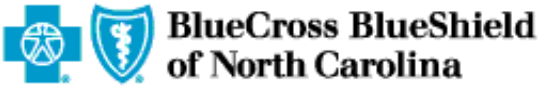


Blue Options HSA[SM*] Proposal for

SEQUENCE, INC

Effective 01/2015

Prepared by

ALAN OVERBEY

Prospect Number 294813

Combo#: 295399

*The Blue Option HSA plan is intended to be a high deductible health plan (HDHP) that qualifies its members to contribute to a health savings account (HSA), unless its members are otherwise ineligible under applicable federal requirements. Please consult a qualified tax advisor if you are unsure about whether or not you are ineligible. In addition, the DEDUCTIBLE and OUT-OF-POCKET LIMIT amounts listed in the Summary Of Benefits may be revised each year in accordance with Internal Revenue Service (IRS) rulings.

The benefit highlight is a summary of Blue Options HSA 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 HSA 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 HSA benefit booklet from BCBSNC Customer Services. The HSA is provided to you directly by a separate HSA Administrator. Detailed information regarding your HSA is provided by that Administrator.

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

Blue Options HSA℠ Benefit Highlights (HSA)

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

Lifetime Maximum, Deductibles & Out-of-Pocket Limits[1]	**In-network**	**Out-of-network**[2]
The following Deductibles and Out-of-Pocket Limits apply to all services unless otherwise indicated:		
Lifetime Maximum	Unlimited	Unlimited
Deductibles (per Benefit Period)		
Employee Only	$3,000	$6,000
Family Aggregate *(Entire family contributes to the Deductible)*	$6,000	$12,000
Out-of-Pocket(OOP) Limit (per Benefit Period)		
Employee Only	$3,000	$7,250
Family Aggregate *(Entire family contributes to the OOP Limit)*	$6,000	$14,500
Physician Office Services		
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 Hospital Services" and "Outpatient Hospital Services".		
Primary Care Provider or Specialist	100% after deductible	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.		
Nutritional counseling is covered and available In-Network and Out-of-Network.		
Routine eye exams are covered as non-mandated Preventive Care.		
Primary Care Provider or Specialist	100%, no deductible	70% after deductible
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 Provider or Specialist	100% after deductible	70% after deductible
Urgent Care Centers and Emergency Room		
Urgent Care Centers	100% after deductible	100% after deductible
Emergency Room Visit	100% after deductible	100% after deductible
Ambulatory Surgical Center	100% after deductible	70% after deductible
Outpatient Hospital Services *(Includes physician services, hospital and hospital-based services, hospital-based clinics, outpatient diagnostic services, and therapy services including rehabilitative and habilitative therapies and other therapies.)*	100% after deductible	70% after deductible
Inpatient Hospital Services *(Includes physician services, hospital and hospital-based services, and maternity delivery, prenatal and post-delivery care.)*	100% after deductible	70% after deductible
Other Services		
Skilled Nursing Facility (60 days per Benefit Period)	100% after deductible	70% after deductible
Home Health Care, Durable Medical Equipment and Hospice	100% after deductible	70% after deductible
Ambulance	100% after deductible	100% after deductible
Maternity		
Maternity Delivery includes Prenatal and Post-delivery care		
Hospital Services (Delivery)	100% after deductible	70% after deductible
Professional Services (Delivery)	100% after deductible	70% after deductible
Transplants		
Hospital Services	100% after deductible	70% after deductible
Professional Services	100% after deductible	70% after deductible

Blue Options HSA℠ Benefit Highlights (HSA)

	In-network	Out-of-network[2]
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 or Specialist	100% after deductible	70% after deductible
Hospital Services	100% after deductible	70% after deductible
Inpatient and Outpatient Professional Services	100% after deductible	70% after deductible
Infertility Drugs	100% after deductible	100% after deductible
Limits apply to Infertility drugs, refer to your benefit booklet.		
Mental Health and Substance Abuse Services		
Mental Health Services		
Office Visit	100% after deductible	70% after deductible
Inpatient/Outpatient	100% after deductible	70% after deductible
Substance Abuse Services		
Office Visit	100% after deductible	70% after deductible
Inpatient/Outpatient	100% after deductible	70% after deductible
Prescription Drugs		
MAC C Pricing, Enhanced Formulary. Prior Plan approval, step therapy and quantity limits may apply.	100% after deductible	100% after deductible
You are responsible for charges over the allowed amount received from an out-of-network pharmacy.		
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: If you selected Employee Only Coverage, the Employee Deductible and Out-of-Pocket Limit will apply; if you selected Family Coverage, the Family Aggregate Deductible and Out-of-Pocket Limit will apply. All covered family members contribute to the same Family Deductible and the same Family Out-of-Pocket Limit which must be met before the respective benefit levels for each are payable by BCBSNC for any individual in the family.

