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DELTA REPORT

10-K

NEUE - BRIGHT HEALTH GROUP INC.

10-K - DECEMBER 31, 2023 COMPARED TO 10-K - DECEMBER 31, 2022

The following comparison report has been automatically generated

TOTAL DELTAS	7809
CHANGES	241
DELETIONS	4064
ADDITIONS	3504

REFINITIV

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2022 December 31, 2023

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission file number 001-40537

BRIGHT HEALTH GROUP,NEUEHEALTH, INC.

(Exact Name of Registrant as Specified in its Charter)

Delaware	**47-4991296**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
8000 Norman Center Drive, 9250 NW 36th St Suite 900, Minneapolis, MN 420, Doral, FL	**55437 33178**
(Address of principal executive offices)	**(Zip Code)**

Registrant's telephone number, including area code: (612) 238-1321

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, $0.0001 par value	**BHG NEUE**	**New York Stock Exchange**

Securities registered pursuant to section 12(g) of the Act:

Common Shares

(Title of class)

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act.

Yes o No ☒

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.

Yes o No ☒

Indicate by check mark whether the registrant: (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports); and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No o

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this

chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No o

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer	☐	Accelerated filer	☒ ☐
Non-accelerated filer	☐ ☒	Smaller reporting company	☐ ☒
		Emerging growth company	☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. o

Indicate by check mark whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☒ o

If securities are registered pursuant to Section 12(b) of the Act, indicate by check mark whether the financial statements of the registrant included in the filing reflect the correction of an error to previously issued financial statements. o

Indicate by check mark whether any of those error corrections are restatements that required a recovery analysis of incentive-based compensation received by any of the registrant's executive officers during the relevant recovery period pursuant to §240.10D-1(b). o

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes o No ☒

The aggregate market value of voting stock held by non-affiliates of the Registrant on June 30, 2022 June 30, 2023, based on the closing price of $1.82 $12.22 for shares of the Registrant's common stock as reported by the New York Stock Exchange, was approximately $549,215,469. $47,165,380. Shares of common stock beneficially owned by each executive officer, director, and holder of more than 10% of our common stock have been excluded in that such persons may be deemed to be affiliates.

As of March 6, 2023 March 12, 2024, the registrant had 630,331,300 8,054,122 shares of common stock, $0.0001 par value per share, outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

None.

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FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K ("Annual Report") contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended, or the Securities Act, and Section 21E of the Securities Exchange Act of 1934, as amended, or the Exchange Act. Statements made in this Annual Report that are not statements of historical fact, including statements about our beliefs and expectations, are forward-looking statements, and should be evaluated as such. Forward-looking statements include any statement or information concerning possible or assumed future results of operations, our business plan and strategies, and our operational and financial outlook, estimates, projections, and guidance. These statements often include words such as "anticipate," "expect," "plan," "believe," "intend," "project," "forecast," "estimates," "projections," "should," "might," "may," "will," "ensure" and other similar expressions. Such forward-looking statements are subject to various risks, uncertainties and assumptions. Accordingly, there are or will be important factors that could cause actual outcomes or results to differ materially from those indicated in these statements. Factors that might materially affect such forward-looking statements include: our ability to raise capital and continue as a going concern; our ability to comply with the terms of our credit facility, including financial covenants, both during and after any waiver period, and/or obtain any additional waivers of any terms of our credit facility to the extent required; our ability to receive the impacts remaining proceeds from the sale of our corporate restructuring and the associated headcount reduction; Medicare Advantage ("MA") business in California in a timely manner; our ability to obtain any short or long-term debt or equity financing needed to operate our business; our ability to quickly and efficiently complete the wind down of our Individual and Family Plan ("IFP") businesses and Medicare Advantage ("MA") MA businesses outside of California; California, including by satisfying liabilities of those businesses when due and payable; potential disruptions to our business due to any restructuring and any resulting headcount reduction; our ability to accurately estimate and effectively manage the costs relating to changes in our business offerings and models; a delay or inability to withdraw regulated capital from our subsidiaries; our ability to comply with ongoing regulatory requirements, including consent decrees or government orders; a lack of acceptance or slow adoption of our business model; our ability to retain existing consumers and expand consumer enrollment; our ability and our Care Partner's abilities to obtain and accurately assess, code, and report IFP and MA risk adjustment factor scores for consumers; scores; the ability of our ability payor partners to contract with care providers and arrange for pay amounts due to us in a timely manner, or at all; the provision solvency of quality care; our ability to accurately estimate our medical expenses, effectively manage our costs and claims liabilities or appropriately price our products and charge premiums; payor partners; our ability to obtain claims information timely and accurately; the impact of the ongoing COVID-19 any pandemic or epidemic on our business and results of operations; the risks associated with

our reliance on third-party providers to operate our business; the impact of modifications or changes to the U.S. health insurance markets; our ability to manage the any growth of our business; our ability to operate, update or implement our technology platform and other information technology systems; our ability to retain key executives; our ability to successfully pursue acquisitions, and integrate acquired businesses; businesses and divest businesses as needed; the occurrence of severe weather events, catastrophic health events, natural or man-made disasters, and social and political conditions or civil unrest; our ability to prevent and contain data security incidents and the impact of data security incidents on our members, patients, employees and financial results; our ability to comply with requirements to maintain effective internal controls; our ability to adapt to new the risks associated with our expansion into the ACO Reach program; our ability to comply with the continued listing standards of the New York Stock Exchange; Accountable Care Organizations ("ACO") Realizing Equity, Access, and Community Health ("REACH") businesses, including any unanticipated market or regulatory developments; and the other factors set forth under the heading Item 1A – "Risk Factors" in this Annual Report.

The preceding list is not intended to be an exhaustive list of all of the factors that might affect our forward-looking statements. The forward-looking statements are based on our beliefs, assumptions and expectations of future performance, taking into account the information currently available to us. These statements are only predictions based upon our current expectations and projections about future events. There are important factors that could cause our actual results, level of activity, performance or achievements to differ materially from the results, level of activity, performance or achievements expressed or implied by the forward-looking statements. Other sections of this Annual Report may include additional factors that could adversely impact our business and financial performance. Moreover, we operate in a very competitive and rapidly changing environment. New risks emerge from time to time and it is not possible for our management to predict all risks, nor can we assess the impact of all factors on our business or the extent to which any factor, or combination of factors, may cause actual results to differ materially from those contained in any forward-looking statements we may make.

You should not rely upon forward-looking statements as predictions of future events. Our forward-looking statements speak only as of the date of this Annual Report and, although we believe that the expectations reflected in the forward-looking statements are reasonable, we cannot guarantee that the future results, levels of activity, performance and events and circumstances reflected in such forward-looking statements will be achieved or occur at all. Except as required by law, we undertake no obligation to update publicly any forward-looking statements for any reason after the date of this release to conform these statements to actual results or to changes in our expectations.

SUMMARY OF KEY RISK FACTORS

Investing in our securities involves a high degree of risk. You should carefully consider the risk factors set forth under the heading Item 1A – "Risk Factors" in this Annual Report, together with other information in this Annual Report, before deciding whether to invest in shares of our common stock. The following summary highlights certain of the principal risks and uncertainties included in the discussion of our risk factors in Item 1A – "Risk Factors" in this Annual Report. This is not a complete list of the risks set out in that section and readers are encouraged to review the "Risk Factors" section of this Annual Report in its entirety for a more fulsome understanding of the risks and uncertainties that may impact the Company.

Risks Related to Our Business

- Our revised business model and associated corporate restructuring could disrupt our business.
- Our new business model may not be accepted or will be slow to be adopted by the healthcare industry.
- We may not be able to contract with third-party payors and other partners.
- Failure to appropriately set our rates or effectively manage our costs could negatively affect us.
- We have incurred net losses each year since our inception.
- Our limited operating history makes it difficult to evaluate our business and assess our future prospects.
- We operate in competitive markets within a highly competitive industry.
- The failure to enter into or maintain value-based care agreements with health plans could materially impact our business.
- Our consumers are concentrated in certain geographic areas and amongst certain populations.
- If we decide to enter new markets, they may not be as economical to serve as our existing markets.
- If we grow rapidly, we may not be able to manage our growth effectively.
- Any future epidemics or pandemics may adversely affect our business and results of operations.
- Large-scale medical emergencies in one or more states in which we operate could disrupt our business.
- We require additional capital, that may not be available and which might not be available on acceptable terms.
- Our corporate restructuring and the associated headcount reduction could disrupt our business. terms, if at all.
- Management action plans in place may not fully alleviate doubt about our ability to continue as a going concern.
- Lack of acceptance or slow adoption of If we fail to achieve robust brand recognition our business model could impact our business and results of operations.
- Our inability to retain existing consumers, expand consumer enrollment, or diversify and expand our portfolio of products and services may adversely affect our business and results of operations.
- We may not be able to contract with care providers on favorable terms or at all, or to arrange for the provision of the quality care necessary to attract consumers.
- We may be required to work with care providers who are not contracted with our health plans or in our networks, which may result in costly out-of-network claims.
- Failure to appropriately set premiums or effectively manage our costs could negatively affect our results.
- If we grow rapidly, we may not be able to manage our growth effectively.

- We have incurred net losses each year since our inception, and we may not achieve or maintain profitability in the future.
- Our limited operating history makes it difficult to evaluate our business and assess our future prospects.
- The ongoing COVID-19 pandemic has and may continue to adversely affect our business and results.
- Large-scale medical emergencies could significantly increase costs or overwhelm and disrupt our systems.
- Delays in our receipt of health plan premiums could adversely affect our results.
- Our membership is concentrated in certain geographic areas and amongst certain populations, exposing us to unfavorable changes in local benefit costs, reimbursement rates, competition and economic conditions.
- If we decide to enter new markets, they may not be as economical to serve as our existing markets.
- We operate in competitive markets within a highly competitive industry.
- We may fail to enter into value-based care agreements with health plans or renegotiate them.
- If we are not able to maintain required statutory capital levels, our balance sheet may be adversely affected.
- We may If we fail to achieve robust brand recognition or maintain or enhance our reputation.
- Failure to provide offer high-quality customer support may adversely affect in our business, our reputation and our ability to maintain or expand membership or attract Care Partners and third-party payors.
- Reductions in the quality ratings of our MA health plans could have a materially negative impact our results.
- We may fail to identify and acquire suitable acquisition candidates or integrate acquired companies. suffer.
- Medical liability claims made against us in the future could cause us to incur significant expenses and pay significant damages. expenses.
- We rely on our talent, The loss of any members of senior management or other key employees. employees or an inability to hire, retain, motivate or develop other highly skilled employees could harm our business.
- Negative global Global economic conditions and economic uncertainty or downturns could adversely affect our results.
- Shortages of qualified personnel or other factors could increase labor costs materially and adversely affect our results.
- Our health plan products are subject to risk adjustment programs business and may not be managed properly.
- Our expansion into ACO REACH presents new risks to our business. operating results.

Risks Related to our Intellectual Property, Information Technology, and Data Privacy

- Protecting our intellectual property rights may be expensive and demand management's attention.

- Claims that allege we violated intellectual property right violations of others rights, may be costly to defend and limit our ability to operate.
- We may not be able to maintain the accuracy, integrity or availability of our data.
- Our new enterprise resource planning system may prove ineffective.
- Our The technology platform systems and platforms we utilize may not operate properly or as we expect and requires continued development and maintenance. them to operate.
- Security incidents or breaches, loss of data and other disruptions could compromise sensitive or legally protected information, disrupt information.
- Failure of third-party service providers to meet contractual obligations to us or comply with applicable laws or regulations may adversely affect our business, and expose us to liability. business.

Risks Related to our Indebtedness

- We may Our ability to incur a substantial level of indebtedness and may reduce our financial flexibility.
- The Credit Agreement Our current credit agreement contains, and any agreements governing future debt issuances may contain, restrictions and covenants that affect on our ability to operate our business. business and to pursue our business strategies.

Risks Related to Legal Proceedings and Governmental Regulations

- The Modifications or changes to the U.S. health insurance market is subject to modification and changes, including those of legislation.
- We are unable to predict the ultimate impact of the CARES Act and other stimulus legislation on markets, could adversely affect our business.
- Our MA plans, contracts with third-party MA plans and reimbursement from fee-for-service Medicare are subject to changes to the Medicare program.
- Failure If we fail to comply with certain healthcare laws, and incurring we could face substantial penalties could result in adverse financial condition penalties.
- Our use and disclosure of PII and PHI is subject to federal and state privacy and security regulations.
- Laws regulating the corporate practice of medicine could restrict the manner in which we conduct of our business.
- We are and may be subject to litigation, administrative proceedings or investigations.
- We are subject to a pending putative securities class action lawsuit.

- We are subject to inspections, reviews, audits and investigations under government programs and contracts.
- Our employees, independent contractors, partners, suppliers and other third parties may engage in misconduct or other improper activities, including noncompliance with regulatory standards and requirements.

Risks Related to our Financial Statements

- We have identified material weaknesses in our internal controls over financial reporting. reporting and may identify additional material weaknesses in the future or otherwise fail to maintain an effective system of internal controls.
- Accounting for health plan benefits is complicated and subject to foreseen and unforeseen risks.
- Failure to comply with requirements to design, implement and maintain effective internal controls could adversely affect our stock price.
- Our ability to use our net operating losses and research and development tax credit carryforwards to offset future taxable income may be subject to certain limitations.
- The impairment of a significant portion of our intangible assets would negatively affect our results of operations.

Risks Related to Ownership of Our Common Stock

- We received notice from If we are not in compliance with the continued listing standards of the New York Stock Exchange, (the "NYSE") that we were not in compliance with its continued listing standards regarding the average closing price of our common stock, and we may be subject to permanent delisting from the NYSE. New York Stock Exchange.
- Our stock price has experienced significant volatility and may change significantly in the future.
- Our quarterly operating results fluctuate and may fall short of prior results periods, our projections or the expectations of securities analysts or investors, which could materially adversely affect our stock price.
- We currently do not intend to declare dividends on our common stock in the foreseeable future.
- If securities analysts do not publish research or reports about our business or if they downgrade our stock or our sector, our stock price and expectations. trading volume could decline.
- Our management may use the proceeds of any financings in ways with which you may disagree or that may not be profitable.
- Provisions in our organizational documents could delay or prevent a change of control.
- Our amended and restated certificate of incorporation provides, subject to limited exceptions, that the Court of Chancery of the State of Delaware and, to the extent enforceable, the federal district courts of the United States of America will be the sole and exclusive forums for certain stockholder litigation matters.

Risks Related to Investing in Our Common Stock

- The Issuances of shares of our common stock in connection with the conversion of our outstanding Preferred Stock, or exercise of outstanding warrants, would cause substantial dilution dilution.
- Our board of directors is authorized to issue and may have significant influence on certain corporate matters. designate shares of our preferred stock in additional series without stockholder approval.

PART I

ITEM 1. BUSINESS

NeueHealth, Inc. (formerly known as Bright Health Group, Inc.) ("Bright Health, NeueHealth," "we," "our," "us," or the "Company"), was founded in 2015 to transform healthcare. Although 2022 was a year of significant transition for the business has evolved, our business, our mission commitment to making high-quality, coordinated healthcare accessible and affordable to all populations remains the same: unchanged.Making Healthcare Right. Together. It is built upon the belief that by connecting and aligning the best local resources in healthcare delivery with the financing of care, leveraging what we call the "Value Layer" of healthcare, we can drive a superior consumer experience, reduce systemic waste, lower costs, and optimize clinical outcomes.

Bright Health NeueHealth consists of two reportable segments:

• ***Consumer NeueCare (formerly Care Delivery)*** — Our value-driven care delivery business that manages risk in partnership with external payors. payors and serves all populations across The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 ("ACA") Marketplace, Medicare, and Medicaid.

• ***Bright HealthCare NeueSolutions (formerly Care Solutions)*** — Our delegated senior managed care provider enablement business that partners with includes a tight group suite of aligned technology, services, and clinical care solutions that empower providers to thrive in California. performance-based arrangements.

OVERVIEW

At its core, Bright Health NeueHealth is a technology enabled, value-driven healthcare company. company grounded in the belief that all health consumers are entitled to high-quality, coordinated healthcare. We believe we can significantly reduce the current friction and lack of coordination in today's healthcare system by aligning the interests of payors and providers to enable a seamless, consumer-centric healthcare experience that to drive meaningful change, we must leverage technology and bring together the financing and delivery of care, while strengthening healthcare's strongest relationship: that between the consumer and their primary care provider ("PCP"). We look to do this through value-based care arrangements where the company and our payor or care provider partners benefit from improvements in outcomes and lowering risk-adjusted medical costs. drives value for all.

Bright Health is focused on delivering affordable healthcare to At the fast-growing aging and underserved populations in Florida, Texas and California through our fully aligned care model. Bright Health has end of 2022, we exited the Affordable Care Act ACA Marketplace as an insurer ceasing coverage and, as of IFP January 1, 2024, we ceased offering Medicare Advantage products with the sale of our California Medicare Advantage business. After exiting the health insurance business, we adopted NeueHealth as our corporate brand name.

We continue to focus on delivering value-driven, consumer-centric healthcare through Bright HealthCare, our owned and affiliated clinics as well as ending Medicare Advantage insurance coverage outside of California at the end of 2022. enabling independent providers and medical groups to thrive in performance-based arrangements through deep financial alignment, customized population health tools, and strong partnerships with leading health plans and government programs.

OUR APPROACH

U.S. healthcare has traditionally been designed to serve large employers and institutions, with limited focus on the consumer and a bias towards broad, impersonal networks. This dynamic has resulted in a highly fragmented system, where high-performing individual care providers have faced challenges given limited coordination and perverse incentives amongst key stakeholders. Traditional managed care organizations have primarily focused their efforts on cost containment, keeping their network participants at arm's length and leaving the underlying healthcare consumer lost in the mix. We believe this one-dimensional approach has driven a poor consumer experience, sub-optimal clinical outcomes, and tremendous economic waste. While legacy managed care organizations have attempted to address these issues in recent years, we believe their failure to employ a consumer-centric approach has limited their success.

At Bright Health, NeueHealth, we are delivering what we believe is the future of integrated healthcare by deploying a differentiated, value-driven approach that is built on alignment and focused on the consumer and powered by technology. consumer.

Built on Alignment

Bright Health NeueHealth has created a new differentiated alignment model built upon three core principles applied consistently but flexed accordingly to "meet meet our Care Partners provider and payor partners where they are": are to deliver a more personalized care experience for consumers:

- ***Clinical Alignment —*** We believe that alignment in healthcare starts with those responsible for delivering care locally. As each of our Care Partners provider partners has a unique set of clinical tools and capabilities to manage population health risk, our adaptable model lends them the support necessary to enhance local healthcare delivery delivery. Clinical alignment ensures coordination between providers and strengthen existing provider-consumer relationships.

• ***Financial Alignment —*** We have developed value-based payment structures payors to deliver high-quality care that enable us is affordable and tailored to take a staged approach to financial alignment with our Care Partners. We first carefully consider meet each Care Partner's ability and interest to take varying levels of population health risk. Once aligned, we then work with our Care Partners over time to optimize the relationship and prepare them for success under more advanced models of value-based care. consumer's individual needs.

- ***Financial Alignment —*** We have developed performance-based payment structures that enable us to take a staged approach to financial alignment with our provider partners. We first carefully consider each provider's ability and interest to take varying levels of population health risk and work with each partner over time to prepare them for success under more advanced models of value-based care. Our owned clinics align with payor partners, forming strategic relationships to manage all populations along the continuum of need across the ACA Marketplace, Medicare, and Medicaid primarily through performance-based arrangements.

- ***Data and Technology Alignment —*** Our clinical and financial alignment with our Care Partners provider and payor partners is designed to incentivize maximum platform interoperability, data transparency and data transparency, sharing, affording us and our Care Partners everyone a more holistic view of the consumers we serve. Using comprehensive clinical, administrative, and consumer data, we enhance clinical technology by providing each Care Partner with purpose-built tools and experiences that seamlessly embed into existing workflows.

Focused on the Consumer

Our approach to healthcare remains centered around the belief that there is an ongoing shift from broad, employer-driven, one-size-fits-all offerings to a model built on individual choice. This has driven us to implement what we believe is a novel approach to consumer empowerment that focuses on making developing true relationships with our patients early in their healthcare simple, personal, and affordable. journey to understand their specific needs so we can deliver a personalized, consumer-centric healthcare experience.

Powered by Technology

Bright Health's NeueHealth's aligned and consumer-focused model enables us to transform the way technology can affect meaningful change in healthcare. Historically, key stakeholders with misaligned incentives have generally been unwilling to share critical information, thereby limiting the effectiveness of healthcare technology. In addition, data has been transactional, serving the needs of payors and care providers, but not the individual. By aligning stakeholders across the financing and delivery of care and putting consumers in control of their healthcare data, we believe Bright Health NeueHealth can capture a holistic view of the consumer and empower everyone – the individual health consumer, provider, and their care teams payor – to drive better coordination and optimize clinical outcomes.

coordination.

OUR BUSINESS

We deploy our capabilities across Consumer Care our NeueHealth business, which is comprised of two segments – NeueCare and Bright HealthCare, with a shared focus NeueSolutions – each focused on leveraging technology and our aligned value-driven, consumer-centric care model to optimize the healthcare experience. By participating in experience for health consumers, providers, and connecting both the delivery and financing of care, our approach allows us to control the healthcare dollar while rewarding us for reducing the total cost of care, all while engaging with and enhancing the experience and clinical outcomes for the underlying consumer. payors.

Consumer Care NeueCare

Consumer Care seeks NeueCare delivers accessible, affordable healthcare to significantly reduce all populations across the friction ACA Marketplace, Medicare, and current lack Medicaid through owned and affiliated clinics. NeueCare is committed to supporting all patients across the continuum of coordination between payors need with inclusive, proactive, and providers informed care. Leveraging its patient engagement strategies, NeueCare develops a true relationship with patients early in their healthcare journey to enable a truly consumer-centric healthcare experience. Providers are looking for solutions that will enable them to perform understand their specific needs and deliver the right care at the right time, in a value-based world and focus on what matters most: their patients' health. Payors are looking for systems of high-performing providers who can partner with them to deliver setting the best care locally. Consumers want personalized, easy-to-access care, regardless of who is paying for it. Consumer Care brings this together through a combination of technology and services that are scaled centrally and deployed locally. patients trust.

As of December 31, 2022 December 31, 2023, Consumer Care NeueCare operated 74 managed and affiliated 73 risk-bearing clinics, within its integrated under the Centrum Health, AssociatesMD, and Premier Medical Associates brand names, delivering payor-agnostic care delivery system. Through those risk-bearing clinics, Consumer Care maintained over 579,000 unique patient relationships as of December 31, 2022, to approximately 530,000 of which aredelivered under 293,000 value-based arrangements, care consumers across multiple payors, including 46,000 through our Direct Contracting Entities (now ACO Reach). Consumer Care the ACA Marketplace, Medicare, and Medicaid. NeueCare engages in local, personalized care delivery in multiple ways:through its integrated care model:

- ***Integrated Care Delivery —*** As We align the interests of December 31, 2022, Consumer Care operated 74 managed providers, payors, and affiliated risk-bearing clinics providing comprehensive care consumers to all population types. create a better healthcare experience for all. Our integrated system of care includes embedded pharmacy, laboratory, radiology, and population health focused specialty services. We proactively manage the needs of consumers take a consumer-centric approach to care, engaging each individual and offer offering expansive preventive care services to proactively meet the needs of each consumer, reduce hospitalizations and other unnecessary utilization of the healthcare system. Our clinics leverage Consumer Care's NeueHealth's data and technology capabilities as well as NeueSolution's provider enablement tools to ensure a comprehensive care system for our at-risk patients. Consumer Care patients, including chronic care management, transitions of care and referral management. NeueCare is tightly aligned with our third-party payor partners. partners, increasing access to high-performing, clinically integrated networks and driving differentiated performance by delivering higher quality care at lower cost.

Our care delivery approach focuses on three primary components:

1. ***Simplicity, Convenience and Convenience Coordination —*** We offer a one-stop-shop for consumers offering providing primary care, behavioral health, rotating specialties, pharmacy, radiology, and laboratory services, many times at a single location. For services not provided we can refer to high quality, in-network providers and ensure continuity of care.

2. ***Community Connectivity —*** Our clinics are designed to foster a sense of local community, bring consumers together to build supportive true relationships and support their non-medical needs.

3. ***Proactive Engagement —*** Leveraging our technology, we keep our local consumers highly engaged in their healthcare. We proactively communicate with our consumers to close care gaps and, when appropriate, arrange for medical transportation to and from appointments, all while making our Personalized Care Teams care teams available 24/7 through call centers and virtual connectivity, maximizing adherence to a consumer's care plan.

NeueCare Customer Segments

NeueCare serves customers through its value-driven, consumer-centric care model, including:

• ***Value Services Organization External Payors*** — Consumer Care empowers primary care practices NeueCare owned and care delivery organizations affiliated clinics contract with various third-party payors primarily through value-based arrangements.

• ***Health Consumers —*** NeueCare provides high-quality, affordable healthcare to evolve health consumers across the ACA Marketplace, Medicare, and Medicaid.

NeueSolutions

NeueSolutions enables providers and medical groups to succeed in their evolution towards risk-bearing primary performance-based arrangements. NeueSolutions also participates in the Centers for Medicaid and Medicare Innovation's ("CMMI") ACO REACH program, providing high-quality healthcare access to Medicare beneficiaries.

As of December 31, 2023, NeueSolutions served approximately 62,000 value-based care delivery. We help these organizations consumers. NeueSolutions takes a comprehensive approach to provider enablement:

• ***Provider Enablement Solutions:*** Through deep financial alignment, customized population health tools, and strong partnerships with leading health plans and government programs, NeueSolutions enables independent providers and medical groups to enter value-based arrangements designed around their needs, while simultaneously empowering them with the tools and capabilities necessary to maximize their success. Consumer Care's Value Services Organization takes a comprehensive approach to provider enablement focusing on:

1. ***Organizing and Aligning Providers —*** Building, managing, and delivering high-performing, aligned delivery systems in local markets.
2. ***Transforming Practices —*** Redesigning practice workflows and facilitating culture change with care providers so that they understand and embrace value-based care.
3. ***Driving Outcomes —*** Empowering consumers to access care in the way they desire and providing tools that empower providers to effectively manage risk and deliver outcomes.
4. ***Enabling Frictionless Transactions —*** Reducing administrative complexity for consumers and care providers, while supporting transitions of care across the ecosystem.
5. ***Assessing and Improving Performance —*** Evaluating financial, clinical, and quality performance under risk-based contracts, empowering providers to improve and succeed.

Consumer Care

NeueSolutions Customer Segments

Consumer Care NeueSolutions serves a diverse set of customers across the healthcare ecosystem, including:

- ***External Payors —*** Consumer Care managed NeueCare and affiliated clinics currently contract with various third-party payors through primarily value-based arrangements.

• ***Affiliated Providers (e.g., IDNs, IPAs, Medical Groups, etc.) —*** Consumer Care NeueSolutions supports these care providers with a suite of services including technology, payor contracting, risk management, and administrative support to accelerate the transition to value-based care.

- ***Federal and State Governments —*** Consumer Care NeueSolutions currently participates in the ACO Reach REACH program, where managing traditional Medicare beneficiaries through value-based relationships in partnership with its owned and affiliated providers, it manages traditional Medicare beneficiaries through value-based relationships. providers.

Bright HealthCare

Bright HealthCare delivers simple, personal, and affordable financing solutions that are focused on consumer retail healthcare and delivered through Bright Health's alignment model. We tailor our plan design and experiences to meet consumer needs, align top-to-bottom incentives to drive the best outcomes for our stakeholders, and develop capabilities to enable superior performance.

We also participate in a number of specialized plans and are the nation's third largest provider of Chronic Condition Special Needs Plans ("C-SNPs").

Bright HealthCare Customer Segments

Bright HealthCare's customers include:

• ***Commercial —*** Bright HealthCare offered commercial health plans to more than 1.0 million individuals as of December 31, 2022. Bright Health has exited the Affordable Care Act Marketplace as an insurer, ceasing coverage of IFP products through Bright HealthCare at the end of 2022.

• ***Medicare Advantage —*** Bright HealthCare offers Medicare Advantage plans to approximately 125,000lives as of December 31, 2022. Bright HealthCare has focused its Medicare Advantage business for 2023 on the California market, exiting other states as a Medicare Advantage insurer at the end of 2022.

Through these diversified businesses, we believe we are able to align consumer, provider, and payor interests, creating localized, high-performing, value-based systems of care where everybody wins.

OUR COMPETITIVE ADVANTAGES

We Believe We Have a Differentiated Business Model That Integrates the Delivery and Financing of Healthcare. Unlike the traditional relationship between payors and providers, our aligned model brings together the delivery and financing of healthcare. Our Bright HealthCare products healthcare to create a seamless, more coordinated care experience for consumers. We are designed in close collaboration with focused on uniquely aligning the interests of health consumers, providers, and payors though our delegated partners to ensure financial incentives which reward value-driven, consumer-centric care model that lowers total cost of care, reduction, optimizes clinical outcome optimization, outcomes and creates a better consumer experience, enhancement maximizing value for all.

We Serve a Diverse Customer Base. We are not limited to serving one population or specific set of needs. We are committed to making high-quality healthcare accessible and affordable to all populations across the ACA Marketplace, Medicare, and Medicaid. We adapt our care model to meet patients where they are no matter their circumstance.

We Believe Our Approach to Patient Engagement Drives Optimal Care. We are committed to supporting our patients with inclusive, proactive, and informed care. Core to this is our differentiated approach to patient engagement as well as the personalized touchpoints we provide throughout the healthcare journey. We build a trusted relationship with our patients early in place. Our Consumer Care segment partners with external payors who believe in managing care under value-based arrangements. their healthcare journey so we can understand their specific needs and deliver a personalized, consumer-centric healthcare experience that leads to better health outcomes at a lower cost.

We Have a Purpose-Built, Consumer Deep Understanding of Local Markets and Provider Technology Platform. **the Patients We Serve.** Our technology approach to transforming healthcare is purpose-built local. We have strong experience and a deep commitment to support all key stakeholders the communities we serve, developing partnerships with providers and payors to address the underlying consumers' holistic needs beyond their current condition, but considering environmental, social, and economic factors as well.

We Have a Flexible Model with the Ability to Meet the Needs of Any Provider. Our value-driven model is flexible to meet the needs of providers across the spectrum of performance-based arrangements.We adapt and tailor our suite of enablement services to drive differentiated results for our provider partners whether they are new to performance-based payment models or have a history of participating in healthcare delivery. We believe our proprietary technology platform provides value-based care. Our adaptable model allows us to form deep relationships with providers to enable the first truly consumer-centric healthcare platform designed to bridge healthcare enablement and delivery and bring a connected experience to consumers and their care teams. of high-quality, affordable healthcare.

***We Have a Seasoned Management Team Built for Scale*.** Our executive leadership team has extensive experience leading multi-billion multibillion dollar organizations across a wide range of industries, from healthcare to consumer retail to technology. organizations. Our team has a proven track record of growing organizations and leading large, publicly traded enterprises. We believe our team's experience in navigating through different healthcare regulatory regimes positions us to be able to adapt quickly as needed, scale our business model, and drive continued success in any political or regulatory environment.

***We Have a Multi-Pronged Growth Strategy*.** We believe our growth will be driven by a mix of different channels across both the payor and provider landscape. We are in fast growing healthcare markets for aging and underserved consumer populations, with opportunities for overall market growth and gaining market share. Each future expansion in each of our segments and business lines has segments. We have opportunities to bring our services to new consumers growing and grow our partnerships relationships with our payor and provider partners.

GROWTH STRATEGIES

Bright Health's NeueHealth's alignment model allows us to pursue additional growth through the following avenues, aligned around the integration of delivery, financing, and optimization of care. avenues:

- ***Increase Membership in Existing Markets*.** We plan to continue to drive membership growth through greater consumer awareness of our brand and our ability to deeply align and integrate with our delegated partners in our Senior Managed Care business. In addition, we plan to expand the relationships we have with our payor partners in the Consumer Care business, growing the core markets we serve through capacity and service expansions, accretive tuck-in clinic acquisitions, membership we are managing on behalf of those partners. growth initiatives and new partnerships.

- ***Expand Our Care Delivery Footprint*.** We plan to add build on longstanding relationships with existing payor partners as well as prioritize growth with new payor contracts payors to serve additional more consumers at our existing clinics, while integrating additional services. Additionally, our Our exportable model also affords us valuable opportunities for de novo growth through the addition of new clinics across both existing and future markets.

- ***Take and Support Enable Providers in the Management of Population Health Risk.*** We leverage our actuarial expertise and population health management infrastructure to take population health risk under total cost of care arrangements in close collaboration with our Care Partners. provider partners. In addition, we help our Care Partners provider partners maximize the benefit of value-based arrangements through tools and capabilities that enable high-touch, high-quality care for consumers at a lower total cost.

- ***Participate in Emerging Direct-to-Government Programs*.** We were one of the first participants in these innovative new programs and in 2023, approximately 65,000 62,000 of our value-based consumers are attributable to our ACO Reach businesses. REACH business.

• Introduce New Product Offerings. Leveraging our trusted Care Partner relationships, we are well-positioned to launch new, innovative products within our Consumer Care and Bright HealthCare businesses focused on serving additional segments of the population.

SALES AND MARKETING

We view sales and marketing as a strategic imperative and core differentiator for our products and services. We use data and technology to effectively predict marketing outcomes and constantly improve our campaigns. We market our Bright HealthCare plans through a number of channels including, but not limited to: (1) an extensive network of brokers and field marketing organizations, (2) direct to the consumer, and (3) our Care Partner relationships. We support these organizations with in-house advertising, sales collateral, and other materials. Our sales representatives, as well as independent brokers and agents, earn commissions based on applications submitted and plans effectuated.

We market the services within our Consumer Care business using sophisticated technology and data resources to target and engage consumers in tight partnership with our payor partners. Using zip+4, we deliver our advertising content to the right audiences across expanded geographic areas. We employ message testing to identify core messages that drive our performance. Consumer Care delivers these messages through all media channels including display, search, digital video, audio, direct mail, telesales and materials in provider offices.

COMPETITION

The market for personalized care delivery and health insurance products and plans provider enablement is highly competitive. Our industry involves evolving regulatory requirements and changing consumer preferences and demands and requires us to develop new product offerings at competitive prices adapt accordingly in order to effectively successfully compete. See "Risk Factors – Risks Related to Our Business – We operate in competitive markets within a highly competitive industry" for additional discussion of our risks related to competition."

Our principal competitors vary considerably in type and identity by each market. Our Consumer Care business competes We compete with other provider enablement companies, as well as medical groups in the markets in which we operate clinics. Our competitors include MSOs, IPAs, managed service organizations ("MSOs"), independent physician associations ("IPAs"), and other organizational providers of primary care services, such as Agilon Health, Inc. ("Agilon Health"), Cano Health, Inc. ("Cano Health"), ChenMed LLC ("ChenMed"), Iora Health, Inc., Oak Street Health, Inc. ("Iora Health"), OptumHealth of UnitedHealth Group Incorporated ("OptumHealth"), and Village Practice Management Company, LLC (VillageMD) ("VillageMD"). Our Consumer Care business We also competes compete with other participants in the Medicare Shared Savings Program and other programs designed to bring value-based care to fee-for-service Medicare beneficiaries.

Our Bright HealthCare business currently faces competition from a range of companies, including other health plans, many of whom are developing their own technology or partnering with third-party technology providers to drive improvements in care. Our competitors in this segment include large, national insurers, such as Aetna, Inc., Anthem, Inc., Humana Inc., Molina Healthcare, Inc., UnitedHealthcare of UnitedHealth Group Incorporated and others. These companies are more established and have greater financial resources than we do, and each of them provides products that compete with ours in the markets where we operate. Other competitors include regionally-focused payors such as Blue Cross Blue Shield licensees, Kaiser Permanente and other provider-sponsored health plan organizations. These companies have significant regional market share, making competition in those geographies more difficult. Our competitors also include recent market entrants such as Alignment Healthcare, Inc. and others. These companies utilize disruptive models and other approaches to increase consumer engagement and grow their market share.

To effectively compete, and better engage with consumers, we believe we must offer a compelling and affordable range of products and services, as well as increased access to high-quality, affordable healthcare that is tailored to meet the needs of all consumers, no matter their circumstance. We are committed to supporting our patients with inclusive, proactive, and informed care, providers. building a trusted relationship with each patient, and providing personalized touchpoints throughout the healthcare journey. In addition, we our suite of services and capabilities positions providers to thrive in performance-based arrangements and capture the full benefits of value-based care. We aim to provide excellent customer service,align the interests of stakeholders across the healthcare ecosystem, including providers, health consumers, and payors, in order to create a seamless, onboarding more coordinated healthcare experience ready access to our Care Partners and their medical personnel, and tools to assist in our consumers' understanding of their healthcare benefits.

We differentiate our products and services on the basis that managed care, when built maximizes value for and embedded within the delivery system, drives better outcomes. all. We believe in our ability to align the financing and delivery of care while maintaining agility to constantly evolve our model to better serve our consumers.

RESEARCH AND DEVELOPMENT

Our product and engineering teams focus on constantly refining and improving our technology platform, which connect our consumers with their providers. We leverage the data generated by our platform to better assess specific consumer needs and to guide towards future innovation. We continue to devote significant resources to further develop, expand and upgrade our platform to enhance consumer experience and enable an integrated, aligned healthcare ecosystem.

INTELLECTUAL PROPERTY

Our continued growth and success depend, in part, on our ability to protect our intellectual property and internally developed technology, including BiOS and Panorama. technology. We primarily protect our intellectual property through a

combination of copyrights, trademarks and trade secrets, and contractual rights (including confidentiality, non-disclosure and assignment-of- invention assignment-of-invention agreements with our employees, independent contractors, consultants and relevant companies with which we conduct business). We have applied for, and in many instances, obtained registration in the U.S. for a number of trademarks, including Bright Health, NeueHealth, and Physicians Plus. trademarks. We pursue trademark registrations to the extent management believes doing so would be the most appropriate and effective means of protecting our brands.

We are not presently a party to any legal proceedings relating to intellectual property that, in the opinion of our management, would individually or taken together have a material adverse effect on our business, financial condition, results of operations or cash flows.

However, our efforts to protect and maintain our intellectual property rights may not prevent others from competing with us, or from infringing our intellectual property rights. We may be unable to obtain, maintain or enforce our intellectual property rights, and assertions by third parties that we violate their intellectual property rights could have a material adverse effect on our business, financial condition and results of operations. See "Risk Factors – Risks Related to Our Business – Protecting our intellectual property rights may be expensive and demand management's attention, and failure to protect or enforce our intellectual property rights could harm our business and results of operations" and "Risk Factors–

Risks Related to Our Business — In the future, we may be subject to claims that we violated intellectual property rights which can be costly to defend and could require us to pay significant damages and limit our ability to operate."

GOVERNMENT REGULATION

The provision of healthcare services and the marketing and sale of insurance products and plans is a heavily regulated industry. Our business is governed by comprehensive federal, state, and local laws and regulations, including those relating to the healthcare industry, the insurance industry, and state and federal privacy and data security laws. laws, and laws regarding the direct provision of healthcare and related services to consumers. Our Consumer Care business is subject to various standards relating to, among other things, the provision of healthcare services and licensing requirements. Our Bright HealthCare business is subject to, among other things, laws requirements, pharmacy care services, and regulations governing our marketing and advertising activities in states which require prior review of our marketing collateral. As a provider of health plan products in one or more states, durable medical equipment. In some cases, we are required to apply for, comply with, and maintain various licenses and approvals and we are subject to frequent audits of our financial soundness and operational compliance with the respective laws and regulations. The laws and regulations applicable to our business continue to change and evolve over time. Current proposals and directives to change or modify the implementation of such laws and regulations, whether legislative, regulatory, or in the form of executive orders, create areas of uncertainty and, if such proposals are enacted, the potential for material adverse impacts on our business.

HIPAA and Privacy and Security Laws

We are subject to federal and state laws and regulations that protect the use and disclosure of patient and other personal, sensitive or regulated data. These include the Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health Act, each as amended, and the regulations that implement these laws (collectively "HIPAA"), which created privacy and security standards that limit the use and disclosure of protected health information referred to as PHI. ("PHI"). HIPAA governs the use and disclosure of PHI and requires covered entities, which include health plans and healthcare providers who transmit health information electronically in connection with certain transactions, and their business associates to implement and maintain administrative, physical and technical safeguards to ensure the confidentiality, integrity and availability of individually identifiable health information. In addition, HIPAA imposed obligations on covered entities and business associates with respect to the use and disclosure of PHI, including requirements for written agreements known as business associate agreements and breach notification requirements.

Covered entities must notify affected individuals of breaches of unsecured PHI without unreasonable delay but no later than 60 days after discovery of the breach, and such timelines are generally shortened under state law obligations and contractual provisions. Reports must be made to the HHS Department of Health and Human Services Office for Civil Rights and, for breaches of unsecured PHI involving more than 500 residents of a state or jurisdiction, to the media. Various state laws and regulations may also require us to notify affected individuals in the event of a data breach involving personal information. If we experience a breach under HIPAA or state laws, we may be subject to fines, penalties or other regulatory action, and we may face class action or other lawsuits from customers or individuals impacted by the breach. See "Risk Factors – - Risks Related to Our Business – - Security incidents or breaches, loss of data and other disruptions to our or our third-party service providers' systems, information technology infrastructure, and networks could compromise sensitive or legally protected information related to our business or consumers, disrupt our business operations, and expose us to liability, which could adversely affect our business and our reputation" and "Risk Factors – - Risks Related to Legal Proceedings and Governmental Regulations – - Our use and disclosure of PII and PHI is subject to federal and state privacy and security regulations, and our

failure to comply with those regulations or to adequately secure the information we hold could result in significant liability or reputational harm and, in turn, a material adverse effect on our client based base and revenue."

Violations of HIPAA may result in civil or criminal penalties, enforcement actions, settlement payments, resolution agreements, and other sanctions. Further, state attorneys general may bring civil actions seeking either injunctions or damages in response to violations of HIPAA that threaten the privacy of state residents and may also negotiate settlements for related cases on behalf of their respective residents. There can be no assurance that we will not be the subject of an investigation (arising out of a reportable breach incident, audit or otherwise) alleging noncompliance with HIPAA. While HIPAA does not create a private right of action allowing individuals to sue us in civil court for violations of HIPAA's requirements, its standards have been used as a basis for the duty of care in state civil suits, such as those for negligence or recklessness in the handling, misuse or breach of PHI. Any such penalties or lawsuits could harm our business, financial condition, results of operations and prospects.

In addition to HIPAA, numerous state and federal laws and regulations govern the collection, dissemination, use, privacy, confidentiality, security, availability, integrity, creation, receipt, transmission, storage, and other processing of PHI and other personally identifiable information ("PII"). Privacy and data security laws and regulations are often uncertain, contradictory and subject to change or differing interpretations. For example, HHS the Department of Health and Human Services has also proposed new regulations on patient

access to PHI and substance use disorder records and issued guidance on the use of tracking technologies. The complex, dynamic legal landscape regarding privacy, data protection and

information security creates significant compliance challenges for us, potentially restricts our ability to collect, use and disclose data, and exposes us to additional expense, and, if we cannot comply with applicable laws in a timely manner or at all, adverse publicity, harm to our reputation, and liability.

States are beginning to adopt have adopted additional requirements, including California, which is one of our largest markets, where the California Consumer Privacy Act ("CCPA") took effect on January 1, 2020. The CCPA requires covered businesses to provide certain notices and disclosures to California residents, and also gives California residents rights to opt-out of selling their personal information, and to exercise rights such as obtaining access to and requesting deletion of their personal information. The CCPA allows for certain civil penalties for violations, as well as private rights of action for data breaches under certain circumstances. Additionally, the California Privacy Rights Act ("CPRA"), which further expanded the CCPA with additional data privacy compliance requirements that may impact our business, and established a regulatory agency dedicated to enforcing those requirements which took effect on January 1, 2023. Other states have passed their own comprehensive consumer privacy laws that have taken effect, and still other states are considering passing comparable or more restrictive legislation, with comparable or greater penalties for non-compliance, and such requirements could negatively impact our business. See "Risk Factors – Risks Related Recently, several states have enacted broadly applicable laws to Our Business – Our protect the privacy of personal health information. These laws generally require consent for the collection, use or sharing of any "consumer health data", which is defined as personal information that is linked or reasonably linkable to a consumer and disclosure of PII and PHI is subject to federal and state privacy and security regulations, and our failure to comply with those regulations that identifies a consumer's past, present, or to adequately secure the information we hold could result in significant liability future physical or reputational harm and, in turn, a material adverse effect on our client base and revenue." mental health. Additionally, companies that we interact with, such as payors and, Care Providers, have increasingly stringent expectations relating to privacy and security protections for PHI and other PII. We have incurred, and may incur in the future, significant costs to develop new processes and procedures to comply with evolving privacy and security laws, regulations and expectations of third parties. Violations of privacy and security laws and regulations, or of contractual obligations relating to privacy and data security, may result in significant liability and expense, damage to our reputation, or termination of our relationships with government-run health insurance exchanges and payors, our consumers, Care Providers and other important partners.

In addition, we have entered, and will continue to enter, into contracts with third-party service providers and others under which they will engage in the collection, maintenance, protection, use, transmission, disclosure and disposal of the sensitive personal information of our consumers and for which we will remain primarily responsible. We must ensure that each of these parties is strictly following all applicable rules and regulations and implement audit procedures that will ensure full compliance therewith.

Federal consumer protection laws may also apply in some instances to our privacy and security practices related to personally identifiable information. The Federal Trade Commission ("FTC") and many state attorneys general are interpreting existing federal and state consumer protection laws to impose evolving standards for the collection, storage, processing, use, retention, disclosure, transfer, disposal and security of information about individuals, including health-related information, and to regulate the presentation of website content. The FTC has become increasingly aggressive in prosecuting certain data breach cases as unfair and deceptive acts or practices under the FTC Act and has charged companies with violating this act based on failures to appropriately and transparently safeguard personal information and respect consumers' privacy rights and based on disclosures of health and personal information to third parties, the failure to

limit third-party use of health information, the failure to implement policies and procedures to prevent the improper or unauthorized disclosure of health information, and the failure to provide notice and obtain consent before the use and disclosure of health information for advertising. Courts may also adopt the standards for fair information practices promulgated by the FTC, which concern consumer notice, choice, security and access. Consumer protection and other laws require us to inform our consumers how we handle their PII and the choices which consumers may have about how we collect, handle, share, and secure PII. If such information that we share with our consumers is found to be untrue, we We could be subject to government claims of unfair or deceptive trade practices, which could lead to significant liabilities and consequences. For information that is not subject to HIPAA and deemed to be "personal health records", the FTC may also impose penalties for violations of the Health Breach Notification Rule ("HBNR") to the extent we are considered a "personal health record-related entity" or "third party service provider." The FTC has taken several enforcement actions under HBNR and indicated that the FTC will continue to protect consumer privacy through greater use of the agency's enforcement authorities. As a result, we expect scrutiny by federal and state regulators and others of our collection, use and disclosure of health information.

State Regulation Our and our vendors' use of Insurance Companies

We must obtain artificial intelligence ("AI") and maintain machine learning ("ML") technologies may subject us to growing regulatory approvals obligations, including related to sell privacy. There is increasing U.S. regulation of AI and operate specific health plans other similar uses of technology and in the jurisdictions last few months, the Biden Administration, members of Congress, the FTC, and other federal regulators have expressed interest in which we conduct business. The nature regulating AI through executive orders, new legislation, and extent current enforcement authorities, with attention towards reducing claims denial rates. Further, several states and localities have enacted measures related to the use of state regulation varies by jurisdiction, AI and state insurance regulators generally ML in products and services. We may have broad administrative authority with

respect to all aspects of the insurance business. The Model Audit Rule, where adopted by states, requires expanded governance practices, risk and solvency assessment reporting and the filing of periodic financial and operating reports. Most states have adopted these or similar measures to expand the scope of regulations relating to corporate governance and internal control activities of insurance companies. Health insurers are subject to state examination and periodic regulatory approval renewal proceedings. Some of change our business activity is subject practices to other healthcare-related regulations comply with such obligations. For example, our use of generative AI technologies could result in additional compliance costs, regulatory investigations and requirements, including utilization review, pharmacy service, or provider-related regulations actions, and regulatory approval requirements. These requirements differ from state consumer lawsuits. If we are unable to state use generative AI, it could make our business less efficient and may contain network, contracting, product and rate, licensing and financial and reporting requirements. There are result in competitive disadvantages. Depending on how these AI laws and regulations that set specific standards for delivery of services, appeals, grievances, and payment of claims, adequacy of healthcare professional networks, fraud prevention, protection of consumer health information, pricing and underwriting practices, and covered benefits and services. Additionally, certain states are interpreted, we may have laws that prohibit submitting a false claim or making a false record or statement in order to secure reimbursement from an insurance company.

In addition, we are regulated as an insurance holding company and are subject to the insurance holding company laws of the states in which our health insurance subsidiaries are domiciled. These laws and other laws that govern operations of insurance companies contain certain reporting requirements, as well as restrictions on transactions between an insurer and its affiliates, and may restrict the ability of our health insurance subsidiaries to pay dividends make changes to our holding companies. Under New York law, for example, Bright Health Insurance Company of New York, our New York-domiciled insurance subsidiary, may not declare or distribute a dividend to shareholders except out of earned surplus (as defined under New York law). Additionally, absent prior approval of the Superintendent of the Department of Financial Services (the "Superintendent"), Bright Health Insurance Company of New York may not declare or distribute any dividend to shareholders which, together with all dividends declared or distributed by us during the preceding 12 months, exceeds the lesser of (a) ten percent of Bright Health Insurance Company of New York's surplus to policyholders as shown by its last statement on file with the Superintendent, or (b) one hundred percent of adjusted net investment income (as defined under New York law) during such period. Holding company laws and regulations generally require registration with applicable state departments of insurance and the filing of reports describing capital structure, ownership, financial condition, certain intercompany transactions, enterprise risks, corporate governance, and general business operations. In addition, state insurance holding company laws and regulations generally require notice or prior regulatory approval of certain transactions including acquisitions, material intercompany transfers of assets, and guarantees and other transactions between the regulated companies and their affiliates, including parent holding companies. Applicable state insurance holding company acts also restrict the ability of any person to obtain control of an insurance company without prior regulatory approval. These acts generally define "control" as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person. Some state laws have different definitions or applications of this standard. Dispositions of control generally are also regulated under applicable state insurance holding company laws.

The states of domicile of our health insurance subsidiaries have statutory risk-based capital requirements for insurance companies based on the Risk-Based Capital For Health Organizations Model Act. These risk-based capital requirements are intended to assess the capital adequacy of life and health insurers, taking into account the risk characteristics of a company's investments and products. In general, under these laws, an insurance company must submit a report of its risk-based capital level to the insurance regulator of its state of domicile each calendar year. These laws typically require increasing degrees of regulatory oversight and intervention if a company's risk-based capital declines below certain thresholds. As of December 31, 2022, the risk-based capital levels of certain of our insurance subsidiaries failed to meet or exceed applicable mandatory risk-based capital requirements, and as a result such subsidiaries are or may be subject to

supervision orders under state insurance laws.Such supervision orders require additional reporting as well as approval of certain transactions by our regulators.

Further, almost all states require insurers practices to comply with the standards set forth in the Model Audit Rule, which imposes financial reporting, independent audit, and corporate governance requirements.

Additionally, as a company that directly or indirectly controls insurers, we have an obligation such obligations. These obligations may make it harder for us to adopt a formal enterprise risk management function and file enterprise risk reports on an annual basis. The enterprise risk management function and reports must address any activity, circumstance, event, or series of events involving the insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer, including anything that would cause the insurer's risk-based capital to fall below certain threshold levels or that would cause further transaction of business to be hazardous to policyholders or creditors, or the public. Similarly, in accordance with National Association of Insurance Commissioners' Risk Management and Own Risk Solvency Assessment Model Act, we must complete an annual "own risk and solvency assessment," which is an internal assessment, appropriate to the nature, scale, and complexity of our company, of the material and relevant risks associated with the current business plan, and of the sufficiency of capital resources to support those risks.

Healthcare Reform

The U.S. Congress and certain state legislatures have introduced and passed a large number of proposals and legislation designed to make major changes in the healthcare system, including changes that have impacted access to health insurance. The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 ("ACA") significantly increased oversight of health plans and reformed healthcare in the United States, including how healthcare services are covered, delivered, and reimbursed. Since then, there have been political and legal efforts to expand, repeal, replace, and modify the ACA. Federal regulatory agencies continue to modify regulations and guidance related to the ACA and markets more broadly, often as a result of presidential directives. We cannot predict how healthcare consumers might react to special or extended enrollment periods or to federal or state legislation and regulation, whether already enacted or enacted in the future. For example, the American Rescue Plan Act of 2021, temporarily increased the amounts of premium tax credits, temporarily expanded eligibility for premium tax credits for unemployment compensation beneficiaries who receive such compensation in 2021, and expanded eligibility for Advance Premium Tax Credits ("APTCs") for households with annual incomes above 400% of the federal poverty level. The Inflation Reduction Act extended the APTCs through the end of 2025. While we anticipate continued changes with respect to the ACA, either through Congress, court challenges,

executive actions, or administrative action, we expect the major portions of the ACA to remain in place and continue to significantly impact conduct our business operations and results of operations, including pricing, minimum medical loss ratios and the geographies in which our products are available.

The ACA prohibits annual and lifetime limits on essential health benefits, consumer cost-sharing on specified preventive benefits, and pre-existing condition exclusions. Further, the ACA implemented certain requirements for insurers, including changes using AI/ML, lead to Medicare Advantage payments and the minimum medical loss ratio ("MLR") provision that requires insurers to pay rebates to consumers when insurers do not meet regulatory fines or exceed the specified annual MLR thresholds. In addition, the ACA required a number of other changes with significant effects on both federal and state health insurance markets, including strict rules on how health insurance is rated, what benefits must be offered, the assessment of new taxes and fees (including annual fees on health insurance companies), the creation of public Health Insurance Marketplaces for individuals and small employer group health insurance and the availability of premium subsidies for qualified individuals. The ACA allows individual states to choose to enact additional state-specific requirements that extend ACA mandates and some of the states where we operate have implemented higher MLR percentage requirements, lower tobacco user rating ratios, and different age curve variations. Changes to our business environment are likely to continue as elected officials at the national and state levels continue to enact, and both elected officials and candidates for election continue to propose, significant modifications to existing laws and regulations, including changes to taxes and fees. Also, although the U.S. Supreme Court's 2021 decision preserved the ACA in its current form, legal challenges regarding the ACA could have a material adverse effect on our business, cash flows, financial condition, and results of operations.

Further, the ACA increases oversight responsibilities imposed on health insurers that may result in increased governmental audits, increased assertions of alleged liability under the federal False Claims Act ("FCA"), and an increased risk of other litigation.

Other health reform initiatives, requirements and proposals, including requirements aimed at price transparency and out-of-network charges, may impact prices, our competitive position, and our relationships with patients, insurers, and ancillary

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providers (such as anesthesiologists, radiologists, and pathologists). For example, the No Surprises Act imposes new limitations and prohibitions on surprise billing and requires providers to send an insured patient's health plan a good faith estimate of expected charges, including billing and diagnostic codes, prior to when the patient is scheduled to receive the item or service. As another example, the Transparency in Coverage rule issued in 2020 by the HHS, the DOL and the Department of the Treasury requires most group health plans and health insurance issuers in the individual and group markets to publicly disclose price and cost-sharing information for all items and services to participants and enrollees. Health plans and health insurers must publicly disclose (i) in-network provider negotiated rates, and (ii) historical out-of-network allowed amounts and billed charges. In 2023, we will be required to make available to members personalized cost-sharing information for 500 covered health care items and services. In 2024, this cost-sharing information requirement will expand to all items and services, including prescription drugs. Insurers offering group or individual health insurance coverage may receive credit in their MLR calculations for certain savings they share with enrollees that result from the enrollees shopping for, and receiving care from, lower-cost, higher-value providers. Other industry participants, such as private payors and large employer groups and their affiliates, may also introduce financial or delivery system reforms. We are unable to predict the nature and success of such health reform initiatives, which may have an adverse impact on our business.

Additionally, there is the potential for changes due to health reform efforts at the state level. Some states have imposed individual health insurance mandates, and other states have explored or offer public health insurance options. Some reforms may have a positive impact on our business, while others may increase our operating costs, adversely impact the reimbursement we receive, or penalties, require us to modify certain aspects retrain our AI/ML, or prevent or limit our use of our operations.

While there may be significant changes to the healthcare environment in the future, the specific changes and their timing are not yet apparent. Any failure to successfully implement strategic initiatives that respond to future legislative, regulatory, and executive changes could have a material adverse effect on our business, results of operations and financial condition.

CMS Guidelines

Our Bright HealthCare segment is subject to regulations and guidelines issued by CMS and state departments of insurance that put numerous requirements on insurance payors, agents and brokers during the marketing and sale of MA and IFP plans. CMS and state insurance department regulations and guidelines include a number of prohibitions regarding the ability to contact Medicare-eligible individuals and restrictions on the marketing of Medicare-related plans. For example, our IFP and MA plans must file certain information with CMS and state departments of insurance such as sales scripts and marketing materials for our Medicare plans. In some circumstances, CMS or state departments of insurance must provide pre-approval for those marketing materials. The rules, laws, regulations and guidance around the marketing and sale of IFP and MA plans are complicated and frequently change.

We are also subject to CMS review of our compliance with CMS contracts, the performance of our plans, adherence to governing rules and regulations, and the quality of care we provide to Medicare beneficiaries, among other areas. A portion of each MA plan's reimbursement is tied to the plan's Star Ratings system, which awards between 1.0 and 5.0 stars to MA plans based on a variety of performance measures adopted by CMS, including quality of preventative services, chronic illness management, compliance and overall consumer satisfaction. None of our plans achieved an overall 4.0 Star Rating in 2022, which is required to obtain significant quality bonus payments and could materially impact our financial performance. Medicare Advantage plans with an overall Star Rating of 4 or more stars are eligible for a quality bonus in their basic premium rates. Our inability to improve our Star Rating could limit the benefits that our plans can offer, which could materially and adversely affect the marketability of our plans, our membership levels, results of operations, financial position and cash flows. CMS may modify the methodology and measures included in the Star Ratings system. Our ability to improve our Star Rating has been adversely impacted by the ongoing COVID-19 pandemic, which has prevented plans from encouraging conduct to address consumer care gaps and collecting information required

to demonstrate plan compliance with and performance on Star Rating metrics. There can be no assurances that we will be successful in maintaining or improving our Star Ratings in future years, and our Medicare Advantage plans may not become eligible for full level quality bonuses.AI/ML.

Corporate Practice of Medicine and Fee-Splitting Laws

Our Consumer Care segment includes direct medical service providers and, as such, are subject to additional laws and regulations. Some states have corporate practice of medicine laws that prohibit specific types of entities from practicing medicine, preventing unlicensed persons from interfering with or influencing a physician's professional judgment or

employing physicians to practice medicine. Although we have structured our operations to comply with our understanding of applicable state statutory and regulatory requirements, interpretative legal precedent and regulatory guidance varies by jurisdiction and is often sparse and not fully developed. The consequences associated with violating corporate practice of medicine laws vary by state and may result in physicians being subject to disciplinary action, as well as to forfeitures of

revenue from government payors for services rendered. For lay entities, violations may also bring both civil and, in more extreme cases, criminal liability for engaging in the practice of medicine without a license. Some of the relevant laws, regulations, and agency interpretations in states with corporate practice of medicine restrictions have been subject to limited judicial and regulatory interpretation. In limited cases, courts have required companies to divest or reorganize structures deemed to violate corporate practice restrictions. In the event that regulatory authorities or other third parties were to challenge these arrangements, we could be subject to adverse judicial or administrative interpretations, to civil or criminal penalties, our contracts could be found legally invalid and unenforceable or we could be required to restructure our arrangements with our care providers. A determination that we are in violation of applicable laws and regulations in any jurisdiction in which we operate could have a material adverse effect on our business, particularly if we are unable to restructure our operations and arrangements to comply with the requirements of that jurisdiction, if we are required to restructure our operations and arrangements at a significant cost, or if we are subject to penalties or other adverse action. Additionally, certain states prohibit certain entities from engaging in fee-splitting practices that involve sharing in the fees or revenue with a professional practice. These prohibitions can be either statutory or regulatory, or may be imposed through judicial interpretation, and are subject to change.

Licensing and Telehealth Laws

Our care providers must be licensed to practice medicine in the state in which they are located and must comply with licensing laws and regulations and requirements regarding notification of licensing agencies regarding certain material events. These licensing requirements vary from state to state. In addition to state requirements, we and/or our care providers are in some cases subject to federal licensing and certification requirements, such as certification or waiver under the Clinical Laboratory Improvement Amendments of 1988 for performing limited laboratory testing and Drug Enforcement Administration registration requirements for writing prescriptions for controlled substances. Certain of the states where we currently operate or may choose to operate in the future regulate the operations and financial condition of risk-bearing providers. These regulations can include capital requirements, licensing or certification, governance controls and other similar matters. In addition, our care providers must remain in good standing with the applicable boards of medicine, board of nursing or other applicable regulatory authority, as activities that qualify as professional misconduct under state laws may subject our care providers to sanctions or result in the loss of their licensure. Furthermore, they cannot be excluded, suspended or debarred from participation in certain government programs at either the state or federal levels, such as Medicare and Medicaid.

Failure to comply with federal, state and local licensing and certification laws, regulations and standards could result in a variety of consequences, including the cessation of our services, loss of our contracts, prior payments by government payors being subject to recoupment, requirements to make significant changes to our operations, or civil or criminal penalties. We routinely take the steps we believe are necessary to retain or obtain all requisite licensure and operating authorities. While we endeavor to comply with federal, state, and local licensing and certification laws and regulations and standards as we interpret them, the laws and regulations in this area are complex, changing, and often subject to varying interpretations. Any failure to satisfy applicable laws and regulations could have a material adverse impact on our business, results of operations, financial conditions, cash flows and reputation.

Additionally, states generally require providers of professional healthcare services via telehealth to a patient to be licensed in that state where the patient is physically located at the time services are rendered. States have established a variety of licensing and other regulatory requirements around the provision of telehealth services. We have established systems for ensuring that our providers are appropriately licensed under applicable state laws and that their provision of telehealth occurs in each instance in compliance with applicable laws and regulations governing telehealth. Failure to comply with these laws and regulations could result in licensure actions against the providers as well as civil, criminal or administrative penalties against the providers and/or those engaging the services of the provider.

The Anti-Kickback Statute, Federal False Claims Laws and Stark Law

Our products and services are subject to federal and state anti-kickback laws, false claims acts ("FCA"), and other laws related to reimbursement by government programs. A federal law commonly referred to as the "Anti-Kickback Statute" prohibits the offer, payment, solicitation, or receipt of any form of remuneration to induce, or in return for, the referral of Medicare or

other governmental health program patients or patient care opportunities or in return for the purchase, lease, or order of items or services, or arranging for or recommending the purchase, lease or order of any good, facility, item or service that are covered by Medicare or other federal governmental health programs. The federal Anti-Kickback Statute has been interpreted to apply to, among others, financial arrangements between entities that have the ability to refer and generate business that is subject to healthcare reimbursement. Accordingly, the Anti-Kickback Statute applies to both our Bright HealthCare and Consumer Care segments. Sanctions for violating federal and state anti-kickback laws may include criminal and civil fines and exclusion from federal and state healthcare programs. While there are a number of statutory exceptions and regulatory safe harbors protecting some common activities from prosecution, the exceptions and

safe harbors are drawn narrowly and practices that involve remuneration may be subject to scrutiny if they do not qualify for an exception or safe harbor. Our practices may not always meet all of the criteria for protection under a statutory exception or regulatory safe harbor. A person or entity does not need to have specific intent or knowledge to violate in order to have committed a violation, and a claim including an item or a service resulting from a violation of the federal Anti-Kickback Statute constitutes a false or fraudulent claim for purposes of the FCA described below.

The federal false claims laws, including the civil FCA, among other things, impose criminal and civil penalties against individuals or entities for knowingly presenting, or causing to be presented, to the federal government, claims for payment or approval that are false or fraudulent, for knowingly making, using or causing to be made or used, a false record or statement material to a false or fraudulent claim, or for knowingly making or causing to be made a false statement to avoid, decrease or conceal an obligation to pay money to the federal government. There has been increased government scrutiny on health insurers' diagnosis coding and risk adjustment practices, particularly for Medicare plans. We are and may be subject to audits, reviews and investigation of our practices and arrangements and the federal government might conclude that they violate the FCA, the Anti-Kickback Statute and/or other federal and state laws governing fraud and abuse. Further, the FCA can be enforced by private citizens through civil qui tam actions. A claim includes "any request or demand" for money or property presented to the U.S. government.

In addition, Section 1877 of the Social Security Act (the "Stark Law") prohibits physicians, subject to certain exceptions described below, from referring Medicare or Medicaid patients to an entity providing "designated health services" in which the physician, or an immediate family member, has an ownership or investment interest or with which the physician, or an immediate family member, has entered into a compensation arrangement. Certain We provide certain services provided by our Consumer Care business that qualify as "designated health services." Persons or entities found to be in violation of the Stark Law are subject to denial of payment for services furnished pursuant to an improper referral, civil monetary penalties, and exclusion from the Medicare programs. New CMS and OIG final regulations on Anti-Kickback Statute safe harbors and the federal Stark Law took effect in 2021 and 2022, and we continue to evaluate what effect, if any, the rule will have on our business.

Many states have enacted similar laws to combat the issues covered by the Anti-Kickback Statute, federal false claims laws and the Stark Law, which may provide for criminal penalties, fines, and damages and can apply more broadly than just those services paid for by Medicare or Medicaid. In addition, most states have statutes, regulations and professional codes that can restrict our Care Partners from accepting various kinds of remuneration in exchange for making referrals. These laws vary widely from state to state.

We believe that our segments' operations comply with the Anti-Kickback Statute, the FCA, the Stark Law, and similar federal or state laws addressing fraud and abuse. These laws are subject to modification and changes in interpretation and are enforced by authorities vested with broad discretion. We continually monitor developments in these regulatory areas, and we must operate our business within the requirements of these laws. If these laws change or are interpreted in a manner contrary to our current interpretation or are reinterpreted, or if new legislation is enacted with respect to healthcare fraud and abuse, illegal remuneration, or similar issues, we may be required to modify our operations or policies to maintain compliance with such laws. There can be no assurances that any such modification will be possible or, if possible, would not have a material adverse effect on our results of operations, financial position, or cash flows. Violations of any of these laws may result in potentially significant penalties, including criminal and civil and administrative penalties, damages, fines, disgorgement, imprisonment, exclusion from participation in government healthcare programs, contractual damages, reputational harm, administrative burdens, diminished profits and future earnings, and the curtailment or restructuring of our operations.

Civil Monetary Penalties Statute

The federal Civil Monetary Penalties Statute authorizes the imposition of civil monetary penalties, assessments and exclusion against an individual or entity based on a variety of prohibited conduct, including, but not limited to:

- offering remuneration to a federal healthcare program beneficiary that the individual or entity knows or should know is likely to influence the beneficiary to order or receive healthcare items or services from a particular provider;
- arranging contracts with or making payments to an entity or individual excluded from participation in the federal healthcare programs or included on CMS's preclusion list; and
- failing to report and return an overpayment owed to the federal government.

We could be exposed to a wide range of allegations to which the federal Civil Monetary Penalty Statute would apply. We perform monthly checks on our employees and certain affiliates and vendors using government databases to confirm that these individuals have not been excluded from federal programs or otherwise ineligible for payment. We have also implemented processes to ensure that we do not make payments to providers listed on CMS's preclusion list nor make payments for drugs prescribed by individuals on the preclusion list. However, should an individual or entity be excluded on the preclusion list, or otherwise ineligible for payment and we fail to detect it, a federal agency could require us to refund amounts attributable to all claims or services performed or sufficiently linked to such individual or entity. Due to this area of risk and the possibility of other allegations being brought against us, we cannot foresee the possibility it is possible that we could face allegations subject to the Civil Monetary Penalty Statute with the potential for a material adverse impact on our business, results of operations and financial condition.

State Regulation of Insurance Companies

Although we exited the commercial health insurance business at the end of the 2022 plan year, we are still completing the run-out and wind down of this business and are required to continue to comply with certain state insurance regulations. While we exited the commercial market in 2023, we must maintain the specified levels of statutory capital and surplus throughout an extended run out period.

The nature and extent of state regulation varies by jurisdiction, and state insurance regulators generally have broad administrative authority with respect to all aspects of the insurance business. Most states have adopted rules governing corporate governance, financial reporting, and internal control activities of insurance companies.

In addition, during the run-out period, we continue to be regulated as an insurance holding company and are subject to the insurance holding company laws of the states in which our remaining health insurance subsidiaries are domiciled. These laws and other laws that govern operations of insurance companies contain certain reporting requirements, as well as restrictions on transactions between an insurer and its affiliates, and may restrict the ability of our health insurance subsidiaries to pay dividends to our holding company.

The states of domicile of our remaining health insurance subsidiaries have statutory risk-based capital requirements for insurance companies based on the Risk-Based Capital For Health Organizations Model Act. These risk-based capital requirements are intended to assess the capital adequacy of life and health insurers, taking into account the risk characteristics of a company's investments and products. In general, under these laws, an insurance company must submit a report of its risk-based capital level to the insurance regulator of its state of domicile each calendar year. These laws typically require increasing degrees of regulatory oversight and intervention if a company's risk-based capital declines below certain thresholds. As of December 31, 2023, the risk-based capital levels of certain of our insurance subsidiaries failed to meet or exceed applicable mandatory risk-based capital requirements, and as a result such subsidiaries are or may be subject tosupervision orders under state insurance laws. Such supervision orders require additional reporting as well as approval of certain transactions by our regulators.

Additionally, as a company that directly or indirectly continues to control insurers, we have an obligation to maintain a formal enterprise risk management function and file enterprise risk reports on an annual basis. The enterprise risk management function and reports must address any activity, circumstance, event, or series of events involving the insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer, including anything that would cause the insurer's risk-based capital to fall below certain threshold levels or that would cause further transaction of business to be hazardous to policyholders or creditors, or the public.

Healthcare Reform

The federal and various state governments have made major changes in the healthcare system in recent years, including the ACA. The ACA significantly reformed healthcare in the United States, including how healthcare services are covered, delivered, and reimbursed. Since then, there have been political and legal efforts to expand, repeal, replace, and modify the ACA. Federal regulatory agencies continue to modify regulations and guidance related to the ACA and markets more broadly, often as a result of presidential directives. We cannot predict how government payors or healthcare consumers might react to federal or state legislation and regulation, whether already enacted or enacted in the future. While we anticipate continued changes with respect to the ACA, either through Congress, court challenges, executive actions, or administrative action, we expect the major portions of the ACA to remain in place and may significantly impact the business operations of our payor partners and, as a result, our business operations and results of operations, including pricing, and the geographies in which our products are available.

Other health reform initiatives, requirements and proposals may impact prices, our competitive position, and our relationships with patients, payors, and ancillaryproviders (such as anesthesiologists, radiologists, and pathologists). For example, the No Surprises Act imposes new limitations and prohibitions on surprise billing and requires providers to send an insured patient's health plan a good faith estimate of expected charges, including billing and diagnostic codes, prior to when the patient is scheduled to receive the item or service.

While there may be significant changes to the healthcare environment in the future, the specific changes and their timing are not yet apparent. Any failure to successfully implement strategic initiatives that respond to future legislative, regulatory, and executive changes could have a material adverse effect on our business, results of operations and financial condition.

INDEMNIFICATION AND INSURANCE

Our business exposes us to potential liability including, but not limited to, potential liability for (i) breach of contract or negligence claims by our consumers, (ii) medical malpractice and professional negligence, (iii) non-compliance with applicable laws and regulations, including SEC rules and regulations, and (iv) employment-related claims.

To manage our potential liability, we currently maintain property, general liability, umbrella, managed care errors and omissions, cyber and privacy liability and other coverage in amounts and on terms deemed adequate by management, based on our actual claims experience and expectations for future claims. We procure additional medical liability insurance to manage any potential liability of the affiliated medical groups we work with through our Consumer Care business, and are currently considering an umbrella policy to provide coverage with respect to such potential liability. business. See "Risk Factors – Risks Related to Our Business – Medical liability claims made against us in the future could cause us to incur significant expenses and pay significant damages if not covered by insurance." Our care providers are otherwise required to maintain their own malpractice insurance. Although we consider our insurance coverage to be adequate, the coverage may not be sufficient for all claims made and such claims may be contested by applicable insurance payors.

We also have certain reinsurance arrangements, where the reinsurer assumes a portion of the ceding company's risk in exchange for a corresponding percentage of premiums or in excess of a specified amount. There can be no assurance that we will be able to renew our reinsurance contracts on similar terms, or at all, or that we will be able to negotiate coverage with another reinsurance carrier if we are unable to renew our existing arrangements.

HUMAN CAPITAL MANAGEMENT

We are led by a diverse and talented team of seasoned executives who have extensive experience leading multi-billion multibillion dollar organizations across a wide range of industries, from healthcare to consumer retail, to technology and services. organizations. We employ a deep bench of health insurance healthcare professionals, sales and operations specialists, software engineers and developers, and other subject matter experts. As of December 31, 2022 December 31, 2023, we employed a total of 2,840 1,252 individuals. We believe that our employees are fundamental to the success of our company, and we have built a high-performance environment based on mutual trust, confidence, humility, and inclusion, which provides significant opportunities for our people to grow and be recognized. We work hard to ensure our employees are engaged, and none of our employees are represented by a labor union or party to a collective bargaining agreement.

We have endeavored to create a mission-driven company, with a culture of inclusion, partnership and desire to challenge the status quo. Our values reflect this future-oriented culture of teamwork:

1. **Be Brave.** Challenge the status quo with curiosity, courage and tenacity.
2. **Be Brilliant.** Deliver predictable excellence with a learning mindset.
3. **Be Accountable.** Live by your word, always.

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4. **Be Inclusive.** Value all voices and contributions to achieve big things.
5. **Be Collaborative.** Fearlessly partner with all people.

