2024 HEALTH BENEFITS GUIDE

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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 28 for more details.

Welcome to your 2024 Benefit Guide

MESSAGE FROM THE COMPANY

At Pulmonx, we believe that a healthy, happy, and financially secure workface is at the cornerstone of our success. Our benefits and wellness program is built on three core pillars of health: Physical Health, Emotional Health, and Financial Health. These pillars are designed to empower you to live your best life, both inside and outside of the workplace. This guide is organized to provide you with the highlights of our comprehensive benefits program, "Pillars of Health".

The symbol of "Pillars of Health" represents lungs, as the foundation of our business and products. The symbol is also holding hands, representing caring and community, and an apple which symbolizes optimal health. Together they are an amalgam of healthy living, community & caring. Our goal is to ensure Pulmonx provides a comprehensive health and welfare program for our employees and for each Pulmonx employee to know and understand our benefits and resources available.

Please take the time to review so you have the knowledge to select the best coverage options for you and your family. In addition to this guide, we have provided many more resources which may be reviewed at our new website (www.pulmonxbenefits.com). If you would like to discuss any of our benefits in more detail, you are encouraged to reach out to our U.S. HR team at HRPulmonxUS@pulmonx.com or our partners with McGriff by sending an email to pulmonxbenefits@mcgriff.com or calling the McGriff Employee Benefits Service Center at 800-810-2363 (BENE), select Option 2-2-1 during business hours: Monday through Friday, 8am to 5pm PST.

PULMONX OFFERS:

- Medical:
  - Kaiser Permanente HMO (California only)
  - Kaiser Permanente HSA-Qualified HDHP HMO (California Only)
  - Cigna OA-20
  - Cigna PPO - choice of two PPO plans
  - Cigna HDHP PPO
  - Teladoc
- Dental: Cigna 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: 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 23.

Eligibility and Enrollment

WHO IS ELIGIBLE AND WHEN

You are eligible to enroll in group benefits effective on your 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 on your date of hire.

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 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.

CIGNA ID CARDS

Cigna does not automatically provide physical ID Cards. Access your digital ID card through myCigna.com® and the myCigna® app. For quick access register online at myCigna.com® or scan the QR code to download the myCigna® App and register now. If you wish to request a physical ID card, you may do so through your online account or by calling Cigna directly.

Medical Insurance

KASIER HMO & HSA-QUALIFIED HDHP HMO (CA ONLY)

	KAISER PERMANENTE TRADITIONAL HMO $20 COPAY In-Network Only	KAISER PERMANENTE HSA-QUALIFIED HDHP HMO $1,600 In-Network Only
CALENDAR YEAR DEDUCTIBLE	None	$1,600 Individual $3,200 Individual in a family / $3,200 Family
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	$2,000 Individual $4,000 Family	$3,200 Individual $6,400 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	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

CIGNA OPEN ACCESS PLAN (ALL STATES)

	CIGNA OA-20 In-Network Only
CALENDAR YEAR DEDUCTIBLE	None
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	$2,000 Individual $4,000 Family
COINSURANCE	10%
OFFICE VISIT	PCP: $20 copay Specialist: $20 copay
VIRTUAL (VIDEO) VISIT	MDLIVE - No charge
PREVENTIVE SERVICES	No charge
CHIROPRACTIC (20 VISITS) & ACUPUNCTURE (12 VISITS)	$20 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 (Specialty): 20% up to $250 max copay/Rx
SPECIALTY PRESCRIPTION - MAIL ORDER (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
DURABLE MEDICAL EQUIPMENT (DME)	No charge
WEBSITE	**www.mycigna.com**

Cigna's Open Access plan acts like an HMO as it only provides in-network benefits, it differs from an HMO as you are not required (although recommended) to designate a primary care physician and you may self-refer to specialists as long as they are in network. This plan is also available to employees in all states.

