
2026
BENEFITS
GUIDE
AlphaSense

AlphaSense

2026 BENEFITS GUIDE

AlphaSense appreciates your commitment to our success. We're equally committed to providing you with competitive, affordable health and wellness benefits to help you take care of yourself and your family.

Please read this guide carefully. It has a summary of your plan options and helpful tips for getting the most value from your benefit plans. Making informed benefit decisions includes understanding how the plans work, the total value they offer and the premiums you will pay. We encourage you to take the time to carefully review the health care (medical, dental and vision) and other benefit election options for 2026 so that you can choose the plan options that best fit you and your family's needs. Although this guide contains an overview of benefits, for complete information about the plans available to you, please visit www.alphasensebenefits.com.

This guide is not your only resource. If you have questions about benefits or the enrollment process, you can contact benefits@alpha-sense.com or refer to our Benefits website, www.alphasensebenefits.com.

Enrolling in Benefits

If you would like to enroll in benefits in 2026 for yourself and your eligible dependents, you must enroll through Workday within 31 days of your date of hire. If you need to add or remove coverage for yourself or your eligible dependents after the enrollment period, you must wait until the next annual open enrollment period, unless you have a qualifying life event as defined by the IRS.

If you experience a qualifying life event, the IRS requires that you make changes to your coverage within 31 days. You'll need to provide proof of the event, such as a marriage certificate, divorce decree, birth certificate or loss-of-coverage letter.

Please remember to add/verify your Social Security number. In addition, please make sure your dependent(s) have a Social Security number, date of birth, and gender listed.

QUALIFYING LIFE EVENTS

It is your responsibility to notify benefits@alpha-sense.com and submit appropriate documentation within 31 days of the qualifying life event. Failure to do so may result in an inability to change your benefit election(s).

Here are some examples of qualifying life events:

- Birth, adoption, legal guardianship, or foster care placement of a child.
- Marriage, divorce or legal separation.
- Dependent child reaches age 26.
- Spouse or dependent loses or gains coverage elsewhere.
- Death of your spouse or dependent child.
- Spouse or dependent becomes eligible or ineligible for Medicare/Medicaid or the state children's health insurance program.
- Change in residence that changes coverage eligibility.
- Court-ordered change.
- Spouse's open enrollment that occurs at a different time than yours.

ELIGIBILITY

You may enroll in the benefits program if you are a full-time (regular and fixed-term) employee who is actively working 30+ hours per week. As a benefits eligible employee, you have the opportunity to enroll in benefit plans as a new hire or during the annual open enrollment period. s

If you're enrolling as a new employee, you become eligible for benefits the first of the month on or following your date of hire.

DEPENDENT ELIGIBILITY

As you become eligible for benefits, so do your eligible dependents. In general, eligible dependents include:

- Spouse or domestic partner
- Your children up to the age of 26. This includes your natural children and those of your spouse, adopted children, stepchildren, foster children, or children obtained through court-appointed legal guardianship. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided to and approved by the Benefits team. Additionally, children who have been named in a qualified medical child support order are covered by our plan.

ALEX by Jellyvision

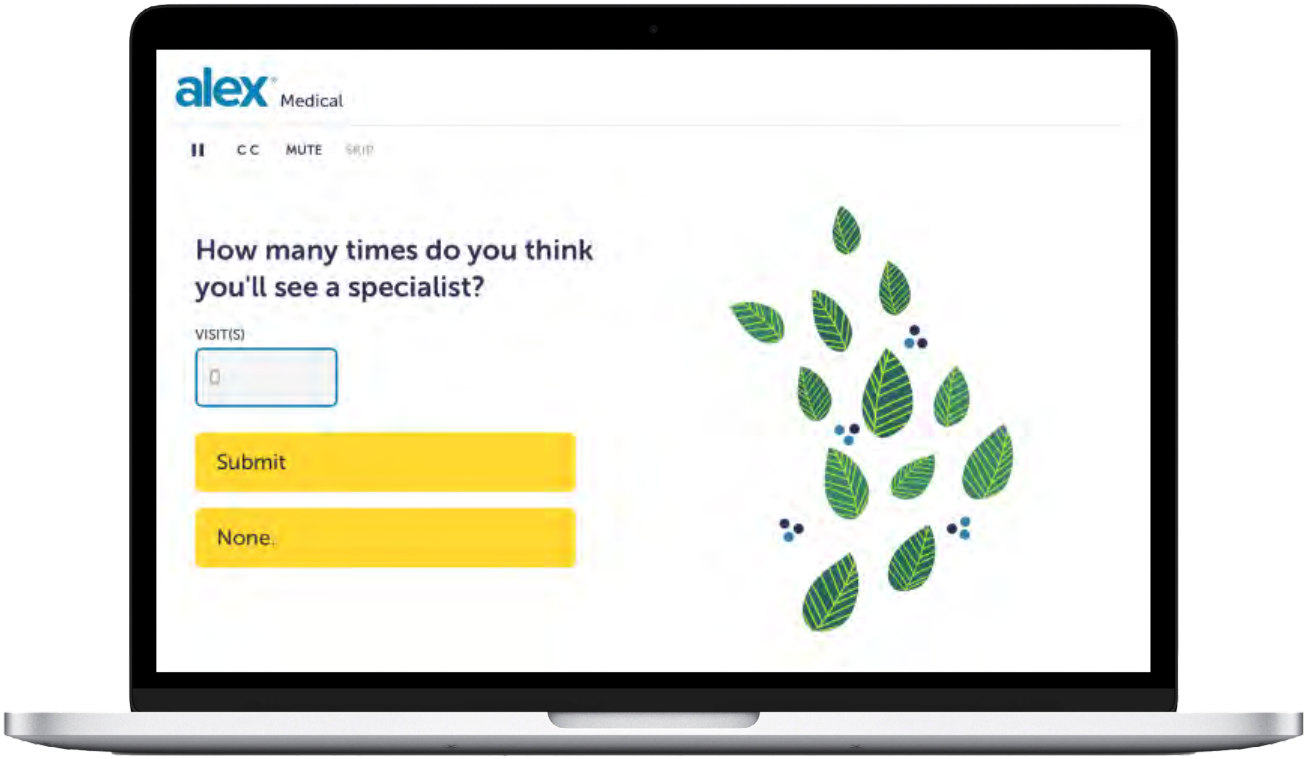
WWW.START.MYALEX.COM/ALPHASENSE

Alex is a platform that helps you make better decisions about your health insurance plan options, 401(k) contributions, and other benefit options. Far from a one-size-fits-all employee benefits decision support tool, ALEX takes in information about your family needs, chronic conditions, and more to deliver tailored advice. Your information is confidential — AlphaSense does not have access to what you share with ALEX.

The platform uses straightforward language and well-placed humor to help you truly understand your benefits and make smarter, more cost effective choices.

ALEX shows you exactly how much you'll save when you make the right plan decisions and the right contributions to your FSAs, HSAs, and retirement accounts.

CLICK HERE
TO ACCESS ALEX!



AlphaSense

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Medical Benefits

CIGNA | MYCIGNA.COM | 866.494.2111
CIGNA PRE-ENROLLMENT LINE: 888.806.5094

You will not receive a physical medical ID card but you can access an electronic card through the myCigna app. To print an ID card, please visit mycigna.com.