ADDITIONAL INFORMATION

Our executive offices are located at 8000 Norman Center Drive, 9250 NW 36th St Suite 900, Minneapolis, Minnesota 55437, 420, Doral, Florida 33178, and our telephone number is (612) 238-1321.238-1321.

You can access our website at www.brighthealthgroup.com www.neuehealth.com to learn more about our company. From the site you can download and print copies of our annual reports to stockholders, annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K, along with amendments to those reports. Our reports filed with the SEC also may be found on the SEC's website at www.sec.gov. You can also download from our website our certificate of incorporation and bylaws; Board of Directors Committee Charters; Code of Conduct; and Corporate Governance Guidelines. We make periodic reports and amendments available, free of charge, on our website, as soon as reasonably practicable after we file or furnish these reports to the SEC. We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. The Company may use its website as a distribution channel of material company information. To request a copy of any of the documents listed above, please submit your request to: Bright Health Group, NeueHealth, Inc., 8000 Norman Center Drive, Suite 900, Minneapolis, Minnesota 55437, Attn: Corporate Secretary. Information on or linked to our website is neither part of nor incorporated by reference into this Annual Report or any other SEC filings.

ITEM 1A. RISK FACTORS

Investing in our securities involves a high degree of risk. You should carefully consider the following risk factors together with other information in this Annual Report, including our consolidated financial statements and related notes included elsewhere in this Annual Report, before deciding whether to invest in shares of our common stock. The occurrence of any of the events described below could harm our business, financial condition, results of operations and growth prospects. In such an event, the trading price of our common stock may decline and you may lose all or part of your investment.

Risks Related to Our Business

Although we raised capital in 2022, 2023, based on our projected cash flows and absent any other action, we may will require additional capital, which might not be available on acceptable terms, if at all. If capital is not available to us, our business and financial condition may be impaired, and we may not be able to continue as a going concern.

We have invested heavily in our business. We expect to make additional investments to support our business growth and may require additional capital to respond to business needs, requirements and opportunities, including to develop and enhance new and existing products and services, enter new markets, further develop our infrastructure, and comply with any statutory capital and risk-based capital requirements. In addition, we may continue to make strategic acquisitions as the opportunities arise, some of which may be material to our operations. Accordingly, although we raised capital in 2022, 2023, we may make future commitments of capital resources and may need to engage in additional equity or debt financings to secure additional funds. Whether we issue debt or equity securities will, in part, depend on contractual, legal and other restrictions that may limit our ability to raise additional capital. For example, our our New Credit Agreement contains, (as defined in the *Indebtedness* section of the Results of Operations within Item 7 of this Annual Report) contains, and any agreements governing our future indebtedness could may contain, restrictive covenants relating to our financial and operational matters, including covenants that limit the amount of debt we may incur. In addition, we may not be able to obtain additional or sufficient financing on terms favorable to us, if at all. If we are unable to obtain adequate financing or financing on terms satisfactory to us when we require it, our ability to continue to support our business growth and to respond to business challenges could be significantly limited or impaired.

As previously disclosed, we have The Company has a history of operating losses, and we generated a net loss from continuing operations of $638 million $1.3 billion for the year ended December 31, 2022 December 31, 2023. These losses, as well as significant additional expenses and future projected Additionally, the Company experienced negative operating cash outflows in flows primarily related to our discontinued Bright HealthCare – Commercial segment which has required us for the year ended December 31, 2023, requiring additional cash to infuse additional cash be infused to satisfy statutory capital requirements, have reduced requirements. The Company paid $1.5 billion of 2022 related risk adjustment obligations in September 2023, and certain of its insurance subsidiaries entered into repayment agreements for an aggregate amount of $380.2 million with the Centers for Medicare & Medicaid Services' ("CMS") with respect to the unpaid amount of risk adjustment obligations. The amount owing under the repayment agreements is due March 15, 2025 and bears interest at a rate of 11.5% per annum. As further described in Note 18, Deconsolidation of Bright Healthcare Insurance Company of Texas, on November 29, 2023, Bright Healthcare Insurance Company of Texas was placed into liquidation and the Texas Department of Insurance was appointed as receiver. Of the $380.8 million of risk adjustment repayment liabilities, $89.6 million of this relates to Bright Healthcare Insurance Company of Texas, leaving $291.1 million as a risk adjustment obligation of the Company and is due within one year following the date the consolidated financial statements are issued. The Company's IFP discontinued operations also continue to experience negative cash available flows through the fourth quarter of 2023 as it continues to fund operations. pay out the remaining inventory of medical claims.

In addition, We closed on the sale of our California Medicare Advantage business effective as noted earlier, we breached of January 1, 2024, resulting in net proceeds of $31.6 million after debt repayment of $274.6 million, cash collateralization of existing letters of credit of $24.1 million, contingent consideration of $110.0 million, estimated net equity adjustment of $57.3 million and other transaction related fees. See Note 5, *Short-Term Borrowings* for further details around the minimum liquidity covenant of our debt repayment. Further, as described in Note 6, *Long-Term Borrowings and Common Stock Warrants*, the Company entered into the New Credit Agreement in 2023 and borrowed a total of $66.4 million as of December 31, 2023. While payment isn't due for more than 12 months, there are no additional amounts currently available for borrowing in these agreements.

Cash and investment balances held at regulated insurance entities are subject to regulatory restrictions and can only be accessed through dividends declared to the first quarter non-regulated parent company or through reimbursements from administrative services agreements with the parent company. The Company declared no dividends from the regulated insurance entities to the parent company during the year ended December 31, 2023. The regulated legal entities are required to hold certain minimum levels of fiscal year

2023. We entered into a limited waiver risk-based capital and consent (the "Waiver") under our Credit Agreement, which, among other matters, provides for a temporary waiver for the period from January 25, 2023 through April 30, 2023 surplus to meet regulatory requirements. As noted further in Note 19, *Discontinued Operations*, we are out of compliance with the minimum liquidity covenant set forth levels for certain of our regulated insurance legal entities. In certain of our other regulated insurance legal entities, we hold surplus levels of risk-based capital, and as we

complete the wind-down exercise related to these entities over the next two years, we expect to recapture through dividends and final liquidation actions approximately $110.0 million of cash held in Section 11.12.2 other regulated insurance legal entities as of December 31, 2023.

We believe that the Credit Agreement. Based existing cash on hand and investments will not be sufficient to satisfy our projected anticipated cash flows and absent any other action, requirements for the Company may not meet certain covenants under the Credit Agreement or the Waiver, which may result in the obligations under the Credit Agreement being accelerated. Based on our projected cash flows and absent any other action, we will require additional liquidity to meet our obligations as they come due in the 12 next twelve months following the date of the consolidated financial statements contained in this annual report on Form 10-K.

While we have Annual Report are issued, for items such as IFP risk adjustment payables, medical costs payable, remaining obligation to the deconsolidated entity, and other liabilities. These conditions raise substantial doubt about the Company's ability to continue as a going concern. In response to these conditions, management has implemented a restructuring plan to reduce capital needs and our operating expenses in the future to drive positive operating cash flow and increase liquidity. Additionally, the Company is actively engaged with our the Board of Directors and outside advisors to evaluate financing opportunities, we additional financing. However, the Company may not fully collect the contingent consideration associated with the sale of the California Medicare Advantage business or be able to obtain required financing on acceptable terms, as any potential financing both of these matters will be subject to market conditions that are not fully within our the Company's control. In the event we are the Company is unable to receive the contingent consideration from the sale of our California Medicare Advantage business to obtain additional financing or take other management actions, to alleviate these concerns, among other potential consequences, the Company forecasts we may will be unable to satisfy our financial obligations as they become due or obligations. As a result, the Company has concluded that management's plans do not alleviate substantial doubt about the Company's ability to continue as a going concern.

Our revised business model and associated corporate restructuring and the associated headcount reduction could disrupt our business, may not result in anticipated savings, and could result in total costs and expenses that are greater than expected.

In October 2022, we announced, among other things, that we will focus on delivering affordable healthcare to aging We exited the commercial health care business and underserved populations through our fully aligned care model in Florida, Texas and California, and that we will no longer offer IFP products through Bright HealthCare in 2023, or MA products Medicare Advantage business outside of California. California at the end of 2022, and we ceased conducting our Medicare Advantage business in California on January 1, 2024. As a result of these strategic changes, on November 4, 2022, our Board approved a plan to restructure we have significantly restructured our workforce and reduce reduced expenses based on our updated business model (the "Restructuring"). model.

The Restructuring This restructuring has resulted in the loss of institutional knowledge and expertise, as well as the reallocation and combination of certain roles and responsibilities across the Company, all of which could adversely affect our operations. These effects could have a material adverse effect on our ability to execute on our updated business model. There can be no assurance that we will be successful in implementing the Restructuring. The Restructuring model and may also be disruptive to our operations. For example, our headcount Headcount reductions could yield unanticipated consequences, such as increased cause difficulties in implementing our business strategy including retention of our remaining employees. Future and future growth would impose significant added responsibilities on members of management, including the need to identify, recruit, maintain and integrate additional employees. Due to our limited resources, we may not be able to effectively manage our operations or recruit and retain qualified personnel, which may result in weaknesses in our infrastructure and operations, risks that we may not be able to comply with legal and regulatory requirements, and loss of employees and reduced productivity among remaining employees. Our future financial performance will depend, in part, on our ability to effectively manage any future growth or restructuring, as applicable. In addition, we may not realize, in full or in part, the anticipated benefits, savings and improvements in our cost structure from the Restructuring this restructuring due to unforeseen difficulties, delays or unexpected costs. If we are unable to realize the expected operational efficiencies and cost savings, from the Restructuring, our operating results and financial condition would be adversely affected. Furthermore, we may incur unanticipated charges or make cash payments as a result of the Restructuring this restructuring initiative that were not previously contemplated which could result in an adverse effect on our business or results of operations.

Management action plans in place may not fully alleviate doubt about our ability to continue as a going concern concern.

We have a history of operating losses. These losses, as well as significant growth in consumers in the Bright HealthCare – Commercial segment over the last few years, which required us to set aside additional cash for equity contributions to maintain minimum regulatory amounts, have reduced the cash available to fund operations. These factors raised

significant doubt about our ability to meet future obligations and continue as a going concern concern. See “-Although we raised capital in the second quarter of 2022 2023, based on our projected cash flows and caused absent any other action, we will require additional capital, which might not be available on acceptableterms, if at all. If capital is not available to us, our business and financial condition may be impaired, and we may not be able to seek additional financing. continue as a going concern.”

In response, to these conditions, management is implementing we have revised our business model and implemented a restructuring plan to reduce our capital needs and our operating expenses in the future future. We have, and continue to, drive positive operating cash flow and increase liquidity. The Company’s Bright HealthCare business has exited the Commercial marketplace beginning with the 2023 plan year and is focusing on its Medicare Advantage business in California. In addition to our market exits, management is implementing additional restructuring activities, which include reducing our workforce, exiting exit excess office space, and terminating terminate or restructuring restructure contracts. The Company also raised $925.0 million in 2022 to capitalize our continuing operations as further described in Note 12. While the Company believes its restructuring initiatives, along with existing cash and investments, will provide sufficient liquidity to meet its obligations as they come due in the 12 months following the date the consolidated financial statements are issued, of this Annual Report, there can be no assurance that such actions will be sufficient or that such actions will fully alleviate the fears of investors and creditors that we may be unable to continue as a going concern. In addition, there can be no assurance that we will not face conditions in the future that raise doubts about our ability to continue as a going concern.

If our new business model is not accepted or is slow to be adopted by the healthcare industry, our growth could be impacted and our business and results of operations could be adversely affected.

Key to the growth of our Bright HealthCare business is our ability to drive provider adoption of value-based care arrangements that give our Care Partners a stake in the financial and quality outcomes of our health plans. We cannot assure you that our contracting approach will achieve and sustain acceptance by care providers, consumers or the healthcare industry generally. Additionally, in some locations, provider risk-sharing and value-based compensation models are less prevalent among parties serving the MA population. Acceptance of our business model may be affected by a variety of factors, including but not limited to the lack of willingness of certain care providers to embrace value-based care payment arrangements with payors, and the entrenchment of historical fee-for-service models of compensation.

For the year ended December 31, 2022, 52% of our total revenue was generated by our Consumer Care business (including affiliate revenue). The growth of our Consumer Care business will depend on our ability to attract high-performing care delivery partners new consumers, third-party payors, and new patients. other partners. If we are unable to attract and successfully develop relationships with such provider organizations, these participants, we may not be successful in building and growing our Consumer Care business. Also, if we are unable to provide adequate tools and capabilities to support value-based care, to directly manage risk, and to deliver care under

value-based arrangements, we may not be able to enter and rapidly scale our Consumer Care NeueCare business across and within markets, or to deliver superior outcomes for consumers nationally. consumers. If we are unable to convince new patients of the benefits of our offerings or if potential or existing patients prefer the care provider model of one of our competitors, we may not be able to effectively implement our growth strategy, which depends on our ability to grow organically and attract new patients. In addition, our growth strategy is dependent on patients selecting our Consumer Care business as their primary care provider. Our inability to recruit new patients and retain existing patients would harm our ability to execute our growth strategy and may have a material adverse effect on our business operations and financial position.

If we are unable to retain existing consumers, expand consumer enrollment, or diversify and expand our portfolio of products and services, our business and results of operations may be adversely affected.

We generate, and expect may not be able to continue to generate, a substantial portion of our revenue from consumers enrolled in our MA health plans. As a result, the continued enrollment of individuals into and adoption of our health plans, through our platform, our broker network, employers, or other third parties, is paramount to our future growth and success. If we fail to retain existing consumers, grow consumer enrollment, or diversify and expand our portfolio of products and services, our business and results of operations may be negatively impacted. In addition, if we do not grow our membership, we could find it difficult to retain or increase the number of contracted Care Partners contract with third-party payors and other network providers at partners on favorable rates terms or at all, which could jeopardize our ability or to provide health plan products in our current markets arrange for the provision of the quality care necessary to attract consumers.

Our strategy requires that we successfully contract with third-party payors and our ability other partners, to expand into new markets in a cost-efficient manner. manage medical costs and utilization, and to better monitor and ensure the quality of care being delivered.

Our ability to retain existing payors, consumers, expand consumer enrollment and other partners, and diversify and expand our portfolio of products and services depends on a number of factors, some of which are beyond our direct control. Some of these factors include:

- our ability to provide low-cost and high-value plans which meet a broad range of consumer needs;
- the ease of our consumers' third party-payors, consumers and other partners' adoption of, and enrollment into, our products and services;
- our ability to seamlessly onboard our third-party payors, consumers and other partners and create a positive overall experience with our products and services;
- our consumers' ability to easily use our technology;
- our consumers' ability to receive convenient and ready access to quality medical care and treatment through our Care Partner networks;
- our ability to grow our provider networks and contract with Care Partners that support our model of care on competitive terms;
- our ability to safeguard our consumers' data;
- our ability to anticipate and respond to regulatory changes and shifting consumer preferences for healthcare products and services in a timely manner;
- our ability to retain licenses required to conduct our existing business and obtain licensing in new geographies into which we intend to expand; and
- our ability to effectively compete against our competitors, who may offer products containing fewer restrictions on the network of care providers available to consumers, may provide higher quality levels of care, or may be priced more competitively than our offerings; offerings.
- our ability to market and sell our plans effectively in our target markets, including our ability to retain and incentivize our broker network at reasonable commission rates; and
- regulatory changes pertaining to the marketing and/or enrollment of our consumers, which might negatively impact the overall pool of eligible beneficiaries across our health plans.

In addition, our ability to retain our existing consumers and expand consumer enrollment could be adversely impacted by delays in, or increased difficulty or cost associated with, the implementation of our growth strategies, strategic initiatives and operating plans, and the incurrence of unexpected costs associated with operating our business.

The growth in our membership is also highly dependent upon our success in attracting new consumers during annual and open enrollment periods. If our ability or the ability of our partners, including our broker network, to market and sell our

products and services is constrained during an enrollment period for any reason, such as technology failures, reduced allocation of resources, commission costs, any inability on the part of our sales partners to timely employ, license, train, certify and retain employees and contractors and their agents to sell plans, interruptions in the operation of our website or systems, disruptions caused by other external factors, such as the ongoing COVID-19 pandemic, cyber-attacks, or security breaches or incidents or other computer-related penetrations, we could acquire fewer new consumers than expected or suffer existing consumer attrition and our business, operating results and financial condition could be adversely affected.

We may not be able to contract with care providers on favorable terms or at all, or to arrange for the provision of the quality care necessary to attract consumers.

Our strategy across both our Bright HealthCare and Consumer Care businesses requires that we successfully contract with care providers to ensure access to quality healthcare services for our consumers, to manage medical costs and utilization, and to better monitor and ensure the quality of care being delivered. We compete with other health plans and networks to contract with healthcare providers based on reimbursement rates, timeliness and accuracy of claims payments, the potential to deliver new patient volume and/or support the retention of existing patients, the effectiveness of resolution of calls and complaints, and other factors.

We cannot assure you that we will be able to continue to attract and retain the right Care Partners necessary to deliver healthcare through high-performing networks in the geographic areas we serve, while providing high-quality care to our consumers. In addition, certain care providers, particularly hospitals, physician/hospital organizations and specialists, or their related care provider networks, may have significant negotiating power due to their size or market positions and could demand higher payment rates or otherwise negotiate contracts on terms that are less favorable to us. With respect to our Bright HealthCare business, if our health plans are unable to contract with care providers or if we contract with care providers on unfavorable terms, care provider access for our consumers could be restricted or limited, and we may not be able to deliver the high-quality healthcare that our consumers expect, which could drive consumer attrition or make it more difficult for us to attract new consumers. In addition, we could be exposed to higher medical costs and our health plans may not meet regulatory or accreditation requirements, which could restrict us from offering such plans and could lead to lower revenues.

Our Consumer Care business also involves contracts with physicians and other healthcare providers to create high-performing networks on behalf of its own risk-bearing organizations or RBOs, ("RBOs"), and on behalf of its third-party payor or IPA clients. Our Consumer Care business is subject to the same risks described above relating to its ability to contract with healthcare providers on favorable terms, or at all. If our Consumer Care business is we are unable to contract with physicians and other healthcare providers at all due to regulatory or other restrictions, or at affordable rates and/or in a manner that leads to high-performing networks, it may yield poor financial and quality results for its own RBOs and may result in dissatisfaction amongst its our third-party payor clients.

Further, our RBOs rely on a limited number of physician and other provider groups to assume a certain amount of risk, and we depend on the creditworthiness of these groups. These groups are subject to a number of risks including reductions in payment rates from governmental programs, higher than expected health care costs, fewer than expected patients, and lack of predictability of financial results when entering new lines of business, particularly with high-risk populations. If the financial condition of our partners declines, our credit risk could increase. In 2023, Babylon, one of our ACO REACH partners, declared bankruptcy, resulting in the Company recording $22.4 million in bad debt. Should one or any more of our significant partners declare bankruptcy, be declared insolvent or otherwise be restricted by state or federal laws or regulation from continuing in some or all of their operations, this could adversely affect our ongoing revenues, the collectability of our accounts receivable, our bad debt reserves and our net income.

In addition, although we have long-term contracts with many such provider groups, these contracts may be terminated before their term expires for various reasons, such as changes in the regulatory landscape and poor performance by us, subject to certain conditions. Certain loss of our contracts are terminable immediately upon the occurrence of certain events. Certain of our contracts may be terminated immediately by the partner if we lose applicable required licenses, go bankrupt, lose our liability insurance bankruptcy, or receive an exclusion, suspension or debarment from state or federal government authorities. Additionally, if such a group were to lose applicable licenses, go bankrupt, lose liability insurance, become insolvent, file for bankruptcy or receive an exclusion, suspension or debarment from state or federal government authorities, our contract with such group could in effect be terminated. In addition, certain of our contracts may be terminated immediately if we

become insolvent or file for bankruptcy. debarment. If any of our contracts with these groups is terminated, we may not be able to recover all fees due under the terminated contract, which may adversely affect our operating results.

We may be required to work with care providers who are not contracted with our health plans or in our networks, which may result in costly out-of-network claims.

We may, from time to time, be required to work with care providers who are not contracted with our health plans. In those cases, there is no pre-established understanding between the provider or provider network and our health plan regarding the amount of compensation that is due to the provider or provider network for rendering healthcare services. This can result in high levels of out-of-network claims, which can be significantly more costly than claims based on rates that have been pre-negotiated with our provider network Care Partners. In some states, the amount of compensation for out-of-network claims is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that makes the financial implications unclear. In such instances, care providers may believe they are underpaid for their services and may either litigate or arbitrate their dispute with our health plan, and any subsequent adjustment of the payment made to such care providers could adversely affect our results of operations.

Failure to appropriately set premiums: our rates or effectively manage our costs could negatively affect our profitability, results of operations and cash flows.

The premiums we set for our health plans are a material source of our revenue. We set our premiums using actuarial estimates and our failure to set appropriate premiums, including as a result of inaccuracies in our actuarial estimates, could adversely affect our profitability and cash flows. We use a substantial portion of our health plan revenue to pay the costs of healthcare services delivered to our consumers. As such, our profitability depends in large part on our ability to accurately estimate and manage such costs. Relatively small differences between estimated and actual medical costs as a percentage of revenue can result in significant changes in our financial results. emergency or urgent care) in geographic service areas where there are shortages of available and accessible providers of the health plans who are willing to contract with us and/or our competitors. Any

Our use of actuarial methods to determine premiums and estimate other healthcare costs involves a significant degree of judgment and is subject to a number of inherent uncertainties and assumptions. Such actuarial methods are consistently applied, centrally controlled, and are based upon various data points, including our historical submissions and payment data, cost trends, patient and product mix, seasonality, utilization of healthcare services, contracted service rates and other factors for our consumers. Our ability to accurately estimate such costs depends on various factors, many of which are not within our control, including:

- the utilization rates of medical facilities and services;
- the cost of medical services (including as a result of labor market constraints);
- the use or cost of prescription drugs, in particular the increased use of specialty prescription drugs;
- the introduction or widespread adoption of new or costly treatments, including new technologies;
- our membership mix;
- variances in actual versus estimated levels of cost associated with new products, benefits, lines of business, product changes or benefit level changes;
- changes in the demographic characteristics of an account or market;
- changes in economic conditions (including as a result of the ongoing COVID-19 pandemic);

- changes or reductions related to our utilization management functions such as preauthorization of services, concurrent review, or requirements for physician referrals;
- changes in our pharmacy volume rebates received from drug manufacturers;
- catastrophes, including acts of terrorism, pandemics (such as the ongoing COVID-19 pandemic and other similar unforeseen cost drivers), epidemics or severe weather (e.g., hurricanes, wildfires or earthquakes, including those as a result of climate change);
- medical cost inflation; and
- potential changes in legislation or other rules and regulations, such as changes in government mandated benefits or consumer eligibility criteria.

The impact of many of these items on the ultimate costs for claims is difficult to estimate, and they could have a material impact on our business. In addition, the historical data on which our assumptions are based may not necessarily be indicative of the actual costs of claims due to our rapid growth in consumer enrollment and our recent expansion into new businesses and markets. If we were to commence operations in a new state, region, or other market, or introduce a new product line, we would have limited information from which to estimate our potential medical claims liability. For a period of time after such entry, our inception of a new business, or our acquisition of an existing business, we base our estimates on government-provided and third-party historical actuarial data and limited actual incurred and received claims and inpatient acuity information. The addition of new categories of eligible individuals or coverage requirements for certain items or services, as well as new plan designs we may offer, may make it difficult for us to estimate our medical claims liability and may result in the actual cost of claims being higher than we anticipate.

We set our premiums for twelve-month periods several months prior to the commencement of the premium period and do not change our premiums during such period, consistent with industry practice. Our inability to implement changes in premium rates within a given period is also governed by federal and state regulatory agencies. For example, we are required to submit data on all proposed rate increases to The U.S. Department of Health and Human Services (HHS) on many of our products, and under the ACA, we are prohibited from implementing unreasonable rate increases. If our medical costs exceed our estimates, we will not be able to recover the difference through higher premiums, and our results of operations and financial condition could be adversely affected.

Conversely, if we set our premium rates too high, our existing membership may decline or we may not grow our membership. We operate in a competitive industry, and while health plans compete on the basis of many factors, including service, breadth of benefits, and the quality and depth of provider networks, we believe that price is and will continue to be the most significant driver in our and our competitors' ability to attract consumers. If we do not appropriately price our products, our results of operations and financial condition could be materially and adversely affected.

Furthermore, in order for our health plan premium revenue to adequately cover our losses and expenses and enable us to profitably grow our business, we must effectively manage our costs, including healthcare spend. To do so, we must negotiate appropriate unit rates for each healthcare service provided by our Care Partners to our consumers. If we are unable to negotiate new Care Partner contracts or renew existing Care Partner contracts with favorable provisions relating to unit costs, we may not be able to contain our medical costs at a level that would be adequately covered by the premium levels we set, and our profitability could be adversely impacted. In addition, we must drive effective utilization management to control our costs by evaluating the necessity, appropriateness, and efficiency of the use of healthcare services, procedures, and facilities, while successfully educating our health plan consumers and directing them to the most appropriate and cost-effective healthcare treatments, Care Partners, and sites of care.

Our Consumer Care managed and affiliated medical groups and managed service organizations (MSOs) MSOs negotiate agreements with third-party payors for which the Consumer Care some of our entities serve as RBOs. Our RBOs manage the medical costs and quality metrics on behalf of such payors and are at financial risk for the performance of those payors' medical costs for consumers attributed to our RBOs. Our ability to manage the financial risk depends on our ability to achieve quality targets and to accurately estimate and manage medical costs, and these estimates contain inherent uncertainties and assumptions, similar to those facing our health plan business, which depend on various factors outside of our control, as described above. Additionally, third-party payors may modify their product mix, benefit designs, or member mix in ways that could limit the ability of Consumer Care our RBOs to effectively manage the financial performance under our risk

arrangements. Our failure to effectively drive quality outcomes, optimize financial performance, or manage medical cost spend could negatively impact the profitability and marketability of our Consumer Care business.

Further, and as discussed more below, the MA markets we serve employ risk adjustment programs that impact the revenue we recognize for our enrolled membership. If our Care Partners do not accurately record our consumers' "risk scores", we may not be able to accurately estimate our revenue and medical costs. In the past, we have had difficulties accurately capturing consumers' risk scores in a timely manner, which has resulted in higher than expected liabilities and lower than expected revenue. Although we have and continue to make operational changes to address these challenges, we may not be successful, which may materially adversely impact our financial results.

If we grow rapidly, we may not be able to manage our growth effectively.

From our inception through 2022, we experienced rapid growth, with total revenue having grown from $130.6 million in 2018 to $2.4 billion in 2022.This growth placed and, notwithstanding our updated business model, we expect it will continue to place, significant demands on our management team and our operational and financial resources. Sustaining growth will require additional resources to improve our operational, management, and financial controls, which can take time and may require new capabilities in mission-critical areas, to support growth. We have experienced, and may continue to experience, significant personnel changes related to acquisition-related integration efforts. Our organizational structure may also become more complex as we add these additional resources, making it more difficult to manage. Further, as a result of our Restructuring, we have fewer resources available to manage the multiple aspects of any growth or expansion of our business.

Furthermore, in order to effectively operate our business, we rely heavily on third-party vendors. Any growth could outpace the capacity of our third-party service providers to effectively support our business needs. Certain of our third-party service providers have in the past been unable to effectively scale their operations to meet our increased demands resulting from our rapid expansion at any time. Any rapid growth in membership similar to what we have seen in recent years could significantly impact our ability to pay claims on a timely basis, provide effective utilization management and have sufficient operational resources in these and other areas in order to keep pace with our members' needs. In the event that our existing third-party service providers are unable to meet our needs as our business grows, we may need to find alternative service providers. If we are unable to do so in a timely manner or if we are unable to contract with new service providers on terms that are acceptable to us or at all, our ability to operate our business may be disrupted, which may adversely affect our business, financial condition, results of operations, and cash flows. See "— We rely on various third-party service providers to support the operation of our

business. If these service providers fail to meet their contractual obligations to us or comply with applicable laws or regulations, or if we are unable to renew our contracts with them, our business may be adversely affected."

If we grow in a new market or expanded territory, the risks associated with new market entry can exacerbate the strains on our operational capabilities, including provider contract fee schedule loading in claims systems, provider credentialing, prompt pay claims adjudication, customer service capacity, and utilization management.

Continued growth in our business may exacerbate certain of the risks described elsewhere in this section, including our ability to accurately estimate costs, price our products, and charge appropriate premiums, as well as our ability to accurately assess, code and report MA risk adjustment factor ("RAF") scores for our consumers. If we are not able to manage growth effectively while maintaining the quality of our services and consumer satisfaction, our business, financial condition and results of operations may be materially adversely affected.

We have incurred net losses each year since our inception, and we may not be able to achieve or maintain profitability in the future.

We have incurred net losses on an annual basis since our inception, and our net losses have grown as we have invested heavily in our business. We incurred net losses of $1.5 billion, $1.2 billion, and $248.4 million for the years ended December 31, 2022, 2021 and 2020, respectively. We must generate and sustain higher revenue levels in future periods to become profitable, and, even if we do, we may not be able to maintain or increase our profitability. If we continue to invest to grow our consumer base, diversify our product service offerings, add additional Care Partners, and invest in additional assets related to the delivery of healthcare, we expect our operating costs will increase and therefore expect to incur net losses in

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the near to medium term. We may not achieve the benefits anticipated from these investments, which could be more costly than we currently anticipate, or the realization of these benefits could be delayed. These investments may not result in increased revenue or growth in our business and, accordingly, we may not be able to generate sufficient revenue to offset these cost increases and achieve and sustain profitability. Our recent and historical Historical growth should also not be considered indicative of our future performance. If we fail to achieve and sustain growth and profitability, the market price of our common stock could decline.

Our limited operating history makes it difficult to evaluate our business and assess our future prospects.

We have encountered and will continue to encounter significant risks and uncertainties frequently experienced by new and growing companies in heavily regulated industries, such as difficulties determining appropriate investments given limited resources, effectively managing growth and efficiently navigating and complying with evolving regulations. In the last three years, we significantly expanded our products and services across both our Bright HealthCare and Consumer Care businesses, including as a result of the acquisitions we have made. We also expanded our operations to different lines of business and geographies. As such, the complexity of our business increased significantly in a short period of time.Then, in October 2022, we announced that we will focus on delivering affordable healthcare to aging and underserved populations through our fully aligned care model in Florida, Texas and California, and that we will no longer offer IFP products through Bright HealthCare in 2023, or MA products outside of California.Although our updated business model resulted in a reduction of the scale of our business, we still operate multiple businesses in several different markets, as well as managing run-out of our IFP products and MA products outside of California. insurance plans. Our growth, strategy and ability to achieve and sustain profitability could be negatively impacted if we are unable to effectively manage this complexity. Any inability to manage our business effectively could result in slowing demand for our services, increased competition, a failure to capitalize on growth opportunities or the need to dispose of underperforming business units.

The ongoing COVID-19 pandemic has adversely affected, and may continue to adversely affect, our business and results of operations.

The severity and magnitude of the ongoing COVID-19 pandemic has continued to evolve, and it has adversely affected our business and results of operations. The extent to which the COVID-19 pandemic will continue to impact our business, results of operations and financial condition will depend on future developments, including whether COVID-19 becomes endemic, are unknown at this time. Factors that could impact our results include: the ultimate geographic spread, severity and duration of the COVID-19 pandemic; the impact of business closures, travel restrictions, government actions taken to contain the spread of COVID-19 and to address the related economic and financial impacts; the volume of canceled, delayed or rescheduled procedures or medical care and treatment; the effectiveness of actions taken to reduce transmission of the virus that causes COVID-19 (including the ongoing administration of vaccines, the availability of effective medical treatments, tests, and vaccines for additional groups of individuals, such as children under age five, continued research into treatments, the virus, and the disease); the ongoing emergence of new variants of the virus that causes COVID-19; the impact of the pandemic on economic activity and the labor market (particularly in the healthcare industry); and any impairment in value of our tangible or intangible assets which could be recorded as a result of weaker economic conditions caused by the pandemic. In addition, the long-term impact of the COVID-19 pandemic may not be fully understood or reflected in our results of operations and overall financial condition until future periods.

As a result of the ongoing COVID-19 pandemic and the associated protective and preventative measures and economic impacts, we have experienced and may continue to experience disruptions to our business. Risks presented by the ongoing effects of COVID-19 include, but may not be limited to, the following:

- *Cost of Care for Consumers.* The COVID-19 pandemic disproportionately impacts older adults, especially those with chronic illnesses, who constitute a significant portion of our MA consumer base, particularly in California. We have experienced increased internal and third-party medical costs attributable to the provision of care for consumers suffering from the virus, primarily attributable to inpatient hospitalizations. Additionally, those of our consumers who have been infected by, and recovered from, the disease

potentially face long-term health consequences which medical researchers continue to investigate. The total financial impact of the COVID-19 pandemic is difficult to estimate.

- *Changes to Care for Consumers and Patients.* Many individuals have been prevented from seeking, have been reluctant to seek, or have intentionally delayed or postponed, in-person, non-life-threatening medical care and treatment, including elective procedures. Such reduction in healthcare services in our managed and affiliated medical groups has resulted in reduced Consumer Care fee-for-service revenue, while concurrent COVID-19 prevention protocols have increased costs. If our medical groups and MSOs continue to experience losses, Consumer Care's financial results may be adversely affected.

- *Documentation of Health Conditions.* Due to the COVID-19 pandemic, we may not be able to adequately document the health conditions of our consumers and patients, as many of them have avoided in-person medical visits. Our third-party clients for our Consumer Care MSO may similarly be unable to adequately document the health conditions of their members. Inaccurate or inadequate documentation could result in an inaccurate RAF score, which could materially and adversely impact our Bright HealthCare revenue for future periods. In addition, inaccurate documentation could impact the ability of our Consumer Care MSOs to manage medical costs and quality metrics on behalf of its clients, putting it at greater financial risk and potentially adversely affecting the profitability of our Consumer Care business.

- *Operational Disruptions and Heightened Cyber Security and Data Privacy Risks.* The COVID-19 pandemic has resulted in our employees and those of many of our vendors working from home and conducting work via the internet. If the infrastructure of internet providers required for such work becomes overburdened by increased usage or is otherwise unreliable or unavailable, our employees', our consumers', and our vendors' employees' access to the internet could be limited. Such a disruption could result in work stoppages, delays, loss of productivity, and general business interruptions, all of which have the potential to harm our business operations, financial condition, and results of operations.

These remote working arrangements can also result in significantly more external touchpoints into our network and lead to a heightened risk of cyber security attacks or data security incidents. As we have grown and continued to operate remotely, and similar to other public companies, we have experienced an increase in attempted cyber-attacks, targeted intrusion, ransomware and phishing campaigns, and the pandemic has created additional difficulties in managing risk in the work-from-home environment. In the last eighteen months, one of our subsidiaries and one of our third-party suppliers experienced cyber security incidents. See "— Security incidents or breaches, loss of data and other disruptions to our or our third-party service providers' systems, information technology infrastructure, and networks could compromise sensitive or legally protected information related to our business or consumers, disrupt our business operations, and expose us to liability, which could adversely affect our business and our reputation" for further information. We have incurred and may continue to incur increased expenses to improve our security controls and remediate security vulnerabilities in response to these heightened cyber security risks. Over time, however, the sophistication of these threats continues to increase and the preventative actions we take to reduce the risk of cyber security incidents and protect our information may be insufficient.If such attempts are successful in the future or if PHI, or other proprietary, confidential, or personal data or information were to be exposed or compromised or our systems were shut down or became unavailable, our reputation, business and results of operations could be materially harmed. In addition, as mentioned above, our vendors have been, and may in the future be, subject to increased risks due to the current remote working environment, and any attempted cyber-attacks or other security incidents impacting our vendors could also disrupt our business and harm our reputation, business and results of operation.

- *Changes in Regulatory Requirements.* As a result of the COVID-19 pandemic, regulatory agencies have made, and may continue to make, significant changes (temporary or otherwise) to benefit coverage requirements (including the provision of free in-home COVID-19 test or other related products), enrollment standards or disenrollment standards, in each case, that could negatively impact our financial performance. For example, mandatory coverage of COVID-19 testing in the workplace or coverage requirements related to surprise medical bills and new mandates for continuity of care for certain patients, price comparison tools, disclosure of broker compensation and reporting on pharmacy benefits and drug costs contained in the Appropriations Act could result in substantial expenses that are not contemplated by our current rates. Furthermore, mandatory termination deferrals due to nonpayment of insurance premiums could result in a situation where we incur significant medical expense without the ability to collect any associated premium revenue.

- *Market Disruption.* If the pandemic continues to create disruptions or turmoil in the credit or financial markets, it could adversely affect the price of our common stock and our ability to access capital on favorable terms and continue to meet our liquidity and any acquisition financing needs.

To the extent the ongoing COVID-19 pandemic continues to adversely affect our business and financial results, it may also have the effect of heightening many of the other risks described in this section of this Annual Report titled "*Risk Factors*."

Large-scale medical emergencies in one or more states in which we operate our business could significantly increase utilization rates, medical costs or risk overwhelming and disrupting our systems.

Large-scale medical emergencies can take many forms which may be associated with widespread illness, such as the ongoing COVID-19 pandemic, medical conditions or general threats to wellness. Currently, our largest markets are in California, Florida, and Texas, which can from time to time be impacted by hurricanes, flooding, earthquakes, wildfires, winter storms and other similar natural events, including as a result of climate change. A significant event of this kind could impact one or more of our markets by affecting outsized portions of our consumer population and require increased medical care or intervention, which could result in an unexpected increase in our medical costs. For example, we have experienced significant increased costs attributable to the provision of care for consumers suffering from COVID-19 and its related variants. Other conditions that could impact our consumers include labor shortages in critical need areas, a particularly virulent influenza season, pandemics or epidemics, and other foreign or domestic viruses or new variants of existing viruses for which vaccines may not exist, are not effective, or have not been widely administered. The medical costs and operating costs associated with assisting our consumers in response to any of these large-scale medical emergencies is difficult to predict. However, if one of the states in which we operate were to experience a large-scale natural disaster, a viral epidemic or pandemic, or some other large-scale event affecting the health of a large number of our consumers, our consumer costs in that state could rise, which could have a material adverse effect on our business, financial condition, cash flows and results of operations.

Large-scale medical emergencies may also adversely impact our Consumer Care managed and affiliated medical groups, causing disruption in patient scheduling; displacement of patients, employees and care management personnel; or force clinics to close entirely for periods of time.

In addition, we may not be able to adequately maintain system functionality and business continuity due to any such events. This risk is further exacerbated by our reliance on third-party providers that perform critical operational functions for us. Any such disruption to our ability to conduct business could have a material adverse effect on our business, cash flows and results of operations.

Delays in our receipt of health plan premiums could adversely affect our operations, financial position and cash flows.

A substantial portion of our revenue is derived from health plan premiums. While we recognize premium revenue over the period that coverage is effective, there can be no assurance that we will receive premiums within a relevant coverage period. In addition, the implementation of certain policies by the state and federal governments could result in increased delays in the receipt of health plan premiums.

Our membership is concentrated in certain geographic areas and amongst certain populations, exposing us to unfavorable changes in local benefit costs, reimbursement rates, competition and economic conditions in those areas or affecting those populations.

Our membership is concentrated in certain states in the United States. As of December 31, 2022, approximately 92% of our consumers were residents of California, Florida, and Texas. In particular, our MA business in California made up 43% of total revenue for the year ended December 31, 2022, and as of January 1, 2023, 99% of our membership was in California. Unfavorable changes in the regulatory environment for healthcare, unforeseen changes affecting the cost of living, other benefit costs, inflation (including wage inflation), reimbursement rates or increased competition in these states or any other geographic area where our membership becomes concentrated in the future could therefore have a disproportionately adverse effect on our operating results.

If we decide to enter new markets, they may not be as economical to serve as our existing markets.

Due to a variety of factors, such as novel local market dynamics and increased administrative costs relating to compliance with state laws and regulations, we may have difficulty providing the same level and types of healthcare in any new markets as we and our Care Partners currently provide in our established markets for the same cost. If we are unable to adequately price our new products in these markets, if the medical expenses of new consumers are higher than we anticipate, if the market is saturated with significant competition or if the rates of adoption for our business model or the demand for our product offerings in such new geographies are lower than we anticipate, we may not be able to serve those regions while realizing economic results as favorable as those results realized in the markets we currently serve. If we are unable to profitably grow and diversify our membership geographically, our results of operations may be materially and adversely affected.

We operate in competitive markets within a highly competitive industry.

The health insurance and care delivery markets are highly competitive. Competitors across the markets in which we compete are subject to dynamic regulatory requirements and industry expectations, emerging new product and service offerings, and constantly evolving consumer preferences and demands. Our principal competitors for consumers and payor contracts vary considerably in type and identity by market.

Our Bright HealthCare business currently faces competition from a range of health insurance companies targeting the MA market, many of whom are developing their own technology or partnering with third-party technology providers to drive improvements in care. These competitors include large, national insurers, such as Aetna, Anthem, Centene,

Cigna, Humana, and UnitedHealthcare and others, in addition to more regionally-focused insurers, such as Blue Cross Blue Shield licensees, Kaiser Permanente and other provider-sponsored health plan organizations.

Our Consumer Care business currently operates medical groups and competes with other medical groups in the same localities. Our Consumer Care business We also competes compete with MSOs, IPAs and other organizational entities aggregating and enabling providers to deliver primary care services under value-based care arrangements. These competitors include companies such as Agilon Health, Cano Health, ChenMed, Iora Health, Oak Street Health, OptumHealth, and VillageMD. In addition, our Consumer Care business participates in the Medicare Shared Savings Program and other government programs designed to bring value-based care to fee-for-service Medicare beneficiaries, and our Consumer Care business competes with other participants in such programs.

Many of our competitors have longer operating histories; greater brand recognition; stronger, more developed, and more extensive networks of physicians and other care providers; significantly greater financial, technical, marketing, and other resources; lower labor and development costs due to economies of scale; greater access to healthcare data; and larger membership bases, than we do. These competitors may engage in more extensive research and development efforts; undertake broader, more expensive, and more powerful marketing campaigns; and adopt more aggressive pricing or payment policies, each of which may enable them to build membership faster than us and to establish a larger patient base more quickly than us. Our competitors may also provide more differentiated products or services to their clients.

Furthermore, the healthcare industry in the United States has experienced a substantial amount of consolidation. If our competitors were to be acquired by third parties with greater resources, such as, for example, Oak Street Health's acquisition by CVS Health, these competitive risks could intensify, and we may face significant challenges in markets that have experienced significant competitor consolidation.

In addition, other companies may enter our markets in the future, including emerging competitors targeting MA and other populations, or other markets, services or products we choose to enter or be in at the time. We do not believe the barriers to enter our markets are substantial, and new competitors with comparable, better, or differentiated healthcare products and plans or services may emerge, or competitors may develop new approaches to value-based care, which could put us at a competitive disadvantage. In addition, because health plans are generally renewed annually, consumers enjoy significant flexibility in moving between health plans.

One of the key factors on which we compete for our consumers, especially in uncertain economic environments, is overall cost. We are therefore under pressure to contain premium price increases despite being faced with increasing healthcare

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and other benefit costs, as well as increasing operating costs. If, as a result of the competition we face, we are unable to increase our premium rates or our prices commensurate with increasing costs, our profitability could be adversely affected. To the contrary, if we do not limit our price increases, we may lose consumers to our competitors offering more favorable pricing. In response to rising prices, our consumers may also purchase different types of products from us that are less profitable. If we are unable to compete effectively with our current and potential competitors for market share, we may also see a reduction in the demand for our products and services. Any of the foregoing could materially and adversely affect our business, results of operations and financial condition.

The failure to enter into value-based care agreements with health plans or the renegotiation, non-renewal or termination of such agreements could materially negatively impact our business, results of operations, financial condition and cash flows.

The success of our Consumer Care business is dependent on our ability to enter into value-based care agreements with third-party payors. Even if we are successful at entering into these agreements, such agreements may be subject to renegotiation, and the renegotiated terms may not be as favorable to us. Additionally, under certain of our existing value-based care agreements with third-party payors, the health plan is permitted to modify their benefit designs, their pricing parameters, and the specific terms and conditions governing the value-based arrangement from time to time during the terms of the agreements. If a health plan makes such changes during the term of our agreement, or if we enter into contracts with unfavorable economic terms, we could suffer losses with respect to such contract. In particular, if we enter into capitation or other value-based care contracts with unfavorable terms, or such contracts are amended to include unfavorable terms, we could experience significant losses. Depending on the health plan at issue and the amount of revenue associated with Consumer Care's the agreement with the health plan, if the contract permits a renegotiation of the terms triggered by health plan changes, the renegotiated terms or termination could materially negatively impact our business, results of operations, financial condition and cash flows.

Our consumers are concentrated in certain geographic areas and amongst certain populations, exposing us to unfavorable changes in local benefit costs, reimbursement rates, competition and economic conditions in those areas or affecting those populations.

The lives served by NeueHealth are concentrated in Florida and Texas. Unfavorable changes in the regulatory environment for healthcare, unforeseen changes affecting the cost of living, other benefit costs, inflation (including wage inflation), reimbursement rates or increased competition in these states or any other geographic area where our membership

becomes concentrated in the future could therefore have a disproportionately adverse effect on our operating results.

If we decide to enter new markets, they may not be as economical to serve as our existing markets.

Due to a variety of factors, such as novel local market dynamics and increased administrative costs relating to compliance with state laws and regulations, we may have difficulty providing the same level and types of healthcare in any new markets as we and our partners currently provide in our established markets for the same cost. If we are unable to adequately price our new services in these markets, if the medical expenses of new consumers are higher than we anticipate, if the market is saturated with significant competition or if the rates of adoption for our business model or the demand for our service offerings in such new geographies are lower than we anticipate, we may not be able to serve those regions while realizing economic results as favorable as those results realized in the markets we currently serve. If we are unable to profitably grow and diversify our membership geographically, our results of operations may be materially and adversely affected.

If we grow rapidly, we may not be able to manage our growth effectively.

Rapid growth would place significant demands on our management team and our operational and financial resources. Sustaining growth will require additional resources to improve our operational, management, and financial controls, which can take time and may require new capabilities in mission-critical areas, to support growth. We have experienced, and may

continue to experience, significant personnel changes. Further, as a result of recent headcount reductions, we have fewer resources available to manage the multiple aspects of any growth or expansion of our business.

Furthermore, in order to effectively operate our business, we rely heavily on third-party vendors. Any growth could outpace the capacity of our third-party service providers to effectively support our business needs. In the event that our existing third-party service providers are unable to meet our needs as our business grows, we may need to find alternative service providers. If we are unable to do so in a timely manner or if we are unable to contract with new service providers on terms that are acceptable to us or at all, our ability to operate our business may be disrupted, which may adversely affect our business, financial condition, results of operations, and cash flows. See "— We rely on various third-party service providers to support the operation of our business. If these service providers fail to meet their contractual obligations to us or comply with applicable laws or regulations, or if we are unable to renew our contracts with them, our business may be adversely affected."

Any future epidemics or pandemics may adversely affect our business and results of operations.

The COVID-19 pandemic adversely affected our business and results of operations. The extent to which any future epidemics or pandemics will impact our business, results of operations and financial condition are unknown. In addition, the long-term impact of the COVID-19 pandemic or any future epidemics or pandemics may not be fully understood or reflected in our results of operations and overall financial condition until future periods.

Risks presented by future epidemics or pandemics include, but may not be limited to, the following:

- *Cost of Care.* Underlying causes of epidemics and pandemics may disproportionately impact older adults, especially those with chronic illnesses, which may result in increased internal and third-party medical costs. In addition, the long-term health consequences of COVID-19 and other new illnesses are uncertain, which may increase costs.

- *Changes to Care.* Individuals may be prevented from seeking or be reluctant to seek, non-life-threatening medical care and treatment, including elective procedures. Such reduction in healthcare services may result in reduced fee-for-service revenue, while prevention protocols may increase costs.

- *Documentation of Health Conditions.* We may not be able to adequately document the health conditions of our consumers, as they may avoid in-person medical visits. Our third-party clients for our MSOs may similarly be unable to adequately document the health conditions of their members. In addition, inaccurate documentation could impact the ability of our MSOs to manage medical costs and quality metrics on behalf of its clients, putting it at greater financial risk and potentially adversely affecting the profitability of our business.

- *Operational Disruptions and Heightened Cyber Security and Data Privacy Risks.* Future epidemics and pandemics may result in an increase in the number of our employees and those of many of our vendors working from home and conducting work via the internet. If the infrastructure of internet providers required for such work becomes overburdened, unreliable or unavailable, it could result in disruptions, work stoppages, delays, loss of productivity, and general business interruptions, all of which have the potential to harm our business operations, financial condition, and results of operations.

  These remote working arrangements can also result in significantly more external touchpoints into our network and lead to a heightened risk of cyber security attacks or data security incidents. As we have grown and continued to operate remotely, and similar to other public companies, we have experienced an increase in attempted cyber-attacks, targeted intrusion, ransomware and phishing campaigns, and the pandemic has created additional difficulties in managing risk in the work-from-home environment. In the last two years, more than one of our third-party suppliers experienced cyber security incidents. See "— Security incidents or breaches, loss of data and other

disruptions to our or our third-party service providers' systems, information technology infrastructure, and networks could compromise sensitive or legally protected information related to our business or consumers, disrupt our business operations, and expose us to liability, which could adversely affect our business and our reputation."

We have incurred and may continue to incur increased expenses to improve our security controls and remediate security vulnerabilities in response to these heightened cyber security risks. Over time, however, the sophistication

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of these threats continues to increase and the preventative actions we take to reduce the risk of cyber security incidents and protect our information may be insufficient. If such attempts are successful in the future or if PHI, or other proprietary, confidential, or personal data or information were to be exposed or compromised or our systems were shut down or became unavailable, our reputation, business and results of operations could be materially harmed. In addition, as mentioned above, our vendors have been, and may in the future be, subject to increased risks due to the current remote working environment, and any attempted cyber-attacks or other security incidents impacting our vendors could also disrupt our business and harm our reputation, business and results of operation.

- *Market Disruption.* Future epidemics and pandemics may create disruptions or turmoil in the credit or financial markets, which could adversely affect the price of our common stock and our ability to access capital on favorable terms and continue to meet our liquidity and any acquisition financing needs.

Large-scale medical emergencies in one or more states in which we operate our business could significantly increase utilization rates, medical costs or risk overwhelming and disrupting our systems.

Large-scale medical emergencies can take many forms which may be associated with widespread illness, medical conditions or general threats to wellness. Currently, our largest markets are in Florida and Texas, which can from time to time be impacted by hurricanes, flooding, earthquakes, wildfires, winter storms and other similar natural events, including as a result of climate change. A significant event of this kind could impact one or more of our markets by affecting outsized portions of our consumer population and require increased medical care or intervention, which could result in an unexpected increase in our medical costs. Other conditions that could impact our consumers include labor shortages in critical need areas, a particularly virulent influenza season, pandemics or epidemics, and other foreign or domestic viruses or new variants of existing viruses for which vaccines may not exist, are not effective, or have not been widely administered. The medical costs and operating costs associated with assisting our consumers in response to any of these large-scale medical emergencies is difficult to predict. However, if one of the states in which we operate were to experience a large-scale natural disaster, a viral epidemic or pandemic, or some other large-scale event affecting the health of a large number of our consumers, our consumer costs in that state could rise, which could have a material adverse effect on our business, financial condition, cash flows and results of operations.

Large-scale medical emergencies may also adversely impact our managed and affiliated medical groups, causing disruption in patient scheduling; displacement of patients, employees and care management personnel; or force clinics to close entirely for periods of time.

In addition, we may not be able to adequately maintain system functionality and business continuity due to any such events. This risk is further exacerbated by our reliance on third-party providers that perform critical operational functions for us. Any such disruption to our ability to conduct business could have a material adverse effect on our business, cash flows and results of operations.

If we are not able to maintain required statutory capital levels, our balance sheet may be adversely affected.

Our MA discontinued insurance plans (and our IFP and employer plans that have been discontinued but that are being run out) out are operated through regulated insurance subsidiaries in various states. These subsidiaries are subject to state regulations that, among other things, require us to maintain minimum levels of statutory capital, or net worth, as defined by each applicable state. Such states may raise or lower the statutory capital level requirements at will. Our history of losses has generally meant that we have had to infuse more capital into our largest states. Certain other states have adopted risk-based capital requirements based on guidelines adopted by the National Association of Insurance Commissioners, which tend to be, although are not necessarily, higher than existing statutory capital requirements. The state departments of insurance, or applicable bodies regulating insurance, in any state could require our regulated insurance subsidiaries to maintain minimum levels of statutory capital in excess of amounts required under the applicable state laws if they determine that maintaining additional statutory capital is in the best interests of our consumers.

As of December 31, 2022 December 31, 2023, the amount of capital in certain of our insurance subsidiaries failed to meet or exceed applicable mandatory risk-based capital requirements, and as a result such subsidiaries are or may become subject to supervision orders under state insurance laws.Such supervision orders require additional reporting as well as approval of certain transactions by our regulators. These The scope of these orders may be expanded, we may become subject to additional orders, or both, any of which may harm our ability to execute our business strategy, invest in growth opportunities, and adversely adversely affect our balance sheet and results of operations. On November 29, 2023, Bright Healthcare Insurance Company of Texas was placed into liquidation and the Texas Department of Insurance was appointed as receiver.

Further, these agencies could require our regulated insurance subsidiaries to maintain minimum levels of statutory capital in excess of amounts required under the applicable state laws if they determine that maintaining additional statutory capital is in the best interests of our consumers. In addition, although we will no longer offer health plans, in certain states, if we are unable to withdraw, or are subject to an unexpected delay in withdrawing, the statutory capital in these subsidiaries, this could reduce our available funds, which could harm our ability

to execute our business strategy, invest in growth opportunities, and adversely affect our balance sheet and results of operations.

If we expand our plan offerings and grow our membership, we may be required to maintain higher levels of statutory capital. If higher level of statutory capital are required, this could reduce our available funds, which could harm our ability to execute our business strategy and invest in our growth opportunities. In addition, laws in many states require increasing degrees of regulatory oversight and intervention if a company's risk-based capital declines below certain thresholds. If our

levels of statutory capital were to decline below these thresholds, we may be subject to heightened supervision, examination, rehabilitation or liquidation.

Our Consumer Care business RBO businesses may be subject to state regulations that, among other things, require us to maintain minimum capital reserves, as defined by each applicable state in connection with the assumption of financial risk for the performance of for consumers attributed to our Consumer Care RBOs. consumers.

If we fail to achieve robust brand recognition or are unable to maintain or enhance our reputation, our business, financial condition and results of operations may be adversely affected.

Developing strong brand recognition and maintaining and enhancing our reputation in both our Bright HealthCare and Consumer Care businesses is critical to maintaining our existing relationships and to our ability to attract new consumers, Care Partners partners and other constituents to our platform. After exiting the health insurance business, we adopted NeueHealth as our corporate brand name. Promoting our new brand requires substantial investments and we anticipate that, as our market remains increasingly competitive, our marketing initiatives may become increasingly expensive and challenging to successfully implement. Attempts to grow our brand and investments in marketing our platform and plans may not be successful or yield increased revenue as we expect, and even if these activities result in increased revenue, the increased revenue may not offset the expenses we incur to achieve such results. In addition, much of our marketing efforts to date have been limited to certain geographic regions and markets where our business operates to ensure an efficient use of resources. If we expand, we will need to spend additional resources to build strong national brand recognition and there can be no assurance that our efforts will be effective. If we do not successfully develop widespread brand recognition and maintain and enhance our reputation, our business may not grow and we could lose our existing relationships, which could harm our business, financial condition and results of operations.

If we fail to offer high-quality customer support in our business, our reputation and our ability to maintain or expand membership or attract Care Partners care partners and third-party payors could suffer, which could adversely affect our results of operations.

Providing high-quality operational support and service to our consumers, Care Partners care partners and third-party payors is an important part of our business. Our ability to attract and retain consumers is largely dependent upon our ability to offer an easy-to-navigate membership enrollment process as well as upon our ability to provide cost effective, quality customer service, including effective call center operations and claims processing support, that meets or exceeds our consumers' expectations. Certain user support operations are supported by third-party vendors. If we or our vendors fail to provide services that meet our customers' expectations, we may have difficulty retaining or growing our membership as well as Care Partner care partner and third-party payor relationships, which could adversely affect our business, financial condition and results of operations.

We expect that the importance of offering high-quality support to our consumers will increase if we grow or expand our business, add new services or products, and pursue new consumers, Care Partners, care partners, and third-party payors. This has put, and will continue to put, pressure on our ability to maintain high-quality customer support, or a market perception that we do not maintain high-quality user support, could harm our reputation and negatively impact our ability to grow membership, build Care Partner care partner relationships, and attract third-party payors, which could adversely affect our business, results of operations, and financial condition. Additionally, as our number of consumers, Care Partners care partners and third-party payors grows, we will need to hire additional support personnel to provide efficient platform support at scale. If we are unable to provide such support, our business, results of operations, financial condition and reputation could be harmed.

Reductions in the quality ratings of our MA health plans could have a materially negative impact on our business, results of operations, financial condition and cash flows.

Many of the government healthcare coverage programs in which we participate are subject to the prior satisfaction of certain conditions or performance standards or benchmarks. For example, a portion of each Medicare Advantage plan's reimbursement is tied to the plan's Star Rating. A plan's Star Rating affects its image in the market, and plans that perform well are able to offer enhanced benefits and market more effectively. The Star Rating system considers various measures adopted by CMS, including, among others, quality of care, preventive services, chronic illness management and consumer satisfaction. Only plans with a rating of four (4.0) stars or higher qualify for bonus payments. Medicare Advantage plans with Star Ratings of five (5.0) stars are eligible for year-round open enrollment; conversely, plans with lower Star Ratings

have more restricted times for enrollment of beneficiaries. Medicare Advantage plans with Star Ratings of less than three (3.0) stars for three consecutive years are denoted as “low performing” plans on the CMS website and in the CMS “Medicare and You” handbook. In addition, in 2019, CMS had its authority reinstated to terminate Medicare Advantage contracts for plans rated below three (3.0) stars for three consecutive years. As a result, Medicare Advantage plans that achieve higher Star Ratings may have a competitive advantage over plans with lower Star Ratings. To date, we have not been able to achieve a four (4.0) Star Rating on our MA plans, which are therefore not currently eligible for quality bonuses. Furthermore, the Star Rating system is subject to change annually by CMS, which may make it more difficult to achieve and maintain three (3.0) Star Ratings or greater in the future. We cannot assure you that we will be successful in maintaining or improving our Star Ratings in the future. In addition, audits of our performance for past or future periods may result in downgrades to our Star Ratings. Our health insurance subsidiaries' operating results, premium revenue, and benefit offerings will likely depend significantly on their Star Ratings, and there can be no assurances that we will be successful in achieving and maintaining favorable Star Ratings. If we do not achieve an acceptable level of Star Ratings, our plans will not be eligible for quality bonuses in the future and we may experience a negative impact on our revenue and the benefits that our plans can offer, which could materially and adversely affect the marketability of our plans, our membership levels, results of operations, financial position and cash flows. Any changes in standards or care delivery models that apply to government healthcare programs, including Medicare, or our inability to maintain or improve our quality scores and Star Ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs, which in turn could materially negatively impact our results of operations, financial position and cash flows.

We may be unsuccessful in identifying and acquiring suitable acquisition candidates or integrating acquired companies, which could impede our growth and ability to remain competitive.

Over the course of the last several years, we have acquired several businesses. Maintaining acceptable growth may rely in part on our ability to successfully acquire and integrate companies that complement and accelerate the execution of our strategies in new and existing markets. However, we may not successfully identify suitable acquisition candidates or we may have difficulty in identifying prospective acquisition candidates. In addition, we may not be able to successfully complete an acquisition after identifying a candidate. We sometimes compete for acquisition and expansion opportunities with entities that have greater financial resources or are otherwise willing to pay more than us. Furthermore, pursuing an acquisition strategy is likely to require us to seek additional financing, which we may not be able to obtain on satisfactory terms and conditions, or at all. Furthermore, any additional financing would increase our level of indebtedness, exacerbating the risks described under “—Our ability to incur a substantial level of indebtedness may reduce our financial flexibility, affect our ability to operate our business, and divert cash flow from operations for debt service.”

Even after the acquisition of a business, we may be unable to successfully integrate the acquired business with our existing business and operations or the business may not perform in accordance with the projections that informed the purchase price for such acquisition. The integration of an acquired business involves a number of factors that may negatively affect our operations, including, but not limited to:

- distraction of management or lack of leadership within the acquired business to succeed retiring leaders;
- significant costs and difficulties, including implementing or remediating controls, procedures, and policies at the acquired company; integrating the acquired company's accounting, human resource and other administrative systems; integrating and/or remediating information security systems; coordinating product and sales and marketing functions; transitioning operations, consumers, clients, and other users onto our existing technology platforms; and retaining of key personnel;
- tax and accounting issues, including the creation of significant future contingent liabilities relating to earn-outs for acquisitions or other financial liabilities; and
- unanticipated problems or legal liabilities, or lack of adequate compliance or regulatory policies, processes, technologies and resources.

Although we conduct due diligence with respect to the business and operations of each of the companies we acquire, we may not have identified all material facts concerning these companies. Unanticipated events or liabilities relating to these companies could have a material adverse effect on our results of operations, financial condition and cash flow. Furthermore, once we have integrated an acquired company, it may not achieve levels of revenue, profitability, or productivity comparable to our existing business, or otherwise perform as expected, and we cannot assure you that past or

future acquisitions will be accretive to earnings or otherwise meet our operational or strategic expectations. Our failure to successfully acquire and integrate businesses may cause us to fail to realize the anticipated benefits of such acquisitions or investments, cause us to incur unanticipated liabilities and/or harm our business generally, which may have an adverse effect on our revenue, results of operations, financial condition and cash flow.

Medical liability claims made against us in the future could cause us to incur significant expenses and pay significant damages if not covered by insurance.

The risk of medical liability claims against our Consumer Care business managed and affiliated medical groups, as well as against the treating physicians and other medical practitioners, is an inherent part of our business. While we endeavor to carry appropriate levels of insurance covering medical malpractice claims, successful medical liability claims might exceed our insurance coverage or the coverage held by our provider partners, which could make us secondarily liable for such incidents. Furthermore, professional liability insurance, including medical malpractice insurance, is expensive and insurance premiums may increase significantly in the future, especially as we continue to expand our service offerings. As a result, adequate professional liability insurance may not be available to our physicians and other medical practitioners or to us in the future at acceptable costs or at all.

Additionally, our health plan business may be targeted for medical liability lawsuits based on vicarious liability or other legal theories by which plaintiffs seek to hold our health plans liable for medical results associated with care rendered by our managed and affiliated medical groups or other network providers.

Any claims made against us that are not fully covered by insurance could be costly to defend against, result in substantial damage awards against us and divert the attention of our management and our partners from our operations, which could have a material adverse effect on our business, reputation, financial condition and results of operations. Additionally, any claims made against us, whether meritorious or not, may increase the cost of our insurance premiums which could adversely impact our business.

We rely on our talent, and the loss of any members of senior management or other key employees or an inability to hire, retain, motivate or develop other highly skilled employees could harm our business or impact our ability to grow effectively.

We are led by a seasoned management team with decades of healthcare and public company operating experience. The success of our business relies, in part, on the continued services of our senior management team and other key employees. Competition for talent is intense in our industry. While we use various measures to attract and retain talent, including fair and reasonable market-based compensation plans and an equity incentive program for key executive officers and other employees, these measures may not be adequate to hire, retain, motivate and develop the personnel we require to successfully scale our business and to operate our business effectively. Furthermore, members of our senior management team are difficult to replace. In particular, the loss of the employment contributions of our Chief Executive Officer, Mr. Mikan, or other key members of the executive management team, could significantly delay or prevent the achievement of our strategic objectives.

Global economic conditions and economic uncertainty or downturns, particularly as it impacts particular industries, could materially and adversely affect our business and operating results.

In recent years, our business has been and may continue to be affected by various factors and events that are beyond our control. The United States has experienced economic downturns and market volatility, and domestic and worldwide economic conditions remain uncertain. For example, Russia's attack on Ukraine has had significant impacts on a wide variety of financial markets and supply chains around the world. It may be extremely difficult for us, our Care Partners care partners and our other key constituents to accurately plan future business activities and execute on our business objectives as a result of economic uncertainty and other macroeconomic factors. In addition, global economic conditions and economic uncertainty may cause our consumers to slow spending on our health plans or Care Partners care partners to cease partnering with our business, which could ultimately harm our business. Furthermore, during uncertain economic times our consumers may face challenges or delays in obtaining access to funds used to make monthly premium payments, which could result in an impairment of their ability to make timely payments to us. payments. In addition, our business relies on third parties, and we are susceptible to risks related to the potential financial instability of such third parties, including vendors that provide services

to us or to whom we delegate certain functions. If these third-party vendors cease to do business as a result of broader economic conditions or if they become unable to provide us with the level of service we expect, we may not be able to find an alternative service provider in a timely manner, or on acceptable financial terms, which could impact our ability to meet the expectations and needs of our consumers.

We cannot predict the timing, severity or duration of any economic slowdown or the strength or speed of any subsequent recovery generally. If the conditions in the general economy and the markets in which we operate worsen from present levels, our business, financial condition and results of operations could be materially adversely affected.

We compete for physicians and other healthcare personnel for our Consumer Care business, and shortages of qualified personnel or other factors could increase our labor costs and adversely affect our revenue, profitability and cash flows.

Our Consumer Care business is dependent on the efforts, abilities and experience of employed and contracted physicians, nurse practitioners, registered nurses and other medical professionals. We compete with other healthcare providers, hospitals, clinics, networks and other facilities, in attracting physicians, nurses and medical staff required to support our business. Recruiting and retaining qualified management and support personnel responsible for the daily operations of our business is vital to the continued growth and success of our business, as well as our profitability. In many markets in which we operate, the lack of availability of clinical personnel, such as nurses and mental health professionals, has become a significant operating issue facing our business and all healthcare providers exacerbated by increased worker attrition as a result of the ongoing COVID-19 pandemic. providers. As a result of this competition, we may need to continue to enhance wages and benefits to recruit and retain qualified personnel or to contract for more expensive temporary personnel. We may not be able to attract new physicians and clinical personnel to replace the services of terminating personnel or to service our growing membership.

We may not be able to raise rates or to grow our business to offset increased labor costs. Because a significant percentage of our revenue consists of fixed, prospective payments, our ability to pass along increased labor costs is limited.

We have employment contracts with physicians and other health professionals in Florida, Texas, and other states. Some of these contracts include provisions preventing these physicians and other health professionals from competing with us both during and after the term of our contract with them. The current laws governing non-compete agreements and other forms of restrictive covenants varies from state to state, and the Federal Trade Commission recently proposed a nationwide ban on non-competition covenants. California, Florida, and other states' laws and, if enacted, federal law, may prohibit us from enforcing our non-competition covenants with our professional staff particularly in rural locations or in specialty practice areas. Some states are reluctant to strictly enforce non-compete agreements and restrictive covenants applicable to physicians and other healthcare professionals. There can be no assurance that our non-compete agreements related to physicians and other health professionals will be found enforceable if challenged. In such event, we would be unable to prevent physicians and other health professionals formerly employed by us from competing with us, potentially resulting in the loss of some of our patients and other health professionals professionals.

Our health plan products are subject to risk adjustment programs, which if not managed properly can result in risk adjustment payments that do not reflect our true risk profile, which could adversely impact our financial results and cash flows.

The IFP and MA markets we serve (and previously served) employ risk adjustment programs that impact the revenue we recognize for our enrolled membership. These risk adjustment programs are designed to compensate us for the level of risk we take in providing healthcare services to our overall consumer population. In order to be reimbursed by government payors, for MA products, or by other market participating health plans, for IFP products, at a level commensurate with our consumer population risk, we must ensure that our Care Partners are identifying and properly inputting data to document all chronic and severe diagnoses to create an accurate health profile for each consumer. If our Care Partners do not accurately record this patient data, we may not be able to accurately estimate our revenue and medical costs. If we fail to obtain accurate claims or other related data in a timely manner, we may not be able obtain accurate risk scores during the time period in which we expected to, or at all. See "– We rely on various third-party service providers to support the operation of our business. If these service providers fail to meet their contractual obligations to us or comply with applicable laws or regulations, or if we are unable to renew our contracts with them, our business may be adversely affected." If the data on our consumer population overstates the health risk of our consumer population, we may be obligated to return funds to government payors, for MA products, or to other market participating health plans, for IFP products, that we have received. Conversely, if we understate the health risk of our consumer population, we will not

receive funds from government payors, for MA products, or other market participating health plans, for IFP products, that we would otherwise be entitled to receive. As a result of the variability of certain factors that go into the development of the risk adjustment we recognize, such as risk scores and other market-level factors where applicable, the actual amount of revenue could be materially more or less than our estimates. Consequently, our estimate of our health plans' risk scores for any period, and any resulting change in our accrual of revenue related thereto, could have a material adverse effect on our results of operations, financial condition, and cash flows. The data provided to CMS to determine risk scores is subject to audit by CMS even several years after the annual settlements occur. If the risk adjustment data we submit is found to incorrectly overstate the health risk of our consumers, we may be required to refund monies previously received by us and/or be subject to penalties or sanctions, including potential liability under the FCA, which could be significant and would reduce our revenue in the year that repayment or settlement is required. We have had in the past to take reserves against our premium revenue because of our difficulty to accurately estimate risk adjustment in our business. Furthermore, if the data we provide to CMS incorrectly understates or overstates the health risk of our consumers, we might be underpaid or overpaid for the care that we must provide to our consumers, which could have a negative impact on our results of operations and financial condition.

It is possible that claims associated with consumers with higher RAF scores could be subject to more scrutiny in such an audit and that the findings of an audit could result in future adjustments to premiums or in adjustments to the payments made by CMS to us. CMS may also assess penalties for inaccurate or unsupportable RAF scores provided by us or our Care Partners. In addition, we could be liable for penalties to the government under the FCA that range from $5,500 to $11,000 (adjusted for inflation) for each false claim, plus up to three times the amount of damages caused by each false claim, which can be as much as the amounts received directly or indirectly from the government for each such false claim. In 2022, the Department of Justice increased the range of FCA penalties on a per claim basis from $12,537 to $25,076 per claim. Because CMS conducts its audits at random, there can be no assurance that we will not be randomly selected or targeted for review by CMS or that the outcome of such a review will not result in a material adjustment in our revenue and profitability, even if the information we submitted to CMS is accurate and supportable. Substantial changes to the risk adjustment mechanism, including changes that result from enforcement or audit actions, could materially affect our reimbursement.

Our expansion into ACO REACH business presents new risks to our business. unique risks.

We expanded our business into CMS' CMS's ACO REACH model (formally known as the Direct Contracting model) (the "ACO REACH Model") in January 2022, enabling us to target a larger market opportunity, the Medicare FFS fee-for-service ("FFS") market, which is the largest segment of Medicare. As such, although we have completed our first year two years in the ACO REACH model, we are subject to the risks inherent to the launch of any new business, including the risks that we may not generate sufficient returns to justify our investment, it may take longer or be more costly to achieve the expected benefits from this new program, and that it may require us to, at least initially, divert management attention and other resources from our existing businesses. In connection with our expansion into ACO REACH, we have formed and continue to form relationships with a greater number of physicians, which may pose challenges to scaling quickly, influencing physician behavior and directly engaging beneficiaries, and we may face additional new risks and difficulties, many of which we may not be able to predict or foresee. Any potential future changes to the ACO REACH model may have a significant impact on our ability to carry out our business. Similarly, while ACO REACH is expected to continue through 2026, Centers for Medicare & Medicaid Services Innovation Center (CMMI) CMMI can determine to

terminate the program at any time, and in some cases may be required to do so. If the program is terminated, we would need to reevaluate our Medicare FFS strategic options, which in turn could reduce the return on our investments and negatively impact our business, financial condition, results of operations and future prospects. Additionally, our ACO REACH participation agreements with CMS permit CMS to take certain actions if CMS determines that any provision may have been violated, including requiring the ACO to provide additional information to CMS, placing the ACO on a monitoring and/or auditing plan developed by CMS, requiring the ACO to terminate its relationship with any other individual or entity performing functions or services related to certain ACO or marketing activities, amending the agreement without the consent of the ACO to take certain actions, including denying, terminating or amending the use of any capitation payment mechanism. CMS may also immediately or with advance notice terminate an ACO REACH participation agreement if CMS determined that the ACO has failed to comply with any term of the agreement or any other Medicare program requirement, rule or regulation or if CMS determines that the ACO has taken or failed to take certain other actions. If our ACO REACH participation agreements were terminated, our business, financial condition, results of operations and future prospects would be negatively impacted.

Our executive officers, directors and holders of 5% or more of our common stock collectively beneficially own, on a fully diluted basis, approximately 58% 59.5% of the outstanding shares of our common stock as of December 31, 2022 December 31, 2023, and have substantial control over us, which may limit your ability to influence the outcome of important transactions.

Our executive officers, directors and each of our stockholders who own 5% or more of our outstanding common stock and their affiliates, in the aggregate, beneficially own, on a fully diluted basis, approximately 58% 59.5% of the outstanding shares of our common stock, as of December 31, 2022 December 31, 2023. As a result, these stockholders, if acting together, may continue to exercise significant influence over or control matters requiring approval by our stockholders, including the election and removal of directors and the approval of mergers, acquisitions or other extraordinary transactions. They may also have interests that conflict or differ from yours and may vote in a way with which you disagree and which may be adverse to your interests. This concentration of ownership may also have the effect of delaying, preventing or deterring a change in control of our company, and could deprive our stockholders of an opportunity to receive a premium for their common stock as part of a sale of our company or by discouraging others from making tender offers for our shares, which may ultimately affect the market price of our common stock.

Risks Related to our Intellectual Property, Information Technology, and Data Privacy

Protecting our intellectual property rights may be expensive and demand management's attention, and failure to protect or enforce our intellectual property rights could harm our business and results of operations.

