**Advance Notice of Non-Covered Services**

<table>
<thead>
<tr>
<th>Items or Services</th>
<th>Reason Medicare May Not Pay:</th>
<th>Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) 1385-Gene Pan-Cancer Mutation Test</td>
<td>This item or service is not covered for your condition.</td>
<td>(1) $3,375.00</td>
</tr>
</tbody>
</table>

**WHAT YOU NEED TO DO NOW:**
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the items or services listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have.

**OPTIONS:** Check only one box. We cannot choose a box for you.

- **OPTION 1.** Your insurance company has informed us that this procedure(s) is not a covered benefit of your plan. An estimated priced for the non-covered procedure(s) has been established that is due in full prior to your treatment, and this procedure(s) will not be billed to your insurance company.
- **OPTION 2.** This procedure(s) may not be a covered benefit of your plan, but you have requested that we submit a claim for these services to your insurance. If your insurance covers any portion of this procedure(s), you are responsible for your normal/regular coinsurance and/or deductible amounts. If your insurance does not cover any portion of this procedure(s), you are responsible for the full price of any non-covered services. While we may have obtained an authorization from your insurance carrier for this procedure(s), you are responsible for the full price of any non-covered portion of the procedure should it be denied or payment recouped due to an exclusion in coverage determined by your insurance. The payment of your estimated out-of-pocket balance after insurance and any package plan amount is due in full prior to the procedures being rendered.

**Additional Information:** This pricing information include only those services listed above. It does not include additional anesthesia, laboratory, pathology or radiology/imaging services that may be required by the facility or additional procedures that may be performed. Please understand that, in some rare cases, there may be unusual circumstances, unexpected conditions or complications that require additional charges. **These additional charges may or may not be covered by your insurance.** Signing below means that you have received and understand this notice and agree to pay your designated amount(s) as described within it. You also receive a copy.

**Signature:**

**Date:**