Health Compliance

Benefits Import Pipe Delimited File Specification

Creation Date: **07/24/2015**
Modified Date: **06/01/2018**
Version**: 4.0**

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Benefits Data Interface

Overview

Medical benefits data is required by the ADP Health Compliance system in order to determine any potential penalties. An employer may be subject to Affordable Care Act (ACA) penalties if they do not meet certain thresholds related to benefit eligibility and affordability. **The ADP Health Compliance system uses the data received in the Benefit files for determining whether or not an ACA full-time employee has been offered affordable coverage.**

This is a Pipe Delimited ASCII text file with multiple record types, each identified by the initial element. Each record has a defined number of fields, all records must include the exact number of defined fields otherwise the record will fail to import correctly.

Employees to Include

Only information pertinent to ACA related medical coverage specified in this document is to be included on the file.

ADP Health Compliance does not support passive enrollment. Annual Enrollment files, containing all active benefit offers, elections, and dependents covered, must be provided for each new plan year and contain updated coverage start dates.

ADP recommends sending all eligible medical Plan Offerings at the employee only (EE Only) coverage level, for each event (Annual Enrollment, Marriage, Birth of Child, etc.) that are available to the employee. It is expected that the Offer and Selected Coverage be sent in the same transmission. If the Offer and Selected Coverage cannot be sent in the same transmission, the Offer data must be received prior to the Selected Coverage data for ADP Health Compliance to match the Selected Coverage to the corresponding offer of coverage.

If unable to meet the recommendation above, at a minimum, ADP requires that the Offer contain both the lowest cost EE Only coverage level Plan- that meets Minimum Essential Coverage (MEC) and Minimum Value Plan (MVP) and the Plan being passed as the employee's Selected Coverage.

Initial File

It is expected that clients implementing Affordability for the current plan year include employee plan offering and selected coverage history dating back to the beginning of the plan year, usually corresponding with the Annual Enrollment event. Subsequent changes in eligibility, adding or dropping dependents and/or the addition of new hires, up to the selected current date, are also to be included on the file. All changes for an employee should be included and ordered chronologically by event. Clients implementing Affordability for an upcoming plan year are to begin the transmittal of data upon the trigger of the Annual Enrollment event.

Transactions to Include

It is recommended the Benefits system provide all transactional records for employees back to the beginning of the current benefit plan year. All changes for an employee should be included and ordered chronologically by event date. Benefit eligible employees should have a minimum of one event record on the file (Annual Enrollment) and multiple event records if the employee has had a change in eligibility or selected coverage during the benefit plan year. Examples (including but not limited to):

- Employee experiences a change in eligibility.
- Employee is provided an opportunity to enroll in an ACA related medical plan.
- A change in any of the election attributes (e.g., plan cost change, change in attestation).
- A dependent of the employee has a change in coverage (e.g., termination, dependent age out, loss of eligibility).
- Previous record sent to ADP contained errors and requires correction.

Frequency of Data

In order to perform accurate eligibility and affordability calculations, as well as annual filings, it is important that the ADP Health Compliance system frequently receives medical benefit related data. It is expected that the Benefits system of record will provide data to the ADP Health Compliance system on a time sensitive schedule. These schedules vary in frequency and cannot be received less frequently than once a month in order for ADP to perform affordability calculations.

It is recommended that files transmit on a monthly basis.

Loss of Eligibility

If an employee loses eligibility for medical benefits, an OFFR should be sent for the event triggering the loss in eligibility, without any plans (ELIG) listed with the offer.

Only the Event Reason and Event Date are required in the OFFR for this scenario.

Termination of Coverage

When a previously reported medical coverage to the ADP Health Compliance system is terminated, the effective coverage end date shall be provided in the Coverage End Date element in the COVG record. Corresponding dependent coverage shall be terminated using the same effective end date.

To terminate coverage for an employee and all dependents, only the Event Reason, Event Date and Coverage End Date elements should be valued in the COVG record.

Removal of Dependents

There are two methods which can be utilized to end dependent coverage in ADP Health Compliance.

Method #1:

Resend the previously reported employee and dependent coverage record with an explicit coverage end date for the dependent(s) ending coverage.

Method #2:

The absence of a previously reported dependent on a new employee coverage (COVG) record implies the dependent coverage ended the day prior to the new coverage start date.