We rely on a combination of trade secret, copyright and trademark laws and confidentiality agreements, along with other contractual provisions to protect our proprietary technology and intellectual property rights, including the content and design of our brand brands and logo, logos, our website, our platform, our software code and our data. We believe that our intellectual property rights are an essential asset of our business and critical to our success. We endeavor to maintain and protect our intellectual property. Despite such efforts, unauthorized parties may attempt to copy aspects of our intellectual property or obtain and use information that we regard as proprietary and, if we do not adequately protect our intellectual property, our brand and reputation could be harmed and competitors may be able to erode or negate our competitive advantage, which could materially harm our business, negatively affect our position in the marketplace, limit our ability to commercialize our technology and delay or render impossible our achievement of profitability. We cannot guarantee that confidentiality agreements we have put into place will not be breached, that we will have adequate remedies in the event of a breach, or that such agreements will adequately protect our intellectual property rights, internally developed technology and other information that we consider proprietary. Moreover, there can be no assurance that our proprietary technology will not be independently developed by competitors or that the intellectual property rights we own or license will provide competitive advantages or will not be challenged or circumvented by our competitors.

Obtaining, maintaining and defending our intellectual property rights can be expensive, and a failure to protect our intellectual property rights in a cost-effective and meaningful manner could have a material adverse effect on our ability to compete. In particular, we believe it is important to maintain, protect and enhance our brands. Accordingly, we pursue the registration of domain names and our trademarks and service marks in the United States. Third parties may challenge our use of our trademarks, oppose our trademark applications, or otherwise impede our efforts to protect our brand. In the event that we are unable to register our trademarks in certain jurisdictions, we could be forced to rebrand our products, services, which could slow our growth in those jurisdictions, harm our brand recognition, or could require us to devote resources to advertising and marketing new brands.

In addition, we may not always detect or protect against infringement of our intellectual property rights. Litigation may be necessary to enforce or defend our intellectual property rights or determine the validity and scope of proprietary rights claimed by others. Any litigation of this nature, regardless of outcome or merit, could result in substantial costs and diversion of management attention and technical resources, any of which could adversely affect our business and results of operations. Furthermore, our efforts to enforce our

intellectual property rights may be met with defenses, counterclaims, countersuits and adversarial proceedings that attack the validity and enforceability of our intellectual property rights.

If we fail to maintain, protect and enhance our intellectual property rights, our business, results of operations and financial condition may be harmed and the market price of our common stock could decline.

In the future, we may be subject to claims that we violated intellectual property rights, which can be costly to defend and could require us to pay significant damages and limit our ability to operate.

We cannot be certain that the operation of our business does not and will not infringe the intellectual property rights of others, or that third parties will not claim, legitimately or otherwise, that our products and services infringe their intellectual property rights. Our future success could be affected by claims of intellectual property infringement, whether or not such

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claims have merit. There may be intellectual property rights held by others that cover important parts of our technologies, content, branding or business methods, and we may be unaware of such rights.

We may be subject to legal proceedings and claims in the ordinary course of our business, including claims of alleged infringement of intellectual property rights of third parties by us or our consumers in connection with their use of our products and services. These claims also could subject us to significant liability for damages and could force us to stop using technology, content, branding or business methods found to be in violation of another party's intellectual property rights. We might be required or may opt to seek a license for rights to intellectual property rights owned by others, which may be unavailable on commercially reasonable terms, or at all. We could be required to pay significant royalties to license products, increasing our operating expenses. We may also be required to develop alternative non-infringing technology, content, branding or business methods, which could require significant effort and expense, be infeasible or make us less competitive in the market. Such disputes could also disrupt our business, which could adversely impact our consumer satisfaction and ability to attract consumers. Some of our competitors may be able to sustain the costs of complex patent litigation more effectively than we can because they have substantially greater resources. If we cannot license or develop technology, content, branding or business methods for any allegedly infringing aspect of our business, we may be unable to execute our business strategy. Furthermore, we may be obligated to indemnify other parties as a result of litigation. In the case of infringement or misappropriation caused by technology that we obtain from third parties, the indemnification or other protections we receive from such third parties, if any, may be insufficient to cover the liabilities we incur as a result of such

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infringement or misappropriation. Any of these outcomes could have knock-on effects and harm our business and operating results.

We may not be able to maintain the accuracy, integrity or availability of our data.

Our Bright HealthCare and Consumer Care businesses are highly dependent on the accuracy, integrity and availability of the data we generate and use to serve our consumers, Care Partners care partners and other constituents, and to provide patient care. The volume of healthcare data generated, and the uses of data, including for electronic health records, are rapidly expanding. Our ability to implement new and innovative services, adequately price our products and services, provide timely and effective service to our consumers and clients and accurately report our results of operations depends on the accuracy and the integrity of the data in our information systems. If the data we rely upon to run our businesses is found to be inaccurate, unreliable or unreliable, unavailable, we could experience adverse effects on our ability to effectively conduct our business, including our ability to:

- accurately estimate revenue and medical costs;
- establish appropriate collect payments and timely pricing and accurately code confirm eligibility of our consumers' RAF scores; consumers;
- prevent, detect and control fraud;
- prevent disputes with consumers and network providers;
- prevent errors in medical records;
- manage value-based care contracts;
- prevent regulatory sanctions, scrutiny or penalties; and
- reduce the incurrence of increased operating expenses.

Our new enterprise resource planning system may prove ineffective.

In 2022, we implemented a new We have an enterprise resource planning ("ERP") system, which includes a system for recording revenue and performing day-to-day business activities, such as accounting, procurement, and supply chain. Our ERP system is key to our ability to execute our strategy, provide important information to management, accurately maintain our books and records, prepare our financial statements in a timely and efficient manner and fulfill our contractual obligations. Our businesses may be disrupted if the system does not work as expected. Such disruptions could impact our ability to make payments timely or accurately to our service providers. This system may also discover or create data integrity problems or other technical issues, which could impact our business or financial results. In addition, periodic or prolonged disruption of our financial functions could result from our adoption of the new system, general use of the ERP system, regular updates or other external factors outside of our control. If unexpected issues arise with our ERP system or related systems or technology infrastructure, our business, results of operations and financial condition could be adversely affected.

Our The technology platform systems and platforms we utilize may not operate properly or as we expect it them to operate. We must continue to develop and maintain our technology platform to grow our business.

Our ability to drive brand awareness and to increase our membership and client base in our Bright HealthCare and Consumer Care businesses will depend, in part, on our ability to develop and improve our healthcare platform, BiOS, which includes Panorama, our administrative platform supporting our employees, and Consumer360, our intelligent data hub. Although we launched the initial version of BiOS in 2021, we are still in the process of fully developing it. We cannot assure you that it the technology systems and platforms we use will be broadly adopted by the market, including operate properly or as we expect them to operate. We or our consumers, providers and third-party payors, or that any component of BiOS will be timely completed. This system vendors may encounter unforeseen difficulties, such as performance problems, undetected defects or errors, data integrity problems or other and technical glitches. Any of these issues could impact the user experience and cause us to lose consumers, providers and payors, which could adversely impact our ability to execute on our growth strategy and adversely affect our business and results of operations.

Furthermore, recent trends toward greater consumer and client engagement in healthcare require new and enhanced technologies, including more sophisticated applications for mobile devices. Our information systems and platforms require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards and changing consumer and client preferences.

In addition, we periodically consolidate, integrate, upgrade and expand our information technology systems' capabilities as a result of technology initiatives and new regulations, changes in our system platforms and integration of new business acquisitions. Any failure to protect, consolidate and integrate our systems successfully could result in higher-than-expected costs and diversion of management's time and energy, which could materially and adversely affect our results of operations, financial position and cash flows. In addition, if any such failure causes our platform to malfunction or be temporarily unavailable, our existing consumers could become dissatisfied and leave our platform to join a competitor, we may be unable to attract new consumers and our brand and reputation could be adversely impacted. As a result, our revenue may not grow as expected, which could have a material adverse effect on our business, financial condition and results of operations.

Security incidents or breaches, loss of data and other disruptions to our or our third-party service providers' systems, information technology infrastructure, and networks could compromise sensitive or legally protected information related to our business or consumers, disrupt our business operations, and expose us to liability, which could adversely affect our business and our reputation.

In the ordinary course of our business, we create, receive, collect, maintain, store, use, process, transmit and disclose ("Process") sensitive data, including PHI, and other types of personal data, personal information or personally identifiable information protected by various laws and regulations (collectively, "PII"). We also use third-party service providers to Process PHI, PII, sensitive information and other confidential information, including that of our consumers and service providers. We manage and maintain our technology platform and data using a combination of on-site systems, managed data center systems and cloud-based systems. Because of the sensitivity of the PHI, other PII and other confidential information we and our consumers and service providers process, the security of our technology platform and other aspects of our services, including those provided or facilitated by our third-party service providers, are critically important to our operations and business strategy.

The operation, stability, integrity and availability of our technology platform and underlying network infrastructure are critical to the implementation of our business strategy, our financial results, our brand and reputation, our relationship with our Care Partners, care partners, consumers, network providers, broker network, third-party providers and other key constituents. Any system failure, including network, software or hardware failure, that causes an interruption in our network or a decrease in the responsiveness of our technology platform could result in dissatisfaction and a loss of trust with those constituents and adversely impact our business and reputation. Although we have redundancies in place that will permit us to respond, at least to some degree, to service outages, it could take significant time to have all systems fully operational and our third-party cloud providers are also subject to vulnerabilities.

Security incidents and breaches of our infrastructure or our third-party service providers' infrastructure, including physical or electronic break-ins, computer viruses, ransomware, or other malware, employee or contractor error or malfeasance, can disrupt or shut down our systems, or allow unauthorized access to, or misuse, disclosure, modifications or loss of confidential information, PHI, and other PII. PII, and result in a material adverse impact to our results of operations and business, including our ability to collect payments, process claims, and confirm patient information. Such breaches could result in legal claims or proceedings, liability under laws and regulations that protect the privacy of PHI or other PII, such as HIPAA, the CCPA, and other state and federal laws and regulations. We may also be required to notify government authorities, individuals, the media, and other third parties in connection with a security incident or breach involving PHI or other PII, and could become subject to investigations, consent decrees, resolution agreements, monitoring agreements and similar agreements, and civil penalties. We require business associates and other outsourcing subcontractors who handle consumer and patient information to enter into business associate agreements, if applicable, and to agree to use reasonable efforts to safeguard PHI, other PII and other sensitive information. However, these measures may not adequately protect us from the risks associated with the Processing of such information.

In addition, breaches of our security systems or those systems used by our third-party service providers or other cyber security incidents could also result in the misappropriation of confidential or proprietary information of ourselves, our consumers, our patients, or other third parties; viruses, spyware, ransomware or other malware being served from our network, platform or systems; the deletion or modification of content or the display of unauthorized content on our platform; the loss of access to critical data or systems through ransomware, destructive attacks or other means; and business delays, service or system disruptions such as denials of service attacks. For example, although none In 2023, certain of our consumers' PHI or PII was put at risk in either case, in 2021, one vendors experienced data security incidents. Upon learning of each such incident, we promptly took steps to cut off access to any of our third-party suppliers was subject systems that connected to a ransomware attack, which caused delays in our claims payment processing to consumers. Further, in 2022 and 2023, unauthorized third parties gained access to the internal any systems of two separate such vendor, and took other preventative measures, such as supplementing existing security monitoring, scanning and protective measures, as appropriate. These vendors notified appropriate governmental authorities and impacted parties and individuals, as required. While we did not suffer any material adverse impact as a result of ours. any of these incidents, we may incur significant costs to address or prevent future incidents, implement remedial measures, mitigate violations, and address reputational damage.

We cannot guarantee that our recovery protocols and backup systems or those of our third-party service providers will be sufficient to prevent data loss now or in the future, or that our remedies against third-party service providers will be sufficient to protect us in the event such a service provider suffers a security breach or similar incident.

If we and our third-party service providers are not or are perceived to not be able to prevent such security breaches or privacy violations or implement acceptable remedial measures, we and our third-party service providers may be unable to operate our platform, perform our services, provide consumer assistance services, maintain accurate patient medical

records, conduct research and development activities, collect, process and prepare company financial information, or provide information about our current and future products. services. There can be no assurance that we or our third-party service providers will be able to prevent another a security incident such as occurred with True Health or that any future incidents will not have a more significant impact on our operations. There is an increased risk that we may experience cyber security-related events such as COVID-19-themed phishing attacks and other security challenges as a result of our employees and service providers working remotely from non-corporate-managed networks during the ongoing pandemic and beyond. The True Health breach and any Any future such breaches and violations may result in litigation, fines and penalties, require us to comply with breach notification laws, require us to verify the accuracy of database contents, and expose us to material operating expenses related to investigation, remediation and resolution of claims, all of which could result in increased costs.

As a result, we could suffer a loss of business and we may suffer reputational harm, adverse impacts on consumer and investor confidence and negative impact to our results of operations.

We rely on various third-party service providers to support the operation of our business. If these service providers fail to meet their contractual obligations to us or comply with applicable laws or regulations, or if we are unable to renew our contracts with them, our business may be adversely affected.

We rely on a number of third parties to perform certain operational functions and services for us, as well as to support our technology platform and our general services and administration functions. The continued growth of our business will depend, in part, on the ability of these third parties to perform their contractual obligations and our ability to achieve and maintain successful business relationships with these third parties. These third parties include but are not limited to:

- *Claims management vendors.* Our claims management vendors adjudicate and pay claims and generally manage the billing of medical services provided to our consumers and to members of our Consumer Care business' third-party payors and other clients. We rely on two principal suppliers for claims management. Any disruption or loss of either of these suppliers, or failure by them to comply with their contractual obligations and/or to timely and accurately provide

claims information to us, could cause considerable strain on our business, result in delays in billings and collections, and negatively impact the experience of our consumers, our network providers, and our third-party payors and other clients.

•*Utilization management vendors.* Our utilization management vendors assist our business in managing healthcare costs by educating our health plan consumers and directing them to effective, efficient and personalized healthcare treatments based on evidence-based criteria or guidelines. If our utilization management vendors became less effective or were unable to provide their services to us, the costs of healthcare for our consumers may increase and our results of operations and financial condition may be adversely affected. Furthermore, our Consumer Care business also relies on the services of utilization management vendors when our Consumer Care business has been delegated responsibility for utilization management by its third-party payors and other clients.

•*Pharmacy benefit management ("PBM") service providers*. Our PBM services suppliers provide us and certain of our consumers with services that include claims processing, specialty pharmacy services, mail pharmacy services, formulary services and coordination of benefits, retail network pharmacy network, participating pharmacy audits and reporting, all of which are crucial to our business.

•*Cloud service providers and internet infrastructure service providers*. We rely on cloud service providers and other service providers to host certain aspects of our IT infrastructure. We do not control the operation of our cloud service providers' infrastructure or the facilities where their servers are located. The level of service provided by cloud service providers or managed data center providers could affect the availability or speed of our platform, which may also impact the usage of, and our consumers', Care Partners' care partners' and other constituents' satisfaction with, our platform and could seriously harm our business and reputation. We also cannot guarantee that the contractual remedies we may have in place with these service providers would be sufficient to cover our losses.

- *Software license providers*. Our technology platform utilizes We utilize and integrates integrate software licensed from third parties. However, it is possible that this software may not continue to be available on commercially reasonable terms, or at all. Any loss of the right to use any of this software could result in delays in the provisioning of our services until equivalent technology is either developed by us, or, if available, is identified, obtained and integrated. We also cannot guarantee that the contractual remedies we may have in place with such software providers will adequately protect us in the event such software is modified in a manner such that it can no longer be integrated with our own systems and networks, or if such software includes viruses, malware, other corruptants, or security vulnerabilities that impact our own systems and networks.

•*Other vendors of core business functions.* We rely on the systems of our third-party vendors to submit plan enrollment applications from potential consumers. If these systems were to fail or experience disruptions, we could experience significant failures and interruptions of our systems and the systems of our vendors, which could harm our business, operating results and financial condition. Because the Medicare annual enrollment period is typically open for a limited time each year and is critical to our overall annual consumer enrollment, if these failures or interruptions occurred during that period or during other open enrollment periods, the negative impact on us would be amplified and could result in harm to our business and results of operations.

While we have entered into agreements with these third-party service providers, they have no obligation to renew their agreements on similar terms or on terms that we find commercially reasonable, or at all. Identifying replacement third-party service providers, and negotiating agreements with them, requires significant time and resources. If any one of our material third-party service provider's ability providers' abilities to perform their obligations was were impaired, we may not be able to find an alternative supplier in a timely manner or on acceptable financial terms, and we may not be able to meet the full demands of our consumers and Care Partners care partners within the time periods expected, or at all. While we believe we will be able to insource the responsibilities of many of our third-party service providers in the future, there can be no assurance that we will be able to do so in a manner that enables us to meet the demands of our consumers and Care Partners. care partners.

In addition, any shift in business strategy, corporate reorganization, or financial difficulties faced by our third-party providers, such as bankruptcy, may have negative effects on our ability to execute our business strategy. If our third-party providers are unable to keep up with our growing needs for capacity, it could have an adverse effect on our business and reputation, cause us to lose consumers or harm our ability to attract new consumers to our health plan business, or to maintain and grow our other businesses. In the event we make any material changes to our third-party service providers

due to changes in our business needs or otherwise, such as mid-year changes or efforts to insource currently outsourced services, we may experience significant operational and service disruptions.

In addition, we may not be able to ensure that our third-party providers perform in accordance with agreed upon, regulated and expected standards, and we could be held accountable for their failure to do so which may subject us to fines or other

sanctions or otherwise materially negatively impact our business and results of operations. See "— We are subject to inspections, reviews, audits and investigations under federal and state government programs and contracts. The results of such audits could adversely and negatively affect our business, including our results of operations, liquidity, financial condition and reputation."

Any termination of our agreements with, or disruption in the performance of, one or more of these service providers could result in service disruption or unavailability, and harm our ability to continue to develop, maintain and improve our products. service offerings. This could reduce our ability to attract Care Partners, limit enrollment in our health plan business, care partners, increase our medical costs, hinder expansion of our Consumer Care business, and result in an inability to meet our obligations or require us to seek alternative service providers on less favorable contract terms, any of which could adversely affect our business, brand, reputation or operating results.

Further, in connection with the transition to of our updated business model we have become subject over the last two years has subjected us to an increased number of disputes with service providers, and we expect to continue to be subject to an increased number several of such these disputes while we are in transition. We cannot guarantee we will resolve these disputes favorably, which could materially negatively impact our business, results of operations, financial condition and cash flows.

Risks Related to our Indebtedness

Our ability to incur a substantial level of indebtedness may reduce our financial flexibility, affect our ability to operate our business, and divert cash flow from operations for debt service.

As of March 1, 2023 December 31, 2023, we had $46.1 million of outstanding letters of credit $66.4 million borrowed under the New Credit Agreement (as defined in the *Indebtedness* section of the Results of Operations within Item 7 of this Annual Report), and no remaining availability thereunder. Based on our projected cash flows and absent any other action, we will require additional liquidity to meet our obligations as they come due in the 12 months following the date of this annual report on Form 10-K.

In the event we obtain additional equity or debt financings, the terms of such financings may include covenants we may not be able to meet, which may result in the obligations under such financings being accelerated. In the event we require additional financing, we may not be able to obtain it on acceptable terms, as any potential financing will be subject to market conditions that are not within our control. In the event we are unable to obtain financing or take other management actions to alleviate these concerns, among other potential consequences, we may be unable to satisfy our financial obligations as they become due or continue as a going concern.

Our borrowings, current and future, will require interest payments and will need to be repaid or refinanced, which could require us to divert funds identified for other purposes to debt service and could create additional cash demands or impair our liquidity position and add financial risk. Diverting funds identified for other purposes for debt service may adversely affect our business and growth prospects. If we cannot generate sufficient cash flow from operations to service our debt, we may need to refinance our debt, dispose of assets, reduce or delay expenditures, or issue equity to obtain necessary funds. We do not know whether we would be able to take any of these actions on a timely basis, on terms satisfactory to us or at all.

Our level of indebtedness could affect our operations in several ways, including but not limited to the following:

- it may be difficult for us to satisfy our obligations with respect to our debt;
- the covenants contained in the Credit Agreement any current or in future agreements governing our outstanding indebtedness credit agreement may limit our ability to borrow additional funds, refinance debt, dispose of assets, and make certain investments;
- our debt covenants investments, and may also affect our flexibility in planning for, and reacting to, changes in the economy and in our industry;
- a high level of debt would increase our vulnerability to general adverse economic and industry conditions;
- a high level of debt may place us at a competitive disadvantage as compared to our competitors that are less leveraged and therefore may be able to take advantage of opportunities that our level of indebtedness would prevent us from pursuing; and
- a high level of debt may impair our ability to obtain additional financing in the future for working capital, capital expenditures, debt service requirements, acquisitions, or other purposes.

In addition, borrowings under the Credit Agreement credit agreements often bear interest at variable rates based on prevailing conditions in the financial markets, and changes to such variable market rates may affect both the amount of cash we must pay for interest as well as our reported interest expense. Assuming our $350 million credit facility were to be

fully drawn, a 100 basis point increase to the applicable variable rate of interest would increase the amount of interest expense by $3.5 million per annum.

If we are unable to generate sufficient cash flows to pay the interest expense on our debt, future working capital, borrowings, or equity financing may not be available from which to pay or refinance such debt. Further, the publication of LIBOR is expected to be discontinued in mid-2023. We are currently assessing the impact that the discontinuation of LIBOR may have on us. It is possible that the transition from LIBOR will result in interest rates and/or payments that result in higher borrowing costs over time than would have been our obligations if LIBOR continued to be available in its current form. See "Management's Discussion and Analysis of Financial Condition and Results of Operations — Liquidity and Capital resources — Indebtedness."

The Credit Agreement Our current credit agreement contains, and any agreements governing future debt issuances may contain, restrictions on our ability to operate our business and to pursue our business strategies, and our failure to comply with, cure breaches of, or obtain waivers of covenants could result in an acceleration of the maturity date on our indebtedness.

The Credit Agreement Our current credit agreement contains, and any agreements governing future debt issuances may contain, contain, covenants that restrict our ability to finance future operations or capital needs, to respond to changing business and economic conditions, or to engage in other transactions or business activities that may be important to our growth strategy or otherwise important to us. The Credit Agreement Our current credit agreement restricts, subject to certain exceptions, among other things, our ability and the ability of our subsidiaries to:

- incur additional indebtedness and guarantee indebtedness;
- create or incur liens;
- make investments and loans;
- engage in mergers, consolidations, or sales of all or substantially all of our assets;
- pay dividends or make other distributions, in respect of, or repurchase or redeem, capital stock;
- prepay, redeem, or repurchase certain debt;
- engage in certain transactions with affiliates;
- sell or otherwise dispose of assets; and
- amend, modify, waive, or supplement certain subordinated indebtedness to the extent such amendments would be materially adverse to lenders.

In addition, any future financing arrangements entered into by us or any of our subsidiaries may contain similar restrictions. As a result of these covenants and restrictions, through our subsidiaries we are and will be limited in how we conduct our business, and we may be unable to raise additional debt or equity financing to compete effectively or to take advantage of new business opportunities. In addition, we are required to maintain specified financial ratios and satisfy other financial condition tests. See "Management's Discussion and Analysis of Financial Condition and Results of Operations — Liquidity and Capital Resources — Indebtedness." The terms of any future indebtedness we or our subsidiaries may incur could include more restrictive covenants. We cannot assure you that we will be able to maintain compliance with these covenants in the future and, if we fail to do so, that we will be able to obtain waivers from the lenders and/or amend the covenants.

Our or our subsidiaries' failure to comply with the restrictive covenants described above as well as others contained in our or our subsidiaries' future debt instruments from time to time could result in an event of default, which, if not cured or waived, could require us to repay these borrowings before their maturity. As of September 30, 2022, we were not in compliance with the total debt to capitalization ratio covenant of our Credit Agreement. On November 8, 2022, we executed an amendment to the Credit Agreement pursuant to which, among other things, it was agreed that we would not be required to testour debt to capitalization ratio covenant during and including the four quarter test period ending September 30, 2022 through and including the four quarter test period ending September 30, 2023.

Further, as noted earlier, we breached the minimum liquidity covenant of our Credit Agreement in the first quarter of fiscal year 2023. We entered into a limited waiver and consent (the "Waiver") under our Credit Agreement, which, among other things, provides for a temporary waiver for the period from January 25, 2023 through April 30, 2023 of compliance with the minimum liquidity covenant set forth in Section 11.12.2 of the Credit Agreement. During the Waiver Period, the Company will be subject to a minimum liquidity covenant of not less than $75 million until March 3, 2023, and not less than $85 million thereafter until the end of the Waiver Period. In addition, during the Waiver Period, the Company will not have access to certain negative covenant baskets and will be subject to additional cash-flow and cash balance reporting

requirements. Any non-compliance with the covenants under the Credit Agreement or the Waiver may result in the obligations under the Credit Agreement being accelerated. Based on our projected cash flows and absent any other action, we will require additional liquidity to meet our obligations as they come due in the 12 months following the date the consolidated financial statements are issued. These conditions raise substantial doubt about our ability to continue as a going concern. In addition, as we previously disclosed,

during the waiver period referred to above, we will not have access to certain negative covenant baskets and will be subject to additional cash-flow and cash balance reporting requirements, which limits our ability to execute on our updated strategy.

If we are forced to refinance our borrowings on less favorable terms or cannot refinance them, our results of operations and financial condition could be adversely affected. If we were unable to repay or otherwise refinance these borrowings, the lenders under the Credit Agreement could proceed against the collateral granted to them to secure such indebtedness, which our current credit agreement, and any agreements governing future debt issuances, could force us into bankruptcy or liquidation. Any acceleration of amounts due under the Credit Agreement, our current credit agreement, and any agreements governing future debt issuances, or the exercise by the applicable lenders or agent of their rights under the any related security documents, would likely have a material adverse effect on our business.

Risks Related to Legal Proceedings and Governmental Regulations

Modifications or changes to the U.S. health insurance markets, including as a result of legislation, could adversely affect our business and operating results.

Our business operates in the evolving public and private sectors of the U.S. health insurance system, and our future financial performance will depend in part on growth in the market for private health insurance, as well as our ability to adapt to regulatory developments and the development of new state and federal government programs. Such modifications and changes could reduce demand and adversely affect our business. For example, elected officials have introduced proposals to expand the Medicare program, which range from the creation of a new single-payor national health insurance program for all residents to less overarching proposals, including lowering the age of eligibility for the Medicare program, expanding Medicare to a larger population and creating a new public health insurance option that could compete with

private insurers. In addition, in some states, legislators have regularly introduced proposals to establish a single-payor or government-run healthcare system at the state level. There is uncertainty regarding whether, when, and what other health reform measures will be adopted, the timing and implementation of alternative provisions, and the impact of alternative provisions on providers, plans, and other healthcare industry participants. Other health reform initiatives and proposals, such as the limitations and prohibitions on surprise billing enacted under the Appropriations Act and price transparency requirements, may impact prices, our competitive position and our relationships with patients, consumers, insurers, and ancillary providers (such as anesthesiologists, radiologists, and pathologists). Other industry participants, such as private payors and large employer groups and their affiliates, may also introduce financial or delivery system reforms. The U.S. Department of Health These and Human Services proposed regulatory changes for 2023 and beyond whereby individual market health plan products would need to meet standardized benefit design requirements and heightened network adequacy standards that may impact how our products operate in existing service areas. These other changes may impact our ability to ensure Care Partner care partner networks meet evolving adequacy and availability standards. Until the details of these evolving requirements and any additional future reform standards are clarified, we are unable to predict the nature and success of such health reform initiatives, which may have an adverse impact on our business. We continue to evaluate the effect that such proposals would have on our business.

As the regulatory and legislative environments within which we operate are evolving, we may not be able to ensure timely compliance with such changes due to limited resources. Furthermore, we face challenges prioritizing the allocation of resources between implementing systems responsive to new legislative or regulatory requirements, focusing on growth-related operations and implementing adequate management systems and controls. If our operations are found to be in violation of any of the federal and state regulations that apply to us, we may be subject to penalties that curtail our operations, which could adversely affect our ability to operate our business and our results of operations.

We are unable to predict the ultimate impact of the CARES Act and other stimulus legislation, or the effect that such legislation and other governmental responses intended to assist providers in responding to COVID-19, may have on our business.

In response to the ongoing COVID-19 pandemic, federal and state governments have passed legislation, promulgated regulations and taken other administrative actions intended to assist healthcare providers in providing care to COVID-19 and other patients during the public health emergency and to provide financial relief. Together, the CARES Act, the Paycheck Protection Program and Health Care Enhancement Act, the Appropriations Act, and the American Rescue Plan

Act (ARPA) authorized over $186 billion in funding to be distributed to eligible healthcare providers.These funds are intended to reimburse eligible providers, including Medicare- and/or Medicaid-enrolled providers and suppliers, for lost revenues and health care related expenses attributable to COVID-19. Recipients are not required to repay these funds, provided that they attest to and comply with certain terms and conditions, including limitations on balance billing, not using funds received to reimburse expenses or losses that other sources are obligated to reimburse and audit and reporting requirements.

The CARES Act also made other forms of financial assistance available to healthcare providers, including through Medicare and Medicaid payments adjustments. The CARES Act and related legislation temporarily suspended the Medicare sequestration payment adjustment, which would have otherwise reduced payments to Medicare providers by 2%, but

extended sequestration through 2030. The sequestration adjustment was phased back in and returned to 2% on July 1, 2022. For the first six months of fiscal year 2030, the adjustment will increase to 2.25%, and for the last six months of fiscal year 2030, the adjustment will increase to 3%. ARPA, in addition to providing funding for healthcare providers, increases the federal budget deficit in a manner that triggers an additional statutorily mandated sequestration under the Pay-As-You-Go Act. Congress has delayed implementation of this 4% payment reduction several times, most recently for 2023 and 2024 in the Consolidated Appropriations Act, 2023.

Beyond financial assistance, federal and state governments have enacted legislation and established regulations intended to increase access to medical supplies and equipment and ease legal and regulatory burdens on healthcare providers. These efforts have included, for example, expanding access to and payment for telehealth services. There is still a high degree of uncertainty surrounding potential future legislation passed in response to the COVID-19 pandemic and additional future virus variants. HHS' interpretation of such underlying terms and conditions, including auditing and reporting requirements, continues to evolve. Further, we may be subject to or incur costs from related government actions including payment recoupment, audits and inquiries by governmental authorities, and criminal, civil or administrative penalties.

Some of the federal and state legislative and regulatory measures allowing for flexibility in delivery of care and various financial supports for health care providers are available only for the duration of the COVID-19 public health emergency. Many states have ended their declared states of emergency, and the current public health emergency declaration is set to expire May 11, 2023. Additionally, the federal government may consider additional stimulus and relief efforts, but we are unable to predict whether any additional measures will be enacted or their impact. We are unable to assess the extent to which anticipated ongoing impacts on us arising from the COVID-19 pandemic will be offset by benefits which we may recognize or receive in the future under the CARES Act and other stimulus legislation or any future stimulus measures. Further, there can be no assurance that the terms of provider relief funding or other programs will not change in ways that affect our funding or eligibility to participate. We continue to assess the potential impact of the COVID-19 pandemic and government responses to the pandemic on our business, results of operations, financial position and cash flows.

Our MA plans, contracts with third-party MA plans and reimbursement from fee-for-service Medicare are subject to changes to the Medicare program.

We service approximately 125,000 MA consumers, primarily in California. The reimbursement rates for our MA plans and Our contracts with third-party MA plans are based on published Medicare rates. In addition, our managed and affiliated medical groups receive fee-for-service Medicare reimbursements. As a result, government funding levels for the MA program, as well as the policies and decisions of the federal government regarding the fee-for-service Medicare program have a substantial impact on our profitability and health plan consumer satisfaction. These governmental policies and decisions, which are not within our control, include:

- administrative or legislative changes to base rates or reimbursement policies and methodologies;
- reductions or restrictions in funding of programs;
- limits on the services or types of providers for which Medicare will provide reimbursement;
- expansion of benefits under Medicare without adequate funding;
- other changes in coverage (including those related to the ongoing COVID-19 pandemic);
- changes in methodology for patient assessment and/or determination of payment levels;
- the reduction or elimination of annual rate increases; and
- changes to timing of or delays in reimbursements.

Certain of these changes will affect the premiums or other revenue we receive with respect to our MA plans, the eligibility and enrollment of consumers in our MA plans, the services we provide to our MA plan consumers and the cost of such services to such consumers, as well as other costs relating to our participation in the Medicare program. Significant reductions or significant modifications of reimbursement policies and methodologies in the fee-for-service Medicare program could reduce the profitability of our managed and affiliated medical groups. We have no control over these changes, including when or how frequently they are made. These changes may be instituted by statutes, regulations, administrative or executive orders or judicial decisions. Budget pressures often lead the federal government to reduce or place limits on reimbursement rates under Medicare. Implementation of these and other types of measures could result in substantial reductions in our revenue and operating margins with respect to our MA plans and our Consumer Care business. The costs of compliance with any changes could be significant, and if we fail to meet implementation requirements, we could be exposed to fines and payment reductions.

In addition, CMS issues a final rule each year to establish the benchmark MA payment rates for the following calendar year. Any reduction to MA rates may have a material adverse effect on our business, results of operations, financial condition and cash flows. The final impact of the MA rates can vary from any estimate we may have, and may be exacerbated by the rapid growth of our MA membership. If we underestimate the impact of any change to the MA rates on our business, it could have a material adverse effect on our results of operations, financial condition and cash flows.

If we fail to comply with certain healthcare laws, including fraud and abuse laws, we could face substantial penalties and our business, results of operations and financial condition could be adversely affected.

Our business is highly regulated, and we are subject to broadly applicable federal and state fraud and abuse and other federal and state healthcare laws and regulations. These laws require significant compliance oversight, which can have the effect of constraining our businesses, financial arrangements and relationships through which we conduct our operations. Laws and regulations which particularly affect our business and operations, include the following:

- the federal Anti-Kickback Statute, which prohibits, among other things, persons or entities from knowingly and willfully soliciting, offering, receiving or providing any remuneration (including any kickback, bribe or certain rebates), directly or indirectly, overtly or covertly, in cash or in kind, in return for, either the referral of an individual or the purchase, lease or order or arranging for or recommending the purchase, lease or order of any good, facility, item or service, for which payment may be made, in whole or in part, under a federal healthcare program such as Medicare. The federal Anti-Kickback Statute has been interpreted to apply to, among others, financial arrangements between entities that have the ability to refer and generate business that is subject to reimbursement under federal healthcare programs. There are a number of statutory exceptions and regulatory safe harbors protecting some common activities from prosecution. The exceptions and safe harbors are drawn narrowly and practices that involve remuneration may be subject to scrutiny if they do not qualify for an exception or safe harbor. Our practices may not in all cases meet all of the criteria for protection under a statutory exception or regulatory safe harbor. A person or entity does not need to have actual knowledge of the federal Anti-Kickback Statute or specific intent to violate it in order to have committed a violation, and a claim including items or services resulting from a violation of the federal Anti-Kickback Statute constitutes a false or fraudulent claim for purposes of the FCA (described immediately below);

- the federal false claims laws, including the civil FCA, which, among other things, impose criminal and civil penalties against individuals or entities for knowingly presenting, or causing to be presented, to the federal government, claims for payment or approval that are false or fraudulent, knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim, or from knowingly making or causing to be made a false statement to avoid, decrease or conceal an obligation to pay money to the federal government. There has been increased government scrutiny and litigation involving Medicare plans under the federal FCA related to diagnosis coding and risk adjustment practices. While we believe that our risk adjustment practices and relationships with providers comply with applicable laws, we are and may be subject to audits, reviews and investigation of our practices and arrangements and the federal government might conclude that they violate the FCA, the Anti-Kickback Statute and/or other federal and state laws governing fraud and abuse. Further, the FCA can be enforced by private citizens through civil qui tam actions. A claim includes “any request or demand” for money or property presented to the U.S. government;

- the Stark Law provides that physicians, subject to certain exceptions, cannot refer Medicare or Medicaid patients to an entity providing “designated health services” in which such physician, or its immediate family member, has an interest or any compensation arrangement. Medical groups managed by and affiliated with our Consumer Care business provide

one or more of these designated health services and as such are subject to the Stark Law. Those found in violation of the Stark Law are subject to denial of payment for services provided through an improper referral, civil monetary penalties and exclusion from the Medicare and Medicaid programs;

- the federal beneficiary inducement civil monetary laws, which generally prohibit giving something of value to an individual if the remuneration is likely to influence that beneficiary’s choice of a particular provider, supplier or practitioner for services covered by applicable federal healthcare programs. A violation of this statute includes fines or exclusion from federal healthcare programs;

- HIPAA, which created additional federal criminal statutes that prohibit, among other things, knowingly and willfully executing, or attempting to execute, a scheme to defraud or to obtain, by means of false or fraudulent pretenses, representations or promises, any money or property owned by, or under the control or custody of, any healthcare benefit program; willingly obstructing a criminal investigation of a healthcare offense; and knowingly and willfully falsifying, concealing or covering up by trick, scheme or device, a material fact or making any materially false, fictitious or fraudulent statement in connection with the delivery of or payment for healthcare benefits, items or services. Like the federal Anti-Kickback Statute, a person or entity need not have actual knowledge of the statute or specific intent to violate it in order to have committed a violation; and

- analogous state and foreign laws and regulations, such as state anti-kickback and false claims laws, which may be more restrictive and may apply to healthcare items or services reimbursed by non-governmental third-party payors, including private insurers or by the patients themselves.

Ensuring business arrangements with third parties comply with applicable healthcare laws and regulations is a costly endeavor. If our operations are found to be in violation of any of the federal and state healthcare laws described above or any other current or future governmental regulations that apply to us, we may be subject to penalties, including without limitation, civil, criminal and/or administrative penalties, damages, fines, disgorgement, individual imprisonment, exclusion from participation in government programs, such as Medicare, injunctions, private “qui tam” actions brought by individual whistleblowers in the name of the government, or refusal to allow us to enter into government contracts, contractual damages, reputational harm, administrative burdens, diminished profits and future earnings, additional reporting obligations and oversight if we become subject to a corporate integrity agreement or other agreement to resolve allegations of non-compliance with these laws, and the curtailment or restructuring of our operations, any of which could adversely affect our ability to operate our business and our results of operations.Any claims made against us, regardless of

their merit or eventual outcome, could damage our reputation and business and our ability to attract and retain consumers and employees.

Our use and disclosure of PII and PHI is subject to federal and state privacy and security regulations, and our failure to comply with those regulations or to adequately secure the information we hold could result in significant liability or reputational harm and, in turn, a material adverse effect on our client base and revenue.

We are subject to numerous state and federal laws and regulations that govern the Processing, security, retention, destruction, confidentiality, availability and integrity of PII, including PHI. These laws and regulations include HIPAA and the CCPA. HIPAA establishes a set of basic national privacy and security standards for the protection of PHI by health plans, healthcare clearinghouses and certain healthcare providers, referred to as covered entities, which includes us, and the business associates with whom such covered entities contract for services, which also includes us.

HIPAA requires healthcare plans and providers — and until our insurance plans are fully run-out, we are both — to develop and maintain policies and procedures with respect to PHI that is used or disclosed, including the adoption of administrative, physical and technical safeguards to protect such information. HIPAA also implemented the use of standard transaction code sets and standard identifiers that covered entities must use when submitting or receiving certain electronic healthcare transactions, including activities associated with the billing and collection of healthcare claims.

Penalties for failure to comply with a requirement of HIPAA vary significantly depending on the nature of violation and could include civil monetary or criminal penalties. HIPAA also authorizes state attorneys general to file suit on behalf of their residents. Courts are able to award damages, costs and attorneys' fees related to violations of HIPAA in such cases. While HIPAA does not create a private right of action allowing individuals to sue us in civil court for violations of HIPAA,

its standards have been used as the basis for duty of care in state civil suits such as those for negligence or recklessness in the misuse or breach of PHI.

In addition, HIPAA mandates that the Secretary of HHS conduct periodic compliance audits of HIPAA-covered entities and business associates for compliance with HIPAA. It also tasks HHS with establishing a methodology whereby harmed individuals who were the victims of breaches of unsecured PHI may receive a percentage of the fine paid by the violator under the federal Civil Monetary Penalty Statute.

HIPAA further requires that individuals be notified of any unauthorized acquisition, access, use or disclosure of their unsecured PHI that compromises the privacy or security of such information, with certain exceptions related to unintentional or inadvertent use or disclosure by employees or authorized individuals. HIPAA specifies that such notifications must be made "without unreasonable delay and in no case later than 60 calendar days after discovery of the breach", though states and contractual obligations may require us to provide notice within shorter timeframes, such as five days or less. If a breach of unsecured PHI affects 500 individuals or more, it must be reported to HHS without unreasonable delay, and HHS will post the name of the breaching entity on its public web site. Breaches affecting 500 individuals or more in the same state or jurisdiction must also be reported to the local media. If a breach involves fewer than 500 individuals, the covered entity must record it in a log and notify HHS at least annually.

Numerous other federal and state laws protect the processing, security, retention, destruction, confidentiality, availability and integrity of, and may otherwise limit and restrict how we can use, PII, including PHI. These laws in many cases are more restrictive than, and may not be preempted by, the HIPAA rules and may be subject to varying interpretations by courts and government agencies, creating complex compliance issues for us and our Care Partners care partners and business associates and potentially exposing us to additional expense, adverse publicity and liability. For example, Recently, several states have enacted broadly applicable laws to protect the CCPA which came into effect on January 1, 2020 requires covered businesses that collect information on California residents to inform consumers about their data privacy of personal health information. These laws generally require consent for the collection, use or sharing of any "consumer health data", which is defined as personal information that is linked or reasonably linkable to a consumer and sharing practices, to allow consumers to opt out of sales of their data to third parties, and to exercise certain individual rights regarding their personal information. The CCPA also provides that identifies a cause of action for some data breaches affecting certain types of personal information. Penalties for noncompliance with the CCPA are up to $2,500 per unintentional violation, consumer's past, present, or up to $7,500 per intentional violation. Additionally, the CPRA was approved by the California electorate via ballot initiative in November 2020, and came into effect January 1, 2023. CPRA imposed additional data protection obligations on companies doing business in California, including additional consumer rights with respect to their data. It also created a new California data protection agency specifically tasked with enforcing the law, which will likely result in increased regulatory scrutiny of California businesses in the areas of data protection and security. Virginia, Colorado, Connecticut and Utah have similarly enacted comprehensive privacy laws which emulate the CCPA and CPRA in many respects. future physical or mental health. At the federal level, various bills have been introduced in congress seeking to establish a comprehensive privacy regime including many of the concepts found in other state and federal privacy bills/laws, such as consent requirements for sensitive data, data subject rights, and privacy policy requirements. Such laws may have potentially conflicting requirements that would make compliance challenging. Such changes may also require us to modify our products services and features and may limit our ability to develop new products services and features that make use of the data that we collect about our consumers. We anticipate federal and state regulators to continue to enact legislation related to privacy and cyber security.

New health information standards, whether implemented pursuant to HIPAA, state or federal legislative action or otherwise, could have a significant effect on the manner in which we must handle healthcare-related data, and the cost of complying with standards could be significant. If we do not comply with existing or new laws and regulations related to PHI, we could be subject to criminal or civil sanctions.

We also publish privacy statements to our consumers that describe how we handle and protect PII. Any failure or perceived failure by us to maintain posted privacy policies which are accurate, comprehensive and fully implemented, and any violation or perceived violation of our privacy-, data protection- or information security-related obligations to providers, consumers or other third parties could result in claims of deceptive practices brought against our Company, which could lead to significant liabilities and consequences, including, without limitation, governmental investigations or enforcement actions, costs of responding to investigations, defending against litigation, settling claims, complying with resolution, monitoring or other agreements, civil penalties, and complying with regulatory or court orders. Such liabilities and consequences could have material impacts on our revenue and operations.

Furthermore, the FTC and many state attorneys general continue to enforce federal and state consumer protection, health breach notification, and other laws against companies for online collection, use, dissemination and security practices that

appear to be unfair or deceptive. For example, the FTC has taken enforcement actions based on disclosures of health information to third parties, the failure to limit third-party use of health information, the failure to implement policies and

procedures to prevent improper or unauthorized disclosures of health information, and the failure to provide notice and obtain consent before the use and disclosure of health information for advertising. For information that is not subject to HIPAA and deemed to be “personal health records”, the FTC may also impose penalties for violations of the HBNR to the extent we are considered a “personal health record-related entity” or “third party service provider.” There are a number of legislative proposals in the United States, at both the federal and state level, that could impose new obligations. We cannot yet determine the impact that future laws, regulations and standards may have on our business.

Our and our vendors’ use of artificial intelligence and machine learning in the products they provide to us present regulatory and legal challenges that could negatively affect our business and our reputation.

Our and our vendors’ use of AI and ML technologies and recent technological advances in AI/ML pose risks to us and may subject us to new laws and regulations. While we are committed to responsible use of AI/ML and following applicable laws and regulations, any failure by our employees, contractors or vendors to use AI/ML responsibly and to adhere to such laws and regulations could have a material adverse effect on our business, results of operations, and financial condition. Depending on how such laws and regulations are interpreted, we may have to make changes to our business practices to comply with such obligations. These obligations may make it harder for us to conduct our business using AI/ML, lead to regulatory fines or penalties, require us to retrain our AI/ML, or prevent or limit our use of AI/ML. Our use of AI/ML technologies could also result in additional compliance costs, regulatory investigations and actions, and consumer or other lawsuits. If we or our vendors are unable to use AI/ML, regulators restrict our ability to use AI/ML for certain purposes or our confidential information or PII or PHI becomes part of a dataset that is accessible by other third-party AI/ML applications and uses, it could make our business less efficient, result in competitive disadvantages, and subject us to potential liabilities. To the extent that we rely on or use the output of AI/ML, any inaccuracies, biases or errors could have adverse impacts on us, our business, our results of operations or financial condition. The impact of regulatory and legal risks associated with AI/ML is unknown and the overall impact on our business may be material.

Laws regulating the corporate practice of medicine could restrict the manner in which we are permitted to conduct our business, and the failure to comply with such laws could subject us to penalties or require a restructuring of our business.

Some of the states in which we currently operate have laws that prohibit business entities from directly owning physician practices, practicing medicine, employing physicians to practice medicine, exercising control over medical decisions by physicians or engaging in certain arrangements, such as fee-splitting, with physicians (such activities are generally referred to as the “corporate practice of medicine”). In some states these prohibitions are expressly stated in a statute or regulation, while in other states the prohibition is a matter of judicial or regulatory interpretation. Other states in which we may operate in the future may also generally prohibit the corporate practice of medicine. While we endeavor to comply with state corporate practice of medicine laws and regulations as we interpret them, the laws and regulations in these areas are complex, changing, and often subject to varying interpretations. The interpretation and enforcement of these laws vary significantly from state to state. Penalties for violations of the corporate practice of medicine vary by state and may result in physicians being subject to disciplinary action, as well as to forfeiture of revenue from payors for services rendered. For business entities such as us, violations may also bring both civil and, in more extreme cases, criminal liability for engaging in the practice of medicine without a license.

Some of the relevant laws, regulations and agency interpretations in states with corporate practice of medicine restrictions have been subject to limited judicial and regulatory interpretation, and state laws and regulations are subject to change. Regulatory authorities and other parties may assert that our employment of physicians in some states means

that we are engaged in the prohibited corporate practice of medicine. If this were to occur, we could be subject to civil and/or criminal penalties, our employment of physicians by our medical groups and the health plans' agreements with physicians could be found legally invalid and unenforceable (in whole or in part) or we could be required to restructure our arrangements with physicians, in each case in one or more of the jurisdictions in which we operate. Any of these outcomes may have a material adverse effect on our business, results of operations, financial condition, cash flows and reputation.

From time to time we are and may be subject to litigation, administrative proceedings or investigations, which could be costly to defend and could strain corporate resources or harm our business.

Legal proceedings and claims that may arise in the ordinary course of business, such as claims brought by consumers, Care Partners and other network participants, care partners, third-party payor clients, consultants and vendors in connection with commercial disputes or employment claims made by our current or former associates could strain corporate responses and involve significant costs. In addition, from

time to time, we are and may be subject to government requests or investigations, including market conduct examinations and requests for information from, various government agencies, regulatory authorities, state attorneys generals general and other governmental authorities. In particular, investigating and prosecuting healthcare and other insurance fraud, waste and abuse has been of special interest to government authorities in the United States. With respect to healthcare, fraud, waste and abuse prohibitions constitute a spectrum of activities, such as kickbacks for referral of consumers, fraudulent coding practices, billing for unnecessary medical and/or other covered services, improper marketing and violations of patient privacy rights and Stark Law violations. Regulators have recently increased their scrutiny of healthcare payors and providers under the federal FCA, in particular, and there have been a number of investigations, prosecutions, convictions and settlements in the healthcare industry.

Litigation and audits, investigations or reviews by governmental authorities or regulators or compliance with applicable laws may result in fines, substantial costs, and potentially, the loss of a license, and may divert management's attention and strain corporate resources, which may substantially harm our business, financial condition and results of operations. While we maintain general liability, umbrella, managed care errors and omissions and employment practices liability coverage, as well as other insurance, we cannot provide assurance that such insurance will cover such claims or provide sufficient payments to cover all of the costs to resolve one or more such claims and will continue to be available on terms acceptable to us, if available at all. It is possible that resolution of some matters against us may result in our having to pay significant fines, judgments or settlements that exceed the limits of our insurance policies. Further, settlements with governmental authorities or regulators could contain additional compliance and reporting requirements as part of a consent decree or settlement agreement, such as corporate integrity agreements, which could significantly increase our regulatory and compliance costs. Additionally, governmental or regulatory authorities could review our payment practices, including as part of their market conduct oversight, which could result in fines or other enforcement actions if such authorities

determine that our payment practices do not comply with state laws and regulations. Any of the foregoing could adversely affect our results of operations and financial condition, thereby harming our business.

We are subject to a pending putative securities class action lawsuit.

On January 6, 2022, a putative securities class action lawsuit was filed against us and certain of our officers and directors in the Eastern District of New York. The case is captioned *Marquez v. Bright Health Group, Inc.* et al., 1:22-cv-00101 (E.D.N.Y.). The lawsuit alleges, among other things, that we made materially false and misleading statements regarding our business, operations, and compliance policies, which in turn adversely affected our stock price. No specific amounts of damages have been alleged in the putative securities class action lawsuit. We intend to vigorously defend this action; but there can be no assurance that we will be successful in any defense. An amended complaint was filed on June 24, 2022, which expands on the allegations in the original complaint and alleges a putative class period of June 24, 2021 through March 1, 2022. The amended complaint also adds as defendants the underwriters of our initial public offering. The Company has served a motion to dismiss the amended complaint, which has not yet been ruled on by the court.This and other legal proceedings could damage our reputation and adversely affect our stock price.

We are subject to inspections, reviews, audits and investigations under federal and state government programs and contracts. The results of any such actions could adversely and negatively affect our business, including our results of operations, liquidity, financial condition and reputation.

From time to time we are subject to various state and federal governmental inspections, reviews, audits and investigations to verify our financial and/or operational compliance with governmental rules and regulations governing the products and services we sell. Care Partners Payors and other health care industry participants may also reserve have the right to conduct audits of our health plan business and third-party payors and government clients of our Consumer Care business will also have the right to audit Consumer Care businesses. We also periodically conduct internal audits and reviews of our regulatory compliance. An adverse inspection, finding, review, audit or investigation could result in requests for additional information, enforcement actions, corrective action plans, monitoring agreements or other actions, including:

- refunding amounts we have been paid pursuant to the government programs including penalties, fines or from payors;
- state or federal agencies imposing fines, penalties and other sanctions, on us;
- temporary suspension of payment for new consumers to the facility or agency;
- decertification, and debarment, suspension or exclusion from participation in the Medicare programs or one or more payor networks;
- self-disclosure of violations to applicable regulatory authorities;
- damage to our reputation;
- the revocation of an agency's license; and
- loss of certain rights under, or termination of, our contracts with payors or Care Partners.exclusion.

The U.S. Department of Justice and the OIG have continuously increased their scrutiny of healthcare payors, providers and Medicare Advantage insurers under the FCA in particular, which has led to a number of investigations, prosecutions, convictions and settlements in the healthcare industry. We expect this trend to continue, particularly in light of the HHS's 2020 announcement regarding the creation of a False Claims Act Working Group aimed at enhancing HHS's partnership with the DOJ to combat fraud and abuse. CMS and the OIG also periodically perform risk adjustment data validation ("RADV") audits of selected Medicare Advantage health insurance plans to validate the coding practices of, and supporting documentation maintained by healthcare providers. Certain of our health plans may be selected for such audits, which could in the future result in retrospective adjustments to payments made to our health plans, fines, corrective action plans or other adverse action by CMS. On January 30, 2023, CMS released a final rule outlining its audit methodology, approach to the use of extrapolation, and related policies for the contract-level MA RADV program. Under the final rule, CMS will extrapolate RADV audit findings beginning with payment year 2018. CMS will only collect the non-extrapolated overpayments identified in the RADV audits and HHS-OIG audits between payment years 2011 and 2017. CMS stated that after April 3, 2023, the effective date of the final rule, CMS will begin issuing enrollee-level audit findings from the RADV audits that have been completed and recovering the enrollee-level improper payments identified in HHS-OIG audits. CMS did not adopt a specific extrapolated audit methodology in the final rule, but stated that CMS will rely on any statistically valid method for sampling and extrapolation that is determined to be well-suited to a particular audit. CMS also stated that it is finalizing a policy whereby CMS will not apply an FFS Adjuster in RADV audits because CMS determined that an FFS Adjuster is not appropriate. The final rule also codifies the requirement that MA organizations remit improper

payments identified during RADV audits in a manner specified by CMS. The final rule is expected to be the subject of legal challenges, but if it takes effect on April 3, 2023, the final rule may have potential adverse effects, which could be material, on the Company's operating results, financial condition, and cash flows, and could result in some combination of degraded plan benefits, higher monthly premiums and reduced choice for the population served by MA insurers. In particular, there has recently been increased scrutiny by the government on health insurers' diagnosis coding and risk adjustment practices, particularly for Medicare Advantage plans. In some proceedings involving Medicare Advantage plans, there have been allegations that certain financial arrangements with providers violate other laws governing fraud and abuse, such as the federal Anti-Kickback Statute.

We may in the future be required to refund amounts we have been paid and/or pay fines and penalties as a result of these inspections, reviews, audits and investigations. In addition, due to our reliance on third-party providers to perform many critical health plan operations, we may not be able to adequately perform pre-delegation audits of such providers' capabilities and/or adequately monitor and oversee their day-to-day performance of our delegated functions to ensure compliance with applicable laws and regulations. The occurrence of adverse inspections, reviews, audits or investigations

or any of the results noted above could have a material adverse effect on our business and operating results. Furthermore, the legal, document production and other costs associated with complying with these inspections, reviews, audits or investigations could be costly. costly and result in damage to our reputation.

Our employees, independent contractors, partners, suppliers and other third parties may engage in misconduct or other improper activities, including noncompliance with regulatory standards and requirements, which could expose us to liability and hurt our reputation.

We are exposed to the risk that our employees, independent contractors, Care Partners, care partners, care providers, partners, suppliers and others may engage in fraudulent conduct or other illegal activity. Misconduct by these parties could include intentional, reckless and/or negligent conduct or disclosure of unauthorized activities to us that violates laws and regulations that we are subject to, including, without limitation, healthcare fraud and abuse laws or laws that require the true, complete and accurate reporting of financial information or data. Such activities could result in regulatory sanctions and cause serious harm to our reputation. It is not always possible to identify and deter misconduct, and the precautions we take to detect and prevent this activity may not be effective in controlling unknown or unmanaged risks or losses or in protecting us from governmental investigations or other actions or lawsuits stemming from a failure to be in compliance with such laws or regulations. In addition, we are subject to the risk that a person or government could allege such fraud or other misconduct, even if none occurred.

If any such actions are instituted against us, and we are not successful in defending ourselves or asserting our rights, those actions could have a significant impact on our business and financial results, including, without limitation, the imposition of significant civil, criminal and administrative penalties, damages, monetary fines, possible exclusion from participation in Medicare, Medicaid and other federal healthcare programs, reputational harm, adverse impact on profitability and our operations, any of which could adversely affect our business, results of operations and financial condition.

Risks Related to our Financial Statements

We have identified material weaknesses in our internal controls over financial reporting and may identify additional material weaknesses in the future or otherwise fail to maintain an effective system of internal controls, which may result in material misstatements of our consolidated financial statements or cause us to fail to meet our periodic reporting obligations.

For the year ended December 31, 2021 December 31, 2022, we identified a material weakness in our related to the control activities component of the Committee of Sponsoring Organizations of the Treadway Commission ("COSO") 2013 revised internal control over financial reporting. integrated framework. A material weakness is a deficiency, or a combination of deficiencies, in internal control over financial reporting such that there is a reasonable possibility that a material misstatement of our annual or interim financial statements will not be prevented or detected on a timely basis. The material weakness identified related to claims pertaining to our IFP business, which were processed by a third-party service provider. The claims were processed inaccurately according to terms of provider contracts and/or related fee schedules, or did not consistently go through claims re-pricing, where necessary, prior to payment.

In response to this material weakness, we focused on enhancing our pre-pay and post-pay claims quality assurance procedures and data mining capabilities. These capabilities have enabled early identification of overpayment issues so the issues can be addressed timely. Additionally, our provider data improvement initiatives have enhanced the accuracy of our provider rosters, determination of in-network versus out-of-network status, and alignment of providers to appropriate

contracts and fee schedules. Finally, additional front-end claims review procedures implemented in the first quarter of fiscal year 2022 have resulted in improved claims payment accuracy, based on fee schedules agreed-upon with providers.

For the year ended December 31, 2022, we identified a new material weakness related to the control activities component of the Committee Of Sponsoring Organizations (COSO) 2013 revised internal control integrated framework. The material weakness relates to the Company's announcement in Q4 2022 to exit the IFP business effective December 31, 2022, and a subsequent decision by management to decrease its focus on performing certain control activities in accordance with policies and procedures. Relevant IFP In 2023, the Company made significant efforts to remediate this material weakness, including conducting additional training sessions to communicate expectations, and enhance awareness and understanding of control activities and related responsibilities, creating or enhancing certain policies and procedures for processes where control deficiencies existed, allocating resources from the Company's discontinued operations to those remaining continuing operations and, significant accounts not evaluated in Q4 2022 include, but are not limited to, revenue and membership, enrollment and eligibility, claims processing and reserving, risk adjustment, and broker commissions. remediating certain control activities that were previously identified as deficient.

With Despite these efforts, the discontinuation Company was unable to conclude the material weakness was remediated as of December 31, 2023. The continuation of the IFP business effective December 31, 2022, management believes this new material weakness will be remediated Company's reorganization in during 2023 resulted in shifting control owner roles and responsibilities across several areas, and changes in the year ended December 31, 2023. scope of relevant controls. These changes caused delays with the performance of certain control activities and/or inconsistencies with how those activities were documented, and as a result, control activities did not consistently have sufficient time to demonstrate operational effectiveness.

We are currently undertaking and evaluating several steps to address this material weakness. However, we cannot assure you that the measures we have taken to date, and actions we may take in the future, will be sufficient to remediate the control deficiency that led to such material weakness or that they will prevent or avoid a potential future material weakness. In addition, we cannot assure you that we have identified all of our existing material weaknesses, or that we will not in the future have additional material weaknesses. Our failure to implement and maintain effective internal controls over financial reporting could result in errors in our consolidated financial statements that could result in a restatement of our financial statements, and could cause us to fail to meet our reporting obligations, any of which could diminish investor confidence in us and cause a decline in the price of our shares of common stock.

Accounting for health plan benefits is complicated and subject to foreseen and unforeseen risks.

Although we have exited the health insurance market, until the run-out of all of our legacy insurance plans is finished, we will continue to account for health plan activities. Accounting for health plan benefits is complicated and involves the use of estimates, assumptions and judgment. While we spend considerable time establishing our estimates and assumptions, we cannot be certain they will be correct. If our estimates are incorrect or if actual circumstances differ from our assumptions, our results of operations could be negatively affected.

Risk Adjustment Programs

The IFP and Medicare Advantage markets employ risk adjustment programs that impact the revenue we recognize for our enrolled membership. Risk adjustment is a process that takes into account the underlying health status and health spending of the enrollees in an insurance plan. It is designed to compensate payors for the level of risk present in their respective members. For proper reimbursement by CMS or payment to CMS, we must ensure that our Care Providers are identifying and properly documenting chronic and severe diagnosis codes/conditions to create an accurate health profile for each consumer. If our Care Partners do not accurately record a consumer's health conditions, we may not be able to accurately estimate the appropriate risk adjustment reimbursement or payment; our estimate could be materially inaccurate due to the many factors that comprise our estimate. Consequently, our estimate of our health plans' risk scores for any period, and any resulting change in our accrual of revenue related thereto, could adversely affect our results of operations, financial condition, and cash flows. Additionally, the data provided to CMS to determine the risk score are subject to audit even several years after the annual settlements occur. If the risk adjustment data we submit are found to incorrectly overstate the health risk of our consumers, we may be required to refund funds previously received and may be subject to penalties or sanctions, including potential liability under the FCA which could be significant. If the data we provide to CMS incorrectly understates the health risk of our consumers, we might be underpaid for the care that we provide to our consumers, which could have a negative impact on our results of operations and financial condition.

Incurred But Not Reported Claims

Because of the elapsed time between when medical services are actually rendered by care providers and when we receive, process and pay a claim for those medical services, our medical care costs incorporate estimates of our incurred but not reported ("IBNR") claims. We estimate our medical cost liabilities using actuarial methods based on historical submissions and payment data, cost trends, patient and product mix, seasonality, utilization of healthcare services, contracted service rates and other relevant factors. Actual conditions could differ from the assumptions we use. We continually review and modify our cost estimation methods and the resulting accruals and make adjustments when the criteria used to determine IBNR claims change and when actual claim costs are ultimately determined. As a result of the uncertainties stemming from the factors used in these assumptions we make about expenses incurred, the actual amount of medical expense that we incur may be materially higher or lower than the amount of IBNR claims originally estimated. If our estimates of IBNR claims are inadequate in the future,

our reported results of operations would be negatively impacted. Further, our inability to estimate IBNR claims accurately may also affect our ability to take timely corrective actions, further exacerbating the extent of any adverse effect on our results of operations. See "Management's Discussion and Analysis of Financial Condition and Results of Operations — Critical Accounting Policies and Estimates."

Failure to comply with requirements to design, implement and maintain effective internal controls could adversely affect our stock price.

As a public company, we have significant requirements for financial reporting and internal controls. The process of designing and implementing effective internal controls is a continuous effort that requires us to anticipate and react to changes in our business and the economic and regulatory environments and to expend significant resources to maintain a system of internal controls that is adequate to satisfy our reporting obligations as a public company. If we are unable to maintain appropriate internal financial reporting controls and procedures, it could cause us to fail to meet our reporting obligations on a timely basis, result in material misstatements in our consolidated financial statements and harm our results of operations. In addition, we are required, pursuant to Section 404 of the Sarbanes-Oxley Act of 2002 ("SOX"), to furnish a report by management on, among other things, the effectiveness of our internal controls over financial reporting in the second annual report following the completion of our initial public offering ("IPO"). reporting. This assessment includes disclosure of any material weaknesses identified by our management in our internal controls over financial reporting. The rules governing the standards that must be met for our management to assess our internal controls over financial reporting are complex and require significant documentation, testing and possible remediation. Testing and maintaining internal controls may divert our management's attention from other matters that are important to our business. Our Depending on the value of our shares of common stock held by the general public, our independent registered public accounting firm is required to issue an attestation report on the effectiveness of our internal controls annually.

In connection with the implementation of the necessary procedures and practices related to internal controls over financial reporting, we may identify deficiencies that we may not be able to remediate in time to meet the deadline imposed by the U.S. Sarbanes-Oxley Act of 2002 ("SOX") SOX for compliance with the requirements of Section 404. In addition, we may encounter problems or delays in completing the remediation of any deficiencies identified by our independent registered public accounting firm in connection with the issuance of their attestation report.

If we fail to effectively remediate material weaknesses in our internal control over financial reporting, if we identify future material weaknesses in our internal control over financial reporting or if we are unable to comply with the demands placed upon us as a public company, including the requirements of Section 404 of the SOX, in a timely manner, we may be unable to accurately report our financial results, or report them within the time frames required by the SEC. Our testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal controls over financial reporting that could be deemed to be material weaknesses, and could result in a material misstatement of our annual or quarterly consolidated financial statements or disclosures that may not be prevented or detected. We may not be able to conclude on an ongoing basis that we have effective internal controls over financial reporting in accordance with Section 404 or our independent registered public accounting firm may not issue an unqualified opinion. If either we are unable to conclude that we have effective internal controls over financial reporting or our independent registered public accounting firm is unable to provide us with an unqualified opinion, investors could lose confidence in our reported financial information, which could have a material adverse effect on the trading price of our common stock.

Our ability to use our NOLs and research and development tax credit carryforwards to offset future taxable income may be subject to certain limitations.

As of December 31, 2022 December 31, 2023, we had outstanding net operating losses ("NOLs") of approximately $5.8 billion, $2.5 billion, which are available to reduce future taxable income. Our carryforwards are subject to review and possible adjustment by the appropriate taxing authorities. In addition, the carryforwards that may be utilized in a future period may be subject to limitations based upon changes in the ownership of our stock in a future period. In general, under Section 382 of the Internal Revenue Code of 1986, as amended, (the "Code" or "IRC"), and corresponding provisions of state law, a corporation that undergoes an "ownership change," generally defined as a greater than 50 percentage point change (by value) in its equity ownership by certain stockholders over a three year period, is subject to limitations on its ability to utilize its pre-change NOLs, research and development tax credit carryforwards and disallowed interest expense carryforwards to offset future taxable income.

Our balance sheet includes significant amounts of goodwill and intangible assets. The impairment of a significant portion of these assets would negatively affect our results of operations.

A significant portion of our total assets of continuing operations consists of goodwill and intangible assets. Goodwill and intangible Intangible assets, net, together accounted for approximately 21.6% 23.1% of total assets of our continuing operations on our consolidated balance sheet as of December 31, 2022 December 31, 2023. We evaluate goodwill for impairment annually in the fourth quarter. We also review goodwill and intangible assets for impairment whenever events or circumstances make it more likely than not that the carrying value may not be recoverable. Under current accounting rules, any determination that impairment has occurred would require us to record an impairment charge, which would adversely affect our earnings. An impairment of a significant portion of goodwill or intangible assets could adversely affect our operating results.

Risks Related to Ownership of Our Common Stock

We received notice from If we are not in compliance with the continued listing standards of the New York Stock Exchange (the "NYSE") that we were not in compliance with its continued listing standards regarding the average closing price of our common stock, and , we may be subject to permanent delisting from the NYSE.

On December 6, 2022, we received notice from The NYSE continued listing standards require listed companies to maintain minimum market capitalization and stock price levels. If the NYSE that we were Company is not in compliance with the continued listing standard set forth in Section 802.01C these standards for certain periods of the NYSE's Listed Company Manual (the "Manual"), as the average closing price of our common stock on the NYSE was less than $1.00 per share over a consecutive 30 trading-day period ending December 2, 2022. The notice has no immediate impact on the listing of the Company's common stock on the NYSE, subject to the Company's compliance with the NYSE's other continued listing requirements.

The Company has responded to the NYSE with respect to its intent to cure the deficiency. The Company intends to consider available alternatives, including, but not limited to, a reverse stock split, subject to stockholder approval no later than at the Company's next annual meeting of stockholders, if necessary, to regain compliance. Pursuant to Section 802.01C, the Company has a period of six months following the receipt of the notice to regain compliance with the minimum share price requirement. Section 802.01C also provides for an exception to the six-month cure period if the action required to cure the price condition requires stockholder approval, in which case, the action needs to be approved by no later than the Company's next annual meeting of stockholders. If the Company is unable to regain compliance with the $1.00 share price rule within this period, time, the NYSE will initiate procedures to suspend and delist our common stock. The NYSE can take accelerated delisting action in the event that it determines that our common stock trades at levels that it views to be abnormally low.

If the NYSE permanently delisted our shares, it would negatively impact us because it could, among other things: (i) reduce the liquidity and market price of our common stock; (ii) reduce the amount of news and analyst coverage for our company; (iii) reduce the number of investors willing to hold or acquire our common stock, which could negatively impact our ability to raise equity financing and the ability of our stockholders to sell our common stock; (iv) limit our ability to use a registration statement to offer and sell freely tradable securities, thereby preventing us from accessing the public capital markets; (v) impair our ability to provide liquid equity incentives to our employees; and (vi) have negative reputational impact for us with our customers, suppliers, employees and other persons with whom we have business relationships.

Our stock price has experienced significant volatility and may change significantly in the future, as a result you investors may not be able to resell shares of our common stock at or above the price investors paid or at all, and investors could lose all or part of their investment as a result.

The trading price of our common stock has been, in recent months, and may continue to be, volatile. The volatile, and the broader stock market has recently experienced extreme significant volatility. This volatility often has been unrelated or disproportionate to the operating performance of particular companies. Investors may not be able to resell their shares at or above the price they paid for the stock.

Broad market and industry fluctuations may materially adversely affect the market price of our common stock, regardless of our actual operating performance. In addition, price volatility may be greater if the public float and trading volume of our common stock are low.

In the past, following periods of market volatility, stockholders have instituted securities class action litigation. As described above, we are currently subject to a pending putative securities class action.This and other potential securities litigation, could have a substantial cost and divert resources and the attention of executive management from our business regardless of the outcome of such litigation.

Our quarterly operating results fluctuate and may fall short of prior periods, our projections or the expectations of securities analysts or investors, which could materially adversely affect our stock price.

Our operating results have fluctuated from quarter to quarter in the past, and they may do so in the future. Therefore, results of any one fiscal quarter are not a reliable indication of results to be expected for any other fiscal quarter or for any year. If we fail to increase our results over prior periods, to achieve our projected results or to meet the expectations of securities analysts or investors, our stock price may decline, and the decrease in the stock price may be disproportionate to the shortfall in our financial performance. Results may be affected by various factors, including those described in these risk factors.

We currently do not intend to declare dividends on our common stock in the foreseeable future and, as a result, your returns on your investment may depend solely on the appreciation of our common stock.

We currently do not expect to declare any dividends on our common stock in the foreseeable future. Instead, we anticipate that all of our earnings in the foreseeable future will be used to provide working capital, to support our operations and to finance the growth and development of our business. Any determination to declare or pay dividends in the future will be at the discretion of our board of directors, subject to applicable laws and dependent upon a number of factors, including our earnings, capacity to pay dividends under the Credit Agreement any agreements governing current or future indebtedness, and overall financial condition. In addition, our ability to pay dividends in the future depends in part on the earnings and distributions of funds from our health insurance subsidiaries. Applicable state insurance laws restrict the ability of such health insurance subsidiaries to declare stockholder dividends and require our health insurance subsidiaries to maintain specified levels of statutory capital and surplus. Accordingly, your only opportunity to achieve a return on your investment in our company may be if the market price of our common stock appreciates and you sell your shares at a profit. The market price for our common stock may never exceed, and may fall below, the price that you pay for such common stock.

If securities analysts do not publish research or reports about our business or if they downgrade our stock or our sector, our stock price and trading volume could decline.

The trading market for our common stock relies in part on the research and reports that industry or financial analysts publish about us or our business or industry. We do not control these analysts. If one or more of these analysts ceases coverage of us or fails to publish reports on us regularly, we could lose visibility in the market, which in turn could cause our stock price or trading volume to decline. Furthermore, if one or more of the analysts who do cover us were to downgrade our stock or our industry, or the stock of any of our competitors, or publish inaccurate or unfavorable research about our business or industry, the price of our stock could decline.

Our management may use the proceeds of our 2022 Capital Raises any financings in ways with which you may disagree or that may not be profitable.

We generally have broad discretion as to the application of the net proceeds of capital we raised in 2022 raise and can use them for purposes other than those contemplated by us at the time of such offerings. We utilized a portion of these net proceeds to pay down the principal balance of indebtedness outstanding under our revolving credit agreement. We also utilized a portion of the proceeds to make additional capital contributions to certain regulated entities. We have not specifically identified a large single use for which to use the remainder of these net proceeds and, accordingly, we are not able to allocate these amounts for specific uses due to a variety of factors. financings. You may not agree with the manner in which our management chooses to allocate and use these net proceeds. Our management may use the proceeds for corporate purposes that may not increase our profitability or otherwise result in the creation of stockholder value. In addition, pending our use of the proceeds, we may invest the proceeds primarily in instruments that do not produce significant income or that may lose value.

Provisions in our organizational documents could delay or prevent a change of control.

Certain provisions of our amended and restated certificate of incorporation and amended and restated bylaws may have the effect of delaying or preventing a merger, acquisition, tender offer, takeover attempt or other change of control transaction that a stockholder might consider to be in its best interest, including attempts that might result in a premium over the market price of our common stock.

These provisions will provide for, among other things:

- the authorization of undesignated preferred stock, the terms of which may be established and shares of which may be issued without stockholder approval; and
- advance notice requirements for stockholder proposals.

These provisions could make it more difficult for a third party to acquire us, even if the third party's offer may be considered beneficial by many of our stockholders. As a result, our stockholders may be limited in their ability to obtain a premium for their shares.

Our amended and restated certificate of incorporation provides, subject to limited exceptions, that the Court of Chancery of the State of Delaware and, to the extent enforceable, the federal district courts of the United States of America will be the sole and exclusive forums for certain stockholder litigation matters, which could limit our stockholders' ability to obtain a favorable judicial forum for disputes with us or our current and former directors, officers, employees or stockholders.

Our amended and restated certificate of incorporation provides, subject to limited exceptions, that unless we consent in writing to the selection of an alternative forum, the Court of Chancery of the State of Delaware shall, to the fullest extent permitted by law, be the sole and exclusive forum for any (i) derivative action or proceeding brought on behalf of our company, (ii) action asserting a claim of breach of a fiduciary duty owed by any current or former director, officer, employee or stockholder of our company to the Company or our stockholders, (iii) action asserting a claim against the Company or any current or former director, officer, employee or stockholder of the Company arising pursuant to any provision of the DGCL, Delaware General Corporation Law, or our amended and restated certificate of incorporation or our amended and restated bylaws (as either might be amended from time to time) or (iv) action asserting a claim governed by the internal affairs doctrine of the State of Delaware. Unless we consent in writing to the selection of an alternative forum, the federal district courts of the United States of America shall be the exclusive forum for the resolution of any complaint asserting a cause of action arising under the federal securities laws of the United States of America. Any person or entity purchasing or otherwise acquiring any interest in shares of our capital stock shall be deemed to have notice of and consented to the forum provisions in our amended and restated certificate of incorporation. Although our amended and restated certificate of incorporation contains the exclusive forum provision described above, it is possible that a court could find that such a provision is inapplicable for a particular claim or action or that such provision is unenforceable. Our exclusive forum provision does not relieve the Company of its duties to comply with the federal securities laws and the rules and regulations thereunder, and our stockholders will not be deemed to have waived our compliance with these laws, rules and regulations.

