



2023 BENEFITS GUIDE

WELCOME

to your 2023 Benefits Guide. Your benefits are a valuable addition to your overall compensation. Please make sure you get the most from them by taking the time to understand your options and by selecting the best coverage for you and your family.



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Welcome to your Benefits Guide

MESSAGE FROM THE COMPANY

We believe it is critical to the viability of a company to have a comprehensive benefits program in place! The reason employers buy benefits is simple: they want the ability to hire and retain quality employees, like you. We know a comprehensive, affordable benefits program is necessary for us to remain competitive in our marketplace today, and we are committed to providing you with a comprehensive benefits program as part of your total compensation.

You are urged to read this guide carefully and keep it handy for easy reference. If you are well-informed, you will be in a better position to make the appropriate choices and take full advantage of your benefits as a member of the Pulmonx family.

PULMONX OFFERS:

Medical:

- Kaiser Permanente HMO (California only)
- Kaiser Permanente HSA-Qualified HDHP HMO (California Only)
- Blue Shield of California HMO (California only)
- Blue Shield of California PPO - choice of two PPO plans
- Blue Shield of California HDHP PPO
- Teladoc

Dental: Delta Dental PPO

Vision: Vision Service Plan (VSP)

- Basic Life/AD&D: Lincoln Financial Group
- Short Term Disability: Lincoln Financial Group
- Long Term Disability: Lincoln Financial Group
- Flexible Spending Accounts (FSA): Igoe
- Health Savings Account (HSA): Igoe
- Commuter Benefits: Igoe
- Employee Assistance Program: Concern
- Employee Assistance Program: Lincoln Financial Group
- 401(K): Empower Retirement

IMPORTANT NOTICE: READ CAREFULLY

This benefits guide briefly describes your benefit choices and your options to enroll. All benefits, and your eligibility for benefits, are subject to the terms and conditions of the benefit plans, including group insurance contracts. This guide is not intended to be a complete description of the benefit plans and it is not a summary plan description or plan document. In the event of any conflict or discrepancy between this guide and the plan documents, the plan documents will govern. Information contained in this Employee Benefits Guide is proprietary and confidential to Pulmonx Corporation, referred to as "Pulmonx" in this booklet. Pulmonx reserves the right to modify or terminate any of the described benefits at any time and for any reason. This guide is not a guarantee of current or future employment or benefits.

UNDERSTANDING YOUR RIGHTS: READ ALL NOTICES

Employees and family members eligible for Pulmonx's benefits may have rights under applicable federal or state laws. Annual plan notices may be found on page 22.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 26 for more details.

Eligibility and Enrollment

WHO IS ELIGIBLE AND WHEN

You are eligible to enroll in group benefits effective the first of the month following date of hire if you work 20 or more hours per week. Eligible dependents include: your spouse, domestic partner and dependent children up to age 26.

Your dependent children include: sons, daughters, stepsons, stepdaughters, adopted children or eligible foster children, regardless of the qualifying young adult's marital status.

You may be required to provide proof of dependent status. Any falsification of this information will result in disciplinary action, up to and including termination.

Note: The value of health care coverage provided for a domestic partner or any enrolled dependent children of your domestic partner is treated as income to you for federal tax purposes (and in most cases, state tax purposes). Pulmonx will report the value of the coverage as income to you on your Form W-2 and will withhold applicable taxes. The amounts taxable to you can be substantial. It is recommended you consult with your tax advisor for more information on how this affects you.

MAKING CHANGES

Family or life events — such as marriage, divorce, legal separation, birth, adoption, death in the family, spouse loss of other coverage, dependent child reaching limiting age — may require you to change your benefits to accommodate your new situation. Following IRS regulations, you can make changes consistent with your life event by notifying Human Resources within 31 days of the date of the event. If you miss the 31 day period, you will have to wait until the next Open Enrollment to change your benefits.

WHAT YOU NEED TO DO

You will need to make choices about which benefits you'd like to participate in during "enrollment windows". Enrollment windows are specific times that will require you to take action and select your benefits:

- When you are eligible to participate in benefits, elections you make generally become effective first of the month following your date of hire.
- During Open Enrollment, any changes you make become effective January 1, 2023.

Each time an enrollment window occurs, use this guide to familiarize yourself with the most current information on our benefit programs and what coverage options are available to you.

HOW TO ENROLL

ADP - Enroll in Benefits Online

Enrolling on the internet is simple and secure. Eligible employees will enroll in benefits by using ADP. Upon login, a New/Open Enrollment wizard will pop up and you can begin the process by following the prompts.

You can access and review benefits by navigating to Myself > Benefits > Enrollments.

Employees will also use ADP to make changes to their benefits during Open Enrollment, or whenever there is a qualifying life event.

Enroll online at: <https://workforcenow.adp.com>

Medical Insurance

HOW TO CHOOSE THE BEST PLAN FOR YOU AND YOUR FAMILY

When choosing a medical plan, it is important to look at budget, preferences, age and health for you and your covered dependents. You should consider the key differences between plan types and choose one that best suits you and your family. The plans differ in the following areas:

- Cost of coverage, including payroll contributions and how you and the plan pay for services throughout the year
- Convenience, covered services, access to providers, and ease of use

PRE-AUTHORIZATION REQUESTS

Certain medical services and benefits require pre-authorization. Your health care provider must request prior authorization from the carrier before the services are performed. If pre-authorization is not approved before the services are rendered, the medical carrier has the right to deny any claims related to those services.

SELECTING PRIMARY CARE PHYSICIANS

You are not required to select a primary care physician (PCP) if you enroll in a PPO plan. However, most HMOs require that you and each of your covered dependents select a PCP from the plan's network. If you do not designate your preferred PCP, the HMO will assign one for you. To choose a different PCP, call your plan after you receive your ID card and request that your PCP selection be made retroactive to the new plan year.



Medical Insurance - HMO & HSA- Qualified HDHP HMO (CA Only)

KAISER PERMANENTE TRADITIONAL HMO \$20 COPAY

In-Network Only

KAISER PERMANENTE HSA-QUALIFIED HDHP HMO \$1,500

In-Network Only

	KAISER PERMANENTE TRADITIONAL HMO \$20 COPAY In-Network Only	KAISER PERMANENTE HSA-QUALIFIED HDHP HMO \$1,500 In-Network Only
CALENDAR YEAR DEDUCTIBLE	None	\$1,500 Individual \$3,000 Individual in a family / \$3,000 Family
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	\$2,000 Individual \$4,000 Family	\$3,000 Individual \$6,000 Family
COINSURANCE	N/A	10%
OFFICE VISIT	\$20 copay	10% after deductible
VIRTUAL (VIDEO) VISIT	No charge	No charge after deductible
PREVENTIVE SERVICES	No charge	No charge (deductible waived)
CHIROPRACTIC & ACUPUNCTURE (20 VISITS/YEAR COMBINED)	\$15 copay	\$15 copay after deductible
X-RAY & DIAGNOSTICS	\$10 copay per encounter	10% after deductible
INPATIENT HOSPITAL - SERVICES & STAY	\$250 per admit	10% after deductible
OUTPATIENT HOSPITAL - SURGERY	\$100 per procedure	10% after deductible
EMERGENCY ROOM	\$100 copay (waived if admitted)	10% after deductible
URGENT CARE	\$20 copay	10% after deductible
PRESCRIPTION DRUG CALENDAR YEAR DEDUCTIBLE	None	Subject to combined medical/Rx deductible
PRESCRIPTION - RETAIL (30-DAY SUPPLY)	Generic: \$15 copay Brand: \$30 copay	Generic: \$10 copay after deductible Brand: \$30 copay after deductible
SPECIALTY PRESCRIPTION (30-DAY SUPPLY)	30% up to \$250 max copay/Rx	20% after deductible, up to \$250 max copay/Rx
PRESCRIPTION - MAIL ORDER (100-DAY SUPPLY)	Generic: \$30 copay Brand: \$60 copay	Generic: \$20 copay after deductible Brand: \$60 copay after deductible
DURABLE MEDICAL EQUIPMENT (DME)	20%	10% after deductible
WEBSITE	www.kp.org	www.kp.org

