RADENCE

Standard of Care Framework

Transforming the Latest Medical Science into Individualized Healthcare

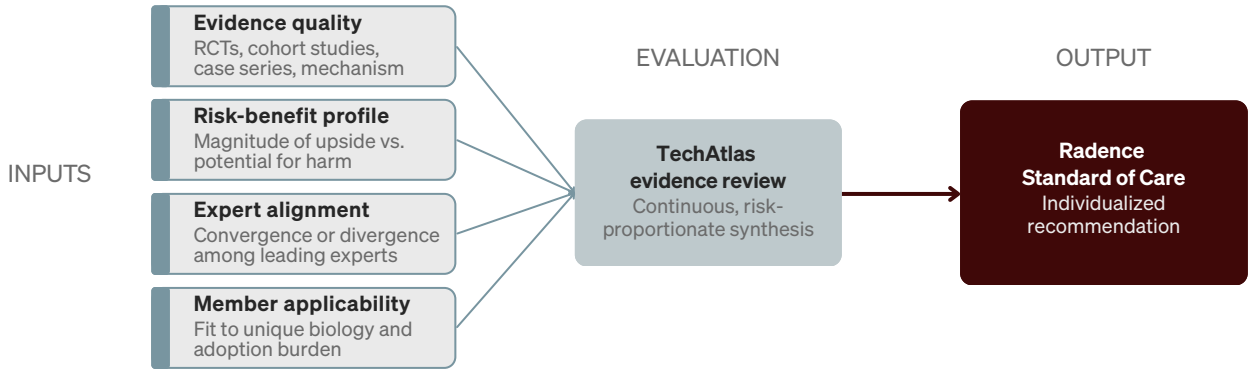
Conventional medicine waits for consensus and focuses on care at the group level. By the time a clinical guideline is published and practice is updated, the underlying evidence is often five to ten years old (or more). Trial data are filtered through committee structures designed to protect against liability and to apply to millions of people. That delay is appropriate for the system it serves. It is not appropriate for members whose biology, resources, and time horizon allow for something more precise. Radence applies evidence to individuals before guidelines catch up. This document explains how.

Our process is anchored by TechAtlas, the famed research group within RA Capital that evaluates emerging biomedical evidence in its investment work. TechAtlas PhDs and MDs dissect clinical trial data every day to determine the best treatments in a medical field. They use networks of leading physicians to predict where the cutting edge will be five and ten years in the future to gain deep insights into how a field will evolve. The same frameworks applied to capital allocation decisions is applied to what enters the Radence standard of care, with several additional layers of clinical pressure testing by physicians and specialists.

The Framework at a Glance

Four Decision Dimensions Built to Answer One Question: What's Best for You?

Four inputs feed every recommendation. The published evidence base, the risk-benefit profile of the intervention, the alignment of leading experts, and the fit to a Radence member's biology and willingness to adopt. TechAtlas weighs all four continuously and synthesizes them into an individualized recommendation. The sections below explain each input and how the synthesis works in practice.



1. How We Evaluate Evidence

Medicine Designed at the Pace of Breakthroughs, Not the Lag of Guidelines

Not all evidence is equal, and the differences matter. At the top of our hierarchy sit large, rigorously-designed randomized controlled trials, where participants are assigned to treatment by chance and outcomes are measured prospectively. These are the strongest tool medicine has for establishing whether an intervention actually causes a benefit, separating signal from coincidence.

Below that, in descending order of strength, we generally weigh analyses of groups of trials, prospective cohort studies that track defined groups over time, then retrospective analyses of existing data, then case series, and finally mechanistic and preclinical (non-human) work. Each layer is informative. Each carries different uncertainty. A registry of fifty thousand patients can reveal a real-world signal that a small trial missed. A mechanistic study in cells can suggest a biological plausibility that takes a decade to confirm clinically. There are exceptions to this order. Randomized trials can be poorly designed, or group analyses can include mismatched trials which confuses signals. Therefore, this is a general direction rather than an absolute rule.

TechAtlas reads this literature continuously, not in scheduled cycles. New publications, conference presentations, and trial readouts are evaluated as they appear. The question is not what the latest guideline says. The question is what the totality of current evidence supports right now, for a member with a specific risk profile.

