Once upon a time in a city, there was a large healthcare company named **"HealthPlus"** that offered various insurance plans to its members. The company was looking for a way to manage its complex claims processing, provider relationships, and ensure its customers got the best healthcare benefits without getting tangled in too many rules. That’s when **Facets**, a software solution by **Cognizant's TriZetto**, came to their rescue.

**Scene 1: Setting Up Health Plans**

The company wanted to offer a variety of plans for different needs, like **Medical, Dental, and Vision**. Each of these plans had a unique name, and every plan needed to have detailed information like:

* Who can enroll in the plan (Eligibility)?
* What are the benefits? For example, **Routine Check-ups**, **Surgeries**, and **Emergency Visits**.
* How long the coverage will last for each person (Stop Age).
* When does the coverage start after someone enrolls (Waiting Period)?

To organize all of this information, the team used **Facets**. They started by creating **Plans** and linking them to **Products**.

* **Plan**: A high-level category like "HealthPlus Gold Plan."
* **Product**: The detailed structure that includes all the benefits, rules, and pricing .

For instance, if a new member, **John**, joins the **HealthPlus Gold Plan** in January 2023, his coverage begins immediately because there’s no waiting period for new employees (Waiting Period = 0).

**Scene 2: John Visits a Doctor**

One day, John wasn't feeling well and decided to see a doctor. The doctor he chose was a part of the **HealthPlus Network** (Participating Provider), which meant he could go for treatment without paying extra charges. This relationship between HealthPlus and the doctor was pre-determined by a **Network Set** (Collection of Providers).

* If John visited a doctor outside this network, he would have to pay higher fees because that doctor would be considered **Out of Network**.

John’s visit to the doctor was logged in Facets using a special code called a **Procedure Code** (99215). This code was part of the **Standard Industry Codes** list that Facets maintained to ensure that services provided are billed correctly. Along with that, a **Diagnosis Code** was added to show what condition John was being treated for.

**Scene 3: Processing the Claim**

After the visit, the doctor generated a **Claim** for the services provided to John. The claim went through **Claims Adjudication** (the process of evaluating whether the claim is eligible for payment and how much should be paid). Facets uses several components to make this decision:

1. **Place of Service (POS)**: Defines where the service was provided, e.g., at a hospital or in a clinic.
2. **Explanation Codes**: Justifications added to clarify why a claim was approved, denied, or partially paid.
3. **Benefit Components**: Rules like whether the service was eligible under John’s plan, or if a deductible needs to be paid first.

Facets verified John’s claim by checking these rules, ensuring that it was processed accurately.

**Scene 4: Provider Payment**

After John’s claim was processed, HealthPlus had to pay the doctor. This payment depends on how the doctor is contracted with HealthPlus:

* **Fee for Service (FFS)**: If John’s doctor charges per service, he gets paid for each visit or procedure done.
* **Capitation**: If the doctor is part of a **Capitation Plan**, he gets a fixed amount per member per month, no matter how many times members visit him.

For example, if John’s doctor had a **Capitation Contract** of $2000 for 10 members, he would receive $20,000 monthly even if John and others didn’t visit him that month.

**Scene 5: Administrative Configurations**

Meanwhile, the HealthPlus admin team ensured that rules like **Stop Age** and **Waiting Period** were in place:

* **Stop Age**: If John turned 65, his coverage would automatically end, as 65 was the designated stop age.
* **Waiting Period**: If John joined the company on January 1st, 2023, and his plan had a 10-day waiting period, his coverage would start on January 11th, 2023.

They also ensured that the plan had a **Rate Guarantee** so that premiums wouldn’t change for the next two years.

**Scene 6: Complex Claims and Coordination of Benefits (COB)**

One day, John got injured and had to get treatment in an Out of Network hospital. HealthPlus was able to determine how much to pay by checking **Coordination of Benefits (COB)**. If John had another insurance policy, HealthPlus would decide whether to be the primary or secondary payer.

* **Primary Payer**: Pays first and covers the maximum allowed amount.
* **Secondary Payer**: Covers the remaining amount after the primary payer has made its contribution.

**Scene 7: Making Adjustments and Benefits Enhancement**

HealthPlus wanted to add new benefits like **Vaccination Camps** and **Counseling Sessions** under John’s plan. Using the **Benefit Components Table**, they updated the plan to include these new benefits and set new **Variable Components** for cost-sharing like copays or deductibles.

If John wanted to use these services, he could now do so without incurring extra charges. All these changes were stored in the **Administrative Information Table**, ensuring the system was always updated.

**Final Scene: Putting It All Together**

By using **Facets** effectively, HealthPlus was able to create a comprehensive plan, manage claims, handle payments to providers, and even update benefits dynamically. This entire workflow was managed through **Facets Workflow**, which automated many manual processes, allowing the team to focus on delivering high-quality service to members like John.

In this way, Facets helped **HealthPlus** simplify its operations, reduce administrative costs, and provide better healthcare services to its members.