Medical	PPO OAP Gold Plan		CDHP OAP Gold Plan		CDHP OAP Silver Plan	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Deductible: Employee only / Family	$1,000 / $2,000 (embedded)	$2,000 / $4,000 (embedded)	$1,700 / $3,400 (non-embedded)	$3,000 / $6,000 (non-embedded)	$2,800 / $5,600 (non-embedded)	$2,800 / $5,600 (non-embedded)
Coinsurance (what the plan pays after the deductible is reached)	90%	70%	90%	70%	90%	70%
Out-of-pocket maximum (includes deductible) Employee only / Family	$4,000 / $8,000 (embedded)	$8,000 / $16,000 (embedded)	$2,500 / $5,000 (non-embedded)	$10,000 / $20,000 (non-embedded)	$5,000 / $10,000 (embedded)	$10,000 / $20,000 (embedded)
Preventive care	100%	Ded & Coins	100%	Ded & Coins	100%	Ded & Coins
Office visit (PCP/specialist)	$20/$40	70% Coins	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins
Emergency room	$150	$150	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins
Urgent care	$50	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins
Inpatient care	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins
Outpatient care	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins
Prescription drugs	Employee pays					
Retail (30-day supply)	In-network	Out-of-network	In-network Deductible applies	Out-of-network	In-network Deductible applies	Out-of-network
Tier 1 — generics	$10	N/A	$10	N/A	$10	N/A
Tier 2 — preferred	$25	N/A	$25	N/A	$25	N/A
Tier 3 — nonpreferred	$50	N/A	$50	N/A	$50	N/A
Mail order (90-day supply)	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Tier 1 — generics	$30	N/A	$30	N/A	$30	N/A
Tier 2 — preferred	$75	N/A	$75	N/A	$75	N/A
Tier 3 — nonpreferred	$150	N/A	$150	N/A	$150	N/A

MEDICAL AND PRESCRIPTION MONTHLY EMPLOYEE PAYROLL CONTRIBUTIONS

	PPO OAP Gold Plan	CDHP OAP Gold Plan	CDHP OAP Silver Plan
Employee	$222.92	$139.00	$97.93
Employee + spouse	$529.20	$339.51	$251.55
Employee + child(ren)	$478.80	$309.13	$230.56
Family	$755.99	$476.22	$345.94

Employees can elect the medical and prescription drug plan without enrolling in the dental or vision plan.

Cigna Tools

CIGNA | MYCIGNA.COM | 866.494.2111

CIGNA WEBSITE

- Coverage details (copays, deductibles, out-of-pocket maximums, etc.).
- Review your claims activity and history.
- Print a temporary ID card, or order a physical ID card.
- See frequently asked questions (FAQs).
- Registered nurses are available to provide immediate assistance and advice on medical treatment.

MYCIGNA APP

- Personalize, organize, and access important plan information on your phone or tablet
- Manage and track claims, view ID card information, find in-network physicians, compare provider costs, quality of care and prescription prices, review your coverage, and more
- Download the myCigna App for your mobile device via Google play, App Store, or Kindle Fire, or go to myCigna.com to register

HOW TO FIND A PREFERRED CIGNA PROVIDER

The preferred designation identifies doctors in the Cigna network who have achieved top results on Cigna's quality and cost-efficiency measures. To find one of these doctors, please visit myCigna.com.

24/7 NURSELINE

In a time of illness or minor injury when you may want advice and support right away, simply call 24/7 nurseline. Call the toll free number 800.342.5773 to speak to a nurse.

COST OF CARE ESTIMATOR

Cigna members also have access to a cost estimator tool. Go to myCigna.com or the myCigna app and search for a provider. From there, click on the providers name to open up the full information. Scroll down to the provider information page to see the estimated cost chart.

PRESCRIPTION DRUG PRICE TOOL

With the online Prescription Drug Price Quote tool on myCigna.com and the myCigna App, you can:

- View real-time medication costs based on your pharmacy benefit plan.
- Find out if you can save money by switching to Cigna Home Delivery Pharmacy.℠
- Discover generic and low-cost alternatives.
- Locate retail pharmacies that are near you.

Log in to myCigna.com and find the tool. To get to the Prescription Drug Price Quote tool:

- Click on the *Prescription* dropdown at the top of the page.
- Select *Price a Medication*.

TIP:

Sign up for telemedicine when you're feeling well so that when you're sick and need to see a doctor, you're already set up. Visit myCigna.com, click on the "Talk to a Doctor" button or the "Find Care & Costs" tab

Virtual Care

CIGNA | MYCIGNA.COM | 866.494.2111

See a doctor when it's convenient for you, from the comfort of your own home, via Cigna's telemedicine offering. This service, provided by Cigna, is available to all AlphaSense medical plan enrollees and their covered dependent(s). It offers 24/7 access to board-certified doctors and behavioral health therapists via online video, phone or mobile app, for non-emergency care, general medical care if you are traveling, or prescriptions for short-term medications. No appointment is required.

Doctors can diagnose and treat common medical issues, including:

- Allergies
- Anxiety
- Child learning and behavior
- Cold and flu
- Depression
- Pink eye
- Respiratory and ear infections
- 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

- Select the type of care you need: medical care or counseling; cost will be displayed on both myCigna.com and MDLIVE
- Follow the prompts for an on-demand urgent care visit, to make an appointment for primary or behavioral care, or to upload photos for dermatology care

Appointments are available via video or phone, whenever it's most convenient for you. Virtual dermatology does not require an appointment.

Virtual Mental Health Support

Note: you must be enrolled in one of AlphaSense's medical plans to access these services. Services through both of these programs are subject to your normal health plan rules (copays/coinsurance and deductible apply)

Headspace Care

ORGANIZATIONS.HEADSPACE.COM/CONNECT

Everyone deserves access to incredible mental healthcare. That's why Headspace created the world's first integrated mental healthcare system where coaches, therapists, and psychiatrists work as a team to coordinate the best, personalized care right from your smartphone, whenever you need it. It's like a virtual clinic without the waiting room. Headspace's mental health services are in-network and accessible through your behavioral health benefits.

- **Coaching:** Connect with a coach via text- based chat to receive personalized support for whatever you are going through.
- **Skill-building resources:** Our library of tips, tools, and insights includes articles, classes, and podcasts offering expert guidance on a range of topics. This in-app content is available for you to use in your own time to help you move toward your goals.
- **Therapy and psychiatry:** A licensed therapist or psychiatrist can be added to your care team if you need extra support and based on your health plan benefits. These sessions are video- based and available evening and weekends to fit your schedule. .

READY TO GET STARTED?

Download the Headspace Care app from the App Store or Google Play. Questions? Email caresupport@headspace.com or visit us at organizations.headspace.com/connect.

Talkspace

TALKSPACE.COM/COVERED

Talkspace is a digital space for private and convenient mental health support. With Talkspace, you can choose your therapist from a list of recommended, licensed providers and receive support day and night from the convenience of your device (iOS, Android, and Web).

How it Works: Our members can begin to exchange unlimited messages (text, voice, and video) with their personal therapist immediately after registration. Therapists engage daily, five days per week, which often includes weekends. Every Talkspace member is granted a complimentary, 10-minute video session to get to know their new therapist. Additional video sessions can also be scheduled.

You will continue to work with the same therapist throughout your journey. However, you're always welcome to switch providers so you can find the perfect fit. Talkspace's clinical network features thousands of licensed, insured, and verified clinical professionals with specialties ranging from behavioral to emotional and wellness needs, including:

- Stress
- Anxiety
- Depression
- Relationships
- Healthy living
- Trauma & grief
- Eating disorders
- Substance use
- Sleep
- Identity struggles
- Chronic issues
- And more

READY TO GET STARTED?

Visit talkspace.com/covered
Complete our QuickMatch survey
Review your best matches and choose your personal therapist.

Maternity Support

Healthy Babies

Cigna's Healthy Babies program supports you during your pregnancy by:

- Providing information to help you learn about pregnancy and babies, including information from the March of Dimes, which is a non-profit organization that works to improve the health of babies and mothers
- 24/7 telephone support for help with questions on anything from morning sickness to maternity benefits
- Access to maternity specialists if you are hospitalized during pregnancy or your baby is in the NICU
- Keep a list of things to talk about with your health care provider, and set reminders.
- Watch educational videos about your baby's weekly development.
- Connect with your baby with the Baby Boost relaxation tool.
- Get personalized notifications on developmental milestones and to-dos for baby's first two years.
- View our expanded content library with helpful information on topics such as, behavioral health, loneliness, gun safety, coping with loss and pediatrics for baby's first two years.
- Add toddlers (from birth to two) to your profile and receive specific content just for them.