Medical Insurance

CIGNA PPO PLAN

	CIGNA PPO-15	
	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	MDLIVE - No charge	Not covered
PREVENTIVE SERVICES	No charge (deductible waived)	30% after deductible
CHIROPRACTIC (UP TO 20 VISITS/YEAR)	$15 per visit (deductible waived)	30% after deductible
ACUPUNCTURE (UP TO 12 VISITS/YEAR)	$15 per visit (deductible waived)	30% after deductible
X-RAY & DIAGNOSTICS -PHYSICIANS OFFICE -OUTPATIENT CENTER -OUTPATIENT HOSPITAL	$15 copay after deductible No charge after deductible 10% after deductible	30% after deductible
INPATIENT HOSPITAL SERVICES & STAY	10% after deductible	30% after deductible
OUTPATIENT HOSPITAL SURGERY	10% after deductible	30% after deductible
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 (Specialty): 30% up to $250 max copay/Rx	Tier 1: 25% Tier 2: 25% Tier 3: 25% Tier 4: 25%
SPECIALTY PRESCRIPTION - MAIL ORDER (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	Not covered
DURABLE MEDICAL EQUIPMENT (DME)	10% after deductible	30% after deductible
WEBSITE	**www.mycigna.com**	

Medical Insurance

CIGNA PPO PLAN

	CIGNA PPO-25	
	In-Network	Out-of-Network
CALENDAR YEAR DEDUCTIBLE	$750 Individual $2,250 Family	$1,500 Individual $4,500 Family
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	$5,250 Individual $10,500 Family	$10,500 Individual $21,000 Family
CO-INSURANCE	20%	40%
OFFICE VISIT	$25 copay (deductible waived)	40% after deductible
VIRTUAL (VIDEO) VISIT	MDLIVE - No charge	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 12 VISITS/YEAR)	$25 per visit (deductible waived)	Not covered
X-RAY & DIAGNOSTICS **-PHYSICIANS OFFICE** **-OUTPATIENT CENTER** **-OUTPATIENT HOSPITAL**	$25 copay after deductible 20% after deductible 20% after deductible	40% after deductible
INPATIENT HOSPITAL SERVICES & STAY	20% after deductible	40% after deductible
OUTPATIENT HOSPITAL SURGERY	20% after deductible	40% after deductible
EMERGENCY ROOM	$150 copay (waived if admitted)	
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 (Specialty): 30% up to $250 max copay/Rx	Tier 1: 25% Tier 2: 25% Tier 3: 25% Tier 4: 25%
SPECIALTY PRESCRIPTION - MAIL ORDER (30-DAY SUPPLY)	30% up to $250 max copay/Rx	Not covered
PRESCRIPTION - MAIL ORDER (90-DAY SUPPLY)	Tier 1: $30 copay Tier 2: $90 copay Tier 3: $150 copay	Not covered
DURABLE MEDICAL EQUIPMENT (DME)	20% after deductible	Not covered
WEBSITE	**www.mycigna.com**	

Medical Insurance

CIGNA HDHP PPO $1,600 PLAN

	CIGNA HDHP PPO $1,600	
	In-Network	Out-of-Network
CALENDAR YEAR DEDUCTIBLE	$1,600 Individual $3,200 Individual in a family / $3,200 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	MDLIVE - 10% after deductible	Not covered
PREVENTIVE SERVICES	No charge (deductible waived)	40% after deductible
CHIROPRACTIC (UP TO 20 VISITS/YEAR)	10% after deductible	40% after deductible
ACUPUNCTURE (UP TO 12 VISITS/YEAR)	10% after deductible	40% after deductible
X-RAY & DIAGNOSTICS **-PHYSICIANS OFFICE** **-OUTPATIENT CENTER** **-OUTPATIENT HOSPITAL**	10% after deductible	40% after deductible
INPATIENT HOSPITAL SERVICES & STAY	10% after deductible	40% after deductible
OUTPATIENT HOSPITAL SURGERY	10% after deductible	40% after deductible
EMERGENCY ROOM	$150 copay (waived if admitted)	
URGENT CARE	10% after deductible	40% after 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 (Specialty): 30% after deductible up to $250 max copay/Rx	Tier 1: 25% Tier 2: 25% Tier 3: 25% Tier 4: 25%
SPECIALTY PRESCRIPTION - MAIL ORDER (30-DAY SUPPLY)	30% up to $250 max copay/Rx after deductible	Not covered
PRESCRIPTION - MAIL ORDER **(90-DAY SUPPLY)**	Tier 1: $30 copay after deductible Tier 2: $75 copay after deductible Tier 3: $120 copay after deductible	Not covered
DURABLE MEDICAL EQUIPMENT (DME)	10% after deductible	40% after deductible
WEBSITE	**www.mycigna.com**	

