FINANCIAL ASSISTANCE APPLICATION

GeneDx, Inc. is pleased to help you with your genetic testing needs. We understand genetic testing can be expensive so we offer a Financial Assistance Program (FAP). To help us know if you qualify for this program please complete the application below. **To avoid any delays, make sure to fill in all fields.**

PLEASE NOTE: Financial assistance is only for testing that is billed through insurance. Governmental health plans and some commercial health plans will not allow GeneDx to offer financial assistance. Financial assistance is not available for self-pay. If you are covered by any governmental health insurance such as Medicare, Medicaid, Managed Medicaid, Medicare Advantage, Tricare, Railroad, CHAMPUS and/or Federal BCBS or if you are not using health insurance, **please do not use this form.** To discuss other payment options or to find out if your commercial health plan allows for financial assistance, please contact us at (888) 729-1206, option 2 or billing@genedx.com.

PATIENT INFORMATION (U.S. RESIDENTS ONLY)			
Name (Last, First, Middle Initial)			Date of Birth (MM/DD/YYYY)
Email Address		Primary Phone Number	
Address	City		State
Accession Number or Account Number from GeneDx bill (if known)	Household Size	Household Income (pre-tax)	

To see if you qualify for GeneDx's Financial Assistance Program (FAP), we need to know your household size (the number of people who live in your home) and household income before taxes. Your total household income includes the following for ALL members of your household: Gross Salary (your wages), Unemployment Compensation, Disability and Worker's Compensation, Social Security and/or Supplemental (SSI) Benefits, Public Assistance (TANF, SNAP, etc.), Pension/Retirement, Dividends/Interest, Rents/Royalties, Unemployment or Worker's Compensation, Alimony, and/or other Assets.

Your health insurance company will soley determine what your member financial responsibility will be for the GeneDx testing. This amount will be listed on the Explanation of Benefits (EOB) letter your health insurance company sends to you (the EOB letter is **not** a bill). GeneDx will then bill you based on the EOB member financial responsibility. If you are approved for FAP, we will discount your final bill from GeneDx by the percentage listed in the table below for which you are eligible. The table is based on the 2021 federal poverty guidelines and will be updated as federal guidelines change annually.

HOUSEHOLD SIZE	DISCOUNT BASED ON HOUSEHOLD INCOME			
	97%	95%	90%	85%
1	$12,880	$25,760	$38,640	$51,520
2	$17,420	$34,840	$52,260	$69,680
3	$21,960	$43,920	$65,880	$87,840
4	$26,500	$53,000	$79,500	$106,000
5	$31,040	$62,080	$93,120	$124,160
6	$35,580	$71,160	$106,740	$142,320
7	$40,120	$80,240	$120,360	$160,480
8	$44,660	$89,320	$133,980	$178,640

We need some additional documents to confirm your household income. We are required by applicable law to collect this information.

Along with this completed form, please send copies of two of the three types of supporting documentation:

- Type 1: Your most recent federal tax return (1040 or 1040EZ)
- Type 2: Your W-2 withholding statement
- Type 3: Your two, most recent and consecutive paystubs (2 paystubs count as one type of documentation)

Other Extreme Financial Situations – Please provide documentation for any other financial difficulties that you would like GeneDx to take into consideration, such as:

- A copy of your bankruptcy status
- A summary of excessive medical bills
- The recent death or disability of a household earner

IMPORTANT: All information you send to us is handled safely and securely but only your first and last name, date of birth, and gross income information are needed on the documents you send us.

Please black-out other sensitive personal information such as social security number and net income.

Please send this completed form and your blacked-out supporting documents to us via one of the following secure options:

1. Fax to: 201-421-2020
2. Mail to: GeneDx Inc.
   P.O. Box 21997
   New York, NY 10087-1997

AS A REMINDER: By applying for our financial assistance program, GeneDx will bill your insurance.