You will find a wealth of information by signing in at myCigna.com or downloading the Cigna Healthy Pregnancy app and entering your due date, myCigna user ID and password

Note: you must be enrolled in one of AlphaSense's medical plans to access these services

Dental Plan

CIGNA | MYCIGNA.COM | 866.494.2111

Although you can choose any dental provider, when you use an in-network dentist, you will generally pay less for treatments because your share of the cost will be based on negotiated discount fees. With out-of-network dentists, the plan will pay the same percentage but the reimbursement level will be contingent on which plan you enroll in. You may be billed for the difference.

Dental exams can tell your doctor a lot about your overall health. It's important to schedule regular exams to help detect significant medical conditions before they become serious. You may use your Health Savings Account (HSA) or Healthcare Flexible Spending Account (FSA) to pay for your dental care on a tax-free basis.

To see a current provider directory, please visit myCigna.com.

Dental	PPO High Plan		PPO Low Plan	
	In-network	Out-of-network	In-network	Out-of-network
Deductible				
Employee only	$50	$50	$50	$50
Family	$150	$150	$150	$150
Is the deductible waived for preventive services?	Yes	Yes	Yes	Yes
Annual plan maximum (per individual)	$3,500	$3,500	$2,000	$2,000
Diagnostic and preventive				
Oral exams, X-rays, cleanings, fluoride, space maintainers, sealants	100%	100%	100%	100%
Basic				
Oral surgery, fillings, endodontic treatment, periodontic treatment, repairs of dentures and crowns	90%	80%	80%	80%
Major				
Crowns, jackets, dentures, bridge implants	60%	50%	50%	50%
Orthodontia				
Children	50%	50%	50%	50%
Adults	50%	50%	N/A	N/A
Lifetime orthodontia plan maximum (per individual)	$2,000	$2,000	$1,500	$1,500

DENTAL MONTHLY EMPLOYEE PAYROLL CONTRIBUTIONS

	High	Low
Employee	$14.02	$6.21
Employee + spouse	$30.94	$15.28
Employee + child(ren)	$41.30	$20.63
Family	$64.26	$33.34

You can elect the Cigna dental plan regardless of whether you are enrolled in the medical or vision plan.

You will not receive a physical dental ID card but you can access an electronic card through the myCigna app. To print an ID card, please visit mycigna.com.

Vision Plan

VSP | VSP.COM | 800.877.7195

VSP's vision care benefits include coverage for eye exams, standard lenses and frames, and contact lenses, plus discounts for laser surgery. The vision plan is built around a network of eye care providers, with better benefits at a lower cost to you when you use providers who belong to the VSP network. When you use an out-of-network provider, you will have to pay more for vision services.

Eye exams can tell your doctor a lot about your overall health. It's important to schedule regular exams to help detect significant medical conditions before they become serious. You may use your HSA or FSA to pay for your vision care on a tax-free basis.

VSP Vision Care App

Scan the QR code below to download the VSP Vision Care App from the Apple App or Google Play Stores. Get instant access to your benefit coverage, Member ID Card, Exclusive Member Extras, and more.

Vision	VSP PPO	
	In-network	Out-of-network
Eye exam with dilation as necessary (once per frequency period)	$10	$45 Allowance
Frames	$180 Allowance	$70 Allowance
Standard lenses (once per frequency period)		
Single vision	$20	$30 Allowance
Bifocal	$20	$50 Allowance
Trifocal	$20	$65 Allowance
Lenticular	$20	$100 Allowance
Contact lenses ($20 copay waived)		
Medically necessary	$20	$210 Allowance
Elective	$180 Allowance	$105 Allowance

VISION EMPLOYEE MONTHLY PAYROLL CONTRIBUTIONS

	VSP PPO
Employee	$1.56
Employee + spouse	$3.37
Employee + child(ren)	$3.44
Family	$5.34

You will not receive a physical vision ID card but you can access an electronic card through the VSP app. To print an ID card, please visit vsp.com.

You can elect the VSP vision plan regardless of whether you are enrolled in the medical or dental plan.

Health Savings Account (HSA)

BENEPASS | APP.GETBENEPASS.COM

An HSA is a personal healthcare bank account you can use to pay out-of-pocket medical expenses with pretax dollars. If you enroll in a Consumer Directed Health Plan (CDHP), you can open an HSA. You will have access to your balances and can interact with the account via the Benepass app.

An HSA puts you in control of your healthcare decisions and expenses. It allows you to:

- Prepare for health expenses not accounted for in your personal finances.
- Increase your tax savings.
- Roll over money if you do not use it in the calendar year.
- Take it with you wherever you go – it's always yours, even if you change health plans or jobs.
- Create healthcare savings for retirement.
- Earn interest on your account and via investment options, once you reach a minimum of $100 in your account.

YOU ARE ELIGIBLE TO OPEN AND FUND AN HSA IF:

- You are not enrolled in any other non-HSA qualified health insurance plan.*
- You are not covered by your spouse's health plan (unless it is a qualified CDHP), flexible spending account (FSA) or health reimbursement account (HRA).
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare, TRICARE or TRICARE For Life.
- Care received through the VA in the preceding three calendar months was dental, vision or preventive care or was provided to a veteran who has a disability rating from the VA.

*You must not have any other first-dollar health insurance coverage before the deductible is met. Preventive care services are not required to be subject to the deductible. Individuals may also carry separate coverage for accidents, disability, dental or vision care, and long-term care, not subject to the deductible.

IMPORTANT!: 2026 MAXIMUM CONTRIBUTIONS

AlphaSense employer contributions count toward the annual HSA contribution limits, so you need to plan carefully how much you'll contribute annually to avoid excess contributions. These limits apply even for participants entering the plan midyear.* Prior-year contributions may be made through April 15 of the following year.

	Under age 55	Age 55 and older (and not enrolled in Medicare)
Individual	$4,400	$5,400
Family	$8,750	$9,750

**If you make the full-year contribution based upon your status of Dec. 1, you may be subject to an IRS Testing Period and could owe tax and a penalty on part of that contribution if you do not remain an eligible individual through Dec. 31 the following year. You may also need to prorate your contribution if you drop or reduce the level of your coverage midyear.*

2026 ALPHASENSE EMPLOYER CONTRIBUTIONS

	CDHP OAP Gold	CDHP OAP Silver
Individual	$500	$1,000
Family	$1,000	$2,000

AlphaSense employer contributions are processed throughout the year in a prorated amount that aligns with the timing of regular benefit paycheck deductions.

HOW TO ACCESS/MAKE CONTRIBUTIONS TO YOUR HSA

You can enroll in a Health Savings Account (HSA) through Workday. Changes to your HSA contributions can be made at any time throughout the year through Workday. Note it may take between 1-2 paychecks for a HSA change to be processed. Once your account has been created, you can access it via app.getbenepass.com.

DISTRIBUTIONS

- HSA distributions are tax-free if they are used to pay for qualified medical expenses, such as:
  - Qualified medical, dental and vision expenses not covered by insurance, such as deductibles, copays, etc.
  - Qualified long-term care services and long-term care insurance.
  - Continuation of coverage required by federal law (i.e., COBRA).
  - Health insurance for the unemployed.
  - Medicare expenses (but not Medigap).
  - Retiree health expenses for individuals age 65 or older.
- Distributions made for any other purpose are subject to income tax and a 20% penalty. The 20% penalty is waived in the case of death or disability. The 20% penalty is also waived for distributions made by individuals age 65 or older.

NOTE THIS IMPORTANT INFORMATION ON HEALTH SAVINGS ACCOUNTS

- Due to the US banking system's customer identification process (CIP) requirements, your account cannot be opened until the CIP is completed. If Benepass is unable to complete the CIP requirements automatically, they will reach out directly to confirm the missing information.
- If you do not complete the required steps to open an account, any employer contributions that cannot be deposited due to failure to open an account will be forfeited.
- Upon death, HSA ownership may transfer to the spouse on a tax-free basis or to another named beneficiary as estate income.