Medical Insurance - HMO (CA Only)

BLUE SHIELD OF CALIFORNIA
ACCESS+ HMO PER ADMIT 20-250

In-Network Only

CALENDAR YEAR DEDUCTIBLE	None
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	\$2,000 Individual \$4,000 Family
COINSURANCE	N/A
OFFICE VISIT	PCP: \$20 copay Access+ Specialist (self-referred): \$30 copay Other Specialist (PCP referred): \$20 copay
VIRTUAL (VIDEO) VISIT	Teladoc - no charge
PREVENTIVE SERVICES	No charge
CHIROPRACTIC & ACUPUNCTURE (30 VISITS/YEAR COMBINED)	\$10 copay
X-RAY & DIAGNOSTICS	No charge
INPATIENT HOSPITAL - SERVICES & STAY	\$250 per admission
OUTPATIENT HOSPITAL - SURGERY	\$200 per procedure
EMERGENCY ROOM	\$150 copay (waived if admitted)
URGENT CARE	\$20 copay
PRESCRIPTION - RETAIL (30-DAY SUPPLY)	Tier 1: \$10 copay Tier 2: \$15 copay Tier 3: \$30 copay Tier 4: 20% up to \$250 max copay/Rx
SPECIALTY PRESCRIPTION (30-DAY SUPPLY)	20% up to \$250 max copay/Rx
PRESCRIPTION - MAIL ORDER (90-DAY SUPPLY)	Tier 1: \$20 copay Tier 2: \$30 copay Tier 3: \$60 copay Tier 4: 20% up to \$500 max copay/Rx
DURABLE MEDICAL EQUIPMENT (DME)	20%
WEBSITE	www.blueshieldca.com

Medical Insurance - PPO

BLUE SHIELD OF CALIFORNIA

FULL PPO COMBINED DEDUCTIBLE 15-250 90/70

	In-Network	Out-of-Network
CALENDAR YEAR DEDUCTIBLE	\$250 Individual \$750 Family	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	\$2,750 Individual \$5,500 Family	\$10,250 Individual \$20,500 Family
CO-INSURANCE	10%	30%
OFFICE VISIT	\$15 copay (deductible waived)	30% after deductible
VIRTUAL (VIDEO) VISIT	Teladoc - no charge (deductible waived)	Not covered
PREVENTIVE SERVICES	No charge (deductible waived)	Not covered
CHIROPRACTIC (UP TO 20 VISITS/YEAR)	\$15 per visit (deductible waived)	30% after deductible
ACUPUNCTURE (UP TO 20 VISITS/YEAR)	\$15 per visit (deductible waived)	30% after deductible
X-RAY & DIAGNOSTICS (OUTPATIENT CENTER)	\$15 copay after deductible (advanced imaging: 10% after deductible)	30% after deductible
X-RAY & DIAGNOSTICS (OUTPATIENT HOSPITAL)	\$40 copay after deductible (advanced imaging: 20% after deductible)	30% after deductible up to \$350/day benefit limit
INPATIENT HOSPITAL SERVICES & STAY	10% after deductible	30% after deductible up to \$600/day benefit limit
OUTPATIENT HOSPITAL SURGERY	15% after deductible	30% after deductible up to \$350/day benefit limit
EMERGENCY ROOM	\$150 copay (waived if admitted) + 10% (deductible waived)	
URGENT CARE	\$15 copay (deductible waived)	30% after deductible
PRESCRIPTION - RETAIL (30-DAY SUPPLY)	Tier 1: \$10 copay Tier 2: \$30 copay Tier 3: \$50 copay Tier 4: 30% up to \$250 max copay/Rx	Tier 1: \$10 copay + 25% Tier 2: \$30 copay + 25% Tier 3: \$50 copay + 25% Tier 4: 30% + 25% up to \$250 max copay/Rx
SPECIALTY PRESCRIPTION (30-DAY SUPPLY)	30% up to \$250 max copay/Rx	Not covered
PRESCRIPTION - MAIL ORDER (90-DAY SUPPLY)	Tier 1: \$20 copay Tier 2: \$60 copay Tier 3: \$100 copay Tier 4: 30% up to \$500 max copay/Rx	Not covered
DURABLE MEDICAL EQUIPMENT (DME)	10% after deductible	30% after deductible
WEBSITE	www.blueshieldca.com	

Medical Insurance - PPO

BLUE SHIELD OF CALIFORNIA FULL PPO SPLIT DEDUCTIBLE 25-750 80/60

	In-Network	Out-of-Network
CALENDAR YEAR DEDUCTIBLE	\$750 Individual \$2,250 Family	\$2,250 Individual \$6,750 Family
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	\$5,250 Individual \$10,500 Family	\$9,500 Individual \$19,000 Family
CO-INSURANCE	20%	40%
OFFICE VISIT	\$25 copay (deductible waived)	40% after deductible
VIRTUAL (VIDEO) VISIT	Teladoc - no charge (deductible waived)	Not covered
PREVENTIVE SERVICES	No charge (deductible waived)	Not covered
CHIROPRACTIC (UP TO 20 VISITS/YEAR)	\$25 per visit (deductible waived)	40% after deductible
ACUPUNCTURE (UP TO 20 VISITS/YEAR)	\$25 per visit (deductible waived)	40% after deductible
X-RAY & DIAGNOSTICS (OUTPATIENT CENTER)	\$25 copay after deductible (advanced imaging: 20% after deductible)	40% after deductible
X-RAY & DIAGNOSTICS (OUTPATIENT HOSPITAL)	\$50 copay after deductible (advanced imaging: 30% after deductible)	40% after deductible up to \$350/day benefit limit
INPATIENT HOSPITAL SERVICES & STAY	20% after deductible	40% after deductible up to \$600/day benefit limit
OUTPATIENT HOSPITAL SURGERY	25% after deductible	40% after deductible up to \$350/day benefit limit
EMERGENCY ROOM	\$150 copay (waived if admitted) + 20% (deductible waived)	
URGENT CARE	\$25 copay (deductible waived)	40% after deductible
PRESCRIPTION - RETAIL (30-DAY SUPPLY)	Tier 1: \$10 copay Tier 2: \$30 copay Tier 3: \$50 copay Tier 4: 30% up to \$250 max copay/Rx	Tier 1: \$10 copay + 25% Tier 2: \$30 copay + 25% Tier 3: \$50 copay + 25% Tier 4: 30% + 25% up to \$250 max copay/Rx
SPECIALTY PRESCRIPTION (30-DAY SUPPLY)	30% up to \$250 max copay/Rx	Not covered
PRESCRIPTION - MAIL ORDER (90-DAY SUPPLY)	Tier 1: \$20 copay Tier 2: \$60 copay Tier 3: \$100 copay Tier 4: 30% up to \$500 max copay/Rx	Not covered
DURABLE MEDICAL EQUIPMENT (DME)	20% after deductible	40% after deductible
WEBSITE	www.blueshieldca.com	