Health Savings Account (HSA)

IGOE

If you enroll in the Kaiser HSA-Qualified HDHP HMO $1,600 Deductible plan or the Cigna HDHP PPO $1,600 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 $850 per year to your Health Savings Account (HSA) after you enroll yourself (employee only coverage) or $1,700 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 $425 when you enroll yourself (employee only coverage) or $850 when you enroll as a family (you plus at least one or more dependents).

You may also elect to contribute to your Health Savings Account (HSA) through convenient pre-tax** payroll deductions.

2024 HSA Contribution Maximums (employer and employee contributions combined):

- $4,150 for employee only coverage on the HDHP medical plan
- $8,300 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 Health Savings Account (HSA) Features:

- Triple tax benefits: tax-free contributions**, tax-free interest on your Health Savings Account (HSA) balance and investment gains, and 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 Health Savings Account (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 Health Savings Account (HSA) only if you are enrolled in a qualified High-Deductible Health Plan (Kaiser HSA-Qualified HDHP HMO $1,600 Deductible plan or Cigna HDHP PPO $1,600 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 Health Savings Account (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 Flexible Spending Account (FSA)
- You cannot be claimed as a dependent under someone else's tax return

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)	HEALTH SAVINGS ACCOUNT (HSA)
• 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	• 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.*

If you enroll in a High Deductible Health Plan, you must select the Health Savings Account in ADP to ensure you receive the Pulmonx contribution. If you do not wish to contribute any additional money to the HSA, you may select $0 for employee contributions.

To view to the full list of Health Savings Account (HSA) eligible expenses, visit: **https://hsastore.com/HSA-Eligibility-List**.

Additional Benefits - Kaiser Members

TELADOC

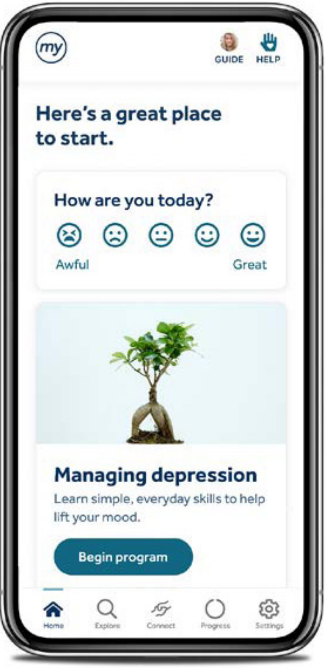
MYSTRENGTH

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 - Cigna Members

MDLIVE

Cigna is partnered with MDLIVE to offer a comprehensive suite of convenient virtual care options— available by phone or video whenever it works for you. MDLIVE board-certified doctors, dermatologists, psychiatrists and licensed therapists have an average of over 10 years of experience, and provide personalized care for hundreds of medical and behavioral health needs.

Connect with video or phone, whenever it's convenient for you. Best of all, virtual care from MDLIVE board-certified doctors is available to you and your eligible dependents as part of your health benefits.

MDLIVE doctors are available to help with:

- Primary care, including preventive/wellness screenings
- Urgent care for minor medical conditions, prescriptions as needed
- Behavioral care, talk therapy and psychiatry from the privacy of home
- Dermatology, customized care for skin, hair and nail conditions

MDLIVE licensed professionals can help you manage mental and behavioral health conditions including:

- Anxiety
- Depression
- Addiction
- Grief and more

Access MDLIVE by logging into **myCigna.com** and clicking on "Talk to a doctor." You can also call MDLIVE at 888-726-3171.

HAPPIFY

Cigna is partnered with Happify, a free app with science-based games and activities that are designed to help you:

- Defeat negative thoughts
- Gain confidence
- Increase mindfulness and emotional well-being
- Boost health and performance
- Reduce stress and anxiety

Using Happify is fun, free, quick and easy. Simply answer a few simple questions, play the games and activities, and earn points for completed activities.