Flexible Spending Account (FSA)

BENEPASS | APP.GETBENEPASS.COM

A great way to plan ahead and save money over the course of a year is to participate in an FSA. An FSA lets you redirect a portion of your salary on a pretax basis into a reimbursement account, saving you money on taxes. Each year that you would like to participate in the FSAs, you must elect the amount you want to contribute.

AlphaSense offers two types of FSAs that can help you save on a pretax basis for out-of-pocket expenses.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT

The healthcare FSA lets you set aside up to $3,400* per year to pay for medical expenses that are not covered by your health, vision or dental plans, including deductibles, copays, coinsurance, etc.

You have access to the money you elect to contribute on day one. For example, if you have a large expense early in the year and you want to use the full amount you've elected to contribute for the year (even before that money is deducted from your paycheck), you can.

You will receive a virtual debit card that gives you convenient, instant access to the money in your account. You can request a physical card be shipped to you in the mail.

When you have expenses to be reimbursed, submit a claim form along with a bill or itemized receipt from the provider at app.benepass.com or through the mobile Benepass app. Be sure to keep all receipts to substantiate that your pre-tax funds were used for eligible expenses in the event of an audit.

Rollover benefit. The maximum contribution in 2026 for the healthcare flexible spending account is $3,400* per household. All services must be incurred from Jan. 1, 2026, through Dec. 31, 2026. Claims must be submitted by March 31, 2027.

Our plan has a carryover feature that allows up to $680 of your unused funds to be carried forward to the following plan year. These carryover dollars can be used for expenses incurred at any point within the new plan year. Any unused amount over $680 will be forfeited, therefore we recommend only contributing the amount that you can reasonably use during the year.

IMPORTANT:

If you are contributing to an HSA through AlphaSense or through your spouse's plan, you are not eligible to participate in the healthcare FSA.

* Subject to change from the IRS

Dependent Care Flexible Spending Account

BENEPASS | APP.GETBENEPASS.COM

Dependent Care FSAs allow you to set aside money pretax to pay eligible out-of-pocket child care expenses for your eligible children under the age of 13, and for elder care for your eligible dependent adults so that you or your spouse can work or attend school full-time. You must contribute money through payroll deduction to your dependent care FSA before you can spend it.

You may contribute up to $7,500 if you are filing jointly and/or by household, or up to $3,750 if you are married and file separate tax returns.

ELIGIBLE EXPENSES

- Elder care facilities
- Child day care*
- After-school care*
- Babysitting (work-related, in your home or someone else's home)*
- Babysitting by your relative who is not a tax dependent (work-related)*
- Nanny or au pair*
- Custodial elder care
- Transportation to and from eligible care (provided by your care provider)

* To be eligible for Dependent Care FSA reimbursement, the care provider must claim their earnings as income. For tax filing purposes, you are required to provide the care provider's name, address and taxpayer identification number. In cases where the care provider is an individual, the taxpayer identification number is his/her social security number.

INELIGIBLE EXPENSES

- Babysitting (not work-related, for other purpose)
- Babysitting by your tax dependent (work-related or for other purpose)
- Custodial elder care (not work-related, for other purpose)
- Dance lessons, piano lessons or sports lessons
- Educational, learning or study skills services for child(ren)
- Household services (housekeeper, maid, cook, etc.)

Commuter Benefits

BENEPASS | APP.GETBENEPASS.COM

The Benepass Commuter Benefit Account allows you to set aside pre-tax dollars for public transit–including train, subway, bus, ferry and eligible vanpool–and parking as part of your daily commute to work.

HOW IT WORKS

Order what you need for your monthly commute. Up to a maximum of $340* per month for transit and $340 per month for parking can be deducted from your paycheck on a pre-tax basis to be used towards your order for qualified expenses.

You will receive a virtual debit card, which you may use on a maximum of $340* of eligible commuter expenses each month. You must have the money in your Commuter spending account before you can use it. You can request a physical card be shipped to you in the mail.

Benefit	Defined As	Contribution Limits
Transit	Mass Transit is defined by the IRS as: ▪ Transportation in a commuter highway vehicle (which seats at least six passengers) in connection with travel between your residence and place of employment, or; ▪ Any transit pass (token, fare card, voucher) purchased for travel between your residence and place of employment.	$340/ month*
Parking	Qualified Parking is defined by the IRS as: ▪ Out-of-pocket parking costs at or near your employer, or; ▪ Parking at a location from which you commute to work by mass transit, commuter highway vehicle or carpool (e.g. the cost of a parking lot at a train station so you can continue your commute via train, bus or carpool).	$340/ month*

*Subject to change from the IRS

Unused commuter funds may be forfeited if you leave the company so it's recommended that you only contribute amounts that you intend to use each month.

Group Term Life and Accidental Death and Dismemberment (AD&D)

PRUDENTIAL | PRUDENTIAL.COM/MYBENEFITS | 800.842.1718

AlphaSense's comprehensive benefits package includes financial protection for you and your family in the event of an accident or death. Group term life and AD&D coverage are provided automatically at no cost to you upon employment.

GROUP TERM LIFE

In the event of your death, the life insurance policy provides a benefit to the beneficiaries you designate. If your death is the result of an accident or if an accident leaves you with a covered debilitating injury, you are covered under the AD&D insurance for the same amount.

Group term life and AD&D	100% paid by the employer
Employee	2x salary to $1,000,000

AGE REDUCTION SCHEDULE

- Age 65: Benefit decrease by 35%
- Ages 70+: Benefit decrease by 50%.

ACCIDENTAL DEATH AND DISMEMBERMENT

The group term life coverage includes accidental death and dismemberment coverage. AD&D insurance provides additional coverage in the event of accidental death, loss of limb or eyesight, brain damage, etc. In the event of a covered accident that results in your death, AD&D coverage is in addition to your group term life.

Voluntary Life and AD&D

PRUDENTIAL | PRUDENTIAL.COM/MYBENEFITS | 800.842.1718

You have the opportunity to purchase voluntary life and AD&D insurance for yourself, your spouse and/or your dependent children. Your cost for this coverage is based on the amount you elect and your age. New hires may elect up to the Guaranteed amounts shown below without submitting an Evidence of Insurability (EOI) application. During other enrollment periods, new additions of or increases to this coverage will be subject to medical underwriting.

Coverage	Available benefit	Guaranteed amount
Employee	1 to 5 times your covered annual earnings, in $10,000 increments, up to a maximum benefit of the lesser of 5x earnings or $750,000	$250,000
Spouse	Increments of $5,000 up to a maximum of $250,000	$25,000
Dependent child(ren)	Increments of $2,000* up to a maximum of $10,000 for children up to age 26 unmarried	$10,000

Spouse rates will be determined by the employee age.

Voluntary life employee rates per $1,000 of coverage	
Under 25	$0.026
25-29	$0.027
30-34	$0.035
35-39	$0.052
40-44	$0.075
45-49	$0.123
50-54	$0.187
55-59	$0.270
60-64	$0.351
65-69	$0.454
70-74	$0.832
75+	$2.793

Voluntary AD&D employee rate per $1,000 of coverage
$0.013

Voluntary life spouse/child rate per $1,000 of coverage
$0.015

EXAMPLE

If the rate for employee life insurance is $0.052 per $1,000, and the rate for AD&D insurance is $0.013 per $1,000, and the enrollee elects $20,000 in coverage, the monthly premium would be $1.54.

Plan rate (determined by age)		$0.065
Coverage per $1,000	x	20
Monthly premium		$1.30

Short-Term and Long-Term Disability

PRUDENTIAL | PRUDENTIAL.COM/MYBENEFITS | 800.842.1718

AlphaSense offers two company-paid disability plans through Prudential to provide financial assistance in case you become disabled or unable to work. Both of these benefits are available to eligible full-time employees the first of the month on or following your date of hire.

SHORT-TERM DISABILITY (STD) PLAN

STD benefits are designed to replace a portion of your income for a non-work-related short-term injury or illness. STD benefits are paid at 60% of your eligible weekly base pay, up to $3,000 weekly, during the first 26 weeks of injury or illness.

