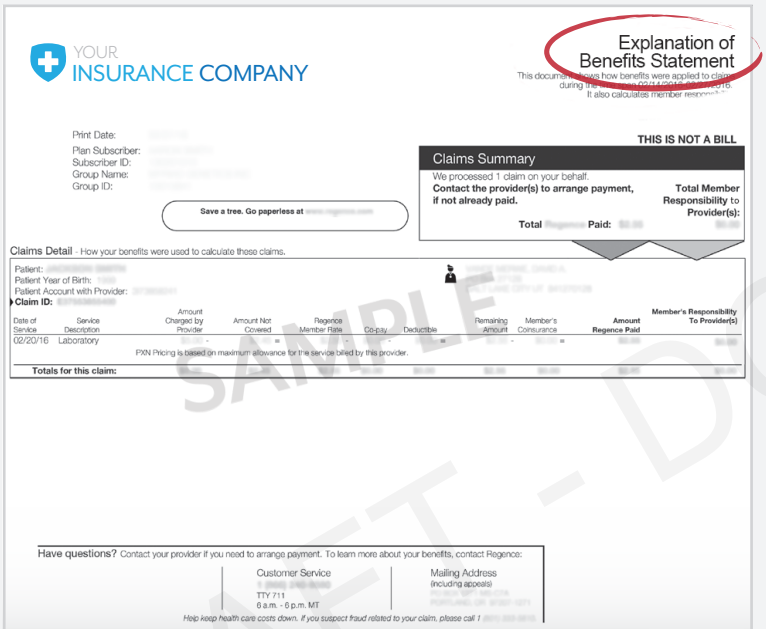
This Is NOT a Bill

The Explanation of Benefits is from your insurance company. It not necessarily represent the amount you will owe.



YOUR INSURANCE COMPANY

Explanation of Benefits Statement

This document shows how benefits were applied to claim[illegible] during the [illegible] It also calculates member responsibility.

Print Date:
Plan Subscriber:
Subscriber ID:
Group Name:
Group ID:

THIS IS NOT A BILL

Save a tree. Go paperless at [illegible]

Claims Summary

We processed 1 claim on your behalf.

Contact the provider(s) to arrange payment, if not already paid.

Total Member Responsibility to Provider(s):

Total [illegible] Paid:

Claims Detail - How your benefits were used to calculate these claims.

Patient:
Patient Year of Birth:
Patient Account with Provider:
Claim ID:

Date of Service	Service Description	Amount Charged by Provider	Amount Not Covered	Regence Member Rate	Co-pay	Deductible	Remaining Amount	Member's Coinsurance	Amount Regence Paid	Member's Responsibility To Provider(s)
02/20/16	Laboratory		=	=			=			

PXN Pricing is based on maximum allowance for the service billed by this provider.

Totals for this claim:

Have questions? Contact your provider if you need to arrange payment. To learn more about your benefits, contact Regence:

Customer Service
[illegible]
TTY 711
6 a.m. - 6 p.m. MT

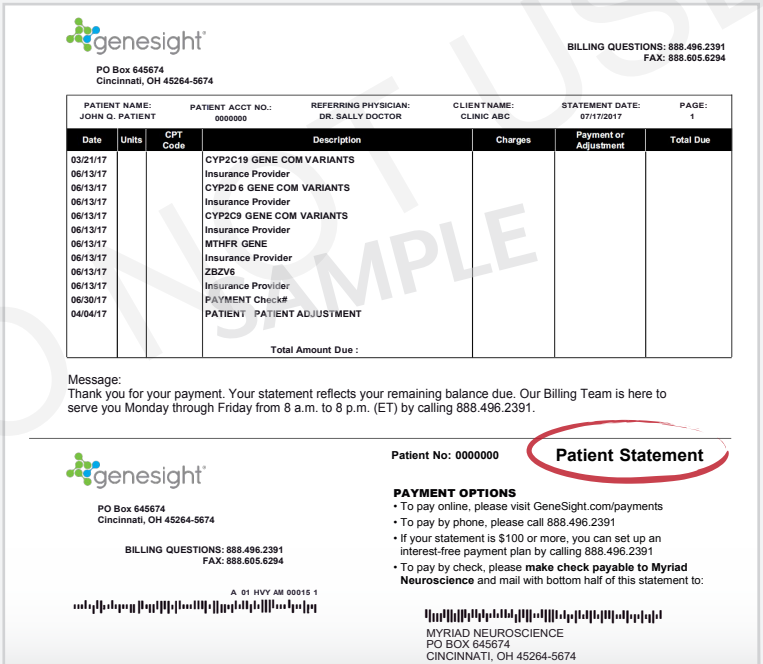
Mailing Address
(including appeals)
[illegible]

Help keep health care costs down. If you suspect fraud related to your claim, please call 1 [illegible]

SAMPLE

This Is a Bill

The bill is from GeneSight. This is the amount you will owe.



genesight

PO Box 645674
Cincinnati, OH 45264-5674

BILLING QUESTIONS: 888.496.2391
FAX: 888.605.6294

PATIENT NAME:	PATIENT ACCT NO.:	REFERRING PHYSICIAN:	CLIENT NAME:	STATEMENT DATE:	PAGE:
JOHN Q. PATIENT	0000000	DR. SALLY DOCTOR	CLINIC ABC	07/17/2017	1

Date	Units	CPT Code	Description	Charges	Payment or Adjustment	Total Due
03/21/17			CYP2C19 GENE COM VARIANTS			
06/13/17			Insurance Provider			
06/13/17			CYP2D 6 GENE COM VARIANTS			
06/13/17			Insurance Provider			
06/13/17			CYP2C9 GENE COM VARIANTS			
06/13/17			Insurance Provider			
06/13/17			MTHFR GENE			
06/13/17			Insurance Provider			
06/13/17			ZBZV6			
06/13/17			Insurance Provider			
06/30/17			PAYMENT Check#			
04/04/17			PATIENT PATIENT ADJUSTMENT			
			Total Amount Due :			

Message:
Thank you for your payment. Your statement reflects your remaining balance due. Our Billing Team is here to serve you Monday through Friday from 8 a.m. to 8 p.m. (ET) by calling 888.496.2391.

genesight

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Cincinnati, OH 45264-5674

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FAX: 888.605.6294

A 01 HVY AM 00015 1

Patient No: 0000000

Patient Statement

PAYMENT OPTIONS

- To pay online, please visit GeneSight.com/payments
- To pay by phone, please call 888.496.2391
- If your statement is $100 or more, you can set up an interest-free payment plan by calling 888.496.2391
- To pay by check, please **make check payable to Myriad Neuroscience** and mail with bottom half of this statement to:

MYRIAD NEUROSCIENCE
PO BOX 645674
CINCINNATI, OH 45264-5674

SAMPLE

GENESIGHT PROMISE

Insurance can be complicated, and we want you to feel comfortable knowing what you'll owe. We promise if your patient responsibility could be more than $330, we'll call you before we process the test.

If you have any questions regarding your insurance Explanation of Benefits or your bill, please contact:

888.496.2391 or visit us online at GeneSight.com/cost

GSBL.001.193