Medical Insurance - HDHP PPO

BLUE SHIELD OF CALIFORNIA
HDHP PPO \$1,500 DEDUCTIBLE

	In-Network	Out-of-Network
CALENDAR YEAR DEDUCTIBLE	\$1,500 Individual \$3,000 Individual in a family / \$3,000 Family	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	\$3,500 Individual \$7,000 Family	\$6,000 Individual \$12,000 Family
CO-INSURANCE	10%	40%
OFFICE VISIT	10% after deductible	40% after deductible
VIRTUAL (VIDEO) VISIT	Teladoc - no charge after deductible	Not covered
PREVENTIVE SERVICES	No charge (deductible waived)	Not covered
CHIROPRACTIC (UP TO 20 VISITS/YEAR)	10% after deductible	40% after deductible
ACUPUNCTURE (UP TO 20 VISITS/YEAR)	10% after deductible	40% after deductible
X-RAY & DIAGNOSTICS (OUTPATIENT CENTER)	10% after deductible (advanced imaging: 10% after deductible)	40% after deductible
X-RAY & DIAGNOSTICS (OUTPATIENT HOSPITAL)	20% after deductible (advanced imaging: \$100 copay + 10% after deductible)	40% after deductible up to \$350/day benefit limit
INPATIENT HOSPITAL SERVICES & STAY	10% after deductible	40% after deductible up to \$600/day benefit limit
OUTPATIENT HOSPITAL SURGERY	15% after deductible	40% after deductible up to \$350/day benefit limit
EMERGENCY ROOM	\$150 copay (waived if admitted) + 10% after deductible	
URGENT CARE	10% after deductible	40% after deductible
PRESCRIPTION DRUG CALENDAR YEAR DEDUCTIBLE	Subject to combined medical/Rx deductible	
PRESCRIPTION - RETAIL (30-DAY SUPPLY)	Tier 1: \$10 copay after deductible Tier 2: \$25 copay after deductible Tier 3: \$40 copay after deductible Tier 4: 30% after deductible up to \$250 max copay/Rx	Tier 1: \$10 copay + 25% after deductible Tier 2: \$25 copay + 25% after deductible Tier 3: \$40 copay + 25% after deductible Tier 4: 30% + 25% after deductible up to \$250 max copay/Rx
SPECIALTY PRESCRIPTION (30-DAY SUPPLY)	30% up to \$250 max copay/Rx after deductible	Not covered
PRESCRIPTION - MAIL ORDER (90-DAY SUPPLY)	Tier 1: \$20 copay after deductible Tier 2: \$50 copay after deductible Tier 3: \$80 copay after deductible Tier 4: 30% after deductible up to \$500 max copay/Rx	Not covered
DURABLE MEDICAL EQUIPMENT (DME)	10% after deductible	40% after deductible
WEBSITE	www.blueshieldca.com	

Health Savings Account (HSA)

IGOE

If you enroll in the Kaiser HSA-Qualified HDHP HMO \$1,500 Deductible plan or the Blue Shield of California HDHP PPO \$1,500 Deductible plan, **you may be eligible** to open a Health Savings Account (HSA) with Igoe. Refer to the Important IRS Rules below to determine if you are eligible. If you decide to open a Health Savings Account (HSA) through Igoe, Pulmonx will contribute to your HSA to help you by funding 50% of the deductible according to the following schedule:

If you are hired January 1st through June 30th, Pulmonx will contribute \$750 per year to your HSA after you enroll yourself (employee only coverage) or \$1,500 per year if you enroll as a family (you plus at least one or more dependents).

For new employees hired July 1st through the end of the calendar year, Pulmonx will contribute 50% of the annual amount or \$375 when you enroll yourself (employee only coverage) or \$750 when you enroll as a family (you plus at least one or more dependents).

You may also elect to contribute to your HSA through convenient pre-tax** payroll deductions. See the chart below for the 2023 HSA contribution limits set by the I.R.S. The amounts are the total of employer plus employee contributions combined.

- \$3,850 for employee only coverage on the HDHP medical plan
- \$7,750 for employee plus family coverage (enrolled with one or more family members on the HDHP medical plan)
- Those age 55 or older may make a catch-up contribution of \$1,000

Some HSA Features:

- Triple tax benefits: 1) tax-free** contributions, 2) tax-free interest on your HSA balance and investment gains, and 3) tax-free withdrawals for qualified medical expenses
- Plan balance rolls over from year to year, there is no “use it or lose it” rule
- You own the account and you take the money with you even if you change jobs or retire
- You may use your HSA to pay for qualified medical, dental and vision expenses for yourself and for your spouse and children as long as they are recognized as IRS tax-dependents

Important IRS Rules:

- You can contribute to an HSA only if you are enrolled in a qualified High-Deductible Health Plan (Kaiser HSA-Qualified HDHP HMO \$1,500 Deductible plan or Blue Shield of California HDHP PPO \$1,500 Deductible plan are qualified High Deductible Health Plans)
- You cannot be covered under any other non-qualified medical plan, including your spouse’s plan, Medicare, Medicaid, Tricare, etc
- If you have an HSA, you cannot participate in a Health Care Flexible Spending Account (including under your spouse’s Health Care Flexible Spending Account), you may enroll in Limited Purpose FSA
- You cannot be claimed as a dependent under someone else’s tax return

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

- Comprehensive medical coverage after you pay the deductible
- Preventive care (before you meet the deductible)
- Plan pays a percentage of covered services
- Out-of-pocket maximum protects you from high costs

HEALTH SAVINGS ACCOUNT (HSA)

- You can contribute up to the annual limit each year
- Helps pay your deductible and other expenses

****Tax-free contributions, earnings and payments at the Federal level (for qualified expenses). HSAs can be taxable at the state level – for example, HSAs are subject to state income tax in California. Consult with your tax advisor for more information.**

To view to the full list of HSA eligible expenses, visit: <https://hsastore.com/HSA-Eligibility-List.aspx>.

Additional Benefits - Kaiser Members

TELADOC

MYSTRENGTH

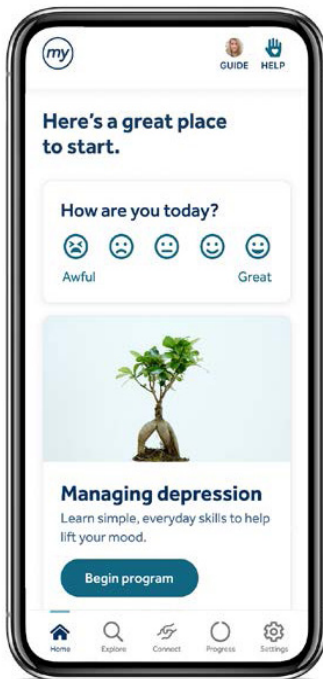
myStrength is a flexible and comprehensive digital program with proven tools and dedicated support for stress, depression, sleep and more; all tailored to your unique needs. Explore activities and techniques that can benefit anyone - either as self-guided, self-care, or complements to clinical support. They're not intended to replace treatment or advice, but they can help you build resilience, set goals and take meaningful steps towards becoming a healthier, happier you.

What's included:

- Personalized plan:** Answer a series of questions, and myStrength will create a plan designed just for you
- Teletherapy your way:** Connect with a licensed therapist of your choice by appointment seven days a week from the comfort of home. Therapy visits are free for you and your enrolled, eligible family members (age 18+)
- Recommended activities and content:** Explore skill-building tools and resources based on your ongoing needs and preferences
- In the moment tools:** Calm yourself down, shift your thinking, get inspired and feel more hopeful

Sign up at: www.teladoc.com/mystrength

Download the **myStrength** app from the Apple App Store or Google Play. Sign in on the app to get started.



HEALTH AND WELLNESS SERVICES

CALM APP

Calm is an app that uses meditation and mindfulness to help lower stress, reduce anxiety, and improve sleep quality. Practicing mindfulness with Calm can help you support your overall health and wellness.

Anyone can benefit from Calm, the app offers something for everyone:

- A new 10-minute Daily Calm meditation everyday
- Guided meditations covering anxiety, stress, gratitude, and more
- Sleep stories (soothing bedtime stories for grown-ups)
- Music for focus, relaxation, and sleep
- Calm Masterclass taught by world-renowned experts and celebrities

Adult members can get Calm at kp.org/selfcareapps.

WELLNESS COACH

If you need a little extra support, Kaiser offers Wellness Coaching by Phone at no cost to members. You'll work one-on-one with your personal coach to make a plan to help you reach your health goals. Visit kp.org/wellnesscoach for more information.

