Medical

Interface Requirements Specification

# First Community Credit Union

# Contact Information

## Customer Contact

|  |  |  |
| --- | --- | --- |
| **Name** | **Phone** | **Email** |
| Cathy Furstenberg |  | Cathy.Furstenberg@fccu.org |

## Vendor Contact

|  |  |  |
| --- | --- | --- |
| **Name** | **Phone** | **Email** |
| **Terry Balbier** |  | Terrence.Balbier@Cigna.com |

## Integration Contact

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| --- | --- | --- |
| **Name** | **Phone** | **Email** |
| **Lea King** | **515-480-4262** | **lking@tekpartners.com** |

## 

# Revision History

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Date | Version | Revision Description | Comments | Author |
| 1 | 03/13/2020 | 1.01 | Initial Draft |  | Lea King |
| 2 |  |  |  |  |  |
| 3 |  |  |  |  |  |

# Customer Confirmation

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

1. **Vendor Name: Cigna**
2. **Group or Policy Number:** 00628466-F
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)*:

Exclude emptype TES

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:**02/01/2020
2. **Confirm the applicable UltiPro Deduction Codes for each that apply:**

|  |
| --- |
| **Ded codes** |
| MHDHP/MHVP/MHEVP |
| MUHCC/MCVP/MCEVP |
| MSEPO/MSVP/MSEVP/MSCEO |

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 or DP

“Children” CHL, DIS or STC

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

X 3rd Party Cobra Administrator

☐ Self-Administered

☐ Other:

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

# Mapping/Notes to Developer

# 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?**

02/01/2020

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

☒ Actual Benefit Coverage Start Date as keyed on the EMP and DEP Record – including future dated term dates