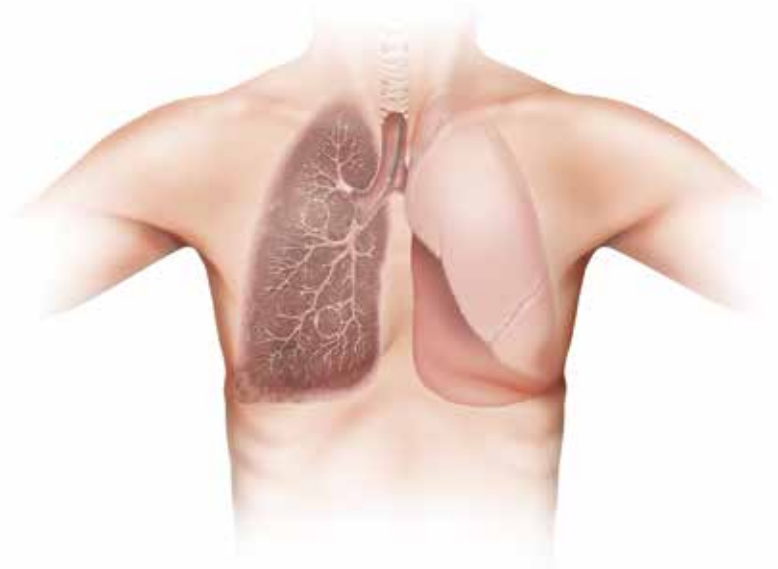


A genomic test that helps diagnose interstitial lung disease subtype

The Envisia Genomic Classifier is a new genomic test that aids your physician in differentiating between idiopathic pulmonary fibrosis (IPF) and other interstitial lung diseases (ILD), without having to do a surgical lung biopsy.

Envisia detects a genomic pattern of usual interstitial pneumonia (UIP), which helps to predict IPF.

The test results enable your doctor to more confidently diagnose and treat your condition.



The test analyzes lung tissue samples collected during a transbronchial biopsy (TBB), a nonsurgical procedure commonly used to diagnose lung diseases.

HOW THE ENVISIA TEST WORKS



Your doctor collects 3–5 tissue samples during a transbronchial biopsy (TBB) and sends them to the lab



The test looks at 190 genes commonly associated with fibrosis or inflammation



The results indicate either positive or negative for usual interstitial pneumonia (UIP), which helps guide next steps

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.

- + For Medicare patients, there is no copayment
- + For privately insured patients, copay is determined by the individual plan
- + 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**

To learn more about Envisia, visit **veracyte.com/lung**.

VERACYTE ACCESS ELIGIBILITY FOR U.S. RESIDENTS*

Patient's household[†] income[‡] must be less than these amounts to qualify for 100% reduction[§]

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

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

Patient's household[†] income[‡] must be within these amounts to qualify for 75% reduction[§]

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

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.

†Number of dependents and personal exemptions claimed for tax filings

‡Based on all income in the prior calendar year by any source before deductions

§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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