Short-term disability eligibility — full-time employees	100% paid by the employer
Weekly benefit amount	60%
Weekly benefit maximum	$3,000
Benefits duration	26 weeks
Waiting period	7 days

The STD benefit is paid for by AlphaSense; there is no cost to you. However, any income replacement benefits received are taxable.

COORDINATION OF DISABILITY BENEFITS

Your benefit may be reduced if you receive disability benefits from other sources such as, but not limited to, retirement, Social Security, workers' compensation, state disability insurance, no-fault benefits or return-to-work earnings. Refer to your certificate of coverage for more details

LONG-TERM DISABILITY (LTD) PLAN

This benefit offers financial protection to you when you need it most — if you become disabled and can no longer work. The plan will also help you return to work, if appropriate.

If you become totally disabled, you will receive 60% of your base salary, up to $15,000 monthly, after you have satisfied the 180-day waiting period for benefits. Your benefit amount may be offset by other benefits you are receiving, such as Social Security or workers' compensation. Your monthly benefits are subject to federal income tax and may be subject to state and local taxes.

Long-term disability eligibility — full-time employees	100% paid by the employer
Monthly benefit amount	60%
Monthly benefit maximum	$15,000
Benefits duration	AD EA I w/ SSNRA
Preexisting condition limitation	3/12 Limit

Hospital Indemnity

PRUDENTIAL | PRUDENTIAL.COM/MYBENEFITS | 800.842.1718

HOW DOES IT WORK?

Prudential's Hospital Indemnity Insurance helps employees and their families cope with the financial impact of an inpatient hospitalization. You can receive benefits when you're admitted to the hospital for a covered accident, illness, or childbirth. The money is paid directly to you – not to a hospital or care provider. The money can also help you pay the out-of-pocket expenses your medical plan may not cover, such as coinsurance, copays and deductibles.

WHAT'S INCLUDED?

- $1,250 for each covered hospital admission - Up to 5 time(s) per calendar year
- $1,250 for each covered ICU admission - Up to 5 time(s) per calendar year
- $100 for each hospital confinement- Up to 365 days per confinement
- $200 for each ICU confinement- Up to 30 days per confinement

WHO CAN GET COVERAGE?

- You - if you're actively at work
- Your spouse or domestic partner
- Your children - Dependent children until their 26th birthday, regardless of marital or student status

Employee must purchase coverage for themselves in order to purchase spouse or child coverage. Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage. Spouses and dependent children must reside in the United States to receive coverage. Certain states may have limitations.

In order for employees residing in CA, MA, NJ, NY or DC to be eligible to enroll for Accident, Hospital Indemnity or Critical Illness Insurance, you must be enrolled in a major medical plan.

HOSPITAL INDEMNITY MONTHLY EMPLOYEE CONTRIBUTIONS

	Hospital Indemnity
Employee	$7.55
Employee + spouse	$17.79
Employee + child(ren)	$14.09
Family	$24.34

Employees enrolled in the CDHP medical plans receive Hospital Indemnity Insurance automatically at no cost.

Critical Illness

PRUDENTIAL | PRUDENTIAL.COM/MYBENEFITS | 800.842.1718

HOW DOES IT WORK?

Prudential's Critical Illness coverage will pay you a lump sum if you are diagnosed with a serious illness or condition, regardless of your medical or disability plans. Benefits are paid directly to you to spend however you like, including out-of-pocket medical costs and everyday living expenses.

You are eligible for a Wellness benefit which is a $50 benefit payable once per calendar year if you receive one of the specified health screening tests while not confined in a hospital. More details can be found in the Critical Illness booklet on the alphasensebenefits.com.

WHAT'S INCLUDED?

- Alzheimer's Disease - 100% of benefit
- Severe Coronary Artery Disease - 100% of benefit
- Heart Attack (Myocarial Infarction) - 100% of benefit
- Major Organ Failure - 100% of benefit
- Stroke - 100% of benefit
- Renal Failure - 100% of benefit
- Cancer
  - Invasive Cancer (including breast cancer) - 100% of benefit
  - Non-invasive Cancer - 75% of benefit
  - Skin Cancer - $500

WHO CAN GET COVERAGE?

- You - if you're actively at work
- Your spouse or domestic partner
- Your children - Dependent children until their 26th birthday, regardless of marital or student status

Employee must purchase coverage for themselves in order to purchase spouse or child coverage. Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage. Spouses and dependent children must reside in the United States to receive coverage. Certain states may have limitations.

In order for employees residing in CA, MA, NJ, NY or DC to be eligible to enroll for Accident, Hospital Indemnity or Critical Illness Insurance, you must be enrolled in a major medical plan

CRITICAL ILLNESS MONTHLY EMPLOYEE CONTRIBUTIONS

Employee cost per $10,000
Spouse cost per $10,000
Be Well benefit: $50

Age	Employee & Child(ren)	Spouse
<25	$1.425	$1.425
25-29	$1.847	$1.847
30-34	$2.547	$2.547
35-39	$3.447	$3.447
40-44	$5.047	$5.047
45-49	$7.647	$7.647
50-54	$11.547	$11.547
55-59	$16.447	$16.447
60-64	$24.047	$24.047
65-69	$35.247	$35.247
70-74	$52.147	$52.147
75-79	$70.247	$70.247
80-84	$89.247	$89.247
85+	$128.047	$128.047

CRITICAL ILLNESS BENEFITS

Employees are able to elect $10,000, $20,000, or $30,000 of coverage. You may also elect Spousal coverage for the same amount. Children up to 26 years of age are automatically covered for half of the employee's benefit at no additional cost.

Accident

PRUDENTIAL | PRUDENTIAL.COM/MYBENEFITS | 800.842.1718

HOW DOES IT WORK?

Prudential's Accident Insurance pays you for any accidental injury, whether minor or catastrophic, regardless of what your medical plan covers. Your benefits are paid directly to you to spend however you like, including out-of-pocket medical and non-medical costs or everyday living expenses.

WHAT'S INCLUDED?

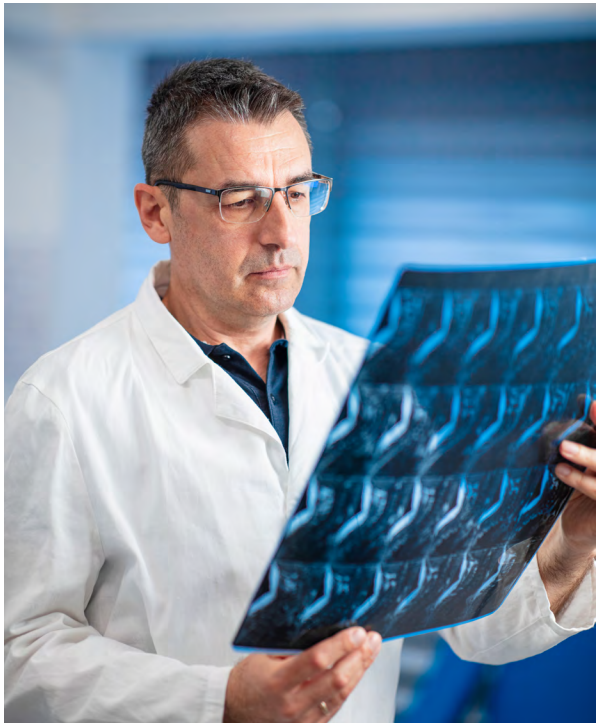
The amount of the benefit is based on the treatment, services or injury. You can receive benefits for an ambulance ride, use of the emergency room, surgery, anesthesia, stitches and more.

WHO CAN GET COVERAGE?

- You - if you're actively at work
- Your spouse or domestic partner
- Your children - Dependent children until their 26th birthday, regardless of marital or student status

Employee must purchase coverage for themselves in order to purchase spouse or child coverage. Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage. Spouses and dependent children must reside in the United States to receive coverage. Certain states may have limitations.