ENJOY MEMBER DISCOUNTS

Get reduced rates on a variety of health-related products and services through The ChooseHealthy program, these include:

- Acupuncture: up to 25% if a contracted acupuncturist's regular rates
- Active&Fit Direct: members pay \$25 per month (plus a one-time \$25 enrollment fee) for access to a national network of more than 10,000 fitness centers
- Chiropractic care: up to 25% off contracted chiropractor's regular rates
- Massage therapy: up to 25% off a contracted massage therapist's regular rates

Find a provider:

Go to kp.org/choosehealthy

Choose your region

Click the "ChooseHealthy" link and click "Find a Provider"

Additional Benefits - Blue Shield

TELADOC

Get support from mental health professionals and licensed doctors no matter where you are with Teladoc.

As a Blue Shield member, you have access to Teladoc's national network of U.S. board-certified physicians. Whenever you need care, Teladoc medical doctors are available 24/7/365 by phone or video.

You can also speak to licensed therapists, psychiatrists, and mental health professionals who can help you manage addiction, depression, stress or anxiety, domestic abuse, grief, and more.

Teladoc doctors can treat many medical conditions including:

- Cold and flu symptoms
- Allergies
- Respiratory infections
- Sinus problems

Teladoc licensed professionals can help you manage mental health conditions including:

- Depression
- Addiction
- Grief and more

Visit blueshieldca.com/teladoc to register or log in. If you have questions or need help creating an account, call 800-835-2362.

WELLVOLUTION

Wellvolution is Blue Shield's digital platform for health and well-being. It offers over 50 tested apps and programs to help you achieve your health goals - at no extra cost. You choose the areas to focus on:

- Prevent and reverse diseases: Conditions like obesity, type 2 diabetes, cardiovascular disease, and more
- Eat Better: Get help with meal planning, use nutritional calculators, and lose weight
- Exercise more: Get support with movement tracking, workout routines, and coaching
- Sleep better: Track sleep patterns and enjoy relaxation exercises for better rest
- Quit smoking: Get the support you need to stop smoking with nicotine replacement therapy and other methods

Learn more at wellvolution.com.



FITNESS YOUR WAY

Get healthy and feel good on your own terms with Fitness Your Way. The program offers you the flexibility to work out at any network fitness location on a budget that you can live with. Fitness Your Way is available to Blue Shield of California members through Tivity Health. It's a flexible, affordable, and accessible way to adopt a healthy lifestyle and remain committed to it. You and your dependents who are age 18 and older are eligible.

Network includes more than 800 fitness locations in California and over 10,000 nationally.

- Finding locations is quick and easy: visit fitnessyourway.tivityhealth.com/bsc
- Visit any participating location anywhere as often as you like
- \$25 initiation (one-time fee) and \$25 per month per person

Enroll today in Fitness Your Way:

Go to fitnessyourway.tivityhealth.com/bsc and click Enroll. Or you can enroll over the phone at 833-283-8387, Monday through Friday 5:00 AM to 5:00 PM PST.

IDENTITY PROTECTION

As an eligible Blue Shield member, you can get identity protection services from Experian such as identity repair assistance, identity theft insurance, and credit monitoring for you and your covered family members at no additional cost to you.

You can access these services by contacting Experian's customer care team at 866-274-3891, or online at experianidworks.com/blueshieldca. When creating your account, you will need to provide the activation code **BCBSCALI20**.

Dental Insurance

DELTA DENTAL

In order to take full advantage of your dental plan, we recommend that you verify a dentist’s participation status before each appointment. There are two ways to check dental participation: online through the provider search function located at www.deltadentalins.com or by calling customer service at 800-765-6003.

In-network versus out-of-network: To pay the least out-of-pocket always use in-network dentists. If you choose to visit an out-of-network provider, your out of pocket costs may be higher as Delta Dental will only pay up to their contract allowances which may be lower than your dentist’s actual fees. Out-of-network dentists may balance bill you the difference between the contracted allowance and their fee.

Pre-treatment estimates: Pre-treatment estimates are not required, however, we recommend that you request a pre-treatment estimate before beginning any dental procedures beyond preventive care. Your dental provider may submit a pre-treatment plan to the dental insurance company which outlines the services that will be provided to you. The dental insurance company will then estimate what portion of the services will be covered and what portion will be considered your responsibility.

DELTA DENTAL - PPO

In-Network

Out-of-Network

CALENDAR YEAR DEDUCTIBLE	\$50 per individual (up to \$150 max per family) (waived for diagnostic and preventive services)	
CALENDAR YEAR BENEFIT MAXIMUM*	\$2,500 per person	
DIAGNOSTIC AND PREVENTIVE SERVICES	No charge	No charge
BASIC SERVICES	10% after deductible	20% after deductible
MAJOR SERVICES	40% after deductible	50% after deductible
ORTHODONTICS	Adults and Children: 50% up to a lifetime maximum of \$1,500 per person	
WEBSITE	www.deltadentalins.com	

*Diagnostic and preventive services do not count toward the benefit maximum.



Vision Insurance

VISION SERVICE PLAN (VSP)

You may elect vision coverage through VSP for your eyewear and eye care needs. In order to take full advantage of your vision plan, we recommend that you visit in-network providers. You may find in-network providers online at www.vsp.com or by calling Customer Service at 800-877-7195. If you decide to receive services from an out-of-network vision provider, you will be responsible for paying for those services up front. You may then request reimbursement from VSP based on a reimbursement schedule.

VISION SERVICE PLAN (VSP)

	In-Network (VSP Signature Network)	Out-of-Network
COPAY		Exam: \$10 Materials: \$25
EXAMS (EVERY 12 MONTHS)	No charge after copay	Up to \$50
LENSES (EVERY 12 MONTHS)	Single Vision: no charge after copay Lined Bifocal: no charge after copay Lined Trifocal: no charge after copay Lenticular: no charge after copay	Single Vision: Up to \$50 Lined Bifocal: Up to \$75 Lined Trifocal: Up to \$100 Lenticular: Up to \$125
FRAMES (EVERY 12 MONTHS)	\$150 allowance (\$80 allowance at Costco and \$150 allowance at Walmart/Sam’s Club)*	Up to \$70
CONTACTS - IN LIEU OF GLASSES (EVERY 12 MONTHS)	Elective: \$150 allowance Medically Necessary: no charge after copay <i>Contact lens fitting and evaluation: copay not to exceed \$60</i>	Elective: Up to \$105 Medically Necessary: up to \$210 <i>Contact lens fitting and evaluation: no benefit</i>
CORRECTIVE EYE SURGERY	Discounts available	N/A
WEBSITE	www.vsp.com	

*Glasses or contacts are covered as in-network (as outlined above) with an \$80 frame allowance at Costco and \$150 frame allowance at Walmart/Sam’s Club. For eye exams, eye care providers contract independently with VSP, so always check www.vsp.com to see if the provider is in-network or out-of-network.



Income Protection Plans

LIFE & AD&D

LINCOLN FINANCIAL GROUP

Life insurance and Accidental Death and Dismemberment (AD&D) insurance provide funds for those who have lost someone or for those who are seriously injured. Life insurance pays funds to your designated beneficiaries after your death, while AD&D pays an amount equal to your life insurance in the event of an accidental death or for certain accidental injuries. It's very important that you have a current beneficiary designated in ADP, especially after experiencing a life event such as marriage or divorce. This is an employer sponsored plan.

SHORT TERM DISABILITY (STD)

LINCOLN FINANCIAL GROUP

Short term disability provides income replacement for up to 26 weeks for employees who become unable to work due to injury or illness, including pregnancy. Benefits received under this plan will be offset by benefits you receive, or are entitled to receive, under any state or federal compulsory benefit act or law, such as state disability, workers' compensation and Social Security. This is an employer sponsored plan.