If terminating coverage for all dependents, but the employee is continuing coverage, a new COVG record for the Plan/Coverage Level the employee is covered under can be passed, without the dependents. This will result in all dependent records being end dated one date prior to the Coverage Start Date received in the new employee coverage (COVG) record.

If the employee and all covered dependents are terminating coverage, only a COVG record, populated with Event Date, Event Reason and Coverage End Date is required.

File Naming Convention

Please reference the transmission summary document provided by the ADP implementation specialist.

Format

The ADP Health Compliance system will accept Benefits data in a pipe (|) delimited format.

The interface requires multiple types of data. For example, the system requires benefits eligibility, benefits coverage and dependent information. In order to process all of these various sets of data, the interface will require a record type on each record. The record type will identify the type of data included on that particular record.

The following record types are supported for Benefits imports:

HEAD: The header record for the file. This record is used to identify the client. This record is required on all files.

EEID: The identity record for the participant. This record is required on all files.

OFFR: The offer (i.e. event) of coverage to the participant.

ELIG: The plans for which the participant is eligible.

COVG: The plan coverage the participant has actually enrolled in.

DEPI: Dependent information

FOOT: The footer record for the file. This record provides the number of participants on the file.

Fields included on the Interface

Header Record (always required)

The HEAD record contains company identifying information for the ADP Health Compliance system. Only one HEAD record should be present within the file and should be the first record in the file.

Field Number	Element	Notes	Req?	Length*	Example
1.	Record Type	Constant “HEAD”	Y	4	HEAD
2.	Client Identifier	Unique 16 character COID assigned by ADP (included in the transmission summary document)	Y	16	2FA6CFC739A34284
3.	Client Name	The name of the client. Client defined value.	N	100	Company ABC

Employee Identifier Record (always required)

The EEID record contains the indicative employee data. There should only be one EEID record per employee, per file, regardless of how many events are being sent for the employee.

Field Number	Element	Notes	Req?	Length*	Example
1.	Record Type	Constant “EEID”	Y	4	EEID
2.	Participant Identifier	Uniquely identifies the participant. This identifier will appear on every record that is associated with this participant to link them. The identifier may be comprised of Alphanumeric characters only.	Y	16	114781
3.	Participant SSN	The social security number of the employee.	Y	11	Format: XXXXXXXXX (Preferred) Or XXX-XX-XXXX
4.	Participant First Name	The first name of the employee.	Y	50	Benedict
5.	Participant Middle Name	The middle name of the employee.	N	50	Timothy
6.	Participant Last Name	The last name of the employee.	Y	50	Cumberbatch
7.	Gender	The gender of the employee.	N	1	M – Male F – Female U - Unknown
8.	Date of Birth	The date of birth of the employee.	Y	10	07/19/1976 MM/DD/YYYY

Offer Record (required when eligible event triggers)

The Event Offering Data element is required when an employee experiences any change in eligibility or is provided an opportunity to enroll in an ACA related medical plan. These changes are typically associated with, but are not limited to: Qualifying Life Event (QLE), Work Event, or System Event.

At a minimum, a new <OFFR> record must be provided for all eligible employees at the beginning of the benefit plan year (this applies to passive and active Annual Enrollments). ADP Health Compliance assumes eligibility does not extend beyond the Plan Year End Date passed in the OFFR record.

*Offers are matched in the Health Compliance system by Event Reason and Event Date. In order to correct data for a previously loaded event, the same Event Reason and Event Date should be sent, with the correct plans available to the employee, so that the previously loaded data will be overwritten by the new file.

* Elements marked with a red asterisk become optional in the case of a loss of eligibility.

Field Number	Element	Notes	Req?	Length*	Example
1.	Record Type	Constant “OFFR”	Y	4	OFFR
2.	Participant Identifier	Uniquely identifies the participant. This identifier will appear on every record that is associated with this participant to link them. The identifier may be comprised of Alphanumeric characters only.	Y	16	114781
3.	Offer Identifier	This value is used to link the eligibility data to the applicable offer. The value in the OFFR record should be the same on all ELIG records associated with that offer. The value does not have to be unique across all participants. It must be unique for this participant SSN. 2 different participants (different SSNs) may have the same value for an offer id. Client defined value.	Y	50	OE01/01/2018
4.	Event Reason*	The event reason associated with the offer of coverage. Client defined value	Y	50	Annual Enrollment

