CORPORATE HEADQUARTERS
8310 Clinton Park Drive
Ft. Wayne, IN 46825
Phone | 260-482-7400
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Toll Free | 866-222-0102
www.benicompadvantage.com

Sample Employee
12345 Main Street
Anytown, ST Zip

This Wellness Screening Report has been prepared to inform you of the results of your recent Wellness Screening with BeniComp Advantage. The National Institutes of Health (NIH) Goal Levels are also included for your information. *NEW THIS YEAR:* New tools to help you understand your results! Use the directions below to log to www.benicompadvantage.com. If you have questions, call BeniComp Customer Service at 866-222-0102.

Questions or Appeals

Please review your results and if you feel any of the results are not accurate or you wish to provide additional information, you may file an appeal. **All supporting documentation related to appeals must be received by BeniComp no later than 30 days from the date of this report**. If it is unreasonably difficult due to a medical condition for you to achieve the standards for a reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward, there may be alternative ways to qualify. If you have questions, or to file an appeal, contact BeniComp Customer Service at 866-222-0102. You can also download an appeal form online at www.benicompadvantage.com.

NEW! BCA EMPLOYEE WEB PORTAL!

The BeniComp Advantage Employee Web Portal is your quick access to all your BCA screening, claims and reimbursement information. You'll be able to check your screening results and find out what the numbers mean, access helpful links to health resources, review your specific company's plan information, and view processed Explanation of Benefits (EOB) forms to see your claims and how your reimbursements were accrued and distributed!

Registration is easy and secure.

1. Log into www.benicompadvantage.com
2. Click the "Employee Login" 

3. Click "Register New User" 

4. After the registration process is complete, you will receive an email with your password to login!

EMPLOYEE INFORMATION	
Participant Name:	Sample Employee
Participant ID:	BCA000111K
Coverage Level:	Family
Company Name:	ABC Co.
For Plan Year Ending:	12/31/09
Report Date:	February 10, 2010

ADDITIONAL PLAN DOCUMENTS

After your credits are finalized, you will receive a Schedule of Benefits outlining your final credits earned and your adjusted net deductible. At that time, your full Certificate of Coverage and Summary Plan Description will also be available online at www.benicompadvantage.com, or you can request an ID Card online or a paper copy of any of the plan documents by calling 866-222-0102.

VALUE OF EARNED CREDITS – *Add Employee and Spouse[1] Credits Together for Total Family Credits.*	Single	Family
Blood Pressure Credit:	$300	$600
LDL Cholesterol Credit:	$300	$600
Body Mass Index Credit:	$300	$600
Tobacco/Nicotine Credit Employee:	$300	$300
Tobacco/Nicotine Credit Spouse[1]:	N/A	$300[1]

Wellness Screening Results for
Sample Employee
Prepared by *BeniComp Advantage (BCA)*

CREDIT ELIGIBLE CRITERIA (Refer to the "Value of Earned Credits" and subtract the earned credits from the base deductible to determine the net adjusted deductible)				
Credit Category	**NIH Goals**	**Your Company's Goals**	**Your Results**	**Credit Status**[1]
Blood Pressure	≤120/80	≤140/90	*130/80*	*Pass*
LDL Cholesterol	≤100	≤160	*110*	*Pass*
Body Mass Index	≤24.9	≤29.9	*26.0*	*Pass*
Tobacco/Nicotine Use	Negative	Negative	*Negative*	*Pass*
Tobacco/Nicotine Use Spouse[1]:	Negative	Negative	*Pending*	*Pending*

ADDITIONAL RESULTS (Not Eligible for Credit, but provided for your information)		
Category	**Desired Range**	**Your Results**
Albumin	3.8-5.0 g/dL	*4.0*
ALB/GLO Ratio	>1.0	*1.0*
ALP-Alkaline Phosphatase	60-109 mg/dL	*70*
ALT	<50 U/L	*50*
AST	<40 U/L	*40*
Bilirubin	<1.4 mg/dL	*1.0*
BUN	8-25 mg/dL	*9*
Total Cholesterol	160-240 mg/dL	*180*
Chol/HDL Ratio	3.5-5	*3.5*
Creatinine	0.6-1.4 mg/dL	*1.1*

ADDITIONAL RESULTS (Not Eligible for Credit, but provided for your information)		
Category	**Desired Range**	**Your Results**
Fructosamine/GSP	<270 umol/L	*200*
GGT	<65 U/L	*40*
Globulin	2.2-3.7 g/dL	*2.5*
Glucose	≤100	*90*
HDL	40-80 mg/dL	*70*
LDL	<100 mg/dL	*See Credit Criteria*
LDL/HDL Ratio	<2.5:1 to 3.5:1	*2.5*
Serum Cotinine (nicotine)	Negative	*See Credit Criteria*
Total Protein	6.5 to 8.3 g/dL	*7.0*
Triglycerides	<150	*120*

[1] If a spouse is not covered under the base medical plan and the employee has Family or Employee Plus Child(ren) coverage, the employee will earn the spouse Tobacco/Nicotine credit automatically.

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Fax or Mail Appeals to:
BeniComp Advantage, Inc
ATTN: Appeals Department
8310 Clinton Park Drive
Fort Wayne, IN 46825
Fax: (260) 482-8991

Tobacco/Nicotine Use Affidavit

Addendum to BeniComp Advantage Application

PLEASE PRINT IN DARK INK. THE APPLICANT MUST INITIAL ANY CROSS OUTS.

Employee Information

Name (Last)	(First)	(MI)	**Social Security No.**

Home Address	City	State	Zip Code

Home Phone	**Alternate Phone** ☐ Cell ☐ Work	**E-Mail Address**

Employer Name and Division (if applicable)	**Employer Location**

Please Note:

- If you have selected Employee Plus Child(ren) or Single coverage you ***do not*** need to complete this form.
- If you have selected Employee Plus Spouse or Family coverage, please check the statement that describes you.

  ☐ My Spouse is **NOT** covered under my base health insurance plan.
  ☐ My Spouse **IS** covered under this plan.

- If your spouse is covered by this plan, they MUST complete the form in its entirety and mail it back in the envelope provided within 30 days.

Spouse Affidavit

Spouse (*To be completed by employees spouse.)

(Last)	*(First)*	*(MI)*	*(Date of Birth)*

Please indicate your tobacco or nicotine usage including but not limited to: cigarettes, cigars, pipe smoking, snuff, chewing tobacco, nicotine, gum or other nicotine supplements.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information will be subject to criminal penalties applicable to state laws.

☐ I hereby attest that I *have used* tobacco or nicotine, including nicotine substitutes (such as patches or gum) within the last 90 days.

☐ Nicotine products (cigar, cigarettes, pipe, chew, snuff, etc.) ☐ Nicotine supplements (nicotine patch, gum etc.)

☐ I hereby attest that I *have not used* any form of tobacco or nicotine, including nicotine substitutes (such as patches or gum) within the last 90 Days

_____ _____

Signature of Spouse **Date**

_____

Printed Name