2. How We Set Thresholds

Act on Risk When it's Early Enough to Change Your Outcome

The most important decision in any clinical framework is not what the evidence says. It is how much evidence is enough to act. Radence answers that question differently than guideline bodies do, and the difference is what allows precision medicine to function.

Our threshold is risk-proportionate. The lower the risk of a given intervention, and the higher its potential benefit, the more proactively we are willing to act on emerging evidence. The higher the risk, the more uncertain the benefit, the more we demand from the data before

recommending it. This is not a lower bar than conventional medicine. In many cases it is a higher one. It is simply a calibrated bar.

Consider three concrete contrasts. A whole-body MRI carries no radiation exposure and relatively low risk, while potentially identifying disease before symptoms develop. Because the downside is relatively low, emerging evidence may be sufficient to support its use in appropriately selected individuals. While a DEXA scan has some low-level radiation exposure, it is not zero. The benefit in identifying bone density issues before a fracture occurs, however, could be clinically significant and worthwhile, particularly in individuals with risk factors for osteoporosis, such as sedentary lifestyles and nutritional deficiencies. Scans such as Coronary CT angiography (CCTA) carry additional considerations, including radiation exposure, intravenous contrast, and potentially medication to optimize physiological parameters for imaging quality requirements. It can, however, provide a detailed assessment of soft and calcified coronary plaque burden. The same evidentiary standard applied uniformly to all three would either move too slowly on the first or too aggressively on the third. Both are failures of judgment.

3. Where Expert Consensus Fits

Every Recommendation Anchored in Peer-Reviewed Science, Pressure-Tested Against the Brightest Minds in Medicine

Published evidence is necessary but rarely sufficient on its own. Leading physicians, who spend decades gaining expertise in these data, carry information that does not always appear in print. We talk to them. While a large group of physicians is rarely fully aligned on every single aspect of a topic, we listen for common themes. We listen for overall impressions, estimated effect sizes, risks, unknown downstream effects, and whether they would want themselves or their families treated according to a given protocol.

TechAtlas maintains active relationships with key opinion leaders across cardiology, oncology, neurology, endocrinology, and the precision diagnostics field. When leading experts converge on the same general interpretation of new evidence, that convergence functions as a modifier on our threshold. It lowers the bar somewhat, because consensus among informed clinicians reduces the probability that we are misreading the data. When leading experts converge on the same general interpretation of new evidence, that convergence functions as a modifier on

our threshold. It lowers the bar somewhat, because consensus among informed clinicians reduces the probability that we are misreading the data. When experts are divided, the bar moves up. Disagreement among people who know a field best is itself a signal that the evidence is not yet ready to act on. This is more demanding than reading the literature alone, and it produces faster decisions than waiting for formal guideline channels to resolve.

4. Why This Differs From Conventional Guidelines

Because You Deserve Medicine Built Around You

Standard clinical guidelines are designed for a different problem than the one Radence solves. They are built to give population-level direction to clinicians treating heterogeneous patients, often under time and resource constraints, with liability frameworks shaped by malpractice systems rather than by individualized risk-benefit analysis. They average across millions of people, which means they are calibrated to the median patient and they are slow by design.

Radence operates differently because the member-level inputs are different. A member with whole-genome sequencing, advanced imaging, multi-cancer early detection screening, comprehensive cardiovascular and metabolic phenotyping, and continuous follow-up should not be treated like a statistical average. The data available on that individual member are magnitudes richer than guideline committees consider at a group level. That richness changes what is actionable.

When we know a member's APOE genotype, lipoprotein(a), coronary calcium score, and family history with precision, we can interpret an emerging therapy in the context of that specific biology rather than against a population average. This requires a more demanding standard of interpretation, not a lower one. The evidence has to be strong enough to support an individualized decision, not just a population recommendation. That is the substance behind our claim that Radence acts on evidence the conventional system is still waiting on. We are not skipping steps. We are doing more work, on more data, with more accountability, for a smaller number of members. The result is a standard of care that moves at the pace of science rather than at the pace of consensus.