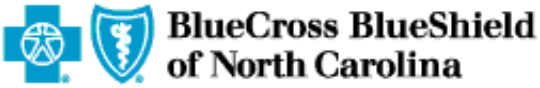

Blue Options℠ Proposal For

SEQUENCE, INC

Effective 01/2015

Prepared By

ALAN OVERBEY

Prospect Number 294813

Quote Number 4773577

The benefit highlight is a summary of Blue Options benefits. This is meant only to be a summary. You will also be receiving a Summary of Benefits and Coverage document (referred to as an SBC) required under Health Care Reform. Both documents are provided as a convenience to compare available health plan coverage options. Final interpretation of the Blue Options health plan and a complete listing of benefits and what is not covered are found in and governed by the group contract and benefit booklet. You may preview the benefit booklet by requesting a copy of the Blue Options benefit booklet from BCBSNC Customer Services.

Pharmacy deductible (if applicable), co-pays and coinsurance count towards true out-of-pocket limit.

Blue Options[SM] Benefit Highlights (PPO)

The coinsurance amounts that appear on this benefit highlight represent Plan responsibility. The coinsurance amounts that display in the benefit booklet represent member responsibility.

Physician Office Services *(See "Hospital Based Clinics" for "outpatient clinic" or "hospital-based" services.)*	**In-network**	**Out-of-network[1]**
Office Visit		
Includes Office Surgery, Consultation, X-rays and Labs, and a benefit period maximum of 4 office visits for the evaluation and treatment of obesity in and out-of-network. See "Inpatient and Outpatient Services".		
Primary Care Provider	$25 copayment	70% after deductible
Specialist	$50 copayment	70% after deductible
Preventive Care *(Primary Preventative Diagnosis Only)*		
For the most updated list of general preventive/screenings, immunizations, well-baby/well-child care and womens preventive care services mandated under Federal law, see our website at bcbsnc.com/preventive.		
Routine eye exams are covered only In-Network as non-mandated Preventive Care.		
Nutritional counseling is covered and available In-Network and Out-of-Network.		
Primary Care Provider	100%, no deductible	Not Available*
Specialist	100%, no deductible	Not Available*
**Colorectal screening, bone mass measurement, newborn hearing screening, prostate specific antigen tests (PSAs), gynecological exams, cervical cancer screening, ovarian cancer screening and mammograms are state mandated and also covered Out-of-Network.*		
Therapies		
Rehabilitative and Habilitative Therapies (Maximums apply to Home, Office and Outpatient Settings):		
Physical/Occupational: 30 visits per Benefit Period;Speech Therapy: 30 visits per Benefit Period		
Primary Care	$25 copayment	70% after deductible
Specialist	$50 copayment	70% after deductible
Urgent Care Centers and Emergency Room		
Urgent Care Centers	$50 copayment	$50 copayment
Emergency Room Visit	$300 copayment	$300 copayment
(If admitted from the ER, the copayment does not apply; instead, Inpatient Hospital benefits apply. If held for observation, outpatient benefits apply. See "Inpatient and Outpatient Hospital Services".)		
Ambulatory Surgical Center	80% after deductible	70% after deductible
Inpatient and Outpatient Hospital Services		
Hospital and Hospital Based Services	80% after deductible	70% after deductible
Hospital Based Clinics(other than preventive services above)	80% after deductible	70% after deductible
Professional Services	80% after deductible	70% after deductible
Outpatient Diagnostic Services		
Outpatient lab tests and mammography, when performed alone		
(Physician and Hospital-based services)	100%, no deductible	70% after deductible
Outpatient lab tests and mammography, when performed with another service		
Physician Services	100%, no deductible	70% after deductible
Hospital and Hospital-based Services	80% after deductible	70% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic tests such as EEG's and EKG's	80% after deductible	70% after deductible
CT scans, MRI 's, MRA's and PET scans in any location, including physician's office	80% after deductible	70% after deductible
Other Services		
Skilled Nursing Facility *(60 days per Benefit Period)*	80% after deductible	70% after deductible
Home Health Care, Durable Medical Equipment and Hospice	80% after deductible	70% after deductible
Ambulance	80% after deductible	80% after deductible
Maternity		
Maternity Delivery includes Prenatal and Post-delivery care		
Hospital Services *(Delivery)*	80% after deductible	70% after deductible
Professional Services *(Delivery)*	80% after deductible	70% after deductible
Transplants		
Hospital Services	80% after deductible	70% after deductible
Professional Services	80% after deductible	70% after deductible
Infertility Services		
Combined In-Network and Out-of-Network Lifetime Maximum of 3 ovulation induction cycles, with or without insemination, per Member for Infertility services, provided in all places of service.		
Primary Care Provider	$25 copayment	70% after deductible
Specialist	$50 copayment	70% after deductible
Hospital Services	80% after deductible	70% after deductible
Inpatient and Outpatient Professional Services	80% after deductible	70% after deductible

Blue Options[SM] Benefit Highlights (PPO)

Lifetime Maximum, Deductibles & Out-of-Pocket Limits	**In-network**	**Out-of-network** [1]
The following Deductibles and Out-of-Pocket Limits apply to all services unless otherwise indicated and Mental Health and Substance Abuse services below:		
Lifetime Benefit Maximum	Unlimited	Unlimited
Deductibles		
Individual *(per Benefit Period)*	$2,000	$4,000
Family *(per Benefit Period)*	$4,000	$8,000
Out-of-Pocket Limits		
Individual *(per Benefit Period)*	$4,000	$8,000
Family *(per Benefit Period)*	$8,000	$16,000