Field Number	Element	Notes	Req?	Length*	Example
5.	Event Date*	Date of the Event This should be the date which triggered the offer or change in eligibility.	Y	10	Format: MM/DD/YYYY Example: 01/01/2018
6.	Coverage Start Date*	The date coverage would become effective if elected. The date passed should be the most recent effective date of the change (price, coverage tiers, etc). If no change occurs from plan year to plan year, this value must be the new plan year effective date. If the Coverage Start Date varies by plan, this should be the Coverage Start Date for the lowest cost, employee only coverage, that meets the MEC and MVP attestations. This date cannot be prior to the Event Date and must be within the Plan Year Start Date and Plan Year End Date, inclusive.	Y	10	Format: MM/DD/YYYY Example: 01/01/2018
7.	Plan Year Start Date*	This represents the first day of the plan year in which the Coverage Start Date falls. This information is used by ADP Health Compliance in affordability and IRS reporting. Not required in the case of a loss of eligibility.	Y	10	Format: MM/DD/YYYY Example: 01/01/2018
8.	Plan Year End Date*	This represents the last day of the plan year in which the Coverage Start Date falls. This information is used by ADP Health Compliance in affordability and IRS reporting. The benefit plan year dates need to be provided for all records with the exception of a loss of eligibility. Missing or inaccurate plan year dates will result in IRS Reporting inaccuracies for all or part of an employer's population.	Y	10	Format: MM/DD/YYYY Example: 12/31/2018

Field Number	Element	Notes	Req?	Length*	Example
9.	Transaction Date	This is the date time stamp when the offer was created in the source system.	N	29	Format: MM/DD/YYYY HH:MM:SS.SSSSSS AM/PM Example: 10/20/2017 02:11:24.158000 PM

Eligibility Record (required when reporting eligible plans)

The ELIG record is required whenever the OFFR record is present (excluding loss of eligibility). This section contains pertinent medical plan information. If multiple tier coverage levels for a plan are included, each must be supplied within its own ELIG record. For example, your typical medical plan has four tier coverage levels: Employee Only, Employee plus spouse, Employee plus child(ren), and Employee plus family. This would equate to 4 separate ELIG records. The only required tier level for each medical plan is the Employee Only tier.

If an employee loses eligibility (including termination), a new OFFR record with Event Reason and Event Date needs to be sent with no ELIG records tied to it.

Field Number	Element	Notes	Req?	Length*	Example
1.	Record Type	Constant “ELIG”	Y	4	ELIG
2.	Participant Identifier	Uniquely identifies the participant. This identifier will appear on every record that is associated with this participant to link them. The identifier may be comprised of Alphanumeric characters only.	Y	16	114781

Field Number	Element	Notes	Req?	Length*	Example
3.	Offer Identifier	This value is used to link the eligibility data to the applicable offer. The value in the OFFR record should be the same on all ELIG records associated with that offer. The value does not have to be unique across all participants. It must be unique for this participant SSN. 2 different participants (different SSNs) may have the same value for an offer id. Client defined value.	Y	50	OE01/01/2018
4.	Medical Plan Code	Medical Plan Code from the System of Record. Client defined value	Y	40	BCBSOPT1
5.	Medical Plan Description	Medical Plan Description from the System of Record. Client defined value.	Y	100	Blue Cross Blue Shield Option 1
6.	Medical Plan Coverage Level Code	Coverage Level Code for Medical Plan. Client defined value	Y	40	EEOnly
7.	Medical Plan Coverage Level Description	Coverage Level Description for Medical Plan. Client defined value	Y	100	Employee Only
8.	Employee Only Coverage Level Flag	A Flag indicating if the plan and coverage level associated with this record represents Employee Only coverage. If sending a waived/no coverage plan, this indicator must be “N”.	Y	1	Valid Values: Y = Yes N = No
9.	Monthly Employee Cost	Monthly Employee Cost associated with the plan and coverage level. This value must correctly reflect the cost to the employee with respect to tobacco incentives, wellness incentives, opt-out credits, etc, per IRS guidelines.	Y	10	Format: x.xx Examples: 174.68 0.00