LONG TERM DISABILITY (LTD)

LINCOLN FINANCIAL GROUP

If you continue to be disabled for more than 180 days, you may be eligible to receive disability benefits on a monthly basis under our Long Term Disability (LTD) plan offered through Lincoln Financial Group. You will continue to receive payments under the LTD plan as long as you are deemed "disabled" until you reach Social Security Normal Retirement Age (SSNRA). Benefits will be offset by other sources of disability income you receive. This is an employer sponsored plan.

	Carrier	Coverage	Maximum Benefit
BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)	Lincoln Financial Group	2x annual income*	\$500,000
SHORT TERM DISABILITY	Lincoln Financial Group	60% of weekly income*	Up to a maximum of \$3,500 per week (up to 26 weeks)
LONG TERM DISABILITY	Lincoln Financial Group	66.67% of monthly income*	Up to a maximum of \$14,000 per month (up to SSNRA)

*Income includes base salary, commissions and bonuses.

Flexible Spending Accounts (FSA)

IGOE

Pulmonx’s Health Care FSA and Dependent Care FSA plans are administered by Igoe. Employees can make an annual election which will be payroll deducted in equal, pre-tax increments over the course of the plan year, which is from January 1 to December 31. Flexible Spending Accounts (FSA) help you save money on health care and dependent care expenses by enabling you to pay for eligible expenses with pre-tax dollars. You must re-enroll in the accounts every year.

If you are enrolled in the Kaiser HSA-Qualified HDHP HMO \$1,500 Deductible plan or the Blue Shield of California HDHP PPO \$1,500 Deductible plan, you can only enroll in a Limited Purpose FSA. If you are enrolled in one of the two HMO plans or one of the two PPO plans, this limitation does not apply.

REMINDER: Certain Over the Counter (OTC) medications are eligible expenses without the need for a doctor’s prescription. Additionally, menstrual products are eligible expenses.

HEALTH CARE FSA	The Health Care FSA allows employees to receive reimbursement for eligible expenses, such as copays, deductibles, and other health related services, including vision and dental.
LIMITED PURPOSE FSA	The Limited Purpose FSA allows employees to receive reimbursement for eligible dental and vision expenses only, until you have met your medical plan deductible. Once you’ve met your medical plan deductible, you have the option of converting your Limited Purpose FSA so that it will begin also covering medical expenses.
MAXIMUM ANNUAL CONTRIBUTION FOR HEALTH CARE FSA AND LIMITED PURPOSE FSA	\$3,050
DEPENDENT CARE FSA	The Dependent Care FSA allows for reimbursement of day care expenses for dependent children up to the age of 13 as well as for custodial care for elderly or disabled adults.
MAXIMUM ANNUAL CONTRIBUTION FOR DEPENDENT CARE	\$5,000 (if married and filing separate tax returns, each spouse may contribute \$2,500)
WEBSITE	www.goigoe.com
TO REFER TO THE FULL LIST OF HEALTH CARE FSA ELIGIBLE EXPENSES	visit: https://fsastore.com/FSA-Eligibility-List.aspx

IT’S IMPORTANT TO PLAN CAREFULLY

Estimate your expenses and make your contribution elections wisely. The balances in your Health Care and Dependent Care accounts are “use it or lose it”. What you do not use each year must be forfeited, per IRS rules.

The Health Care FSA includes a carryover provision which allows up to \$610 of your unused Health Care FSA contributions to carry over into the following plan year. This applies to the Limited Purpose FSA plan as well.

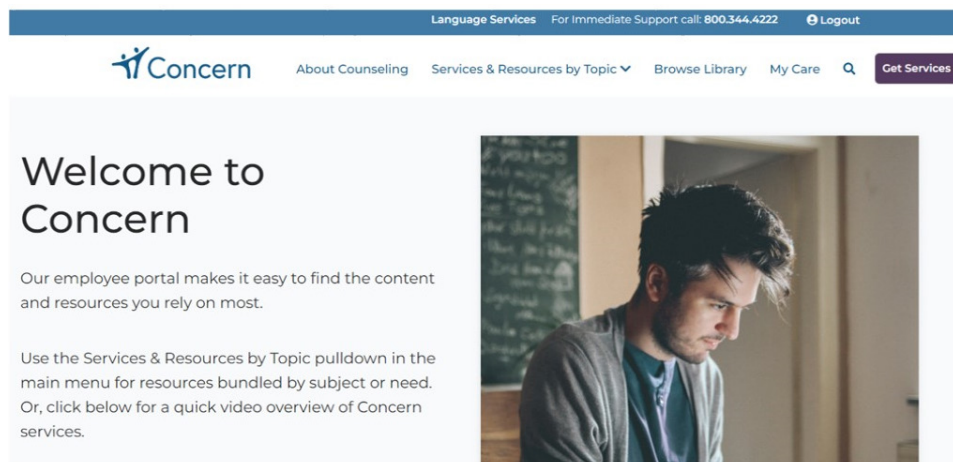
The Dependent Care FSA includes a grace period which allows you to incur expenses until March 15, 2024, with all claims submitted by March 31, 2024.

Employee Assistance Program (EAP)

CONCERN EAP

Pulmonx provides a confidential Employee Assistance Program (EAP) through Concern.

Concern has a broad inventory of content and resources—from webinars, articles, guides and case studies to newsfeeds and downloads. All are customized and sortable for each user. All are designed to guide, educate and elevate.



- Short Term Counseling: Each individual can use up to 5 visits with an expert Concern counselor, per problem, per 12-month period for help with personal issues. Concern offers assessment, crisis intervention, short-term counseling and referrals. Counseling services are confidential. Counseling is elevated to 10 face-to-face visits for alcohol or substance abuse
- Parenting and Childcare Referrals: Childcare specialists provide consultations to address a wide range of childcare needs from infancy to young adult. Complimentary new baby kit included
- Eldercare Referrals: Complimentary eldercare resource guide included
- Legal Consultations: Attorneys provide free 30-minute consultation on most legal issues, plus discounted fees for engaged services
- Financial Coaching: Certified financial experts and fraud resolution specialists provide two free 30-minute consultations on financial topics ranging from money management to identity theft

Digital Platform

Concern's powerful and simple-to-use digital platform quickly connects you to the help you need to navigate life's ups and downs. Accessible from your phone, tablet or computer, the platform is your digital front door to everything Concern has to offer.

The Digital Platform combines technology, counseling, self-help tools, life balance resources, and compassionate human interaction all in one place.

eM Life

Practicing mindfulness benefits physical and emotional wellbeing. Through Concern's partnership with eMindful, you have access to eM Life - an entire suite of evidence-based live and on-demand mindfulness solutions. With eM Life, members can participate in live daily 14-minute mindfulness programs led by experts, offered multiple times each day.

The EAP is company-sponsored, confidential and provided at no cost to you and your dependents. All services are accessible by calling 800-344-4222. You can call anytime, 24 hours a day, 7 days a week. You can also visit <https://employees.concernhealth.com>, using company code **Pulmonx**, for easy access to all available Concern services.

Additional Benefits

COMMUTER BENEFITS

IGOE

Pulmonx provides a Commuter Benefits Account through Igoe which is a pre-tax option available for eligible transit or parking costs. The Commuter Benefits plan allows employees to set aside pre-tax dollars each month to pay for qualified, work related transit and parking expenses.

- Transit monthly maximum: \$300
- Parking monthly maximum: \$300

Eligible expenses include:

- Transit: pass, token fare card, voucher that entitles the employee to transportation or mass transit for purposes of commuting to and from work
- Parking: business premises, parking lot, location from which an employee carpools to work

Ineligible expenses include:

- Tolls, gas, mileage, carpool, taxi fares

Parking & Transit Debit Card

Your Igoe benefits debit card gives you easy access to funds in your tax-advantaged benefit accounts. Simply swipe the card at the point of sale or provide your card details to pay a bill. Your Benefits Card is a stored value card - similar to a gift card and is designed to work at eligible merchant locations that accept MasterCard.