In order for employees residing in CA, MA, NJ, NY or DC to be eligible to enroll for Accident, Hospital Indemnity or Critical Illness Insurance, you must be enrolled in a major medical plan



ACCIDENT MONTHLY EMPLOYEE CONTRIBUTIONS

	Accident
Employee	$9.57
Employee + spouse	$14.21
Employee + child(ren)	$14.20
Family	$22.35

Retirement Plan

PRINCIPAL | PRINCIPAL.COM | 800.986.3343

AlphaSense offers a 401(k) plan intended to help you prepare for retirement.

ELIGIBILITY

US-based employees are eligible to participate in the plan immediately.

AUTO-ENROLLMENT:

All US-based new hires will be auto-enrolled into the 401k plan at 3% on the 30th day following your date of hire.

COMPANY MATCH

AlphaSense matches your pre-tax and Roth contributions up to 50% (half) of the first 4% of eligible earnings you contribute.

After one year of employment at the Company, you will be 100% vested in the employer match.

2026 MAXIMUM CONTRIBUTIONS

The IRS has not yet released the 2026 contribution limits for 401(k) plans; this guide will be updated to reflect the new limits once they are announced.

COMPANY MATCH EXAMPLES

If you contribute **3%** of your salary, AlphaSense will contribute **1.5%** (half your contribution).

If you contribute **6%** of your salary, AlphaSense will contribute **2%** (half the maximum contribution of 4%).

Pet Insurance

ASPCA PET HEALTH INSURANCE | ASPCAPETINSURANCE.COM/ALPHASENSE | 866.204.6764
PRIORITY CODE: EB22ALPHASENSE

COMPLETE COVERAGE BY ASPCA

ASPCA pet insurance helps you cover veterinary expenses so you can provide your pets with the best care possible without worrying about the cost. ASPCA Pet insurance allows you to choose between different deductibles and reimbursement percentages. Deductibles are available at $100, $250, and $500. You may also choose between 70%, 80% and 90% reimbursement options. The lower the reimbursement percentage you choose, the lower the premiums will be.

Because of AlphaSense's partnership with ASPCA, you are able to get 10% off of the cost of your pet insurance. Coverage includes:

- Accidents
- Illnesses
- Hereditary and congenital conditions
- Cancer
- Alternative therapies
- Behavioral issues
- Chronic conditions
- Prescription medications
- Prescription food & supplements
- Microchip implantation
- Option to add on preventative care for an additional charge

Note: An injury or illness that has been cured and free of treatment and symptoms for 180 days will no longer be regarded as pre-existing, with the exception of knee and ligament conditions.

VET LOCATOR

Visit https://www.aspcapetinsurance.com/vet-locator/ to find a Veterinarian or veterinary specialist in your area

Employee Assistance Program (EAP)

GUIDANCERESOURCES | GUIDANCERESOURCES.COM | 800.311.4327

Personal problems, planning for life events or simply managing daily life can affect your work, health and family. GuidanceResources is a company-sponsored service that is available to you and your dependents, at no cost, to provide confidential support, resources and information to get through life's challenges

CONFIDENTIAL COUNSELING

The EAP's confidential assistance program helps address the personal issues you and your dependents are facing by connecting you to experienced GuidanceConsultants℠ who are available 24 hours a day, 7 days a week to listen to your concerns and refer you to a local provider for in-person counseling or to resources in your community. Call any time with personal concerns, including:

- Depression
- Marital and family conflicts
- Job pressures
- Stress and anxiety
- Alcohol and drug abuse
- Grief and loss

Counseling is available for 3 visits per issue per employee/dependent.

FINANCIAL RESOURCES AND TOOLS

Financial issues can arise at any time, from dealing with debt to saving for college. Our financial professionals are here to discuss your concerns and provide you with the tools and information you need to address your finances, including:

- Saving for college
- Getting out of debt
- Retirement planning
- Tax questions
- Estate planning

AVAILABLE 24 HOURS A DAY, 7 DAYS A WEEK

Call: 800.311.4327 | TDD: 800.697.0353

Online: guidanceresources.com | Web ID: GEN311

LEGAL RESOURCES AND CONSULTATION

When a legal issue arises, our attorneys are available to provide confidential support with practical, understandable information and assistance. If you require representation, you can also be referred to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter. Call any time with legal issues including:

- Divorce and family law
- Debt obligations
- Landlord and tenant issues
- Real estate transactions
- Bankruptcy
- Criminal actions
- Civil lawsuits
- Contracts

ONLINE INFORMATION AND TOOLS

GuidanceResources® Online is your one stop for expert information to assist you with the issues that matter to you, from personal or family concerns to legal and financial concerns. Create your own account by going to guidanceresources.com to find personalized, relevant information based on your individual life needs. You can:

- Review in-depth HelpSheets℠ on topics you select
- Get answers to specific questions
- Search for services and referrals
- Use helpful planning tools

Discount Program

PERKSPOT | PERKSPOT.COM

PerkSpot through Lockton provides you and your family with access to thousands of deals on travel, hotels, entertainment, and more.

Your PerkSpot Discount Program is a one-stop shop for thousands of exclusive discounts in more than 25 different categories. You can even find local deals by inputting your zip code to find offers near you or suggest businesses where you'd like to see a discount. That means there's something for everyone!

HOW TO REGISTER

1. Register at locktonnortheast.perkspot.com
2. Click Create an Account at the bottom
3. Enter your information and access savings!

Business Travel Accident (BTA) Coverage

CHUBB | TRAVELASSISTANCE.CHUBB.COM

AlphaSense's Business Travel Accident policy covers you and your eligible spouses and dependents while on travel out of the country for business, as well as up to 14 days of personal deviation.

The policy includes:

- Up to $500,000 in emergency medical expenses
- Accidental Death and Dismemberment benefits
- Travel Assistance Services

When an emergency happens away from home, Chubb partners with AXA Assistance, a leading global travel and medical assistance provider, to give you access to local care and assistance—wherever you are.

To access our Chubb insurance card, visit alphasensebenefits.com/bta/.

Basic Insurance Terms

COINSURANCE: Coinsurance is your share of the costs of a covered healthcare service, calculated as a percent (for example, 20%) of the allowed amount for the service. Your coinsurance will begin after you have met your deductible. For example, if the health plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health plan pays the rest of the allowed amount.

COPAY: A copay is a fixed dollar amount you pay for a healthcare service. The amount can vary by the type of service. Your copays will not count toward your deductible but will count toward your out-of-pocket maximum.

DEDUCTIBLE: The deductible is the amount you owe for covered healthcare services before your plan begins to pay benefits. For example, if your deductible is $2,800, your plan won't pay anything until you've met your $2,800 deductible for covered healthcare services subject to the deductible. Preventive care is not subject to the deductible as it is covered 100% by any medical plan option.

EMBEDDED DEDUCTIBLE OR OUT-OF-POCKET MAXIMUM: If you are on a family medical plan with an embedded deductible or out-of-pocket maximum, your plan contains two components: an individual component and a family component. Having two components to the out-of-pocket maximum allows each member of your family to have your insurance policy cover their medical bills prior to the entire dollar amount of the family out-of-pocket maximum being met. The individual out-of-pocket maximum is embedded in the family out-of-pocket maximum.

EXPLANATION OF BENEFITS (EOB): An EOB is a statement from the insurance company showing how claims were processed. The EOB tells you what portion of the claim was paid to the healthcare provider and what portion of the payment, if any, you are responsible for.

IN-NETWORK VS. OUT-OF-NETWORK: A network is composed of all contracted providers. Networks request providers to participate in their network, and in return, providers agree to offer discounted services to their patients. If you pick an out-of-network provider, your claims will be higher because you will not receive the discounts the in-network providers offer.

OUT-OF-POCKET MAXIMUM: The out-of-pocket maximum is designed to protect you in the event of a catastrophic illness or injury. Your out-of-pocket maximum includes your deductible, coinsurance and copays that come out of your pocket. After you have paid the specified out-of-pocket amount during a policy year, the plan pays the remaining covered services at 100%.