Field Number	Element	Notes	Req?	Length*	Example
10.	Monthly Employer Cost	Monthly Employer Cost associated with the plan and coverage level.	Y	10	Format: x.xx Examples: 261.92 0.00
11.	Minimum Essential Coverage	An employer attestation flag to indicate the plan meets Minimum Essential Coverage (MEC) requirements. This flag must be set to the same value for all coverage levels within the same Medical Plan Code. If sending a waived/no coverage plan, this indicator must be “N”.	Y	1	Valid Values: Y = Yes N = No
12.	Minimum Value Plan	An employer attestation flag to indicate the plan meets the Minimum Value Plan (MVP) standard. This flag must be set to the same value for all coverage levels within the same Medical Plan Code. If sending a waived/no coverage plan, this indicator must be “N”.	Y	1	Valid Values: Y = Yes N = No
13.	Dependent Coverage Available	If dependents can be covered under this Medical Plan Code, the flag must be set to “Y” for all coverage levels (including employee only). Dependent indicates children.	Y	1	Valid Values: Y = Yes N = No
14.	Spouse Coverage Available	If the spouse can be covered under this Medical Plan Code, the flag must be set to “Y” for all coverage levels (including employee only). This includes domestic partners. If the medical plan is conditionally offer to spouses or domestic partners, this value should be set to “S”	Y	1	Valid Values: Y = Yes N = No

Field Number	Element	Notes	Req?	Length*	Example
15.	Self-Insured Plan	A flag indicating if the plan is a self-insured plan. Valid Values: Y – Yes, it is self-insured medical plan. N – No, it is not self-insured medical plan. It is a fully insured medical plan.	Y	1	Valid Values: Y = Yes N = No
16.	ACA Base Plan Actuarial Value Percentage	Minimum is 0.00 Maximum is 100.00	N	6	Format: xxx.xx
17.	Wait period Indicator	Indicates whether or not the Plan offers a 90 day or less waiting period for all eligible employees.	N	1	Valid Values: Y – Yes N – No
18.	Future Use				

Coverage Record (required when reporting coverage)

The Benefits COVG record is required whenever an employee and/or dependent has a change in coverage. It is important to emphasize that selected benefit coverage records must match an existing eligible plan (Medical Plan Code) offering (ELIG), either within the same interface file or on a previous offering.

At the beginning of each benefit plan year, a new <COVG> record must be provided for all employees who elect or waive coverage. This applies to passive and active Annual Enrollments.

When reporting “Waived Coverage” or “Opt-out” elections by the employee, elements marked with a red asterisk * become optional. For a “Waived Coverage” selection (<WaivedCoverage> = ‘Y’), no value should be passed in the Medical Plan Code or Medical Plan Description fields.

Field Number	Element	Notes	Req?	Length*	Example
1.	Record Type	Constant “COVG”	Y	4	COVG
2.	Participant Identifier	Uniquely identifies the participant. This identifier will appear on every record that is associated with this participant to link them. The identifier may be comprised of Alphanumeric characters only.	Y	16	114781
3.	Event Reason	The reason for the event. Client defined value. This is not linked to the OFFR.	Y	50	Annual Enrollment
4.	Event Date	Format: MM/DD/CCYY The date of the Event.	Y	10	Format: 01/01/2018 Example: MM/DD/YYYY
5.	Medical Plan Code*	Medical Plan Code from the System of Record. Client defined value. System must find a matching Plan Code in the OFFR of the current file or in the system from a previous load.	Y	40	BCBSOPT1

Field Number	Element	Notes	Req?	Length*	Example
6.	Medical Plan Description*	Medical Plan Description from the System of Record. Client defined value.	Y	100	Blue Cross Blue Shield Option 1
7.	Medical Plan Coverage Level Code*	Coverage Level Code for Medical Plan. Client defined value.	Y	40	EEOnly
8.	Medical Plan Coverage Level Description*	Coverage Level Description for Medical Plan Client defined value.	Y	100	Employee Only
9.	Monthly Employee Cost*	Format: X.XX Examples: 261.92 0.00 The monthly cost of the selected plan and coverage level associated to the employee.	Y	10	Format: x.xx Examples: 261.92 0.00
10.	Monthly Employer Cost*	Format: X.XX Examples: 261.92 0.00 The monthly cost of the selected plan and coverage level associated to the employer.	Y	10	Format: x.xx Examples: 261.92 0.00