Clipper Card – Bay Area Participants

Your debit card can be used to add funds to the Clipper Card. The Clipper Card is accepted by most Bay Area transit providers. When you use your Igoe debit card as your primary method to add funds to your Clipper Card, it is important that you provide Clipper with a secondary payment option just in case there are not enough funds available on your Igoe debit card to fulfill an order.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

LINCOLN FINANCIAL GROUP

Pulmonx provides an additional and confidential Employee Assistance Program (EAP) to all employees through Lincoln Financial Group. Employees and their dependents may receive up to 5 sessions per person, per issue, per year, for a wide range of emotional health, family and work issues.

Common issues that EAP Counselors can assist with:

- Mental health and well-being
- Personal and professional relationships
- Substance abuse
- Family life
- Daily stress

Call: 888-628-4824

Or visit: www.guidanceresources.com

Username: **LFGsupport**

Password: **LFGsupport1**

Representatives are available 24/7, 365 days a year.



Financial Retirement Plan 401(K)

EMPOWER RETIREMENT

Pulmonx offers you a 401(K) Plan to help you save for your retirement. One of the ways to plan for retirement is to participate in the 401(K) Plan. The sooner you begin saving for retirement, the more supplemental income you will receive when it is time for you to retire. Also, because the money is deducted from your paycheck on a pre-tax basis, you will also benefit from tax advantages. The IRS annual limit for 2023 is \$22,500. The catch-up contribution limit for employees aged 50 and over is \$7,500.

Eligibility

- You can join our 401(K) plan at any time — there is no waiting period

401(K) Change Dates

- You can change your deferral percentage (the amount of money you are contributing to the plan) at any time
- You can stop your contributions at any time
- You can change the funds in which you are invested as often as you like, as long as the fund in question does not have short term redemption fees associated with it
- For more information on the funds with restrictions, please contact Empower Retirement at 800-338-4015

Loans and Withdrawals

- Loans are permitted
- Financial hardship withdrawals are permitted with company approval



2023 Employee Cost Summary

When you elect medical and/or dental & vision coverage through Pulmonx, your per pay period contributions noted below are deducted from your pay before income and social security taxes are withheld. This means that you will not have to pay federal income tax, Social Security tax or Medicare tax on the amount of your premium payments that are paid each pay period. You may wish to consult your legal and/or tax advisor regarding the actual tax savings you may realize. Domestic partner contributions are post-tax and the employer contribution for domestic partners is imputed as income, per IRS.

TOTAL PER PAY PERIOD COST - EFFECTIVE 1/1/2023	EMPLOYEE COST	EMPLOYER COST
KAISER TRADITIONAL HMO \$20 COPAY (CALIFORNIA ONLY)		
Employee Only	\$25.00	\$405.38
Employee + Spouse/Domestic Partner	\$140.00	\$806.83
Employee + Child(ren)	\$120.00	\$740.75
Employee + Family	\$185.00	\$1,106.12
KAISER HSA-QUALIFIED HDHP HMO \$1,500 DEDUCTIBLE (CALIFORNIA ONLY)		
Employee Only	\$7.50	\$344.19
Employee + Spouse/Domestic Partner	\$90.00	\$683.70
Employee + Child(ren)	\$70.00	\$633.37
Employee + Family	\$120.00	\$935.05
BLUE SHIELD ACCESS+ HMO PER ADMIT 20-250 (CALIFORNIA ONLY)		
Employee Only	\$52.50	\$411.24
Employee + Spouse/Domestic Partner	\$190.00	\$876.58
Employee + Child(ren)	\$152.50	\$635.84
Employee + Family	\$267.50	\$1,077.32
BLUE SHIELD FULL PPO COMBINED DEDUCTIBLE 15-250 90/70		
Employee Only	\$52.50	\$406.06
Employee + Spouse/Domestic Partner	\$215.00	\$839.68
Employee + Child(ren)	\$160.00	\$619.55
Employee + Family	\$280.00	\$1049.82
BLUE SHIELD FULL PPO SPLIT DEDUCTIBLE 25-750 80/60		
Employee Only	\$20.00	\$379.70
Employee + Spouse/Domestic Partner	\$140.00	\$779.31
Employee + Child(ren)	\$102.50	\$576.99
Employee + Family	\$197.50	\$961.63
BLUE SHIELD HDHP PPO \$1,500 DEDUCTIBLE		
Employee Only	\$11.25	\$354.05
Employee + Spouse/Domestic Partner	\$107.50	\$732.69
Employee + Child(ren)	\$80.00	\$541.01
Employee + Family	\$132.50	\$926.87
DELTA DENTAL PPO & VSP VISION PPO		
Employee Only	\$5.00	\$32.27
Employee + Spouse/Domestic Partner or Child	\$10.00	\$58.67
Employee + Children	\$10.00	\$101.00
Employee + Family	\$15.00	\$96.00

Contact Information

PLAN TYPE/PROVIDER	WEBSITE	PHONE	GROUP NUMBER
MEDICAL			
Kaiser Permanente HMO (California Only)	www.kp.org	800-464-4000	642421
Kaiser Permanente HSA-Qualified HDHP HMO (California Only)	www.kp.org	800-464-4000	642421
Blue Shield of California HMO (California Only)	www.blueshieldca.com	888-256-1915	W00101931000
Blue Shield of California PPO	www.blueshieldca.com	888-256-1915	W00101931000
Blue Shield of California HDHP PPO	www.blueshieldca.com	888-256-1915	W00101931000
Teladoc Kaiser Teladoc Blue Shield	www.teladoc.com/mystrength www.blueshieldca.com/Teladoc	1-800-Teladoc	394817
DENTAL			
Delta Dental PPO	www.deltadentalins.com	800-765-6003	07481-03888
VISION			
Vision Service Plan (VSP)	www.vsp.com	800-877-7195	30037800
BASIC LIFE/AD&D			
Lincoln Financial Group	www.lfg.com	800-423-2765	10169385
SHORT TERM DISABILITY			
Lincoln Financial Group	www.lfg.com	800-423-2765	10257535
LONG TERM DISABILITY			
Lincoln Financial Group	www.lfg.com	800-423-2765	10169386
EMPLOYEE ASSISTANCE PROGRAM (EAP)			
Concern	https://employees.concernhealth.com	800-344-4222	company code: Pulmonx
Lincoln Financial Group	www.guidanceresources.com	888-628-4824	username: LFGsupport password: LFGsupport1
401(K) GROUP RETIREMENT ACCOUNT			
Empower Retirement	www.empowermyretirement.com	800-338-4015	370197-01
HEALTH SAVINGS ACCOUNT (HSA), FLEXIBLE SPENDING ACCOUNTS (FSA) & COMMUTER BENEFITS			
Igoe	www.goigoe.com	800-633-8818	
PULMONX INTERNAL CONTACT			
Melinda Kayan	HR/Office Manager	650-216-0120	mkayan@pulmonx.com

FOR THE ABOVE GROUP HEALTH BENEFIT PROGRAMS CONTACT: MCGRUFF EMPLOYEE BENEFITS SERVICE CENTER

Pulmonx offers you and your dependents a comprehensive benefits program. If you have questions regarding claims, eligibility, plan details, etc. on any of your health benefit programs, please contact McGriff:

Toll Free: 800-810-2363, Option 2-2-1
PulmonxBenefits@mcgriff.com

Glossary of Terms

AD&D (ACCIDENTAL DEATH AND DISMEMBERMENT)	A plan that provides benefits in the event of an accidental death or dismemberment (generally, an accident that results in death, loss of part of the body, or the loss of the use of part of the body).
BENEFICIARY	A person designated by a participant, or by the terms of an employee benefit plan, which is or may become entitled to a benefit under the plan.
COBRA	Federal law (Consolidated Omnibus Budget Reconciliation Act of 1985) requiring certain employers that offer group health plans to provide continuation coverage to employees and their dependents who incur certain qualifying events.
COINSURANCE OR COST SHARING	The portion of covered health care costs for which you are financially responsible. Coinsurance does not include deductibles or copays.
CO-PAYMENT OR COPAY	A set amount you pay out of pocket for a particular service. The plan pays the balance.
DEDUCTIBLE	The out-of-pocket amount you must pay each calendar year before the plan pays for eligible benefits.
EVIDENCE OF INSURABILITY	Many insurance companies require prospective clients/ individuals to prove that they are in good health and are therefore good insurance risks before the company will cover them.
EXPLANATION OF BENEFITS (EOB)	A statement from a plan explaining what portion of a claim was paid.
HIPAA AUTHORIZATION	Under HIPAA, a document that authorizes the use or disclosure of an individual's Protected Information by a Covered Entity for any purpose described in the document and meets specific requirements.
IN-NETWORK PROVIDER	A provider who has contracted with a health care plan (a medical, dental or vision plan) and agreed to certain rates. In most cases, you pay less and receive a higher benefit when you use in-network providers. Check with your plan for coverage details.
NEGOTIATED RATES	The costs for health care services negotiated between the insurance carrier and in-network health care providers. Negotiated rates are usually less than usual, customary and reasonable (UCR) charges.
OUT-OF-POCKET EXPENSES	Copays, deductibles, and other expenses that are not covered by the health plan.
OUT-OF-NETWORK PROVIDER	A state-licensed health care provider who has not contracted with a health care plan (medical, dental or vision plan) and has not agreed to certain rates. In most cases, you pay more and receive a lower level of benefits when you use out-of-network providers. See your plan for coverage details.
QUALIFYING LIFE EVENT	Certain events which may allow you to make allowable changes to your benefits. Qualifying events include: marriage, divorce, death, birth, adoption or placement for adoption, and significant change in employment.
REASONABLE AND CUSTOMARY (R&C) OR USUAL, REASONABLE, AND CUSTOMARY (UCR)	A term used in many health plans, defined as the price at or below which the majority of health-care professionals of similar expertise charge for similar procedures within a specific geographic area.

2023 Legal Notices

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE PART A: GENERAL INFORMATION

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace? The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November 2022 for coverage starting as early as January 1, 2023.

Can I Save Money on my Health Insurance Premiums in the Marketplace? You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace? Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.12% of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit. An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefits costs covered by the plan is no less than 60% of such costs.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after- tax basis.

How Can I Get More Information? For more information about your coverage offered by your employer, please check your summary plan description; contact the Member Services Department of your health care provider as shown on your benefit ID card, or contact your plan administrator, Melinda Kayan at 650-216-0120.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.HealthCare.gov), or if you reside in California, www.CoveredCA.com, for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. **This information is numbered to correspond to the Marketplace application.**

3. Employer Name: Pulmonx Corporation	4. EIN: 77-0424412
5. Employer Street Address: 700 Chesapeake Drive	6. Phone: 650-216-0120
7. City: Redwood City	8. State: CA
	9. Zip: 94063
10. Who can we contact about employee health coverage at this job?	
11. Phone No. (if different from above):	12. Email: MKayan@pulmonx.com

Here is some basic information about health coverage offered by this employer:

As your employer, we offer a health plan to:

All Employees. Eligible employees are:

Some Employees. Eligible employees are: those who work more than 20 hours per week.

With respect to dependents:

We do offer coverage. Eligible dependents are spouses or domestic partners, and your children, up to the age of 26, regardless of their student status, residency, marital status or financial dependence, or to any age if verifiably disabled.

We do not offer coverage.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

* An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60% of such costs (Section 36B(c)(2)C(ii) of the Internal Revenue Code of 1986).

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to

week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid- year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, www.healthcare.gov/, or if you reside in California, www.CoveredCA.com, will guide you through the process.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA places limitations on a group health plan's ability to impose preexisting condition exclusions, provides special enrollment rights for certain individuals and prohibits discrimination in group health plans based on health status. In addition, HIPAA establishes a set of national standards to address the use and disclosure of individuals' health information – called protected health information.

HIPAA NOTICE OF AVAILABILITY OF NOTICE OF PRIVACY PRACTICES

This Plan is required by law to provide notice of the Plan's duties and privacy practices with respect to covered individuals' protected health information by providing a Notice of Privacy Practices (NOPP) to participants. The Plan's NOPP is available upon request. To obtain a copy of the NOPP, or for more information regarding the Plan's privacy policies or your rights under HIPAA, contact Human Resources at 650-216-0120.

HIPAA SPECIAL ENROLLMENT RULES

HIPAA requires we notify you about your right to later enroll yourself and eligible dependents for coverage in Pulmonx's health plan under "special enrollment provisions" briefly described below.

- Loss of Other Coverage.** If you decline enrollment for yourself or for an eligible dependent because you have other group health plan coverage or other health insurance, you may be able to enroll yourself and your dependents under Pulmonx's health plan if you or your dependents lose eligibility for that other coverage, or if the other employer stops contributing toward your or your dependents' other coverage. You must request enrollment within 31 days after you or your dependents' other coverage ends, or after the other employer stops contributing toward the other coverage.
- New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.** If you gain a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents under Pulmonx's health plan. You must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. In the event you acquire a new dependent by birth, adoption, or placement for adoption, you may also be able to enroll your spouse, if your spouse was not previously covered.
- Enrollment Due to Medicaid/CHIP Events.** If you or your eligible dependents are not already enrolled in Pulmonx's health plan, you may be able to enroll yourself and your eligible dependents if: (i) you or your dependents lose coverage under a state Medicaid or children's health insurance program (CHIP), or (ii) you or your dependents become eligible for premium assistance under state Medicaid or CHIP. You must request enrollment within 60 days from the date of the Medicaid/CHIP event. The CHIP Model Notice containing additional information about this right as well as contact information for state assistance is included below. You may also request a copy from Human Resources.

Please contact Human Resources at 650-216-0120 for details, including the effective dates of coverage applicable to each of these special enrollment provisions. Additional information regarding your rights to enroll in group health coverage is found in the applicable group health plan summary plan description(s) or insurance contract(s).

PATIENT PROTECTION DISCLOSURE – NON-GRANDFATHERED PLANS

Blue Shield of California and Kaiser Permanente generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you and/or your family members. Until you make this designation, Blue Shield of California and Kaiser will designate one for you. For information on how to select a primary care provider, and for a list of participating primary care providers, contact Kaiser Permanente at 800-464-4000 or Blue Shield of California at 888-256-1915.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Blue Shield of California or Kaiser Permanente or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Kaiser Permanente at 800-464-4000 or Blue Shield of California at 888-256-1915.

REBATES FOR FAILURE TO MEET MEDICAL LOSS RATIO REQUIREMENTS

In the event that Pulmonx qualifies and receives a return of premium (Rebate) as a result of an insurance issuer's failure to meet the Medical Loss Ratio requirements under the Affordable Care Act, Pulmonx at its option, shall either:

- Reimburse Plan participants through a payroll adjustment in the amount determined under the Affordable Care Act regulations;
- Reduce employee contributions by an amount determined under Affordable Care Act regulations to reflect the employee's share of the Rebate; or
- Use the Rebate to enhance benefits under the Plan by an amount determined under Affordable Care Act regulations.

WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and,
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance or copays applicable to other medical and surgical benefits provided under this Plan. Therefore, the deductibles and coinsurance shown in the medical section of this guide apply.