PREVENTIVE CARE: Routine healthcare services can minimize the risk of certain illnesses or chronic conditions. Examples of preventive care services include but are not limited to physical exams, mammograms, flu vaccines, prostate tests and smoking cessation.

REASONABLE AND CUSTOMARY: The amount of money a health plan determines is the normal or acceptable range of charges for a specific health-related service or medical procedure. If your healthcare provider submits higher charges than what the health plan considers normal or acceptable, you may have to pay the difference.

Contacts

MEDICAL PLAN

Cigna

Member services and Nurseline: 866.494.2111
General website: myCigna.com

HEALTH SAVINGS ACCOUNT

Benepass

Website: app.getbenepass.com
Help Center: support.getbenepass.com/en/

HOSPITAL INDEMNITY, CRITICAL ILLNESS AND ACCIDENT INSURANCE

Prudential

Phone: 800.842.1718
Website: prudential.com/mybenefits

RETIREMENT PLAN

Principal

Phone: 800.986.3343
Website: principal.com

FLEXIBLE SPENDING ACCOUNTS

Benepass

Website: app.getbenepass.com
Help Center: support.getbenepass.com/en/

COMMUTER BENEFITS

Benepass

Website: app.getbenepass.com
Help Center: support.getbenepass.com/en/

DENTAL

Cigna

Phone: 866.494.2111
Website: myCigna.com

VISION

VSP

Phone: 800.877.7195
Website: vsp.com

EMPLOYEE ASSISTANCE PROGRAM

Prudential

Phone: 800.311.4327 | TDD: 800.697.0353
Website: guidanceresources.com
Web ID: GEN311

LIFE/AD&D

Prudential

Phone: 800.842.1718
Website: prudential.com/mybenefits

SHORT- AND LONG-TERM DISABILITY

Prudential

Phone: 800.842.1718
Website: prudential.com/mybenefits

PET INSURANCE

ASPCA Pet Insurance

Phone: 866.204.6764
Website: aspcapetinsurance.com/AlphaSense

EMPLOYEE DISCOUNTS

PerkSpot

Website: perkspot.com

BUSINESS TRAVEL ACCIDENT (BTA)

CHUBB

Website: travelassistance.chubb.com

ALPHASENSE BENEFITS TEAM

benefits@alpha-sense.com

The descriptions of the benefits are not guarantees of current or future employment or benefits. If there is any conflict between this guide and the official plan documents, the official documents will govern.

AlphaSense, Inc.

HEALTH PLAN NOTICES

TABLE OF CONTENTS

IMPORTANT NOTICE

This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From AlphaSense, Inc. About Your Prescription Drug Coverage and Medicare."

MEDICARE PART D CREDITABLE COVERAGE NOTICE

IMPORTANT NOTICE FROM ALPHASENSE, INC. 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 with AlphaSense, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. AlphaSense, Inc. has determined that the prescription drug coverage offered by the AlphaSense, Inc. Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end- stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty

There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage

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. See the AlphaSense, Inc. Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D

Generally speaking, if you decide to join a Medicare drug plan while covered under the AlphaSense, Inc. Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the AlphaSense, Inc. Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your AlphaSense, Inc. prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information, or call 646-609-8055. **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 AlphaSense, Inc. changes. You also may request a copy.

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 them at 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 whether or not you are required to pay a higher premium (a penalty).

Date:	October 13, 2025
Name of Entity/Sender:	Taryn Hewett
Contact—Position/Office:	Senior Director, Global Benefits & Wellness
Address:	24 Union Square East 5th Floor New York, NY 10003
Phone Number:	646-609-8055

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

ALPHASENSE, INC. IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is provided to you on behalf of:

AlphaSense Health and Welfare Plan*

* This notice pertains only to healthcare coverage provided under the plan. For the remainder of this notice,

AlphaSense, Inc. is referred to as Company.

1. Introduction: This Notice is being provided to all covered participants in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to apprise you of the legal duties and privacy practices of the Company's self- insured group health plans. If you are a participant in any fully insured group health plan of the Company, then the insurance carriers with respect to those plans is required to provide you with a separate privacy notice regarding its practices.

2. General Rule: A group health plan is required by HIPAA to maintain the privacy of protected health information, to provide individuals with notices of the plan's legal duties and privacy practices with respect to protected health information, and to notify affected individuals follow a breach of unsecured protected health information. In general, a group health plan may only disclose protected health information (i) for the purpose of carrying out treatment, payment and health care operations of the plan, (ii) pursuant to your written authorization; or (iii) for any other permitted purpose under the HIPAA regulations.

3. Protected Health Information: The term "protected health information" includes all individually identifiable health information transmitted or maintained by a group health plan, regardless of whether or not that information is maintained in an oral, written or electronic format. Protected health information does not include employment records or health information that has been stripped of all individually identifiable information and with respect to which there is no reasonable basis to believe that the health information can be used to identify any particular individual.

4. Use and Disclosure for Treatment, Payment and Health Care Operations: A group health plan may use protected health information without your authorization to carry out treatment, payment and health care operations of the group health plan.
   - An example of a "treatment" activity includes consultation between the plan and your health care provider regarding your coverage under the plan.
   - Examples of "payment" activities include billing, claims management, and medical necessity reviews.
   - Examples of "health care operations" include disease management and case management activities.

   The group health plan may also disclose protected health information to a designated group of employees of the Company, known as the HIPAA privacy team, for the purpose of carrying out plan administrative functions, including treatment, payment and health care operations.

5. Disclosure for Underwriting Purposes. A group health plan is generally prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of underwriting.

6. Uses and Disclosures Requiring Written Authorization: Subject to certain exceptions described elsewhere in this Notice or set forth in regulations of the Department of Health and Human Services, a group health plan may not disclose protected health information for reasons unrelated to treatment, payment or health care operations without your authorization. Specifically, a group health plan may not use your protected health information for marketing purposes or sell your protected health information. Any use or disclosure not disclosed in this Notice will be made only with your written authorization. If you authorize a disclosure of protected health information, it will be disclosed solely for the purpose of your authorization and may be revoked at any time. Authorization forms are available from the Privacy Official identified in section 23.

7. Special Rule for Mental Health Information: Your written authorization generally will be obtained before a group health plan will use or disclose psychotherapy notes (if any) about you.

8. Uses and Disclosures for which Authorization or Opportunity to Object is not Required: A group health plan may use and disclose your protected health information without your authorization under the following circumstances:
   - When required by law;
   - When permitted for purposes of public health activities;
   - When authorized by law to report information about abuse, neglect or domestic violence to public authorities;
   - When authorized by law to a public health oversight agency for oversight activities;
   - When required for judicial or administrative proceedings;

- When required for law enforcement purposes;
- When required to be given to a coroner or medical examiner or funeral director;
- When disclosed to an organ procurement organization;
- When used for research, subject to certain conditions;
- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat; and
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

9. Minimum Necessary Standard: When using or disclosing protected health information or when requesting protected health information from another covered entity, a group health plan must make reasonable efforts not to use, disclose or request more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use, disclosure or request. The minimum necessary standard will not apply to: disclosures to or requests by a health care provider for treatment; uses or disclosures made to the individual about his or her own protected health information, as permitted or required by HIPAA; disclosures made to the Department of Health and Human Services; or uses or disclosures that are required by law.

10. Disclosures of Summary Health Information: A group health plan may use or disclose summary health information to the Company for the purpose of obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the participant claims history and other information without identifying information specific to any one individual.

11. Disclosures of Enrollment Information: A group health plan may disclose to the Company information on whether an individual is enrolled in or has disenrolled in the plan.

12. Disclosure to the Department of Health and Human Services: A group health plan may use and disclose your protected health information to the Department of Health and Human Services to investigate or determine the group health plan's compliance with the privacy regulations.