These choice of forum provisions may limit a stockholder's ability to bring a claim in a different judicial forum, including one that it may find favorable or convenient for disputes with us or any of our directors, officers or other employees which may discourage lawsuits with respect to such claims. Alternatively, if a court were to find the choice of forum provisions that will be contained in our amended and restated certificate of incorporation to be inapplicable or unenforceable with respect to one or more of the specified types of actions or proceedings, we may incur additional costs associated with resolving such action in other jurisdictions, which could harm our business, operating results and financial condition.

Risks Related to Investing in Our Common Stock

Issuance of shares of our common stock in connection with the conversion of our outstanding Preferred Stock, or the exercise of outstanding warrants, would cause substantial dilution, which could materially affect the trading price of our common stock and earnings per share. Holders Certain holders of our Preferred Stock and warrants own a significant percentage of our capital stock and may be able to influence certain corporate matters.

Pursuant to the Certificate of Designations designating the shares of our Series A Convertible Perpetual Preferred Stock and the Certificate of Designations designating the shares of our Series B Convertible Perpetual Preferred Stock (collectively, the "Preferred Stock") each of which we filed with the Secretary of State of the State of Delaware (together, the "Certificate of Designations"), the Preferred Stock ranks senior to our shares of common stock with respect to dividend rights and rights on the distribution of assets on any voluntary or involuntary liquidation, dissolution or winding up of the affairs of the Company. The Preferred Stock is convertible into common stock and is entitled to an initial liquidation preference, in each case subject to certain limitations outlined in the Certificates of Designations. Further, holders of Preferred Stock are entitled to vote with the holders of common stock on an as-converted basis, solely with respect to (i) a change of control transaction (to the extent such change of control transaction is submitted to a vote of the holders of common stock) or (ii) the issuance of capital stock by the Company in connection with an acquisition by the Company (to the extent such issuance is submitted to a vote of the holders of common stock), subject to certain restrictions. Holders of the Preferred Stock are entitled to a separate class vote with respect to, among other things, amendments to the Company's organizational documents that have an adverse effect on the Preferred Stock, authorizations or issuances by the Company

of securities that are senior to the Preferred Stock, increases or decreases in the number of authorized shares of Preferred Stock, and issuances of shares of the Preferred Stock.

Any conversion of the Preferred Stock into common stock or exercise of any warrants to purchase our common stock would dilute the ownership interest of existing holders of our common stock, and any sales in the public market of common stock issuable upon such conversion or exercise could adversely affect prevailing market prices of our common stock. In addition, we granted the holders of Preferred Stock registration rights in respect of the Preferred Stock and any shares of common stock issued upon conversion thereof. Holders of Preferred Stock that hold warrants also have registration rights covering the common stock issuable upon exercise of their warrants. These registration rights could facilitate the resale of such securities into the public market, and any resale of these securities would increase the number of shares of our common stock available for public trading. Sales of a substantial number of shares of our common stock in the public market, or the perception that such sales might occur, could have a material adverse effect on the price of our common stock.

The interests of the holders of these shares may not always coincide with the interests of our other stockholders. Because of the potential degree of concentration of voting power upon the conversion of Preferred Stock into common stock, the concentration of ownership by these holders may have the effect of adversely impacting actions favored by our other stockholders and could depress our stock price.

Our board of directors is authorized to issue and designate shares of our preferred stock in additional series without stockholder approval.

Our amended and restated certificate of incorporation authorizes our board of directors, without the approval of our stockholders, to issue 100,000,000 shares of our preferred stock, subject to limitations prescribed by applicable law, rules and regulations and the provisions of our amended and restated certificate of incorporation, as shares of preferred stock in series, to establish from time to time the number of shares to be included in each such series and to fix the designation, powers, preferences and rights of the shares of each such series and the qualifications, limitations or restrictions thereof. The powers, preferences and rights of these additional series of preferred stock may be senior to or on parity with our common stock, which may reduce its value.

We incur increased costs as a result of operating as a publicly traded company, and our management is required to devote substantial time to new compliance initiatives.

As a publicly traded company, we incur additional legal, accounting, and other expenses that we did not previously incur. Although we are currently unable to estimate these costs with any degree of certainty, they may be material in amount. In addition, the SOX, the Dodd-Frank Wall Street Reform and Consumer Protection Act, and the rules of the SEC, and the NYSE stock exchange on which our shares of common stock are listed, have imposed various requirements on public companies. Our management and other personnel will need to devote a substantial amount of time to these compliance initiatives as well as investor relations. Moreover, these rules and regulations result in increased legal and financial compliance costs and will make some activities more time-consuming and costly. For example, we expect these rules and regulations to make it more difficult and more expensive for us to obtain director and officer liability insurance, and we may be required to incur additional costs to maintain the same or similar coverage.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 1C. CYBERSECURITY

Risk Management and Strategy

Risk is an inherent component of the Company's strategic activities and operating environment. The ability to effectively identify, assess, measure, respond, monitor, and report on risks is critical to the achievement of the Company's mission and strategic objectives. Cybersecurity risk, including the risk of managing cybersecurity threats, is a key risk integrated into our enterprise risk management ("ERM") program and processes. In addition to cybersecurity risk being included in our annual enterprise risk assessment process, other cybersecurity-related risk assessments, such as threat and vulnerability assessments, are performed regularly. Cybersecurity risk is also considered in the Company's annual fraud risk assessment.

Annually, the Company completes a National Institute of Standards and Technology ("NIST") Cybersecurity Framework ("CSF") maturity assessment to identify and evaluate the areas of strength and opportunities for improvement. These maturity assessments, which are performed leveraging independent third-party advisors or through self-assessments,

evaluate the organization's cyber maturity based on predefined standards and criteria (e.g., NIST Special Publication (SP) 800-66). Results of these assessments commonly set the roadmap for future cybersecurity improvement initiatives.

Additionally, for third party vendors providing services to the Company, a security risk assessment is completed during vendor due diligence, before execution of agreements. The assessment evaluates, among other areas, the vendors' data security, access identity, endpoint protection and incident management and response capabilities. Vendors are required to either complete a security questionnaire based on the HIPAA Security Rule requirements or provide evidence of a current Service Organization Control report completed by a third-party, Health Information Trust Alliance certification, or similar security and compliance attestation. These risk assessments are refreshed regularly during the duration of an agreement with the vendor, and the results can be used to influence the vendor to make improvements where weaknesses in their security and compliance measures are identified.

Governance

Board of Directors

The Board of Directors has direct responsibility for the risk profile of the Company, as defined by the requirements of the shareholders. Inherently included in the Company's risk profile is the risk of cybersecurity threats. The Audit Committee of the Board of Directors has been delegated the responsibility to oversee the management of risks for the Company, including those pertaining to cybersecurity. The Audit Committee is responsible for:

- Providing oversight of risks, including but not limited to finance, operations, information technology and information security, privacy, legal and regulatory.
- Meeting periodically with management to review the Company's significant risks and the steps management has taken to monitor, control or mitigate such risks.
- Reviewing required disclosures pertaining to risks.

Cybersecurity risk is a standing agenda topic at quarterly Audit Committee meetings. Common topics discussed include, but are not limited to, cybersecurity risks, threats and vulnerabilities, and the related monitoring activities, as well as progress made with the Company's information security roadmap. The Audit Committee is apprised of the results of cybersecurity risk assessment and prevention/detection activities (e.g., vulnerability scanning, penetration testing, security awareness training) as well as any changes to cybersecurity laws and regulations, current leading practices, and the changing threat landscape.

Annually, the results of the Company's enterprise risk assessment are presented to the Audit Committee. These results include a discussion on the top enterprise risks (including, when appropriate, cybersecurity risk) identified through the enterprise risk assessment process, controls in place to address the risks, as well as the mitigation plans management will take to address any uncontrolled risks.

Following most Audit Committee meetings, the Chair of the Audit Committee provides an update to the full Board of Directors at the Board's next regularly scheduled meeting. It is through this update where the Board of Directors would be apprised of any material risks or threats, including those pertaining to cybersecurity matters.

Management

Management of risks, including risks of cybersecurity threats, is delegated to the Company's Head of Information Security, who reports administratively to the Chief Information Officer and has informal reporting relationships with the General Counsel and Chief Audit Executive. The Head of Information Security has over 30 years of information technology and security experience with assessing and managing cybersecurity threats and is responsible for the day-to-day information security program objectives. The Head of Information Security is also responsible for attending quarterly Audit Committee meetings and reporting results of the cybersecurity program to the Audit Committee, including results of preventative activities (e.g. endpoint protection, security training), ongoing monitoring activities (e.g., vulnerability testing), and remediation activities (e.g., issues identified through audits and assessment activities).

The Head of Information Security utilizes various tools and resources to manage and monitor cybersecurity threats, vulnerabilities, and incidents, most of which are delivered through third-party solutions. Examples include, but are not limited to:

- Endpoint and network device vulnerability identification and scanning
- Internal and external penetration testing services with an emphasis on on-premise and cloud security
- Security training and awareness, with an emphasis on phishing threats
- Third-party security risk assessments
- NIST CSF assessment tools
- Security information and event management for monitoring infrastructure events.

The Company's enterprise threat and vulnerability identification and detection capabilities operate on an ongoing basis, with results reported to Information Security daily. The capabilities utilize endpoint sensors and network scanning to meet and maintain leading bad actor tactics and techniques, including machine learning and artificial intelligence, to protect against potential malicious threats or other potentially unwanted programs or identity abuse, including privilege escalation or abuse of least privilege access enforced by the

Company. The information gathered by the Head of Information Security through these activities, through assessment results provided by cybersecurity consultants or advisors, as well as through gathering cyber-risk landscape insights from various other third-party sources, informs the Company's assessment of the risk of cybersecurity threats.

Finally, the Company's Disclosure Committee is responsible for assisting the CEO, CFO and Audit Committee to prepare SEC-required disclosures, confirming the Company's disclosure controls and procedures are properly implemented and asserting the accurate, complete, timely and fair presentation of public disclosures. The Disclosure Committee is comprised of the Company's CFO, Chief Accounting Officer, General Counsel, Chief Audit Executive, Head of Information Security, and senior members of our external reporting, financial planning and analysis, and tax departments. The Disclosure Committee meets quarterly prior to the issuance of required quarterly SEC filings, and in these meetings relevant cybersecurity risks would be discussed.

Based on the Company's most recent assessments of cybersecurity risk, as of the date of this Form 10-K, we are not aware of any risk from cybersecurity threats that has caused or is reasonably likely to cause a material effect on the Company's business strategy, results of operations, or financial condition. For further discussion of the risks associated with cybersecurity incidents, see the cybersecurity risk factor under the caption "Risks Related to our Intellectual Property, Information Technology, and Data Privacy" included in Part I, Item 1A. - Risk Factors" in this Form 10-K.

ITEM 2. PROPERTIES

We have 13four corporate offices across the U.S., including our corporate headquarters in Minneapolis, Minnesota Doral, Florida and a key offices administrative office in California and Florida. Minnesota. We lease or sublease all of our corporate offices, which serve both our Consumer Care NeueCare and NeueSolutions and Bright HealthCare segments. We also lease 82 73 properties in three two states for our medical offices and clinics.

We believe that our facilities are adequate for our operations. As we proceed with our restructuring plan current operations, however we are continuously assessing the facilities necessary to support our ongoing business and seeking to sublet or negotiate lease terminations for any locations we may deem redundant. business.

ITEM 3. LEGAL PROCEEDINGS

The information required by this item is incorporated herein by reference to the information included under the caption "Legal Proceedings" in Note 17 14 of the Notes to Consolidated Financial Statements included in Part II, Item 8 – Financial Statements.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

INFORMATION ABOUT OUR EXECUTIVE OFFICERS

The following sets forth certain information regarding our executive officers as of March 6, 2023 March 12, 2024, including the business experience of each executive officer during the past five years:

Name	Age	Position
G. Mike Mikan	51 52	Chief Executive Officer, President and Director
Catherine R. Smith Jay Matushak	59 50	Chief Financial and Administrative Officer
Jeff Cook Tomas Orozco	52 48	Chief Operating Officer Executive Vice President, NeueHealth
Jeff Craig	40 41	General Counsel and Corporate Secretary

G. Mike Mikan has served as our Chief Executive Officer and President since April 2020. Mr. Mikan joined as our Vice Chairman and President in January 2019. Prior to joining Bright Health, NeueHealth, Mr. Mikan served as Chairman and Chief Executive Officer of Shot-Rock Capital, LLC, a private investment firm, from January 2015 until December 2018. From January 2013 until December 2014, he served as President of ESL Investments, Inc. Mr. Mikan served as the Interim Chief Executive Officer of Best Buy Co., Inc. from April 2012 until September 2012. From November 1998 through February 2012, he served in various executive positions at UnitedHealth Group, Inc., including as Chief Financial Officer and as Chief Executive Officer of UnitedHealth Group's Optum subsidiary. Mr. Mikan serves as a director of AutoNation, Inc. Mr. Mikan was selected to serve on our board of directors because of his management experience and expertise in the healthcare sector.

Catherine R. Smith Jay Matushak has served as our Chief Financial and Administrative Officer since January 2020. Prior to joining Bright Health, Ms. Smith was Executive May 2023. Mr. Matushak previously served as Senior Vice President, and Bright HealthCare, from November 2022 to May 2023, as Chief Financial Officer of Target Corporation, a customer-centric, omni-channel retailer, Bright HealthCare from September 2015 May 2022 to November 2019. From 2022, as interim Chief Executive Officer of Bright HealthCare from February 2022 to December 2014, Ms. Smith was Executive Vice President May 2022, and as Chief Financial Officer of Express Scripts Holding Company, a Fortune 20 company. Prior Bright HealthCare from October 2021 to Express Scripts, Ms. Smith held February 2022. Before joining NeueHealth, Mr. Matushak served as the Chief Financial Officer positions of Blue Cross Blue Shield of Minnesota from April 2015 to October 2021. Prior to Blue Cross Blue Shield of Minnesota, Mr. Matushak spent fifteen years at Walmart International, GameStop Corp., Centex Corp. UnitedHealth Group in various financial leadership roles within Optum and others. Ms. Smith currently serves as the audit committee chair of PPG Industries, Inc., and Baxter International Inc. UnitedHealthcare

Jeff Cook Tomas Orozco has served as our Chief Operating Officer Executive Vice President for NeueHealth since November 2022, and 2023. Prior to that, Tomas served as chief executive officer of Consumer Care, our personalized care delivery business, from June 2022 to November 2022. Prior to Bright Health, he served as national Vice President of CVS Health HUBs, CVS' suite of HUB clinical services, from May 2020 to June 2022. Before that, Mr. Cook was the South Central Regional President of CVS Health/Aetna, where he led the commercial and Medicare Advantage business in Texas, Oklahoma, and New Mexico from January 2018 to January 2020, and was the Chief Executive Officer of Texas Centrum Medical Holdings, LLC ("Centrum") since August of 2021. Tomas was the Regional President for Elevance Health Aetna overseeing the Medicare line of business across the east coast from 2016 August 2017 to May 2020, during which time he led the development of a joint venture between Texas Health Resources and Aetna to create a joint health plan from the ground up. January 2021. Prior to those this, he served as President of Elevance Health's Florida Medicare Advantage business. Prior to Elevance Health, Tomas held senior executive roles he held at various leadership positions at Ascension Health and UnitedHealthcare. Mr. Cook has broad health care experience plans that were portfolio companies of MBF Healthcare Partners, a leading initiatives at the forefront of value-based care and consumer-driven healthcare, and holds a Bachelor of Business Administration from Baylor University and a Masters of Science private equity firm concentrated in Health Administration from Texas State University. healthcare.

Jeff Craig has served as General Counsel and Corporate Secretary since March 2022, and before that served as Vice President, Consumer Care Legal, and Assistant Vice President, Legal since March 2020. Mr. Craig previously served as Vice President, Legal, as well as in other senior legal roles, at MGM Resorts International since 2013. Prior to MGM, Jeff was an in-house attorney with Western Digital Corporation, a Fortune 500 hard drive manufacturer, and a corporate transactional attorney with Gibson Dunn, a leading international law firm.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELEASED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Market Information

Our common stock is traded on the New York Stock Exchange under the symbol "BHG" "NEUE".

Holders of our Common Stock

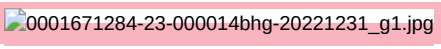
As of March 6, 2023 March 12, 2024, there were 201 175 holders of record of our common stock. The actual number of stockholders is greater than this number of holders of record, and includes stockholders who are beneficial owners, but whose shares are held in street name by brokers and other nominees. This number of holders of record also does not include stockholders whose shares may be held in trust by other entities.

Dividends

We have never declared or paid dividends, and we currently do not expect to declare any dividends on our common stock in the foreseeable future. Instead, we anticipate that all of our earnings in the foreseeable future will be used to provide working capital, to support our the operations and to finance the growth and development of our business. Any determination to declare dividends in the future will be at the discretion of our board of directors, subject to applicable laws, and will be dependent on a number of factors, including our earnings, capacity to pay dividends under the Credit Agreement, our credit agreement, capital requirements and overall financial condition. In addition, our ability to pay dividends in the future depends in part on the earnings and distributions of funds from our health insurance subsidiaries. Applicable state insurance laws restrict the ability of such health insurance subsidiaries to declare stockholder dividends and require our health insurance subsidiaries to maintain specified levels of statutory capital and surplus. While we exited the commercial market in 2023, we must maintain the specified levels of statutory capital and surplus throughout an extended runout period. If we elect to pay dividends in the future, we may reduce or discontinue entirely the payment of such dividends at any time.

Stock Performance Graph

The following graph and related information shows a comparison of the cumulative total return for our common stock, Standard & Poor's 500 Index ("S&P 500 Index") and the Standard & Poor's Health Care Index ("S&P Health Care Index") between June 24, 2021 (the date our common stock commenced trading on the NYSE) through December 31, 2022. All values assume an initial investment of $100 and reinvestment of any dividends. The comparisons are based on historical data and are not indicative of, nor intended to forecast, the future performance of our common stock.



	6/24/2021	6/30/2021	9/30/2021	12/31/21	3/31/2022	6/30/2022	9/30/2022	12/31/22
Bright Health Group	$ 100.00	$ 103.13	$ 49.04	$ 20.67	$ 11.60	$ 10.94	$ 6.31	$ 3.91
S&P 500 Index	$ 100.00	$ 100.74	$ 101.33	$ 112.50	$ 107.33	$ 90.05	$ 85.65	$ 92.13
S&P Health Care Index	$ 100.00	$ 100.66	$ 102.11	$ 113.51	$ 110.59	$ 104.05	$ 98.66	$ 111.30

Sales of Unregistered Securities

On December 6, 2021 the Company entered into an Investment Agreement (as amended through the date hereof, the "Series A Investment Agreement") with certain subsidiaries of Cigna Corporation and certain affiliates of New Enterprise Associates (collectively, the "Series A Purchasers"), relating to the issuance and sale by the Company to the Purchasers of 750,000 shares of the Company's Series A Convertible Perpetual Preferred Stock, par value $0.0001 per share (the "Series A Preferred Stock"), for an aggregate purchase price of $750.0 million, or $1,000 per share (the "Series A Issuance"). The Series A Issuance was consummated on January 3, 2022. The Series A Issuance was undertaken in reliance upon an exemption from the registration requirements of the Securities Act, pursuant to Section 4(a)(2) thereof. No advertising or general solicitation was employed relating to the Issuance.

We entered into an investment agreement as of October 10, 2022 with certain purchasers (as amended through the date hereof, the "Series B Investment Agreement") with certain purchasers (collectively, the "Series B Purchasers"), relating to the issuance and sale by the Company to the Series B Purchasers of 175,000 shares of the Company's Series B Convertible Perpetual Preferred Stock, par value $0.0001 per share (the "Series B Preferred Stock" and, together with the Series A Preferred Stock, the "Preferred Stock"), for an aggregate purchase price of $175.0 million, or $1,000 per share (the "Series B Issuance"). On October 17, 2022, the Series B Issuance was consummated. In connection with the closing of the Series B Issuance, the Certificate terms of Designations for the Company's Series A Convertible Perpetual Preferred Stock par value $0.0001 per share (the "Series A Preferred Stock") was were amended to provide for a weighted average anti-dilution adjustment in connection with issuances of equity-linked securities with a purchase or conversion price less than the optional conversion price of the Series A Preferred Stock. The Series B Issuance was undertaken in reliance upon an exemption from the registration requirements of the Securities Act, pursuant to Section 4(a)(2) thereof. No advertising or general solicitation was employed relating to the Series B Issuance.

On August 4, 2023, we entered into a warrantholders agreement (the "NEA Warrantholders Agreement") with NEA 18 Venture Growth Equity, L.P. ("NEA") and the lenders from time to time party thereto, setting forth the rights and obligations of the Company and the lenders as holders of the warrants to acquire shares of Common Stock at an exercise price of $0.01 per share, and providing for the issuance of 1,656,789 warrants at a fair market value of $15.12 (closing

share price on August 4th, 2023 minus the $0.01 exercise price). The NEA Warrantholders Agreement was entered into in conjunction with a $60.0 million credit agreement with NEA at a weighted-average effective interest rate of 15.00%. On October 2, 2023, we entered into a warrantholders agreement (the "CalSTRS Warrantholders Agreement") with California State Teachers' Retirement System, setting forth the rights and obligations of the Company and the lenders as holders of the warrants to acquire shares of Common Stock at an exercise price of $0.01 per share, and providing for the issuance of 176,724 warrants at a fair market value of $5.80 (closing share price on October 2, 2023 minus the $0.01 exercise price). The CalSTRS Warrantholders Agreement was entered into in conjunction with a $6.4 million credit agreement with CalSTRS at a weighted-average effective interest rate of 15.00%. The warrants do not contain any exercise contingencies and expire on the fifth anniversary of the first closing date.

The issuance of the warrants was undertaken in reliance upon an exemption from the registration requirements of the Securities Act, pursuant to Section 4(a)(2) thereof. No advertising or general solicitation was employed relating to the issuance of the warrants. In connection with the issuance of the warrants, the terms of the Preferred Stock were amended to provide for a weighted average anti-dilution adjustment in connection with issuances of equity-linked securities with a purchase or conversion price less than the optional conversion price of the Preferred Stock.

Issuer Purchases of Equity Securities

None.

ITEM 6. [Reserved]

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion summarizes the significant factors affecting our operating results, financial condition, liquidity, and cash flows as of and for the periods presented below. The following discussion and analysis should be read in conjunction with the Consolidated Financial Statements and the Notes to Consolidated Financial Statements included elsewhere in this Annual Report. The statements in this discussion regarding industry outlook, our expectations regarding our future performance, liquidity, and capital resources, and all other non-historical statements in this discussion are forward-looking statements and are based on the beliefs of our management, as well as assumptions made by, and information currently available to, our management. Actual results could differ materially from those discussed in or implied by forward-looking statements as a result of various factors, including those discussed below and elsewhere in this Annual Report, particularly under "Forward-Looking Statements" and Item 1A – Risk Factors.

Business Overview

Bright Health Group, NeueHealth, Inc. ("Bright Health," "we," "our," "us," or the "Company") was founded in 2015 to transform healthcare. Although 2022 was a year of significant transition for the business has evolved, our business, our mission commitment to making high-quality, coordinated healthcare accessible and affordable to all populations remains the same: unchanged. Making Healthcare Right. Together. It is built upon the belief that by connecting and aligning the best local resources in healthcare delivery with the financing of care, leveraging what we call the "Value Layer" of healthcare, we can drive a superior consumer experience, reduce systemic waste, lower costs, and optimize clinical outcomes. Bright Health Group NeueHealth consists of two reportable segments within our continuing operations: Consumer Care NeueCare and Bright HealthCare. NeueSolutions. Additionally, we have one two reportable segment segments in our discontinued operations: Bright HealthCare and Bright HealthCare – Commercial.

NeueCare (formerly Care Delivery within Consumer Care. Care). Our value-driven care delivery business that manages risk in partnership with external payors. Consumer Care, payors and serves all populations across the ACA Marketplace, Medicare, and Medicaid. NeueCare aims to significantly reduce the friction and current lack of coordination between payors and providers to enable a truly consumer-centric healthcare experience. As of December 2022, Consumer Care 2023, NeueCare delivers high-quality virtual in-person and in-person virtual clinical care through its 74 73 owned primary care clinics within an integrated care delivery system. Through these risk-bearing clinics and our affiliated network of care providers, NeueCare maintained approximately 336,000 consumers, inclusive of 293,000 value-based care consumers and 43,000 fee-for-service consumers.

NeueSolutions (formerly Care Solutions within Consumer Care maintained over 579,000 unique patient relationships as Care). Our provider enablement business that includes a suite of December 31, 2022, technology, services, and clinical care solutions that empower providers to thrive in performance-based arrangements. As of December 31, 2023, NeueSolutions had approximately 530,000 of which are served through 62,000 value-based arrangements, across multiple payors. care consumers attributed to its REACH ACOs and 106,000 enablement services lives.

Bright HealthCare. Included in our discontinued operations, oOur ur delegated senior managed care California Medicare Advantage business that partners partnered with a tight group of aligned providers in California. Bright HealthCare delivers simple, personal, On June 30, 2023, the Company entered into the Molina Purchase Agreement to sell its California Medicare Advantage business, which consists of Brand New Day and affordable financing solutions that are focused on consumer retail healthcare and delivered through

Bright Health's alignment model. Central Health Plan. As of December 31, 2022, Bright HealthCare's MA products served over 125,000 lives and generally focus on higher risk, special needs, or other traditionally underserved populations. The transaction was consummated in January 2024.

Bright HealthCare – Commercial. Included in our discontinued operations, our Commercial healthcare financing and distribution business focused on commercial plans. In October 2022, we announced that we will would no longer offer commercial health plans in 2023. effective as of the end of 2022.

Key Factors Affecting Our Performance

NeueHealth is focused on our mission to connect and align the best local resources in healthcare delivery with the financing of care, driving a superior consumer experience, reducing systemic waste, lowering costs, and optimizing clinical outcomes creating tangible value for all of our customers – payors, consumers, providers. We believe that the growth and future success of our business depends on executing against a number of key factors described below. While each of these factors presents significant opportunities for our business, they also pose important challenges that we must successfully address to sustain our growth and continue to improve results of operations. below:

Consumer Care's ability to deliver• Expanding our presence in core, highly attractive, growing Florida and enable high-quality, value-based care drives revenue Texas markets through capacity and service expansions, accretive tuck-in clinic acquisitions, and membership growth initiatives.

Our Consumer Care business supports• Increasing access to high-quality healthcare for all through growth in new markets, leveraging proven aligned care model to provide payor-agnostic, value-driven care.

- Leveraging enablement solutions as platform for growth in managing underserved populations.

- Expanding our provider partnerships, meeting providers where they are and manages providers enabling them to thrive in value-based and fee-for-service contracts with payors. We help organizations enter value-based arrangements designed around their needs, while simultaneously empowering them with the tools and capabilities necessary to maximize their success. In order to drive financial performance, our Consumer Care business must effectively manage risk and continue to develop and deliver tools and services supporting both managed and affiliated providers. performance-based arrangements.

Consumer Care's• Building on longstanding relationships with existing payors, while also prioritizing engagement and growth with new payors.

- Continuing to drive strong results in ACO REACH, and our ability to identify and align with high-performing care delivery partners drives performance providers through the program.

Our Consumer Care• Executing on the efficient run-off of our Bright Healthcare – Commercial business engages providers through a variety and recapturing excess regulatory capital.

- Continued right-sizing of alignment options ranging from having providers participate our administrative overhead costs to reflect the changes in our networks to having providers employed by us. We must continue to build legacy businesses and maintain an ecosystem of care delivery assets capable of supporting our third-party payors. the new organization.

Consumer Care's ability• Securing additional capital to grow meet our consumer base, inclusive of growth in our ACO Reach membership near-term liquidity requirements.

Consumer Care grows its consumer base through contractual relationships with third party payors, alignment of consumers participating in the ACO Reach program as well as patient satisfaction.

Bright HealthCare's ability to grow membership and retain consumers drives revenue growth

Bright HealthCare MA products are primarily sold for the following year through an annual enrollment period. Outside of an annual selling season, MA products typically can only be sold during Special Enrollment Periods ("SEPs") based on the consumer's eligibility status and certain life events. It is critical to effectively engage both prospective and existing consumers through our multi-channel distribution strategy. We aim to offer competitive benefits at an affordable price to meet the needs of our consumers. Historically, we have increased our MA consumer base during SEPs, given our consumers' eligibility to enroll during those periods.

Our MA business is afforded additional in-year growth opportunity due to its focus on serving low-income seniors and special needs individuals, who can enroll in and change MA health plans at any time. Therefore, constant engagement with this population is critical to effectively retain membership and drive in-year growth.

Bright HealthCare's ability to capture complete and accurate risk adjustment data affects revenue

Portions of premium revenue from our MA plans are determined by the applicable CMS risk adjustment models, which compensate insurers based on the underlying health status (acuity) of insured consumers. CMS requires that a consumer's health status be documented annually and accurately submitted to CMS to determine the appropriate risk adjustment. Ensuring that complete and accurate health conditions of our consumers are captured within documentation submitted to CMS is critical to recognizing accurate risk adjustment, which is reflected in our revenue year-over-year.

Bright HealthCare's ability to drive lower unit costs and medical utilization reduces medical costs and Medical Cost Ratio ("MCR")

Bright HealthCare utilizes our Bright Health Networks to provide healthcare services primarily within its exclusive provider networks under capitated contracts and fee-for-service arrangements. Certain provider and payor contracts include value-based incentive compensation based on providers meeting contractually defined quality and financial performance metrics. To effectively manage medical costs, Bright HealthCare must ensure a consumer's healthcare needs are primarily delivered through its Care Partners to recognize discounted contracted rates, which limits the amount of out-of-network utilization that can have an adverse financial impact on medical costs and MCR.

Our business is generally affected by the seasonal patterns of medical expenses. With respect to MA plans, medical costs are impacted by the severity of the flu season, generally from December to March, and we typically experience slightly higher Part D medical costs early in the year, which decline toward the end of year due to standard plan design.

Bright Health Group's ability to achieve operating cost efficiencies and scale profitably

Bright Health Group, including Bright HealthCare and Consumer Care, needs to continue to adjust our costs to our more focused business. We must continue to act on our restructuring plan, aligning our expenses with the business over the course of the run-out period of the exited markets.

Components of Our Results of Operations

Revenue

We generate Capitated revenue from premiums, including

Capitated revenue represents revenue under value-based provider arrangements entered into by NeueCare's affiliated medical groups in which the responsibility for control of an attributed patient's medical care is partially or wholly transferred to such medical groups. Such revenue fee-for-service provider revenue received from consumers and payors, Direct Contracting revenue includes capitation payments, as well as income from our investments. quality incentive payments, and shared savings distributions payable upon achievement of certain financial and quality metrics. Value-based revenue aligns incentives between the payor, the payor's consumers, and NeueHealth.

Premium ACO REACH revenue

Premium ACO REACH revenue represents the revenue from participation in CMS's ACO REACH program within our NeueSolutions segment. ACOs participate in the ACO REACH Model and assume full risk for the total cost of care of aligned beneficiaries. As part of our participation in the ACO REACH Model, we are guaranteeing the performance of our participating and preferred providers. The intention of the ACO REACH Model is to align and enhance the quality of care for Medicare FFS beneficiaries, while supporting a focus on complex, chronically ill patients, and encouraging physician organizations that have not typically participated in Medicare FFS programs to serve Medicare FFS beneficiaries.

Service revenue

Service revenue primarily represents revenue from fee-for-service payments received by NeueCare's affiliated medical groups. These include patient copayments and deductibles collected directly from patients and payments from third-party payors based upon contractual terms that define the fee-for-service reimbursement for specific procedures performed.

Investment income

The sources of investment income are interest income and realized gains and losses derived from the Company's investment portfolio that is comprised primarily of money market funds and certificates of deposit.

Operating Expenses

Medical costs

Medical costs of our continuing business are medical costs we assume from our third-party payor partners associated with our attributed value-based care consumers under full risk delegation arrangements. Medical costs consist of reimbursements to providers for medical services, risk share payments to payors, and quality incentive, management fees and shared savings compensation to providers net of any reinsurance recoveries. The Company contracts with hospitals, physicians and other providers of healthcare primarily within its exclusive provider networks under fee-for-service and value-based arrangements. The majority of medical costs in 2023 fall under CMS FFS where CMS is paying the claims but NeueHealth is held liable in ACO risk sharing with CMS. Reinsurance arrangements enable us to cede a specified percent of our premiums and claims to our third-party reinsurers. Under such contracts, the reinsurer is paid to cover claims-related

losses over a specified amount, which mitigates catastrophic risk. We make quality incentive and shared savings compensation payments to certain providers in accordance with the terms of the contractual arrangement upon the achievement of certain financial and quality metrics.

For value-based arrangements in which we bear limited risk, we recognize revenue on a net basis. Medical costs incurred from these arrangements are presented net of the associated capitated revenue.

Operating Costs

Operating costs are comprised of the expenses necessary to execute the Company's business operations. These include employee compensation for salaries and related benefit costs, share-based compensation, outsourced vendor contracted service and technology fees, professional services, technological infrastructure and service fees, facilities costs and other administrative expenses.

Restructuring Charges

Restructuring charges are comprised of employee termination benefits, long-lived asset impairments and contract termination costs. The charges included within our continuing operations are those not directly attributable to our decisions to sell our California Medicare Advantage business or to exit the Commercial business for the 2023 plan year.

Goodwill Impairment

Goodwill impairment within our continuing operations is derived from Bright HealthCare MA plans sold comprised of the full impairment of the goodwill assigned to consumers, our NeueCare reporting unit. Due to the decline in our stock price and market capitalization the carrying value of the NeueCare reporting unit exceeded its estimated fair value which was determined using a combination of discounted cash flows and market multiples.

Depreciation and Amortization

Depreciation and amortization consist of depreciation of property, equipment and capitalized software, as well as Consumer Care value-based capitation revenue amortization of definite-lived intangible assets acquired in business combinations, including customer relationships and trade names.

Other Income and Expenses

Interest Expense

Interest expense consists of interest payments on credit facilities.

Income Tax Expense (Benefit)

Income tax expense (benefit) consists primarily of changes to our current and deferred federal tax assets and liabilities net of applicable valuation allowances.

Loss from serving patients. Discontinued Operations

Bright HealthCare MA - Commercial premium revenue

In 2023, premium revenue for Bright HealthCare - Commercial, within discontinued operations, consists of retroactive adjustments to Advance Premium Tax Credit subsidies that are based on consumers' income levels and compensated directly by the federal government, as well as adjustments related to the ACA risk adjustment program, which adjusts premium revenue based on the demographic factors and health status of each consumer as derived from current-year

medical diagnoses. The 2022 premium revenue was predominantly derived from individual and family plan insurance contracts of Bright HealthCare - Commercial, within the scope of ASC 944, *Financial Services - Insurance*.

Bright HealthCare - premium revenue

The sources of MA premium revenue for Bright HealthCare, within discontinued operations, are Medicare Part C premiums related to consumers' medical benefit coverage and Part D premiums related to consumers' prescription drug benefit coverage. Medicare Part C premiums are comprised of CMS monthly capitation premiums that are risk adjusted based on CMS defined formulas using consumers' demographics and prior-year medical diagnoses. Medicare Part D premiums are comprised of CMS monthly capitation premiums that

are risk adjusted, consumer billed premiums and CMS low-income premium subsidies for the Company's insurance risk coverage. Medicare Part D premiums are subject to risk sharing with CMS under the risk corridor provisions based on profitability of the Part D benefit.

Consumer Care premium revenue

Consumer Care premium revenue represents revenue under value-based arrangements entered into by Consumer Care's Value Services Organization and affiliated medical groups in which the responsibility for control of an attributed patient's medical care is wholly transferred to such medical groups. Such revenue includes capitation payments, as well as quality incentive payments, and shared savings distributions payable upon achievement of certain financial and quality metrics. Value-based revenue shifts responsibility for control over the medical care delivered to attributed patients to the Company and aligns incentives around the overall well-being of the payor's consumers.

Direct Contracting revenue

Direct Contracting revenue represents the revenue from participation in CMS' Global and Professional Direct Contracting model ("DC Model") on our Consumer Care segment. Our two Direct Contracting Entities ("DCE's") participate in the DC Model through the global risk arrangement and assuming full risk for the total cost of care of aligned beneficiaries. As part of our participation in the DC Model, we are guaranteeing the performance of our care network of participating and preferred providers. The intention of the DC Model is to enhance the quality of care for Medicare FFS beneficiaries while reducing the administrative burden, supporting a focus on complex, chronically ill patients, and encouraging physician organizations that have not typically participated in Medicare FFS programs to serve Medicare FFS beneficiaries. Our Direct Contracting revenue is presented net of reinsurance costs. CMS redesigned the DC Model and renamed the model the ACO Realizing Equity, Access, and Community Health (REACH) Model ("ACO REACH Model") effective January 1, 2023.

Service revenue

Service revenue primarily represents revenue from fee-for-service payments received by Consumer Care's affiliated medical groups. These include patient copayments and deductibles collected directly from patients and payments from private and government payors based upon contractual terms that define the fee-for-service reimbursement for specific procedures performed.

Investment income

The sources of investment income are interest income and realized gains and losses derived from the Company's investment portfolio that is comprised of debt securities of the U.S. government and other government agencies, corporate

investment grade, money market funds and various other securities, as well as realized and unrealized gains and losses from equity securities.

Operating Expenses

Medical costs

Medical costs within discontinued operations consist of reimbursements to providers for medical services, costs of prescription drugs, supplemental benefits, risk share payments to payors, reinsurance and quality incentive management fees and shared savings compensation to providers net in relation to our Medicare Advantage business and the run out of any reinsurance recoveries. our Commercial products. The Company contracts contracted with hospitals, physicians and other providers of healthcare primarily within its exclusive provider networks under fee-for-service and value-based arrangements. Emergency medical services incurred out-of-network are a covered benefit to consumers and reimbursed to providers according to the Company's payment policies that are based on applicable regulations. Prescription drug costs are determined based on the contracts with our pharmacy benefits managers, which includes pharmacy rebates that are received for certain drug utilization levels or contracted minimums. Dental, vision, and other supplemental medical services are provided to consumers under capitated arrangements. Reinsurance arrangements enable us to cede a specified percent of our premiums and claims to our third-party reinsurers. Under such contracts, the reinsurer is paid to cover claims-related losses over a specified amount, which mitigates catastrophic risk. We make quality incentive and shared savings compensation payments to certain providers in accordance with the terms of the contractual arrangement upon the achievement of certain financial and quality metrics.

For value-based arrangements in which we bear limited risk, we recognize revenue on a net basis. Medical costs incurred from these arrangements are presented net of the associated premium revenue.

Operating Costs

Operating costs are comprised of the expenses necessary to execute the Company's business operations. These include employee compensation for salaries and related benefit costs, share-based compensation, outsourced vendor contracted service and technology fees, professional services, technological infrastructure and service fees, facilities costs and other administrative expenses. We expect operating costs to decrease with our exit of the Commercial market beginning with the 2023 plan year and the restructuring of our operations.

Restructuring Charges

Restructuring charges are comprised of contract termination costs and severance costs as part of a workforce reduction in 2022. The charges included within our continuing operations are those not directly attributable to our decision to exit the Commercial business for the 2023 plan year.

Goodwill Impairment

Goodwill impairment within our continuing operations is primarily comprised of the impairment of our Bright HealthCare reporting unit, formerly Medicare Advantage, that was primarily driven by an increase in the discount rate, which was impacted by higher interest rates and other market factors.

Intangible Assets Impairment

The intangible assets impairment within our continuing operations is primarily related to a full impairment of Centrum's reacquired contract with Bright HealthCare Florida as a result of our announcement that we will no longer offer Commercial products for the 2023 plan year.

Depreciation and Amortization

Depreciation and amortization consist of depreciation of property, equipment and capitalized software, as well as amortization of definite-lived intangible assets acquired in business combinations, including customer relationships, trade names, reacquired contracts and developed technology.

Other Income and Expenses

Interest Expense

Interest expense consists of interest payments on credit facilities, as well as amortization of debt issuance costs.

Income Tax Expense (Benefit)

Income tax expense (benefit) consists primarily of changes to our current and deferred federal tax assets and liabilities net of applicable valuation allowances.

Loss from Discontinued Operations

Commercial premium revenue

Premium revenue within discontinued operations is derived from commercial plans sold to consumers. The sources of commercial premium revenue are primarily IFP products which are comprised of APTC subsidies that are based on consumers' income levels and compensated directly by the federal government, as well as billed consumer premiums. IFP products reflect adjustments related to the ACA risk adjustment program, which adjusts premium revenue based on the demographic factors and health status of each consumer as derived from current-year medical diagnoses.

Investment income

The sources of investment income are interest income and realized gains and losses derived from the Company's investment portfolio that is comprised of debt securities of the U.S. government and other government agencies, corporate investment grade, money market funds and various other securities. Impairments recognized on our investments are also included within investment income of our discontinued operations.

Medical costs

Medical costs consist of reimbursements to providers for medical services, costs of prescription drugs, supplemental benefits, reinsurance and quality incentive and shared savings compensation to providers in relation to our Commercial products. The Company contracts with hospitals, physicians and other providers of healthcare primarily within its exclusive provider networks under fee-for-service and value-based arrangements. Emergency medical services incurred out-of-network are a covered benefit to consumers and reimbursed to providers according to the Company's payment policies that are based on applicable regulations. Prescription drug costs are were determined based on the contracts with our pharmacy benefits managers, which includes pharmacy rebates that are received for certain drug utilization levels or contracted minimums. Dental, vision, and other supplemental medical services are provided to consumers under capitated arrangements. Reinsurance arrangements enable us to cede a specified percent of our premiums and claims to our third-party reinsurers. Under such contracts, the reinsurer is paid to cover claims-related losses over a specified amount, which mitigates catastrophic risk. We make quality incentive and shared savings compensation payments to certain providers in accordance with the terms of the contractual arrangement upon the achievement of certain financial and quality metrics.

Operating Costs

Operating costs within discontinued operations are direct expenses primarily incurred in the operation of our California Medicare Advantage business and support of the runout operations of our Commercial business. These include employee compensation for salaries and related benefit costs, outsourced vendor contracted service and technology fees,

professional services, technological infrastructure and service fees and other administrative expenses. Operating costs also include payments made by the discontinued operations to Consumer Care for the provision of Bright Health Networks services; selling and marketing expenses from external broker commissions and advertising, primarily related to consumer acquisition; and premium taxes, exchange fees and other regulatory costs, which are primarily based on premium revenue. Additionally, in prior years, the premium deficiency reserve expense for expected future losses in certain markets is included in operating costs.

Restructuring Charges

Restructuring charges are comprised of employee termination benefits, long-lived asset impairments and contract termination costs and severance costs as part of a workforce reduction in 2022 and impairment of long-lived assets. costs. The charges included within our discontinued operations are those directly attributable to our decision decisions to sell our California Medicare Advantage business or to exit the Commercial business for the 2023 plan year. business.

Goodwill Impairment

Goodwill impairment within our discontinued operations is comprised of the impairment of our Bright HealthCare — Commercial reporting unit, specifically Commercial business, that unit. This impairment was driven by the $100.0 million decrease in the purchase price and additional contingencies and Tangible Net Equity ("TNE") adjustments in connection with the sale of our decision California Medicare Advantage business. To estimate the fair value of the Bright HealthCare reporting unit we reduced the $500.0 million purchase price by $175.8 million, the amount subject to exit contingencies and TNE adjustments that create uncertainties in what will be the Commercial markets beginning for final adjusted purchase prices as well as the 2023 plan year. transaction costs incurred to complete the sale. As the carrying

Intangible Assets Impairment

Intangible assets impairment within our discontinued operations is comprised value of the Bright HealthCare reporting unit exceeded the calculated fair value, we recognized an impairment of intangible assets related to our TrueHealth New Mexico ("THNM") acquisition, that was driven by our decision to exit the Commercial markets beginning for the 2023 plan year. goodwill.

COVID-19 Impact

The ongoing COVID-19 pandemic, including its effect on the macroeconomic environment, and the response of local, state, and federal governments to contain and manage the virus, continues to impact our business. The emergence of COVID-19 variants in the United States and abroad continues to prolong the risk of additional surges of the virus. In addition, certain new variants have emerged that appear more transmissible and more resistant to current vaccines. Some individuals have also delayed or are not seeking routine medical care to avoid COVID-19 exposure. These and other responses to the COVID-19 pandemic have meant that our MCR may be subject to additional uncertainty as certain segments of the economy and workforce come back on line, members resume care that may have been foregone, and the broader population becomes vaccinated.

For the years ended December 31, 2022, 2021, and 2020 the impact of COVID-19 increased our medical costs by $36.4 million, $59.4 million, and $30.2 million respectively.
Overall measures to contain the COVID-19 outbreak may remain in place for a significant period of time, as new strains of COVID-19 that appear to be more transmissible and may potentially evade vaccines have emerged. The duration and severity of this pandemic is unknown and the extent of the business disruption and financial impact depends on factors beyond our knowledge and control.

Business Update

Our mission – *Making Healthcare Right. Together.* – is built on Although our business has evolved over the belief that by connecting and last few years, our core beliefs have not changed. Since our founding, we have been committed to uniquely aligning the best local resources interests of payors, providers, and consumers to deliver a better healthcare experience for all. The healthcare industry continues to evolve and shift towards value-based care. We are confident in healthcare delivery the future of our differentiated, value-driven care model focused on our two go-forward business segments, NeueCare and NeueSolutions.

NeueCare

Our NeueCare segment is focused on delivering value-driven, consumer-centric care through our owned clinics and partnerships with affiliated providers. Our model is differentiated, and we've shown that when we tightly align the financing interests of care, stakeholders clinically, financially, and through data and technology, we can drive differentiated value and deliver better outcomes, at a lower cost, truly personalized care experience that's tailored to meet the needs of each consumer.
In 2024, we expect to continue to drive growth in our NeueCare segment, strengthening relationships with our existing payor partners, engaging in new payor partnerships, and continuing to attract and retain consumers through our value-driven model. We see our ability to effectively manage a diverse population mix – agnostic of product category – as a key differentiator that will fuel future growth.

NeueSolutions

Our NeueSolutions segment is our provider enablement business focused on partnering with independent providers and medical groups to enable them to succeed in performance-based arrangements. NeueSolutions also supports our NeueCare business with care management, referral management, and other population health tools and capabilities. This business reflects our core and overarching focus on aligning interests to maximize value for all consumers. and represents a significant growth opportunity as more providers look to enter risk-bearing arrangements. We believe NeueSolutions provides a strong platform for our Company to continue to grow, enter new provider partnerships and manage a diverse population base. Specifically, we see growth opportunities to serve additional Medicaid consumers in partnership with Federally Qualified Health Centers and other provider groups.

In October 2022, our ACO REACH business, we announced encountered some headwinds that impacted our business will be focused on delivering affordable healthcare for aging and underserved populations results in 2023, including the largest healthcare markets in the country and continuing to leverage bankruptcy filing of one of our Fully Aligned Care Model with external payor ACO REACH care partners and affiliate care providers. the impacts of CMS adjustments to financial benchmarks, notably the Coding Intensity Factor. Excluding these factors, our REACH ACOs' performance was in-line with expectations. For 2024, we re-evaluated the participating providers in our ACOs and did not renew the contracts of underperforming groups. We will continue also added new strategic provider partners more closely aligned with our goals. As a result, we expect to build on have greater insight into the value-driven care model that returning population of Medicare beneficiaries we have been advancing since the start of the company. are managing and a more optimal partner mix.

We have started implementing restructuring plans are seeing strong growth opportunities on the provider enablement side of NeueSolutions. During the fourth quarter, we secured new partnerships with provider groups, increasing the lives we are serving to adjust over 106,000. This growth is significant and shows the value providers see in our costs to partnership and deep experience in managing diverse populations in performance-based arrangements. We see our more focused business in order to achieve our 2023 gross margin provider enablement and operating expense targets. We will continue to take steps to adjust our expenses in-line ACO REACH businesses as complementary with milestones in each driving future growth opportunities for the marketplace business over the course of the run-out period of the exited markets. other.

As Sale of California MA Business

On January 1, 2024, we move forward into 2023, we are focusing closed the sale of our business on our Consumer Care care delivery business and our Medicare Advantage health plans in California. We have a scaled California Medicare Advantage business, in California, which consisted of Brand New Day and Central Health Plan, to Molina. Concurrent with the largest market for seniors close of the sale, we also announced that we made the final repayment on our amended credit facility with J.P. Morgan as administrative agent. This eliminated the Company's secured debt and underserved populations, and we have built was a high performing Fully Aligned Care Model with significant step as it allows us to further focus on our Care Partners. In Florida and Texas, our Consumer Care risk-bearing value-driven care delivery and provider affiliate management business continues to deliver differentiated results. We expect to expand our footprint over time serving the aging and enablement business.

underserved consumers in Medicare and the consumer marketplace, together with our key health plan partners. We will also continue to grow our Direct Contracting business in the new ACO Reach program, building on our 2022 performance.

While we wind down the marketplace business, we will remain focused on the growth opportunities for our Bright HealthCare and Consumer Care businesses. We believe both businesses are in attractive markets with strong tailwinds, where we have differentiated offerings. We intend to manage each business to maximize operating profitability in 2023, as well as working to manage corporate expenses to maximize consolidated Adjusted EBITDA profitability.

We believe the near-term steps that we are taking our differentiated care model and ability to improve our performance will optimize the business for long-term success. serve all populations in performance-based arrangements puts us in a strong position to capture this growing opportunity in 2024 and beyond.

Key Metrics and Non-GAAP Financial Measures

In addition to our GAAP financial information, we review a number of operating and financial metrics, including the following key metrics, to evaluate our business, measure our performance, identify trends affecting our business, formulate our business plan and make strategic decisions. The following table provides the approximate numbers of consumers and patients served as of December 31, 2023 and 2022.

	Year Ended December 31,		
	2022	**2021**	**2020**
Bright HealthCare Consumers Served			
Medicare Advantage	**125,000**	117,000	62,000
Consumer Care Patients			
Value-Based Care Consumers	**530,000**	170,000	21,000

	Year Ended December 31,	
	2023	**2022**
Value-Based Care Consumers (1)	**355,000**	117,000
Enablement Services Lives	**106,000**	—

(1)The value-based care consumers at December 31, 2022 have been recast for comparability to exclude consumers attributable to our Bright HealthCare - Commercial business that we exited beginning in 2023.

Key Metrics

Bright HealthCare Consumers Served

Consumers served include Bright HealthCare individual lives served via MA plans in markets across the country. We historically believed growth in the number of consumers for both our Commercial plans and Medicare Advantage plans was a key indicator of the performance of our Bright HealthCare business. However, given Bright HealthCare's decision to exit the commercial marketplace for the 2023 plan year, we expect Commercial consumers to decline to zero, and we will focus on growth in our Medicare Advantage consumers in California. The number of consumers served also informs our management of the operational, clinical, technological and administrative functional area needs that will require further investment to support future consumer growth.

Value-Based Care Consumers

Value-based care consumers are consumers attributed to providers contracted under varied various value-based care delivery models in which the responsibility for control of an attributed patient's medical care is transferred, in part or wholly, to our Consumer Care managed NeueHealth owned or affiliated medical groups. We believe growth in the number of value-based care consumers is a key indicator of the performance of our Consumer Care NeueHealth business. It also informs our management of the operational, clinical, technological and administrative functional area needs that will require further investment to support expected future patient growth. While we expect We saw a year over year increase in value-based care consumers of approximately 238,000 consumers. Our focus is to continue to grow the number of value-based care consumers Consumer Care supports in 2023 through third-party payor relationships.

Enablement Services Lives

Enablement services lives represent members attributed to decline compared NeueHealth by provider partner groups that are outside of the NeueHealth owned network. We bring the people, process, and technology platforms necessary to 2022 due to Bright HealthCare's commercial market exits, manage the administrative support for these value-based and risk arrangement members, on behalf of our provider partners. As a result of the value we expect external value-based payor contracts as well as drive, we ended the conversion of fee for service patients into value-based patients, will increase the number of patients managed in value-based arrangements over time. year with approximately 106,000 enablement services lives under contract within those organizations.

	Year Ended December 31,				Year Ended December 31,	
($ in thousands)	*($ in thousands)*	**2022**	**2021**	**2020**	*($ in thousands)*	**2023**	**2022**
Net Loss	**Net Loss**	**$(1,359,880)**	(1,178,365)	(248,442)			
Adjusted EBITDA (1)	**Adjusted EBITDA** (1)	**$ (233,489)**	(321,317)	(151,692)			

(1) See "Non-GAAP Financial Measures" below for reconciliations to the most directly comparable financial measures calculated in accordance with GAAP and related disclosures.

Non-GAAP Financial Measures

Adjusted EBITDA

We define Adjusted EBITDA as net Net loss excluding loss from discontinued operations, interest expense, income taxes, transaction costs, depreciation and amortization, any share-based compensation expense, restructuring and contract termination costs, impairment of goodwill or and intangible assets, adjusted for changes in the impact fair value of acquisition contingent consideration, and financing-related transaction costs, share-based compensation, changes in the fair value of equity securities changes in and derivatives, and losses related to the fair value bankruptcy of contingent consideration, contract termination costs and restructuring costs. one of our ACO REACH partners. Adjusted EBITDA has been presented in this Annual Report as a supplemental measure of financial performance that is not required by, or presented in accordance with, GAAP, because we believe it assists management and investors in comparing

our operating performance across reporting periods on a consistent basis by excluding items that we do not believe are indicative of our core operating performance. Management believes Adjusted EBITDA is useful to investors in highlighting trends in our operating performance, while other measures can differ significantly depending on long-term strategic decisions regarding capital structure, the tax jurisdictions in which we operate and capital investments. Management uses Adjusted EBITDA to supplement GAAP measures of performance in the evaluation of the effectiveness of our business strategies, to make budgeting decisions, to establish discretionary annual incentive compensation and to compare

our performance against that of other peer companies using similar measures. Management supplements GAAP results with non-GAAP financial measures to provide a more complete understanding of the factors and trends affecting the business than GAAP results alone.

Adjusted EBITDA is not a recognized term under GAAP and should not be considered as an alternative to net income (loss) as a measure of financial performance or cash provided by operating activities as a measure of liquidity, or any other performance measure derived in accordance with GAAP. Additionally, this measure is not intended to be a measure of free cash flow available for management's discretionary use as we do not consider certain cash requirements such as interest payments, tax payments and debt service requirements. The presentation of this measure has limitations as an analytical tool and should not be considered in isolation, or as a substitute for analysis of our results as reported under GAAP. Because not all companies use identical calculations, the presentation of this measure may not be comparable to other similarly titled measures of other companies and can differ significantly from company to company.

The following table provides a reconciliation of net Net loss to Adjusted EBITDA for the periods presented:

		Year Ended December 31,					
		Year Ended December 31,					Year Ended December 31,
(in thousands)	*(in thousands)*	**2022**	**2021**	**2020**	*(in thousands)*	**2023**	**2022**
Net loss	**Net loss**	**$(1,359,880)**	$(1,178,365)	$(248,442)			
Loss from discontinued operations (a)		**721,915**	855,255	87,220			
Loss from Discontinued Operations (a)							
EBITDA adjustments from continuing operations:	EBITDA adjustments from continuing operations:						
Interest expense	Interest expense	**12,821**	7,230	—			
Income tax expense (benefit)		**3,680**	(26,521)	(9,161)			
Interest expense							
Interest expense							
Income tax (benefit) expense							
Transaction costs (b)							
Depreciation and amortization	Depreciation and amortization	**50,430**	35,049	8,289			
Goodwill impairment		**71,225**	—	—			
Intangible assets impairment		**42,611**	—	—			
Transaction costs (b)		**1,661**	2,064	4,950			
Share-based compensation expense (c)	Share-based compensation expense (c)	**109,713**	68,423	5,452			
Change in fair value of equity securities (d)		**80,231**	(80,231)	$ —			
Restructuring and contract termination costs (d)							
Impairment of goodwill and long-lived assets							

ACO REACH care partner bankruptcy (e)				
Change in fair value of warrant liability (f)				
Change in fair value of contingent consideration (e) (g)	Change in fair value of contingent consideration (e) (g)	**332**	(4,221)	—
Contract termination costs (f)		**1,241**	—	—
Restructuring costs (g)		**30,531**	—	—
Change in fair value of equity securities				
EBITDA adjustments from continuing operations	**EBITDA adjustments from continuing operations**	**404,476**	**1,793**	**9,530**
Adjusted EBITDA	**Adjusted EBITDA**	**$ (233,489)**	$ (321,317)	$(151,692)

(a) Beginning in the fourth quarter of 2022, Adjusted EBITDA excludes the impact of discontinued operations. The comparable period in 2021 2022 has been recast to exclude these impacts. Loss from discontinued operations represents Represents losses associated with the Commercial business segment and MA Legacy operations that we exited at the end of 2022. The loss from discontinued operations includes over $180 million of investment impairments, restructuring costs, goodwill 2022 and intangibles impairments and other exit related costs the California Medicare Advantage business classified as held for the twelve months ended December 31, 2022, respectively. sale.

(b) Transaction costs include accounting, tax, valuation, consulting, legal and investment banking fees directly relating to business combinations and certain costs associated with our initial public offering. financing initiatives. These costs can vary from period to period and impact comparability, and we do not believe such transaction costs reflect the ongoing performance of our business.

(c) Represents non-cash compensation expense related to stock option and restricted stock unit award grants, which can vary from period to period based on a number of factors, including the timing, quantity and grant date fair value of the awards.

(d) Beginning in 2022, Adjusted EBITDA excludes Restructuring and contract termination costs represent severance costs as part of a workforce reduction, amounts paid for early termination of leases, and impairment of certain long-lived assets primarily relating to our decision to exit the impact of changes in unrealized gains and losses on equity securities. The comparable prior periods have been recast to exclude changes in unrealized gains and losses on equity securities. Commercial business for the 2023 plan year.

(e) Represents the non-cash costs expected to be incurred as a result of one of our ACO REACH care partners filing for bankruptcy; includes the full allowance established for the outstanding receivable and ongoing costs incurred to manage and provide service to members attributed to the care partner that would have otherwise been reimbursed prior to the care partner's bankruptcy.

(f) Represents the change in the fair value of the warrant liability established for warrants included in our financing arrangements, which are remeasured at fair value each reporting period.

(g) Represents the change in fair value of contingent consideration from business combinations, which is remeasured at fair value each reporting period.

(f) Represents amounts paid for early termination of existing vendor contracts.

(g) Restructuring costs represent severance costs as part of a workforce reduction in 2022 and impairment of certain long-lived assets relating to our decision to exit the Commercial business for the 2023 plan year.

Acquisitions

Effective April 30, 2020, we acquired Universal Care, Inc. (d.b.a. Brand New Day) ("BND"), which is focused on serving primarily MA special needs consumers. This Bright HealthCare acquisition was completed to bolster our MA platform and provide entry into California.

Effective December 31, 2020, we acquired a 62% controlling interest in Premier Medical Associates of Florida, LLC ("PMA"). This Consumer Care acquisition was completed to enhance our clinical capabilities to better serve enrollees as part of our Florida market expansion in 2021.

Effective March 31, 2021, we acquired THNM, which offers policies available through the commercial market for individual on- and off-exchange and employer-sponsored health coverage. Included in our discontinued operations, this acquisition was completed to enter into a new state of strategic interest and to leverage THNM's strong local clinical model of care.

Effective March 31, 2021, we acquired Zipnosis, Inc. ("Zipnosis"), which is a telehealth platform that offers virtual care to health systems around the U.S. This Consumer Care acquisition was completed to enhance our proprietary technology platform, DocSquad, and our consumer and provider connectivity with Zipnosis' virtual care capabilities.

Effective April 1, 2021, we acquired Central Health Plan of California, Inc. ("CHP"), an insurance provider of MA health maintenance organization ("HMO") services. This Bright HealthCare acquisition was completed to gain synergies from leveraging CHP's clinical model and California consumer expertise to continue to expand our MA business in the California market.

Effective July 1, 2021, we acquired Centrum, a value-based primary care focused, multi-specialty medical group, serving Commercial, Medicare, and Medicaid consumers across multiple payors. This Consumer Care acquisition was completed for the incremental financial benefits achievable through our Fully Aligned Care Model, whereby Commercial, Medicare, and Medicaid consumers across multiple payors are cared for under value-based arrangements with Centrum. This model brings together the financing, distribution, and delivery of high-quality healthcare.

See Note 3 in the Notes to Consolidated Financial Statements for more information regarding our business combinations.

Results of Operations

The following table summarizes our audited consolidated statements of income (loss) data for the years ended December 31, 2022, 2021 December 31, 2023 and 2020. 2022.

(in thousands)	*(in thousands)*	**Year Ended December 31,**			*(in thousands)*	**Year Ended December 31,**	
Consolidated Statements of Income (loss) and operating data:	**Consolidated Statements of Income (loss) and operating data:**	**2022**	**2021**	**2020**	**Consolidated Statements of Income (loss) and operating data:**	**2023**	**2022**
Revenue:	Revenue:						
Premium revenue		**$ 1,764,949**	$ 1,390,330	$ 487,905			
Direct Contracting revenue		**654,087**	—	—			
Capitated revenue							
Capitated revenue							
Capitated revenue						**$ 219,774**	$ 112,904
ACO REACH revenue					ACO REACH revenue	**896,504**	654,087
Service revenue	Service revenue	**48,013**	42,469	18,514	Service revenue	**44,438**	39,601
Investment income (loss)	Investment income (loss)	**(55,019)**	80,234	8,468	Investment income (loss)	**86**	(55,429)
Total revenue	**Total revenue**	**2,412,030**	1,513,033	514,887	**Total revenue**	**1,160,802**	751,163
Operating costs	Operating costs						
Medical costs	Medical costs	**2,206,243**	1,294,158	451,918			
Medical costs							
Medical costs						**996,582**	662,972

Operating costs	Operating costs	**632,030**	527,453	225,063	Operating costs	**287,138**	354,436
Bad debt expense					Bad debt expense	**27,407**	12
Restructuring charges	Restructuring charges	**31,739**	—	—	Restructuring charges	**6,990**	29,178
Goodwill impairment	Goodwill impairment	**71,225**	—	—	Goodwill impairment	**401,385**	—
Intangibles impairment	Intangibles impairment	**42,611**	—	—	Intangibles impairment	**—**	42,611
Depreciation and amortization	Depreciation and amortization	**50,430**	35,049	8,289	Depreciation and amortization	**18,296**	30,710
Total operating costs	**Total operating costs**	**3,034,278**	1,856,660	685,270	**Total operating costs**	**1,737,798**	1,119,919
Operating loss	**Operating loss**	**(622,248)**	(343,627)	(170,383)	**Operating loss**	**(576,996)**	(368,756)
Interest expense	Interest expense	**12,821**	7,230	—	Interest expense	**38,203**	12,822
Other income		**(784)**	(1,226)	—			
Warrant expense					Warrant expense	**13,971**	—
Loss from continuing operations before income taxes	**Loss from continuing operations before income taxes**	**(634,285)**	(349,631)	(170,383)	**Loss from continuing operations before income taxes**	**(629,170)**	(381,578)
Income tax expense (benefit)	Income tax expense (benefit)	**3,680**	(26,521)	(9,161)	Income tax expense (benefit)	**(1,428)**	3,664
Net loss from continuing operations	**Net loss from continuing operations**	**(637,965)**	(323,110)	(161,222)	**Net loss from continuing operations**	**(627,742)**	(385,242)
Loss from discontinued operations, net of tax (Note 4)		**(721,915)**	(855,255)	(87,220)			
Loss from discontinued operations, net of tax (Note 19)					Loss from discontinued operations, net of tax (Note 19)	**(638,066)**	(974,638)
Net loss	**Net loss**	**(1,359,880)**	(1,178,365)	(248,442)	**Net loss**	**(1,265,808)**	(1,359,880)
Net earnings from continuing operations attributable to noncontrolling interests		**(95,664)**	(6,497)	—			
Net loss (earnings) from continuing operations attributable to noncontrolling interests					Net loss (earnings) from continuing operations attributable to noncontrolling interests	**114,354**	(95,664)

Series A preferred stock dividend accrued	Series A preferred stock dividend accrued	**(37,889)**	—	—	Series A preferred stock dividend accrued	**(40,139)**	(37,889)
Series B preferred stock dividend accrued	Series B preferred stock dividend accrued	**(1,798)**	—	—	Series B preferred stock dividend accrued	**(9,006)**	(1,798)
Net loss attributable to Bright Health Group, Inc. common shareholders		**$ (1,495,231)**	$ (1,184,862)	$ (248,442)			
Net loss attributable to NeueHealth, Inc. common shareholders					**Net loss attributable to NeueHealth, Inc. common shareholders**	**$ (1,200,599)**	$(1,495,231)
Adjusted EBITDA	Adjusted EBITDA	**$ (233,489)**	$ (321,317)	$ (151,692)	Adjusted EBITDA	**$ (8,480)**	$ (75,095)
Operating Cost Ratio (1)	Operating Cost Ratio (1)	**26.2 %**	34.9 %	43.7 %	Operating Cost Ratio (1)	**24.7 %**	47.2%

(1) Operating Cost Ratio is defined as operating costs divided by total revenue.

2022 Compared to 2021

Total revenue increased by $899.0 million, $409.6 million, or 59.4% 54.5%, for the year ended December 31, 2022 December 31, 2023, as compared to the same period in 2021. 2022. The increase is largely attributable to our two DCEs three REACH ACOs aligned with our Consumer Care NeueSolutions segment that began participating in the DC Model effective January 1, 2022, which contributed $654.1 $242.4 million of the increase in total revenue. revenue, primarily driven by an increase of approximately 16,000 aligned beneficiaries. In addition, premium capitated revenue increased $374.6 $106.9 million, or 26.9% 94.7%, due to organic growth of increased membership through our Bright HealthCare business third-party payor contracts as well as a full year of CHP operations that was acquired on April 1, 2021. Also contributing compared to the premium revenue increase was an year ended December 31, 2022; we had a year over year increase of over 360,000 approximately 238,000 value-based care consumers as well as organic increases in consumers served by our Bright HealthCare business. The increases in premium revenue and Direct Contracting revenue were partially offset by a reduction in consumers. In addition, for the year ended December 31, 2022 we had an investment income loss of $55.4 million driven by changes in the fair value of our investments in equity securities. securities; we held no equity securities during the year ended December 31, 2023, as such there was not equivalent activity in the current period.

Medical costs increased by $912.1 million, $333.6 million, or 70.5% 50.3%, for the year ended December 31, 2022 December 31, 2023, as compared to the same period in 2021. 2022. Medical The increase in medical costs incurred associated with was primarily driven by an increase in beneficiaries aligned to our DCEs contributed to the increase as well as organic growth in our Bright HealthCare business. In 2022, we also had a full year of medical costs from CHP that was acquired on April 1, 2021. REACH ACOs.

Operating costs increased decreased by $104.6 million, $67.3 million, or 19.8% 19.0%, for the year ended December 31, 2022 December 31, 2023, as compared to the same period in 2021. 2022. The increase decrease in operating costs was primarily due to a $97.3 million increase $61.1 million decrease in compensation and fringe benefits inclusive of share-based compensation expense. This increase is partially offset by the release of the $9.4 million premium deficiency reserve in the year ended December 31, 2022 that was accrued in the year ended December 31, 2021 for the then future expected losses in certain markets in 2022 in expense; resulting from our Bright HealthCare segment.restructuring efforts and reduced workforce throughout 2023 as compared to 2022.

Our operating cost ratio of 26.2% 24.7% for the year ended December 31, 2022 December 31, 2023 improved 870 by 2,250 basis points as compared to the same period in 2021. 2022. The decrease was is primarily due to operating costs increasing at a slower rate than the increased premium revenues earned due to consumer growth and participating in the DC Model, as we gain leverage on result of our operating costs as we grow. restructuring efforts.

We recognized $31.7 million Our restructuring costs decreased by $22.2 million for the year ended December 31, 2023, as compared to the same period in 2022. This decrease was driven by $24.0 million of restructuring costs charges related to employee termination benefits for the year ended December 31, 2022 for employee termination benefits, contract termination costs and long-lived asset impairments incurred in relation as compared to the actions we have taken to restructure the Company's workforce and reduce expenses based on our updated business model. There were no restructuring costs in $5.9 million for the year ended December 31, 2021 December 31, 2023.

WeDue to the decline in our stock price and market capitalization, we recognized $71.2 million$401.4 million of non-cash goodwill impairment for the year ended December 31, 2023. For the year ended December 31, 2022, which included $70.0 million we did not recognize any goodwill impairment in our Bright HealthCare segment. continuing operations. We also recognized $42.6 million$42.6 million of non-cash intangible assets impairment for the year ended December 31, 2022, which included impairments impairment of the reacquired contract at our Consumer Care segment. NeueCare segment due to the decision to exit the Commercial market beginning in 2023. There were no impairments of goodwill or intangibles in the year end December 31, 2021 ended December 31, 2023.

Depreciation and amortization Bad debt expense increased by $15.4 million, or 43.9%,$27.4 million for the year ended December 31, 2022December 31, 2023, as compared to the same period in 2021.2022. The increase is primarily due to in bad debt expense was primarily driven by one of our ACO REACH care partners filing for bankruptcy in the third quarter of 2023 and a full year of amortization expense from 2021 acquisitions in allowance being established on the 2022 period compared to only portions of the 2021 period specifically the acquisition of CHP on April 1, 2021 and Centrum on July 1, 2021. Additionally, depreciation expense increased in 2022 due to depreciation related to capitalized software projects completed in the past year. corresponding receivables.

Interest expense increased $5.6 million,Depreciation and amortization decreased by $12.4 million, or 77.3% 40.4%, for the year ended December 31, 2022 December 31, 2023, as compared to the same period in 2021 2022. The decrease is primarily due to the full impairment of the reacquired contract intangible asset during the third quarter of 2022; for the year ended December 31, 2022 amortization of the reacquired contract intangible asset was $9.9 million, as compared to no related expense for the year ended December 31, 2023.

Interest expense increased $25.4 million, or 197.9%, for the year ended December 31, 2023, as compared to the same period in 2022, primarily due to increased borrowings on the credit agreement we entered into March 1, 2021 throughout the period as well as new borrowing agreements established in the third and fourth quarters of 2023.

We recognized warrant expense of $14.0 million for the year ended December 31, 2023, as compared to none in the same period in 2022. This is a result of the Warrantholders Agreement executed in conjunction with the New Credit Agreement in the third quarter of 2023; there were no warrants prior to the third quarter of 2023.

Income tax expense benefit was $3.7 million$1.4 million for the year ended December 31, 2022 December 31, 2023, as compared to the $26.5 million$3.7 million income tax benefit expense for the year ended December 31, 2021 December 31, 2022. The impact from income taxes varies from the federal statutory rate of 21.0% due to state income taxes, changes in the valuation allowance for deferred tax assets and adjustments for permanent differences. The expense benefit for the year ended December 31, 2023 largely relates to the removal of the accrued amortization of originating goodwill from asset acquisitions and estimated state income taxes attributable to income earned in separate filing states without state net operating loss carryforwards. The tax expense recognized during the year ended December 31, 2022 largely primarily relates to amortization of originating goodwill from asset acquisitions and estimated state income taxes attributable to income earned in separate filing states without state net operating loss carryforwards. The overall tax benefit recognized during the year ended December 31, 2021 primarily relates to adjustments to the valuation allowance for federal and state deferred tax assets, as well as the effect of deferred taxes recorded as part of business combination accounting for the BND, Zipnosis, and CHP acquisitions

2021 Compared to 2020

Total revenue increasedLoss from discontinued operations decreased by $1.0 billion, or 193.9%,$336.6 million for the year ended December 31, 2021 December 31, 2023, as compared to the same period in 2020. 2022. The increase was largely driven by an increase in our Medicare Advantage consumers of approximately 55,000 consumer lives, or 88.7%, through both organic and inorganic growth. The year ended December 31, 2021 also included $781.8 million from the acquisitions of PMA, Zipnosis, CHP and Centrum and a full year of BND, which was acquired on April 30, 2020. These acquisitions were the primary driverDecember 31, 2023 is reflective of the increase in service revenue contributing $23.8 million for the year ended December 31, 2021. In addition, investment income increased due to unrealized gains from investments in equity securities run out of $80.2 million.

Medical costs increased by $842.2 million, or 186.4% for the year ended December 31, 2021 our Bright HealthCare - Commercial business as compared to active operations of the same period in 2020. The increase in medical costs was driven by an increase in consumers through both organic growth in our

Bright HealthCare commercial business and inorganic growth attributable to the acquisitions of PMA, CHP and Centrum, as well as a full year of BND. We also experienced an increase in medical costs from COVID-19 during the year ended December 31, 2021 December 31, 2022.

Operating costs increased by $302.4 million, or 134.4%, for For the year ended December 31, 2021 as compared to the same period in 2020. The increase in operating costs was primarily due to increased marketing and selling expenses and increased compensation and benefit costs driven by an increase in employees and an increase in share-based compensation costs.

Operating cost ratio of 34.9% for the year ended December 31, 2021 improved 880 basis points as compared to the same period in 2020. This was primarily due to operating costs increasing at a slower rate than revenue increases as the Company grew.

Depreciation and amortization increased by $26.8 million, or 322.8%, for the year ended December 31, 2021 as compared to the same period in 2020. The increase was primarily due to an increase in amortization expense resulting from intangible assets acquired in the PMA, Zipnosis, CHP, and Centrum acquisitions, for which there were no comparable amounts in 2020 as well as the full year of amortization expense of the intangible assets acquired as part of the BND acquisition on April 30, 2020.