Mental Health and Substance Abuse Services				
Mental Health Services				
Office Visit	$50	copayment	70%	after deductible
Inpatient/Outpatient	80%	after deductible	70%	after deductible
Substance Abuse Services				
Office Visit	$50	copayment	70%	after deductible
Inpatient/Outpatient	80%	after deductible	70%	after deductible

Prescription Drugs				
Up to 30 day supply. 31-60 day supply is two copayments and 61-90 day supply is three copayments.				
MAC B Pricing (Brand Penalty when Generic Equivalent is available and Provider does not require Brand to be dispensed). Penalty does not count toward OOP Limit. Enhanced Formulary. Prior Plan approval, step therapy and quantity limits may apply.				
Tier 1 *(Generic Drugs)*	$10	copayment	$10	copayment
Tier 2 *(Preferred Brand Drugs)*	$40	copayment	$40	copayment
Tier 3 *(Non-Preferred Brand and Preferred Specialty Drugs)*	$55	copayment	$55	copayment
Tier 4 *(Non-Preferred Specialty Drugs)*	75%		75%	
For each 30-day supply of a Tier 4 Specialty Drug, you will pay a minimum of $50 in coinsurance, but not more than $100. Any Out-of-Network charges over the allowed amount are not included in this maximum. You are responsible for charges over the allowed amount received from an out-of-network pharmacy.				
Limits apply to Infertility drugs, refer to your benefit booklet.				
Preventive OTC Medications and Contraceptive Drugs and Devices as listed at bcbsnc.com/preventive	100%, no deductible		100%, no deductible	

Lens and Frame Coverage*	
BCBSNC will reimburse you up to the Benefit Period Maximum for glasses, hard, soft or disposable contact lenses.	
Prescribed Eyeglass Lens and Frame Benefit Period Maximum	$150

*Does not apply to the out-of-pocket limit

1 NOTICE: Your actual expenses for covered services may exceed the stated coinsurance percentage or co-payment amount because actual provider charges may not be used to determine the payment obligations for BCBSNC and its members.

ADDITIONAL INFORMATION ABOUT BLUE OPTIONS FROM BCBSNC

Benefit Period
The period of time, usually 12 months as stated in the group contract, during which charges for covered services provided to a member must be incurred in order to be eligible for payment by BCBSNC. A charge shall be considered incurred on the date the service or supply was provided to a member.

Allowed Amount
The maximum amount that BCBSNC determines is to be paid for covered services provided to a member.

Out-of-Pocket Limit
The dollar amount you pay for covered services in a benefit period before BCBSNC pays 100% of covered services. It includes deductible, coinsurance and copayments. It does not include charges over the allowed amount, premiums, and charges for non-covered services.

Day and Visit Maximums
All day and visit maximums are on a combined In- and Out-of Network basis.

Utilization Management
To make sure you have access to high quality, cost-effective health care, we manage utilization through a variety of programs including certification, transplant management, concurrent and retrospective review.

If you have a concern regarding the final determination of your care, you have the right to appeal the decision. If you would like a copy of a benefit booklet providing more information about our Utilization Management programs, call the toll free number listed in your information packet.

Certification
Certification is a program designed to make sure that your care is given in a cost effective setting and efficient manner.

If you need to be hospitalized, you must obtain certification. Non-emergency and non-maternity hospital admissions must be certified prior to the hospitalization. If the admission is not certified, a penalty will be applied.

For maternity admissions, your provider is not required to obtain certification from BCBSNC for prescribing a length of stay up to 48 hours for a normal vaginal delivery, or up to 96 hours for delivery by cesarean section. You or your provider must request certification for coverage for additional days, which will be given by BCBSNC, if medically necessary.

All inpatient and certain outpatient Mental Health and Substance Abuse services must be certified in advance by Magellan Behavioral Health. Call Magellan Behavioral Health at 1-800-359-2422. Office visits do not require certification.

In-network providers are responsible for obtaining certifications. The member will bear no financial penalties if the in-network provider fails to obtain the appropriate authorization. The member is responsible for obtaining certification for services rendered by an out-of-network or out-of-state provider.

Health and Wellness Program
Because we want to help you stay healthy, we offer a variety of wellness benefits and services. You can take advantage of HealthLine Blue, our 24-hour health information service, a health topics library, asthma and diabetes management and a prenatal program. You will also have access to online health and wellness information at www.bcbsnc.com. With our program you can get health advice anytime you need it, so you can learn how to take charge of your health.

What is Not Covered?
The following are summaries of some of the coverage restrictions. A full explanation and listing of restrictions will be found in your benefit booklet.

Your health benefit plan does not cover services, supplies, drugs or charges that are:

- Not medically necessary
- For injury or illness resulting from an act of war
- For personal hygiene and convenience items
- For inpatient admissions that are primarily for diagnostic studies
- For palliative or cosmetic foot care
- For investigative or experimental purposes
- For hearing aids or tinnitus maskers, except as specifically covered by the benefit plan
- For cosmetic services or cosmetic surgery
- For custodial care, domiciliary care or rest cures
- For treatment of obesity, except for surgical treatment of morbid obesity, or as specifically covered by your health benefit plan
- For reversal of sterilization
- For treatment of sexual dysfunction not related to organic disease
- For assisted reproductive technologies as defined by the Centers for Disease Control and Prevention
- For self-injectable drugs in the provider's office