13. Disclosures to Family Members, other Relations and Close Personal Friends: A group health plan may disclose protected health information to your family members, other relatives, close personal friends and anyone else you choose, if: (i) the information is directly relevant to the person's involvement with your care or payment for that care, and (ii) either you have agreed to the disclosure, you have been given an opportunity to object and have not objected, or it is reasonably inferred from the circumstances, based on the plan's common practice, that you would not object to the disclosure.

    For example, if you are married, the plan will share your protected health information with your spouse if he or she reasonably demonstrates to the plan and its representatives that he or she is acting on your behalf and with your consent. Your spouse might to do so by providing the plan with your claim number or social security number. Similarly, the plan will normally share protected health information about a dependent child (whether or not emancipated) with the child's parents. The plan might also disclose your protected health information to your family members, other relatives, and close personal friends if you are unable to make health care decisions about yourself due to incapacity or an emergency.

14. Appointment of a Personal Representative: You may exercise your rights through a personal representative upon appropriate proof of authority (including, for example, a notarized power of attorney). The group health plan retains discretion to deny access to your protected health information to a personal representative.

15. Individual Right to Request Restrictions on Use or Disclosure of Protected Health Information: You may request the group health plan to restrict (1) uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or (2) uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the group health plan is not required to and normally will not agree to your request in the absence of special circumstances. A covered entity (other than a group health plan) must agree to the request of an individual to restrict disclosure of protected health information about the individual to the group health plan, if (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and (b) the protected health information pertains solely to a health care item or service for

which the individual (or person other the health plan on behalf of the individual) has paid the covered entity in full.

16. Individual Right to Request Alternative Communications: The group health plan will accommodate reasonable written requests to receive communications of protected health information by alternative means or at alternative locations (such as an alternative telephone number or mailing address) if you represent that disclosure otherwise could endanger you. The plan will not normally accommodate a request to receive communications of protected health information by alternative means or at alternative locations for reasons other than your endangerment unless special circumstances warrant an exception.

17. Individual Right to Inspect and Copy Protected Health Information: You have a right to inspect and obtain a copy of your protected health information contained in a "designated record set," for as long as the group health plan maintains the protected health information. A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the group health to make decisions about individuals.

    The requested information will be provided within 30 days. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline, provided that you are given a written statement of the reasons for the delay and the date by which the group health plan will complete its action on the request. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may contact the Secretary of the U.S. Department of Health and Human Services.

18. Individual Right to Amend Protected Health Information: You have the right to request the group health plan to amend your protected health information for as long as the protected health information is maintained in the designated record set. The group health plan has 60 days after the request is made to act on the request. A single 30- day extension is allowed if the group health plan is unable to comply with the deadline. If the request is denied in whole or part, the group health plan must provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

19. Right to Receive an Accounting of Protected Health Information Disclosures: You have the right to request an accounting of all disclosures of your protected health information by the group health plan during the six years prior to the date of your request. However, such accounting need not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own protected health information; (3) prior to the compliance date; or (4) pursuant to an individual's authorization.

    If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the group health plan may charge a reasonable fee for each subsequent accounting.

20. The Right to Receive a Paper Copy of This Notice Upon Request: If you are receiving this Notice in an electronic format, then you have the right to receive a written copy of this Notice free of charge by contacting the Privacy Official (see section 23).

21. Changes in the Privacy Practice. Each group health plan reserves the right to change its privacy practices from time to time by action of the Privacy Official. You will be provided with an advance notice of any material change in the plan's privacy practices.

22. Your Right to File a Complaint with the Group Health Plan or the Department of Health and Human Services: If you believe that your privacy rights have been violated, you may complain to the group health plan in care of the HIPAA Privacy Official (see section 24). You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The group health plan will not retaliate against you for filing a complaint.

23. Person to Contact at the Group Health Plan for More Information: If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Official

.

Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

Taryn Hewett
Senior Director, Global Benefits & Wellness
thewett@alpha-sense.com
646-609-8055

Effective Date

The effective date of this notice is: October 13, 2025.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

ALPHASENSE, INC. EMPLOYEE HEALTH CARE PLAN

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *30 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within *30 days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Taryn Hewett
Senior Director, Global Benefits & Wellness
thewett@alpha-sense.com

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

GENERAL COBRA NOTICE

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs.
Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;

- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended: Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. If you believe you are eligible for this extension, contact the Plan Administrator.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.
If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.
For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.
Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator. **Plan contact information**

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:
Taryn Hewett
Senior Director, Global Benefits & Wellness
24 Union Square East 5th Floor
New York, NY 10003
thewett@alpha-sense.com
646-609-8055

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

AlphaSense, Inc. Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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 lymphedemas.

The AlphaSense, Inc. Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

PPO OAP Gold	In-Network	Out-of-Network
Individual Deductible	$1,000	$2,000
Family Deductible	$2,000	$4,000
Coinsurance	90%	70%
CDHP OAP Gold	In-Network	Out-of-Network
Individual Deductible	$1,700	$3,000
Family Deductible	$3,400	$6,000
Coinsurance	90%	70%
CDHP OAP Silver	In-Network	Out-of-Network
Individual Deductible	$2,800	$2,800
Family Deductible	$5,600	$5,600
Coinsurance	90%	70%

If you would like more information on WHCRA benefits, please refer to your Plan Administrator at:
Taryn Hewett, Senior Director, Global Benefits & Wellness
thewett@alpha-sense.com
646-609-8055

MICHELLE'S LAW NOTICE

(To Accompany Certification of Dependent Student Status)

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or
- The date coverage would otherwise terminate under the plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the plan, of a participant or beneficiary; and
- Have been enrolled in the plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the plan.

If you believe your child is eligible for this continued eligibility, you must provide to the plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact Taryn Hewett, Senior Director, Global Benefits & Wellness, 646- 609-8055.

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, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: 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+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – 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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid	LOUISIANA – 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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	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	**MASSACHUSETTS – Medicaid and CHIP**
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs- services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for- medicaid-health-insurance-premium-payment-program- hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	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	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration 1-866-444-EBSA (3272)	U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services **www.dol.gov/agencies/ebsa** **www.cms.hhs.gov** 1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

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OMB Control Number 1210-0137 (expires 1/31/2026)

Employer Name:	**AlphaSense, Inc.**
Employer State of Situs:	**New York**
Name of Issuer:	**Cigna**
Plan Marketing Name:	**Cigna Gold HSA**
Plan Year:	**2026**

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2025 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)

Item	EHB Benefit	EHB Category	Benchmark Page # Reference	Employer Plan Covered Benefit?
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	No
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes

6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	Yes
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	Yes
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	No
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	No
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Yes
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	No
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	No
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	No

30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Yes
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Yes
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes - Pap and Prostate tests
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Yes - Rehad services

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

Employer Name:	**AlphaSense, Inc.**
Employer State of Situs:	**New York**
Name of Issuer:	**Cigna**
Plan Marketing Name:	**Cigna PPO OAP Gold Plan**
Plan Year:	**2026**

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2025 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)

Item	EHB Benefit	EHB Category	Benchmark Page # Reference	Employer Plan Covered Benefit?
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	No
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes

6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	Yes
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	Yes
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	No
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	No
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Yes
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	No
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	No
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	No

30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Yes
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Yes
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes - Pap and Prostate tests
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Yes - Rehad services

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

Employer Name:	**AlphaSense, Inc.**
Employer State of Situs:	**New York**
Name of Issuer:	**Cigna**
Plan Marketing Name:	**Cigna Silver HSA**
Plan Year:	**2026**

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2025 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)

Item	EHB Benefit	EHB Category	Benchmark Page # Reference	Employer Plan Covered Benefit?
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	No
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes

6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	Yes
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	Yes
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	No
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	No
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Yes
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	No
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	No
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	No

30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Yes
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Yes
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes - Pap and Prostate tests
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Yes - Rehad services

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

AlphaSense, Inc.

Fixed Indemnity Notice

This notice contains information pertaining to your Hospital Indemnity insurance policy.

IMPORTANT: This is a fixed indemnity policy, NOT health insurance.

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your state Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (**naic.org**) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.