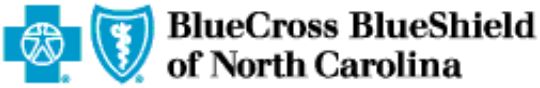


Blue Options HSA[SM*] Proposal for

SEQUENCE, INC

Effective 01/2017

Prepared by

ALAN OVERBEY

Prospect Number 294813

Combo#: 323725

*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] *The following Deductibles and Out-of-Pocket Limits apply to all services unless otherwise indicated:*	**In-network**	**Out-of-network**[2]
Lifetime Maximum	Unlimited	Unlimited
Deductibles (per Benefit Period)		
Employee Only	$3,000	$6,000
Family Member	$6,000	$12,000
Family Total	$6,000	$12,000
Out-of-Pocket(OOP) Limit (per Benefit Period)		
Employee Only	$3,000	$7,250
Family Member	$6,000	$13,250
Family Total	$6,000	$15,750
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". Nutritional counseling is covered and available In-Network and Out-of-Network.*		
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.*		
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		
Adaptive Behavior Treatment: $40,000 maximum per benefit period for members age 18 and younger		
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)

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.	**In-network**	**Out-of-network**[2]
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

[1]NOTICE: If you selected Employee Only Coverage, the Employee Deductible and Out-Of-Pocket Limit will apply. If you selected Family Coverage, either the Family Member or Family Total Deductible and Out-of-Pocket Limit will apply. All covered family members contribute to the same Family Total Deductible and the same Family Total Out-of-Pocket Limit, however any individual Family Member who reaches his or her Family Member Deductible and Out-Of-Pocket Limit will have the benefit levels for each apply to them only, and not the entire Family. The Family Total Deductible and Out-Of-Pocket Limit must be met before the respective benefit levels for each are payable for all Family Members, regardless of whether each individual Family Member's Deductible and Out-Of-Pocket Limit has been met.

[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, the claim will be denied.
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 and all Adaptive Behavior Treatment must be certified in advance by Magellan Behavioral Health. Call Magellan Behavioral Health at 1-800-359-2422. Mental Health and Substance Abuse 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 many wellness benefits and services, including Health Line Blue℠ - our 24-hour nurse support line. We also provide wellness programs for prenatal care and for chronic condition management, plus a variety of health tools and trackers at BlueConnectNC.com. We're making it easier than ever for you 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.

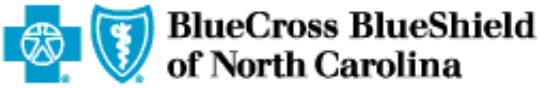
Your health benefit plan does not cover services, supplies, drugs or charges that are:

- 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.

Flexible Spending Account
A Flexible Spending Account (FSA) is established by your employer and separately administered by BCBSNC. An FSA helps participants pay for medical and dependent care expenses. Participants contribute money pre-tax into an FSA, to help pay the medical expenses that insurance does not pay and get reimbursed for dependent care expenses. Your detailed FSA information shall be provided separately.

Employee: **PB78860 R041780 MP51900 SP45000 C000100 V000100 D000100**
Family: **PB86333 R041780 MP51900 SP45000 C000100 V000100 D000100**
Billing arrangement: ee, ee+spouse, ee+children, fam



Blue Options℠ Proposal For

SEQUENCE, INC

Effective 01/2017

Prepared By

ALAN OVERBEY

Prospect Number 294813

Quote Number 5050742

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	50% after deductible
Specialist	$50 copayment	50% 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.		
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 screening 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		
Adaptive Behavior Treatment: $40,000 maximum per Benefit Period for members age 18 and younger		
Primary Care	$25 copayment	50% after deductible
Specialist	$50 copayment	50% after deductible
Urgent Care Centers and Emergency Room		
Urgent Care Centers	$75 copayment	$75 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	50% after deductible
Inpatient and Outpatient Hospital Services		
Hospital and Hospital Based Services	80% after deductible	50% after deductible
Hospital Based Clinics(other than preventive services above)	80% after deductible	50% after deductible
Professional Services	80% after deductible	50% after deductible
Outpatient Diagnostic Services		
Outpatient lab tests when performed alone		
(Physician and Hospital-based services)	100%, no deductible	70% after deductible
Outpatient lab tests when performed with another service		
Physician Services	100%, no deductible	70% after deductible
Hospital and Hospital-based Services	80% after deductible	50% after deductible
Outpatient Mammography	100%, no deductible	70% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic tests such as EEG's and EKG's	80% after deductible	50% after deductible
CT scans, MRI 's, MRA's and PET scans in any location, including physician's office	80% after deductible	50% after deductible
Other Services		
Skilled Nursing Facility *(60 days per Benefit Period)*	80% after deductible	50% after deductible
Home Health Care, Durable Medical Equipment and Hospice	80% after deductible	50% after deductible
Ambulance	80% after deductible	80% after deductible
Maternity		
Maternity Delivery includes Prenatal and Post-delivery care		
Hospital Services *(Delivery)*	80% after deductible	50% after deductible
Professional Services *(Delivery)*	80% after deductible	50% after deductible
Transplants		
Hospital Services	80% after deductible	50% after deductible
Professional Services	80% after deductible	50% 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	50% after deductible
Specialist	$50 copayment	50% after deductible
Hospital Services	80% after deductible	50% after deductible
Inpatient and Outpatient Professional Services	80% after deductible	50% 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	50%	after deductible
Inpatient/Outpatient	80%	after deductible	50%	after deductible
Substance Abuse Services				
Office Visit	$50	copayment	50%	after deductible
Inpatient/Outpatient	80%	after deductible	50%	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 Drugs	$10	copayment	$10	copayment
Tier 2 Drugs	$40	copayment	$40	copayment
Tier 3 Drugs	$55	copayment	$55	copayment
Tier 4 Drugs	75%		75%	

For each 30-day supply of a Tier 4 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

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, the claim will be denied.

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 and all Adaptive Behavior Treatment must be certified in advance by Magellan Behavioral Health. Call Magellan Behavioral Health at 1-800-359-2422. Mental Health and Substance Abuse 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 many wellness benefits and services, including Health Line Blue℠ - our 24-hour nurse support line. We also provide wellness programs for prenatal care and for chronic condition management, plus a variety of health tools and trackers at BlueConnectNC.com. We're making it easier than ever for you 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