Sign up and download the free app today at **happify.com/Cigna**.

MY HEALTH ASSISTANT

Cigna members have access to an online coaching program powered by WebMD®. This motivating program can help you reach big health and wellness goals in small, easy-to-do steps.

Simply choose the program that most closely aligns with your health goals and needs. Then you'll get personalized activities to help you reach the goals you've chosen. You'll have a weekly plan created just for you – you check in to track and update your progress and receive friendly reminders and encouragement. Each program has daily, weekly and one-time activities to complete to help you along your health journey.

My Health Assistant offers the following goals to help you in your journey to better health and wellness:

- Balance your diet, lose weight, enjoy exercise
- Cope with the blues, keep stress in check
- Quit tobacco
- Manage diabetes, heart failure, asthma, and heart disease
- Manage chronic obstructive pulmonary disease (COPD)

To enroll online, visit **myCigna.com**, then select "My Health Assistant" under the "Wellness" drop down menu.

IDENTITY PROTECTION

Cigna members have access to identity protection services from IdentityForce to proactively monitor, alert, and help fix any identity theft compromises. This benefit is available to Cigna members, and their dependents (up to age 18), at no additional cost.

Three ways to enroll

1. Visit: **https://cigna.identityforce.com/starthere**
2. Call: 833-580-2523
3. Employees enrolled in a Cigna medical plan who have provided their email addresses on myCigna.com® will receive a registration link via email from IdentityForce.

Wellness Program

In alignment with our unwavering commitment to the Pillars of Health, we are thrilled to introduce our comprehensive wellness program designed exclusively for you. Our primary mission is to bolster your personal journey towards optimal health and well-being by offering a rich array of tools, resources, and exciting opportunities.

Within our wellness program, you can expect a steady stream of enriching content to guide you on your path to better health. Our monthly wellness newsletters cover an array of topics aimed at equipping you with valuable insights and tips for enhancing your overall wellness. Furthermore, we proudly present a diverse selection of webinars and meditative sessions in partnership with our trusted broker, McGriff.

Throughout the year, we ignite your motivation by hosting a variety of engaging challenges that encourage you to invest in your well-being. Challenge champions will have the chance to accumulate points, which can then be exchanged for fabulous rewards from our global reward catalog, with the added convenience of home delivery.

So, gear up for a year full of exciting challenges, personal growth, and, of course, some well-deserved fun. Your well-being journey is about to get a whole lot more enjoyable!

Pillars of Health
powered by pulmonx

Newsletters

Meditations

Webinars

Challenges

Earn Prizes!

Dental Insurance

CIGNA 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.mycigna.com** or by calling customer service at 800-244-6224.

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 Cigna 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.

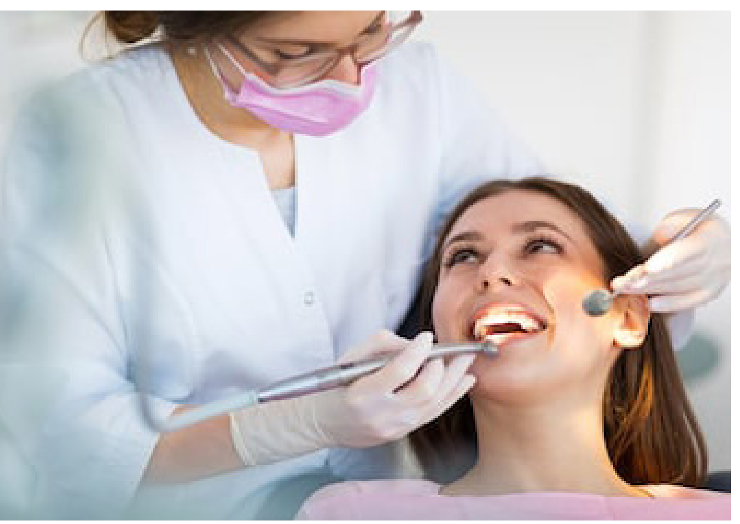
Pre-treatment estimates: Pre-treatment estimates are not required, however, we recommend that you request a pre-treatment estimate before beginning any dental procedures beyond preventive care. Your dental provider may submit a pre-treatment plan to the dental insurance company which outlines the services 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.