Field Number	Element	Notes	Req?	Length*	Example
11.	Coverage Start Date	Format: MM/DD/CCYY This is the effective date for the coverage. The date passed should be the most recent effective date of the change (price, coverage tiers, etc). If no change occurs from plan year to plan year, this value must be the new plan year start date. This date cannot be prior to the Event Date.	Y	10	Format: MM/DD/YYYY Example: 01/01/2018
12.	Coverage End Date	Format: MM/DD/CCYY The last full day that coverage was effective for the employee. Required when terminating coverage.	CR	10	Format: MM/DD/YYYY Example: 05/22/2018
13.	Future Use				
14.	Future Use				
15.	Future Use				
16.	Waived Coverage	A flag indicating that the employee has “Waived” or “Opted-out” of coverage.	Y	1	Valid Values: Y = Yes N = No

Field Number	Element	Notes	Req?	Length*	Example
17.	Reason for Waiver Code	Required if Waived Coverage flag is “Y”. A code which identifies the reason the employee has waived coverage. Valid values are: 01 – Public Exchange Coverage 02 – Alternative private coverage 03 – Medicaid Coverage 04 – Medicare Coverage 05 – No Coverage 06 – Unknown If the Benefits system does not track reasons for waive or does track it but for some reason it is not valued, this field should be populated with “06” for any employee that has waived coverage.	CR	2	01 = Public Exchange 02 = Private Coverage 03 = Medicaid Coverage 04 = Medicare Coverage 05 = No Coverage 06 = Unknown
18.	Reason for Waiver Description	Required if Waived Coverage flag is “Y”. The reason description for the employee “Waive” or “Opt-Out” of coverage. Client defined value.	CR	100	Unknown
19.	Transaction Date	This is the date time stamp when the coverage was created in the source system.	Y	29	Format: MM/DD/YYYY HH:MM:SS.SSSSSS AM/PM Example: 10/20/2017 02:11:24.158000 PM
20.	Coverage Identifier	This field is required if the employee has dependents and is used to link the COVG record to any covered Dependent record(s). For example, if an employee selects Employee + Spouse coverage and lists their spouse as a covered dependent, the Coverage Identifier would be used to link the two records.	CR	50	01/01/2018

Field Number	Element	Notes	Req?	Length*	Example
		The identifier must be unique at the employee level, for each COVG record, not necessarily at the file level. The same value would be passed on all DEPI records that should be linked to that particular participant coverage. In instances where there is not a native unique identifier ADP recommends using the coverage start date.			

Dependent Record (required when reporting dependents)

The Dependent Coverage element (DEPI) is nested within the parent Employee coverage once the file is converted. Due to this nesting, if coverage for the employee is modified, resulting in an updated COVG record, a DEPI record is required for all covered dependents.

Field Number	Element	Notes	Req?	Length*	Example
1.	Record Type	Constant “DEPI”	Y	4	DEPI
2.	Participant Identifier	Uniquely identifies the participant. This identifier will appear on every record that is associated with this participant to link them. The identifier may be comprised of Alphanumeric characters only.	Y	16	114781
3.	Dependent Identifier	The unique identifier assigned to the dependent by the client system of record. Client defined value. This value must be unique for all dependents passed for an employee and should not include any social security number	Y	40	114781-01

Field Number	Element	Notes	Req?	Length*	Example
		information, be that of the employee or the dependent.			
4.	Dependent SSN	May be provided with or without dashes. This field should be provided if available.	N	11	Format: XXXXXXXXX (Preferred) OR XXX-XX-XXXX
5.	Dependent First Name		Y	50	Sophie
6.	Dependent Middle Name		N	50	Irene
7.	Dependent Last Name		Y	50	Hunter
8.	Relationship	The relationship of the dependent to the employee. Text in this field will be the relationship displayed in ADP Health Compliance. Client defined value.	Y	50	Spouse
9.	Spouse Indicator	A flag that specifies if the relationship represents that of a spouse, including Domestic Partners. Should be set to N for dependents that are not a spouse.	Y	1	Valid Values: Y = Yes N = No
10.	Dependent Date of Birth	The date of birth of the dependent.	Y	10	Format: MM/DD/CCYY Example: 04/16/1968
11.	Gender	The gender of the dependent.	Y	1	M = Male F = Female U = Unknown
12.	Coverage Start Date	The effective start date for dependent coverage. This value should be the same as the Coverage Start Date passed for the employee.	Y	10	Format: MM/DD/YYYY Example: 01/01/2018
13.	Coverage End Date	The last full day that coverage was effective for this dependent. Dependent coverage can be ended multiple ways and the method selected will depend on the benefit system of record.	CR	10	Format: MM/DD/YYYY Example: 05/22/2018

