UIT UNITED INFORMATION TECHNOLOGIES
1095 Pingree Road, Suite 207, Crystal Lake, IL 60014

Dear New Employee:

Welcome to UIT!

Enclosed is the Century Healthcare (CHC) Insurance information you requested. If you are interested in enrolling in the (CHC) Insurance please fill out the enclosed application and return it to me by fax (847-658-3263) or email (cheryl@uitonline.com).

The cost for the CHC Coverage is located on the bottom of the first page of the attached information.

Please feel Free to call me at 800-624-0424 x204 if you have any questions or concerns.

Have a great day.

Cheryl L. Passenheim

Cheryl Passenheim
Vice President of HR & Financial Services
800-624-0424 x204
Email: Cheryl@uitonline.com

United Information Technologies
A Leader in Consulting, Staffing, and Training

CHC

Limited Benefit Medical Plan

Limited Benefit Medical Plans are being offered by your employer to help meet the insurance needs of you and your family. For your convenience, premiums are payroll deducted. This brochure is intended to give you a brief overview of the benefits.

- No Deductibles or Co-pays
- First Dollar Benefits
- Pharmaceutical Benefits
  Visit ***www.regencerx.com*** or call (888) 437-1508
- One Medical Identification Card
- True Insurance Coverage
- Claims Filed By Your Doctor
- National PPO Network
  To locate a hospital or physician Visit ***www.beechstreet.com*** or call (800) 877-1444 for assistance in English or Spanish.
- Coverage That Is Easy To Use
- Guaranteed Issue For Eligible Employees & Their Dependents

DESCRIPTION	SELECT	PREMIER
Doctor's Office Visit	Up to $100 per visit (8 visits)	Up to $125 per visit (10 visits)
Adult Wellness Visit	Up to $150 per visit (1 visit)	Up to $200 per visit (2 visits)
Well Child Visit	Up to $150 per visit (3 visits)	Up to $200 per visit (3 visits)
Outpatient X-Ray & Lab	Up to $150 per visit (5 visits)	Up to $250 per visit (5 visits)
Emergency Room Benefit	Up to $150 per visit (1 sickness)	Up to $250 per visit (1 sickness)
Ambulance	N/A	Up to $250 per occurrence (1 trip)
In-Patient/Out-Patient Surgery & Anesthesia Benefits	Up to $2,000/Plan Year 25% of Surgery benefit up to $500/Plan Year	Up to $3,500/Plan Year 25% of Surgery benefit up to $875/Plan Year
First Hospital Confinement	N/A	Days 1-2: $500 per day Days 3-6: $1,000 per day
Hospital Confinement	Pays $350 per day (Maximum of 30 days)	Day 1: Pays $1,000 Days 2-30: $500 per day
Maternity	Included	Included
ICU	Pays $350 per day (Maximum of 10 days)	Pays $500 per day (Maximum of 10 days)
Substance Abuse	Pays $175 per day (Maximum of 10 days)	Pays $250 per day (Maximum of 10 days)
Mental Nervous	Pays $175 per day (Maximum of 10 days)	Pays $250 per day (Maximum of 10 days)
Skilled Nursing Facility	Pays $175 per day (Maximum of 20 days)	Pays $250 per day (Maximum of 20 days)
Accident Medical ($100 deductible per occurrence)	Up to $5,000 per occurrence	Up to $5,000 per occurrence
Accidental Death & Dismemberment		
Employee	$15,000	$15,000
Spouse	$7,500	$7,500
Child	$3,000	$3,000
Critical Illness		
Employee	N/A	$10,000
Spouse		$10,000
Child		$1,000
Pharmaceutical Benefits Co-Pay Drug	Co-Pay Drug [a]	Co-Pay Drug [b]

$10 Generic only. No deductible. Monthly maximum of $250 employee / $500 family.[a]

$10 Generic / Preferred Brand $50 or 50%; whichever is greater. No deductible.[b]
Monthly maximum of $250 employee / $500 family. Mandatory Generic when available.

BeechStreet PPO Network Access

All plan designs provide covered individuals access to a PPO Network that allows them to take advantage of network negotiated rates prior to the above benefits being applied.

Dental/Vision NurseLine

All plan designs provide covered individuals 24-Hour telephone access to nurses for medical decision support and patient advocacy (available in multiple languages with an audio health information library). Dental savings from 20%-60% on most procedures. Vision savings from 10%-60% on exams, lenses and contacts.