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

ADDITIONAL INFORMATION ABOUT BLUE OPTIONS HSA 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 and care management.
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.

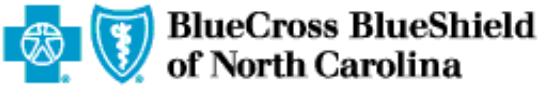
What is Not Covered?
The following are summaries of some of the coverage restrictions. A full explanation and listing of restrictions will be found in your benefit booklet.

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
- 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

Health Savings Account
Blue Options HSA is not a Health Savings Account (HSA), but it instead is a health insurance plan intended to be paired with an HSA. The HSA is provided to you directly by a separate HSA Administrator. An HSA is a savings vehicle for medical care expenses. It helps to pay the expenses that insurance does not pay. Individuals and employers can contribute money into an HSA on a tax-deductible or pre-tax basis for individuals. If used to pay for qualified health care expenses, your HSA account's growth and use is tax-free. In addition, HSAs roll over from year to year and are fully portable if an individual changes jobs. HSAs can only be opened by and contributed to on behalf of individuals who are covered under a qualified High Deductible Health Plan (HDHP). For more information on your HSA eligibility if you have other, additional health coverage, consult your tax advisor.

Employee: **PB27170 R041780 MP51900 SP45000 C000100 V000500 D000100**
Family: **PB27230 R041780 MP51900 SP45000 C000100 V000500 D000100**
Billing arrangement: ee, ee+spouse, ee+children, fam



Dental Blue® Proposal For

SEQUENCE, INC

Effective 01/2015

Prepared By

ALAN OVERBEY

Prospect Number 294813

Quote Number 4779428

The benefit highlight is a summary of Dental Blue 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 Dental Blue 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 Dental Blue benefit booklet from BCBSNC Customer Services.

Dental Blue® Benefit Highlights - Rollover Plan

Services	Benefits
Diagnostic & Preventive Care Routine Oral Exams, Cleanings, X-rays, Fluoride Application, Sealants, Space Maintainers	100%
Basic Care Routine Fillings, Oral Surgery, Simple Extractions, Endodontics, Periodontics	80% after Dental deductible
Major Care Crowns, Inlays and Onlays, Complete Dentures, Fixed Partial Dentures	50% after Dental deductible
Benefit Period Deductible *(Applies to Basic and Major Care)*	
Individual	$50
Family	$150
Combined Benefit Period Maximum *(Includes Diagnostic and Preventive, Basic and Major Restorative Care)*	$1,250
Orthodontic Care *(Covered for all eligible members to age 19)*	50%
Lifetime Orthodontic Maximum	$1,250
Annual Benefit Threshold *(total amount claims cannot exceed within a Benefit Period to qualify for Rollover)*	$600
Annual Rollover Amount *(total amount that a qualified member will be eligible to use in subsequent benefit periods)*	$300
Maximum Rollover Amount *(the highest amount a qualified member may accumulate during the Benefit Period)*	$850

Some services may have frequency limitations. For example 2 exams and cleanings per benefit period, replacements of crowns & dentures every 8 years.

ADDITIONAL INFORMATION ABOUT DENTAL BLUE 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.

Waiting Period
Waiting periods may apply to some services if the group or member does not have evidence of prior dental coverage. A waiting period is the amount of time that a member must be enrolled in this dental benefit plan prior to receiving specific services.

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

- Not medically necessary
- Hospitalization for any dental procedure
- Dental procedures solely for cosmetic or aesthetic reasons
- Dental procedures not directly associated with dental disease
- Procedures that are considered to be experimental
- Drugs or medications obtainable with or without a prescription unless they are dispensed and utilized in the dental office during the patient visit
- Services related to temporomandibular joint (TMJ)
- Expenses for dental procedures begun prior to the member's eligibility with BCBSNC
- Clinical situations that can be effectively treated by a more cost effective, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure
- Dental implants, oral orthotic devices, palatal expanders and orthodontics except as specifically covered by your dental benefit plan

The benefit highlights is a summary of dental benefits. This is meant only to be a summary. Final interpretation 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 benefit booklet from BCBSNC Customer Services.

NOMEDIC R000100 MX00100 SX00100 C000100 V000100 DS35002
Billing arrangement: ee, ee+spouse, ee+children, fam