomical Therapeutic Classification (ATC) international coding systems and detailed up-to package and price information.

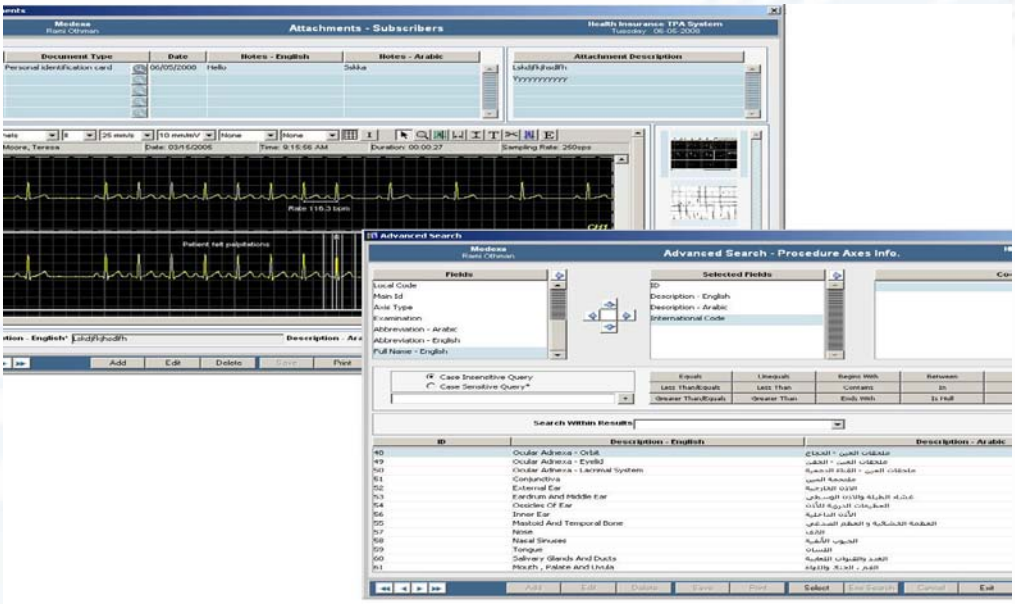
Bellow is screenshot of the drug search screen which allows searching for particular drug information by trade name, active ingredient and anatomical therapeutic classification.



Documents Archiving Module

The document archiving module is designed to capture all scanned documents, and store these documents in categories fashion which is dynamically defined in the system. The document archiving module allows (but not limited to) Store the captured scanned images with image type and/or comments, notes, description, and store unlimited number of scanned images.

Valid images formats supported only JPG and GIF. Archiving can be called from many modules, such as claim, visit, insured, contract, network, medical provider, insurance parties, etc.



Treaties Module

The treaty module is designed to support all types of treaties as well as to generate contract templates (Programs/Plans) to be used later in the contracts (policy) creation when needed. The treaty module allows to (but not limited to) handle all types of treaty (quota share, surplus, facultative, excess of loss, etc), define and maintain contract rules, treaty premium and expenses shares, discount types, payments and reporting time, monitoring figures and equations basis, business types, handling the expected premium income, and generates treaty wise summary figures and statistical information.

Pre-Authorization & Admission Module

The pre-authorization & admission module is designed to receive the requested (admission and/or pre-Authorization) forms from the medical provider such as hospitals and medical centers. The pre-authorization is uses a new re-engineered checking engine that will validate the requested form information, such as ICD-10, HCPCS, ICHI, ATC, etc. Against, contract conditions, medical factoid, subscriber information & history, etc. Resulting an auto-response and printing a covering latter with all information for liabilities. Also it will be used in the claims and visit information for latter checking and validation issues.

Pricing Module

The pricing module is designed to support the rapid pricing changes; the procedure pricing for example can be assigned to any level of price list, medical provider type, medical provider specialty, contract level… etc. The pricing module allows to (but not limited to) define and/or maintain HCPCS prices based on medical provider type, prices can be defined based on fixed amount, percentage amounts or points. The prices are stored with historical information and multi-currency information.

Financial Module

The financial module is designed to manage, provide and generate financial information, calculated from the different integrated modules in the system. That will provide the amount of money spent or earned.

Also the financial module is responsible to validate and verify the claims HCPCS prices and claimed amounts, and provides the correct information, such as rejected amount, discounts, services, etc.

In conjunction with and upon completing the claim processing phases, the financial module is capable to generate voucher information in order to be billed and settled with the risk carrier and attaching covering letter generated with the voucher information detailing and requesting due amounts.

Once dues received from the risk carrier, an accountant shall enter all amounts paid and log it to the system in order to allow it to generate medical provider checks in order to settle medical provider dues. In addition to all that, the paid management is capable to manage and follow up the unpaid dues by alerting the user of the overdue amounts.