Field Number	Element	Notes	Req?	Length*	Example
		The Example Scenarios below provide additional detail around each method.			
14.	Future Use				
15.	Coverage Identifier	This field is used to link the Dependent record(s) to the COVG record for the employee that the dependent is covered under. For example, if an employee selects Employee + Spouse coverage and lists their spouse as a covered dependent, the Coverage Identifier would be used to link the two records together. The identifier must be unique at the employee level, for each employee COVG record, not necessarily at the file level. The same value would be passed on all DEPI records that should be linked to that particular employee coverage. Client defined value. In instances where there is not a native unique identifier ADP recommends using the coverage start date.	Y	50	01/01/2018

Footer Record (required)

Field Number	Element	Notes	Req?	Length*	Example
1.	Record Type	Constant “FOOT”	Y	4	FOOT
2.	Number of EEID Records	Total number of EEID records included on the file.	Y	9	3981

* Length: The maximum number of characters supported for each element/field

File Specification Structure

Sample Data

Social Security Numbers have been masked with “XXX-XX-XXX” in this example. Actual SSN’s must be provided when transmitting files.

```
HEAD|2FA6CFC739A34284|Company ABC
EEID|1446572|XXXXXXXXX|Benedict|Timothy|Cumberbatch|M|02/12/1975
OFFR|1446572|AE01/01/2018|AE|01/01/2018|01/01/2018|01/01/2018|12/31/2018|12/31/2017 02:11:24.158000 PM
ELIG|1446572|AE01/01/2018|BCBSPRMR|BCBS Premier|EE|Employee Only|Y|172.38|572.38|Y|Y|Y|Y|Y|84.00|Y|
COVG|1446572|AE|01/01/2015|BCBSPRMR|BCBS Premier|EES|Employee + Spouse|172.38|572.38|01/01/2018|||||N|||12/31/2017 02:11:24.158000 PM|01/01/2018
DEPI|1446572|01|234567891|Sophie||Hunter|Spouse|Y|04/16/1978|F|01/01/2018|||01/01/2018
FOOT|1
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File Spec Companion Information

This section is to be used as a supplement to, and in conjunction with the technical file specification details above. **The purpose is to provide additional information related to the requirements of this file, elements within the file and best practices related to the varying scenarios that one might encounter within their employee population.**

Minimum Requirements – At a minimum, ADP requires that the lowest cost employee only coverage level plan, that meets both MEC and MVP, as well as the plan that the employee ultimately selects, be passed within the offer. The ADP Health Compliance system needs this lowest cost plan for Affordability calculations, as well as 1095C reporting, and cannot load coverage as selected by an employee, unless it sees that plan as offered to the employee, hence both of these plans are required in the offer. Providing the data in this way means that the benefit system of record or interface must be able to identify that lowest cost plan. This also means that on all files, the interface must generate an offer containing the lowest cost employee only plan that meets MEC and MVP offered to the employee, as well as the plan that the employee is selecting.

Example Scenarios

The following examples can be found in the sample file, Attached to this document.

Scenario	Notes
File Details This file will contain medical eligibility, selected coverage and dependent coverage back to the beginning of the benefit plan year to support IRS reporting for the tax year ADP Health Compliance will be reporting.	
Example 444444: Enrolled, Later Adds Child to Coverage John Bender received an offer and enrolled in coverage during Open Enrollment and then had a child later in the year, before the initial load file was created. (ADP Preferred)	• The Coverage Start Date cannot be prior to the event date • The Coverage Start Date should fall on or within the plan year dates being passed. • OFFR > ELIG: It is only necessary to pass the employee only coverage levels in the offer • This example illustrates multiple offers and selected coverage records for one employee in a single file.

Example 555555: Enrolled, Later Adds Child to Coverage (Min Requirements) Ferris Bueller received an offer and enrolled in coverage during Open Enrollment then had a child later in the year. The elected medical plan and coverage level changed. (Minimum Requirements)	• The Offer only includes the lowest cost offer and the offer for the selected medical plan (both at the employee only coverage level).
Sample File, Example 111111: Eligible, Waived Coverage Freddy Krueger received an offer during Open Enrollment, but waived coverage.	
