2nd.MD Eyemed

Interface Requirements Specification

# 2nd.MD

# Contact Information

## Customer Contact

|  |  |  |
| --- | --- | --- |
| **Name** | **Phone** | **Email** |
| **Stephanie Williams** |  | **stephanie.williams@2nd.md** |

## Vendor Contact

|  |  |  |
| --- | --- | --- |
| **Name** | **Phone** | **Email** |
|  |  |  |

## Integration Contact

|  |  |  |
| --- | --- | --- |
| **Name** | **Phone** | **Email** |
| **Richard Vars** | **352.213.0066** | **rvars@tekpartners.com** |

## 

# Revision History

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Date | Version | Revision Description | Comments | Author |
| 1 | 7/23 | 1.01 | Initial Draft | Draft | Richard Vars |
| 2 |  |  |  |  |  |
| 3 |  |  |  |  |  |

# Customer Confirmation

Health and Welfare Exports (Medical, Dental, and Vision)

1. **Vendor Name: Eyened**
2. **Group or Policy Number: F024962**
3. **Will you have employees that are active in multiple component companies?**

☒ No ☐ Yes

1. **Are there any Employee Types, Pay Groups, Org Levels, etc. that need to be excluded?**

☐No ☒ Yes

If Yes, please list field and values to exclude or include *(whichever is a shorter list)*:

1. **Which Employees would you like to include on this export?**☒ Employees Active on Applicable Deduction Code

☐ Active Only Employees

☐ All Employees with YTD Earnings

☐ Other: Click or tap here to enter text.

1. **When did you start coverage with this provider:**1/1/2018
2. **Confirm the applicable UltiPro Deduction Codes for each that apply:**

**Type UltiPro Deduction Code**

Medical

Dental

Vision VIS

Other

1. **Confirm how you would like to send termination of coverage on this file:**

**☒** Terminations sent one time only - based on the actual (audit) date entered into UltiPro.

☐ Terminations sent one time only - based on the actual (audit) date entered into UltiPro, with no future dated terminations.

☐ Effective Date of Termination within last \_\_ days (Ex. 30 days).

1. **What is the Relationship Code(s) that define:**

“Spouse” SPS

“Children” CHL

1. **How do you currently administer COBRA?**

☐ 3rd Party Cobra Administrator

☐ Self-Administered

☐ Other:

1. **If you selected “Self-Administered” above, please note that you will need to have a Cobra Specific Deduction Code for each of your plans currently covered under Cobra. Please confirm the following for each of your applicable Cobra Deduction Codes based on the below Cobra Coverage Types**

|  |  |  |
| --- | --- | --- |
| **Type** | **Specification Name** | **Ultimate Software Project Number** |
| Employee Only |  |  |
| Employee + Family |  |  |
| Dependent Only |  |  |

1. **Open Enrollment Option = 2 files will be built based on the two Open Enrollment Sessions – one Active and one Passive.**

**What month is your OE effective?**

**What type of enrollment will you be offering?**

☐ Active ☐ Passive

*An ACTIVE session requires all employees to go in and make an election. If an employee does not re-elect their benefit, they will be dropped from that benefit. Since this is a changes-only file, we need to know if to include the employee with a coverage stop date, or if they will be termed by omission from the file. We do not need to worry about the passive file since this is a full file, and we will send a coverage stop date automatically.*

**If an employee stops their current benefits during an ACTIVE Open Enrollment, would you like to include them on the file with a stop date?**

X No ☐ Yes

1. **Post Live Only: Interface Decommissioning (are there current/other interfaces that this interface is replacing?)**

☐ No ☐Yes, *Customer must open a Support Ticket to request the current interface to be turned off.*

# Mapping/Notes to Developer

See spec.

# Vendor Confirmation

Health and Welfare Exports (Medical, Dental, and Vision)

1. **Do you allow for future-dated coverage START dates on the file?**

☐ No X Yes

If Yes, please include the number of days in the future that are accepted. We will default to 30 days.

1. **Do you allow for future-dated coverage STOP dates on the file?**

☐ No X Yes

If Yes, please include the number of days in the future that are accepted. We will default to 30 days.

1. **Do you require a minimum coverage start date on the file (Ex. We cannot send any effective dates older than 1/1/2018 on the file)? If so, what is that date?**

Click or tap here to enter text.

1. **Benefit Change Effective Date Option:**

☒ Actual Benefit Coverage Start Date as keyed on the EMP and DEP Record.

☐ Most Recent Benefit Option Effective Date from History on the EMP record and Actual Benefit Coverage Date as Keyed on the DEP Records.

☐ Most Recent Benefit Option Effective Date from History on the EMP AND DEP Records.