Income tax benefit was $26.5 million and $9.2 million for the years ended December 31, 2021 and 2020 respectively. The overall tax benefit recognized during the year ended December 31, 2021 was primarily related to adjustments to the valuation allowance for federal and state deferred tax assets, as well as the effect of deferred taxes recorded as part

of business combination accounting for the BND, Zipnosis, and CHP acquisitions. The overall tax benefit recognized during the year ended December 31, 2020 was primarily due to the tax impact of goodwill and intangible assets acquired as part of the BND acquisition in 2020.

Bright HealthCare

(in thousands)	Year Ended December 31,		
Statements of income (loss) and operating data:	**2022**	**2021**	**2020**
Revenue:			
Premium revenue	**1,652,045**	1,297,273	480,112
Investment income (loss)	**410**	(80)	8,468
Total revenue	**1,652,455**	1,297,193	488,580
Operating expenses			
Medical costs	**1,550,934**	1,262,407	454,858
Operating costs	**187,636**	189,648	75,879
Goodwill impairment	**70,017**	—	—
Depreciation and amortization	**17,702**	14,245	1,477
Total operating expenses	**1,826,289**	1,466,300	532,214
Operating loss	**$ (173,834)**	$ (169,107)	$ (43,634)
Medical Cost Ratio (MCR)	**93.9 %**	97.3 %	94.7 %

2022 Compared to 2021

Premium revenue increased by $355.3 million, or 27.4%, for the year ended December 31, 2022 as compared to the same period in 2021. The increase was driven by favorable premium rates and an increase in consumer lives of approximately 15,000 year over year. Additionally, the increase is attributable to a full year of revenue from our acquisition of CHP, which occurred on April 1, 2021

Medical costs increased by $288.5 million, or 22.9%, for the year ended December 31, 2022 as compared to the same period in 2021. The impact of COVID-19 increased our medical costs $36.4 million and $59.4 million for the years ended December 31, 2022 2023, the loss from discontinued operations aligned to our Bright HealthCare - Commercial business decreased and 2021 $447.4 million, respectively. The increase in medical costs was primarily driven by an increase in members,

partially offset by favorable medical cost rates. Additionally, the increase is attributable compared to a full year of medical costs from our acquisition of CHP, which occurred on April 1, 2021

Our MCR of 93.9% for the year ended December 31, 2022 decreased 340 basis points. The loss from discontinued operations aligned to our Bright HealthCare operations classified as compared to the same period in 2021 held for sale increased . Our California Medicare Advantage operations achieved a MCR of 92.0%, excluding prior period claims; this metric excludes the MA markets that we have exited as of December 31, 2022. Our MCR $133.0 millionfor the year ended December 31, 2022 included a 220 basis point unfavorable impact from COVID-19 related costs 2023, as compared to 460 basis point unfavorable impact from COVID-19 included 2022. The increase in Bright HealthCare's net loss is largely driven by the recognition of a $186.2 million goodwill impairment related to our MCR Bright HealthCare reporting unit for the year ended

December 31, 2023, as compared to $70.0 milliongoodwill impairment related to our Bright HealthCare reporting unit for the year ended December 31, 2021 December 31, 2022.

Operating costs decreased by $2.0 million, or 1.1%, The goodwill impairment for the year ended December 31, 2022 as compared to December 31, 2023 resulted from the same period in 2021. Operating costs remained relatively flat year over year due to increases in costs as a result decreased purchase price of consumer growth our California MA business and compensation added contingencies and benefit costs that were offset by the release of the PDR.

We recognized a $70.0 million non-cash impairment of goodwill during TNE adjustments. For the year ended December 31, 2022 which the goodwill impairment was primarily driven by an increase in the discount rate, due to which was impacted by higher interest rates and other market factors.

Depreciation and amortization increased by $3.5 million, or 24.3%, Additionally, the loss from our DocSquad business that was sold in the first quarter of 2023 decreased $22.2 millionfor the year ended December 31, 2023, as compared to 2022.

NeueCare

(in thousands)	Year Ended December 31,	
Statements of income (loss) and operating data:	**2023**	**2022**
Revenue:		
Capitated revenue	**219,774**	112,904
Service revenue	**41,559**	39,487
Total unaffiliated revenue	**261,333**	152,391
Affiliated revenue	**5,876**	1,039,620
Total segment revenue	**267,209**	1,192,011
Operating expenses		
Medical costs	**97,483**	1,217,742
Operating costs	**119,922**	124,780
Bad debt expense	**4,984**	5
Restructuring charges	**130**	—
Goodwill impairment	**401,385**	—
Intangible asset impairment	**—**	42,611
Depreciation and amortization	**12,651**	22,234
Total operating expenses	**636,555**	1,407,372
Operating loss	**$ (369,346)**	$ (215,361)

NeueCare capitated revenue increased by $106.9 million, or 94.7%, for the year ended December 31, 2023, as compared to the same period in 2022. The increase was a result of increased membership through our third-party payor contracts as compared to the year ended December 31, 2022. Our Value-Based Care Consumers within NeueCare increased approximately 222,000 from December 31, 2022 to December 31, 2023.

NeueCare's service revenue increased $2.1 million for the year ended December 31, 2023, as compared to the same period in 2021 2022. The increase was primarily due to a full year of amortization expense of the intangible assets acquired in the CHP acquisition that occurred on April 1, 2021.

2021 Compared to 2020

Premium NeueCare's service revenue increased by $817.2 million, or 170.2%, for the year ended December 31, 2021 as compared to the same period in 2020. The year ended December 31, 2021 included $679.1 million of revenue from our acquisition of CHP on April 1, 2021, and the impact of a full year of revenue from BND, whichDecember 31, 2023 was acquired on April 30, 2020. We also experienced volume increases due to organic growth.

Medical costs increased by $807.5 million, or 177.5%, for the year ended December 31, 2021 as compared to the same period in 2020. For the years ended December 31, 2021 and 2020, the impact of COVID-19 increased our medical costs by $59.4 million and $30.2 million, respectively. The increase in 2021 is also due to an increase in consumers primarily driven by organic growth, unfavorable medical cost rates and inorganic growth as a result of the acquisition of CHP.

Our MCR of 97.3% higher utilization that led to increased fee for the year ended December 31, 2021 increased 260 basis points as compared to the same period in 2020. Our MCR for the year ended December 31, 2021 included a 460 basis point unfavorable impact from COVID-19. Our MCR for the year ended December 31, 2020 included a 630 basis point unfavorable impact from COVID-19 costs. Our MCR for the year ended December 31, 2021, was also impacted by an increase in medical costs from product mix as a result of a full year of activity from BND and the acquisition of CHP.

Operating costs increased by $113.8 million, or 149.9%, for the year ended December 31, 2021 as compared to the same period in 2020. The increase in operating costs was primarily a result of higher compensation and benefit costs driven by an increase in employees to support the growing business. Additionally, operating costs increased from a full year of operating costs related to BND and the CHP acquisition.

Depreciation and amortization increased by $12.8 million, or 864.5%, for the year ended December 31, 2021 as compared to the same period in 2020. The increase was primarily due to a full year of amortization expense of the intangible assets acquired in the BND acquisition as well as nine months of amortization expense of the intangible assets acquired in the CHP acquisition.

Consumer Care

($ in thousands)	Year Ended December 31,		
Statements of income (loss) data:	**2022**	**2021**	**2020**
Revenue:			
Premium revenue	**$ 1,141,936**	$ 338,391	$ 7,793
Direct Contracting revenue	**654,087**	—	—
Service revenue	**48,013**	42,469	29,354
Investment income (loss)	**(55,429)**	80,314	—
Total revenue	**1,788,607**	461,174	**37,147**
Operating expenses			
Medical costs	**1,844,578**	432,318	—
Operating costs	**191,702**	125,444	43,959
Goodwill impairment	**1,208**	—	—
Intangible assets impairment	**42,611**	—	—
Depreciation and amortization	**24,252**	18,333	1,895
Total operating expenses	**2,104,351**	576,095	45,854
Operating loss	**$ (315,744)**	$ (114,921)	**$ (8,707)**

2022 Compared to 2021

Consumer Care premium revenue increased by $803.5 million, or 237.5%. for the year ended December 31, 2022 as compared to the same period in 2021. The increase in premium revenue is primarily due to the full risk transfer for a portion of our commercial business in Florida and Texas to our Consumer Care segment. Also contributing to the increase is the full year of revenue from Centrum, acquired on July 1, 2021. service revenue.

We began participating in the DC Model beginning in January 2022 through two DCEs aligned with our Consumer Care business. Direct Contracting Affiliated revenue was decreased to $654.1 5.9 million for the year ended December 31, 2022. 2023, This revenue was attributable to the alignment of beneficiaries to our DCE entities, which numbered approximately 46,000 at December 31, 2022.

Service Revenue increased by $5.5 million, or 13.1%, for the year ended December 31, 2022 as compared to the same period in 2021. The acquisition of Zipnosis on March 31, 2021 contributed to the year-over-year increase in service revenue.

We had investment loss of $55.4 million 1.0 billion for the year ended December 31, 2022 as compared to investment income a result of our exit of our Commercial business. For the years ended December 31, 2023 and 2022 affiliated revenue was inclusive of $80.3 3.9 million and $8.9 million, respectively, of ACO REACH surplus for our NeueCare clinics transferred from NeueSolutions.

Medical costs decreased by $1.1 billion, or 92.0%, for the year ended December 31, 2023, as compared to the same period in 2022. The decrease is primarily a result of the limited risk contracts that we have entered into with third-party payors that are accounted for on a net basis as compared to the full risk contract with Bright Healthcare - Commercial that was accounted for on a gross basis in the prior period.

Operating costs decreased by $4.9 million, or 3.9%, for the year ended December 31, 2023, as compared to the same period in 2022. The decrease in NeueCare's operating costs is primarily attributable to the reclassification of affiliated capitated management expenses out of professional fees within operating costs to medical costs to more closely align with the nature of the services related to the fees.

Due to the decline in our stock price and market capitalization, we recognized $401.4 million of goodwill impairment of our NeueCare reporting unit for the year ended December 31, 2023. For the year ended December 31, 2022, we did not recognize any goodwill impairment of our NeueCare reporting unit. We recognized $42.6 million of intangible assets impairment for the year ended December 31, 2022, which included impairment of the reacquired contract at our NeueCare segment due to the decision to exit the Commercial market beginning in 2023. There were no impairments of intangible assets in the year ended December 31, 2023.

NeueCare's bad debt expense increased by $5.0 million for the year ended December 31, 2021December 31, 2023, as compared to the same period in 2022. The investment income increase in bad debt expense was primarily driven by an increase in the allowance over certain asset pools as a result of a change in our expectation and loss in both periods was due to gains and losses on equity securities. As estimation of December 31, 2022 we hold no equity securities, so we do not expect investment income or losses within the Consumer Care segment going forward. collectability of those asset pools.

Medical costs increased Depreciation and amortization decreased by $9.6 million, or 43.1%, for the year ended $1.4 billion December 31, 2023,, or 326.7%, as compared to the same period in 2022. The decrease is primarily due to the full impairment of the reacquired contract intangible asset during the third quarter of 2022; for the year ended December 31, 2022 amortization of the reacquired contract intangible asset was $9.9 million, as compared to no related expense for the year ended December 31, 2023. This decrease is partially offset by the depreciation of leasehold improvements.

NeueSolutions

($ in thousands)	Year Ended December 31,	
Statements of income (loss) data:	**2023**	**2022**
Revenue:		
ACO REACH revenue	**896,504**	654,087
Service revenue	**2,879**	114
Total revenue	**899,383**	654,201
Operating expenses		
Medical costs	**904,986**	644,269
Operating costs	**14,474**	8,508
Bad debt expense	**22,423**	—
Total operating expenses	**941,883**	652,777
Operating loss	**$ (42,500)**	$ 1,424

NeueSolutions' ACO REACH revenue increased by $242.4 million, or 37.1% for the year ended December 31, 2023.The increase is primarily driven by an increase of approximately 16,000 aligned beneficiaries for the year ended December 31, 2023, as compared to the same period in 2021. The increase in medical costs was primarily driven by an increase in patient lives as a result of the Centrum acquisition, new market expansion and our participation in Direct Contracting beginning in January 2022.

Operating NeueSolutions' service revenue increased by $2.8 million, for the year ended December 31, 2023, as compared to the same period in 2022. The increase in service revenue was driven by revenue for the managed service organization contracts.

NeueSolutions' medical costs increased $66.3 by $260.7 million,, or 52.8% 40.5%, for the year ended December 31, 2022 2023, as compared to the same period in 2021 2022. The increase in operating medical costs was primarily due correspond to higher compensation and benefit the increase in the ACO REACH revenue as the medical costs as a result of more employees and outsourced vendor fees in support of consumer growth. In addition, are derived from the year ended December 31, 2022 included two additional quarters of costs from Centrum as a result amortization of the acquisition on July 1, 2021. ACO REACH performance obligation that is aligned to the number of beneficiaries aligned to our REACH ACOs. Additionally, NeueSolutions' medical costs were further burdened in the third and fourth quarter of 2023 by the medical costs of the members attributed to the ACO REACH care partner that filed for bankruptcy. The care partner's bankruptcy resulted in a net $14.1 million impact. Prior to the bankruptcy filing these medical costs were fully transferred to the care partner through a risk share arrangement.

We recognized $42.6 million of intangible assets impairment during the year ended December 31, 2022, which related to a full impairment of Centrum's reacquired contract with Bright HealthCare Florida as a result of our decision to no longer

offer Commercial products for the 2023 plan year. We also recognized a $1.2NeueSolutions' operating costs increased by $6.0 million, goodwill disposition during the year ended December 31, 2022.

Depreciation and amortization increased $5.9 million, or 32.3% 70.1%, for the year ended December 31, 2022 2023, as compared to the same period in 2021 2022. The increase was primarily due to These increases were driven by the full year of amortization expense resulting from intangible assets acquired as part of additional compensation and general administrative expenses supporting the Centrum acquisition, which occurred on July 1, 2021. growing business and increased membership.

2021 Compared to 2020

Premium revenue increased by $330.6 million, or 4,242.2%,NeueSolutions' bad debt expense for the year ended December 31, 2021 as compared to the same period in 2020. December 31, 2023 was $22.4 million. The increase in premium revenue for the year ended December 31, 2021 includes $262.4 million of premium revenue from the acquisitions of PMA and Centrum, as well as an organic increase in patient lives.

Service revenue increased by $13.1 million, or 44.7%, for the year ended December 31, 2021 as compared to the same period in 2020. The acquisitions of PMA, Zipnosis and Centrum contributed $23.7 million to the year-over-year increase in service revenue.

Investment income bad debt expense was $80.3 million for the year ended December 31, 2021 due to unrealized gains on equity securities acquired in 2021. Our Consumer Care business did not hold any investments during the year ended December 31, 2020.

Medical costs were $432.3 million for the year ended December 31, 2021, which were primarily driven by an increase in patient lives as a result of the PMA and Centrum acquisitions, as well as organic growth in our value-based arrangements.

Operating costs increased by $81.5 million, or 185.4%, for the year ended December 31, 2021 as compared to the same period in 2020. The increase was primarily due to higher compensation and benefit costs as a result of additional employees and outsourced vendor fees in support of consumer growth, as well as costs from the PMA, Zipnosis and Centrum acquisitions.

Depreciation and amortization increased by $16.4 million for the year ended December 31, 2021 as compared to the same period in 2020. The increase was primarily due to amortization expense of $15.9 million resulting from intangible assets acquired for which there were no comparable amounts in 2020.

Discontinued Operations

($ in thousands)	Year Ended December 31,		
Statements of income (loss) data:	**2022**	**2021**	**2020**
Revenue:			
Premium revenue	**$ 3,998,622**	$ 2,512,384	$ 692,433
Service revenue	**147**	232	—
Investment income (loss)	**(41,221)**	3,740	—
Total revenue	**3,957,548**	2,516,356	692,433
Operating expenses			
Medical costs	**3,732,755**	2,659,516	595,382
Operating costs	**883,318**	710,934	184,271
Restructuring costs	**50,704**	—	—
Goodwill impairment	**4,147**	—	—
Intangible assets impairment	**6,720**	—	—
Depreciation and amortization	**145**	435	—
Total operating expenses	**4,677,789**	3,370,885	779,653
Operating loss	**$ (720,241)**	$ (854,529)	$ (87,220)
Medical Cost Ratio (MCR)	**93.4 %**	105.9 %	86.0 %

In October 2022, we announced that we will no longer offer commercial plans through Bright HealthCare in 2023. As a result, we exited the Commercial marketplace effective December 31, 2022. We determined this exit represented a strategic shift that will have a material impact on our business and financial results that requires presentation as discontinued operations. The discontinued operations presentation has been retrospectively applied to all periods presented.

2022 Compared to 2021

Premium revenue increased by $1.5 billion, or 59.2%, for the year ended December 31, 2022 as compared to the same period in 2021. The increase in revenue, was driven by an increase in consumer lives of approximately 410,000 due to organic growth and entry into new markets in 2022 – particularly entry into Texas. The increase was partially offset by increases in risk adjustment of $1.1 billion, inclusive of a $93.1 million increase in risk adjustment based on final settlement of the 2021 risk adjustment payable.

Service revenue was immaterial to the Bright HealthCare – Commercial segment for the years ended December 31, 2022 and 2021.

Investment income for the year ended December 31, 2022 was a loss of $41.2 million compared to income of $3.7 million due to a $67.7 million impairment one of our available-for-sale securities portfolio resulting from our conclusion, as of December 31, 2022, that it was more likely than not that we would have to sell some of the securities before recovering the amortized cost basis due to our decision to exit the commercial business. This impairment is related to the decrease ACO REACH care partners filing for bankruptcy in the fair value third quarter of debt securities primarily driven by an increase in market interest rates since the time the securities were purchased.

Medical costs increased by $1.1 billion, or 40.4%, for the year ended December 31, 2022 as compared to the same period in 2021. For the years ended December 31, 2022 2023 and 2021, the impact of COVID-19 increased our medical costs $81.7 million and $148.5 million, respectively. The remaining increase is due to an increase in consumers, partially offset by favorable medical cost rates.

Our MCR of 93.4% for the year ended December 31, 2022 decreased 1,250 basis points compared to the same period in 2021. Our MCR for the year ended December 31, 2022 included a 200 basis point unfavorable impact from COVID-19 costs. Our MCR for the year ended December 31, 2021 included a 590 basis point unfavorable impact from COVID-19 costs. The decrease in MCR in 2022 compared to 2021, was primarily due to improved utilization and care management as well as the risk transfer agreement with our Consumer Care segment for the Florida and Texas markets.

Operating costs increased by $172.4 million, or 24.2%, for the year ended December 31, 2022 as compared to the same period in 2021. The increase in operating costs was driven by increases in operating costs from new market entry and increased marketing and selling expenses, partially offset by full a net release of $93.4 million of PDR.

We recognized $50.7 million of restructuring costs for the year ended December 31, 2022 for employee termination benefits, contract termination costs and long-lived asset impairments incurred in relation to the actions we have taken to restructure the Company's workforce and reduce expenses based on our updated business model. There were no restructuring costs in the year ended December 31, 2021.

We recognized non-cash impairments of goodwill and intangible assets of $4.1 million and $6.7 million, respectively, for the year ended December 31, 2022, as a result of our decision to exit the Commercial market for the 2023 plan year.

Depreciation and amortization was immaterial to the Bright HealthCare – Commercial segment for the years ended December 31, 2022 and 2021.

2021 Compared to 2020

Premium revenue increased $1.8 billion, or 262.8%, for the year ended December 31, 2022 compared to the same period in 2021. The increase in revenue was driven by an increase in consumer lives of approximately 520,000 due to organic growth and inorganic growth from the acquisition of THNM, as well as higher net premium rates in certain markets and plan mix, which were partially offset by an increase in risk adjustment payables.

Medical costs increased by allowance being established on the corresponding receivables.$2.1 billion, or 346.7%, There was no bad debt expense recognized for the year ended December 31, 2021 as compared to the same period in 2020. For the years ended December 31, 2021 and 2020, the impact of COVID-19 increased our medical costs by $148.5 million and $16.4 million, respectively. The increase in 2021 is also due to an increase in consumers driven by organic growth, unfavorable medical cost rates and inorganic growth as a result of acquisitions December 31, 2022.

Our MCR of 105.9% for the year ended December 31, 2021 increased 1,990 basis points as compared to the same period in 2020. Our MCR for the year ended December 31, 2021 included a 590 basis point unfavorable impact from COVID-19 related costs as compared to a 240 basis point unfavorable impact from COVID-19 related costs in our MCR for the year ended December 31, 2020. Our MCR for the year ended December 31, 2021, was also impacted by an increase in risk adjustment payable.

Operating costs increased by $526.7 million, or 285.8%, for the year ended December 31, 2021 as compared to the same period in 2020. The increase was primarily due to increases in operating costs from new market entry, increased marketing and selling expenses related to the 2021 SEP in our Commercial business and increased compensation and benefit costs driven by an increase in employees. In addition, the year ended December 31, 2021 also includes $93.4 million of premium deficiency reserve expense due to expected future losses in certain markets in 2022, as well as increased operating costs from the acquisition of THNM.

Depreciation and amortization was immaterial to the Bright HealthCare – Commercial segment for the years ended December 31, 2021 and 2020.

Liquidity and Capital Resources

We assess our liquidity in terms of our ability to generate adequate amounts of cash to meet current and future needs. Our expected primary uses on a short-term and long-term basis are for geographic and service offering expansion, acquisitions, and other general corporate purposes. We have historically funded our operations and acquisitions primarily through the sale of preferred stock and sales of our common stock.

We believe that the existing cash on hand and investments and amounts available under our Credit Agreement described below may will not be sufficient to satisfy our anticipated cash requirements for the next twelve months following the date the consolidated financial statements contained in this Annual Report are issued, for items such as IFP risk adjustment payable associated with the IFP business we are exiting, payables, medical costs payable, accounts payable remaining obligation to the deconsolidated entity, and other current liabilities. We are evaluating additional In response to these conditions, management has implemented a restructuring plan to reduce capital sources through other strategic opportunities needs and our operating expenses in the future to ensure we have drive positive operating cash flow and increase liquidity. Additionally, the liquidity to satisfy these obligations. The Company is actively engaged with the Board of Directors and outside advisors to evaluate additional financing. However, the Company may not fully collect the contingent consideration associated with the sale of the California Medicare Advantage business or be able to obtain financing on acceptable terms, as any potential financing both of these matters will be subject to market conditions that are not fully within the Company's control. In the event the Company is unable to obtain additional financing or take other management actions, among other potential consequences, the Company forecasts we will be unable to satisfy our obligations.

As of December 31, 2023, we had $375.3 million in cash and cash equivalents and $35.6 million in short-term investments across our continuing and discontinued operations. As of December 31, 2023, we had no long-term investments across our continuing and discontinued operations. As of December 31, 2022, we had $1.9 billion $1.9 billion in cash and cash equivalents, $290.9 million $1.1 billion in short-term investments, and $849.1 million $5.4 million in long-term investments on the Consolidated Balance Sheet. As of December

31, 2021, we had $1.1 billion in cash across our continuing and cash equivalents, $193.8 million in short-term investments and $675.2 million long-term investments. discontinued operations. Our cash and investments are held at non-regulated entities and regulated insurance entities.

As of December 31, 2023, we had non-regulated cash and cash equivalents of $87.3 million and non-regulated short-term investments of $6.3 million. As of December 31, 2023, we had no non-regulated long-term investments. As of December 31, 2022, we had non-regulated cash and cash equivalents of $275.5 million and $217.0 million, non-regulated short-term investments of $1.6 million. $0.9 million, and non-regulated long-term investments of $5.4 million.

As of December 31, 2021 December 31, 2023, we had non-regulated regulated insurance entity cash and cash equivalents of $76.3 million $288.0 million and short-term investments of $121.5 million.

$29.4 million. As of December 31, 2023, we had no regulated insurance entity long-term investments. As of December 31, 2022, we had regulated insurance entity cash and cash equivalents of $1.7 billion, $1.7 billion and short-term investments of $289.3 million and long-term investments of $849.1 million. $1.1 billion. As of December 31, 2021 December 31, 2022, we had no regulated insurance entity cash and cash equivalents of $984.9 million, short-term investments of $72.4 million and long-term investments of $675.2 million. investments.

Cash and investment balances held at regulated insurance entities are subject to regulatory restrictions and can only be accessed through dividends declared to the non-regulated parent company or through reimbursements from administrative services agreements with the parent company. The Company declared no dividends from the regulated insurance entities to the parent company during the year years ended December 31, 2022, December 31, 2023 and declared two dividends during 2021. 2022. The regulated legal entities are required to hold certain minimum levels of risk-based capital and surplus to meet regulatory requirements. As of December 31, 2022 December 31, 2023 and 2021, $42.1 million 2022, $(225.0) million and $398.5 million, $42.1 million, respectively, was held in risk-based statutory capital and

surplus at regulated insurance legal entities. We are out of compliance with the minimum levels of capital for certain of our regulated insurance legal entities.

Indebtedness

On August 2, 2021 In March 2021, we entered into a $350.0 million revolving credit agreement with JPMorgan Chase Bank, N.A., as Collateral Agent and Administrative Agent (in each such capacity, the Credit Agreement "Agent") and a syndicate of banks (the "Credit Agreement"), which was amended set to change the definition of "Qualified IPO" by reducing the net proceeds required to be received by the Company from $1.0 billion to $850.0 million (the "Amendment"). In addition, prior to such amendment, the Credit Agreement contained a covenant that required the Company to maintain a total debt to capitalization ratio of (a) 0.25 to 1.00 prior to a Qualified IPO, and (b) 0.30 to 1.00 after a Qualified IPO. The Amendment changed this covenant by removing the increase in the ratio after a Qualified IPO such that the Company is now required to maintain a total debt to capitalization ratio of 0.25 to 1.00. On August 4, 2021, we elected to extend the maturity date of the Credit Agreement from February 28, 2022 to mature on February 28, 2024. As of December 31, 2022 December 31, 2023, we had $303.9 million borrowed on under the Credit Agreement at an effective annual interest rate of 8.41% 10.06% as well as $46.1 million $22.9 million of outstanding, undrawn letters of credit under the Credit Agreement, which reduce the amount available to borrow. Further to the undrawn As of December 31, 2023, we had letters of credit under the Credit Agreement, we had an additional $7.5 million of unused letters of credit as of December 31, 2022.

On November 8, 2022, we executed an amendment unrelated to the Credit Agreement pursuant to which certain collateral related defaults were waived and, in addition, it was agreed that we would (i) not be required to test our debt to capitalization ratio covenant during and including the four quarter test period ending September 30, 2022 through and including the four quarter test period ending September 30, 2023, (ii) be required to maintain a minimum liquidity of $200.0 $7.9 million, from November 8, 2022 through and including September 30, 2023 and (iii) be required to maintain a minimum liquidity as well as surety bonds of $150.0 million after September 30, 2023. $11.7 million.

On March 1, 2023, the Company disclosed that that during the First Quarter first quarter of 2023, the Company breached the minimum liquidity covenant of the Credit Agreement. The On February 28, 2023, the Company entered into a limited waiver and consent (the "Waiver"

(the "Original Waiver") under the Credit Agreement, which, among other matters, provides provided for a temporary waiver for the period from January 25, 2023 through April 30, 2023 (the "Waiver Period") of compliance with the minimum liquidity covenant set forth in Section 11.12.2 of the Credit Agreement. During

On April 28, 2023, the Company entered into an amended and restated limited waiver and consent (the "Second Waiver") under the Credit Agreement, which amended and restated the Original Waiver. The Second Waiver amended the Original Waiver by, among other things, extending the temporary waiver of compliance with the minimum liquidity covenant set forth in Section 11.12.2 of the Credit Agreement, which originally spanned from January 25, 2023 to April 30, 2023, to January 25, 2023 to June 30, 2023 (the "Extended Waiver Period"). The Second Waiver also (i) amended the Original Waiver and the Credit Agreement by changing the definition of "Minimum Liquidity" to mean unrestricted cash of the Company and the other loan parties and (ii) waived permanently any default or event of default arising from the failure to deliver the 2022 audit report without a qualification as to "going concern." In addition, during the Extended Waiver Period, the Company will be subject to a minimum liquidity covenant of not less than $75 million until March 3, 2023, and not less than $85 million thereafter until the end of the Waiver Period. In addition, during the Waiver Period, the Company will did not have access to certain negative covenant baskets and will be was subject to additional cash-flow, and cash balance, and other reporting requirements. Any non-compliance with

On June 29, 2023, the covenants Company entered into a second amended and restated limited waiver and consent (the "Third Waiver") under the Credit Agreement or Agreement. The Third Waiver amended and restated the Second Waiver, may result which previously amended and restated the Original Waiver. The Third Waiver amended the Second Waiver and the Original Waiver by, among other things, extending the temporary waiver of compliance with the minimum liquidity covenant set forth in the obligations under Section 11.12.2 of the Credit Agreement, being accelerated.

The obligations which spanned from January 25, 2023 to June 30, 2023 under the Credit Agreement are secured Original Waiver and the Second Waiver, to January 25, 2023 to August 29, 2023 (the "Extended Waiver Period"). The Waiver also, among other things, added covenants (a) requiring the Company to deliver by substantially all of July 17, 2023, an agreed term sheet for the assets Bridge Financing to support the Company's ongoing operating cash needs through December 31, 2023 and, by July 31, 2023 (extended to August 4, 2023), definitive documentation for the Bridge Financing and an updated budget of the Company, in form and its wholly owned subsidiaries substance acceptable to the Agent, (b) prohibiting the incurrence of certain types of debt and (c) requiring the Company not to request any interest period for any Term SOFR borrowing other than a one-month interest period.

On August 4, 2023, the Company entered into a Credit Agreement (as amended, supplemented, restated or otherwise modified from time to time, the "New Credit Agreement"), among the Company, NEA and the lenders from time to time party thereto (together with NEA and each of their respective successors and assigns, the "Lenders") to provide for a credit facility pursuant to which, among other things, the lenders have provided $60.0 million delayed draw term loan commitments. The Company may borrow delayed draw term loans under such commitments at any time and from time to time on or prior to the date that are designated as guarantors, including a pledge is nine months after the effective date of the equity New Credit Agreement, subject to the satisfaction or waiver of each of its subsidiaries. customary conditions. Borrowings under the New Credit Agreement accrue interest at a rate per annum of 15.00%, payable quarterly in arrears at the Company's election, either at a rate of: the (i) the sum of (a) the greatest of (1) the Prime Rate (as defined subject to limitations set forth in the Fourth Waiver (defined below) in respect of cash payments under the New Credit Agreement), (2) Agreement, either in cash or "in kind" by adding the rate amount of accrued interest to the Federal Reserve Bank of New York in effect plus 1⁄2 of 1.0% per annum, and (3) London interbank offered rate ("LIBOR"), plus 1% per annum, and (b) a margin of 4.0%; or (ii) the sum of (a) the LIBOR multiplied by a statutory reserve rate and (b) a margin of 5.0%. In addition, the commitment fee is 0.75% of the unused principal amount of the outstanding loans under the New Credit Agreement.

Furthermore, the The New Credit Agreement contains covenants that, among other things, restrict the ability of the Company and its subsidiaries to make dividends or other distributions, certain restricted payments, incur additional debt, engage in certain asset sales, mergers, acquisitions or similar transactions, create liens on assets, engage in certain transactions with affiliates, change its business or make investments. In addition, The New Credit Agreement constitutes the Bridge Financing referred to in the Third Waiver. As of December 31, 2023, we had $60.0 million of short-term borrowings under the New Credit Agreement.

On August 4, 2023, the Company entered into a third amended and restated limited waiver and consent (the "Fourth Waiver") under the Credit Agreement. The Fourth Waiver amended and restated the Third Waiver by, among other things, permanently waiving compliance with the minimum liquidity covenant set forth in Section 11.12.2 of the Credit Agreement, contains which waiver under the Third Waiver previously was temporary and would have expired on August 29, 2023. From August 4, 2023 until the Termination (as defined below), the Company was subject to a minimum liquidity covenant of not less than $25.0 million. The Fourth Waiver also, among other things, (a) removed from the Credit Agreement in its entirety the covenant requiring maintenance of a maximum total debt to capitalization ratio, which absent such removal would have applied after September 30, 2023, (b) prohibited the incurrence of certain types of debt and (c) required the Company not to request any interest period for any Term Benchmark borrowing other than a one-month interest period.

In connection with the New Credit Agreement, on August 4, 2023, the Company and the Lenders entered into a warrantholders agreement setting forth the rights and obligations of the Company and the Lenders as holders (in such

capacity, the "Holders") of the warrants to acquire shares of Common Stock at an exercise price of $0.01 per share (the "Warrants"), and providing for the issuance of the Warrants to purchase up to 1,656,789 shares of Common Stock.

On October 2, 2023, the Company, the Existing Lender, and California State Teachers' Retirement System, as an incremental lender (the "New Lender"), entered into Incremental Amendment No. 1 to the New Credit Agreement to provide for the Commitment Increase by the New Lender under the New Credit Agreement. Loans under the Commitment Increase will have the same terms as loans under the original term loan commitments provided by the Existing Lender.
As of December 31, 2023, we had $66.4 million of long-term borrowings under the New Credit Agreement.

In connection with Incremental Amendment No. 1, on October 2, 2023, the Company and the New Lender entered into a warrantholders agreement setting forth the rights and obligations of the Company and the New Lender as a holder of Warrants, and providing for the issuance of the Warrants to purchase up to 176,724 shares of Common Stock. See Note 6, *Long-Term Borrowings and Common Stock Warrants*, for additional information regarding the New Credit Agreement, Incremental Amendment No. 1 and the Warrantholders Agreement.

As of December 31, 2023, we had $22.9 million of outstanding, undrawn letters of credit under the Credit Agreement, which reduce the amount available to borrow.

On December 27, 2023, we entered into a letter agreement (the "Letter Agreement") with the Agent providing that, in each case subject to the Agent's receipt of (a) the payment in an amount equal to $274.6 million to give effect to the Termination (as defined below) as of January 2, 2024 (the "Payoff Condition") and (b) payment to the issuer of letters of credit outstanding under the Credit Agreement (the "Existing Letters of Credit") cash in an amount equal to $24.1 million, which is equal to 105% of the aggregate face amount of the Existing Letters of Credit (the "Cash Collateral"), which shall be held by the Agent as collateral for the obligation of the Company to reimburse the Agent in an amount equal to the amount of any drawing under the Existing Letters of Credit and to pay certain fees in respect of Existing Letters of Credit until the Existing Letters of Credit have terminated or expired (collectively, the "L/C Condition"), (i) the Lenders and the Agent consented to the sale of our California Medicare Advantage business (this clause (i), the "Consent") and (ii)

all liabilities, obligations and indebtedness of the Company and its applicable subsidiaries that are guarantors under the Credit Agreement and the other related loan documents (collectively, the "Credit Documents"), other than customary covenants, representations obligations that survive termination of the Credit Agreement by their express terms and events the Company's obligations in respect of default. the Existing Letters of Credit, owing by the Company and such subsidiaries under the Credit Documents shall be released, discharged and satisfied in full, all liens securing the obligations under the Credit Agreement (other than in respect of the Cash Collateral) shall be terminated and all guarantees under the Credit Agreement shall be released (this clause (ii), the "Termination"). On January 2, 2024, both the Payoff Condition and the L/C Condition were satisfied and, as a result, the Consent and the Termination occurred. As of January 2, 2024, we had no outstanding borrowings on the Credit Agreement.

Preferred Stock Financing

On January 3, 2022, we issued 750,000 shares of the Company's Series A Convertible Perpetual Preferred Stock, par value $0.0001 per share, for an aggregate purchase price of $750.0 million. We used a portion of the proceeds to repay in full our $155.0 million of outstanding borrowings under the Credit Agreement on January 4, 2022.

On October 10, 2022 October 17, 2022, we issued 175,000 shares of the Company's Series B Convertible Perpetual Preferred Stock, par value $0.0001 per share (together with the Series A Preferred Stock, the "Preferred Stock") for an aggregate purchase price of $175.0 million. $175.0 million.

For additional information on the Preferred Stock, see Note 9, *Preferred Stock*, in our consolidated financial statements of this Annual Report.

Cash Flows

The following table presents a summary of our cash flows for the periods shown:

	Year Ended December 31,				Year Ended December 31,	
(in thousands)	*(in thousands)*	**2022**	**2021**	**2020**	*(in thousands)*	**2023**	**2022**
Net cash provided by (used in) operating activities		**$ 234,466**	$ 82,059	$ (57,238)			
Net cash used in investing activities		**(429,723)**	(552,892)	(689,742)			
Net cash (used in) provided by operating activities							
Net cash provided by (used in) investing activities							
Net cash provided by financing activities	Net cash provided by financing activities	**1,066,368**	1,043,641	712,441			
Net increase (decrease) in cash and cash equivalents		**$ 871,111**	$ 572,808	$ (34,539)			
Net (decrease) increase in cash and cash equivalents							

Cash and cash equivalents at beginning of year	Cash and cash equivalents at beginning of year	**1,061,179**	488,371	522,910
Cash and cash equivalents at end of year	**Cash and cash equivalents at end of year**	**$1,932,290**	$1,061,179	$488,371

Operating Activities

During the year ended December 31, 2023, net cash used in operating activities was $2.7 billion as compared to $234.5 million of cash provided by operating activities for the same period in 2022, a change of $3.0 billion. This fluctuation was primarily driven by our Commercial business being in runout, specifically the settlement of the majority of our risk adjustment and medical costs payable for the 2022 plan year throughout 2023 with no offsetting cash inflows that we would receive during an active policy year.

Investing Activities

During the year ended December 31, 2022 December 31, 2023, net cash provided by operating investing activities increased was $1.1 billion as compared to $429.7 million of cash used in investing activities for the same period in 2022, a change of $1.5 billion. The increase was primarily attributable to an increase in the proceeds of investment sales of $904.8 million during the year ended December 31, 2023, as compared to the year ended December 31, 2022. Investment purchases also decreased by $152.4 million $620.4 million during the year ended December 31, 2023, as compared to the same period in 2021. This was primarily driven by an increase of our risk adjustment payable of $270.6 million as compared to 2021 as well as a $121.6 million year over year reduction in cash used for the purchase of other current assets. The increases were partially offset by 2022.more timely payment of our medical cost liabilities resulting in a reduction of cash generated from medical costs payable and an increase in our net loss.

During the year ended December 31, 2021, net cash provided by operating activities was $82.1 million as compared to $57.2 million cash used in the same period in 2020. This was primarily driven by the increase in consumer growth driving the increased medical costs and risk adjustment payables, as well as accounts payables and other liabilities, and increased medical costs in the MA business driven by a full year of activity from BND and the acquisition of CHP. These increases were partially offset by an increase in our net loss.

Investing Activities

During the year ended December 31, 2022, net cash used in investing activities decreased by $123.2 million as compared to the same period in 2021. The decrease was primarily attributable to a decrease in cash used in acquisitions partially offset by an increase in the cash used in purchases of investments.

During the year ended December 31, 2021, net cash used in investing activities decreased by $136.9 million as compared to the same period in 2020. The decrease was primarily attributable to a decrease in purchases of investments, net of proceeds from sales, paydowns and maturities of investments which was partially offset by an increase in cash used for acquisitions.

Financing Activities

During the year ended December 31, 2022 December 31, 2023, net cash provided by financing activities increased decreased by $22.7 million$1.0 billion as compared to the same period in 2021. The increase was 2022. This decrease is primarily due to $920.4 million in preferred stock financing our Series A and Series B issuance during 2022 the year ended December 31, 2022 and net proceeds from short term borrowings of $155.0 million during that same period; as compared to $887.3 66.4 million in net proceeds from our IPO long-term borrowings in 2021.

During the year ended December 31, 2021, net cash provided by financing activities increased by $331.2 million. The increase was due to $887.3 million of proceeds from our IPO in June 2021, offset by $6.7 million of cash paid for IPO offering costs, and a $155.0 million increase in net proceeds from short-term borrowings. These increases were partially offset by a $711.2 million decrease in proceeds from preferred stock financings in 2020, for which there were no similar offerings in 2021.

December 31, 2023.

Critical Accounting Policies and Estimates

Our management's discussion and analysis of our financial condition and results of operations are based on our consolidated financial statements, which have been prepared in accordance with GAAP. The preparation of these consolidated financial statements requires us to make judgments and estimates that affect the reported amounts of assets, liabilities, revenue, and expenses and the disclosure of contingent assets and liabilities in our consolidated financial statements. We base our estimates on historical experience, known trends and events, and various other factors that we believe to be reasonable under the circumstances, the results of which form the basis for making judgments about the carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates under different assumptions or conditions. On

an ongoing basis, we evaluate our judgments and estimates in light of changes in circumstances, facts, and experience. The effects of material revisions in estimates, if any, are reflected in the consolidated financial statements prospectively from the date of change in estimates.

While our significant accounting policies are described in more detail in the notes to the consolidated financial statements appearing elsewhere in this Annual Report, we believe the following accounting policies used in the preparation of our consolidated financial statements require the most significant judgments and estimates.

ACO REACH Participating Provider Risk Sharing

Our participation in value-based care models, such as shared savings/shared-risk and capitated risk-sharing arrangements are geared towards fostering care coordination, enhancing the quality of care delivered, and aligning incentives around the healthcare expenditures for assigned members. The accounting for these arrangements involves estimation given the inherent uncertainties involved in measuring current performance due to the significant lag time for items like claims run-out. Changes to these estimates over time have the potential to impact our financial results and overall performance.

The ACO REACH Model incentivizes participating providers to manage the total cost of care of the Medicare FFS population aligned to their corresponding REACH ACO. Our REACH ACOs contract directly with CMS to assume the total costs of care risk for Medicare FFS beneficiaries attributed to our Participating Providers within our ACOs. Annually, after a runout period, CMS will perform a settlement process to determine if CMS owes the REACH ACOs payment for surplus (benchmark revenue exceeds actual claim costs incurred for the ACOs attributed beneficiaries) or if the REACH ACO must reimburse CMS for deficits (claim costs incurred for ACO's attributed beneficiaries exceeds the benchmark revenue). We recognize the expected settlement when it becomes both probable and estimable. This expected settlement is then used as an input to the risk share calculation with each of our Participating Providers.

Our REACH ACOs contract separately with each of our Participating Provider groups. The terms of these contracts vary including the amount of upside (surplus) and downside (deficit) risk the Participating Provider has agreed to assume for aligned beneficiaries and administrative fees charged by the Participating Provider and REACH ACO. Payments to Participating Providers under these contracts increase NeueHealth's medical costs. Administrative fees charged, and deficits expected to be recovered from Provider Partners under these contracts result in a decrease in medical costs.

Under these models, Participating Providers are incentivized to coordinate care for aligned beneficiaries by sharing a percentage of net savings (upside risk) or bearing losses on excessive costs (downside risk). Our ACO REACH provider risk sharing may result in providers receiving bonuses (surplus payments) or being obligated to pay deficits contingent on their capacity to deliver cost-efficient quality care.

Medical Costs Payable

Medical costs payable includes estimates for the costs of healthcare services consumers have received but for which claims have not yet been received or processed. Depending on the healthcare professional and type of service, the typical billing lag for services can be up to 90 days from the date of service. Approximately 80% of claims related to medical care services are known and settled within 90 days from the date of service and substantially all within eighteen to twenty-four months. months, or substantially sooner within the ACO REACH line of business where runout is limited to three months after the end of a performance year per the terms of the ACO REACH Participation Agreement.

In each reporting period, our operating results include the effects of more completely developed medical costs payable estimates associated with previously reported periods. If the revised estimate of prior period medical costs is less than the previous estimate, we will decrease reported medical costs in the current period (favorable development). If the revised estimate of prior period medical costs is more than the previous estimate, we will increase reported medical costs in the current period (unfavorable development). Medical costs of our continuing operations in 2023 and 2022 2021, and 2020 included unfavorable favorable medical cost development related to prior years of $7.5 million, $3.5 million $1.1 million and $6.9 million, $2.2 million, respectively. Depending on the healthcare professional and type of service, the typical billing lag for services canbe at least 90 days from the date of service.

In developing our medical costs payable estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For example, for the most recent months, we estimate claim costs incurred by applying observed medical cost trend factors to the average per consumer (member) per month ("PMPM") medical costs incurred in prior months for which more complete claim data is available, supplemented by a review of near-term completion factors.

Completion Factors: A completion factor measures the percentage of paid claims completion relative to an estimate of the total expected ultimate claims at a given point in time for medical services incurred in a given month. Completion factors are the most significant assumptions used in developing our estimate of medical costs payable. For periods prior to the two or three most recent months, completion factors are typically more complete and deemed credible for reliance in estimating unpaid medical claims. For the most recent two or three months, the completion factors are deemed less credible for reliance, and estimates of incurred claims are derived from prior incurred medical PMPM claims experience and adjusted

as appropriate for other considerations such as seasonality, to arrive at forecasted incurred PMPM medical costs to generate estimates of ultimate incurred claims for the most recent three months. In certain instances, when there is unusual disruption to claims processing, such as for CHP and BND during 2022, it may be warranted to apply PMPM

overrides to completion factors exceeding the 75% threshold when it appears they may be overstating completion when a review of the claim processing indicates a backlog has been building, and the completion factors may be overstating completion. There is additional consideration in estimating the ACO REACH claim reserve to account for the limited run out of March 31, 2024 for any 2023 date of service claim. Any claim adjudicated after March 31, 2024 is not a NeueHealth liability per the terms of the ACO REACH Participation Agreement, and a historical run out study informs the Company on how to make reserve adjustments.

The following table illustrates the sensitivity of the completion factors and the estimated potential impact on our medical costs payable estimates as of December 31, 2022 December 31, 2023:

Completion Factors (Decrease) Increase in Factors	Completion Factors (Decrease) Increase in Factors	Increase (Decrease) in Medical Costs Payable
		(in thousands)
(3.00)%	(3.00)%	$ 22,218
(2.00)%	(2.00)%	14,661
(1.00)%	(1.00)%	7,256
1.00%	1.00%	(7,113)
2.00%	2.00%	(14,086)
3.00%	3.00%	(20,924)

Completion Factors (Decrease) Increase in Factors	Increase (Decrease) in Medical Costs Payable
	(in thousands)

The completion factors analysis above includes a wide range of possible outcomes based on the early stage of development, combined with strong growth, that may drive additional volatility. Management believes the amount of medical costs payable is reasonable and adequate to cover our liability for unpaid claims as of December 31, 2022 December 31, 2023; however, actual claim payments may differ from established estimates as discussed above.

Assuming a hypothetical 1% difference between our December 31, 2022 December 31, 2023 estimates of continuing operations medical costs payable and actual continuing operations medical costs payable net earnings would have increased or decreased by approximately $4.1 million. $1.6 million.

See Note 24 and Note 10 19 in the Notes to Consolidated Financial Statements for additional detail on our medical costs payable.

Risk Adjustment

The risk adjustment programs in our MA line of business in our continuing operations and our IFP line of business in our discontinued operations, are designed to mitigate the potential impact of adverse selection and provide stability for health insurers.

Continuing operations: In the MA risk adjustment program, each consumer is assigned a risk score based on their demographic and prior year medical encounters information submitted to CMS that reflects the consumer's predicted health costs based on the CMS risk adjustment methodology. Plans receive higher payments for consumers with higher risk scores than consumers with lower risk scores. As of December 31, 2022 December 31, 2023 the MA risk adjustment receivable was $1.2 million. $51.3 million.

Discontinued operations: Under In the IFP line of business, under the individual and small group risk adjustment program, each plan is assigned a risk score based upon demographic and current year medical encounters information that is submitted to CMS for its consumers and calculated based on the CMS risk adjustment methodology. Plans with a plan level risk score that is lower than the State average risk scores will generally pay into the pool, while plans with a plan level risk score higher than State average risk scores will generally receive distributions. As of December 31, 2022 the IFP risk adjustment payable was $1.9 billion.

For IFP, we utilize external sources to help determine market risk scores, and we estimate the amount of risk adjustment payable or receivable based upon the processed claims and medical diagnosis data submitted and expected to be submitted to CMS. We refine our estimate

As of December 31, 2023, the IFP risk adjustment payable was $291.1 million. Our insurance subsidiaries in Colorado, Florida, Illinois and Texas entered into repayment agreements with CMS with respect to the unpaid amount of their risk adjustment obligations for an aggregate amount of $380.2 million (the "Repayment Agreements"). The amount owing under the Repayment Agreements is due 18 months from September 15, 2023 (the date the first installment payment was made under the Repayment Agreements) and bears interest at a rate of 11.5% per annum. On November 29, 2023, Bright Healthcare Insurance Company of Texas ("BHIC-Texas") was placed into liquidation and the Texas

Department of Insurance was appointed as new information becomes available. receiver. Of the $380.2 million of risk adjustment liabilities within the Repayment Agreements, $89.6 millionrelates to BHIC-Texas.

Goodwill

Historically, we test goodwill for impairment annually at the beginning of the fourth quarter or whenever events or circumstances indicate the carrying value may not be recoverable. We test for goodwill impairment at the reporting unit level. When testing goodwill for impairment, we may first assess qualitative factors to determine if it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. During a qualitative analysis, we consider the

impact of changes, if any, to the following factors: macroeconomic trends, industry and market factors, cost factors, changes in overall financial performance, and any other relevant events and uncertainties impacting a reporting unit. If our qualitative assessment indicates that goodwill impairment is more likely than not, we perform additional quantitative analyses. We may also elect to skip the qualitative testing and proceed directly to the quantitative testing. For reporting units where a quantitative analysis is performed, we perform a test measuring the fair values of the reporting units and comparing them to their aggregate carrying values, including goodwill. If the fair value of the reporting unit is greater than its carrying value, no goodwill impairment is recognized. If the fair value of the reporting unit is less than its carrying value, we recognize an impairment equal to the difference between the carrying value of the reporting unit and its calculated fair value.

For our two reporting units within our continuing operations, the Bright HealthCare and Consumer Care, we estimate the fair values of our reporting units using a combination of discounted cash flows and comparable market multiples. For the one reporting unit within our discontinued operations, Bright HealthCare - Commercial, we estimate the fair value of the reporting unit using discounted cash flows. Our estimation methodology includes assumptions about a wide variety the purchase price, excluding contingencies, of internal the California Medicare Advantage business. As of December 31, 2023, our two reporting units within our continuing operations, NeueCare and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about revenue growth rates, operating margins, capital requirements and income taxes), long-term growth rates for determining terminal value beyond the discretely forecasted periods and discount rates. Underperformance to the financial projections used in the impairment analysis could negatively impact the fair value of our reporting units. Additionally, the passage of time NeueSolutions, and the availability of additional information regarding areas of uncertainty with respect to the Bright HealthCare - Commercial reporting units' unit within discontinued operations, could cause these assumptions to change in the future. had no assigned goodwill.

We determined that our decision to exit the Commercial markets and the decrease in our enterprise market capitalization, due to a decrease in the price of our common stock, represented events a triggering event that indicated the carrying values of our reporting units may not be recoverable. As such, we performed an interim impairment test as of September 30, 2022 September 30, 2023. We estimated the fair values of our reporting units using a combination of discounted cash flows and comparable market multiples, which include assumptions about a wide variety of internal and external factors. As a result of our interim impairment test, we recognized a non-cash an impairment loss of $70.0 million $401.4 million in our Bright HealthCare reporting unit. The impairment of our Bright HealthCare reporting unit was primarily driven by an increase in the discount rate, which was impacted by higher interest rates and other market factors. We estimated the fair value of our, now discontinued, Bright HealthCare – Commercial reporting unit using an adjusted balance sheet approach as a result of our decision to exit the Commercial business for the 2023 plan year. We recognized a $4.1 million non-cash impairment loss related to our Bright HealthCare – Commercial NeueCare reporting unit, which represented all of the goodwill associated with the Bright HealthCare – Commercial NeueCare reporting unit. The impairment of our NeueCare reporting unit was due to the decline in our stock price and market capitalization.

Given the proximity of our interim impairment measurement date (last day of our fiscal third quarter - September 30, 2022 September 30, 2023) to our annual goodwill impairment measurement date (first day of our fiscal fourth quarter - October 1, 2022 October 1, 2023), we performed a qualitative assessment to determine whether it was more likely than not that the fair value of any of our reporting units was less than the carrying value. As material changes in the business that occurred during the valuation procedures but subsequent to our interim impairment measurement date were taken into consideration during our interim impairment assessment, we concluded that there would be no reasonable expectation of changes in estimates or the reporting unit fair values and carrying values between our interim impairment and annual impairment measurement dates.

As of December 31, 2022 December 31, 2023, we recognized a $1.2 $186.2 million goodwill disposition related impairment. This impairment was driven by the amendment to our Consumer Care reporting unit. Additionally, we determined that Molina Purchase Agreement which resulted in a $100.0 million decrease in the sustained decline purchase price as well as additional contingencies and TNE adjustments in our stock price triggered a qualitative assessment connection with the sale of our goodwill to determine if it was more likely than not that California Medicare Advantage business. To estimate the fair value of our the Bright HealthCare reporting units were less than their respective unit we reduced the $500.0 million purchase price by $175.8 million, the amount subject to contingencies and TNE adjustments that create uncertainties in what will be the final adjusted purchase prices as well as the transaction costs incurred to complete the sale. As the carrying values. Through our assessment value of the Bright HealthCare reporting unit exceeded the calculated fair value we recognized an impairment of our goodwill related to our Bright HealthCare reporting units, we concluded that it was not more likely than not that the fair value of our reporting units were less than their respective carrying values as of December 31, 2022. We will continue to closely monitor the operational performance of our reporting units as it relates to goodwill impairment. unit within discontinued operations.

Recently Adopted and Issued Accounting Standards

See Note 2 in the Notes to Consolidated Financial Statements for a discussion of accounting pronouncements recently adopted and recently issued accounting pronouncements not yet adopted and their potential impact to our financial statements.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our earnings and financial position are exposed to financial market risk, including those resulting from changes in interest rates.

Interest Risk

The level of our pretax earnings is subject to market risk due to changes in interest rates and the resulting impact on investment income and interest expense. We invest in a professionally managed portfolio of securities, which includes debt securities of publicly traded companies, obligations of the U.S. government, domestic government agencies, and state and political subdivisions. Interest rate risk is highly sensitive due to many factors, including U.S. monetary and tax policies and other factors outside of our control. Assuming a hypothetical and immediate 1% increase in interest rates across the entire U.S. Treasury curve at December 31, 2022, the aggregate market value decrease to our regulated and unregulated portfolios would be approximately $33.4 million.Not applicable.

Bright Health Group, NeueHealth, Inc. and Subsidiaries

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of Bright Health Group, NeueHealth, Inc.

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of Bright Health Group, NeueHealth, Inc. and subsidiaries (the "Company") as of December 31, 2022 December 31, 2023 and 2021, 2022, the related consolidated statements of income (loss), comprehensive income (loss), changes in redeemable preferred stock and shareholders' equity (deficit), and cash flows, for each of the three two years in the period ended December 31, 2022 December 31, 2023, and the related notes (collectively referred to as the "financial statements"). In our opinion, the financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2022 December 31, 2023 and 2021, 2022, and the results of its operations and its cash flows for each of the three two years in the period ended December 31, 2022 December 31, 2023, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2022, based on criteria established in Internal Control—Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission, and our report dated March 16, 2023 expressed an adverse opinion on the Company's internal control over financial reporting because of a material weakness.

Going Concern

The accompanying financial statements have been prepared assuming that the Company will continue as a going concern. As discussed in Note 2 to the financial statements, the Company has a history of operating losses, negative cash flows from operations and insufficient does not have sufficient cash flow on hand or available liquidity to meet its obligations, that raises raise substantial doubt about its ability to continue as a going concern. Management's plans in regard to these matters are also described in Note 2. The financial statements do not include any adjustments that might result from the outcome of this uncertainty.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) (PCAOB) and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. These Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. The Company is not required to have, nor were we engaged to perform, an audit of its internal control over financial reporting. As part of our audits, we are required to obtain an understanding of internal control over financial reporting but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion.

Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

Critical Audit Matters

The critical audit matters communicated below are matters arising from the current-period audit of the financial statements that were communicated or required to be communicated to the audit committee and that (1) relate to accounts or disclosures that are material to the financial statements and (2) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the financial statements, taken as a whole, and we are not, by communicating the critical audit matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

Bright HealthCare Estimates for Claims Incurred but not Reported (IBNR) ("IBNR") Claim Liability – Liability—Refer to Notes 2 and 10 Note 19 to the Financial Statements

Critical Audit Matter Description

Medical costs payable Current liabilities of discontinued operations includes the Company's estimates for the costs of healthcare services that attributed Medicare Advantage consumers have received but for which claims have not yet been received or fully processed. The IBNR claims are claim liability is developed using an actuarial process that

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requires management to make judgments. These judgments include applying observed medical cost trend factors to the average per consumer (member) per month ("PMPM") medical costs as well as using completion factors that include judgments related to the percentage of paid claims completion relative to an estimate of the total expected ultimate claims at a given point in time.

We identified the IBNR claim liability in discontinued operations related to the Company's California Medicare Advantage business ("Bright HealthCare") as a critical audit matter because of the significant assumptions made by management in estimating the liability. This required complex auditor judgment and an increased extent of effort, including the involvement of actuarial specialists in performing procedures to evaluate the reasonableness of management's methods, assumptions, and judgments in developing the liability.

How the Critical Audit Matter Was Addressed in the Audit

Our audit procedures related to Bright HealthCare IBNR claim liability included the following, among others:

- We tested the effectiveness design and implementation of controls management's control over management's estimate of the Bright HealthCare IBNR claim liability balance in discontinued operations, including controls over the judgements judgments made in the actuarial estimation process, as well as controls over the claims data used in the estimation process.

- We tested the underlying claims, membership data, and other information that served as the basis for the actuarial analysis, to test that the inputs to the actuarial estimate were complete and accurate.

- With the assistance of actuarial specialists, we evaluated the reasonableness of the actuarial methods and assumptions used by management to estimate the Bright HealthCare IBNR claim liability in discontinued operations by:

- Performing an overlay of the historical claims data used in management's current year model to the data used in prior periods to validate that there were no material changes to the claims data tested in the prior periods.

- Developing an independent estimate of the Bright HealthCare IBNR claim liability and comparing our estimate to management's estimate.

- Performing a retrospective review comparing management's prior year estimate of Bright HealthCare IBNR claim liability to claims processed in 2022 2023 with dates of service in 2021 2022 or prior to identify potential bias in the determination of the Bright HealthCare IBNR claims claim liability.

Affordable Care Act (ACA) Risk Adjustment – Discontinued Operations—Refer to Notes 2 and 4 Note 19 to the Financial Statements

Critical Audit Matter Description

The Company records adjustments for changes Company's discontinued operations include operations related to the risk adjustment balances for its individual Bright HealthCare and small group policies in premium revenue. The risk adjustment program adjusts premiums based on the demographic factors and health status of each consumer as derived from current-year medical diagnoses in accordance with Section 1343 of the ACA. Risk score information is calculated at the consumer level in order to determine an average risk score for each legal entity participating in a particular state market, which are then compared to the overall risk score for the state market. The risk adjustment amount is determined based on how each of the Company's average risk scores compare commercial insurance business ("Bright HealthCare—Commercial"). The Company entered into a purchase agreement to sell its Bright HealthCare business to a third party in June 2023. That sale was consummated on January 1, 2024. The Company exited the state's average risk score. The nature of commercial insurance business effective December 31, 2022, and the program requires significant assumptions from balances recognized in the Company in estimating both the final risk scores of its members as well as state average risk scores. current year relate to run out activities.

We identified the ACA risk adjustment liability discontinued operations as a critical audit matter because of discontinued operations are material to the financial statements and the significant judgement estimates and assumptions management makes in relation to estimate determining the amounts in its risk adjustment liability. This requires complex auditor judgment, and an increased extent of audit effort, including consolidated financial statements which should be presented within discontinued operations, versus within continuing operations. These judgments impact both the involvement of our actuarial specialists, when performing audit procedures current year presentation as well as prior year presentation, as the presentation has been retrospectively applied to evaluate the reasonableness of management's assumptions and methods. all periods presented.

How the Critical Audit Matter Was Addressed in the Audit

Our audit procedures related to ACA Risk Adjustment discontinued operations included the following, among others:

- We assessed Reconciled the Company's process presentation of financial results of discontinued operations by major line item to estimate the ACA risk adjustment balance by performing a retrospective review of underlying accounting records for each business unit related to the Company's prior year balance against final settlement amounts. discontinued operations.
- For any adjustments made by management to reflect differences between the discontinued operations as presented and the underlying accounting records, we inquired with management to understand the rationale for the adjustment and inspected additional supporting evidence for the adjustments made.

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- With the assistance of our actuarial specialists, we evaluated the model used to develop the risk adjustment estimates, including the mathematical accuracy of calculations, and tested certain significant assumptions and inputs.

- We obtained the report issued by management's third-party specialist and compared to management's recorded estimate.

Goodwill – Refer to Notes 2, 3, and 8 to the Financial Statements

Critical Audit Matter Description

The Company's evaluation of goodwill for impairment involves the comparison of the fair value of each reporting unit to its carrying value. The Company determines the fair value of its reporting units using a combination of discounted cash flows and comparable market multiples. The determination of fair value using discounted cash flows requires management to make significant estimates and assumptions related to forecasts of revenue growth rates, profit margins, and discount rates. The determination of fair value using comparable market multiples requires management to make significant assumptions related to revenue multiples, including the determination of an appropriate group of peer companies. In 2022, the Company recognized an impairment of goodwill primarily due to an increase in interest rates and other market factors, as well as the Company's decision to exit its Commercial business effective December 31, 2022.

We identified goodwill as a critical audit matter because inspected minutes of the significant estimates and assumptions management makes to estimate the fair value of its reporting units. This required a high degree of auditor judgment and an increased extent of effort, including the need to involve our fair value specialists, when performing audit procedures to evaluate the reasonableness of management's estimates and assumptions related to forecasts of future revenue growth rates, profit margins, revenue multiples, and selection of discount rates.

How the Critical Audit Matter Was Addressed in the Audit

Our audit procedures related to Goodwill included the following, among others:

- We tested the effectiveness of controls over management's goodwill impairment evaluation, including those over the determination of the fair value of its reporting units and development of management's forecasts.
- We evaluated the reasonableness of management's forecasts by evaluating historical forecasts to actual results and comparing the forecasts used in the income approach to (1) historical results, (2) internal communications to management and the Board of Directors and (3) forecasted information included in Company press releases as well as in analyst related committees that evidenced proper authorization and industry reports approval of the Company and companies in its peer group.
- With the assistance of our fair value specialists, we evaluated the discount rates, including testing the underlying source information and the mathematical accuracy sale of the calculations used in the income approach, developing a range of independent estimates and comparing those to the discount rates selected by management.
- With the assistance of our fair value specialists, we evaluated the revenue multiples used in the market approach, including testing the underlying source information and mathematical accuracy of the calculations, comparing the multiples selected by management to its guideline companies, and evaluating management's determination of appropriate guideline companies.

Bright HealthCare business.

/s/ Deloitte & Touche LLP

Minneapolis, Minnesota

March 16, 2023 28, 2024

We have served as the Company's auditor since 2020.

Bright Health Group, NeueHealth, Inc. and Subsidiaries

Consolidated Balance Sheets
(in thousands, except share and per share data)

	December 31,	
	2023	**2022**
Assets		
Current assets:		
Cash and cash equivalents	**$ 87,299**	$ 217,006
Short-term investments	**6,265**	869
Accounts receivable, net of allowance of $14,023 and $6,098, respectively	**39,084**	19,576
ACO REACH performance year receivable	**115,878**	99,181
Current assets of discontinued operations (Note 19)	**822,570**	3,187,464
Prepaids and other current assets	**17,831**	46,538
Total current assets	**1,088,927**	3,570,634
Other assets:		
Long-term investments	**—**	5,401
Property, equipment and capitalized software, net	**14,499**	21,298
Goodwill	**—**	401,385
Intangible assets, net	**93,238**	104,952
Long-term assets of discontinued operations (Note 19)	**—**	529,117
Other non-current assets	**28,816**	32,265
Total other assets	**136,553**	1,094,418
Total assets	**$ 1,225,480**	$ 4,665,052
Liabilities, Redeemable Noncontrolling Interests, Redeemable Preferred Stock and Shareholders' Equity (Deficit)		
Current liabilities:		
Medical costs payable	**$ 157,903**	$ 116,021

Accounts payable	**11,841**	18,714
Short-term borrowings	**303,947**	303,947
Current liabilities of discontinued operations (Note 19)	**699,758**	3,157,236
Risk share payable to deconsolidated entity	**123,981**	—
Warrant liability	**13,971**	—
Other current liabilities	**79,856**	97,241
Total current liabilities	**1,391,257**	3,693,159
Long-term borrowings	**66,400**	—
Other liabilities	**22,441**	32,208
Total liabilities	**1,480,098**	3,725,367
Commitments and contingencies (Note 14)		
Redeemable noncontrolling interests	**88,908**	219,758
Redeemable Series A preferred stock, $0.0001 par value; 750,000 shares authorized in 2023 and 2022; 750,000 shares issued and outstanding in 2023 and 2022	**747,481**	747,481
Redeemable Series B preferred stock, $0.0001 par value; 175,000 shares authorized in 2023 and 2022; 175,000 shares issued and outstanding in 2023 and 2022	**172,936**	172,936
Shareholders' equity (deficit):		
Common stock, $0.0001 par value; 3,000,000,000 shares authorized in 2023 and 2022; 8,053,576 and 7,878,394 shares issued and outstanding in 2023 and 2022*, respectively	**1**	1
Additional paid-in capital	**3,056,027**	2,972,333
Accumulated deficit	**(4,307,849)**	(3,156,395)
Accumulated other comprehensive loss	**(122)**	(4,429)
Treasury stock, at cost, 31,526 shares at December 31, 2023 and 2022	**(12,000)**	(12,000)
Total shareholders' equity (deficit)	**(1,263,943)**	(200,490)
Total liabilities, redeemable noncontrolling interests, redeemable preferred stock and shareholders' equity (deficit)	**$ 1,225,480**	$ 4,665,052

	December 31,	
	2022	2021
Assets		
Current assets:		
Cash and cash equivalents	**$ 466,325**	$ 289,283
Short-term investments	**13,206**	144,477
Accounts receivable, net of allowance of $6,098 and $3,417, respectively	**73,605**	98,882
Direct contracting performance year receivable	**99,181**	**—**
Current assets of discontinued operations (Note 4)	**2,783,474**	1,027,345
Prepaids and other current assets	**134,843**	100,213
Total current assets	**3,570,634**	1,660,200
Other assets:		
Long-term investments	**5,401**	18,608
Property, equipment and capitalized software, net	**42,596**	38,344
Goodwill	**760,078**	830,992
Intangible assets, net	**249,083**	336,995
Long-term assets of discontinued operations (Note 4)	**—**	668,695
Other non-current assets	**37,260**	44,505
Total other assets	**1,094,418**	1,938,139
Total assets	**$ 4,665,052**	$ 3,598,339
Liabilities, Redeemable Noncontrolling Interests, Redeemable Preferred Stock and Shareholders' Equity (Deficit)		
Current liabilities:		
Medical costs payable	**$ 411,753**	$ 263,187
Accounts payable	**67,854**	57,888
Unearned revenue	**242**	2,585
Short-term borrowings	**303,947**	155,000
Current liabilities of discontinued operations (Note 4)	**2,783,474**	1,696,040
Other current liabilities	**121,424**	108,849
Total current liabilities	**3,688,694**	2,283,549
Other liabilities	**36,673**	41,263
Total liabilities	**3,725,367**	2,324,812
Commitments and contingencies (Note 17)		
Redeemable noncontrolling interests	**219,758**	128,407
Redeemable Series A preferred stock, $0.0001 par value; 750,000 and — shares authorized in 2022 and 2021, respectively; 750,000 and — shares issued and outstanding in 2022 and 2021, respectively	**747,481**	—
Redeemable Series B preferred stock, $0.0001 par value; 175,000 shares authorized in 2022 and 2021, respectively; 175,000 and — shares issued and outstanding in 2022 and 2021, respectively	**172,936**	—

Shareholders' equity (deficit):		
Common stock, $0.0001 par value; 3,000,000,000 shares authorized in 2022 and 2021; 630,271,508 and 628,622,872 shares issued and outstanding in 2022 and 2021, respectively	**63**	63
Additional paid-in capital	**2,972,271**	2,861,243
Accumulated deficit	**(3,156,395)**	(1,700,851)
Accumulated other comprehensive (loss) income	**(4,429)**	(3,335)
Treasury stock, at cost, 2,522,148 shares at December 31, 2022 and 2021	**(12,000)**	(12,000)
Total shareholders' equity (deficit)	**(200,490)**	1,145,120
Total liabilities, redeemable noncontrolling interests, redeemable preferred stock and shareholders' equity (deficit)	**$ 4,665,052**	$ 3,598,339

*Shares have been retroactively adjusted to reflect the decreased number of shares resulting from a 1 for 80 reverse stock split

See accompanying Notes to Consolidated Financial Statements

Bright Health Group, NeueHealth, Inc. and Subsidiaries

Consolidated Statements of Income (Loss)

(in thousands, except share and per share data)

	For the Years Ended December 31,		
	2022	**2021**	**2020**
Revenue:			
Premium revenue	**$ 1,764,949**	$ 1,390,330	$ 487,905
Direct Contracting revenue	**654,087**	—	—
Capitated revenue			
Capitated revenue			
Capitated revenue			
ACO REACH revenue			
Service revenue	**48,013**	42,469	18,514
Investment income (loss)	**(55,019)**	80,234	8,468
Total revenue	**2,412,030**	1,513,033	514,887
Operating expenses:			
Medical costs	**2,206,243**	1,294,158	451,918
Medical costs			
Medical costs			
Operating costs	**632,030**	527,453	225,063
Bad debt expense			
Restructuring charges	**31,739**	—	—
Goodwill impairment	**71,225**	—	—
Intangible assets impairment	**42,611**	—	—
Depreciation and amortization	**50,430**	35,049	8,289

	For the Years Ended December 31,	
	2023	**2022**
Revenue:		
Premium revenue		
Direct Contracting revenue		
Capitated revenue		
Capitated revenue		
Capitated revenue	**$ 219,774**	$ 112,904
ACO REACH revenue	**896,504**	654,087
Service revenue	**44,438**	39,601
Investment income (loss)	**86**	(55,429)
Total revenue	**1,160,802**	751,163
Operating expenses:		
Medical costs		
Medical costs		
Medical costs	**996,582**	662,972
Operating costs	**287,138**	354,436
Bad debt expense	**27,407**	12
Restructuring charges	**6,990**	29,178
Goodwill impairment	**401,385**	—
Intangible assets impairment	**—**	42,611
Depreciation and amortization	**18,296**	30,710

Total operating expenses	**Total operating expenses**	**3,034,278**	1,856,660	685,270	**Total operating expenses**	**1,737,798**	1,119,919
Operating loss	**Operating loss**	**(622,248)**	(343,627)	(170,383)	**Operating loss**	**(576,996)**	(368,756)
Interest expense	Interest expense	**12,821**	7,230	—	Interest expense	**38,203**	12,822
Other income		**(784)**	(1,226)	—			
Warrant expense					Warrant expense	**13,971**	—
Loss from continuing operations before income taxes	**Loss from continuing operations before income taxes**	**(634,285)**	(349,631)	(170,383)	**Loss from continuing operations before income taxes**	**(629,170)**	(381,578)
Income tax expense (benefit)	Income tax expense (benefit)	**3,680**	(26,521)	(9,161)	Income tax expense (benefit)	**(1,428)**	3,664
Net loss from continuing operations	**Net loss from continuing operations**	**(637,965)**	(323,110)	(161,222)	**Net loss from continuing operations**	**(627,742)**	(385,242)
Loss from discontinued operations, net of tax (Note 4)		**(721,915)**	(855,255)	(87,220)			
Loss from discontinued operations, net of tax (Note 19)					Loss from discontinued operations, net of tax (Note 19)	**(638,066)**	(974,638)
Net loss	**Net loss**	**(1,359,880)**	(1,178,365)	(248,442)	**Net loss**	**(1,265,808)**	(1,359,880)
Net earnings from continuing operations attributable to noncontrolling interests		**(95,664)**	(6,497)	—			
Net loss (earnings) from continuing operations attributable to noncontrolling interests					Net loss (earnings) from continuing operations attributable to noncontrolling interests	**114,354**	(95,664)
Series A preferred stock dividend accrued	Series A preferred stock dividend accrued	**(37,889)**	—	—	Series A preferred stock dividend accrued	**(40,139)**	(37,889)
Series B preferred stock dividend accrued	Series B preferred stock dividend accrued	**(1,798)**	—	—	Series B preferred stock dividend accrued	**(9,006)**	(1,798)
Net loss attributable to Bright Health Group, Inc. common shareholders		**$(1,495,231)**	$(1,184,862)	$(248,442)			
Net loss attributable to NeueHealth, Inc. common shareholders							
Basic and diluted loss per share attributable to Bright Health Group, Inc. common shareholders							

Basic and diluted loss per share attributable to NeueHealth, Inc. common shareholders				
Basic and diluted loss per share attributable to NeueHealth, Inc. common shareholders				
Basic and diluted loss per share attributable to NeueHealth, Inc. common shareholders				
Continuing operations				
Continuing operations				
Continuing operations	Continuing operations	$ (1.23)	$ (0.84)	$ (1.18)
Discontinued operations	Discontinued operations	(1.15)	(2.18)	(0.64)
Basic and diluted loss per share	Basic and diluted loss per share	(2.38)	(3.02)	(1.82)
Basic and diluted weighted-average common shares outstanding	Basic and diluted weighted-average common shares outstanding	629,459	392,243	136,193
Basic and diluted weighted-average common shares outstanding				
Basic and diluted weighted-average common shares outstanding				

*Shares have been retroactively adjusted to reflect the decreased number of shares resulting from a 1 for 80 reverse stock split

See accompanying Notes to Consolidated Financial Statements

Bright Health Group, NeueHealth, Inc. and Subsidiaries

Consolidated Statements of Comprehensive Income (Loss)
(in thousands)