CIGNA 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.mycigna.com**	

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

Cigna provides digital ID cards. Access your digital ID card through myCigna.com® and the myCigna® app.



Not registered on myCigna yet? It's quick and easy. Visit myCigna.com® or scan the QR code to download the myCigna® App and register now.

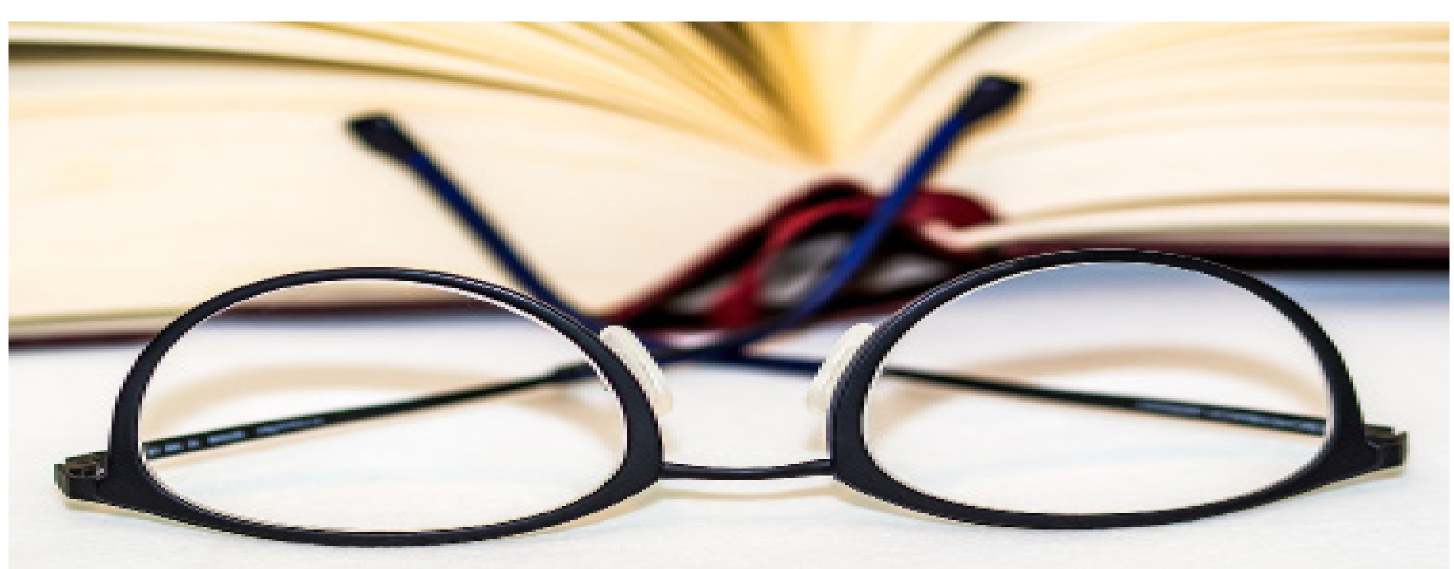
Vision Insurance

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 *Contact lens fitting and evaluation: copay not to exceed $60*	Elective: Up to $105 Medically Necessary: up to $210 *Contact lens fitting and evaluation: no benefit*
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.

Employee Assistance Program (EAP)

LINCOLN FINANCIAL GROUP

Pulmonx provides an 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.

Lincoln EAP also offers additional resources on the following topics:

- Relationships
- Emotional well-being
- Work & Education
- Financial
- Legal
- Lifestyle such as pet insurance discounts & travel tips
- Pet Insurance discounts
- Home & Auto
- 24/7 Travel Connect Services for emergencies when traveling 100+ miles from home

Flexible Spending Accounts (FSA)

IGOE

Pulmonx's Health Care Flexible Spending Accounts (FSA) and Dependent Care Flexible Spending Accounts (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 plan or the Cigna HDHP plan, you can only enroll in a Limited Purpose Flexible Spending Accounts (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 FLEXIBLE SPENDING ACCOUNTS (FSA)	The Health Care Flexible Spending Accounts (FSA) allows employees to receive reimbursement for eligible expenses, such as copays, deductibles, and other health related services, including vision and dental.
LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNTS (FSA)	The Limited Purpose Flexible Spending Accounts (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 to cover medical expenses.
MAXIMUM ANNUAL CONTRIBUTION FOR HEALTH CARE FSA AND LIMITED PURPOSE FSA	$3,200
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS (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 Flexible Spending Accounts (FSA) includes a carryover provision which allows up to $640 of your unused Health Care Flexible Spending Accounts (FSA) contributions to carry over into the following plan year. This applies to the Limited Purpose Flexible Spending Accounts (FSA) plan as well.

