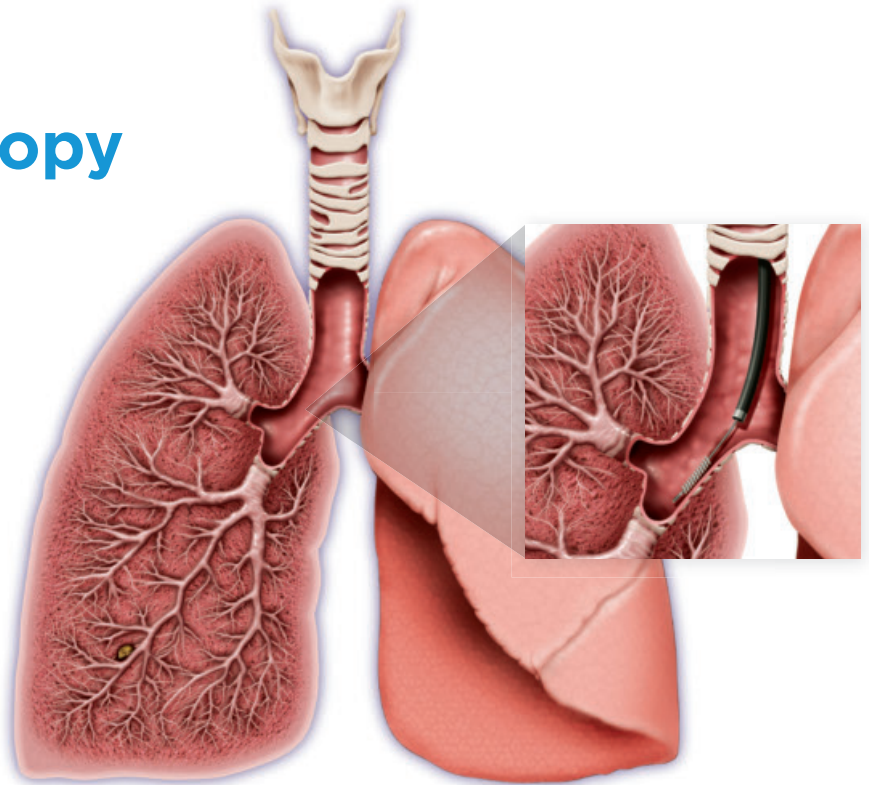


## Adding genomics to your bronchoscopy may help guide next steps

During your bronchoscopy procedure, your doctor collects cells from your airway using a small brush. In the event your bronchoscopy doesn't show a definite result, your doctor may order a test called the **Percepta**® Genomic Sequencing Classifier, which analyzes these cells to determine your risk of lung cancer.



### HOW THE PERCEPTA TEST WORKS



Smoking can cause lasting changes to the genes inside the cells in your airway



The Percepta test looks for these genomic changes and analyzes them



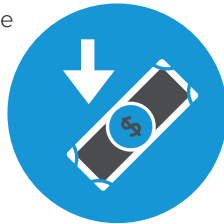
The results of the test help your doctor better assess your risk for lung cancer

# Veracyte Access Program

## PROGRAM DETAILS

Because our testing may resolve important medical decisions, Veracyte is committed to providing all patients with access to our innovative and actionable genomic tests, regardless of their personal financial situation.

- + The Percepta test is covered by Medicare with no copayment
- + The Veracyte Access Program provides financial support for both uninsured and commercially insured patients with financial need



If you have any questions regarding your Veracyte bill, insurance Explanation of Benefits (EOB) or eligibility, **please contact a Veracyte Customer Care representative rather than your healthcare provider.**

We are here to help at **844.464.LUNG (844.464.5864)** or **support@veracyte.com**

## VERACYTE ACCESS ELIGIBILITY FOR U.S. RESIDENTS\*

**Patient's household<sup>†</sup> income<sup>‡</sup> must be less than these amounts to qualify for 100% reduction<sup>§</sup>**

Household of 1 person	<b>\$48,240</b>
Household of 2 people	<b>\$64,960</b>
Household of 3 people	<b>\$81,680</b>
Household of 4 people	<b>\$98,400</b>

Add **\$16,720** for each additional person

**Patient's household<sup>†</sup> income<sup>‡</sup> must be within these amounts to qualify for 75% reduction<sup>§</sup>**

Household of 1 person	<b>\$48,241–\$60,300</b>
Household of 2 people	<b>\$64,961–\$81,200</b>
Household of 3 people	<b>\$81,681–\$102,100</b>
Household of 4 people	<b>\$98,401–\$123,000</b>

Add **\$20,900** for each additional person

\*Non-U.S. residents are not eligible for assistance. Household incomes stated apply to 48 contiguous states and D.C.

<sup>†</sup>Number of dependents and personal exemptions claimed for tax filings

<sup>‡</sup>Based on all income in the prior calendar year by any source before deductions

<sup>§</sup>Relates to what percent of the payment due is reduced

Detach here

## APPLY FOR VERACYTE ACCESS

Submit application within 12 months of Veracyte test date to ensure eligibility.

1. **Complete the Veracyte Access application at right.**
2. **Include proof of income.**  
Examples: Two recent pay stubs, W-2 or IRS Form 1040.
3. **Sign and date the Veracyte Access application.**
4. **Send application and documents to:**  
Veracyte: Veracyte Access Program  
6000 Shoreline Court, Suite 300  
South San Francisco, CA 94080  
or fax to **650.243.6388**

### About the patient

.....  
Last name First name

.....  
Street address Apt.

.....  
City State ZIP

( ) -  
Phone Date of birth (mm/dd/yyyy)

.....  
Name of ordering physician

### About the patient's household

Number of people in the household, including dependents:

1  2  3  4  Other .....

Gross annual household income .....

### Proof of patient's household income

Proof of total household income included (choose one)

Two recent pay stubs  W-2  IRS Form 1040  Other

Proof of United States citizenship or residency included (choose one)

Social Security number (write) .....

U.S. passport (copy)  Green card (copy)

If I do not have insurance, I certify that I am not eligible for Medicare, Medicaid or any other government health insurance, and will not seek reimbursement from any insurance carrier or government agency for fees waived by Veracyte, Inc.

I certify that the information provided is true and accurate. I have read and understand the Veracyte Access Program requirements. I understand and agree that Veracyte, Inc. reserves the right at any time and without notice to modify or terminate this Program, and to audit the information provided on or enclosed with this application.

.....  
Patient signature

.....  
Date



6000 Shoreline Court, Suite 300  
South San Francisco, CA 94080

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F 650.243.6388  
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