Example 222222: Enrolled, Later Terminated Employment Jason Voorhees received an offer and enrolled in coverage during Open Enrollment, and coverage was terminated before the initial load file was created. Coverage was terminated due to change in employment status. (ADP Preferred)	• The HR import will contain a termination date and status, effective 6/1. This does NOT have any impact on benefit eligibility or elections. • Benefits import: ADP Health Compliance does not specify end dates for offers; rather an offer ceases to be in effect when a subsequent offer supersedes it. • When terminating eligibility, it is expected that an Offer with no plans will be passed to show that the employee is no longer eligible. • Since this loss of eligibility offer will end the previously existing offer on the day before, it is necessary to pass the event date of the loss of eligibility offer as the first day they are no longer eligible. • In this example, the selected coverage is terminated using ADP's preferred approach.

Example 654321: Enrolled, Later Terminated Employment (Coverage Extends) Wyatt Donnelly was originally offered and elected benefits, but was terminated later in the year. He terminates employment the middle of July, losing eligibility and ending his selected coverage. The employer allows selected coverage to extend to the end of the month in which the termination of employment occurs. (ADP Preferred)	• The HR import will contain a termination date and status, effective 7/16. This does NOT have any impact on benefit eligibility or elections. • The Offer node reflects the first day of ineligibility as 7/16 • The selected coverage node reflects coverage which is in effect through 7/31.
Example 456789: Waive Coverage, Terminated Later in Year Gary Wallace was originally offered benefits and chose to waive, but was terminated later in the year.	• The OFFR with the Event Reason “TERMINATION” and Event Date 08/01 ends eligibility as of 7/31.
Example 333333: New Hire, Enrolled in Coverage Michael Myers was hired 2 months into the benefit plan year after Open Enrollment.	
Example 666666: Married, Change Elected Coverage Level Jake Ryan was enrolled in EE only coverage and was married later in the year. (ADP Preferred)	
Example 777777: Married, Change Elected Coverage Level (Min Requirements) Jeff Spicoli was enrolled in EE only coverage and was married later in the year. (Minimum Requirements)	

Example 000000: New Hire, Waived Coverage (Min Requirement) Cameron Frye was hired and received an offer of benefits, but waived coverage. (Minimum Requirements)	
Example 111112: Elected Coverage, Married, Moves to Spouses Coverage Lane Myer was originally offered and elected benefits. He is later married and still eligible for benefits, but goes on his spouse's coverage. (ADP Preferred)	• The Marriage event on 9/1 includes an offer with the same medical plans passed for the Open Enrollment event. • The selected coverage Marriage event indicates the employee "waived" coverage as of 9/1. • ADP Health Compliance interprets this combination as a continuation of eligibility and selected coverage is in effect through 8/30.

Removal of Dependents

Dependent coverage can be ended in ADP Health Compliance using any of the methods outlined below. The method selected will depend on how information is stored and can be passed from the benefit system of record.

Example 111114: Elected Coverage, Dependent Ages out of Coverage Hoops McCann is covered under a family plan. One of his children ages out, but he and the rest of the family are still covered. In this example, the dependent coverage end date is inferred based on the absence of a subsequent dependent coverage record.	• The dependent dropped from coverage is Dependent: 111114-04. The new selected coverage record effective 5/31/2018 will force a selected coverage end date of 5/30/2018 for Dependent …-04 • The presence of a new participant coverage (COVG) segment without a corresponding dependent coverage (DEPI) segment causes the dependent's coverage to end the day before the new coverage begins (Coverage Start Date). • To set the correct coverage end date for a dependent(s), the new selected coverage start date must reflect the day after coverage ends for the dependent. • If an employer's benefit eligibility rules allow coverage to extend to the end of the month for dependents that age-out of coverage mid-month, the selected coverage start date must be set to the first day of the month following the loss of dependent coverage. • If terminating coverage for all dependents, but the employee is continuing coverage, a new COVG record for the Plan/Coverage Level the employee is covered under can be passed, without the dependents. This will result in all dependent records being end dated one day prior to the Coverage Start Date received in the COVG record.