The Dependent Care FSA includes a grace period which allows you to incur expenses until March 15, 2025, with all claims submitted by March 31, 2025.

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: $315
- Parking monthly maximum: $315

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.

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 2024 is $23,000. 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

2024 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 1/1/2024	EMPLOYEE COST	EMPLOYER COST
KAISER TRADITIONAL HMO $20 COPAY (CALIFORNIA ONLY)		
Employee Only	$50.00	$474.17
Employee + Spouse/Domestic Partner	$182.00	$967.58
Employee + Child(ren)	$156.00	$889.34
Employee + Family	$240.50	$1,326.01
KAISER HSA-QUALIFIED HDHP HMO $1,600 DEDUCTIBLE (CALIFORNIA ONLY)		
Employee Only	$17.50	$411.38
Employee + Spouse/Domestic Partner	$112.50	$827.43
Employee + Child(ren)	$87.50	$767.25
Employee + Family	$150.00	$1,130.63
CIGNA OA-20		
Employee Only	$37.50	$372.00
Employee + Spouse/Domestic Partner	$162.50	$779.36
Employee + Child(ren)	$132.50	$563.66
Employee + Family	$230.00	$957.56
CIGNA PPO-15		
Employee Only	$52.50	$383.70
Employee + Spouse/Domestic Partner	$215.00	$788.25
Employee + Child(ren)	$160.00	$581.53
Employee + Family	$280.00	$984.98
CIGNA PPO-25		
Employee Only	$20.00	$372.56
Employee + Spouse/Domestic Partner	$140.00	$762.88
Employee + Child(ren)	$102.50	$564.85
Employee + Family	$197.50	$940.92
CIGNA HDHP PPO $1,600 DEDUCTIBLE		
Employee Only	$11.25	$320.58
Employee + Spouse/Domestic Partner	$107.50	$655.71
Employee + Child(ren)	$80.00	$484.12
Employee + Family	$132.50	$829.81
CIGNA DENTAL PPO & VSP VISION PPO		
Employee Only	$5.00	$26.86
Employee + Spouse/Domestic Partner or Child	$10.00	$48.38
Employee + Children	$15.00	$79.32
Employee + Family	$15.00	$79.32

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
Teladoc Kaiser	www.teladoc.com/mystrength	1-800-Teladoc	
Cigna OA-20	www.myCigna.com	866-494-2111	00651525
Cigna PPO-15 / Cigna PPO-25	www.myCigna.com	866-494-2111	00651525
Cigna HDHP PPO	www.myCigna.com	866-494-2111	00651525
DENTAL			
Cigna Dental PPO	www.myCigna.com	800-244-6224	0651525
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)			
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			
Pulmonx HR	HRPulmonxUS@pulmonx.com	650-364-0400	

FOR THE ABOVE GROUP HEALTH BENEFIT PROGRAMS CONTACT: MCGRIFF 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:

Email: **PulmonxBenefits@McGriff.com**

Phone: 800-810-2363
Option 1 Spanish or 2 for English
Then choose 2 Client, 1 Benefits

Glossary of Terms

Term	Definition
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.

2024 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 2023 for coverage starting as early as January 1, 2024.

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 8.39% 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, Pulmonx HR at 650-364-0400.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit 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: 650-364-0400
7. City: Redwood City	8. State: CA	9. Zip: 94063
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone No. (if different from above):	12. Email: HRPulmonxUS@pulmonx.com	

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

As your employer, we offer a health plan to:

☒ 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, martial status or financial dependence, or to any age if verifiably disabled.

☒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.

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 650-364-0400.