If you would like more information on WHCRA benefits, contact Human Resources.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

CALIFORNIA MATERNITY COVERAGE

Group health plans and health insurance issuers with policies or contracts issued in the State of California generally may not, under California law, restrict benefits for inpatient hospital care to a time period less than 48 hours following a normal vaginal delivery and less than 96 hours following a delivery by caesarean section. However, coverage for inpatient hospital care may be for a time period less than 48 or 96 hours if both of the following conditions are met: (a) the decision to discharge the mother and newborn before the 48 or 96 hour time period is made by the treating physicians in consultation with the mother; (b) the contract or policy covers a post discharge follow-up visit for the mother and newborn within 48 hours of discharge, when prescribed by the treating physician. Furthermore, the Plan may not:

- Reduce or limit the reimbursement of the attending provider for providing care to an individual enrollee/insured in accordance with the coverage requirements.
- Provide monetary or other incentives to an attending provider to induce the provider to provide care to an individual enrollee/insured in a manner inconsistent with the coverage requirements.
- Deny a mother or her newborn eligibility, or continued eligibility, to enroll or to renew coverage solely to avoid the coverage requirements.
- Provide monetary payments or rebates to a mother to encourage her to accept less than the minimum coverage requirements.
- Restrict inpatient benefits for the second day of hospital care in a manner that is less than favorable to the mother or her newborn than those provided during the preceding portion of the hospital stay.
- Require the treating physician to obtain authorization from the health care service plan or insurer prior to prescribing any services

NEVADA MATERNITY COVERAGE

Group health plans and health insurance issuers with policies or contracts issued in the State of Nevada that include maternity care and pediatric care for newborn infants generally may not, under Nevada law, restrict benefits for any length of stay in a hospital in connection with childbirth for a mother or newborn infant covered by the plan or coverage to:

- Less than 48 hours after a normal vaginal delivery; and
- Less than 96 hours after a cesarean section.
- If a different length of stay is provided in the guidelines established by the American College of Obstetricians and Gynecologists, or its successor organization, and the American Academy of Pediatrics, or its successor organization, the group health plan or health insurance coverage may follow such guidelines in lieu of following the length of stay set forth above. The length-of-stay provisions do not apply to any group health plan or health insurance coverage in any case in which the decision to discharge the mother or newborn infant before the expiration of the minimum length of stay set forth above is made by the attending physician.

UTAH MATERNITY COVERAGE

Group health plans and health insurance issuers with policies or contracts issued in the State of Utah that cover maternity benefits generally may not, under Utah law, limit benefits for inpatient hospital care to a time period of:

- Less than 48-hours for both mother and newborn with a normal vaginal delivery; and,
- Less than 96-hour benefit for both mother and newborn with a caesarean section delivery.

MEDICARE PART D CREDITABLE COVERAGE NOTICE

Important Notice from Pulmonx About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage offered by the group health plan through Pulmonx and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Pulmonx has determined that the prescription drug coverage offered by the group health plans through Pulmonx is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage through Pulmonx will be affected. Should you join a Medicare drug plan, you can keep your Pulmonx group coverage and your Medicare Part D plan will coordinate with the group plan. Please see your group plan policies for full coordination details. See the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at <http://www.cms.hhs.gov/CreditableCoverage/>), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current group health coverage through Pulmonx, be aware that you and your dependents will not be able to get this coverage back until the next open enrollment period or after a qualifying event, subject to the terms and requirements of such group medical plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current group health coverage through Pulmonx and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Pulmonx changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call 1-800-772-1213 (TTY 1-800-325-0778).

REMEMBER: KEEP THIS CREDITABLE COVERAGE NOTICE. IF YOU DECIDE TO JOIN ONE OF THE MEDICARE DRUG PLANS, YOU MAY BE REQUIRED TO PROVIDE A COPY OF THIS NOTICE WHEN YOU JOIN TO SHOW WHETHER OR NOT YOU HAVE MAINTAINED CREDITABLE COVERAGE AND, THEREFORE, WHETHER OR NOT YOU ARE REQUIRED TO PAY A HIGHER PREMIUM (A PENALTY).

For purposes of this notice, the plan administrator is:

Melinda Kayan
Human Resources
650-216-0120

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

“Out-of-network” describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services. California law also protects consumers from surprise medical bills and prohibits balance billing when you receive emergency services provided by an out-of-network doctor or hospital. (See a summary of your rights and how to file a complaint below).

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

California law protects consumers from surprise medical bills and prohibits balance billing when you receive emergency services provided by an out-of-network doctor or hospital. California law also protects consumers from surprise medical bills when they receive non-emergency services at an in-network facility but are treated there by a professional who is out-of-network.

A summary of your rights can be found at the following website:

<https://www.dmhc.ca.gov/Portals/0/HealthCareInCalifornia/FactSheets/fsab72.pdf>

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact:

Department of Managed Health Care's Help Center at 1-888-466-2219, or file a complaint at <https://www.dmhc.ca.gov/file-a-complaint/contact-your-health-plan.aspx>

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
Website: <http://myakhipp.com/>
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: <https://health.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS – Medicaid

Website: <http://myarhipp.com/>
Phone: 1-855-MyARHIPP 855-692-7447

CALIFORNIA – Medicaid

Website:
Health Insurance Premium Payment (HIPP) Program
<http://dhcs.ca.gov/hipp>
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: <https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: <https://www.colorado.gov/pacific/hcpf/child-health-plan-plus>
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): <https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program>
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: <https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html>
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
Phone: 678-564-1162, Press 1
GA CHIPRA Website: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>
Phone: (678) 564-1162, Press 2

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64

Website: <http://www.in.gov/fssa/hip/>

Phone: 1-877-438-4479

All other Medicaid

Website: <https://www.in.gov/medicaid/>

Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:

<https://dhs.iowa.gov/ime/members>

Medicaid Phone: 1-800-338-8366

Hawki Website: <http://dhs.iowa.gov/Hawki>

Hawki Phone: 1-800-257-8563

HIPP Website: <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>

HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <http://www.kancare.ks.gov/>

Phone: 1-800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:

<https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>

Phone: 1-855-459-6328

Email: KIHIPPPROGRAM@ky.gov

KCHIP Website: <https://kidshealth.ky.gov/Pages/index.aspx>

Phone: 1-877-524-4718

Kentucky Medicaid Website: <https://chfs.ky.gov>

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: <https://www.maine.gov/dhhs/ofa/applications-forms>

Phone: 1-800-442-6003

TTY: Maine relay 711

Private Health Insurance Premium Webpage:

<https://www.maine.gov/dhhs/ofa/applications-forms>

Phone: 1-800-977-6740

TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: <https://www.mass.gov/masshealth/pa>

Phone: 1-800-862-4840

TTY: (617) 886-8102

MINNESOTA – Medicaid

Website:

<https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp>

Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>

Phone: 573-751-2005

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

Phone: 1-800-694-3084

Email: HSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>

Phone: 1-855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: <http://dhcnp.nv.gov>

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: <https://www.dhhs.nh.gov/oii/hipp.htm>

Phone: 603-271-5218

Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website:

<http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>

Medicaid Phone: 609-631-2392

CHIP Website: <http://www.njfamilycare.org/index.html>

CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <https://medicaid.ncdhhs.gov/>

Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>
 Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
 Phone: 1-888-365-3742

OREGON – Medicaid

Website: <http://healthcare.oregon.gov/Pages/index.aspx>
<http://www.oregonhealthcare.gov/index-es.html>
 Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: <https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx>
 Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>
 Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>
 Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: <http://dss.sd.gov>
 Phone: 1-888-828-0059

TEXAS – Medicaid

Website: <http://gethipptexas.com/>
 Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: <https://medicaid.utah.gov/>
 CHIP Website: <http://health.utah.gov/chip>
 Phone: 1-877-543-7669

VERMONT – Medicaid

Website: <http://www.greenmountaincare.org/>
 Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: <https://www.coverva.org/en/famis-select>
<https://www.coverva.org/en/hipp>
 Medicaid Phone: 1-800-432-5924
 CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: <https://www.hca.wa.gov/>
 Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: <https://dhhr.wv.gov/bms/>
<http://mywvhipp.com/>
 Medicaid Phone: 304-558-1700
 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website:
<https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
 Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>
 Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
 Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
 1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
 Centers for Medicare & Medicaid Services
www.cms.hhs.gov
 1-877-267-2323, Menu Option 4, Ext. 61565

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