Example 111115: Elected Coverage, Dependent Ages out of Coverage Vince Larkin is covered under a family plan. One of his children ages out, but he and the rest of the family are still covered. In this example, the dependent coverage end date is explicitly provided by the benefit system of record.	• The dependent dropped from coverage is Dependent: 111115-04. • The dependent coverage end date is passed as 05/30 in the original Open Enrollment event (dated 01/01) and all covered dependent records are included. • In this example, if the selected coverage plan, tier, or price had changed, a subsequent COVG record would be required (effective 5/31) and Dependent: 111115-04 would not be included in the 5/31 coverage record.

Sample File:

File Type	File
Pipe Delimited	The sample file can be downloaded from the “Attachments” section of this document.

Document Revisions

Version	Date	Author	Description
4.0	6/1/2018	J. Johnson	Companion Document contents integrated into file specification. Further clarified employees and transactions to include Further clarified methods for removal of dependents (including new example in sample file) Historical Initial Load File changed to Initial file “Note” incorporated into the Example Scenarios Sample File: removed redundant examples, updated employee and dependent IDs, updated dates
3.2	6/16/2017	J. Johnson	“Ongoing Change File” changed to “Ongoing File” Ongoing File section: 1 Example added of types of “changes” which should be included Frequency of Data: removed weekly transmission recommendation.
3.2	04/10/2017	J. Johnson	<HEAD> Client Identifier, description updated. <Participant Identifier> max field length change from 20 to 16. <OFFR> Note: At a minimum, offers are required for eligible employees at the beginning of each benefit plan year. <OFFR> Description updated for CoverageStartDate element. <OFFR > Description updated for PlanYearStartDate element. <OFFR > Description updated for PlanYearEndDate element. <ELIG> <SpouseCoverageAvailable> New value ‘S’ added to indicate offer conditionally made to spouse. <OFFR> ADP HC matches selected coverage (COVG) to offer of coverage (ELIG) by PlanCode (not plancode and tier level) <COVG> Note: At a minimum, coverage records are required employees who elect coverage, at the beginning of each benefit plan year. <COVG> Note: Enhanced note for passing “waived” coverage elections. <COVG> Description updated for CoverageStartDate element. <DEPI> Relationship element changed to Required.
3.0	08/18/2016	C. Murphy	<ELIG> Employee Only Coverage Level Flag element acceptable value of “U” removed.
3.0	06/13/2016	C. Murphy	Reordered and updated Benefits Data Interface section <HEAD> Added record description. <HEAD> Client Name element removed. <EEID> Participant SSN element description updated. <EEID> Gender element changed to Optional. <OFFR> Added record description. <OFFR> Offer Identifier element description updated.

			<OFFR> Coverage Start Date element description updated. <ELIG> Added record description. <ELIG> Offer Identifier element description updated. <ELIG> Employee Only Coverage Level Flag element description updated. <ELIG> Monthly Employee Cost element description updated. <ELIG> Monthly Employer Cost element description updated. <ELIG> Minimum Essential Coverage element description updated. <ELIG> Minimum Value Plan element description updated. <ELIG> Dependent Coverage Available element description updated. <ELIG> Spouse Coverage Available element description updated. <ELIG> Self Insured Plan element description updated. <ELIG> Wait Period Indicator element change to Optional. <ELIG> Waived Coverage element removed. <COVG> Added record description. <COVG> Medical Plan Code element description updated. <COVG> Monthly Employee Cost element description updated. <COVG> Monthly Employer Cost element description updated. <COVG> Coverage End Date element changed to Conditionally Required. <COVG> Coverage End Date element description updated. <COVG> Self Insured Plan element removed. <COVG> Minimum Essential Coverage element removed. <COVG> Minimum Value Plan element removed. <COVG> Waived Coverage element description updated. <COVG> Reason for Waiver Description element description updated. <COVG> Coverage Identifier element description updated. <DEPI> Added record description. <DEPI> Relationship element changed to Optional <DEPI> Relationship element description updated. <DEPI> Spouse Indicator element description updated. <DEPI> Coverage End Date element description updated. <DEPI> Status element removed. <DEPI> Coverage Identifier element description updated.
2.52	11/20/2015	C. Murphy	Added test file naming convention
2.51	10/06/2015	J. Cobbett	Added Coverage Identifier field to Benefit Coverage record and Dependent record.
2.5	08/06/2015	C. Murphy	Initial Document