TelaDoc Medical Services

TelaDoc is a national network of board certified physicians providing cross coverage consultations 24 hours a day, 365 days a year for members and dependents over the age of 10. TelaDoc physicians use medical records and telephone consultations to diagnose, recommend treatment and write short term prescriptions, when appropriate.* TelaDoc is a convenient, cost-effective alternative for minor medical problems and a current solution for the health care issues of cost and access.

TelaDoc does not replace the existing primary care physician relationship, but instead enhances it with an efficient, cost-effective alternative for minor medical problems. Physicians must meet strict physicians credentialing guidelines.

*TelaDoc does not prescribe DEA controlled substances or lifestyle drugs. TelaDoc is not available to residents of or in the state of Oklahoma. Online information is available at www.teladoc.com

Semi-Monthly Cost	Select	Premier
Employee	$100.00	$175.00
Employee + Spouse	$203.44	$359.20
Employee + Child(ren)	$160.97	$290.38
Family	$271.53	$488.21

All benefits, except Accident Medical Expense and AD&D, are subject to Plan Year maximums as shown above. Plan Year means the 12 consecutive months from the group's original effective date.

ACE American Insurance Company
Philadelphia, PA 19106

Mail or fax completed form to:
Century Healthcare
5000 Legacy Drive, Suite 360
Plano, TX 75024
Fax – (469) 341-2189

Enrollment Form for Group Insurance

Employer - Please complete this section:

Requested Effective Date: ______________

Date of Hire: ________________________

Indicate one of the following:
- ❑ Initial Enrollment
- ❑ Open Enrollment
- ❑ New Hire
- ❑ Life Status Change

Is this:
- ❑ New Coverage
- ❑ Change in Coverage

Employer's Name: **United Information Technologies**

Your Last Name	First Name	Middle Initial	Social Security No.
Your Street Address	City	State	Zip Code
Home Phone	Date of Birth		
Your Email Address			
Location of Employment	Date of Employment		

Sex:
- ❑ Male
- ❑ Female

Marital Status:
- ❑ Single
- ❑ Married
- ❑ Divorced
- ❑ Legally Separated
- ❑ Widowed

Limited Accident & Sickness Plan Option Chosen:
- ❑ Select Plan
- ❑ Premier Plan

Coverage Type:
- ❑ Employee Only
- ❑ Employee & Spouse
- ❑ Employee & Child(ren)
- ❑ Employee & Family

Do you have an eligible spouse? ❑Yes ❑No

How many eligible children do you have? ______________

Provide the following information for all eligible dependents to be insured under the plan:

Name	Date of Birth	Sex	Age	Social Security No.	If age 19-25, is child a full-time college student?
Spouse's Full Name	Date of Birth	❑ M ❑ F	Age	Social Security No.	❑ Yes ❑ No
Child's Full Name	Date of Birth	❑ M ❑ F	Age	Social Security No.	❑ Yes ❑ No
Child's Full Name	Date of Birth	❑ M ❑ F	Age	Social Security No.	❑ Yes ❑ No
Child's Full Name	Date of Birth	❑ M ❑ F	Age	Social Security No.	❑ Yes ❑ No

Refusal of Coverage (check the box below if you are not enrolling in the plan; you do not need to sign/date the form):

❑ I choose not to enroll in the Limited Accident & Sickness Insurance Plan(s) offered by my employer. I understand that, if at a later date, I wish to enroll in this plan. I will not be able to do so unless there is another open enrollment period.

(Continued on Reverse Side)

I have read the Limited Accident & Sickness Insurance Plan enrollment material and accept the terms and conditions of the coverage outlined in it. I understand the Limited Accident & Sickness Insurance Plan does not provide Major Medical or Comprehensive Medical coverage. I have read the enrollment material and understand my coverage is subject to the terms and conditions of the policy issued to my employer. I understand my coverage will go into effect on the date stated in the material only if I am in active service with my employer on that date. If I am not in active service on that date, my coverage will go into effect on the date I return to active service. If I have elected coverage for my dependents, their coverage will not go into effect prior to my effective date. I understand that hospital, surgery and/or disability benefits available under the plan may not be payable for any pre-existing condition until after coverage has been in effect for six months.

I authorize my employer to deduct the required premium for the plan I have elected from my pay.

To the best of my knowledge and belief, all information I have provided is true and complete. I understand my information is protected by privacy laws and will be released only in accordance with these laws. The only people who have access to this information are employees of the Insurance Company who service my policy or claim and other third parties authorized by the Insurance Company. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. In other situations, the Insurance Company will ask me for written authorization to disclosed information about me.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

______________________________ Employee's Signature

____________________ Date Signed

Accidental Death Beneficiary Information:

Beneficiary Name & Address	% of Benefit	Social Security Number	Relationship