		For the Years Ended December 31,		
		2022	**2021**	**2020**
Net loss	**Net loss**	**$(1,359,880)**	$(1,178,365)	$(248,442)
Other comprehensive (loss) income:	Other comprehensive (loss) income:			
Unrealized investment holding gains (losses) arising during the year, net of tax of $—, $—, and $—, respectively		**(5,267)**	(6,163)	1,556
Less: reclassification adjustments for investment gains (losses), net of tax of $—, $—, and $—, respectively		**(4,173)**	(402)	112
Unrealized investment holding gains (losses) arising during the year, net of tax of $0 and $0, respectively				
Unrealized investment holding gains (losses) arising during the year, net of tax of $0 and $0, respectively				
Unrealized investment holding gains (losses) arising during the year, net of tax of $0 and $0, respectively				

	For the Years Ended December 31,	
	2023	**2022**
Net loss	**$(1,265,808)**	$ (1,359,880)
	1,762	(5,267)

Less: reclassification adjustments for investment gains (losses), net of tax of $0 and $0, respectively					Less: reclassification adjustments for investment gains (losses), net of tax of $0 and $0, respectively	**(2,545)**		(4,173)
Other comprehensive (loss) income	**Other comprehensive (loss) income**	**(1,094)**	(5,761)	1,444	**Other comprehensive (loss) income**	**4,307**		(1,094)
Comprehensive loss	**Comprehensive loss**	**(1,360,974)**	(1,184,126)	(246,998)	**Comprehensive loss**	**(1,261,501)**		(1,360,974)
Comprehensive income attributable to noncontrolling interests		**(95,664)**	(6,497)	—				
Comprehensive loss attributable to Bright Health Group, Inc. common shareholders		**$(1,456,638)**	$(1,190,623)	$(246,998)				
Comprehensive loss (income) attributable to noncontrolling interests					Comprehensive loss (income) attributable to noncontrolling interests	**114,354**		(95,664)
Comprehensive loss attributable to NeueHealth, Inc. common shareholders					**Comprehensive loss attributable to NeueHealth, Inc. common shareholders**	**$(1,147,147)**	$	(1,456,638)

See accompanying Notes to Consolidated Financial Statements

Bright Health Group, NeueHealth, Inc. and Subsidiaries

Consolidated Statements of Changes in Redeemable Preferred Stock and Shareholders' Equity (Deficit)

(in thousands)

	Redeemable Preferred Stock		Common Stock		Additional Paid-In Capital	Retained Earnings (Deficit)	Accumulated Other Comprehensive Income (Loss)	Treasury Stock	Total
	Shares	Amount	Shares	Amount					
Balance at December 31, 2019	119,222	871,990	135,509	$ 14	$ 3,184	$ (267,547)	$ 982	$ —	$ (263,367)

	Redeemable Preferred Stock								
	Shares								
Balance at December 31, 2021									
Balance at December 31, 2021									
Balance at December 31, 2021									
Net loss	Net loss	—	—	—	—	—	(248,442)	—	—	(248,442)
Issuance of preferred stock		45,023	809,025	—	—	—	—	—	—	—
Issuance of common stock		—	—	2,154	—	1,241	—	—	—	1,241
Share-based compensation		—	—	—	—	5,452	—	—	—	5,452
Other comprehensive gain		—	—	—	—	—	—	1,444	—	1,444
Balance at December 31, 2020		164,245	1,681,015	137,663	$ 14	$ 9,877	$ (515,989)	$ 2,426	$ —	$ (503,672)
Net loss	Net loss	—	—	—	—	—	(1,184,862)	—	—	(1,184,862)
Issuance of preferred stock		3,487	134,944	—	—	—	—	—	—	—
Conversion of preferred stock to common stock		(167,732)	(1,815,959)	427,897	43	1,815,916	—	—	—	1,815,959
Issuance of common stock		—	—	14,235	1	86,390	—	—	—	86,391

	Redeemable Preferred Stock	Common Stock	Additional Paid-In Capital	Retained Earnings (Deficit)	Accumulated Other Comprehensive Income (Loss)	Trea Sto
Balance at December 31, 2021						
Balance at December 31, 2021						
Balance at December 31, 2021						

Sale of common stock from IPO, net of offering costs	—	—	51,350	5	880,637	—	—	—	880,642
Share-based compensation	—	—	—	—	68,423	—	—	—	68,423
Other comprehensive loss	—	—	—	—	—	—	(5,761)	—	(5,761)
Return of common stock from escrow settlement	—	—	(2,522)	—	—	—	—	(12,000)	(12,000)
Balance at December 31, 2021	—	—	628,623	63	$2,861,243	$(1,700,851)	$ (3,335)	$(12,000)	$1,145,120
Net loss	**Net loss**	**—**	**—**	**—**	**—**	**—**	**(1,455,544)**	**—**	**—**	**(1,455,544)**
Issuance of Series A preferred stock	**Issuance of Series A preferred stock**	**750**	**747,481**	**—**	**—**	**—**	**—**	**—**	**—**	**—**
Issuance of Series B preferred stock	**Issuance of Series B preferred stock**	**175**	**172,936**	**—**	**—**	**—**	**—**	**—**	**—**	**—**
Issuance of common stock	**Issuance of common stock**	**—**	**—**	**1,649**	**—**	**1,315**	**—**	**—**	**—**	**1,315**
Share-based compensation	**Share-based compensation**	**—**	**—**	**—**	**—**	**109,713**	**—**	**—**	**—**	**109,713**
Other comprehensive loss	**Other comprehensive loss**	**—**	**—**	**—**	**—**	**—**	**—**	**(1,094)**	**—**	**(1,094)**
Balance at December 31, 2022	**Balance at December 31, 2022**	**925**	**$ 920,417**	**630,272**	**$ 63**	**$2,972,271**	**$(3,156,395)**	**$ (4,429)**	**$(12,000)**	**$ (200,490)**
Net loss									
Net loss									
Net loss									
Issuance of Series A preferred stock									
Issuance of Series B preferred stock									
Issuance of common stock									
Share-based compensation									
Other comprehensive loss									
Balance at December 31, 2023									

*Shares have been retroactively adjusted to reflect the decreased number of shares resulting from a 1 for 80 reverse stock split

See Notes to Consolidated Financial Statements

Bright Health Group, NeueHealth, Inc. and Subsidiaries

Consolidated Statements of Cash Flows

(in thousands)

	For the Years Ended December 31,		
	2022	**2021**	**2020**

	For the Years Ended December 31,					For the Years Ended December 31,	
	2023					2023	2022
Cash flows from operating activities:	Cash flows from operating activities:						
Net loss	Net loss	$ (1,359,880)	$(1,184,862)	$(248,442)			
Net loss							
Net loss						$(1,265,808)	$ (1,359,880)
Adjustments to reconcile net loss to net cash provided by (used in) operating activities:	Adjustments to reconcile net loss to net cash provided by (used in) operating activities:						
Depreciation and amortization							
Depreciation and amortization							
Depreciation and amortization	Depreciation and amortization	50,575	35,484	8,289		24,167	50,575
Impairment of intangible assets	Impairment of intangible assets	49,331	—	—	Impairment of intangible assets	—	49,331
Impairment of goodwill	Impairment of goodwill	75,372	—	—	Impairment of goodwill	587,535	75,372
Share-based compensation	Share-based compensation	109,713	68,423	5,452	Share-based compensation	83,692	109,713
Deferred income taxes	Deferred income taxes	2,027	(25,654)	—	Deferred income taxes	(3,063)	2,027
Unrealized loss (gain) on equity securities	Unrealized loss (gain) on equity securities	55,449	(80,231)	—	Unrealized loss (gain) on equity securities	—	55,449
Impairment of investments		67,723	—	—			
Investment impairment					Investment impairment	—	67,723
Warrant expense					Warrant expense	13,971	—
Net (accretion) and amortization of investments					Net (accretion) and amortization of investments	(17,986)	2,551
Loss on disposal of property, equipment, and capitalized software					Loss on disposal of property, equipment, and capitalized software	6,418	10,981
Other, net	Other, net	24,163	20,254	2,667	Other, net	1,858	10,631
Changes in assets and liabilities, net of acquired assets and liabilities:	Changes in assets and liabilities, net of acquired assets and liabilities:						
Accounts receivable	Accounts receivable	28,787	(32,941)	24,631			
Direct Contracting performance year receivable		(99,181)	—	—			
Accounts receivable							
Accounts receivable						(7,756)	28,787
ACO REACH performance year receivable					ACO REACH performance year receivable	(16,697)	(99,181)

Other assets	Other assets	**(21,832)**	(143,463)	(44,061)	Other assets	**191,441**		(21,832)
Medical cost payable	Medical cost payable	**279,563**	475,461	78,591	Medical cost payable	**(635,616)**		279,563
Risk adjustment payable	Risk adjustment payable	**1,012,720**	742,075	100,974	Risk adjustment payable	**(1,652,744)**		1,012,720
Accounts payable and other liabilities	Accounts payable and other liabilities	**2,696**	192,611	(3,962)	Accounts payable and other liabilities	**(149,325)**		2,696
Unearned revenue	Unearned revenue	**(42,760)**	14,902	18,623	Unearned revenue	**(10,614)**		(42,760)
Risk share payable to deconsolidated entity					Risk share payable to deconsolidated entity	**123,981**		—
Net cash provided by (used in) operating activities	**Net cash provided by (used in) operating activities**	**234,466**	82,059	(57,238)	**Net cash provided by (used in) operating activities**	**(2,726,546)**		234,466
Cash flows used in investing activities:								
Cash flows from investing activities:								
Purchases of investments								
Purchases of investments								
Purchases of investments	Purchases of investments	**(1,457,444)**	(1,017,588)	(916,823)		**(837,074)**	(1,457,444)	
Proceeds from sales, paydown, and maturities of investments	Proceeds from sales, paydown, and maturities of investments	**1,055,479**	926,901	463,887	Proceeds from sales, paydown, and maturities of investments	**1,960,283**		1,055,479
Purchases of property and equipment	Purchases of property and equipment	**(27,448)**	(30,414)	(6,474)	Purchases of property and equipment	**(2,897)**		(27,448)
Business divestiture					Business divestiture	**(682)**		—
Business acquisitions, net of cash acquired	Business acquisitions, net of cash acquired	**(310)**	(431,791)	(230,332)	Business acquisitions, net of cash acquired	**—**		(310)
Net cash used in investing activities		**(429,723)**	(552,892)	(689,742)				
Net cash provided by (used in) investing activities					**Net cash provided by (used in) investing activities**	**1,119,630**		(429,723)
Cash flows from financing activities:	Cash flows from financing activities:							
Proceeds from issuance of preferred stock	Proceeds from issuance of preferred stock	**920,417**	—	711,200				
Proceeds from issuance of preferred stock								
Proceeds from issuance of preferred stock						**—**		920,417
Proceeds from issuance of common stock	Proceeds from issuance of common stock	**1,315**	11,390	1,241	Proceeds from issuance of common stock	**—**		1,315

Proceeds from long-term borrowings					Proceeds from long-term borrowings	**66,400**		—
Proceeds from short-term borrowings	Proceeds from short-term borrowings	**303,947**	355,000	—	Proceeds from short-term borrowings	**—**		303,947
Repayments of short-term borrowings	Repayments of short-term borrowings	**(155,000)**	(200,000)	—	Repayments of short-term borrowings	**—**		(155,000)
Payments for debt issuance costs		**—**	(3,391)	—				
Distribution to noncontrolling interest holders	Distribution to noncontrolling interest holders	**(4,311)**	—	—	Distribution to noncontrolling interest holders	**(16,494)**		(4,311)
Proceeds from IPO		**—**	887,328	—				
Payments for IPO offering costs		**—**	(6,686)	—				
Net cash provided by financing activities	**Net cash provided by financing activities**	**1,066,368**	1,043,641	712,441	**Net cash provided by financing activities**	**49,906**		1,066,368
Net increase (decrease) in cash and cash equivalents	**Net increase (decrease) in cash and cash equivalents**	**871,111**	572,808	(34,539)	**Net increase (decrease) in cash and cash equivalents**	**(1,557,010)**		871,111
Cash and cash equivalents of continuing and discontinued operations– beginning of year	Cash and cash equivalents of continuing and discontinued operations– beginning of year	**1,061,179**	488,371	522,910	Cash and cash equivalents of continuing and discontinued operations– beginning of year	**1,932,290**		1,061,179
Cash and cash equivalents of continuing and discontinued operations– end of year	Cash and cash equivalents of continuing and discontinued operations– end of year	**$ 1,932,290**	$ 1,061,179	$ 488,371	Cash and cash equivalents of continuing and discontinued operations– end of year	**$ 375,280**	$	1,932,290
Supplemental disclosures of cash flow information:	**Supplemental disclosures of cash flow information:**							
Changes in unrealized gain (loss) on available-for-sale securities in OCI	Changes in unrealized gain (loss) on available-for-sale securities in OCI	**$ (1,094)**	$ (5,761)	$ 1,444				
Changes in unrealized gain (loss) on available-for-sale securities in OCI								
Changes in unrealized gain (loss) on available-for-sale securities in OCI						**$ 4,307**	$	(1,094)
Cash paid for interest	Cash paid for interest	**10,303**	4,592	—	Cash paid for interest	**36,166**		10,303
Supplemental schedule of non-cash activities:								
Redeemable convertible preferred stock issued for acquisitions		**$ —**	$ 134,944	$ 97,825				
Contingent consideration		**332**	(4,221)	—				

Conversion of redeemable convertible preferred stock to common stock upon initial public offering	—	1,815,916	—

See Notes to Consolidated Financial Statements

Bright Health Group, NeueHealth, Inc.
Notes to Consolidated Financial Statements

NOTE 1. ORGANIZATION AND OPERATIONS

Organizational Structure: NeueHealth, Inc. (formerly known as Bright Health Group, Inc.) and subsidiaries (collectively, "Bright Health,"NeueHealth," "we," "our," "us," or the "Company") was founded in 2015 to transform healthcare. Our mission NeueHealth is a value-driven, consumer-centric healthcare company committed to making high-quality, coordinated healthcare accessible and affordable to all populations. We believe we can reduce the friction and current lack of Making Healthcare Right. Together. is built upon the belief that coordination in today's healthcare system by uniquely aligning the best local resources in interests of payors and providers to enable a seamless, consumer-centric healthcare delivery with the financing of care we can drive a superior consumer experience optimize clinical outcomes, reduce systemic waste, and lower costs. We are a healthcare company building a national Integrated System of Care in close partnership with our Care Partners. Our differentiated approach is built on alignment, focused on the consumer, and powered by technology. that drives value for all.

We have two market facing businesses: our NeueCare business, formerly Consumer Care's Care Delivery, and NeueSolutions business, and Bright HealthCare. formerly Consumer Care's Care provides Solutions. NeueCare is our value-driven care delivery business that manages risk in partnership with external payors and value-based serves all populations across The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 ("ACA") Marketplace, Medicare, and Medicaid. NeueSolutions is our provider enablement business that includes a suite of technology, services, through our owned and affiliated clinics. Bright HealthCare offers Medicare health plan products across the nation. clinical care solutions that empower providers to thrive in performance-based arrangements.

Beginning January 1, 2022 During our annual meeting on May 4, 2023, two Direct Contracting Entities ("DCEs") aligned our stockholders voted to approve an amendment to our Ninth Amended and Restated Certificate of Incorporation to effect a reverse stock split at a ratio of not less than 1-for-15 and not greater than 1-for-80, with the exact ratio and effective time of the Reverse Stock Split to be determined by our Consumer Care segment began participating Board of Directors at any time within one year of the date of the Annual Meeting. On May 5, 2023, our Board approved a ratio of 1-for-80. The reverse stock split took effect on May 19, 2023.

The reverse stock split decreased the number of outstanding shares of the Company's common stock by a factor of 80, subject to rounding of shares. The reverse stock split did not affect any stockholder's proportionate equity interest in the Centers Company. The par value of the Company's common stock remains at $0.0001 per share following the reverse stock split and the number of outstanding shares of the Company's common stock was proportionally reduced. As a consequence, the aggregate par value of the Company's outstanding common stock was reduced, while the aggregate capital in excess of par value attributable to the Company's outstanding common stock for Medicare accounting purposes was correspondingly increased. Total stockholder equity was not affected. All shares and Medicaid Services' ("CMS") Global and Professional Direct Contracting model ("DC Model"). Both DCEs assume full risk per share information has been retroactively adjusted following the effective date of the reverse stock split to reflect the reverse stock split for the total cost of care of aligned beneficiaries. all periods presented in future filings.

In October 2022, On June 30, 2023, the Company entered into the Molina Purchase Agreement to sell its California Medicare Advantage business, which consists of Universal Care, Inc. d/b/a Brand New Day, a California corporation ("BND") and Central Health Plan of California, Inc., a California corporation ("CHP"). The aggregate purchase price of the California Medicare Advantage business was reduced in the fourth quarter of 2023 from $600 million to $500 million in cash subject to certain purchase price adjustments. The closing of this transaction occurred on January 1, 2024.

Beginning in 2023, we announced that Bright HealthCare will no longer offer Commercial offered Individual Family Plan ("Commercial") products in 2023 or offer MA Medicare Advantage ("MA") products outside of California. We have presented Both the California MA business (Bright HealthCare) and our Commercial business (Bright HealthCare - Commercial) are presented within discontinued operations for all periods presented within the consolidated financial statements. See Note 4, 19, *Discontinued Operations*, for further discussion of discontinued operations.

The Company's common stock is traded on the New York Stock Exchange (the "NYSE") under the symbol "BHG" "NEUE".

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation: The consolidated financial statements include the accounts of Bright Health Group, NeueHealth, Inc. and all subsidiaries and controlled companies. The consolidated financial statements are prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP"). All intercompany balances and transactions are eliminated upon consolidation.

Use of Estimates: The preparation of our consolidated financial statements in conformance with GAAP requires management to make estimates and assumptions that affect the reported amounts in the consolidated financial statements and accompanying

notes. Our most significant estimates include medical costs payable, provider risk adjustment revenue and associated payables and receivables, premium deficiency reserve share arrangements, and valuation and impairment of goodwill and other intangible assets. Actual results could differ from these estimates.

Business Combinations: We account for business combinations under the acquisition method of accounting. This method requires the recording of acquired assets and assumed liabilities at their acquisition date fair values. The excess of the purchase price over the fair value of assets acquired and liabilities assumed is recorded as goodwill. Results of operations related to business combinations are included prospectively beginning with the date of acquisition and transaction costs related to business combinations are recorded within operating costs.

Capitated Revenue Recognition: Premium Capitated revenue includes revenue derived from insurance contracts of Bright HealthCare, within the scope of earned under capitated agreements recorded in accordance with the Financial Accounting Standards Board ("FASB") Accounting Standard Standards Codification ("ASC") 944, *Financial Services - Insurance*, as well as revenue earned by our Consumer Care business under capitated agreements recorded in accordance with ASC 606, *Revenue from Contracts With Customers*("ASC 606"). Premium Primary care capitation and global capitation revenue is are recognized in the period for which services are covered. Individual policies can be terminated by a consumer without advance notice Our financial performance pertaining to the Company. Consumers that have unpaid premium balances for the coverage period are subject to certain termination requirements depending on whether the premium risk share revenue is subsidized or nonsubsidized by CMS. The Company estimates the portion of unpaid balances that will not be collected from consumers and records an allowance accordingly.

We record adjustments for changes to the risk adjustment balances for individual policies in premium revenue. The risk adjustment program adjusts premiums evaluated based on the demographic factors and health status of each consumer as derived from current-year medical diagnoses as reported throughout the year. Under the risk adjustment program, a risk score is assigned to

each covered consumer to determine an average risk score at the individual and small-group level by legal entity in a particular market in a state. Additionally, an average risk score is determined for the entire subject population for each market in each state. Settlements are determined on a net basis by legal entity and state and are made in the middle of the year following the end of the contract year. Each health insurance issuer's average risk score is compared to the state's average risk score. Risk adjustment is subject to audit by HHS, which could result in future payments applicable to benefit years.

Premium revenue under the MA program includes CMS monthly premiums that are risk adjusted based on CMS defined formulas using consumer demographics and hierarchical condition category codes comparison between our year-to-date Medical Loss Ratio ("HCC risk scores" MLR") calculated based on historical data submitted to CMS on a lagged basis. Risk Adjustment Factor-related ("RAF") premiums settle between CMS and the Company during both a midyear corresponding target MLR and final reconciliation process. Due to the lagged nature of the reconciliation and settlement, RAF-related premiums are estimated based on the lagged information that we submitted to CMS. The accuracy of the data submissions to CMS used in the RAF reconciliation are subject to CMS audit under the RADV audits and could result in future adjustments to premiums. As of December 31, 2022 and 2021, our MA risk adjustment receivable was $62.2 million and $75.3 million, respectively, recorded in accounts receivable.

The Company, in conjunction with the MA program, covers prescription drug benefits under the Medicare Prescription Drug Benefit ("Medicare Part D") program. Premium revenue includes CMS monthly premiums, consumer premium and CMS low-income premium subsidy for our insurance risk coverage. Premiums are recognized ratably over the period in which eligible individuals are entitled to receive covered benefits.

CMS covers 80% of allowed claims costs above the defined standard true out-of-pocket ("TrOOP") threshold of $7,050 for any individual beneficiary enrolled in a Medicare Advantage plan ("MAO"). The reinsurance calculation is based on the benefit actually offered (i.e. basic or enhanced) and with CMS covering 80% of a member's drug costs in the catastrophic phase. CMS provides upfront subsidies to MAO's through a monthly payment in the Monthly Membership Report to cover the estimated cost of federal reinsurance on a per-member-per-month basis. Reinsurance subsidies in excess of federal reinsurance claims are paid back to CMS (a payable). If the MAO does not have enough federal reinsurance revenue to cover the federal reinsurance claims, CMS will pay the shortfall to the MAO.

Our monthly payment from CMS includes prospective subsidies to cover catastrophic reinsurance and low-income cost subsidies, and the Medicare Part D coverage gap discount that the Company must cover at the point-of-sale for prescription drugs. We are not at risk for these portions of the Medicare Part D benefit design. We account for these CMS-provided subsidies and related costs on the Consolidated Balance Sheets and ultimately settle with CMS and pharmaceutical companies during the final Medicare Part D reconciliation subsequent to the plan year. As of December 31, 2022 and 2021, we had receivables of $6.7 million and $24.1 million, respectively, recorded as prepaid and other current assets, and payables of $24.6 million and $9.8 million, respectively, recorded as other current liabilities related to these programs.

Our Medicare Part D premiums are subject to risk sharing with CMS under the risk corridor provisions. The risk corridor provisions compare costs targeted in as per our annual bid to actual prescription drug costs incurred. Our profit or loss agreements. Revenue is shared with or covered by CMS depending on the relative position within the risk corridor band. Changes in the risk corridor payable or receivable are recognized in premium revenue. As of December 31, 2022 and 2021, when we had a risk corridor payable of $15.2 million and $4.1 million, respectively, included in other current liabilities. We had no material risk corridor receivable as of December 31, 2022 and 2021, respectively. Additionally, our individual

policy premiums, MA and Medicare Part D prescription drug plans are subject to MLR requirements under the ACA. Plans with medical loss ratios that fall below certain targets are required to rebate ratable portions of premiums annually. As of December 31, 2022 and 2021, we had MLR rebates payable of $0.5 million and $1.1 million, respectively, which are included in other current liabilities. can reasonably estimate expected performance.

As part of our Consumer Care NeueCare business, we are party to capitation arrangements that generate capitated revenue in the form of a predetermined per member per month fee in exchange for providing all defined healthcare services needed by an eligible member of the health plan, that is the other party to the arrangement. Per ASC 606, *Revenue from Contracts With Customers*, the capitated revenue and corresponding medical costs are presented gross when we serve as the principal in the transaction controlling the path of care in the fulfillment of our obligation and are presented net when we determine that we serve as the agent in the transaction. Additionally, we have concluded that we are precluded from serving as the principal in a transaction where we have a limited financial risk profile, as such we present capitated revenue and corresponding medical costs net when we do not bear the full a meaningful amount of financial risk for the defined healthcare services and care activities in the fulfillment of our obligation and net when we bear limited financial risk. obligation.

ACO REACH Revenue Recognition: Accountable Care Organizations ("ACO") Realizing Equity, Access, and Community Health ("REACH") revenue is recorded in accordance with ASC 460, *Guarantees* ("ASC 460"). At the inception of the performance year, NeueHealth measures and recognizes the performance guarantee receivable and obligation, issued in a standalone arm's length transaction, using the practical expedient to fair value as set forth in ASC 460-10-30-2(a). Consistent with ASC 460-10-25-4, which provides that a guarantor shall recognize in its statement of financial position a liability for that guarantee, we estimate the annualized benchmark recognized as the ACO REACH performance year obligation on the Consolidated Balance Sheets. On a periodic basis CMS adjusts the estimated Performance Year Benchmark based upon revised trend assumptions and changes in attributed membership. CMS will also estimate the shared savings or loss for the REACH ACO periodically based upon the estimated Performance Year Benchmark, changes to membership and various other assumptions. Additionally, when the guarantee is issued in a standalone transaction for a premium, the offsetting entry should be considered received according to ASC 460-10-25-4; as such we recognize the ACO REACH performance year receivable on the Consolidated Balance Sheets. The estimated Performance Year Benchmark is our best estimate of our obligation as we are unable to estimate the potential shared savings or loss due to the "stop-loss arrangement", risk corridor components of the agreement, and a number of variables including but not limited to risk ratings and benchmark trends that could have an inestimable impact on estimated future payments.

We follow ASC 460-10-35-2(b) to subsequently measure and recognize the performance guarantee, applying a systematic and rational approach to reflect our release from risk. Per ASC 460-10-35-2, depending on the nature of the guarantee, the guarantor's release from risk typically can be recognized over the term of the guarantee using one of three methods: (1) upon expiration or settlement, (2) by systematic or rational amortization, or (3) as the fair value of the guarantee changes. Consistent with method (2), as we fulfill our performance obligation, we amortize the guarantee on a straight-line basis for the amount that represents the completed portion of the performance obligation. For each performance year, the final consideration due to the REACH ACOs by the Center for Medicare and Medicaid Services ("CMS") (shared savings) or the consideration due to CMS by the REACH ACOs (shared loss) is reconciled in the year following the performance year.

The above discussion of the ASC 460 accounting treatment for our ACO REACH revenue is related only to the guarantee of the performance of our ACO REACH care partners and not for the performance of our NeueCare affiliates. The revenue generated from the services provided by our NeueCare affiliates is within the scope exception identified within ASC 460-10-15-7(i). a guarantee or an indemnification of an entity's own performance. As such, reported within ACO REACH revenue on the Consolidated Statements of Income (Loss), there is $1.8 million and $1.5 million revenue presented gross in accordance with ASC 606 related to our NeueCare clinics that are participating providers within our REACH ACOs.

Service Revenue Recognition: We generate service revenue from providing primary care services to patients in our medical clinics. Our service revenues include net patient service revenues that we bill the consumer or their insurance plan on a fee-for-service basis. We recognize this revenue as medical services are rendered. Generally patients who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. We estimate the transaction price for

Unearned Revenue: Payments received prior patients with deductibles and coinsurance and from those who are uninsured based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments, discounts, and implicit price concessions. Subsequent changes to the fulfillment estimate of service the transaction price are generally recorded as unearned revenue. adjustments to patient service revenue in the period of the change.

Additionally, we generate service revenue by providing provider enablement services through our Value Services Organization ("VSO") within NeueSolutions. The provider enablement services include an enablement suite of technology, services and clinical care solutions that empower providers to succeed in value-based care arrangements. Our enablement services are primarily billed on a per member per month basis with revenue recognized as the service period is completed.

Medical Costs and Medical Costs Payable: Medical costs payable on the Consolidated Balance Sheets consists primarily of the liability for claims processed but not yet paid, estimates for claims received but not yet processed, estimates for the costs of health care services that enrollees attributed consumers have received but for which claims have not yet been submitted, capitation payable to providers and liabilities for physician, hospital and other medical cost disputes. any calculated provider risk share deficit.

The estimates for claims incurred but not received reported ("IBNR") includes include estimates for claims which have not been received or fully processed, processed. IBNR estimates are developed using an actuarial process that is consistently applied and centrally controlled. The actuarial models consider factors such as historical submission and payment data, cost trends, customer and product mix, seasonality, utilization of health care services, contracted service rates and other relevant factors.

In developing our medical costs payable estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For the most recent months, we estimate claim costs incurred by applying observed medical cost trend factors to the average per consumer per month medical costs incurred in prior months for which more complete claim data is available, supplemented by a review of near-term completion factors. For months prior to the most recent months, we apply the completion factors to actual claims adjudicated-to-date to estimate the expected amount of ultimate incurred claims for those months. These estimates may change as actuarial methods change or as underlying facts upon which the estimates are based change. Management believes the amount of medical costs payable is the best estimate of our liability as of December 31, 2022 December 31, 2023; however, actual payments may differ from those established estimates. Note 10, 4, *Medical Costs Payable*, discusses the development of paid and incurred claims and provides a rollforward of medical costs payable.

We contract with hospitals, physicians and other providers of health care primarily within our exclusive provider networks under discounted fee-for-service arrangements, including case rates and hospital per diems, and capitated agreements to provide medical care to enrollees. Dental, vision, and other supplemental medical services are provided to consumers under capitated arrangements, and these providers are at risk for the cost of medical care services provided to our enrollees; however, we are ultimately responsible for the provision of services should the capitated provider be unable to provide the contracted services.

Quality incentive and shared savings payables to providers are calculated under the contractual terms of each respective agreement. Medical costs payable included $37.8 million $2.4 million and $74.2 million $11.2 million under these contracts at December 31, 2022 December 31, 2023 and 2021, 2022, respectively.

We estimated a claims adjustment expense liability of $10.6 million and $5.1 million as of December 31, 2022 and 2021, respectively, based on historical cost of claims adjudication.

Cash and Cash Equivalents: Cash and cash equivalents include cash and investments with original maturities of three months or less when purchased. as of the reporting date.

Investments: We invest in equity securities and debt securities of the U.S. government and other government agencies, corporate investment grade, money market funds and various other securities. certificates of deposit.

We determine the appropriate classification of investments at the time they are acquired and evaluate the appropriateness of such classifications at each balance sheet date. We classify our investments in individual debt securities as available-for-sale securities or held-to-maturity securities. All available-for-sale investments maturing less than one year from the statement date that management intends to liquidate within the next year are reflected as short-term investments. Available-for-sale investments with a maturity date greater than one year are classified as long-term investments. All available-for-sale investments are measured and carried at fair value. Changes in unrealized holding gains and losses on available-for-sale securities are reflected in other comprehensive income (loss).

Equity investments are classified as short-term investments and measured and carried at fair value. The changes in fair value of our equity securities are reflected in investment income within our Consolidated Statements of Income (Loss).

Realized gains and losses for all investments are included in investment income. The basis for determining realized gains and losses is the specific-identification method. Interest on debt securities is recognized in investment income when earned. Premiums and discounts are amortized/accreted using methods that result in a constant yield over the securities' expected lives.

Beginning January 1, 2020, we adopted the new current expected credit losses (“CECL”) model. The CECL model retained many similarities from the previous OTTI model, except it eliminated the length of time over which the fair value had been less than cost from consideration in the impairment analysis. Also, under the CECL model, expected losses on available-for-sale debt securities are recognized through an allowance for credit losses rather than as a reduction in the amortized cost of the securities. For debt securities whose fair value is less than their amortized cost which we do not intend to sell or are not required to sell, we evaluate the expected cash flows to be received as compared to amortized cost and determine if an expected credit loss has occurred. In the event of an expected credit loss, only the amount of the impairment associated with the expected credit loss is recognized in income with the remainder, if any, of the loss recognized in other comprehensive income (loss). To the extent we have the intent to sell the debt security, or it is more likely than not we will be required to sell the debt security, before recovery of our amortized cost basis, we recognize an impairment loss in income in an amount equal to the full difference between the amortized cost basis and the fair value.

Potential expected credit loss impairment is considered using a variety of factors, including the extent to which the fair value has been less than cost; adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a debt security; changes in the quality of the debt security's credit enhancement; payment structure of the debt security; changes in credit rating of the debt security by the rating agencies; failure of the issuer to make scheduled principal or interest payments on the debt security and changes in prepayment speeds. For debt securities, we take into account expectations of relevant market and economic data. We estimate the amount of the expected credit loss component of a debt security as the difference between the amortized cost and the present value of the expected cash flows of the security. The present value is determined using the best estimate of future cash flows discounted at the implicit interest rate at the date of purchase. The expected credit loss cannot exceed the full difference between the amortized cost basis and the fair value.

Accrued interest receivable relating to our debt securities is presented within prepaids and other current assets in the accompanying Consolidated Balance Sheets. We do not measure an allowance for credit losses on accrued interest receivable. We recognize interest receivable write offs as a reversal of interest income. No accrued interest was written off during the years ended December 31, 2021 and 2020.

Credit Risk Concentration: We maintain cash in bank accounts that frequently exceed federally insured limits. To date, we have not experienced any losses on such accounts.

Restricted Investments and Statutory Deposits: Investments: We hold pledged certificates of deposit for certain vendors and lease requirements. Restricted investments are carried at amortized cost. At December 31, 2022 December 31, 2023 and 2021, 2022, pledged certificates of deposit totaled $1.9 million $8.1 million and $1.4 million $3.8 million, respectively, and are included in short-term investments in the Consolidated Balance Sheets.

The regulated insurance entities of Bright Health are required to, among other things, hold certain statutory deposits cash and comply with certain minimum capital requirements, such as risk-based capital requirements, under applicable state regulations, as further described in Note 17, *Commitments and Contingencies*. Statutory deposits are classified as held-to-maturity investments and are carried at cost. The Company's regulated legal entities held the required deposit amounts at December 31, 2022 and 2021, totaling $9.1 million and $1.4 million, respectively. The statutory deposits are principally held in U.S. Treasury securities within a custodial or controlled account with a custodial trustee and are included primarily in short-term investments and long-term investments, consistent with classification of other similar invested assets, cash equivalents in the Consolidated Balance Sheets.

Accounts Receivable, Net of Allowance: Receivables are reported net of amounts for expected credit loss. The allowance for doubtful accounts is based on historical collection trends, future forecasts and our judgment regarding the ability to collect specific accounts. Accounts receivable include unpaid health insurance premiums from consumers and government sponsors. Balances are carried at original invoice amount less an estimate contractual allowances, implicit price concessions, and estimates made for doubtful accounts based on a review of all outstanding amounts on a monthly basis. Management determines the allowance for doubtful accounts by regularly evaluating individual customer receivables and considering a

customer's financial condition and credit history, and current economic conditions. Accounts receivable are written off when deemed uncollectible. Recoveries of accounts receivable previously written off are

recorded when received. At December 31, 2022 December 31, 2023 and 2021, 2022, accounts receivable was reported net of allowance of $14.0 million and $6.1 million, and $3.4 million, respectively.

Bad Debt Expense: During the year ended December 31, 2023, we recorded bad debt expense of $27.4 million. Our bad debt expense primarily related to one of our ACO REACH care partners filing for bankruptcy during the year ended December 31, 2023. During the year ended December 31, 2022, our bad debt expense was comprised of the allowance recorded per our current expected credit loss policy. There were no similar instances of provider or care partner credit losses during the year ended December 31, 2022.

Reinsurance Recoveries: We seek to limit the risk of loss on insurance our ACO REACH contracts through the use of reinsurance agreements. These agreements do not relieve us of our primary obligation obligations. Refer to policyholders. Note 17, *ACO REACH* for additional explanation of our arrangements to mitigate risk.

We have an agreement with Swiss Re Life & Health America, Inc. ("Swiss Re") in which Swiss Re provides excess loss reinsurance coverage to the Company on individuals covered under our individual and small group policies. Effective January 1, 2021 we entered an agreement with RGA Reinsurance Company ("RGA")("Barbados") in which RGA provides loss reinsurance coverage to the Company on individuals covered under our MA polices.

Receivables from reinsurers under these agreements totaled $14.9 million and $3.4 million as of December 31, 2022 and 2021, respectively, and are recorded in prepaids and other current assets in the Consolidated Balance Sheets. Payables for reinsurance premiums and ceding fees of $4.7 million and $9.8 million are recorded as other current liabilities in the Consolidated Balance Sheets as of December 31, 2022 and 2021, respectively.

Net reinsurance recoveries (net ceded premiums) of $9.5 million, $(1.5) million, and $4.0 million were recorded as a reduction of medical costs in the Consolidated Statements of Income (Loss) for the years ended December 31, 2022, 2021, and 2020, respectively. In addition, quota share ceding fees and reimbursable administrative expenses under reinsurance contracts recorded as operating costs in the Consolidated Statements of Income (Loss) totaled $— million; $0.6 million; and $1.5 million for the years ended December 31, 2022, 2021, and 2020 respectively.

ACO REACH Provider Risk Sharing: Our MA insurance business We have provider risk sharing agreements in California maintains a risk-sharing program place for our ACO REACH arrangements with contracted primary care providers Participating Providers. The accounting for provider risk share arrangements involves estimation given the inherent uncertainties involved in measuring current performance due to the significant lag time for items like claims run-out. Changes to these estimates over time have the potential to impact our financial results and hospitals. Additionally, agreements between our provider practices and insurers contain risk-sharing provisions based on the terms of the contracts.

Additional revenues which we estimate to be earned or payments we expect to make under these arrangements are recorded in prepaids and other current assets or medical costs payable, respectively, in the Consolidated Balance Sheets. overall performance.

Risk sharing payables The ACO REACH Model incentivizes participating providers to manage the total cost of $30.6 million care of the Medicare fee-for-service ("FFS") population aligned to their corresponding REACH ACO. Our REACH ACOs contract directly with CMS to assume the total costs of care risk for Medicare FFS beneficiaries attributed to our Participating Providers within our ACOs. Annually, after a runout period, CMS will perform a settlement process to determine if CMS owes the REACH ACOs payment for surplus (benchmark revenue exceeds actual claim costs incurred for the ACOs attributed beneficiaries) or if the REACH ACO must reimburse CMS for deficits (claim costs incurred for ACO's attributed beneficiaries exceeds the benchmark revenue). We recognize the expected settlement when it becomes both probable and $68.5 million for our MA insurance business in California and risk-sharing receivables of $17.8 million and $12.7 million for agreements between our provider practices and insurers were recorded as of December 31, 2022 and 2021, respectively. estimable.

Premium Deficiency Reserve: Premium deficiency reserve ("PDR") liabilities are established when it is probable that Our REACH ACOs contract separately with each of our Participating Provider groups. The terms of these contracts vary including the amount of upside (surplus) and downside (deficit) risk the Participating Provider has agreed to assume for aligned beneficiaries and administrative fees charged by the Participating Provider and REACH ACO. Payments to Participating Providers under these contracts increase NeueHealth's medical costs. Administrative fees charged, and deficits expected future claims and maintenance expenses will exceed future premium and reinsurance recoveries on existing to be recovered from Provider Partners under these contracts result in a decrease in medical insurance contracts, including consideration of investment income. We assess if a PDR liability is needed through review of current results and forecasts. For purposes of determining premium deficiency losses, contracts are grouped consistent with our method of acquiring, servicing, and measuring the profitability of such contracts. As of December 31, 2022 we accrued no PDR liability; as of December 31, 2021 we accrued a PDR liability of $9.4 million in other current liabilities.costs.

Prepaids and Other Current Assets: Prepaids and other current assets primarily include prepaid operating expenses, pharmacy rebates receivable and, as of December 31, 2020, the escrow receivable related to business acquisitions as further described in Note 3, *Business Combinations*. expenses.

Performance Guarantees: Through our participation in the DC ACO REACH Model, we determined that our arrangements with the providers of our DCE aligned beneficiaries require us to guarantee their performance to CMS. We recognized our obligation to guarantee their performance for the duration of the performance year on the Consolidated Balance Sheets. As we fulfill our obligation, we ratably amortize the guarantee for the amount that represents the completed portion of the performance obligation as Direct Contracting ACO REACH revenue on the Consolidated Statements of Income (Loss). Direct Contracting ACO REACH revenue is derived from the estimated annual sum of the capitation payments made to the DCEs REACH ACOs for services within the scope of the capitation arrangement with CMS and fee-for-service ("FFS") FFS payments from CMS made directly to third-party providers for our aligned beneficiaries. For each performance year, the final consideration due to the DCEs REACH ACOs by CMS (shared savings) or the consideration due to CMS by the DCEs REACH ACOs (shared loss) is reconciled in the year following the performance year. Periodically during the performance year, CMS will measure the shared savings or loss and adjust the performance benchmark and thus the remaining performance obligation if we are in a probable shared loss position.

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Property, Equipment and Capitalized Software: Property, equipment and capitalized software are stated at cost less accumulated depreciation and amortization. Depreciation and amortization are recognized using the straight-line method over the estimated useful life, ranging from 3 yearsto 10 years. years. Leasehold improvements are depreciated over the shorter of the lease term or their useful life. We capitalize costs incurred during the application development stage related to certain software projects for internal use incurred during the application development stage. use. Costs related to planning activities and post implementation activities are expensed as incurred.

Impairment of Long-Lived Assets: Property, equipment, capitalized software and other long-lived assets are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. When evaluating long-lived assets with impairment indicators for potential impairment, we first compare the carrying value of the

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asset to its estimated undiscounted future cash flows. If the sum of the estimated undiscounted future cash flows is less than the carrying value of the asset, we calculate an impairment loss. The impairment loss calculation compares the carrying value of the asset to its estimated fair value, which is typically based on estimated discounted future cash flows. We recognize an impairment loss if in the amount of the asset's carrying value exceeds the asset's estimated fair value. During the year ended December 31, 2022, December 31, 2023 we recorded an impairment loss to on long-lived assets of $43.5 million as a result of Bright HealthCare's decision to no longer offer commercial products for the 2023 plan year and our exit of select MA marketplaces. $1.2 million. There was no long-lived asset impairment within our continuing operations during the year ended December 31, 2022. Long-lived asset impairment expense is recognized in operating costs in the Consolidated Statements of long-lived assets for the years ended December 31, 2021 and 2020. Income (Loss).

Operating Leases: We lease facilities and equipment under long-term operating leases that are non-cancelable and expire on various dates. At the lease commencement date, lease right-of-use ("ROU") assets and lease liabilities are recognized based on the present value of the future minimum lease payments over the lease term, which includes all fixed

obligations arising from the lease contract. We include options to extend or terminate an operating lease in the measurement of the ROU asset and lease liability when it is reasonably certain that such options will be exercised. For operating leases, the liability is amortized using the effective interest method and the asset is reduced in a manner so that rent is expensed on a straight-line basis, with all cash flows included within operating activities in the Consolidated Statements of Cash Flows. Rent expense for operating leases is recognized on a straight-line basis over the lease term, net of any applicable lease incentives. Lease expense for minimum lease payments is recognized on a straight-line basis over the lease term.

When an interest rate is not implicit in a lease, we utilize our incremental borrowing rate for a period that closely matches the lease term. We determine our incremental borrowing rate as the interest rate needed to finance a similar asset over a similar period of time as the lease term. Our ROU assets are included in other non-current assets, and lease liabilities are included in other current liabilities and other liabilities in the Consolidated Balance Sheets.

We have elected the short-term lease exception for all classes of assets and do not apply recognition requirements for leases of 12 months or less. Expense related to short-term leases of 12 months or less is recognized on a straight-line basis over the lease term. See Note 17, 14, *Commitments and Contingencies*, for additional information on our operating leases.

Goodwill and Other Intangible Assets: Goodwill represents the excess of the purchase price over the fair value of identifiable net assets acquired in a business combination. We test goodwill for impairment annually at the beginning of the fourth quarter or whenever events or circumstances indicate the carrying value may not be recoverable. We test for goodwill impairment at the reporting unit level. Reporting units are determined by identifying components of operating segments which constitute businesses for which discrete financial information is available and regularly reviewed by segment management. We have two reporting units – Bright HealthCare NeueCare and Consumer Care – with NeueSolutions. The NeueCare reporting unit had allocated goodwill subject to our annual impairment test while the NeueSolutions reporting unit had no allocated to each of the reporting units. goodwill.

Our goodwill impairment testing involves a multi-step process. We may first assess qualitative factors to determine if it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. We may also elect to skip the qualitative assessment and proceed directly to the quantitative testing. When performing the quantitative testing, we calculate the fair value of the reporting unit and compare it with its carrying value, including goodwill. We estimate the fair values of our reporting units using a combination of discounted cash flows and comparable market multiples, which include assumptions about a wide variety of internal and external factors. We recognized a non-cash impairment loss of $70.0 million Due to the decline in our Bright HealthCare reporting unit stock price and a $1.2 million market capitalization, we fully impaired the NeueCare assigned goodwill disposition related to our Consumer Care reporting unit for the year ended December 31, 2022. worth $401.4 million. There was no goodwill impairment within our continuing operations during the years year ended December 31, 2021 and 2020.December 31, 2022.

Our valuation of identifiable intangible assets acquired is based on information and assumptions available to us at the time of acquisition, using income and market approaches to determine fair value, as appropriate. Intangible assets are amortized over their estimated useful lives using the straight-line method.

Identifiable intangible assets are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. When evaluating intangible assets with impairment indicators for potential impairment, we first compare the carrying value of the asset to its estimated undiscounted future cash flows. If the sum of the estimated undiscounted future cash flows is less than the carrying value of the asset, we calculate an impairment loss. The impairment loss calculation compares the carrying value of the asset to its estimated fair value, which is typically based on estimated discounted future cash flows. We recognize an impairment loss in the amount of the asset's carrying value exceeds

their the asset's estimated useful lives using fair value. There was no intangible asset impairment within our continuing operations during the straight-line method. We evaluate year ended December 31, 2023. During the recoverability of identifiable year ended December 31, 2022 we recorded an impairment loss on intangible assets whenever events or changes in circumstances indicate that an intangible asset's carrying amount may not be recoverable. of $42.6 million, which related to a full impairment of Centrum Medical Holdings' reacquired contract with Bright HealthCare Florida as a result of Bright HealthCare's decision to no longer offer commercial products for the 2023 plan year and our exit of select MA marketplaces.

Operating Costs: Operating costs are recognized as incurred and relate to selling, general and administrative costs not related to medical costs. Additionally, the expense from the change in our PDR liability is included in operating costs. Policy acquisition costs, other than capitalized broker commissions, are expensed in the period incurred. Our operating costs, by functional classification for the years ended December 31, 2022 December 31, 2023, 2021 and 2020, 2022, are as follows *(in thousands)*:

	2022	2021	2020		
2023				**2023**	**2022**
Compensation and fringe benefits	**$355,084**	$257,815	$ 92,863	Compensation and fringe benefits	
Professional fees	**69,711**	70,472	50,699	Professional fees	
Marketing and selling expenses	**82,340**	76,923	34,561		

Premium taxes and fees		**4,288**	5,801	1,182
Premium deficiency reserve		**(9,357)**	9,357	—
Technology expenses				
General and administrative expenses	General and administrative expenses	**77,045**	60,266	25,409
Other operating expenses	Other operating expenses	**52,919**	46,819	20,349
Total operating costs	Total operating costs	**$632,030**	$527,453	$225,063

Share-Based Compensation: We recognize compensation expense for share-based awards, including stock options, restricted stock units ("RSUs"), and performance-based restricted stock units ("PSUs") and restricted stock awards ("RSAs") on a straight-line basis over the related service period (generally the vesting period) of the award. Compensation expense related to stock options is based on the fair value on the date of grant, which is estimated using a Black-Scholes option valuation model. The fair value of RSUs is determined based on the closing market price of our common stock on the date of grant and the fair value of PSUs is determined using a Monte-Carlo simulation. Share-based compensation expense is recognized in operating costs in the Consolidated Statements of Income (Loss).

Income Taxes: The federal income tax returns of Bright Health NeueHealth are completed as a consolidated return. A tax-sharing agreement allocates the consolidated federal tax liability to each company in proportion to the tax liability that would have resulted for each company if computed on a separate return basis.

Deferred taxes are provided on a liability method, whereby deferred tax assets are recognized for deductible temporary differences and operating loss and tax credit carryforwards, and deferred tax liabilities are recognized for taxable temporary differences. Temporary differences are the differences between the reported amounts of assets and liabilities and their tax bases. Deferred tax assets are reduced by a valuation allowance when, in the opinion of management, it is more likely than not that some portion or all of the deferred tax assets will not be realized. Deferred tax assets and liabilities are adjusted for the effects of changes in tax laws and rates on the date of enactment.

We recognize the tax benefit from an uncertain tax position only if it is more likely than not that the tax position will be sustained on examination by taxing authorities, based on the technical merits of the position. The tax benefits recognized in the consolidated financial statements from such a position are measured based on the largest benefit that has a greater than 50% likelihood of being realized upon ultimate settlement. The guidance on accounting for uncertainty in income taxes also addresses derecognition, classification, interest and penalties on income taxes, and accounting in interim periods. Management evaluated the Company's tax positions and concluded that for the years ended December 31, 2022, 2021 December 31, 2023 and 2020, 2022, the Company had taken no uncertain tax positions that require adjustment to the consolidated financial statements to comply with the provisions of this guidance. As of the consolidated financial statement date, open tax years subject to potential audit by the taxing authorities are 2019 2020 through 2021 2022 for the federal tax returns and 2018 2019 through 2021 2022 for the state tax returns. We recognize interest and penalties related to income tax matters in income tax expense (benefit).

Redeemable Noncontrolling Interest: Redeemable noncontrolling interest in our subsidiaries whose redemption is outside of our control are classified as temporary equity.

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Net Loss loss per Share: Basic net loss per share attributable to common stockholders is computed by dividing the net loss attributable to common stockholders by the weighted average number of shares of common stock outstanding for the period. Diluted net loss attributable to common stockholders is computed by adjusting net losses attributable to common stockholders to reallocate undistributed earnings based on the potential impact of dilutive securities. Diluted net loss per share attributable to common stockholders is computed by dividing the diluted net loss attributable to common stockholders by the weighted average number of shares of common stock outstanding for the period, including potential dilutive common shares.

Going Concern: The consolidated financial statements have been prepared in accordance with GAAP applicable to a going concern, which contemplates the realization of assets and the satisfaction of liabilities in the normal course of business.

The Company has a history of operating losses, and we generated a net loss from continuing operations of $638.0 million$1.3 billion for the year ended December 31, 2022December 31, 2023. These losses, as well as significant additional expenses and future projected Additionally, the Company experienced negative operating cash outflows in flows primarily related to our discontinued Bright HealthCare – Commercial segment has required for the Company year ended December 31, 2023, requiring additional cash to infuse additional cash be infused to satisfy statutory capital requirements requirements. The Company paid $1.5 billion of 2022 related risk adjustment obligations in September 2023, and reduced certain of its insurance subsidiaries entered into repayment agreements for an aggregate amount of $380.2 million with the Centers for Medicare & Medicaid Services' ("CMS") with respect to the unpaid amount of risk adjustment obligations. The amount owing under the repayment agreements is due March 15, 2025 and bears interest at a rate of 11.5% per annum. As further described in Note 18, Deconsolidation of Bright Healthcare Insurance Company of Texas, on November 29, 2023, Bright Healthcare Insurance Company of Texas was placed into liquidation and the Texas Department of Insurance was appointed as receiver. Of the $380.8 million of risk adjustment repayment

liabilities, $89.6 million of this relates to Bright Healthcare Insurance Company of Texas, leaving $291.1 million as a risk adjustment obligation of the Company and is due within one year following the date the consolidated financial statements are issued. The Company's IFP discontinued operations also continue to experience negative cash available flows through the fourth quarter of 2023 as it continues to fund operations. pay out the remaining inventory of medical claims.

In addition, We consummated the Company's $350.0 sale of our California Medicare Advantage business in January 2024, resulting in net proceeds of $31.6 million revolving after debt repayment of $274.6 million, cash collateralization of existing letters of credit agreement with a syndicate of banks (the "Credit Agreement"), matures on February 28, 2024. On March 1, 2023 $24.1 million, contingent consideration of $110.0 million, estimated net equity adjustment of $57.3 million and other transaction related fees. See Note 5, *Short-Term Borrowings* for further details around the debt repayment. Further, as described in Note 6, *Long-Term Borrowings and Common Stock Warrants*, the Company disclosed that entered into the New Credit Agreement in 2023 and borrowed a total of $66.4 million as of December 31, 2023. While payment isn't due for more than 12 months, there are no additional amounts currently available for borrowing in these agreements.

Cash and investment balances held at regulated insurance entities are subject to regulatory restrictions and can only be accessed through dividends declared to the non-regulated parent company or through reimbursements from administrative services agreements with the parent company. The Company declared no dividends from the regulated insurance entities to the parent company during the First Quarter year ended December 31, 2023. The regulated legal entities are required to hold certain minimum levels of 2023, the Company breached the minimum liquidity covenant of the Credit Agreement. The Company entered into a limited waiver risk-based capital and consent (the "Waiver") under the Credit Agreement, which, among other matters, provides for a temporary waiver for the period from January 25, 2023 through April 30, 2023 (the "Waiver Period") surplus to meet regulatory requirements. As noted further in Note 19, *Discontinued Operations*, we are out of compliance with the minimum liquidity covenant set forth levels for certain of our regulated insurance legal entities. In certain of our other regulated insurance legal entities, we hold surplus levels of risk-based capital, and as we complete the wind-down exercise related to these entities over the next two years, we expect to recapture through dividends and final liquidation actions approximately $110.0 million of cash held in Section 11.12.2 other regulated insurance legal entities as of December 31, 2023. On February 28, 2024, we obtained approval in two states to execute a total of $13.1 million of dividends.

We believe that the Credit Agreement. During the Waiver Period, the Company will be subject to a minimum liquidity covenant of not less than $75 million until March 3, 2023, existing cash on hand and not less than $85 million thereafter until the end of the Waiver Period. In addition, during the Waiver Period, the Company investments will not have access be sufficient to certain negative covenant baskets and will be subject to additional cash-flow and satisfy our anticipated cash balance reporting requirements. Based on our projected cash flows and absent any other action, requirements for the Company may not meet certain covenants under the Credit Agreement or the Waiver which may result in the obligations under the Credit Agreement being accelerated. The Company will require additional liquidity to meet its obligations as they come due in the 12 next twelve months following the date the consolidated financial statements contained in this Annual Report are issued. issued, for items such as IFP risk adjustment payables, medical costs payable, remaining obligation to the deconsolidated entity, and other liabilities. These conditions raise substantial doubt about the Company's ability to continue as a going concern.

In response to these conditions, management has implemented a restructuring plan to reduce capital needs and our operating expenses in the future to drive positive operating cash flow and increase liquidity. The Company's Bright HealthCare business has exited the Commercial marketplace at the end of the 2022 plan year and is focusing on its Medicare Advantage business in California. This exit will impact all insurance products currently offered by the Company in all states where insurance policies are currently offered. In addition to our market exits, management is in the process of implementing additional restructuring activities, which include reducing our workforce, exiting excess office space, and terminating or restructuring contracts. The Company also closed on a $175.0 million capital raise in October 2022 to capitalize our continuing operations as further described in Note 12, Preferred Stock.

Additionally, the Company is actively engaged with the Board of Directors and outside advisors to evaluate additional financing. However, the Company may not fully collect the contingent consideration associated with the sale of the California Medicare Advantage business or be able to obtain financing on acceptable terms, as any potential financing both of these matters will be subject to market conditions that are not fully within the Company's control.

In the event the Company is unable to obtain additional financing or take other management actions, among other potential consequences, we forecast the Company forecasts we will be unable to satisfy our obligations. As a result, the Company has

concluded that management's plans do not alleviate substantial doubt about the Company's ability to continue as a going concern.

The consolidated financial statements do not include any adjustments relating to the recoverability and classification of recorded asset amounts or the amounts and classification of liabilities that might result from the outcome of this uncertainty.

Recently Issued and Adopted Accounting Pronouncements: In August 2020, November 2023, the FASB issued Accounting Standards Update ("ASU") No. 2020-06, *Debt—Debt 2023-07, Improvements to Reportable Segment Disclosures, which will require disclosure of incremental segment information on an annual and interim basis for all public entities. The amendments do not change how a public entity identifies its operating segments, aggregates those operating segments, or applies the quantitative thresholds to determine its reportable segments. ASU 2023-07 is effective for annual reporting beginning with Conversion the fiscal year ending December 31, 2024, and Other Options (Subtopic 470-20) and Derivatives and Hedging—Contracts for interim periods thereafter. We are currently evaluating the incremental disclosures that will be required in Entity's Own Equity (Subtopic 815-40): Accounting for Convertible Instruments and Contracts in an Entity's Own Equity* ("ASU 2020-06"), which simplifies the accounting for convertible instruments by reducing the number of accounting models available for convertible debt instruments. This guidance eliminates the treasury stock method footnotes to calculate diluted earnings per share for convertible instruments and requires the use of the if-converted method. We adopted ASU 2020-06 on January 1, 2022. The adoption did not have a material impact on our consolidated financial condition, results of operations or cash flows. statements.

There were no other accounting pronouncements that were recently issued and not yet adopted or adopted that had, or are expected to have, a material impact on our consolidated financial position, results of operations, or cash flows.

NOTE 3. BUSINESS COMBINATIONS

Centrum Acquisition: On July 1, 2021, we acquired 75% of the outstanding equity interests of Centrum for cash consideration of $222.4 million and $75.0 million of common stock, for total purchase consideration of $296.2 million, net of $1.2 million of cash acquired. Centrum is a value-based primary care focused, multi-specialty medical group based in Florida. Centrum primarily operates health centers in Florida and Texas serving Commercial, Medicare, and Medicaid consumers across multiple payors. Centrum is included in our Consumer Care reportable segment.

The total purchase consideration for the Centrum acquisition is allocated to tangible and intangible assets acquired and liabilities assumed based on their respective fair values as of the acquisition date. The excess of the purchase price over the net assets acquired is recorded as goodwill, which is predominantly attributable to the incremental financial benefits achievable through Bright Health Group's integrated care delivery model, whereby Bright HealthCare members are cared for under value-based arrangements with Centrum. This model brings together the financing, distribution, and delivery of high-quality healthcare and provides the opportunity to enhance overall margin potential for the Company. The goodwill from the Centrum acquisition is deductible for tax purposes.

The following table discloses the fair values of assets and liabilities acquired by the Company in the Centrum acquisition *(in thousands)*:

Accounts receivable	$	1,874
Prepaids and other current assets		627
Property and equipment		2,557
Intangible assets		102,370
Other assets		8,917
Total assets		116,345
Medical payables		19
Accounts payable		359
Other current liabilities		861
Other liabilities		11,636
Total liabilities		12,875
Net identified assets acquired		103,470
Goodwill		275,066
Redeemable noncontrolling interest		(82,310)
Total purchase consideration	$	296,226

Our intangible assets related to the Centrum acquisition consist of trade names with a 15-year useful life, customer relationships with 2 to 15-year useful lives, and a reacquired contract between Bright HealthCare and Centrum with a useful life of 4.5 years. In the third quarter of 2022, we fully impaired the reacquired contract as a result of our decision to no longer offer commercial products for the 2023 plan year. The value of the trade name was determined using the relief of royalty method and the excess earnings method was used to value the customer relationships; both methods are considered Level 3 fair value measurements. The fair value of noncontrolling interest was determined using a market approach and included a discount to account for the lack of marketability of the noncontrolling interest.

The acquisition of Centrum would not have had a material impact on our revenue or net loss from continuing operations had it been included in the consolidated results of the Company for the year ended December 31, 2021.

Central Health Plan Acquisition: On April 1, 2021, we acquired all of the outstanding shares of CHP for cash consideration of $276.0 million, $79.8 million in Series E preferred stock and $13.9 million of estimated working capital adjustments, for total purchase consideration of $285.6 million, net of $84.1 million of cash acquired. CHP is an insurance provider of MA HMO services. CHP is included in our Bright HealthCare reportable segment.

The total purchase consideration for the CHP acquisition is allocated to tangible and intangible assets acquired and liabilities assumed based on their respective fair values as of the acquisition date. The excess of the purchase price over the net assets acquired is recorded as goodwill. The goodwill for CHP is attributable to synergies from leveraging CHP's clinical model and California consumer expertise to continue to expand our MA business in the California market. The goodwill is not deductible for tax purposes.

The following table discloses the fair values of assets and liabilities acquired by the Company in the CHP acquisition *(in thousands)*:

Accounts receivable	$	17,240
Short-term investments		19,041
Prepaids and other current assets		25,530
Property and equipment		370
Intangible assets		102,000
Other assets		1,249
Total assets		165,430
Medical costs payable		75,643
Accounts payable		2,371
Other current liabilities		7,984
Other liabilities		26,275
Total liabilities		112,273
Net identified assets acquired		53,157
Goodwill		232,442
Total purchase consideration	$	285,599

Our intangible assets related to the CHP acquisition consists of customer relationships with a 10-year useful life, trade names with a 15-year useful life and the provider network with a 7-year useful life. The value of the trade name was determined using the relief from royalty method and the excess earnings method was used to value the customer relationships; both methods are considered Level 3 fair value measurements.

If CHP had been included in the consolidated results of the Company for the year ended December 31, 2021, our pro forma revenue from continuing operations would have been $1.6 billion and our pro forma net loss from continuing operations would have been $311.7 million.

True Health New Mexico and Zipnosis Acquisitions: On March 31, 2021, we acquired all of the outstanding equity interests of THNM for cash consideration of $27.5 million, and $8.1 million of favorable risk-based capital adjustments, net of cash acquired of $24.1 million, for total purchase consideration of $(4.7) million. THNM is a physician-led health insurance company offering policies available through the commercial market for individual on- and off-exchange and employer-sponsored health coverage. THNM is included in our discontinued operations. In addition, on March 31, 2021, we acquired Zipnosis, Inc. ("Zipnosis"), which is a telehealth platform that offers virtual care to health systems around the U.S., for aggregate consideration of $73.0 million, including $55.1 million in Series E preferred stock and adjusted for $0.5 million of tangible net equity adjustments. We acquired $3.2 million of cash as part of the Zipnosis acquisition, for net total purchase consideration of $69.8 million. Zipnosis is included in our Consumer Care reportable segment.

The total purchase consideration for the THNM and Zipnosis acquisitions is allocated to tangible and intangible assets acquired and liabilities assumed based on their respective fair values as of the acquisition date. The excess of the purchase price over the net assets acquired is recorded as goodwill. The goodwill for THNM is attributable to synergies from leveraging THNM's

strong local clinical model of care and the ability to enter into a new state of strategic interest for future growth and expansion. The goodwill from the Zipnosis acquisition is attributable to benefits from the ability to enhance our proprietary technology platform, DocSquad, and Zipnosis' attractive virtual care capabilities to enhance Bright Health's consumer and provider connectivity. The goodwill from the THNM and Zipnosis acquisitions is not deductible for tax purposes.

The following table discloses the fair values of assets and liabilities acquired by the Company in the THNM and Zipnosis acquisitions *(in thousands)*:

	THNM	Zipnosis

Accounts receivable	$ 714	$ 1,062
Short-term investments	4,705	—
Prepaids and other current assets	8,337	141
Property and equipment	—	232
Intangible assets	7,300	9,180
Long-term investments	13,644	—
Other non-current assets	1,324	766
Total assets	36,024	11,381
Medical costs payable	12,617	—
Accounts payable	14,663	136
Unearned revenue	3,645	120
Other current liabilities	11,406	665
Other liabilities	2,499	2,730
Total liabilities	44,830	3,651
Net identified assets acquired	(8,806)	7,730
Goodwill	4,148	62,067
Total purchase consideration	$ (4,658)	$ 69,797

Intangible assets initially recognized related to the THNM acquisition consisted of customer relationships with 10-to 14-year useful lives, trade names with a 15-year useful life and the provider network with a 7-year useful life. In the first quarter of 2022, we fully impaired the intangible assets related to THNM as a result of our decision to no longer offer Commercial products in New Mexico for the 2023 plan year and exit the employer business as contracts expire. For the Zipnosis acquisition, our preliminary estimate of intangible assets consists of customer relationships with a 15-year useful life, trade names with a 5-year useful life and developed technology with a 7-year useful life. For these acquisitions the value of the trade names and developed technology was determined using the relief from royalty method and the excess earnings method was used to value the customer relationships; both methods are considered Level 3 fair value measurements.

If THNM and Zipnosis had been included in the consolidated results of the Company for the year ended December 31, 2021, our pro forma revenue from continuing operations would have been $1.5 billion and our pro forma net loss from continuing operations would have been $324.2 million.

PMA Acquisition: On December 31, 2020, we acquired a 62% controlling interest in PMA in exchange for $59.6 million in cash and $17.8 million in Bright Health Series E preferred stock for total purchase consideration transferred, net of cash acquired of $3.2 million, of $74.2 million. PMA provides care services to Medicare and Medicaid patients in Florida through a network of primary care providers and population health-focused specialists. Transaction costs of $0.7 million incurred in connection with the acquisition are included in operating costs in the Consolidated Statements of Income (Loss) for the year ended December 31, 2021. If PMA had been included in the consolidated results of the Company for the year ended December 31, 2020, our pro forma revenue would have been $1.3 billion, and our pro forma net loss would have been $(239.9) million.

The total purchase consideration for the PMA acquisition was allocated to tangible and intangible assets acquired and liabilities assumed based on their respective fair values as of the acquisition date. The excess of the purchase price over the net assets acquired was recorded as goodwill. The goodwill is attributable to benefits from the ability to enhance our clinical capabilities

to better serve enrollees as part of our Florida market expansion. The full amount of goodwill from the PMA acquisition is expected to be deductible for tax purposes.

The following table discloses the fair values of assets and liabilities acquired by the Company in the PMA acquisition *(in thousands)*:

Accounts receivable	$	10,238
Prepaids and other current assets		76
Property and equipment		1,071
Intangible assets		66,300
Other non-current assets		6,468
Total Assets		84,153
Medical costs payable		6,973
Other current liabilities		3,004
Other liabilities		5,534
Total liabilities		15,511
Net identified assets acquired		68,642
Goodwill		45,142
Redeemable noncontrolling interest		(39,600)
Total purchase consideration	$	74,184

We recognized intangible assets related to the PMA acquisition, which consist of the PMA trade name of $5.8 million with an estimated useful life of 15 years and customer relationships valued at $60.5 million with 7 to 10 year useful lives. The value of the trade name was determined using the relief from royalty method and the excess earnings method was used to value the customer relationships, both approaches are considered Level 3 fair value measurements. The fair value of the noncontrolling interest was determined using an income approach and market approach and included a discount to account for the lack of marketability of the noncontrolling interest shares.

BND Acquisition: On April 30, 2020, we acquired all of the outstanding shares of BND. BND is a leader in providing healthcare services in California and serves Medicare eligible seniors and special needs populations through their extensive network of primary care providers and specialists. BND combines analytics and evidence-based clinical programs with aligned provider relationships to provide high quality, affordable care for complex and vulnerable populations. The total consideration included $206.9 million in cash and $80.0 million in Bright Health Series D preferred stock. We have since applied indemnity escrow adjustments of $44.0 million to the acquisition price, bringing total consideration to $210.1 million, net of cash acquired of $32.8 million. Transaction costs of $3.8 million incurred in connection with the acquisition are included in operating costs in the Consolidated Statements of Income (Loss) for the year ended December 31, 2020. If BND had been included in the consolidated results of the Company for the year ended December 31, 2020, our pro forma revenue would have been $1.4 billion, and our pro forma net loss would have been $(264.4) million.

The total purchase consideration for the BND acquisition was allocated to tangible and intangible assets acquired and liabilities assumed based on their respective fair values as of the acquisition date. The excess of the purchase price over the net assets acquired was recorded as goodwill. The goodwill is attributable to synergies from leveraging BND's strong clinical model of care to drive growth in our MA business outside of California. The goodwill from the BND acquisition is not deductible for tax purposes.

The following table discloses the fair values of assets and liabilities acquired by the Company in the BND acquisition, as well as measurement adjustments made during the year ended December 31, 2021 to the amounts initially recorded in 2020 *(in thousands)*:

Accounts receivable	$	74,128
Prepaid and other currents assets		30,583
Property and equipment		4,375
Intangible assets		74,500
Other non-current assets		2,906
Total assets		186,492
Medical costs payable		119,408
Other current liabilities		42,530
Other liabilities		10,732
Total liabilities		172,670
Net identified assets acquired		13,822
Goodwill		196,268
Total purchase consideration	$	210,090

The measurement period adjustments above primarily resulted from completing valuations for certain intangible assets. The related impact to net earnings that would have been recognized in previous periods if the adjustments were recognized as of the acquisition date is immaterial to the consolidated financial statements. We recognized intangible assets

related to the BND acquisition, which consist of $25.6 million for the BND trade name with an estimated useful life of 15 years, customer relationships valued at $46.9 million with a 12-year useful life, and $2.0 million of other intangibles related to the provider network with a 10-year useful life. The value of the trade name was determined using the relief from royalty method and the excess earnings method was used to value the customer relationships; both methods are considered Level 3 fair value measurements.

NOTE 4. DISCONTINUED OPERATIONS RESTRUCTURING CHARGES

In October 2022, we announced our decision to further focus our business on our Fully Aligned Care Model, and that we will no longer offer commercial plans through our Bright HealthCare - Commercial, segment or Medicare Advantage products outside of California in 2023. As a result, In connection with our October 2022 announcement, we exited the Commercial marketplace effective December 31, 2022. We determined this exit represented a strategic shift that will have a material impact on incurred restructuring charges throughout 2023 to realign and refocus our supporting business and financial results that requires presentation as discontinued operations. The discontinued operations presentation has been retrospectively applied to all prior periods presented. resources.

While we are no longer offering plans in the Commercial marketplace as of December 31, 2022, we will continue to have involvement in the states as we support run out activities of medical claims incurred in the 2022 plan year and perform other activities necessary to wind down our operations in each state, including making final payments of 2022 risk adjustment payable liabilities during the third quarter of 2023. We expect these activities to be substantially complete by the end of 2023.

The financial results of discontinued operations by major line item for the years ended December 31 were as follows *(in thousands)*:

	For the years ending December 31,		
	2022	**2021**	**2020**
Revenue:			
Premium revenue	**$ 3,998,622**	$ 2,512,384	$ 692,433
Service revenue	**147**	232	—
Investment income (loss)	**(41,221)**	3,740	—
Total revenue from discontinued operations	**3,957,548**	2,516,356	692,433
Operating expenses:			
Medical costs	**3,732,755**	2,659,516	595,382
Operating costs	**883,318**	710,934	184,271
Restructuring charges	**50,704**	—	—
Goodwill impairment	**4,147**	—	—
Intangible assets impairment	**6,720**	—	—
Depreciation and amortization	**145**	435	—
Total operating expenses from discontinued operations	**4,677,789**	3,370,885	779,653
Operating loss from discontinued operations	**(720,241)**	(854,529)	(87,220)
Interest expense	**—**	726	—
Loss from discontinued operations before income taxes	**(720,241)**	(855,255)	(87,220)
Income tax expense (benefit)	**1,674**	—	—
Net loss from discontinued operations	**$ (721,915)**	$ (855,255)	$ (87,220)

The following table presents cash flows from operating and investing activities for discontinued operations *(in thousands)*:

	For the years ending December 31,		
	2022	**2021**	**2020**
Cash used in operating activities - discontinued operations	**$ (1,798,234)**	$ (2,334,534)	$ (313,924)
Cash used in investing activities - discontinued operations	**(466,286)**	(131,305)	(427,378)

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Assets and liabilities of discontinued operations were as follows *(in thousands)*:

	December 31,	
	2022	2021
Assets		
Current assets:		
Cash and cash equivalents	**$ 1,465,965**	$ 771,896
Short-term investments	**1,121,435**	49,358
Accounts receivable, net of allowance of $906 and $657, respectively	**11,082**	14,592
Prepaids and other current assets	**184,992**	191,499
Current assets of discontinued operations	**2,783,474**	1,027,345
Other assets:		
Long-term investments	**—**	656,584
Goodwill	**—**	4,148
Intangible assets, net	**—**	6,865
Other non-current assets	**—**	1,098
Long-term assets of discontinued operations	**—**	668,695
Total assets of discontinued operations	**$ 2,783,474**	$ 1,696,040
Liabilities		
Current liabilities:		
Medical costs payable	**$ 685,785**	$ 554,788
Accounts payable	**122,425**	60,252
Unearned revenue	**—**	50,710
Risk adjustment payable	**1,943,890**	931,170
Other current liabilities	**31,374**	99,120
Current liabilities of discontinued operations	**2,783,474**	1,696,040
Total liabilities of discontinued operations	**2,783,474**	1,696,040

Revenue Recognition: We record adjustments for changes to the risk adjustment balances for individual policies in premium revenue. The risk adjustment program adjusts premiums based on the demographic factors and health status of each consumer as derived from current-year medical diagnoses as reported throughout the year. Under the risk adjustment program, a risk score is assigned to each covered consumer to determine an average risk score at the individual and small-group level by legal entity in a particular market in a state. Additionally, an average risk score is determined for the entire subject population for each market in each state. Settlements are determined on a net basis by legal entity and state and are made in the middle of the year following the end of the contract year. Each health insurance issuer's average risk score is compared to the state's average risk score. Risk adjustment is subject to audit by HHS, which could result in future payments applicable to benefit years.

Reinsurance Recoveries: We have a quota share agreement with RGA, an alien unauthorized reinsurer, which cedes proportional percentages of premiums and medical costs of covered business of the Company, with the difference as an experience refund of ceded premiums, less a ceding fee paid to the reinsurer. Coverage includes comprehensive individual commercial policies in Colorado, Nebraska, Oklahoma and Florida. Effective January 1, 2021, we entered into a quota share agreement with the Canada Life Assurance Company ("CLAUS"),an alien unauthorized reinsurer, which cedes proportional percentages of premiums and medical costs of covered business of the Company, with the difference as an experience refund of ceded premiums, less a ceding fee paid to the reinsurer. Coverage includes comprehensive individual commercial policies in Florida. Deposit accounting is used for this arrangement and only ceding fees are recognized in the Consolidated Statements of Income (Loss) for the years ended December 31, 2022 and 2021, respectively.

Effective January 1, 2020, the state of Colorado instituted its own reinsurance program in which insurers are reimbursed at varying coinsurance rates based on the rating area of its consumers for the consumers' aggregate claims between the attachment point and program maximum.

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Restructuring Charges: As a result of the these strategic changes, we announced and have taken actions to restructure the Company's workforce and reduce expenses based on our updated business model.