I hereby certify that the information provided above and the documentation I provide to GeneDx are true and accurate. GeneDx reserves the right, at any time and without notice, to modify the application form, to modify or terminate this program, to audit my information or to request additional documentation of income and financial need. I also certify I am not covered by a governmental insurance plan such as Medicare, Medicaid, Managed Medicaid, Medicare Advantage, Tricare, Railroad, CHAMPUS and/or Federal BCBS.

Patient/Responsible Party's Signature	Date (MM/DD/YYYY)

T: (888)-729-1206 | F: (201) 421-2010 | billing@genedx.com | Genedx.com
207 Perry Parkway Gaithersburg, MD 20877

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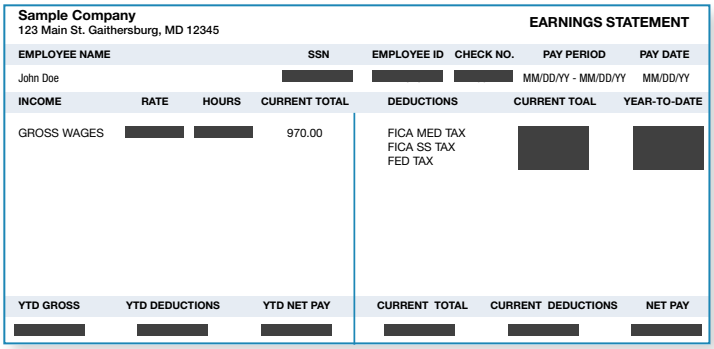
FINANCIAL ASSISTANCE PROGRAM PROCESS

STEP 1: COMPLETE APPLICATION AND PREPARE SUPPORTING DOCUMENTATION

Select two of the three types of supporting documentation from the previous page and black-out your sensitive personal information (i.e. social security number).

GeneDx only needs to be able to view your first and last name, date of birth, and gross income. Here are some examples of how to black-out your documents:



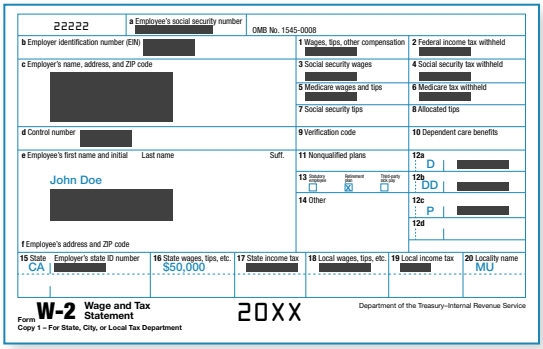
Sample Company
123 Main St. Gaithersburg, MD 12345

EARNINGS STATEMENT

EMPLOYEE NAME			SSN	EMPLOYEE ID	CHECK NO.	PAY PERIOD	PAY DATE
John Doe			[redacted]	[redacted]	[redacted]	MM/DD/YY - MM/DD/YY	MM/DD/YY

INCOME	RATE	HOURS	CURRENT TOTAL	DEDUCTIONS	CURRENT TOAL	YEAR-TO-DATE
GROSS WAGES	[redacted]	[redacted]	970.00	FICA MED TAX FICA SS TAX FED TAX	[redacted]	[redacted]

YTD GROSS	YTD DEDUCTIONS	YTD NET PAY	CURRENT TOTAL	CURRENT DEDUCTIONS	NET PAY
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]



22222 — a Employee's social security number [redacted] — OMB No. 1545-0008

b Employer identification number (EIN) [redacted]
1 Wages, tips, other compensation [redacted]
2 Federal income tax withheld [redacted]
c Employer's name, address, and ZIP code [redacted]
3 Social security wages [redacted]
4 Social security tax withheld [redacted]
5 Medicare wages and tips [redacted]
6 Medicare tax withheld [redacted]
7 Social security tips
8 Allocated tips
d Control number [redacted]
9 Verification code
10 Dependent care benefits
e Employee's first name and initial — Last name — Suff.
John Doe [redacted]
11 Nonqualified plans
12a D [redacted]
13 Statutory employee / Retirement plan [X] / Third-party sick pay
12b DD [redacted]
14 Other
12c P [redacted]
12d
f Employee's address and ZIP code