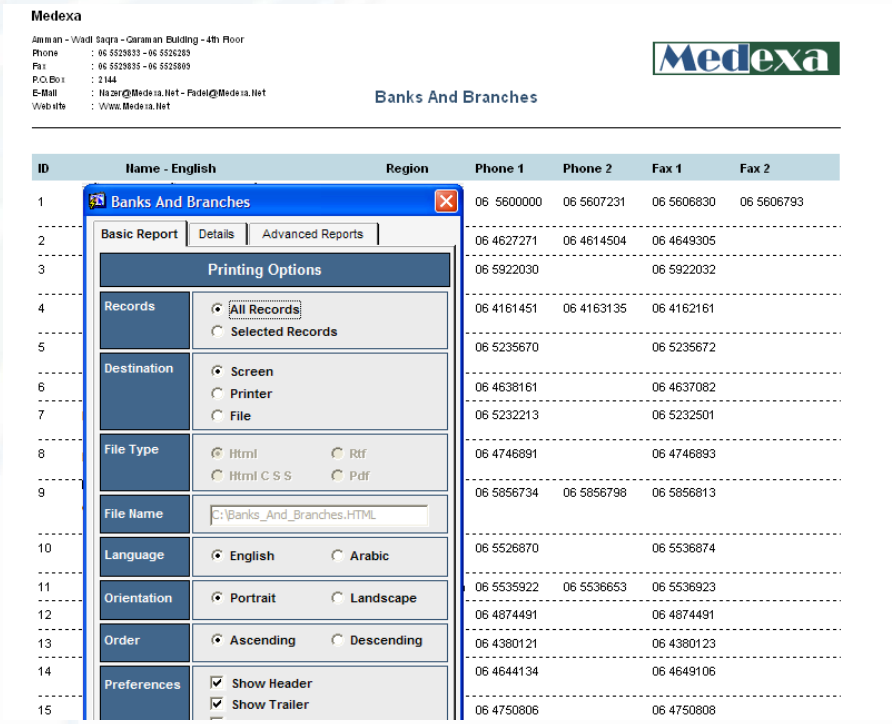
Reports & Data Mobility

The system is designed and armed to generate informative reports to be used in different types of the day-to-day business activities. The reports are to provide statistical and detailed information, and it can be generated in xml, oracle report, html, and text formats this will insure to move and/or manually manipulate information for business different purposes. Each screen and/or module component is armed with many of convenient reports.

The reports are easily accessible by the end-user, and they are categorized based on the module as well as the screen. In addition to all that, the reporting capabilities allowing users to customize there reports by selecting fields to display and selecting different printing options and others.

Different reports can be generated such as:

- **Analysis** Reports: such as group analysis, cost analysis… etc.
- **Statistical** Reports: such as insured group, provider, subscriber… etc.
- **Performance** Reports: such as loss ration, out standing reports, IBNR reports… etc.
- **General** Reports: such as medical provider list, subscriber list… etc.
- **Financial** Reports: such as vouchers, paid information, check information… etc.



Online-Services Integrations

This section describes the different integration modules and/or systems that support and provide extra layers and/or interfaces to the system such as voice activated system, accounting system and personal system.

Voice Activated System [VAS]

The system will be integrated with the voice activated system in order to facilitate the claim data entry by allowing the medical provider to check and enter patient contract and medical treatment information online. Using the Telephony lines linked directly to the database through a secure connection.

The VAS benefits are summaries as follows:

- User Friendliness
- Immediate access via any telephone line with TPA and/or insurance company
- Continuous automatic update of records (claims entry)
- Policy conditions monitored on line
- Providing statistical reports; standard or tailored to all clients via internet
- Reduction in administration time and cost

Smart Card

The smart card technique is integrated to the system and used based on on-line and off-life bases in order to facilitate and add advantages to the following:

Risk carriers:

- Implant policy conditions (before the facts) such as eligibility, limits, exclusions, pre-existing disease, waiting period, co-payment, no of visits, effective and expiry date, online id card renewal or deletion, etc.
- Fully automated no human interference.
- Less administrative running costs.
- Accurate claim management.
- Online Medical audit such as preventing prescribing same or similar drugs, control medicine or procedure related to age, gender, marital status and control drug consumption.
- Minimize abuse by subscribers and malpractice by medical providers.
- Eliminate need to employ field professionals.
- Eliminate need to Invest In technology for management.

Subscribers:

- Full medical files with easy retrieval.
- Around the clock medical services.
- Large network of health care providers.
- No need for paper claims.
- No medicine duplication.
- Online ID card updating.

Medical providers:

- Financial rights are clear.
- Ability to deal with different policies and/or different instructions.
- Implement procedures efficiently.
- Patient medical history always accessible.
- No time wasting on paper work.
- Every processed claim is approved and no more rejection.
- Fast payment.
- Decreasing losses in payments due to subscriber's frauds.