There were no restructuring Restructuring charges by reportable segment and corporate for the years ended December 31, 2021 December 31, 2023 and 2020. Restructuring charges within our discontinued operations for the year ended December 31, 2022 2022 were as follows *(in thousands)*:

Employee termination benefits	16,053
Long-lived asset impairments	5,054
Contract termination and other costs	29,597
Total discontinued operations restructuring charges	$ 50,704

	Year Ended December 31, 2023			
	NeueCare	NeueSolutions	Corporate & Eliminations	Total
Employee termination benefits	$ —	$ —	$ 5,897	$ 5,897
Long-lived asset impairments	—	—	880	880
Contract termination and other costs	130	—	83	213
Total restructuring charges	$ 130	$ —	$ 6,860	$ 6,990

We expect

NeueHealth, Inc.

Notes to incur additional discontinued operations pre-tax restructuring charges of $5.0 million to $10.0 million. We expect the restructuring activities to be substantially completed by the fourth quarter of 2023. Consolidated Financial Statements

	Year Ended December 31, 2022			
	NeueCare	NeueSolutions	Corporate & Eliminations	Total
Employee termination benefits	$ —	$ —	$ 24,033	$ 24,033
Long-lived asset impairments	—	—	—	—
Contract termination and other costs	—	—	5,145	5,145
Total restructuring charges	$ —	$ —	$ 29,178	$ 29,178

There was no restructuring accrual activity The $0.9 million of long-lived asset impairments is the result of a lease abandonment for one of our corporate office locations during the year ended December 31, 2021. December 31, 2023.

Restructuring accrual activity recorded by major type for the year years ended December 31, 2022 December 31, 2023 and 2022 was as follows; employee termination benefits are within Other current liabilities while contract termination costs are within Accounts payable *(in thousands)*:

	Year Ended December 31, 2023		
	Employee Termination Benefits	Contract Termination Costs	Total
Balance at January 1, 2023	$ 24,077	$ —	$ 24,077
Charges	5,897	213	6,110
Cash payments	(21,585)	(213)	(21,798)
Balance at December 31, 2023	$ 8,389	$ —	$ 8,389

	Year Ended December 31, 2022		
	Employee Termination Benefits	Contract Termination Costs	Total
Balance at January 1, 2022	$ —	$ —	$ —
Charges	24,077	—	24,077
Cash payments	—	—	—
Balance at December 31, 2022	$ 24,077	$ —	$ 24,077

liabilities of discontinued operations while contract termination costs are within Accounts payable of discontinued operations *(in thousands)*:

	Employee Termination Benefits	Contract Termination Costs	Total
Balance at January 1, 2022	$ —	$ —	$ —
Charges	16,053	28,538	44,591
Cash payments	—	—	—
Balance at December 31, 2022	$ 16,053	$ 28,538	$ 44,591

Fixed Maturity Securities: Available-for-sale securities within our discontinued operations are reported at fair value as of December 31, 2022 and 2021. Held-to-maturity securities are reported at amortized cost as of December 31, 2022 and 2021. The following is a summary of our investment securities as of December 31 *(in thousands)*:

	2022			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Carrying Value
Cash equivalents	$ 622,267	$ 24	$ —	$ 622,291
Available for sale:				
U.S. government and agency obligations	365,040	1	(2,956)	362,085
Corporate obligations	520,097	523	(623)	519,997
State and municipal obligations	9,653	—	(80)	9,573
Certificates of deposit	8,760	—	(2)	8,758
Mortgage-backed securities	154,864	46	(157)	154,753
Asset backed securities	59,557	—	—	59,557
Other	387	—	(14)	373
Total available-for-sale securities	1,118,358	570	(3,832)	1,115,096
Held to maturity:				
U.S. government and agency obligations	5,974	—	(159)	5,815
Total held-to-maturity securities	5,974	—	(159)	5,815
Total investments	$ 1,746,599	$ 594	$ (3,991)	$ 1,743,202

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	2021			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Carrying Value
Cash equivalents	$ 190,159	$ —	$ —	$ 190,159
Available for sale:				
U.S. government and agency obligations	297,912	237	(2,121)	296,028
Corporate obligations	303,754	308	(1,073)	302,989
State and municipal obligations	14,024	29	(35)	14,018

Mortgage backed securities	38,133	62	(66)	38,129
Other	42,417	13	(30)	42,400
Total available-for-sale securities	696,240	649	(3,325)	693,564
Held to maturity:				
U.S. government and agency obligations	6,313	20	(27)	6,306
Total held-to-maturity securities	$ 6,313	$ 20	$ (27)	$ 6,306
Total investments	$ 892,712	$ 669	$ (3,352)	$ 890,029

As of December 31, 2022, we concluded that it was more likely than not that we would have to sell some of the securities before recovering the amortized cost basis due to our decision to exit the commercial business. We recognized an impairment of $67.7 million in our available-for-sale securities portfolio. This impairment is related to the decrease in the fair value of debt securities primarily driven by an increase in market interest rates since the time the securities were purchased.

Fair Value Measurements: As of December 31, 2022, investments and cash equivalents within our discontinued operations were comprised of $940.5 million and $802.7 million with fair value measurements of Level 1 and Level 2, respectively. As of December 31, 2021, the investments and cash equivalents within our discontinued operations were comprised of $412.1 million and $477.9 million with fair value measurements of Level 1 and Level 2, respectively. See Note 6, *Fair Value Measurements* for additional discussion of methods and assumptions used to determine the fair value hierarchy classification of each class of financial instrument.

Medical Costs Payable: The table below details the components making up the medical costs payable within current liabilities of discontinued operations as of December 31 *(in thousands)*:

	2022	2021
Claims unpaid	**$ 60,477**	$ 19,773
Provider incentive payable	**3,446**	11,352
Claims adjustment expense liability	**45,932**	9,786
Incurred but not reported (IBNR)	**575,930**	513,877
Total medical costs payable of discontinued operations	**$ 685,785**	$ 554,788

The prior period development included in medical costs of discontinued operations for the year ended December 31, 2022 was favorable by $50.2 million.

Risk Adjustment: We record adjustments for changes to the risk adjustment balances for individual policies in premium revenue. The risk adjustment program adjusts premiums based on the demographic factors and health status of each consumer as derived from current-year medical diagnoses as reported throughout the year. Under the risk adjustment program, a risk score is assigned to each covered consumer to determine an average risk score at the individual and small-group level by legal entity in a particular market in a state. Additionally, an average risk score is determined for the entire subject population for each market in each state. Settlements are determined on a net basis by legal entity and state and are made in the middle of the year following the end of the contract year. Each health insurance issuer's average risk score is compared to the state's average risk

score. Risk adjustment is subject to audit by HHS, which could result in future payments applicable to benefit years. Risk adjustment payable for our discontinued operations was estimated to be $1.9 billion and $931.2 million at December 31, 2022 and 2021, respectively.

Accounts Payable: As of December 31, 2022, the Accounts payable of discontinued operations balance included $47.1 million of premium taxes payable, $21.1 million of broker commissions payable as well as the $28.5 million of contract termination costs related to restructuring. As of December 31, 2021, the Accounts payable of discontinued operations balance included $40.7 million of premium taxes payable and no broker commissions payable or contract termination costs related to restructuring.

Restricted Capital and Surplus: Our regulated insurance legal entities are required by statute to meet and maintain a minimum level of capital as stated in applicable state regulations, such as risk-based capital requirements. These balances are monitored regularly to ensure compliance with these regulations. Our regulated subsidiaries had statutory capital and surplus of $(12.9) million and $310.2 million as of December 31, 2022 and 2021, respectively. We are out of compliance with the minimum levels for certain of our regulated insurance legal entities of our discontinued operations.

NOTE 5. INVESTMENTS

Fixed Maturity Securities

Available-for-sale securities are reported at fair value as of December 31, 2022 and 2021. Held-to-maturity securities are reported at amortized cost as of December 31, 2022 and 2021. The following is a summary of our investment securities as of December 31 *(in thousands)*:

	2022			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Carrying Value
Cash equivalents	$ 340,795	$ 8	$ —	$ 340,803
Available for sale:				
U.S. government and agency obligations	8,742	—	(301)	8,441
Corporate obligations	3,401	1	(95)	3,307
State and municipal obligations	712	—	(17)	695
Certificates of deposit	3,318	—	—	3,318
Mortgage-backed securities	156	—	—	156
Asset-backed securities	60	—	—	60
Other	1	—	—	1
Total available-for-sale securities	16,390	1	(413)	15,978
Held to maturity:				
U.S. government and agency obligations	685	—	—	685
Certificates of deposit	1,947	—	—	1,947
Total held-to-maturity securities	2,632	—	—	2,632
Total investments	$ 359,817	$ 9	$ (413)	$ 359,413

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	2021			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Carrying Value
Cash equivalents	$ 2,464	$ —	$ —	$ 2,464
Available for sale:				
U.S. government and agency obligations	14,024	21	(79)	13,966
Corporate obligations	10,210	18	(31)	10,197
State and municipal obligations	2,098	5	(3)	2,100
Certificates of deposit	18,752	—	—	18,752
Mortgage backed securities	425	1	(1)	425
Other	473	—	—	473
Total available-for-sale securities	45,982	45	(114)	45,913
Held to maturity:				
U.S. government and agency obligations	1,426	—	—	1,426
Certificates of deposit	1,447	—	—	1,447
Total held-to-maturity securities	$ 2,873	$ —	$ —	$ 2,873
Total investments	$ 51,319	$ 45	$ (114)	$ 51,250

The fair value of available-for-sale investments, including those that are cash equivalents, with gross unrealized losses by major security type and length of time that individual securities have been in a continuous unrealized loss position at December 31 were as follows *(in thousands)*:

	December 31, 2022		
	Less Than 12 Months	12 Months or Greater	Total

Description of Investments	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
U.S. government and agency obligations	$ 1,316	$ (31)	$ 6,808	$ (270)	$ 8,124	$ (301)
Corporate obligations	740	(9)	2,061	(86)	2,801	(95)
State and municipal obligations	340	(2)	344	(15)	684	(17)
Mortgage-backed securities	2	—	—	—	2	—
Other	—	—	1	—	1	—
Total bonds	$ 2,398	$ (42)	$ 9,214	$ (371)	$ 11,612	$ (413)

	December 31, 2021					
	Less Than 12 Months		12 Months or Greater		Total	
Description of Investments	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
U.S. government and agency obligations	10,688	(79)	—	—	10,688	(79)
Corporate obligations	7,324	(31)	—	—	7,324	(31)
State and municipal obligations	1,227	(3)	—	—	1,227	(3)
Mortgage-backed securities	361	(1)	—	—	361	(1)
Other	321	—	—	—	321	—
Total bonds	$ 19,921	$ (114)	$ —	$ —	$ 19,921	$ (114)

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As of December 31, 2022, we had 721 investment positions out of 2,432 that were in an unrealized loss position. As of December 31, 2021, we had 1,343 investment positions out of 1,836 that were in an unrealized loss position. We believe that we will collect the principal and interest due on our debt securities that have an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate increases and not by unfavorable changes in the credit quality associated with these securities. At each reporting period, we evaluate securities for impairment when the fair value of the investment is less than its amortized cost. We evaluated the underlying credit quality and credit ratings of the issuers, noting no significant deterioration since purchase. Refer to Note 4 *Discontinued Operations* for discussion of the impairment of securities recognized within discontinued operations.

As of December 31, 2022, the maturity of available-for-sale securities, by contractual maturity, reflected at amortized cost and fair value were as follows *(in thousands)*:

	2022	
	Amortized Cost	Fair Value
Due in one year or less	$ 10,756	$ 10,592
Due after one year through five years	5,288	5,039
Due after five years through 10 years	342	343
Due after 10 years	4	4
Total debt securities	$ 16,390	$ 15,978

Investment income for our available-for-sale securities in the Consolidated Statements of Income (Loss) for the years ended December 31, 2022, 2021 and 2020, was $25.2 million, $— million and $8.5 million, respectively. The gross proceeds from the sale of available-for-sale securities for the years ended December 31, 2022, 2021 and 2020 were $14.3 million, $19.8 million and $4.3 million, respectively. Realized gains (losses) of $24.8 million, $(0.1) million and $0.0 million are included within total investment income, and reclassified out of accumulated other comprehensive income (loss), for the years ended December 31, 2022, 2021 and 2020, respectively.

Equity Securities

On April 1, 2021 we completed the purchase of 1.6 million shares of equity securities for aggregate cash consideration of $40.1 million. As of December 31, 2021, the equity securities had a carrying value of $120.4 million included in short-term investments in the Consolidated Balance Sheet. During the year, the Company sold all equity securities for aggregate gross proceeds of approximately $64.9 million We recognized a realized gain of $24.8 million in investment income in the Consolidated Statements of Income (Loss) for the year ended December 31, 2022.

NOTE 6. FAIR VALUE MEASUREMENTS

Fair value measurement: The Fair Value Measurements and Disclosures topic in FASB ASC 820 defines fair value, establishes a framework for measuring fair value, and expands disclosures of fair value measurements, which applies to all assets and liabilities measured on a fair value basis. The standard establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements).

Basis of fair value measurement:

Level 1: Unadjusted quoted prices in active markets that are accessible at the measurement date for identical, unrestricted assets or liabilities

Level 2: Quoted prices for similar assets or liabilities in active markets or quoted prices in markets that are not active, or inputs that are observable, either directly or indirectly, for substantially the full term of the asset or liability

Level 3: Prices or valuation techniques that require inputs that are both significant to the fair value measurement and unobservable (i.e., supported by little or no market activity)

There were no transfers in or out of Level 3 financial assets or liabilities during the years ended December 31, 2022 or 2021.

Nonfinancial assets and liabilities or financial assets and liabilities that are measured at fair value on a nonrecurring basis are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. There were no significant fair value adjustments for these assets and liabilities recorded during the years ended December 31, 2022 or 2021.

A financial instrument's level within the fair value hierarchy is based on the lowest level of input that is significant to the fair value measurement.

The following methods and assumptions were used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument included in the tables below:

Cash and Cash equivalents — The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. Fair values of cash equivalent investments outside of money- market funds and U.S treasury securities are classified as Level 2.

Debt Securities — The fair values of debt securities are based on quoted market prices, where available. We obtain one price for each security primarily from its custodian, or if unavailable, securities evaluations, prices received from a secondary pricing source, or other third-party calculated prices based on observable inputs in the market are used to price securities. If these are unavailable, we are able to provide pricing overrides from other acceptable sources or methods; however, based upon the relatively high rating of our investments, this is generally not required.

Equity Securities — The fair value of the equity securities was determined based on the quoted market price of the underlying securities in an active market.

We are ultimately responsible for determining fair value, as well as the appropriate level within the fair value hierarchy, based on the significance of unobservable inputs. At the end of each reporting period, we review third-party pricing services' pricing methodologies, data sources and pricing inputs to ensure the fair values obtained are reasonable.

There are no investments in Level 3 securities as of December 31, 2022 or 2021.

The following tables set forth our fair value measurements as of December 31, 2022 and 2021, for assets measured at fair value on a recurring basis *(in thousands)*:

	2022			
	Level 1	Level 2	Level 3	Total
Assets				
Cash equivalents	$ 316,752	$ 15,601	$ —	$ 332,353
Fixed maturity securities, available for sale:				
U.S. government and agency obligations	6,354	2,087	—	8,441
Corporate obligations	—	3,307	—	3,307
State and municipal obligations	—	695	—	695
Certificates of deposit	—	3,318	—	3,318
Mortgage-backed securities	—	156	—	156
Asset-backed securities	—	60	—	60
Other	—	1	—	1
Total fixed maturity securities, available for sale:	6,354	9,624	—	15,978
Total assets at fair value	$ 323,106	$ 25,225	$ —	$ 348,331

	2021			
	Level 1	Level 2	Level 3	Total
Assets				
Cash equivalents	$ 2,450	$ 3	$ —	$ 2,453
Fixed maturity securities, available for sale:				
U.S. government and agency obligations	9,575	4,391	—	13,966
Corporate obligations	26	10,172	—	10,198
State and municipal obligations	—	2,100	—	2,100
Certificates of deposit	—	18,752	—	18,752
Mortgage-backed securities	26	398	—	424
Other	—	473	—	473
Total fixed maturity securities, available for sale:	$ 9,627	$ 36,286	$ —	$ 45,913
Equity securities	120,364	—	—	120,364
Total assets at fair value	$ 132,441	$ 36,289	$ —	$ 168,730

The following tables set forth the Company's fair value measurements as of December 31, 2022 and 2021, for certain financial instruments not measured at fair value on a recurring basis *(in thousands)*:

	2022			
	Level 1	Level 2	Level 3	Total
Cash equivalents, held to maturity	$ 8,450	$ —	$ —	$ 8,450
Fixed maturity securities, held to maturity:				
U.S. government and agency obligations	685	—	—	685
Certificates of deposit	—	1,947	—	1,947
Total held to maturity	$ 9,135	$ 1,947	$ —	$ 11,082

	2021			
	Level 1	Level 2	Level 3	Total
Cash equivalents	$ 12	$ —	$ —	$ 12
Held to Maturity:				
U.S. government and agency obligations	1,425	—	—	1,425
Certificates of deposit	—	1,447	—	1,447
Total held to maturity	$ 1,437	$ 1,447	$ —	$ 2,884

NOTE 7. PROPERTY, EQUIPMENT AND CAPITALIZED SOFTWARE 4. MEDICAL COSTS PAYABLE

Property, equipment and capitalized software at December 31, 2022 and 2021, consists The following table shows the components of the following change in medical costs payable for the years ended December 31, *(in thousands)*:

	2022	2021
Software	$ 50,000	$ 38,800
Leasehold improvements	9,585	7,135
Medical equipment	586	586
Other equipment	652	504
Gross property, equipment, and capitalized software	60,823	47,025
Less accumulated depreciation	(18,227)	(8,681)
Property, equipment, and capitalized software, net	$ 42,596	$ 38,344

	2023	2022
Medical costs payable – January 1	**$ 116,021**	$ 6,764
Incurred related to:		
Current year	**997,687**	665,145
Prior year	**(1,105)**	(2,173)
Total incurred	**996,582**	662,972
Paid related to:		
Current year	**839,772**	549,108
Prior year	**114,929**	4,607
Total paid	**954,701**	553,715
Acquired claims liabilities	**—**	—
Medical costs payable – December 31	**$ 157,903**	$ 116,021

Medical costs payable attributable to prior years decreased by $1.1 million and $2.2 million for the years ended December 31, 2023 and 2022, respectively, resulting from claim settlements being less than original estimates. Medical costs payable estimates are adjusted as additional information becomes known regarding claims. There were no significant changes to estimation methodologies in 2023 or 2022.

The table below details the components making up the medical costs payable as of December 31, *(in thousands)*:

	2023	2022
Provider incentive payable	**2,367**	11,233
Incurred but not reported (IBNR)	**155,536**	104,788
Total medical costs payable	**$ 157,903**	$ 116,021

Medical costs payable are primarily related to the current year. There are no reinsurance recovery amounts assumed in medical costs payable at December 31, 2023 or 2022.

NOTE 5. SHORT-TERM BORROWINGS

In March 2021, we entered into a $350.0 million revolving credit agreement with JPMorgan Chase Bank, N.A., as Collateral Agent and Administrative Agent (in each such capacity, the "Agent") and a syndicate of banks (the "Credit Agreement"), which was set to mature on February 28, 2024. As of December 31, 2023 and 2022 we had $303.9 million borrowed under the Credit Agreement at a weighted-average effective annual interest rate of 10.06%, which remained outstanding as of December 31, 2023. Refer to Note 14, *Commitments and Contingencies* for more information on the undrawn letters of credit of $22.9 million under the Credit Agreement, which reduce the amount available to borrow.

In June and August of 2023, the Company entered into two limited waivers and consents, which temporarily waived compliance with the minimum liquidity covenant set forth in Section 11.12.2 of the Credit Agreement, and subsequently reduced the minimum liquidity covenant to $25.0 million. These waivers, among other things, also removed the covenant requiring maintenance of a maximum total debt to capitalization ratio, prohibited certain types of debt and required the Company to provide certain financial information to the lenders thereunder.

Depreciation expense On December 27, 2023, we entered into a letter agreement (the "Letter Agreement") with the Agent providing that, in each case subject to the Agent's receipt of $12.2 million (a) the payment in an amount equal to $274.6 million to give effect to the Termination (as defined below) as of January 2, 2024 (the "Payoff Condition") and (b) payment to the issuer of letters of credit outstanding under the Credit Agreement (the "Existing Letters of Credit") cash in an amount equal to $24.1 million, which is equal to 105% of the aggregate face amount of the Existing Letters of Credit (the "Cash Collateral"), $4.4 million and $2.9 million was recognized which shall be held by the Agent as collateral for the years ended December 31, 2022 obligation of the Company to reimburse the Agent in an amount equal to the amount of any drawing under the Existing Letters of Credit and to pay certain fees in respect of Existing Letters of Credit until the Existing Letters of Credit have terminated or expired (collectively, the "L/C Condition"), 2021 (i) the lenders under the Credit Agreement and 2020, respectively. the Agent consented to the sale of our California Medicare Advantage business (this clause (i), the "Consent") and (ii) all liabilities, obligations and indebtedness of the Company and its applicable subsidiaries that are guarantors under the Credit Agreement and the other related loan documents (collectively, the "Credit Documents"), other than customary obligations that survive termination of the Credit Agreement by their express terms and the Company's obligations in respect of the Existing Letters of Credit, owing by the Company and such subsidiaries under the Credit Documents shall be released, discharged and satisfied in full, all liens securing the obligations under the Credit Agreement (other than in respect of the Cash Collateral) shall be terminated and all guarantees under the Credit Agreement shall be released (this clause (ii), the "Termination").

On January 2, 2024, both the Payoff Condition and the L/C Condition were satisfied and, as a result, the Consent and the Termination occurred.

NOTE 8. GOODWILL 6. LONG-TERM BORROWINGS AND INTANGIBLE ASSETS COMMON STOCK WARRANTS

Changes

On August 4, 2023, the Company entered into a Credit Agreement (as amended, supplemented, restated or otherwise modified from time to time, the "New Credit Agreement"), among the Company, NEA 18 Venture Growth Equity, L.P. ("NEA") and the lenders from time to time party thereto (together with NEA and each of their respective successors and assigns, the "Lenders"), to provide for a credit facility pursuant to which, among other things, the lenders have provided $60.0 million delayed draw term loan commitments, which matures on December 31, 2025.

On October 2, 2023, the Company, NEA, as the existing lender (the "Existing Lender"), and California State Teachers' Retirement System, as an incremental lender ("the New Lender") entered into Incremental Amendment No. 1 to the New Credit Agreement to provide for a term loan commitment increase in an aggregate principal amount of $6.4 million by the carrying value New Lender under the Amended Credit Agreement. Loans under the Commitment Increase will have the same terms as loans under the original term loan commitments provided by the Existing Lender. As of goodwill by reportable segment were as follows *(in thousands)*:

	Bright HealthCare		Consumer Care	
	Gross Carrying Amount	Cumulative Impairment	Gross Carrying Amount	Cumulative Impairment
Balance at January 1, 2021	$ 197,886	$ —	$ 65,149	$ —
Impairment losses	—	—	—	—
Acquisitions	236,037	—	337,133	—
Purchase adjustments	(5,213)	—	—	—
Balance at December 31, 2021	428,710	—	402,282	—
Impairment losses	—	70,017	—	—
Acquisitions	—	—	310	—
Goodwill dispositions	—	—	(1,207)	—
Balance at December 31, 2022	$ 428,710	$ 70,017	$ 401,385	$ —

Historically, we test goodwill for impairment annually at the beginning of the fourth quarter or whenever events or circumstances indicate the carrying value may not be recoverable. During the three months ended September 30, 2022 December 31, 2023, we determined that our decision had $66.4 million borrowed under the New Credit Agreement at a weighted-average effective interest rate of 15.00%, which remains outstanding as of December 31, 2023.

In the third quarter of 2023, the expectation was to exit use the Commercial markets and proceeds from the decrease in our enterprise market capitalization due to a decrease in the price sale of our common stock, represented events that indicated California MA business to repay the carrying values of our reporting units may not be recoverable. As amounts drawn on the New Credit Agreement in early 2024, as such we performed an interim impairment test they were classified as of September 30, 2022.

We estimated the fair values of our Bright HealthCare and Consumer Care reporting units using a combination of discounted cash flows and comparable market multiples, which include assumptions about a wide variety of internal and external factors. short-term borrowings. As a result of our interim impairment test, we recognized a non-cash impairment loss of $70.0 million in our Bright HealthCare reporting unit, specifically to Medicare Advantage, which had a goodwill carrying amount of $358.7 million after impairment. The impairment of our Bright HealthCare reporting unit was primarily driven by an increase the reduction in the discount rate, which was impacted by higher interest rates and other market factors. proceeds received from the sale of the California MA business the expected repayment timeline has changed to a longer term outlook, as such in the fourth quarter of 2023 we have reclassified these to long-term borrowings.

Given On August 4, 2023, we entered into a warrantholders agreement (the "NEA Warrantholders Agreement") with NEA, setting forth the proximity rights and obligations of our interim impairment measurement the Company and NEA as holders of the warrants to acquire shares of Common Stock at an exercise price of $0.01 per share (the "Warrants"), and providing for the issuance of warrants. We established a warrant liability of $25.1 million on this date, (last day of our fiscal third quarter - September 30, 2022) representing the 1.7 million warrants available to our annual goodwill impairment measurement date (first day of our fiscal fourth quarter - October 1, 2022), we performed be issued under the NEA Warrantholders Agreement at a qualitative assessment to determine whether it was more likely than not that the fair market value of $15.12 (closing share price on August 4th, 2023 minus the $0.01 exercise price). The warrants do not contain any exercise contingencies and expire on the fifth anniversary of our reporting units was less than the carrying value. As material changes in the business that occurred during the valuation procedures but subsequent to our interim impairment measurement date were taken into consideration during our interim impairment assessment, we concluded that there would be no reasonable expectation of changes in estimates or the reporting unit fair values and carrying values between our interim impairment and annual impairment measurement dates. first closing date.

As of December 31, 2022 On October 2, 2023, we recognized entered into a $1.2 warrantholders agreement (the "CalSTRS Warrantholders Agreement") with the New Lender, setting forth the rights and obligations of the Company and the lenders as holders of the warrants to acquire shares of Common Stock at an exercise price of $0.01 per share, and providing for the issuance of warrants. We increased the warrant liability by $1.0 million goodwill disposition related on this date, representing the 0.2 million warrants available to our Consumer Care reporting unit. Additionally, we determined that be issued under the sustained decline in our stock price triggered a qualitative assessment of our goodwill to determine if it was more likely than not that the fair value of our reporting units were less than their respective carrying values. Through our assessment of our reporting units, we concluded that it was not more likely than not that the fair value of our reporting units were less than their respective carrying values as of December 31, 2022. We will continue to closely monitor the operational performance of our reporting units as it relates to goodwill impairment.

The gross carrying value and accumulated amortization for definite-lived intangible assets were as follows *(in thousands)*:CalSTRS

	December 31, 2022		December 31, 2021	
	Gross Carrying Amount	Accumulated Amortization	Gross Carrying Amount	Accumulated Amortization
Customer relationships	$ 204,221	$ 41,604	$ 206,321	$ 21,560
Trade names	95,261	12,812	96,041	6,578
Provider networks	—	—	59,000	6,556
Developed technology	—	—	6,300	675
Other	5,400	1,383	5,400	698
Total	$ 304,882	$ 55,799	$ 373,062	$ 36,067

Warrantholders Agreement at a fair market value of $5.80 (closing share price on October 2nd, 2023 minus the $0.01 exercise price). The warrants do not contain any exercise contingencies and expire on the fifth anniversary of the first closing date.

Amortization

We account for our common stock warrants at the time of inception as derivatives, utilizing ASC 815, D*erivatives and Hedging*, by recording a liability equal to the warrants' fair market value that is marked to market at the end of each period. Per the terms of the NEA Warrantholders Agreement, the market value is calculated as the ending stock price less the $0.01 exercise price. As we draw on the available funds, warrants are issued; warrants will remain classified as a liability and be fair valued each period until they are exercised by the warrantholder. Upon exercise, we relieve the associated liability into additional paid in capital at the fair value of the warrants on the date of exercise, classifying the exercised warrants as equity.

	Fair Value
Balance at January 1, 2023	$ —
Newly executed Warrantholders Agreement	26,076
Change in fair value of outstanding warrants	(12,105)
Balance at December 31, 2023	$ 13,971

During the year ended December 31, 2023, we drew $66.4 million on the New Credit Agreement, and issued a total of 1.8 million warrants. As of December 31, 2023 no issued warrants have been exercised and no warrants remain available to be issued under the Warrantholders Agreement. For the year ended December 31, 2023, warrant expense relating to intangible assets of $38.2 million, $30.6 million, was $14.0 million. There was no equivalent liability and $5.4 million was recognized for the years ended December 31, 2022, 2021 and 2020, respectively.

Impairment expense relating to intangible assets activity for the year ended December 31, 2022 was $42.6 million .

The Company classifies its warrant liability as a result of the impairment of the reacquired contract between our discontinued Bright HealthCare - Commercial business and Centrum due to our decision to no longer offer commercial products Level 2 fair value because they are valued using observable, unadjusted quoted prices in active markets. See Note 19, *Discontinued Operations* for the 2023 plan year. We used the income approach in our assessment full definition of the Level 1, Level 2, and Level 3 fair value of the impaired intangible assets. We did not have any impairment expense for the years ended December 31, 2021 and 2020, respectively.

Estimated full year amortization expense relating to intangible assets for each of the next five years ending December 31 is as follows values.*(in thousands):*

2023	$ 27,164
2024	$ 27,025
2025	$ 27,025
2026	$ 27,025
2027	$ 27,025

Bright Health Group, Inc.
Notes to Consolidated Financial Statements

NOTE 9. RESTRUCTURING CHARGES

In October 2022, we announced our decision to further focus our business on our Fully Aligned Care Model, and that we will no longer offer commercial plans through Bright HealthCare, or Medicare Advantage products outside of California in 2023. As a result of these strategic changes, we announced and have taken actions to restructure the Company's workforce and reduce expenses based on our updated business model. 7. PROPERTY, EQUIPMENT AND CAPITALIZED SOFTWARE

There were no restructuring charges Property, equipment and capitalized software at December 31, 2023 and 2022, consists of the following *(in thousands)*:

	2023	2022
Software	$ 14,215	$ 20,961
Leasehold improvements	7,366	9,182
Medical and other equipment	1,111	1,030
Gross property, equipment, and capitalized software	22,692	31,173
Less accumulated depreciation	(8,193)	(9,875)
Property, equipment, and capitalized software, net	$ 14,499	$ 21,298

Depreciation expense of $6.6 million and $9.1 million was recognized for the years ended December 31, 2021 December 31, 2023 and 2020. Restructuring charges 2022, respectively.

NeueHealth, Inc.
Notes to Consolidated Financial Statements

NOTE 8. GOODWILL AND INTANGIBLE ASSETS

Changes in the carrying value of goodwill by reportable segment and corporate for the year ended December 31, 2022 were as follows *(in thousands)*:

	NeueCare	
	Gross Carrying Amount	Cumulative Impairment
Balance at December 31, 2022	401,385	—
Impairment losses	(401,385)	401,385
Balance at December 31, 2023	$ —	$ 401,385

	Bright HealthCare	Consumer Care	Corporate & Eliminations	Total
Employee termination benefits	$ —	$ 44	$ 24,033	$ 24,077
Long-lived asset impairments	—	2,072	—	2,072
Contract termination and other costs	445	—	5,145	5,590
Total restructuring charges	$ 445	$ 2,116	$ 29,178	$ 31,739

For the periods ended December 31, 2023 and 2022, NeueSolutions had no assigned goodwill.

Historically, we test goodwill for impairment annually at the beginning of the fourth quarter or whenever events or circumstances indicate the carrying value may not be recoverable. During the three months ended September 30, 2023, we determined that the decrease in our enterprise market capitalization due to a decrease in the price of our common stock represented an event that indicated the carrying value of our NeueCare reporting unit may not be recoverable. As such, we performed an interim impairment test as of September 30, 2023.

There We estimated the fair value of our NeueCare reporting unit using a combination of discounted cash flows and comparable market multiples, which include assumptions about a wide variety of internal and external factors. As a result of our interim impairment, we fully impaired the NeueCare assigned goodwill due to the decline in our stock price and market capitalization.

Given there was no restructuring accrual activity assigned goodwill at our NeueSolutions and NeueCare segments on our annual goodwill impairment measurement date (first day of our fiscal fourth quarter - October 1, 2023), we did not perform an annual goodwill impairment test.

The gross carrying value and accumulated amortization for definite-lived intangible assets were as follows *(in thousands)*:

	December 31, 2023		December 31, 2022	
	Gross Carrying Amount	Accumulated Amortization	Gross Carrying Amount	Accumulated Amortization
Customer relationships	$ 80,021	$ 26,144	$ 80,021	$ 17,654

Trade names	48,361	9,000	48,361	5,776
Total	$ 128,382	$ 35,144	$ 128,382	$ 23,430

Amortization expense relating to intangible assets of $11.7 million and $21.6 million was recognized for the year years ended December 31, 2021. Restructuring accrual activity recorded by major type December 31, 2023 and 2022, respectively.

Impairment expense relating to intangible assets for the year ended December 31, 2022 was $42.6 million as follows; employee termination benefits are within Other current liabilities while a result of the impairment of the reacquired contract termination costs are within Accounts payable between our discontinued Bright HealthCare - Commercial business and continuing NeueCare business, due to our decision to no longer offer commercial products for the 2023 plan year. We used the income approach in our assessment of the fair value of the impaired intangible assets. We did not have any impairment expense for the year ended (in thousands) December 31, 2023: .

	Employee Termination Benefits	Contract Termination Costs	Total
Balance at January 1, 2022	$ —	$ —	$ —
Charges	24,077	515	24,592
Cash payments	—	—	—
Balance at December 31, 2022	$ 24,077	$ 515	$ 24,592

Bright Health Group, NeueHealth, Inc.
Notes to Consolidated Financial Statements

NOTE 10. MEDICAL COSTS PAYABLE

The following table shows the components Estimated full year amortization expense relating to intangible assets for each of the change in medical costs payable for the next five years ended ending December 31, is as follows *(in thousands)*:

	2022	2021	2020
Medical costs payable – January 1	**$ 263,187**	$ 121,309	$ 4,458
Incurred related to:			
Current year	**2,201,937**	1,298,264	445,620
Prior year	**7,456**	3,510	6,877
Total incurred	**2,209,393**	1,301,774	452,497
Paid related to:			
Current year	**1,793,613**	1,114,903	458,678
Prior year	**267,214**	124,462	8,379
Total paid	**2,060,827**	1,239,365	467,057
Acquired claims liabilities	**—**	79,469	131,411
Medical costs payable – December 31	**$ 411,753**	$ 263,187	$ 121,309

2024	$ 11,574
2025	$ 11,574
2026	$ 11,574
2027	$ 11,574
2028	$ 10,295

NOTE 9. PREFERRED STOCK

Series A Convertible Preferred Stock

On January 3, 2022, we issued 750,000 shares of the Company's Series A Convertible Perpetual Preferred Stock, par value $0.0001 per share (the "Series A Preferred Stock"), for an aggregate purchase price of $750.0 million, or $1,000 per share.

Medical Pursuant to the Certificate of Designations designating the shares of our Series A Preferred Stock and the Certificate of Designations designating the shares of our Series B Convertible Perpetual Preferred Stock (collectively, the "Preferred Stock") each of which we filed with the Secretary of State of the State of Delaware (together, the "Certificate of Designations"), costs payable attributable the Preferred Stock ranks senior to prior years increased by $7.5 million, $3.5 million our shares of common stock with respect to dividend rights and $6.9 million for rights on the years ended December 31, 2022, 2021 and 2020, respectively, resulting from claim settlements being more than original estimates. Medical costs payable estimates are adjusted as additional information becomes known regarding claims. There were no significant changes to estimation methodologies in 2022 distribution of assets on any voluntary or 2021. involuntary liquidation, dissolution or winding up of the affairs of the Company.

The table below details Series A Preferred Stock has an initial liquidation preference of $1,000 per share, which shall increase by accumulated quarterly dividends that are not paid in cash ("Compounded Dividends"). Holders of the components making up Series A Preferred Stock are entitled to a dividend at the medical costs rate of 5.0% per annum, accruing daily and payable quarterly in arrears and subject to certain adjustments, as set forth in the Certificate of Designations. Dividends will be payable in cash, by increasing the amount of Compounded Dividends with respect to a share of Series A Preferred Stock, or any combination thereof, at the sole discretion of the Company. The Series A Preferred Stock had accrued Compounded Dividends of $78.0 million and $37.9 million as of December 31, 2023 and 2022, respectively(in thousands): .

	2022	2021
Claims unpaid	**$ 41,567**	$ 17,101
Provider incentive payable	**37,771**	74,191
Claims adjustment expense liability	**7,290**	4,346
Incurred but not reported (IBNR)	**325,125**	167,549
Total medical costs payable	**$ 411,753**	$ 263,187

Medical costs payable are primarily related The Series A Preferred Stock will be convertible at the option of the holders into (I) the number of shares of common stock equal to the current year. There are no reinsurance recovery amounts assumed in medical costs payable at December 31, 2022 and 2021. The Company has recorded claims adjustment expense as a component quotient of operating costs in (a) the Consolidated Statements sum of Income (Loss).

The following is information about incurred and cumulative paid claims development (x) the liquidation preference (reflecting increases for Compounded Dividends) plus (y) the accrued dividends with respect to each share of Series A Preferred Stock as of December 31, 2022, net of reinsurance, the applicable conversion date divided by (b) the conversion price (initially approximately $364.00 per share and the total claims payable plus expected development on reported claims included within the net incurred claims amounts. The information about incurred and paid claims development for the years ended December 31, 2020 through 2022 is presented as supplementary information as follows and is inclusive of claims incurred and paid related to BND, PMA, CHP and Centrum prior and approximately $283.20 per share subsequent to the acquisition dates issuance of warrants during the year ended (December 31, 2023) as of the applicable conversion date plus (II) cash in thousands) lieu of fractional shares, subject to certain anti-dilution adjustments. At any time after January 3, 2025, if the closing price per share of Common Stock on the New York Stock Exchange was greater than 175% of the then effective conversion price (approximately $283.20 per share subsequent to the issuance of warrants during the year ended : December 31, 2023) for (x) each of at least twenty (20) trading days in any period of thirty (30) consecutive trading days and (y) the last trading day immediately before the Company provides the holders with notice of its election to convert all of the Series A Preferred Stock into the relevant number of shares of common stock, the Company may elect to convert all of the Series A Preferred Stock into the relevant number of shares of common stock.

Under the Certificate of Designations, holders of the Series A Preferred Stock are entitled to vote with the holders of the common stock on an as-converted basis, solely with respect to (i) a change of control transaction (to the extent such change of control transaction is submitted to a vote of the holders of the common stock) or (ii) the issuance of capital stock by the Company in connection with an acquisition by the Company (to the extent such issuance is submitted to a vote of the holders of the common stock), subject to certain restrictions. Holders of the Series A Preferred Stock are entitled to a separate class vote with respect to, among other things, amendments to the Company's organizational documents that have an adverse effect on the Series A Preferred Stock, authorizations or issuances by the Company of securities that are senior to the Series A Preferred
Bright Health Group,

NeueHealth, Inc.
Notes to Consolidated Financial Statements

	Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance (in thousands) For the Years Ended December 31,			Total Incurred but Not Reported Liabilities Plus Expected Development on Reported Claims
Accident Year	(Unaudited) 2020	(Unaudited) 2021	2022	
2020	1,180,234	1,180,196	**1,182,477**	1,190
2021		1,408,909	**1,416,365**	2,255
2022			**2,201,937**	397,100

Total	$ 4,800,779

Accident Year	Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance (in thousands) For the Years Ended December 31, (Unaudited) 2020	(Unaudited) 2021	2022
2020	979,099	1,176,014	**1,181,287**
2021		1,150,523	**1,414,110**
2022			**1,804,837**
Total			**$ 4,400,234**
All outstanding liabilities before 2020, net of reinsurance			**16**
Liabilities for claim and claim adjustment expenses, net of reinsurance			**$ 400,561**

	December 31, 2022
Net outstanding liabilities	**$ 400,561**
Reinsurance recoverable on unpaid claims	**11,192**
Total gross liability for unpaid claims and claims	**$ 411,753**

Stock, increases or decreases in the number of authorized shares of Preferred Stock, and issuances of shares of the Series A Preferred Stock after the Closing Date of January 3, 2022.

At any time following the fifth anniversary of the original issuance date, the Company may redeem all of the Series A Preferred Stock for a per share amount in cash equal to: (i) the sum of (A) the liquidation preference (reflecting increases for Compounded Dividends) thereof plus (B) all accrued dividends as of the applicable redemption date, multiplied by (ii) (A) 105% if the redemption occurs at any time prior to the seventh anniversary of the Closing Date and (B) 100% if the redemption occurs at any time on or after the seventh anniversary of the Closing Date. Upon certain change of control events involving the Company, the holders of the Series A Preferred Stock may, at such holder's election, convert their shares of Series A Preferred Stock into common stock at the then-current conversion price or require the Company to purchase all or a portion of such holder's shares of Preferred Stock that have not been so converted at a purchase price per share of Preferred Stock, payable in cash, equal to the greater of (I) (A) if the change of control effective date occurs at any time prior to the seventh anniversary of the Closing Date, the product of 105% multiplied by the sum of (x) the liquidation preference of such share of Series A Preferred Stock (reflecting increases for Compounded Dividends) plus (y) the accrued dividends in respect of such share of Series A Preferred Stock as of the change of control purchase date and (B) if the change of control effective date occurs on or after the seventh anniversary of the Closing Date, the sum of (x) the liquidation preference (reflecting increases for Compounded Dividends) of such share of Series A Preferred Stock plus (y) the accrued dividends in respect of such share of Series A Preferred Stock as of the change of control purchase date and (II) the consideration that would have been payable in connection with such change of control if such share of Series A Preferred Stock had been converted into common stock immediately prior to the change of control.

Series B Convertible Preferred Stock

On October 10, 2022, we entered into an investment agreement with certain purchasers relating to the issuance of 175,000 shares of the Company's Series B Convertible Perpetual Preferred Stock, par value $0.0001 per share (the "Series B Preferred Stock"), for an aggregate purchase price of $175.0 million, or $1,000 per share. The close of the Series B Preferred Stock issuance occurred on October 17, 2022 (the "Series B Closing Date").

The Series B Preferred Stock ranks senior to the shares of the Company's common stock with respect to dividend rights and rights on the distribution of assets on any voluntary or involuntary liquidation, dissolution or winding up of the affairs of the Company. The Preferred Stock has an initial liquidation preference of $1,000 per share, which shall increase by Compounded Dividends. Holders of the Series B Preferred Stock are entitled to a dividend at the rate of 5.0% per annum, accruing daily and payable quarterly in arrears and subject to certain adjustments, as set forth in the Series B Certificate of Designations. Dividends will be payable in cash, by increasing the amount of liquidation preference (Compounded Dividends) with respect to a share of Series B Preferred Stock, or any combination thereof, at the sole discretion of the Company. The Series B Preferred Stock had accrued Compounded Dividends of $10.8 million and $1.8 million as of December 31, 2023 and 2022, respectively.

The Series B Preferred Stock will be convertible at the option of the holders into (I) the number of shares of common stock equal to the quotient of (a) the sum of (x) the liquidation preference (reflecting increases for Compounded Dividends) plus (y) the accrued dividends with respect to each share of Series B Preferred Stock as of the applicable conversion date divided by (b) the conversion price (initially approximately $113.60 per share and approximately $99.59 per share subsequent to the issuance of warrants during the year ended December 31, 2023) as of the applicable conversion date plus (II) cash in lieu of fractional shares, subject to certain anti-dilution adjustments. At any time after the third anniversary of the Series B Closing Date, if the closing price per share of common stock on the NYSE was greater than 287% of the then effective Series B Conversion Price (approximately $99.59 per share subsequent to the issuance of warrants during the year ended December 31, 2023) for (x) each of at least twenty (20) trading days in any period of thirty (30) consecutive trading days and (y) the last trading day immediately before the Company provides the holders with notice of its election to convert all of the Series B Preferred Stock into the relevant number of shares of common stock, the Company may elect to convert all of the Series B Preferred Stock into the relevant number of shares of common stock.

Under the Series B Certificate of Designations, holders of the Series B Preferred Stock are entitled to vote with the holders of the common stock on an as-converted basis, solely with respect to (i) a change of control transaction (to the extent such change of control transaction is submitted to a vote of the holders of the common stock) or (ii) the issuance of capital stock by the Company in connection with an acquisition by the Company (to the extent such issuance is submitted to a vote of the holders of

the common stock), subject to certain restrictions. Holders of the Series B Preferred Stock are entitled to a separate class vote with respect to, among other things, amendments to the Company's organizational documents that have an adverse effect on the Series B Preferred Stock, authorizations or issuances by the Company of securities that are senior to the Series B Preferred Stock, increases or decreases in the number of authorized shares of Series B Preferred Stock, and issuances of shares of the Series B Preferred Stock after the Series B Closing Date.

At any time following the fifth anniversary of the original issuance date, the Company may redeem all of the Series B Preferred Stock for a per share amount in cash equal to: (i) the sum of (A) the liquidation preference (reflecting increases for Compounded Dividends) thereof plus (B) all accrued dividends as of the applicable redemption date, multiplied by (ii) (A) 105% if the redemption occurs at any time prior to the seventh anniversary of the Series B Closing Date and (B) 100% if the redemption occurs at any time on or after the seventh anniversary of the Series B Closing Date. Upon certain change of control events involving the Company, the holders of the Series B Preferred Stock may, at such holder's election, convert their shares of Series B Preferred Stock into common stock at the then-current conversion price or require the Company to purchase all or a portion of such holder's shares of Preferred Stock that have not been so converted at a purchase price per share of Preferred Stock, payable in cash, equal to the greater of (I) (A) if the change of control effective date occurs at any time prior to the seventh anniversary of the Series B Closing Date, the product of 105% multiplied by the sum of (x) the liquidation preference of such share of Series B Preferred Stock (reflecting increases for Compounded Dividends) plus (y) the accrued dividends in respect of such share of Series B Preferred Stock as of the change of control purchase date and (B) if the change of control effective date occurs on or after the seventh anniversary of the Series B Closing Date, the sum of (x) the liquidation preference (reflecting increases for Compounded Dividends) of such share of Series B Preferred Stock plus (y) the accrued dividends in respect of such share of Series B Preferred Stock as of the change of control purchase date and (II) the consideration that would have been payable in connection with such change of control if such share of Series B Preferred Stock had been converted into common stock immediately prior to the change of control.

NOTE 11. SHORT-TERM BORROWINGS

On March 1, 2021, we entered into a $350.0 million revolving credit agreement with a syndicate of banks. On August 2, 2021, the Credit Agreement was amended to change the definition of "Qualified IPO" by reducing the net proceeds required to be received by the Company from $1.0 billion to $850.0 million. In addition, prior to such amendment, the Credit Agreement contained a covenant that required the Company to maintain a total debt to capitalization ratio of (a) 0.25 to 1.00 prior to a Qualified IPO, and (b) 0.30 to 1.00 after a Qualified IPO. The Amendment changed this covenant by removing the increase in the ratio after a Qualified IPO such that the Company is now required to maintain a total debt to capitalization ratio of 0.25 to 1.00.

On August 4, 2021, we elected to extend the maturity date of the Credit Agreement from February 28, 2022 to February 28, 2024. During the twelve months ended December 31, 2022, we repaid the $155.0 million outstanding under the Credit Agreement as of December 31, 2021. In addition, during the twelve months ended December 31, 2022, we borrowed $303.9 million under the Credit Agreement at an effective annual interest rate of 8.41%, which remains outstanding as of December 31, 2022. Refer to Note 17, *Commitments and Contingencies* for more information on the undrawn letters of credit of $46.1 million under the Credit Agreement, which reduce the amount available to borrow.

On November 8, 2022, we executed an amendment to the Credit Agreement pursuant to which certain collateral related defaults were waived and, in addition, it was agreed that we would (i) not be required to test our debt to capitalization ratio covenant during and including the four quarter test period ending September 30, 2022 through and including the four quarter test period ending September 30, 2023, (ii) be required to maintain a minimum liquidity of $200.0 million from November 8, 2022

through and including September 30, 2023 and (iii) be required to maintain a minimum liquidity of $150.0 million after September 30, 2023.

On March 1, 2023, the Company disclosed that that during the First Quarter of 2023, the Company breached the minimum liquidity covenant of the Credit Agreement. The Company entered into a limited waiver and consent (the "Waiver") under the Credit Agreement, which, among other matters, provides for a temporary waiver for the period from January 25, 2023 through April 30, 2023 (the "Waiver Period") of compliance with the minimum liquidity covenant set forth in Section 11.12.2 of the Credit Agreement. During the Waiver Period, the Company will be subject to a minimum liquidity covenant of not less than $75 million until March 3, 2023, and not less than $85 million thereafter until the end of the Waiver Period. In addition, during the Waiver Period, the Company will not have access to certain negative covenant baskets and will be subject to additional cash-flow and cash balance reporting requirements. Any non-compliance with the covenants under the Credit Agreement or the Waiver may result in the obligations under the Credit Agreement being accelerated.

NOTE 12. PREFERRED STOCK

Series A Convertible Preferred Stock

On December 6, 2021, we entered into an investment agreement with certain subsidiaries of Cigna Corporation ("Cigna") and certain affiliates of New Enterprise Associates ("NEA") (collectively, the "Series A Purchasers") relating to the issuance of 750,000 shares of Series A Preferred Stock, par value $0.0001 per share, for an aggregate purchase price of $750.0 million, or $1,000 per share (the "Series A Issuance"). The close of the Series A Issuance occurred on January 3, 2022 (the "Closing Date").

The Series A Preferred Stock ranks senior to the shares of the Company's common stock with respect to dividend rights and rights on the distribution of assets on any voluntary or involuntary liquidation, dissolution or winding up of the affairs of the Company. The Series A Preferred Stock has an initial liquidation preference of $1,000 per share, which shall increase by accumulated quarterly dividends that are not paid in cash ("compounded dividends"). Holders of the Series A Preferred Stock are entitled to a dividend at the rate of 5.0% per annum, accruing daily and payable quarterly in arrears and subject to certain adjustments, as set forth in the Certificate of Designations. Dividends will be payable in cash, by increasing the amount of liquidation preference (compounded dividends) with respect to a share of Series A Preferred Stock, or any combination thereof, at the sole discretion of the Company. The Series A Preferred Stock had accrued compounded dividends of $37.9 million as of December 31, 2022.

The Series A Preferred Stock will be convertible at the option of the holders into (I) the number of shares of common stock equal to the quotient of (a) the sum of (x) the liquidation preference (reflecting increases for compounded dividends) plus (y) the accrued dividends with respect to each share of Series A Preferred Stock as of the applicable conversion date divided by (b) the conversion price (initially approximately $4.55 per share) as of the applicable conversion date plus (II) cash in lieu of fractional shares, subject to certain anti-dilution adjustments. At any time after the third anniversary of the Closing Date, if the closing price per share of common stock on the NYSE was greater than $7.96 for (x) each of at least twenty (20) trading days in any period of thirty (30) consecutive trading days and (y) the last trading day immediately before the Company provides the holders with notice of its election to convert all of the Series A Preferred Stock into the relevant number of shares of common stock, the Company may elect to convert all of the Series A Preferred Stock into the relevant number of shares of common stock.

Under the Certificate of Designations, holders of the Series A Preferred Stock are entitled to vote with the holders of the common stock on an as-converted basis, solely with respect to (i) a change of control transaction (to the extent such change of control transaction is submitted to a vote of the holders of the common stock) or (ii) the issuance of capital stock by the Company in connection with an acquisition by the Company (to the extent such issuance is submitted to a vote of the holders of the common stock), subject to certain restrictions. Holders of the Series A Preferred Stock are entitled to a separate class vote with respect to, among other things, amendments to the Company's organizational documents that have an adverse effect on the Series A Preferred Stock, authorizations or issuances by the Company of securities that are senior to the Series A Preferred Stock, increases or decreases in the number of authorized shares of Preferred Stock, and issuances of shares of the Series A Preferred Stock after the Closing Date.

At any time following the fifth anniversary of the original issuance date, the Company may redeem all of the Series A Preferred Stock for a per share amount in cash equal to: (i) the sum of (A) the liquidation preference (reflecting increases for compounded

dividends) thereof plus (B) all accrued dividends as of the applicable redemption date, multiplied by (ii) (A) 105% if the redemption occurs at any time prior to the seventh anniversary of the Closing Date and (B) 100% if the redemption occurs at any time on or after the seventh anniversary of the Closing Date. Upon certain change of control events involving the Company, the holders of the Series A Preferred Stock may, at such holder's election, convert their shares of Series A Preferred Stock into common stock at the then-current conversion price or require the Company to purchase all or a portion of such holder's shares of Preferred Stock that have not been so converted at a purchase price per share of Preferred Stock, payable in cash, equal to the greater of (I) (A) if the change of control effective date occurs at any time prior to the seventh anniversary of the Closing Date, the product of 105% multiplied by the sum of (x) the liquidation preference of such share of Series A Preferred Stock (reflecting increases for compounded dividends) plus (y) the accrued dividends in respect of such share of Series A Preferred Stock as of the change of control purchase date and (B) if the change of control effective date occurs on or after the seventh anniversary of the Closing Date, the sum of (x) the liquidation preference (reflecting increases for compounded dividends) of such share of Series A Preferred Stock plus (y) the accrued dividends in respect of such share of Series A Preferred Stock as of the change of control purchase date and (II) the consideration that would have been payable in connection with such change of control if such share of Series A Preferred Stock had been converted into common stock immediately prior to the change of control.

In connection with the closing of the issuance of our Series B Convertible Preferred Stock, the Certificate of Designations for the Company's Series A Convertible Perpetual Preferred Stock was amended to provide for a weighted average anti-dilution adjustment in connection with issuances of equity-linked securities with a purchase or conversion price less than the optional conversion price of the Series A Preferred Stock.

Series B Convertible Preferred Stock

On October 10, 2022, we entered into an investment agreement with certain purchasers relating to the issuance of 175,000 shares of Series B Preferred Stock, par value $0.0001 per share, for an aggregate purchase price of $175.0 million, or $1,000 per share (the "Series B Issuance"). The close of the Issuance occurred on October 17, 2022 (the "Series B Closing Date").

The Series B Preferred Stock ranks senior to the shares of the Company's common stock with respect to dividend rights and rights on the distribution of assets on any voluntary or involuntary liquidation, dissolution or winding up of the affairs of the Company. The Preferred Stock has an initial liquidation preference of $1,000 per share, which shall increase by compounded dividends. Holders of the Series B Preferred Stock are entitled to a dividend at the rate of 5.0% per annum, accruing daily and payable quarterly in arrears and subject to certain adjustments, as set forth in the Certificate of Designations. Dividends will be payable in cash, by increasing the amount of liquidation preference (compounded dividends) with respect to a share of Series B Preferred Stock, or any combination thereof, at the sole discretion of the Company. The Series B Preferred Stock had accrued compounded dividends of $1.8 million as of December 31, 2022.

The Series B Preferred Stock will be convertible at the option of the holders into (I) the number of shares of common stock equal to the quotient of (a) the sum of (x) the liquidation preference (reflecting increases for compounded dividends) plus (y) the accrued dividends with respect to each share of Series B Preferred Stock as of the applicable conversion date divided by (b) the conversion price (initially approximately $1.42 per share) as of the applicable conversion date plus (II) cash in lieu of fractional shares, subject to certain anti-dilution adjustments. At any time after the third anniversary of the Closing Date, if the closing price per share of common stock on the NYSE was greater than 287% of the then effective Conversion Price for (x) each of at least twenty (20) trading days in any period of thirty (30) consecutive trading days and (y) the last trading day immediately before the Company provides the holders with notice of its election to convert all of the Series B Preferred Stock into the relevant number of shares of common stock, the Company may elect to convert all of the Series B Preferred Stock into the relevant number of shares of common stock.

Under the Certificate of Designations, holders of the Series B Preferred Stock are entitled to vote with the holders of the common stock on an as-converted basis, solely with respect to (i) a change of control transaction (to the extent such change of control transaction is submitted to a vote of the holders of the common stock) or (ii) the issuance of capital stock by the Company in connection with an acquisition by the Company (to the extent such issuance is submitted to a vote of the holders of the common stock), subject to certain restrictions. Holders of the Series B Preferred Stock are entitled to a separate class vote with respect to, among other things, amendments to the Company's organizational documents that have an adverse effect on the Series B Preferred Stock, authorizations or issuances by the Company of securities that are senior to the Series B Preferred

Stock, increases or decreases in the number of authorized shares of Preferred Stock, and issuances of shares of the Series B Preferred Stock after the Closing Date.

At any time following the fifth anniversary of the original issuance date, the Company may redeem all of the Series B Preferred Stock for a per share amount in cash equal to: (i) the sum of (A) the liquidation preference (reflecting increases for compounded dividends) thereof plus (B) all accrued dividends as of the applicable redemption date, multiplied by (ii) (A) 105% if the redemption occurs at any time prior to the seventh anniversary of the Closing Date and (B) 100% if the redemption occurs at any time on or after the seventh anniversary of the Closing Date. Upon certain change of control events involving the Company, the holders of the Series B Preferred Stock may, at such holder's election, convert their shares of Series B Preferred Stock into common stock at the then-current conversion price or require the Company to purchase all or a portion of such holder's shares of Preferred Stock that have not been so converted at a purchase price per share of Preferred Stock, payable in cash, equal to the greater of (I) (A) if the change of control effective date occurs at any time prior to the seventh anniversary of the Closing Date, the product of 105% multiplied by the sum of (x) the liquidation preference of such share of Series B Preferred Stock (reflecting increases for compounded dividends) plus (y) the accrued dividends in respect of such share of Series B Preferred Stock as of the change of control purchase date and (B) if the change of control effective date occurs on or after the seventh anniversary of the Closing Date, the sum of (x) the liquidation preference (reflecting increases for compounded dividends) of such share of Series B Preferred Stock plus (y) the accrued dividends in respect of such share of Series B Preferred Stock as of the change of control purchase date and (II) the consideration that would have been payable in connection with such change of control if such share of Series B Preferred Stock had been converted into common stock immediately prior to the change of control.

We have applied the guidance in ASC 480-10-S99-3A, *SEC Staff Announcement: Classification and Measurement of Redeemable Securities*, and have therefore classified the Series A and Series B Preferred Stock outside of shareholders' equity on the Consolidated Balance Sheet because the shares contain liquidation features that are not solely within the Company's control. The Series A and Series B Preferred Stock were recorded at their fair value on the date of issuance net of $4.6 million of issuance costs. The Company has elected not to adjust the carrying value of the Series A and Series B Preferred Stock to the liquidation preference of such shares because of the uncertainty of whether or when such an event would occur. Subsequent adjustments to increase the carrying value to the liquidation preferences will be made only when it becomes probable that such a liquidation event will occur.

2021 Preferred Stock

Post-IPO

Immediately prior to the consummation of our IPO on June 28, 2021, all outstanding shares of our preferred stock were converted to shares of our common stock. We had no preferred stock outstanding as of December 31, 2021.

Pre-IPO

In March 2021, the Company issued 1.4 million shares of Series E Stock at a value of $55.1 million as part of the Zipnosis acquisition. During April 2021, the Company issued 2.1 million shares of Series E Stock at a value of $79.8 million as part of the CHP acquisition.

NOTE 13. 10. SHARE-BASED COMPENSATION

2016 Incentive Plan

The Company adopted its 2016 Stock Incentive Plan (the "2016 Incentive Plan") in March 2016. The 2016 Incentive Plan allowed for the Company to grant stock options, RSUs, and RSAs to certain employees, consultants and non-employee directors. The 2016 Incentive Plan was initially adopted on March 25, 2016, and most recently amended in December 2020. Following the effectiveness of our 2021 Omnibus Plan (the "2021 Incentive Plan"), no further awards will be granted under the 2016 Incentive Plan. However, all outstanding awards granted under the 2016 Incentive Plan will continue to be governed by the existing terms of the 2016 Incentive Plan and the applicable award agreements.

2021 Incentive Plan

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The 2021 Incentive Plan was adopted by our Board of Directors on May 21, 2021 and approved by our stockholders on May 25, 2021 and June 5, 2021. The 2021 Incentive Plan allows the Company to grant stock options, RSAs, RSUs, stock appreciation rights, other equity based awards, and cash based incentive awards to certain employees, consultants and non-employee directors. There are 73.4 million 1.6 million shares of common stock authorized for issuance under the 2021 Incentive Plan. As of December 31, 2021 December 31, 2023, a total of 18.1 million 0.5 million shares of common stock were available for future issuance under the 2021 Incentive Plan.

Share-Based Compensation Expense

We recognized share-based compensation expense of $109.7 million, $68.4 $83.7 million and $5.5 $109.7 million for the years ended December 31, 2022, 2021 December 31, 2023 and 2020, 2022, respectively, which is included in operating costs in the Consolidated Statements of Income (Loss).

Stock Options

The Board of Directors or the Compensation Committee of the Board of Directors determines the exercise price, vesting periods and expiration date at the time of the grant. Stock options granted prior to the third quarter of 2021 generally vest 25% at one year from the grant date, then ratably over the next 36 months with continuous employee service. Stock options granted after

the beginning of the third quarter of 2021 generally vest ratably over three years. Option grants generally expire 10 years from the date of grant.

There were no stock options granted during the year ended December 31, 2023. The calculated value of each option award is estimated on the date of grant using a Black- Scholes option valuation model that used the following assumptions for options granted during 2022, 2021 and 2020: 2022:

	2022	2021	2020
Risk-free interest rate	**1.9 %**	0.8 %	0.9 %
Expected volatility	**54.3 %**	33.4 %	31.3 %
Expected dividend rate	**0.0 %**	0.0 %	0.0 %
Forfeiture rate	**10.2 %**	14.4 %	14.5 %
Expected life in years	**6.0**	6.1	6.1

	2022
Risk-free interest rate	1.9 %
Expected volatility	54.3 %
Expected dividend rate	0.0 %
Forfeiture rate	10.2 %
Expected life in years	6.0

Risk-free interest rates are based on U.S. Treasury yields in effect at the time of grant. Expected volatilities are based on the historical volatility of our publicly traded industry peers. We use historical data to estimate option forfeitures within the valuation model. The expected lives of options granted represent the period of time that the awards granted are expected to be outstanding based on historical exercise patterns.

The activity for the stock options for the year ended December 31, 2022 December 31, 2023 is as follows *(in thousands, except exercise price and contractual life)*:

	Shares	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Life (In Years)	Aggregate Intrinsic Value
Outstanding at January 1, 2022	**69,244**	**1.84**	**8.2**	**$113,908**

	Shares	Shares	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Life (In Years)	Aggregate Intrinsic Value
Outstanding at January 1, 2023					
Granted	Granted	**8,479**	**1.83**		
Exercised	Exercised	**(1,232)**	**1.07**		
Exercised					
Exercised					

Forfeited					
Forfeited					
Forfeited	Forfeited	**(10,156)**	**2.05**		
Expired	Expired	**(2,044)**	**2.02**		
Outstanding at December 31, 2022		**64,291**	**$ 1.82**	**6.7**	**$ 82**
Expired					
Expired					
Outstanding at December 31, 2023					
Outstanding at December 31, 2023					
Outstanding at December 31, 2023					

The weighted-average grant-date fair value of stock options granted during the years year ended December 31, 2022, 2021 and 2020, December 31, 2022 was $0.96, $10.79 and $0.61 , respectively, $76.80 per share. There were no stock options exercised during the year ended December 31, 2023. The aggregate intrinsic value of stock options (the amount by which the market price of the stock on the date of exercise exceeded the exercise price of the option) exercised during the year ended December 31, 2022 was $1.1 million. We recognized share-based compensation expense related to stock options of $35.3 million and $51.4 million for the years ended December 31, 2022, 2021December 31, 2023, and 2020, was $1.1 million, $21.0 million and $2.7 million,2022, respectively. At December 31, 2023

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2022,, there was $81.6 million $27.0 million of unrecognized compensation expense related to stock options that is expected to be recognized over a weighted-average period of 2.1 1.1 years.

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Restricted Stock Units

RSUs represent the right to receive shares of our common stock at a specified date in the future and generally vest over a three-year period. The fair value of RSUs is determined based on the closing market price of our common stock on the date of grant.

The following table summarizes RSU award activity for the year ended December 31, 2022 December 31, 2023 *(in thousands, except weighted average grant date fair value)*:

	RSU	
	Number of RSUs	**Weighted Average Grant Date Fair Value**
Unvested RSUs at January 1, 2022	**15,651**	**$ 3.98**

	RSU	RSU	
	Number of RSUs	**Number of RSUs**	**Weighted Average Grant Date Fair Value**
Unvested RSUs at January 1, 2023			

RSUs granted	30,272	1.74
RSUs vested	(391)	5.04
RSUs canceled	(7,965)	2.97
Unvested RSUs at December 31, 2022	37,567	$ 2.37
Unvested RSUs at December 31, 2023		

We recognized share-based compensation expense related to RSUs of $23.6 million $27.9 million and $1.3 $23.6 million for the years ended December 31, 2022 December 31, 2023 and 2021, 2022, respectively, and is included in operating costs in the Consolidated Statements of Income (Loss). No share-based compensation expense related to RSUs was recognized as of December 31, 2020. As of December 31, 2022 December 31, 2023, there was $54.7 million $24.2 million of unrecognized compensation expense related to the RSU grants, which is expected to be recognized over a weighted-average period of 2.1 1.3 years.

Performance-based Restricted Stock Units

In connection with our IPO, our Board of Directors approved the grant of PSUs to members of our executive leadership team. The grant encompasses a total of 14.7 million PSUs, separated into four equal tranches, each of which are eligible to vest based on the achievement of predetermined stock price goals and a minimum service period of 3 years. This grant is intended to retain and incentivize our executive leadership to lead the Company to sustained, long-term financial and operational performance. The fair value of the PSUs was determined using a Monte-Carlo simulation.

The following table summarizes PSU award activity for the year ended December 31, 2022 December 31, 2023 *(in thousands, except weighted average grant date fair value)*:

	PSU	
	Number of PSUs	Weighted Average Grant Date Fair Value
Unvested PSUs at January 1, 2022	14,700	$ 9.30

	PSU	PSU
	Number of PSUs	Weighted Average Grant Date Fair Value
Unvested PSUs at January 1, 2023		
PSUs granted	—	—
PSUs canceled	(4,200)	9.30
Unvested PSUs at December 31, 2022	10,500	$ 9.30
Unvested PSUs at December 31, 2023		

We recognized share-based compensation expense related to the PSU grant of $34.8 million $20.5 million and $20.5 $34.8 million for the years ended December 31, 2022 December 31, 2023 and 2021, 2022, respectively, and is included in operating costs in the Consolidated Statements of Income (Loss). No share-based compensation expenses related to RSUs was recognized as of December 31, 2020. At December 31, 2022 December 31, 2023, there was $35.1 million $12.4 million of unrecognized compensation expense related to the PSU grant, which is expected to be recognized over a weighted-average period of 1.5 0.5 years.

NOTE 11. NET LOSS PER SHARE

The following table sets forth the computation of basic and diluted net loss per share attributable to common stockholders for the years ended December 31, *(in thousands, except for per share amounts)*:

	2023	2022
Loss from continuing operations, net noncontrolling interests and accrued preferred stock dividends	**$ (562,533)**	$ (520,593)
Loss from discontinued operations	**(638,066)**	(974,638)
Net loss attributable to NeueHealth, Inc. common shareholders	**$ (1,200,599)**	$ (1,495,231)
Weighted-average number of shares outstanding used to compute net loss per share attributable to common stockholders, basic and diluted	**7,954**	7,868
Basic and diluted loss per share attributable to NeueHealth, Inc. common shareholders		
Continuing operations	**$ (70.72)**	$ (66.17)
Discontinued operations	**$ (80.22)**	$ (123.87)
Net loss per share attributable to common stockholders, basic and diluted	**$ (150.94)**	$ (190.04)

The following outstanding shares of potentially dilutive securities were excluded from the computation of diluted net loss per share because including them would have had an anti-dilutive effect for the years ended December 31, *(in thousands)*:

	2023	2022
Redeemable preferred stock	**4,790**	3,982
Issued and outstanding common stock warrants	**1,834**	—
Stock options to purchase common stock	**633**	804
Restricted stock units	**776**	470
Total	**8,033**	5,256

NOTE 12. BENEFIT PLANS

The Company has a 401(k) retirement salary savings plan ("the 401(k) Plan") for all eligible employees. We made safe harbor matching contributions equal to 100% of the first 2% and 50% of the next 4% of employee contributions to the 401(k) Plan. The Company's contribution expense was $5.5 million and $7.0 million for 2023 and 2022, respectively, and was included in operating costs in the Consolidated Statements of Income (Loss).

NOTE 13. INCOME TAXES

The components of income tax expense (benefit) for the years ended December 31, 2023 and 2022 are as follows *(in thousands)*:

	2023	2022
Current	**$ 1,635**	**$ 1,637**
Deferred	**(3,063)**	**2,027**
Total income tax expense (benefit)	**$ (1,428)**	**$ 3,664**

A reconciliation of the statutory tax rate (21%) to the effective income tax rate for the years ended December 31, 2023 and 2022 is as follows *(in thousands)*:

	2023	2022
Tax benefit at federal statutory rate	**$ (108,111)**	$ (80,131)
Increase (decrease) in income taxes resulting from:		
Adjustment to deferred tax valuation allowance	**93,532**	26,225
Permanent adjustments - book NCI reversal adjustment	**(24,014)**	20,089
Permanent adjustments - impairment	**18,043**	14,704

Permanent adjustments - compensation related	**17,208**	16,644
Permanent adjustments - other	**599**	1,091
State income taxes, net of federal benefit	**1,381**	1,708
Prior year adjustments	**7**	92
Other, net	**(73)**	3,242
Income tax expense (benefit)	**$ (1,428)**	$ 3,664
Effective tax rate	**0.3 %**	(1.0 %)

The tax effects of temporary differences related to deferred tax assets and liabilities for the years ended December 31, 2023 and 2022, are as follows *(in thousands)*:

	2023	2022
Deferred tax assets:		
Net operating loss carryforward	$ 285,462	$ 327,644
Impairments	150,138	—
Accrued salaries and benefits	25,211	38,132
Section 195 startup expenditures	1,971	2,645
Adjustment for noncontrolling interest	1,393	—
Intangible amortization	14,984	22,643
Transaction costs	1,293	2,258
Depreciation expense	4,706	3,873
Investment loss	110	—
Claims Incurred but not Reported (IBNR)	40,945	31,887
Bad debt allowance	9,769	1,771
Warrants - Fair Value	3,735	—
Other	1,862	4,037
Total deferred tax assets	541,579	434,890
Less valuation allowance	(488,937)	(362,797)
Total deferred tax assets, net valuation allowance	52,642	72,093
Deferred tax liabilities:		
Prepaid expenses	(967)	(2,855)
Fixed assets	(383)	(383)
Goodwill and intangible assets	(51,292)	(59,847)
Adjustment for noncontrolling interest	—	(3,237)
Investment income	—	(8,834)
Total deferred tax liabilities	(52,642)	(75,156)
Net deferred tax liabilities	$ —	$ (3,063)

Not included in the deferred tax table above as of December 31, 2023 are $667.8 million deferred tax assets, $35.9 million deferred tax liabilities and $631.9 million valuation allowance related to operations classified as discontinued operations in the consolidated balance sheet. Of the $667.8 million deferred tax assets classified as discontinued operations as of December 31, 2023, $634.9 million consists of net operating losses. Not included in the deferred tax table above as of December 31, 2022 are $538.2 million deferred tax assets, $16.5 million deferred tax liabilities and $521.7 million valuation allowance related to operations classified as discontinued operations in the consolidated balance sheet. Of the $538.2 million deferred tax assets classified as discontinued operations as of December 31, 2022, $515.6 million consists of net operating losses.

Net operating losses (“NOLs”) were $2.5 billion and $2.8 billion as of December 31, 2023 and 2022, respectively. These NOLs start to expire in 2036.

Of the operating loss carryforwards noted, a portion of them may not be available after the application of Internal Revenue Code (“IRC”) Section 382 limitations. The IRC Section 382 imposes restrictions on the utilization of various carryforward tax attributes in the event of a change in ownership of the Company, as defined by IRC Section 382. In addition, IRC Section 382 may limit the Company’s built-in items of deduction, including capitalized start-up costs.

In assessing the realization of deferred tax assets, management considers whether it is more likely than not that some portion or all of the deferred tax assets will be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income during periods in which those temporary differences become deductible. Based

on the level of historical taxable losses and projections of future taxable income (losses) over the periods in which the deferred tax assets can be realized, management currently believes that it is not more likely than not that the Company will be able to realize the benefits of these deductible differences. Accordingly, a valuation allowance has been established to reserve for potential benefits of the remaining carryforwards and tax credits in our consolidated financial statements to reflect the uncertainty of future taxable income required to utilize available tax loss carryforwards and other deferred tax assets.

As of December 31, 2023, there were no unrecognized tax benefits recorded.

The Company files income tax returns in the U.S. federal jurisdiction and all state jurisdictions as necessary. The Company's U.S. federal returns are no longer subject to income tax examinations for taxable years before 2020. State tax returns for taxable years before 2019 are no longer subject to examination.

The Company's effective income tax rate varies from the federal statutory rate of 21% due to state income taxes, changes in the valuation allowance for deferred tax assets and adjustments for permanent differences. The overall tax expense for the year ended December 31, 2023 is primarily due to the reversal of the amortization of originating goodwill from asset acquisitions as well as estimated state income taxes attributable to income earned in separate filing states without state net operating loss carryforwards. In the year ended December 31, 2022, the overall tax expense was attributable to amortization of originating goodwill from asset acquisitions and estimated state income taxes attributable to income earned in separate filing states without state net operating loss carryforwards.