15 State	Employer's state ID number	16 State wages, tips, etc.	17 State income tax	18 Local wages, tips, etc.	19 Local income tax	20 Locality name
CA	[redacted]	$50,000	[redacted]	[redacted]	[redacted]	MU

Form **W-2** Wage and Tax Statement — 20XX — Department of the Treasury–Internal Revenue Service
Copy 1 – For State, City, or Local Tax Department

STEP 2: SEND YOUR COMPLETED FORM AND PREPARED DOCUMENTATION

Please send your documents via one of the following secure options:

1. Fax to: 201-421-2020
2. Mail to:
   GeneDx Inc.,
   P.O. Box 21997
   New York, NY 10087-1997

Once you have sent your FAP materials, please contact us to make sure we have received your application and documentation.

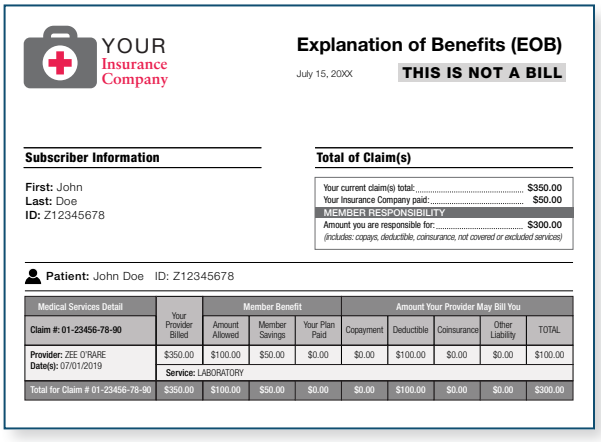
1-888-729-1206, option 2 or billing@genedx.com

STEP 3: FAP REVIEW, EXPLANATION OF BENEFITS (EOB) AND PAYMENT

Once your Financial Assistance Program (FAP) application and documents are reviewed, we will contact you to let you know if you're approved.*

If your testing is complete, your health insurance company will send you your Explanation of Benefits (EOB) letter which may arrive before you have been contacted by GeneDx about your FAP. You do not need to make any payment until GeneDx has notified you and has sent you a GeneDx bill.

If you are approved for FAP, the discounted percentage will be applied to the member financial responsibility listed on your EOB. For example, if your FAP discount percentage is 90% and your member financial responsibility on your EOB is $300, you will receive a bill from GeneDx for $30.00.



YOUR Insurance Company

Explanation of Benefits (EOB)
July 15, 20XX
THIS IS NOT A BILL

Subscriber Information
First: John
Last: Doe
ID: Z12345678

Total of Claim(s)
Your current claim(s) total: $350.00
Your Insurance Company paid: $50.00
MEMBER RESPONSIBILITY
Amount you are responsible for: $300.00
(includes: copays, deductible, coinsurance, not covered or excluded services)

Patient: John Doe ID: Z12345678

Medical Services Detail	Your Provider Billed	Member Benefit			Amount Your Provider May Bill You				
Claim #: 01-23456-78-90		Amount Allowed	Member Savings	Your Plan Paid	Copayment	Deductible	Coinsurance	Other Liability	TOTAL
Provider: ZEE O'RARE **Date(s):** 07/01/2019	$350.00	$100.00	$50.00	$0.00	$0.00	$100.00	$0.00	$0.00	$100.00
	Service: LABORATORY								
Total for Claim # 01-23456-78-90	$350.00	$100.00	$50.00	$0.00	$0.00	$100.00	$0.00	$0.00	$300.00

*You will receive a bill with the full amount if you are not eligible or all required documentation has not been received.

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