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 650-364-0400 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

Cigna 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, Cigna 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 Cigna at 866-494-2111.

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

You do not need prior authorization from Cigna 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 Cigna at 866-494-2111.

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

In the case of an employee or dependent who receives benefits under the plan in connection with a mastectomy and who elects breast reconstruction (in a manner determined in consultation with the attending physician and the patient), coverage will be provided for:

- Reconstruction of the breast on which mastectomy has been performed, including nipple and areola reconstruction and re-pigmentation to restore the physical appearance of the breast;
- Surgery and reconstruction on the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications of all stages of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary". Benefits will be provided on the same basis as for any other illness or injury under the Plan.

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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Under federal law (Newborns' Act), group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with child birth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan, or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification.

A number of states adopted requirements for benefits covering maternity stays prior to the enactment of the Newborns' Act. The federal law does not preempt state law if the state law meets certain criteria. For information on pre-certification, contact Human Resources.

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

If you (and/or your dependents) have Medicare, or will become eligible for Medicare within the next 12 months, federal law gives you more choices about your prescription drug coverage. Please read the following notice for more details.

Please read this notice carefully. It has information about your prescription drug coverage under the Pulmonx health plan (Employer Plan) and the coverage options available to Medicare Part-D eligible individuals. This Notice also provides information on additional resources that may help you decide which prescription drug coverage to choose.

You should keep this notice with your important records. If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Notice of Creditable Coverage

The purpose of this notice is to advise you that the Employer Plan prescription drug coverage listed below is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay. This is known as "creditable coverage."

- Cigna Medical/Rx Plans
- Kaiser Permanente Medical/Rx Plans

Why this is important: Coverage under one of these plans may help you avoid a Medicare Part D late enrollment penalty. If you or your covered dependent(s) are enrolled in the Employer Plan and are currently or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty—as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment.

Late Enrollment Penalty (Higher Premium Charge)

You should know that if you waive or drop coverage under the Employer Plan and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Medicare Part D premium may go up by at least 1% per month for every month that you do not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium may consistently be at least 19% higher than what most other people pay. You may have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Medicare Part D.

Medicare Prescription Drug Coverage

You may have heard about Medicare's prescription drug coverage (called Medicare Part D), and wondered how it would affect you. Medicare offers prescription drug coverage to everyone with Medicare. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become Part D eligible, and each year thereafter during Medicare open enrollment (October 15 through December 7). Individuals who decide to drop their creditable employer/union coverage may be eligible for a two month Medicare Special Enrollment Period.

Interaction Between Coverages

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or a family member of an active employee, your current Employer Plan coverage will not be affected. Employees can keep this coverage if they elect Part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents, etc.). See pages 7- 9 of 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.

In addition, if you waive or drop your current Employer Plan coverage to enroll in a Medicare Part D plan, you and your dependents will be able to re-enroll in the Employer Plan coverage at open enrollment or when you have a special enrollment event.

Additional Information

Contact the person listed at the end of this Notice for further information about your current prescription drug coverage.
NOTE: You may receive this notice at other times in the future—such as before the next period you can enroll in Medicare prescription drug coverage, if the Employer Plan coverage changes, or upon your request.

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

Here’s how to get more information about Medicare prescription drug plans:

- 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.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. For information about this extra help, contact the Social Security Administration (SSA) online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan, you may be required to provide a copy of this notice when you join a Part D plan to show that you have maintained creditable coverage and, therefore, may not be required to pay a higher Part D premium.

For more information about this notice or your employer-sponsored prescription drug coverage, contact Human Resources.

For purposes of this notice, the plan administrator is:
Pulmonx Human Resources
Email: HRPulmonxUS@pulmonx.com
Phone: 650-364-0400

NO SURPRISES ACT (NSA) NOTICE

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 balanced 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.flmedicaidtplrecovery.com/flmedicaidtplrecovery.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
HIPP Phone: 1-800-967-4660

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: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

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.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/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: 711
Email: masspremassistance@accenture.com

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: HHSHIPPProgram@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://dhcfp.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: https://www.hhs.nd.gov/healthcare
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
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

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: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
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://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/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, 2023, 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

Pillars of Health

powered by pulmonx

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.