NOTE 14. NET LOSS PER SHARE

The following table sets forth the computation of basic and diluted net loss per share attributable to common stockholders for the years ended December 31 *(in thousands, except for per share amounts)*:

	2022	2021	2020
Loss from continuing operations, net noncontrolling interests and accrued preferred stock dividends	**$ (773,316)**	$ (329,607)	$ (161,222)
Loss from discontinued operations	**(721,915)**	(855,255)	(87,220)
Net loss attributable to Bright Health Group, Inc. common shareholders	**$ (1,495,231)**	$ (1,184,862)	$ (248,442)
Weighted-average number of shares outstanding used to compute net loss per share attributable to common stockholders, basic and diluted	**629,459**	392,243	136,193
Basic and diluted loss per share attributable to Bright Health Group, Inc. common shareholders			
Continuing operations	**$ (1.23)**	$ (0.84)	$ (1.18)
Discontinued operations	**$ (1.15)**	$ (2.18)	$ (0.64)
Net loss per share attributable to common stockholders, basic and diluted	**$ (2.38)**	$ (3.02)	$ (1.82)

The following outstanding shares of potentially dilutive securities were excluded from the computation of diluted net loss per share because including them would have had an anti-dilutive effect for the years ended December 31 *(in thousands)*:

	2022	2021	2020
Redeemable preferred stock	**318,531**	—	417,437
Stock options to purchase common stock	**64,291**	69,244	63,925
Restricted stock units	**37,567**	15,651	—
Total	**420,389**	84,895	481,362

NOTE 15. BENEFIT PLANS

The Company has a 401(k) retirement salary savings plan ("the 401(k) Plan") for all eligible employees. We made safe harbor matching contributions equal to 100% of the first 2% and 50% of the next 4% of employee contributions to the 401(k) Plan. The Company's contribution expense was $7.0 million, $4.4 million and $1.9 million for 2022, 2021 and 2020, respectively, and was included in operating costs in the Consolidated Statements of Income (Loss).

NOTE 16. INCOME TAXES

The components of income tax expense (benefit) for the years ended December 31, 2022, 2021 and 2020 are as follows *(in thousands)*:

	2022	2021	2020
Current	**$ 1,648**	$ 84	$ —
Deferred	**2,032**	(26,605)	(9,161)
Total income tax expense (benefit)	**$ 3,680**	$ (26,521)	$ (9,161)

A reconciliation of the statutory tax rate (21%) to the effective income tax rate for the years ended December 31, 2022, 2021 and 2020, is as follows *(in thousands)*:

	2022	2021	2020
Tax benefit at federal statutory rate	**$ (153,289)**	$ (254,391)	$ (52,173)
Increase (decrease) in income taxes resulting from:			
Adjustment to deferred tax valuation allowance	**98,695**	219,478	43,012
Permanent adjustments - book NCI reversal adjustment	**20,089**	1,364	—
Permanent adjustments - impairment	**17,239**	—	—
Permanent adjustments - compensation related	**16,644**	13,342	—
Permanent adjustments - other	**2,520**	816	—
State income taxes, net of federal benefit	**1,714**	(9,158)	—
Prior year adjustments	**(57)**	(306)	—
Other, net	**125**	2,334	—
Income tax expense (benefit)	**$ 3,680**	$ (26,521)	$ (9,161)
Effective tax rate	**(0.5 %)**	2.2 %	3.6 %

The tax effects of temporary differences related to deferred tax assets and liabilities for the years ended December 31, 2022 and 2021, are as follows *(in thousands)*:

	2022	2021
Deferred tax assets:		
Net operating loss carryforward	$ 687,867	$ 364,574
Premiums received in advance	536	2,314
Accrued salaries and benefits	39,112	11,194
Section 195 startup expenditures	2,661	2,164
Adjustment for noncontrolling interest	—	5,209
Intangible amortization	23,427	2,798
Transaction costs	2,255	1,472
Depreciation expense	3,579	653
Investment loss	—	232
Unrealized loss	15,292	—
Claims Incurred but not Reported (IBNR)	34,267	1,994
Other	6,186	1,273
Total deferred tax assets	815,182	393,877
Less valuation allowance	(729,683)	(331,625)
Total deferred tax assets, net valuation allowance	85,499	62,252
Deferred tax liabilities:		
Prepaid expenses	(11,291)	(7,972)
Fixed assets	(458)	(458)
Goodwill and intangible assets	(64,336)	(38,712)
Unrealized gains	—	(16,147)
Adjustment for noncontrolling interest	(3,237)	—
Investment income	(9,241)	—
Total deferred tax liabilities	(88,563)	(63,289)
Net deferred tax liabilities	$ (3,064)	$ (1,037)

Net operating losses (NOLs) were $5.8 billion and $1.9 billion as of December 31, 2022 and 2021, respectively. These NOLs start to expire in 2036.

Of the operating loss carryforwards noted, a portion of them may not be available after the application of IRC Section 382 limitations. The IRC Section 382 imposes restrictions on the utilization of various carryforward tax attributes in the event of a change in ownership of the Company, as defined by IRC Section 382. In addition, IRC Section 382 may limit the Company's built-in items of deduction, including capitalized start-up costs.

In assessing the realization of deferred tax assets, management considers whether it is more likely than not that some portion or all of the deferred tax assets will be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income during periods in which those temporary differences become deductible. Based on the level of historical taxable losses and projections of future taxable income (losses) over the periods in which the deferred tax assets can be realized, management currently believes that it is not more likely than not that the Company will be able to realize the benefits of these deductible differences. Accordingly, a valuation allowance has been established to reserve for potential benefits of the remaining carryforwards and tax credits in our consolidated financial statements to reflect the uncertainty of future taxable income required to utilize available tax loss carryforwards and other deferred tax assets.

As of December 31, 2022, there were no unrecognized tax benefits recorded.

The Company files income tax returns in the U.S. federal jurisdiction and all state jurisdictions as necessary. The Company's U.S. federal returns are no longer subject to income tax examinations for taxable years before 2019. State tax returns for taxable years before 2018 are no longer subject to examination.

The Company's effective income tax rate varies from the federal statutory rate of 21% due to state income taxes, changes in the valuation allowance for deferred tax assets and adjustments for permanent differences. The overall tax expense for the year ended December 31, 2022 is primarily due to amortization of originating goodwill from asset acquisitions and estimated state income taxes attributable to income earned in separate filing states without state net operating loss carryforwards. In the year ended December 31, 2021, the overall tax benefit was attributable to the release of a valuation allowance in connection with new deferred tax liabilities recorded on identifiable intangibles as part of business combination accounting for BND, Zipnosis, THNM, and CHP stock acquisitions occurring in the year ended December 31, 2021.

NOTE 17. COMMITMENTS AND CONTINGENCIES

Leases: We lease our facilities under operating leases that are noncancelable and expire on various dates with options to renew. Operating lease costs were $18.3 million, $13.3 million $9.3 million and $5.7 million $13.7 million for the years ended December 31, 2022December 31, 2023, 2021 and 2020, 2022, respectively. The years ended December 31, 2022December 31, 2023 and 2021 2022 included immaterial short-term lease costs and sublease income. Operating lease costs are included in operating costs in the Consolidated Statements of Income (Loss).

At December 31, 2022December 31, 2023 and 2021, 2022, the assets and liabilities related to operating leases in our Consolidated Balance Sheets are as follows *(in thousands)*:

	Balance Sheet Location	2022	2021
Assets			
Operating lease ROU assets	Other non-current assets	$39,066	$45,345
Liabilities			
Operating lease liabilities — current	Other current liabilities	12,660	13,227
Operating lease liabilities — noncurrent	Other liabilities	33,451	37,039

	Balance Sheet Location	2023	2022
Assets			
Operating lease ROU assets	Operating lease ROU assets		
Liabilities			
Operating lease liabilities - current	Operating lease liabilities - current		
Operating lease liabilities - current	Operating lease liabilities - current		

Operating lease liabilities - noncurrent			
Total lease liabilities	Total lease liabilities	$46,111	$50,266

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Supplemental cash flow and noncash information related to our operating leases was as follows *(in thousands)*:

2023		2022	2021		2023	2022
Operating cash flows from operating leases	Operating cash flows from operating leases	$20,385	$16,616	Operating cash flows from operating leases	$ 15,765	$ 14,013
ROU assets obtained in exchange for new lease liabilities	ROU assets obtained in exchange for new lease liabilities	7,417	14,932	ROU assets obtained in exchange for new lease liabilities	2,910	7,417
ROU assets obtained from acquisitions		—	11,956			
Weighted-average remaining lease term (in years)	Weighted-average remaining lease term (in years)	5.0	5.2	Weighted-average remaining lease term (in years)	4.8	5.3
Weighted-average discount rate	Weighted-average discount rate	6.0 %	6.0 %	Weighted-average discount rate	6.0 %	6.0 %

At December 31, 2022December 31, 2023, future minimum annual lease payments under all noncancelable operating leases are as follows *(in thousands)*:

	Minimum Lease Payments	Minimum Lease Payments	
Years ending December 31:	Years ending December 31:		
2023		$ 13,067	
2024			
2024			
2024	2024	11,842	
2025	2025	9,242	
2026	2026	7,271	

2027	2027	4,780
2028		
Thereafter	Thereafter	7,636
Undiscounted future minimum payments	Undiscounted future minimum payments	53,838
Imputed interest	Imputed interest	(7,727)
Total reported lease liability	Total reported lease liability	$ 46,111

Legal proceedings: In the normal course of business, we could be involved in various legal proceedings such as, but not limited to, the following: lawsuits alleging negligence in care or general liability, violation of regulatory bodies' rules and regulations, or violation of federal and/or state laws.

On January 6, 2022, a putative securities class action lawsuit was filed against us and certain of our officers and directors in the Eastern District of New York. The case is captioned *Marquez v. Bright Health Group, Inc.* et al., 1:22-cv-00101 (E.D.N.Y.). The lawsuit alleges, among other things, that we made materially false and misleading statements regarding our business, operations, and compliance policies, which in turn adversely affected our stock price. An amended complaint was filed on June 24, 2022, which expands on the allegations in the original complaint and alleges a putative class period of June 24, 2021 through March 1, 2022. The amended complaint also adds as defendants the underwriters of our initial public offering. The Company has served a motion to dismiss the amended complaint, which has not yet been ruled on by the court.

We intend to vigorously defend the Company in the above actions, but there can be no assurance that we will be successful in any defense.

By letter dated January 28, 2022, we received a demand from a purported stockholder

NeueHealth, Inc.

Notes to inspect our books and records pursuant to Delaware law. The demand sought information related to the December 6, 2021 Investment Agreement that the Company entered into with NEA and Cigna. The Company and the stockholder's counsel executed a confidentiality agreement, and we produced certain books and records in response to the demand. On June 3, 2022, the purported stockholder filed a putative class action complaint against us and our Board of Directors alleging that the standstill provisions and certain transfer restrictions in the Investment Agreement breached fiduciary duties to stockholders. The case is captioned *Berger v. Adkins* et al., 2022-0487 (Del. Ch.). The complaint sought declaratory and injunctive relief, and an award of attorneys' fees, but did not allege damages. The Company settled this matter in the fourth quarter of 2022 and is negotiating the amount of attorneys' fees to be included in the settlement. We have accrued a liability of $0.8 million in relation to this matter.**Consolidated Financial Statements**

Based on our assessment of the facts underlying the claims and the degree to which we intend to defend the Company in these matters, other than as set forth above, the amount or range of reasonably possible losses, if any, cannot be estimated. As a

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result, other than as set forth above, we We have not accrued for any potential loss as of December 31, 2022December 31, 2023 for these actions. There were no material known contingent liabilities as of December 31, 2021.

Other commitments: As of December 31, 2022December 31, 2023, we had $46.1 $22.9 million outstanding, undrawn letters of credit under the Credit Agreement. Further to As of January 2, 2024 the undrawn letters of credit outstanding under the Credit Agreement we had are collateralized in cash in an additional $7.5 amount equal to $24.1 million, which is equal to 105% of unused letters the aggregate face amount of credit as the Existing Letters of December 31, 2022. Credit.

Restricted capital

NOTE 15. SEGMENTS AND GEOGRAPHIC INFORMATION

Factors used to determine our reportable segments include the nature of operating activities, economic characteristics, existence of separate senior management teams and surplus: Our regulated insurance legal entities are required the type of information used by statute the Company's chief operating decision maker ("CODM") to meet evaluate its results of operations. We have identified two operating segments based on our primary product and maintain a minimum level service offerings: NeueCare, formerly Care Delivery, and NeueSolutions, formerly Care Solutions. The Care Delivery and Care Solutions segments were new starting in the second quarter of capital as stated in applicable state regulations, such as risk-based capital requirements. These balances are monitored regularly 2023 and were formerly reported together within the aggregated Consumer Care segment. The updates to ensure compliance with these regulations. Our regulated subsidiaries had statutory capital and surplus of $55.0 million and $88.3 million as of December 31, 2022 and 2021, respectively. The estimated statutory capital and surplus required to satisfy these regulatory requirements was $63.1 million and $33.3 million as of December

31, 2022 and 2021, respectively. We were out of compliance our reportable segments conform with the minimum level for one Company's CODM's view of our regulated insurance legal entities ongoing operations.

NeueCare and NeueSolutions, which make up our value-driven Consumer Care business that manages risk in partnership with external payors, aim to significantly reduce the friction and current lack of coordination between payors by delivering on our Fully Aligned Care Model with multiple payors. The following is a description of the types of products and services from which the two reportable segments of our continuing operations derive their revenues:

NeueCare: Provides care services in our clinics with wrap around care management and have since contributed additional capital to remediate the deficiency. care coordination activities for those members where we take full or partial risk. As of December 31, 2023, NeueCare provides in-person and virtual clinical care through its 73 owned primary care clinics. Through these risk-bearing clinics and our affiliated network of care providers, our NeueCare segment serves approximately 336,000 consumers, inclusive of 293,000 value-based care consumers and 43,000 fee-for-service consumers. NeueCare customers include external payors, third party administrators, affiliated providers, and direct-to-government programs.

NeueSolutions: Our provider enablement business that facilitates care coordination activities through the use of population health tools including technology, data analytics, care and utilization management, and clinical solutions and care teams to support patients. As of December 31, 2023, NeueSolutions has approximately 62,000 value-based care consumers attributed to its REACH ACOs.

The amount Company's accounting policies for reportable segment operations are consistent with those described in Note 2, Summary of ordinary dividends that may be paid out Significant Accounting Policies. We utilize operating income (loss) before income taxes as the profitability metric for our reportable segments.

For all periods presented, all of our long-lived assets were located in the regulated legal entities' unassigned surplus during any given period is subject United States, and all revenues were earned in the United States.

The following tables present the reportable segment financial information for the years ended December 31, 2023, and 2022 *(in thousands)*:

NeueHealth, Inc.
Notes to certain restrictions as specified Consolidated Financial Statements

Year Ended December 31, 2023	NeueCare	NeueSolutions	Corporate & Eliminations	Consolidated
Capitated revenue	$ 219,774	$ —	$ —	$ 219,774
ACO REACH revenue	—	896,504	—	896,504
Service revenue	41,559	2,879	—	44,438
Investment income	—	—	86	86
Total unaffiliated revenue	261,333	899,383	86	1,160,802
Affiliated revenue	5,876	—	(5,876)	—
Total segment revenue	267,209	899,383	(5,790)	1,160,802
Operating loss	(369,346)	(42,500)	(165,150)	(576,996)
Depreciation and amortization	$ 12,651	$ —	$ 5,645	$ 18,296
Bad debt expense	4,984	22,423	—	27,407
Restructuring charges	130	—	6,860	6,990
Goodwill impairment	401,385	—	—	401,385

Year Ended December 31, 2022	NeueCare	NeueSolutions	Corporate & Eliminations	Consolidated
Capitated revenue	$ 112,904	$ —	$ —	$ 112,904
ACO REACH revenue	—	654,087	—	654,087
Service revenue	39,487	114	—	39,601
Investment income	—	—	(55,429)	(55,429)
Total unaffiliated revenue	152,391	654,201	(55,429)	751,163
Affiliated revenue	1,039,620	—	(1,039,620)	—
Total segment revenue	1,192,011	654,201	(1,095,049)	751,163
Operating loss	(215,361)	1,424	(154,819)	(368,756)
Depreciation and amortization	$ 22,234	$ —	$ 8,476	$ 30,710
Bad debt expense	5	—	7	12

Restructuring charges	—	—	29,178	29,178
Goodwill impairment	—	—	—	—
Intangible assets impairment	42,611	—	—	42,611

We do not include asset information by state statutes, which generally require prior-year net income or sufficient statutory capital and surplus. The regulated legal entities did not pay any dividends during 2022, and paid two dividends during 2021 reportable segment in the reporting provided to the parent holding company. CODM.

NOTE 18. SEGMENTS AND GEOGRAPHIC INFORMATION

Factors used to determine our reportable segments include the nature of operating activities, economic characteristics, existence of separate senior management teams and the type of information used by the Company's chief operating decision maker ("CODM") to evaluate its results of operations. We have identified three operating segments based on our primary product and service offerings: Bright HealthCare, formerly Medicare Advantage, and Consumer Care, formerly NeueHealth, within our continuing operations and Bright HealthCare – Commercial within our discontinued operations.

The following is a description of the types of products and services from which the two reportable segments of our continuing operations derive their revenues:

Bright HealthCare: Our delegated senior managed care business that partners with a tight group of aligned providers in California. Our healthcare financing and distribution business focused on serving aging and underserved populations with unmet clinical needs through a Fully-Aligned Care Model. As of December 31, 2022, Bright HealthCare includes MA products in 6 states, which serve over 125,000 lives and generally focus on higher risk, special needs, or other traditionally underserved populations.

Consumer Care: Our value-driven care delivery business that manages risk in partnership with external payors, Consumer Care, aims to significantly reduce the friction and current lack of coordination between payors by delivering on our Fully-Aligned Care Model with multiple payors. Our Consumer Care business delivers virtual and in-person clinical care through its approximately 74 owned primary care clinics within an integrated care delivery system. Through these risk-bearing clinics and our affiliated network of care providers, Consumer Care maintains over 579,000 unique patient relationships as of December 31, 2022, approximately 530,000 of which are served through value-based arrangements, across multiple payors. Through 2022, Consumer Care received network rental fees from our discontinued Bright HealthCare – Commercial segment for the delivery of Consumer Care's Care Partner and network services. In addition, Consumer Care contracted directly with Bright HealthCare – Commercial to provide care through its managed and affiliated clinics. Other Consumer Care customers include external payors, third party administrators, affiliated providers and direct-to-government programs. Beginning in 2023, our discontinued Bright HealthCare – Commercial segment will no longer be a customer of the Consumer Care business with external payors becoming the primary customers of the segment.

Transactions between reportable segments principally consist of care management and local care delivery provided by Consumer Care to Bright HealthCare. We utilize operating income (loss) before income taxes as the profitability metric for our reportable segments.

For all periods presented, all of our long-lived assets were located in the United States, and all revenues were earned in the United States.

The following tables present the reportable segment financial information for the years ended December 31, 2022, 2021 and 2020 *(in thousands)*:

Year Ended December 31, 2022	Bright HealthCare	Consumer Care	Corporate & Eliminations	Consolidated
Premium revenue	$ 1,652,045	$ 112,904	$ —	$ 1,764,949
Direct Contracting revenue	—	654,087	—	654,087
Service revenue	—	48,013	—	48,013
Investment income	410	(55,429)	—	(55,019)
Total unaffiliated revenue	1,652,455	759,575	—	2,412,030
Affiliated revenue	—	1,029,032	(1,029,032)	—
Total segment revenue	1,652,455	1,788,607	(1,029,032)	2,412,030
Operating loss	(173,834)	(315,744)	(132,670)	(622,248)
Depreciation and amortization	$ 17,702	$ 24,252	$ 8,476	$ 50,430
Goodwill Impairment	70,017	1,208	—	71,225
Intangible Assets Impairment	—	42,611	—	42,611
Restructuring charges	445	2,116	29,178	31,739

Year Ended December 31, 2021	Bright HealthCare	Consumer Care	Corporate & Eliminations	Consolidated
Premium revenue	$ 1,297,273	$ 93,057	$ —	$ 1,390,330
Service revenue	—	42,469	—	42,469

Investment income	(80)	80,314	—	80,234
Total unaffiliated revenue	1,297,193	215,840	—	1,513,033
Affiliated revenue	—	245,334	(245,334)	—
Total segment revenue	1,297,193	461,174	(245,334)	1,513,033
Operating loss	(169,107)	(114,921)	(59,599)	(343,627)
Depreciation and amortization	$ 14,245	$ 18,333	$ 2,471	$ 35,049

Year Ended December 31, 2020	Bright HealthCare	Consumer Care	Corporate & Eliminations	Consolidated
Premium revenue	$ 480,112	$ 7,793	$ —	$ 487,905
Service revenue	—	18,514	—	18,514
Investment income	8,468	—	—	8,468
Total unaffiliated revenue	488,580	26,307	—	514,887
Affiliated revenue	—	10,840	(10,840)	—
Total segment revenue	488,580	37,147	(10,840)	514,887
Operating loss	(43,634)	(8,707)	(118,042)	(170,383)
Depreciation and amortization	$ 1,477	$ 1,895	$ 4,917	$ 8,289

We do not include asset information by reportable segment in the reporting provided to the CODM.

NOTE 19. 16. REDEEMABLE NONCONTROLLING INTEREST

Effective December 31, 2020, we acquired a 62% controlling interest in Premier Medical Associates of Florida, LLC ("PMA"). As part of the PMA this acquisition, we entered into a put/call agreement with respect to the equity interests in PMA held by the controlling interest holder. The call options allow for the Company to purchase the 38% noncontrolling interest equity beginning on the fifth anniversary of the transaction date and each subsequent anniversary thereafter, or under certain other accelerating events as defined in the agreement, solely at the Company's discretion. The put option allows the noncontrolling interest holder the ability to cause the Company to purchase their noncontrolling equity interest beginning on the seventh anniversary of the transaction date and each subsequent anniversary thereafter.

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Based on the nature of the put option redemption feature, which is outside the control of the Company, the noncontrolling interests are classified as redeemable in the accompanying Consolidated Balance Sheets. The put option redemption feature that is outside the control of the Company is settled at a multiple of EBITDA, which is an other than fair value settlement amount. As such, we will make a measurement adjustment when the put option redemption price exceeds the carrying amount as calculated under ASC 810, *Consolidation*. n ("ASC 810").

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Effective July 1, 2021, we acquired a 75% controlling interest in Centrum, a value-based primary care focused, multi-specialty medical group, serving Commercial, Medicare, and Medicaid consumers across multiple payors. As part of the Centrum acquisition, we entered into put/call agreements with respect to the equity interests in Centrum held by the controlling interest holder. The call options allow for the Company to purchase the 25% noncontrolling interest equity over time beginning on September 30, 2022, or under certain other accelerating events as defined in the agreement, solely at the Company's discretion. The put options allow the noncontrolling interest holder the ability to cause the Company to purchase their noncontrolling equity interest on consistent terms with the call options.

Based on the nature of the put option redemption feature, which is outside the control of the Company, each of these noncontrolling interests are classified as redeemable in the accompanying Consolidated Balance Sheets at December 31, 2022December 31, 2023. The put option redemption feature that is outside the control of the Company is settled at a multiple of EBITDA, which is an other than fair value settlement amount. As such, we will make a measurement adjustment when the put option redemption price exceeds the carrying amount as calculated under ASC 810, *Consolidation*. 810.

The following table provides details of our redeemable noncontrolling interest activity for the years ended December 31, 2022December 31, 2023 and 2021 2022 *(in thousands)*:

	Redeemable Noncontrolling Interest
Balance at December 31, 2020	$ 39,600
Acquisitions	82,310
Loss attributable to noncontrolling interest	(29,263)
Measurement adjustment	35,760
Balance at December 31, 2021	$ 128,407
Earnings (losses) attributable to noncontrolling interest	29,883
Distributions Distribution to noncontrolling interest holders	(4,311)
Measurement adjustment	65,779
Balance at December 31, 2022	**$ 219,758**
Earnings (losses) attributable to noncontrolling interest	**(73,199)**
Distribution to noncontrolling interest holders	**(16,496)**
Measurement adjustment	**(41,155)**
Balance at December 31, 2023	**$ 88,908**

NOTE 20. DIRECT CONTRACTING 17. ACO REACH

Beginning January 1, 2022, we began participating We participate in CMS' DC the CMS ACO REACH Model with two DCEs three REACH ACOs participating through the global risk arrangement and assuming full risk for the total cost of care of aligned beneficiaries. As part of our participation in the DC ACO REACH Model, we are guaranteeing the performance of our care network of participating and preferred providers. The intention of the DC ACO REACH Model is to enhance the quality of care for Medicare FFS beneficiaries while reducing the administrative burden, supporting a focus on complex, chronically ill patients, and encouraging physician organizations that have not typically participated in Medicare FFS programs to serve Medicare FFS beneficiaries. CMS redesigned the DC Model and renamed the model the ACO Realizing Equity, Access, and Community Health (REACH) Model ("ACO REACH Model") effective January 1, 2023.

Key components of the financial agreement for the DC ACO REACH Model include:

- **Performance Year Benchmark:** The target amount for Medicare expenditures on covered services (Medicare Part A and B) furnished to a DCE's REACH ACO's aligned beneficiaries during a performance year. The Performance Year Benchmark will be compared to the DCE's REACH ACO's performance year expenditures. This comparison will be used to calculate shared savings and shared losses. The Performance Year Benchmark is established at the beginning of the performance year utilizing prospective trend estimates and is subject to retrospective trend adjustments, if warranted, before the Financial Reconciliation.

- **Risk-Sharing Arrangements:** Used in determining the percent of savings and losses that DCEs REACH ACOs are eligible to receive as shared savings or may be required to repay as shared losses.
- **Financial Reconciliation:** The process by which CMS determines shared savings or shared losses by comparing the calculated total benchmark expenditures for a given DCE's REACH ACO's aligned population to the actual expenditures of

that DCE's REACH ACO's aligned beneficiaries over the course of a performance year that includes various risk-mitigation options such as stop-loss reinsurance and risk corridors.

- **Risk-Mitigation Options:** Both DCEs Two of our REACH ACOs elected to participate in a "stop-loss arrangement" for the current and prior performance year offered by CMS. CMS, while one REACH ACO has elected third-party coverage. The "stop-loss arrangement" is and third-party coverage are designed to reduce the financial uncertainty associated with high-cost expenditures of individual beneficiaries. Additionally, CMS has created a mandatory risk corridor program that allocates the DCE's REACH ACO's shared savings and losses in bands of percentage thresholds, after a deviation of greater than 25.0% of the Performance Year Benchmark.

Performance Guarantees

Through our participation in the DC ACO REACH Model, we determined that our arrangements with the providers of our DCE REACH ACO beneficiaries require us to guarantee their performance to CMS. At the beginning of the performance year, we recognized the Direct Contracting ACO REACH estimated performance year obligation and receivable for the duration of the performance year. This receivable and obligation are measured at an amount equivalent to the estimated Performance Year Benchmark per CMS that is representative of the expected Medicare expenditures for beneficiaries aligned to our DCEs. REACH ACOs. As we fulfill our obligation, we amortize the guarantee on a straight-line basis for the amount that represents the completed portion of the performance obligation. The receivable is reduced as we receive payments from CMS for in-network claims or receive CMS reporting detailing out-of-network claims paid by CMS on behalf of our aligned beneficiaries. At the end of each reporting period, we estimate both in-network claims and out-of-network claims incurred by beneficiaries aligned to our DCEs REACH ACOs but not yet reported and record a reserve for the estimated amount which is included in medical costs payable on the Consolidated Balance Sheets. For each performance year, the final consideration due to the DCEs REACH ACOs by CMS (shared savings) or the consideration due to CMS by the DCEs REACH ACOs (shared loss) is reconciled in the year following the performance year. On a quarterly periodic basis CMS adjusts the estimated Performance Year Benchmark based upon revised trend assumptions and changes in attributed membership. CMS will also estimate the shared savings or loss for the DCE on a quarterly basis REACH ACO periodically based upon this revised the estimated Performance Year Benchmark, changes to membership, payments made to the DCE REACH ACO for in-network claims, out-of-network claims paid on behalf of the DCE REACH ACO and various other assumptions including incurred but not reported reserves. The estimated Performance Year Benchmark is our best estimate of our obligation as we are unable to estimate the potential shared savings or loss due to the “stop-loss arrangement”, risk corridor components of the agreement, and a number of variables including but not limited to risk ratings and benchmark trends that could have an inestimable impact on estimated future payments. Our REACH ACOs netted a shared savings of $8.2 million for performance year 2022.

There were no financial statement impacts of the performance guarantee at December 31, 2021 or for the years ended December 31, 2021 or 2020. The tables below include the financial statement impacts of the performance guarantee at December 31, 2022 December 31, 2023 and 2022 and for the year years then ended (in thousands):

	December 31, 2022
Direct contracting performance year receivable(1)(2)	$ 99,181
Direct contracting performance year obligation(2)	—

	2023	2022
ACO REACH performance year receivable(1)(2)	$ 115,878	$ 99,181
ACO REACH performance year obligation(2)	—	—

(1) We estimate there to be $97.1 million $146.1 million in in-network and out-of-network claims incurred by beneficiaries aligned to our DCE REACH ACOs but not reported as of December 31, 2022 December 31, 2023; this is included in medical costs payable on the Consolidated Balance Sheet.

(2) Our CMS benchmark was reduced by $71.6 million $64.8 million and $71.6 million during the year years ended December 31, 2022. December 31, 2023, and 2022, respectively.

	2023	2022
Amortization of ACO REACH performance year receivable	$ 877,685	$ 554,905
Amortization of ACO REACH performance year obligation	894,382	654,087
ACO REACH revenue	896,504	654,087

NOTE 18. DECONSOLIDATION OF BRIGHT HEALTHCARE INSURANCE COMPANY OF TEXAS

On November 29, 2023, BHIC-Texas (the “Deconsolidated Entity”) was placed into liquidation and the Texas Department of Insurance was appointed as receiver. The Deconsolidated Entity’s financial results are included in the Company’s consolidated results through November 28, 2023, the day prior to the date of the receivership. However, under ASC 810, consolidation of a majority-owned subsidiary is precluded where control of the subsidiary does not rest with the majority owners. Once the Texas Department of Insurance was appointed as receiver of BHIC-Texas we concluded the Company no longer controlled the subsidiary, and we deconsolidated BHIC-Texas as of that date.

The deconsolidation of BHIC-Texas resulted in certain related party balances that had previously been eliminated upon consolidation to become liabilities of the Company. In 2022, BHIC-Texas entered into a risk share contract with a different NeueHealth affiliate, whereby losses incurred at BHIC-Texas over a specified medical loss ratio target were transferred from BHIC-Texas to the affiliated entity. On November 29, 2023 the accrued loss of BHIC-Texas related to the risk share contract was $124.0 million. Upon deconsolidation of BHIC-Texas, this liability is required to be recorded as risk share payable to deconsolidated entity on the Consolidated Balance Sheet. The corresponding receivable on BHIC-Texas was included in our carrying value evaluation described below.

The table below presents the balance sheet of BHIC-Texas on November 29, 2023, the date the Deconsolidated Entity was placed into receivership.

	2022
Amortization of Direct contracting performance year receivable Cash and cash equivalents	$ 554,905 60,560
Amortization of Direct contracting performance year obligation Prepaids and other current assets	654,087 1,522
Direct contracting revenue Risk Share Receivable	654,087 123,981
Total Assets	$ 186,063
Accounts payable	135
Medical costs payable	3,283
Other current liabilities	1,523
Risk adjustment payable	89,638
Total Liabilities	$ 94,579
Additional paid in capital	204,753
Accumulated deficit	(113,269)
Total Equity	$ 91,484
Total Liabilities and Equity	$ 186,063

Under ASC 810, this loss of control would likely trigger a gain or loss for the parent as the parent would remeasure its retained noncontrolling investment at fair value. Upon deconsolidation, the Company valued its investment in BHIC-Texas to be $91.5 million, which is equivalent to the Deconsolidated Entity's carrying value. Upon valuing the investment in BHIC-Texas we assessed the current expected credit loss associated with the underlying receivables; as a result of our analysis we recorded a full valuation allowance on the investment due to uncertainties related to the collection of the risk share receivable. The $91.5 million bad debt expense within the discontinued Bright HealthCare - Commercial reporting segment is recorded within net loss from discontinued operations on the consolidated statements of income (loss).

NOTE 21. QUARTERLY FINANCIAL INFORMATION (UNAUDITED) 19. DISCONTINUED OPERATIONS

Correction of prior period financial statements

Subsequent to In April 2023, we announced that we were exploring strategic alternatives for our California Medicare Advantage business, the issuance of Bright HealthCare reporting segment, with the condensed consolidated financial statements focus on a potential sale. At that time, we met the criteria for the quarter ended September 30, 2022, we identified an error "held for sale," in the accounting for gross versus net revenue recognition conclusion from certain value-based care arrangements. As accordance with ASC 205-20. This represents a result, Premium revenue and Medical costs strategic shift that will have been reduced by $23.3 million, $30.4 million for the quarters ended March 31 and June 30, 2022, respectively. There is no a material impact on Operating loss or Net loss. There was no impact our business and financial results. As such, we have reflected amounts relating to the condensed consolidated balance sheets, condensed consolidated statements of comprehensive income (loss), condensed consolidated statements of changes in redeemable preferred stock and shareholders' equity (deficit) and condensed consolidated statements of cash flows.

For the quarter ended September 30, 2022 we also identified an error in the data used to account for RAF, Bright HealthCare as a result disposal group as part of this error as well as the previously noted error in accounting for gross versus net revenue recognition conclusion from certain value-based care arrangements, Premium revenue decreased $49.9 million, Medical costs decreased $39.2 million, and Operating loss and Net loss increased $10.8 million. As of September 30, 2022 there were corresponding decreases of $17.9 million in Accounts receivable and $7.2 million in medical costs payable on the condensed consolidated balance sheets. The impact on net loss, accounts receivable and medical costs payable had corresponding impacts on condensed consolidated statements of comprehensive income (loss), condensed consolidated statements of changes in redeemable preferred stock and shareholders' equity (deficit) and condensed consolidated statements of cash flows.

The Company determined that the correction of these errors was not material to the condensed consolidated financial statements.

The following tables provide details of our quarterly financial information for the years ended December 31, 2022 and 2021 *(in thousands)*:

2022	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Operating Revenues	$ 644,559	$ 599,222	$ 598,875	$ 569,374
Operating Income (Loss) from continuing operations, net of tax	(77,062)	(182,648)	(200,790)	(177,465)
Operating Income (Loss) from discontinued operations, net of tax	(17,115)	(155,134)	(69,339)	(480,327)
Less: Income attributable to non-controlling interests	(1,413)	(36,528)	(46,711)	(11,012)
Less: Preferred Stock Dividends Accrued	(8,938)	(9,461)	(9,684)	(11,604)
Income (Loss) attributable to Bright Health Group, Inc. common shareholders	$ (104,528)	$ (383,771)	$ (326,524)	$ (680,408)

Basic and diluted loss per share attributable to Bright Health Group, Inc. common shareholders				
Continuing operations	$ (0.14)	$ (0.36)	$ (0.41)	$ (0.32)
Discontinued operations	(0.03)	(0.25)	(0.11)	(0.76)
Basic and diluted loss per share	(0.17)	(0.61)	(0.52)	(1.08)

discontinued operations.

Bright Health Group, NeueHealth, Inc.
Notes to Consolidated Financial Statements

2021	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Operating Revenues	$ 252,748	$ 415,105	$ 464,957	$ 380,223
Operating Income (Loss) from continuing operations, net of tax	(47,620)	(29,442)	(76,643)	(169,405)
Operating Income (Loss) from discontinued operations, net of tax	23,075	(14,281)	(217,288)	(646,761)
Less: Income attributable to non-controlling interests	(617)	(795)	(3,942)	(1,143)
Less: Preferred Stock Dividends Accrued	—	—	—	—
Income (Loss) attributable to Bright Health Group, Inc. common shareholders	$ (25,162)	$ (44,518)	$ (297,873)	$ (817,309)
Basic and diluted loss per share attributable to Bright Health Group, Inc. common shareholders				
Continuing operations	$ (0.34)	$ (0.19)	$ (0.13)	$ (0.27)
Discontinued operations	0.16	(0.09)	(0.34)	(1.03)
Basic and diluted loss per share	(0.18)	(0.28)	(0.47)	(1.30)

On June 30, 2023, the Company entered into the Molina Purchase Agreement to sell its California Medicare Advantage business, which consists of Brand New Day and Central Health Plan. On December 13, 2023, the Company, Molina, BHCC, CHP and BND amended the Molina Purchase Agreement, pursuant to which, the parties agreed to amend the total purchase considerations to $500.0 million subject to certain contingencies and tangible net equity ("TNE") adjustments. The transaction was consummated on January 1, 2024.

In October 2022, we announced that we will no longer offer commercial plans through our Bright HealthCare - Commercial segment in 2023. As a result, we exited the Commercial marketplace effective December 31, 2022. We determined this exit represented a strategic shift that will have a material impact on our business and financial results that requires presentation as discontinued operations. The Bright HealthCare - Commercial segment is also inclusive of our MA Legacy business; all periods presented have been recast to reflect this presentation.

While we are no longer offering plans in the Commercial marketplace as of December 31, 2022, we continue to have involvement in the states where we formerly operated in as we support run out activities of medical claims incurred in the 2022 plan year and perform other activities necessary to wind down our operations in each state, including making payments of 2022 risk adjustment payable liabilities during the third quarter of 2023. We are substantially complete with medical claim payments as of the end of 2023, and we will continue to make remaining medical claim payments and payments towards the remaining risk adjustment obligations through 2024 and early 2025.

Our discontinued operations are also inclusive of our DocSquad business that was sold in March 2023; this is presented within the column labeled Other in the tables below.

The discontinued operations presentation has been retrospectively applied to all prior periods presented.

The financial results of discontinued operations by major line item for the years ended December 31 were as follows *(in thousands)*:

NeueHealth, Inc.
Notes to Consolidated Financial Statements

For the year ending December 31, 2023	Bright HealthCare - Commercial	Bright HealthCare	Other	Total
Revenue:				
Premium revenue	$ (18,129)	$ 1,728,182	$ —	$ 1,710,053
Service revenue	30	—	2,383	2,413
Investment income (loss)	57,415	7,419	—	64,834

Total revenue from discontinued operations	39,316	1,735,601	2,383	1,777,300
Operating expenses:				
Medical costs	137,239	1,621,696	—	1,758,935
Operating costs	118,870	222,460	2,380	343,710
Bad debt expense	97,141	93	92	97,326
Restructuring charges	11,620	5	1	11,626
Goodwill impairment	—	186,150	—	186,150
Intangible assets impairment	—	—	—	—
Depreciation and amortization	—	5,871	—	5,871
Total operating expenses from discontinued operations	364,870	2,036,275	2,473	2,403,618
Operating loss from discontinued operations	(325,554)	(300,674)	(90)	(626,318)
Interest expense	11,608	—	—	11,608
Loss from discontinued operations before income taxes	(337,162)	(300,674)	(90)	(637,926)
Income tax expense (benefit)	140	—	—	140
Net loss from discontinued operations	$ (337,302)	$ (300,674)	$ (90)	$ (638,066)

NeueHealth, Inc.
Notes to Consolidated Financial Statements

For the year ending December 31, 2022	**Bright HealthCare - Commercial**	**Bright HealthCare**	**Other**	**Total**
Revenue:				
Premium revenue	$ 4,064,119	$ 1,586,548	$ —	$ 5,650,667
Service revenue	148	—	8,411	8,559
Investment income (loss)	(41,221)	410	—	(40,811)
Total revenue from discontinued operations	4,023,046	1,586,958	8,411	5,618,415
Operating expenses:				
Medical costs	3,808,006	1,475,683	—	5,283,689
Operating costs	916,048	190,549	25,633	1,132,230
Bad debt expense	20,271	194	556	21,021
Restructuring charges	50,748	445	2,072	53,265
Goodwill impairment	4,147	70,017	1,208	75,372
Intangible assets impairment	6,720	—	—	6,720
Depreciation and amortization	145	17,702	2,018	19,865
Total operating expenses from discontinued operations	4,806,085	1,754,590	31,487	6,592,162
Operating loss from discontinued operations	(783,039)	(167,632)	(23,076)	(973,747)
Other income	—	—	799	799
Loss from discontinued operations before income taxes	(783,039)	(167,632)	(22,277)	(972,948)
Income tax expense (benefit)	1,674	3	13	1,690
Net loss from discontinued operations	$ (784,713)	$ (167,635)	$ (22,290)	$ (974,638)

The following table presents cash flows from operating and investing activities for discontinued operations *(in thousands)*:

	For the years ending December 31,	
	2023	**2022**
Cash provided by (used in) operating activities - discontinued operations	$ (2,656,876)	$ 362,695
Cash provided by (used in) investing activities - discontinued operations	1,127,673	(466,385)

Assets and liabilities of discontinued operations were as follows *(in thousands)*:

	December 31, 2023		
	Bright HealthCare - Commercial	Bright HealthCare	Total
Assets			
Current assets:			
Cash and cash equivalents	$ 159,769	$ 128,212	$ 287,981
Short-term investments	9,163	20,218	29,381
Accounts receivable, net of allowance	1,430	51,929	53,359
Prepaids and other current assets	7,838	114,532	122,370
Goodwill	—	172,543	172,543
Intangible assets, net	—	138,982	138,982
Property, equipment, and capitalized software, net	—	17,954	17,954
Current assets of discontinued operations	178,200	644,370	822,570
Total assets of discontinued operations	$ 178,200	$ 644,370	$ 822,570
Liabilities			
Current liabilities:			
Medical costs payable	$ 31,881	$ 272,138	$ 304,019
Accounts payable	25,648	7,719	33,367
Risk adjustment payable	291,146	—	291,146
Other current liabilities	28,045	43,181	71,226
Current liabilities of discontinued operations	376,720	323,038	699,758
Total liabilities of discontinued operations	$ 376,720	$ 323,038	$ 699,758

	December 31, 2022			
	Bright HealthCare - Commercial	Bright HealthCare	Other	Total
Assets				
Current assets:				
Cash and cash equivalents	$ 1,469,577	$ 244,616	$ 1,091	$ 1,715,284
Short-term investments	1,129,800	3,972	—	1,133,772
Accounts receivable, net of allowance	4,167	59,308	1,636	65,111
Prepaids and other current assets	187,818	85,479	—	273,297
Current assets of discontinued operations	2,791,362	393,375	2,727	3,187,464
Other assets:				
Goodwill	—	358,693	—	358,693
Intangible assets, net	—	144,131	—	144,131
Property, equipment, and capitalized software, net	—	21,298	—	21,298
Other non-current assets	—	4,995	—	4,995
Long-term assets of discontinued operations	—	529,117	—	529,117
Total assets of discontinued operations	$ 2,791,362	$ 922,492	$ 2,727	$ 3,716,581
Liabilities				
Current liabilities:				
Medical costs payable	$ 691,221	$ 290,296	$ —	$ 981,517
Accounts payable	160,707	10,858	—	171,565

Risk adjustment payable	1,942,643	1,247	—	1,943,890
Unearned revenue	—	—	242	242
Other current liabilities	19,373	40,002	647	60,022
Current liabilities of discontinued operations	2,813,944	342,403	889	3,157,236
Total liabilities of discontinued operations	$ 2,813,944	$ 342,403	$ 889	$ 3,157,236

Revenue Recognition: Premium revenue includes revenue derived from insurance contracts of Bright HealthCare - Commercial, within the scope of ASC 944, *Financial Services - Insurance*. Premium revenue is recognized in the period for which services are covered. Individual policies can be terminated by a consumer without advance notice to the Company. Consumers that have unpaid premium balances for the coverage period are subject to certain termination requirements depending on whether the premium is subsidized or nonsubsidized by CMS. The Company estimates the portion of unpaid balances that will not be collected from consumers and records an allowance accordingly.

For Bright HealthCare - Commercial, we record adjustments for changes to the risk adjustment balances for individual policies in premium revenue. The risk adjustment program adjusts premiums based on the demographic factors and health status of each consumer as derived from current-year medical diagnoses as reported throughout the year. Under the risk adjustment program, a risk score is assigned to each covered consumer to determine an average risk score at the individual and small-group level by legal entity in a particular market in a state. Additionally, an average risk score is determined for the entire subject population for each market in each state. Settlements are determined on a net basis by legal entity and state and are made in the middle of the year following the end of the contract year. Each health insurance issuer's average risk score is compared to the state's average risk score. Risk adjustment is subject to audit by the Department of Health and Human Services ("HHS"), which could result in future payments applicable to benefit years.

The Company, in conjunction with the MA program, covers prescription drug benefits under the Medicare Prescription Drug Benefit ("Medicare Part D") program. Premium revenue includes CMS monthly premiums, consumer premium and CMS low-income premium subsidy for our insurance risk coverage. Premiums are recognized ratably over the period in which eligible individuals are entitled to receive covered benefits.

CMS covers 80% of allowed claims costs above the defined standard true out-of-pocket threshold of $7,050 for any individual beneficiary enrolled in a Medicare Advantage plan ("MAO"). The reinsurance calculation is based on the benefit actually offered (i.e. basic or enhanced) and with CMS covering 80% of a member's drug costs in the catastrophic phase. CMS provides upfront subsidies to MAO's through a monthly payment in the Monthly Membership Report to cover the estimated cost of federal reinsurance on a per-member-per-month basis. Reinsurance subsidies in excess of federal reinsurance claims are paid back to CMS (a payable). If the MAO does not have enough federal reinsurance revenue to cover the federal reinsurance claims, CMS will pay the shortfall to the MAO.

Premium revenue under the MA program includes CMS monthly premiums that are risk adjusted based on CMS defined formulas using consumer demographics and hierarchical condition category codes calculated based on historical data submitted to CMS on a lagged basis. Risk Adjustment Factor-related ("RAF") premiums settle between CMS and the Company during both a midyear and final reconciliation process. Due to the lagged nature of the reconciliation and settlement, RAF-related premiums are estimated based on the lagged information that we submitted to CMS. The accuracy of the data submissions to CMS used in the RAF reconciliation are subject to CMS audit under the risk adjustment data validation audits and could result in future adjustments to premiums. As of December 31, 2023 and 2022, our MA risk adjustment receivable was $51.3 million and $62.2 million, respectively, recorded in accounts receivable within current assets of discontinued operations.

Our monthly payment from CMS includes prospective subsidies to cover catastrophic reinsurance and low-income cost subsidies, and the Medicare Part D coverage gap discount that the Company must cover at the point-of-sale for prescription drugs. We are not at risk for these portions of the Medicare Part D benefit design. We account for these CMS-provided subsidies and related costs on the Consolidated Balance Sheets and ultimately settle with CMS and pharmaceutical companies during the final Medicare Part D reconciliation subsequent to the plan year. As of December 31, 2023 and 2022, we had receivables of $6.9 million and $6.7 million, respectively, recorded as prepaid and other current assets in current assets of discontinued operations, and payables of $35.0 million and $24.6 million, respectively, recorded as other current liabilities, within current liabilities of discontinued operations related to these programs.

Our Medicare Part D premiums are subject to risk sharing with CMS under the risk corridor provisions. The risk corridor provisions compare costs targeted in our annual bid to actual prescription drug costs incurred. Our profit or loss is shared with or covered by CMS depending on the relative position within the risk corridor band. Changes in the risk corridor payable or receivable are recognized in premium revenue. As of December 31, 2023 and 2022, we had a risk corridor payable of $29.3 million and $15.2 million, respectively, included in other current liabilities in current liabilities of discontinued operations. The 2022 risk corridor payable was not settled as of December 31, 2023. We had no material risk corridor receivable as of December 31, 2023 and 2022, respectively.

NeueHealth, Inc.
Notes to Consolidated Financial Statements

Investments: We invest in debt securities of the U.S. government and other government agencies, corporate investment grade, money market funds and various other securities.

We determine the appropriate classification of investments at the time they are acquired and evaluate the appropriateness of such classifications at each balance sheet date. We classify our investments in individual debt securities as available-for-sale securities or held-to-maturity securities. All available-for-sale investments maturing less than one year from the statement date that management intends to liquidate within the next year are reflected as short-term investments. Available-for-sale investments with a maturity date greater than one year are classified as long-term investments. All available-for-sale investments are measured and carried at fair value. Changes in unrealized holding gains and losses on available-for-sale securities are reflected in other comprehensive income (loss).

Realized gains and losses for all investments are included in investment income. The basis for determining realized gains and losses is the specific-identification method. Interest on debt securities is recognized in investment income when earned. Premiums and discounts are amortized/accreted using methods that result in a constant yield over the securities' expected lives.

Beginning January 1, 2020, we adopted the new current expected credit losses ("CECL") model. The CECL model retained many similarities from the previous OTTI model, except it eliminated the length of time over which the fair value had been less than cost from consideration in the impairment analysis. Also, under the CECL model, expected losses on available-for-sale debt securities are recognized through an allowance for credit losses rather than as a reduction in the amortized cost of the securities. For debt securities whose fair value is less than their amortized cost which we do not intend to sell or are not required to sell, we evaluate the expected cash flows to be received as compared to amortized cost and determine if an expected credit loss has occurred. In the event of an expected credit loss, only the amount of the impairment associated with the expected credit loss is recognized in income with the remainder, if any, of the loss recognized in other comprehensive income (loss). To the extent we have the intent to sell the debt security, or it is more likely than not we will be required to sell the debt security, before recovery of our amortized cost basis, we recognize an impairment loss in income in an amount equal to the full difference between the amortized cost basis and the fair value.

Potential expected credit loss impairment is considered using a variety of factors, including the extent to which the fair value has been less than cost; adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a debt security; changes in the quality of the debt security's credit enhancement; payment structure of the debt security; changes in credit rating of the debt security by the rating agencies; failure of the issuer to make scheduled principal or interest payments on the debt security and changes in prepayment speeds. For debt securities, we take into account expectations of relevant market and economic data. We estimate the amount of the expected credit loss component of a debt security as the difference between the amortized cost and the present value of the expected cash flows of the security. The present value is determined using the best estimate of future cash flows discounted at the implicit interest rate at the date of purchase. The expected credit loss cannot exceed the full difference between the amortized cost basis and the fair value.

Accrued interest receivable relating to our debt securities is presented within prepaids and other current assets of current assets of discontinued operations. We do not measure an allowance for credit losses on accrued interest receivable. We recognize interest receivable write offs as a reversal of interest income. We had no write offs of accrued interest receivable in the years ended December 31, 2023 and 2022.

Medical Costs and Medical Costs Payable: In developing our medical costs payable estimates, we apply completion factors to actual claims adjudicated-to-date to estimate the expected amount of ultimate incurred claims for those months, and also review our remaining claims inventory to further validate expected medical costs. These estimates may change as actuarial methods change or as underlying facts upon which the estimates are based change. Management believes the amount of medical costs payable is the best estimate of our liability as of December 31, 2023; however, actual payments may differ from those established estimates.

Restricted Investments and Statutory Deposits: The regulated insurance entities of NeueHealth are required to, among other things, hold certain statutory deposits and comply with certain minimum capital requirements, such as risk-based capital requirements, under applicable state regulations. Statutory deposits are classified as held-to-maturity investments and are carried at cost. The Company's regulated legal entities held the required deposit amounts at December 31, 2023 and 2022,

totaling $6.8 millionand $8.6 million, respectively. The statutory deposits are principally held in U.S. Treasury securities within a custodial or controlled account with a custodial trustee and are included primarily in short-term investments and long-term investments, consistent with classification of other similar invested assets, in the Consolidated Balance Sheets.

Reinsurance Recoveries: We have a quota share agreement with RGA, an alien unauthorized reinsurer, which cedes proportional percentages of premiums and medical costs of covered business of the Company, with the difference as an experience refund of ceded premiums, less a ceding fee paid to the reinsurer. Coverage includes comprehensive individual commercial policies in Colorado, Nebraska, Oklahoma and Florida. Effective January 1, 2021, we entered into a quota share agreement with the Canada Life Assurance Company,an alien unauthorized reinsurer, which cedes proportional percentages of premiums and medical costs of covered business of the Company, with the difference as an experience refund of ceded premiums, less a ceding fee paid to the reinsurer. Coverage includes comprehensive individual commercial policies in Florida. Deposit accounting is used for this arrangement and only ceding fees are recognized in the Consolidated Statements of Income (Loss) for the years ended December 31, 2023 and 2022, respectively.

Within our Medicare Advantage business we have an agreement with Swiss Re Life & Health America, Inc. ("Swiss Re") in which Swiss Re provides excess loss reinsurance coverage to the Company on individuals covered under our individual and small group policies. Effective January 1, 2021 we entered an agreement with RGA Reinsurance Company ("RGA") in which RGA provides loss reinsurance coverage to the Company on individuals covered under our MA polices. Receivables from reinsurers under these

agreements totaled $10.6 million and $14.9 million as of December 31, 2023 and 2022, respectively, and are recorded in prepaids and other current assets within current assets of discontinued operations in the Consolidated Balance Sheets. Payables for reinsurance premiums and ceding fees of $0.5 million and $4.7 million are recorded as other current liabilities within current liabilities of discontinued operations in the Consolidated Balance Sheets as of December 31, 2023 and 2022, respectively.

Net reinsurance recoveries (net ceded premiums) of $3.4 million and $10.6 million were recorded as a reduction of medical costs within loss from discontinued operations in the Consolidated Statements of Income (Loss) for the years ended December 31, 2023 and 2022, respectively.

Provider Risk Sharing: Our MA insurance business in California maintains a risk-sharing program with contracted primary care providers and hospitals.

Risk-sharing payables of $30.7 million and $30.6 million for our MA insurance business in California and risk-sharing receivables of $28.7 million and $17.8 million for agreements between our provider practices and insurers were recorded as of December 31, 2023 and 2022, respectively. Risk-sharing payables are presented within medical costs payable of our current liabilities of discontinued operations while risk-sharing receivables are presented in prepaids and other current assets of our current assets of discontinued operations.

Premium Deficiency Reserve: Premium deficiency reserve ("PDR") liabilities are established when it is probable that expected future claims and maintenance expenses will exceed future premium and reinsurance recoveries on existing medical insurance contracts, including consideration of investment income. We assess if a PDR liability is needed through review of current results and forecasts. For purposes of determining premium deficiency losses, contracts are grouped consistent with our method of acquiring, servicing, and measuring the profitability of such contracts. As of December 31, 2023 and 2022 we accrued no PDR liability.

Goodwill and Other Intangible Assets: On December 13, 2023 we announced the $100.0 million decrease in the purchase price of our California MA business from $600.0 million to $500.0 million; we identified this decrease in purchase price as an event that indicated the carrying value of our Bright HealthCare reporting unit may not be recoverable. As such we performed an interim impairment test as of December 31, 2023.

To estimate the fair value of the Bright HealthCare reporting unit we reduced the $500.0 million purchase price by $175.8 million, the amount subject to contingencies and TNE adjustments that create uncertainties in what will be the final adjusted purchase prices as well as the transaction costs incurred to complete the sale. As a result of the decreased purchase price, we recognized a $186.2 million goodwill impairment related to our Bright HealthCare reporting unit within discontinued operations for the year endedDecember 31, 2023. For the year ended December 31, 2022, we recognized a $70.0 million

goodwill impairment of the Bright HealthCare reporting unit primarily driven by an increase in the discount rate, which was impacted by higher interest rates and other market factors.

The Company classifies its valuation of the held for sale Bright Healthcare reporting unit as Level 1 fair value because the adjusted purchase price serves as a quoted price for the exact disposal group.

Restructuring Charges: As a result of the strategic changes, we announced and have taken actions to restructure the Company's workforce and reduce expenses based on our updated business model.

Restructuring charges within our discontinued operations for the years ended December 31, 2023, and 2022 were as follows *(in thousands):*

	For the years ending December 31,	
	2023	**2022**
Employee termination benefits	3,743	16,097
Long-lived asset impairments	8,398	7,126
Contract termination and other costs	(515)	30,042
Total discontinued operations restructuring charges	$ 11,626	$ 53,265

Restructuring accrual activity recorded by major type for the years ended December 31, 2023, and 2022 was as follows; employee termination benefits are within Other current liabilities of discontinued operations while contract termination costs are within Accounts payable of discontinued operations *(in thousands)*:

	Employee Termination Benefits	Contract Termination Costs	Total
Balance at January 1, 2023	$ 16,053	$ 29,053	$ 45,106
Charges	3,743	(515)	3,228
Cash payments	(16,929)	(6,046)	(22,975)

Balance at December 31, 2023	$ 2,867	$ 22,492	$ 25,359

	Employee Termination Benefits	Contract Termination Costs	Total
Balance at January 1, 2022	$ —	$ —	$ —
Charges	16,053	29,053	45,106
Cash payments	—	—	—
Balance at December 31, 2022	$ 16,053	$ 29,053	$ 45,106

Fixed Maturity Securities: Available-for-sale securities within our discontinued operations are reported at fair value as of December 31, 2023 and 2022. Held-to-maturity securities are reported at amortized cost as of December 31, 2023 and 2022. The following is a summary of our investment securities as of December 31,*(in thousands)*:

	2023			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Carrying Value
Cash equivalents	$ 150,939	$ —	$ —	$ 150,939
Available for sale:				
U.S. government and agency obligations	1,557	—	(100)	1,457
Corporate obligations	615	—	(11)	604
Certificates of deposit	19,653	—	—	19,653
Mortgage-backed securities	951	—	(63)	888
Total available-for-sale securities	22,776	—	(174)	22,602
Held to maturity:				
U.S. government and agency obligations	6,503	1	(59)	6,445
Certificates of deposit	334	—	—	334
Total held-to-maturity securities	6,837	1	(59)	6,779
Total investments	$ 180,552	$ 1	$ (233)	$ 180,320

	2022			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Carrying Value
Cash equivalents	$ 963,062	$ 32	$ —	$ 963,094
Available for sale:				
U.S. government and agency obligations	372,244	1	(3,239)	369,006
Corporate obligations	520,619	521	(714)	520,426
State and municipal obligations	10,308	—	(96)	10,212
Certificates of deposit	12,012	—	(2)	12,010
Mortgage backed securities	154,167	46	(156)	154,057
Asset backed securities	59,289	—	—	59,289
Other	386	—	(14)	372
Total available-for-sale securities	1,129,025	568	(4,221)	1,125,372
Held to maturity:				
U.S. government and agency obligations	6,622	—	(158)	6,464

Certificates of deposit	$ 1,936	$ —	$ —	$ 1,936
Total held-to-maturity securities	$ 8,558	$ —	$ (158)	$ 8,400
Total investments	$ 2,100,645	$ 600	$ (4,379)	$ 2,096,866

As of December 31, 2023, we believe that we will collect the principal and interest due on our debt securities that have an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate increases and not by unfavorable changes in the credit quality associated with these securities. As of December 31, 2022, we concluded that it was more likely than not that we would have to sell some of the securities before recovering the amortized cost basis due to our decision to exit the commercial business. We recognized an impairment of $67.7 million in our available-for-sale securities portfolio. This impairment is related to the decrease in the fair value of debt securities primarily driven by an increase in market interest rates since the time the securities were purchased. At each reporting period, we evaluate securities for impairment when

the fair value of the investment is less than its amortized cost. We evaluated the underlying credit quality and credit ratings of the issuers, noting no significant deterioration since purchase.

Fair Value Measurements: The Fair Value Measurements and Disclosures topic in FASB ASC 820 defines fair value, establishes a framework for measuring fair value, and expands disclosures of fair value measurements, which applies to all assets and liabilities measured on a fair value basis. The standard establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements).

Basis of fair value measurement:

Level 1: Unadjusted quoted prices in active markets that are accessible at the measurement date for identical, unrestricted assets or liabilities

Level 2: Quoted prices for similar assets or liabilities in active markets or quoted prices in markets that are not active, or inputs that are observable, either directly or indirectly, for substantially the full term of the asset or liability

Level 3: Prices or valuation techniques that require inputs that are both significant to the fair value measurement and unobservable (i.e., supported by little or no market activity)

There were no investments in Level 3 securities and no transfers in or out of Level 3 financial assets or liabilities as of and during the years ended December 31, 2023 or 2022.

Nonfinancial assets and liabilities or financial assets and liabilities that are measured at fair value on a nonrecurring basis are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. There were no significant fair value adjustments for these assets and liabilities recorded during the years ended December 31, 2023 or 2022.

A financial instrument's level within the fair value hierarchy is based on the lowest level of input that is significant to the fair value measurement.

The following methods and assumptions were used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument included in the tables below:

Cash and Cash equivalents — The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. Fair values of cash equivalent investments outside of money- market funds and U.S treasury securities are classified as Level 2.

Debt Securities — The fair values of debt securities are based on quoted market prices, where available. We obtain one price for each security primarily from its custodian, or if unavailable, securities evaluations, prices received from a secondary pricing source, or other third-party calculated prices based on observable inputs in the market are used to price securities. If these are unavailable, we are able to provide pricing overrides from other acceptable sources or methods; however, based upon the relatively high rating of our investments, this is generally not required.

We are ultimately responsible for determining fair value, as well as the appropriate level within the fair value hierarchy, based on the significance of unobservable inputs. At the end of each reporting period, we review third-party pricing services' pricing methodologies, data sources and pricing inputs to ensure the fair values obtained are reasonable.

As of December 31, 2023, investments and cash equivalents within our discontinued operations were comprised of $157.8 million and $22.6 million with fair value measurements of Level 1 and Level 2, respectively. As of December 31, 2022, the investments and cash equivalents within our discontinued operations were comprised of $1.3 billion and $826.0 million with fair value measurements of Level 1 and Level 2, respectively.

NeueHealth, Inc.
Notes to Consolidated Financial Statements

Medical Costs Payable: The table below details the components making up the medical costs payable within current liabilities of discontinued operations as of December 31, *(in thousands)*:

	Bright HealthCare - Commercial		Bright HealthCare	
	December 31, 2023	December 31, 2022	December 31, 2023	December 31, 2022
Claims unpaid	$ 14,500	$ 60,856	$ 33,826	$ 41,188
Provider incentive payable	—	310	40,704	40,907
Claims adjustment expense liability	2,382	46,490	5,167	6,732
Incurred but not reported (IBNR)	14,999	583,565	192,441	201,469
Total medical costs payable of discontinued operations	**$ 31,881**	$ 691,221	**$ 272,138**	$ 290,296

The following table shows the components of the change in medical costs payable for the years ended December 31, *(in thousands)*:

	Bright HealthCare	
	2023	2022
Medical costs payable – January 1	**$ 290,296**	$ 244,534
Incurred related to:		
Current year	**1,593,709**	1,471,297
Prior year	**26,573**	6,244
Total incurred	**1,620,282**	1,477,541
Paid related to:		
Current year	**1,333,531**	1,182,291
Prior year	**304,909**	249,488
Total paid	**1,638,440**	1,431,779
Acquired claims liabilities	**—**	—
Medical costs payable – December 31	**$ 272,138**	$ 290,296

Medical costs payable attributable to prior years increased by $26.6 million and $6.2 million for the years ended December 31, 2023 and 2022, respectively, resulting from claim settlements being more than original estimates. Medical costs payable estimates are adjusted as additional information becomes known regarding claims. There were no significant changes to estimation methodologies in 2023 or 2022.

The following is information about incurred and cumulative paid claims development as of December 31, 2023, net of reinsurance, and the total claims payable plus expected development on reported claims included within the net incurred claims amounts. The information about incurred and paid claims development for the years ended December 31, 2021 through 2023 is presented as supplementary information as follows and is inclusive of claims incurred and paid related to CHP prior and subsequent to the acquisition date *(in thousands)*:

	Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance (in thousands) For the Years Ended December 31,			Total Incurred but Not Reported Liabilities Plus Expected Development on Reported Claims
Accident Year	(Unaudited) 2021	(Unaudited) 2022	2023	
2021	1,313,337	1,319,581	**1,321,798**	860
2022		1,472,587	**1,497,797**	11,961
2023			**1,593,709**	263,611
Total			**$ 4,413,304**	

	Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance (in thousands)

	For the Years Ended December 31,		
	(Unaudited)	(Unaudited)	
Accident Year	2021	2022	2023
2021	1,071,736	1,270,444	**1,320,938**
2022		1,232,941	**1,485,836**
2023			**1,330,098**
Total			**$ 4,136,872**
All outstanding liabilities before 2021, net of reinsurance			**—**
Liabilities for claim and claim adjustment expenses, net of reinsurance			**$ 276,432**

	December 31, 2023
Net outstanding liabilities	**$ 276,432**
Reinsurance recoverable on unpaid claims	**(4,294)**
Total gross liability for unpaid claims and claims	**$ 272,138**

Risk Adjustment: We record adjustments for changes to the risk adjustment balances for individual policies in premium revenue. The risk adjustment program adjusts premiums based on the demographic factors and health status of each consumer as derived from current-year medical diagnoses as reported throughout the year. Under the risk adjustment program, a risk score is assigned to each covered consumer to determine an average risk score at the individual and small-group level by legal entity in a particular market in a state. Additionally, an average risk score is determined for the entire subject population for each market in each state. Settlements are determined on a net basis by legal entity and state and are made in the middle of the year following the end of the contract year. Each health insurance issuer's average risk score is compared to the state's average risk score. Risk adjustment is subject to audit by HHS, which could result in future payments applicable to benefit years. Risk adjustment payable for our discontinued operations was estimated to be $291.1 millionand $1.9 billion at December 31, 2023 and 2022, respectively.

Accounts Payable: As of December 31, 2023, the majority of the Accounts payable of discontinued operations balance included $22.5 million of contract termination costs related to restructuring. As of December 31, 2022, the Accounts payable of discontinued operations balance included $41.8 million of broker commissions payable and $36.5 million of premium taxes payable.

Property, Equipment and Capitalized Software: The table below details the property, equipment and capitalized software at December 31, 2023 and 2022, consists of the following (in thousands).

NeueHealth, Inc.
Notes to Consolidated Financial Statements

	2023	2022
Software	$ 22,521	$ 29,039
Leasehold improvements	288	403
Medical and other equipment	38	208
Gross property, equipment, and capitalized software	22,847	29,650
Less accumulated depreciation	(4,893)	(8,352)
Property, equipment, and capitalized software, net	$ 17,954	$ 21,298

Depreciation expense of $0.7 million and $3.2 million was recognized for the years ended December 31, 2023 and 2022, respectively. Fixed asset impairment expense of $3.9 million and $5.9 million was recognized for the years ended December 31, 2023 and 2022, respectively.

Leases: Operating lease costs were $10.2 million and $4.6 million for the years ended December 31, 2023, and 2022, respectively. The years ended December 31, 2023 and 2022 included immaterial short-term lease costs and sublease income. Operating lease costs are included in operating costs in the Consolidated Statements of Income (Loss). Operating lease ROU assets for our discontinued operations are included in prepaids and other current assets and other non-current assets. Operating lease liabilities for our discontinued operations are included in other current liabilities.

At December 31, 2023 and 2022, the assets and liabilities related to operating leases in our Consolidated Balance Sheets are as follows *(in thousands)*:

	2023	2022

Assets		
Operating lease ROU assets	$ 492	$ 8,545
Liabilities		
Operating lease liabilities	$ 8,983	$ 12,563

We incurred $7.0 million in operating lease costs related to the full abandonment of operating leases for our discontinued operations for the year ended December 31, 2023.

Supplemental cash flow and noncash information related to our operating leases was as follows *(in thousands)*:

	2023	2022
Operating cash flows from operating leases	$ 7,499	$ 6,372
ROU assets obtained in exchange for new lease liabilities	—	—
Weighted-average remaining lease term (in years)	3.7	4.2
Weighted-average discount rate	6.0 %	6.0 %

Restricted Capital and Surplus: Our regulated insurance legal entities are required by statute to meet and maintain a minimum level of capital as stated in applicable state regulations, such as risk-based capital requirements. These balances are monitored regularly to ensure compliance with these regulations. Our regulated subsidiaries had statutory capital and surplus of $(225.0) million and $42.1 million as of December 31, 2023 and 2022, respectively. We are out of compliance with the minimum levels for certain of our regulated insurance legal entities of our discontinued operations.

NeueHealth, Inc.
Notes to Consolidated Financial Statements

NOTE 22. 20. SUBSEQUENT EVENTS

Effective as of January 1, 2024, the Molina Purchase Agreement transaction was consummated for an aggregate purchase price of $500.0 million subject to certain contingencies and TNE adjustments. Upon completion of the sale, the Bright HealthCare reporting unit of our discontinued operations was no longer included in our operations.

On January 3, 2023 January 2, 2024, we granted 27.1 million RSUs that will vest in two years. On March 6, 2023 we granted 26.8 million RSUs that will vest ratably over both the Payoff Condition and the L/C Condition were satisfied pursuant to the Letter Agreement entered into by the Company, the Agent, the Lenders, and the Guarantors. As a three-year period. result, the Consent and the Termination of our Credit Agreement occurred.

We have evaluated the events and transactions that have occurred through the date at which the consolidated financial statements were issued. Other than those described above, no additional events or transactions have occurred that may require adjustment to the consolidated financial statements or disclosures.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURES

None.

ITEM 9A. CONTROLS AND PROCEDURES

Limitations of Effectiveness of Disclosure Controls and Procedures

In designing and evaluating our disclosure controls and procedures, management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving the desired control objectives. In addition, the design of disclosure controls and procedures must reflect the fact that there are resource constraints, and that management is required to apply judgment in evaluating the benefits of possible controls and procedures relative to their costs.

Evaluation of Disclosure Controls and Procedures

Our management, with the participation of our Chief Executive Officer and Chief Financial Officer, evaluated, as of December 31, 2022 December 31, 2023, the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act). Based on that evaluation, our Chief Executive Officer and Chief

Financial Officer concluded that, as of December 31, 2022 December 31, 2023, our disclosure controls and procedures were not effective due to a material weakness in our internal control over financial reporting, as described below.

Previously Disclosed Material Weakness

As of December 31, 2022, multiple deficiencies constituted a material weakness, in the aggregate, relating to deployment of control activities through internal control policies that establish what is expected and procedures that put policies into action. The deficiencies identified were in part related to our announced plans to exit the IFP business effective December 31, 2022. We announced further restructuring plans in the second quarter of 2023, including the intended sale of our MA business. The additional restructuring has led to changes in the scope of controls related to our continuing operations.
Since disclosing this material weakness, the Company has:

- Held SOX training sessions to communicate expectations, and enhance awareness and understanding of control activities and related responsibilities,
- Created or enhanced certain policies and procedures for processes where control deficiencies existed,
- Allocated resources from the Company's discontinued operations to those remaining continuing operations and,
- Remediated certain control activities that were previously identified as deficient.

Despite the progress made in 2023, the Company is unable to conclude the material weakness was remediated as of December 31, 2023. The continuation of the Company's reorganization activities in 2023 resulted in shifting control owner roles and responsibilities across several areas, and changes in the scope of relevant controls. These changes caused delays with the performance of certain control activities and/or inconsistencies with how those activities were documented, and as a result, control activities did not consistently have sufficient time to demonstrate operational effectiveness.

Management's Annual Report on Internal Control over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as defined in Rules 13a-15(f) and 15d-15(f) of the Exchange Act and based upon the criteria established in Internal Control-Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission ("the COSO framework"). Act.

Under the supervision and with the participation of our management, including our Chief Executive Officer and Chief Financial Officer, we have conducted an evaluation of the effectiveness of our internal control over financial reporting based on the COSO framework. criteria established in Internal Control-Integrated Framework (2013) issued by COSO. Based on an evaluation under these criteria, and the existence of the previously disclosed material weakness described below, (mentioned above), management determined that we did not maintain effective internal control over financial reporting as of December 31, 2022 December 31, 2023. A material weakness is a deficiency, or combination of deficiencies, in internal control over financial reporting, such that there is a

reasonable possibility that a material misstatement of the Company's annual or interim financial statements will not be prevented or detected on a timely basis.

As of December 31, 2022, management the Company identified a material weakness in the control activities component of internal control over financial reporting as defined by the COSO framework. COSO. Specifically, multiple deficiencies constituted a material weakness, in the aggregate, relating to deployment of control activities through internal control policies that establish what is expected and procedures that put policies into action.

The following factors contributed to While the identified material weakness Company believes remediation efforts in the Company's 2023 have improved our internal control activities component. The Company announced in the fourth quarter of 2022 plans to exit the IFP business effective December 31, 2022. The Company decreased its focus on performing certain control activities in accordance with policies and procedures. This resulted in our inability to fully validate over financial reporting, remediation of the material weakness identified in will require further validation and testing of the prior year for claims pertaining to our IFP business, due to new operating effectiveness of internal controls and processes that were implemented that did not have over a sufficient sustained period of time to operate effectively. These IFP processes and significant accounts in the fourth quarter of 2022 include, but are not limited to, revenue and membership, enrollment and eligibility, and claims processing. time.

The Our independent registered public accounting firm has not performed an evaluation of the effectiveness of our internal control over financial reporting as during any period in 2023 in accordance with the provisions of December 31, 2022 has been audited by Deloitte & Touche LLP, an independent registered public accounting firm, as stated in their report included in this Annual Report. the Sarbanes-Oxley Act.

2024 Remediation Plans

Management's plan to address the material weakness existing as of December 31, 2023, includes the following:

- Proactively allocate the necessary resources to the operation of control activities impacted by the Company's continued reorganization activities.

Change- Continue to support new control owners through SOX training sessions focused on appropriately executing their internal control responsibilities.

As we continue to evaluate and work to remediate the control deficiencies that gave rise to the material weakness, we may determine that additional measures or time are required to address the control deficiencies or that we need to modify or otherwise adjust the remediation measures described above. The material weakness cannot be considered remediated until the applicable controls have operated for a sufficient period of time and management has concluded, through testing, that these controls are operating effectively. Accordingly, we will continue to assess the effectiveness of our remediation efforts in connection with our evaluation of our internal control over financial reporting.

Changes in Internal Control over Financial Reporting

Other than as Except for the items described below, above, there were no changes during the quarter ended December 31, 2023, in our internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act during the quarter ended December 31, 2022 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Remediation Efforts to Address the Material Weaknesses

In response to the material weakness in our internal control over financial reporting identified as of December 31, 2021, our management, with the oversight of the audit committee of our Board of Directors, has dedicated resources and efforts to improve our internal control over financial reporting and has taken action to remediate the material weakness. The material weakness identified related to claims pertaining to our IFP business, which were processed by a third-party service provider. The claims were processed inaccurately according to terms of provider contracts and/or related fee schedules, or did not consistently go through claims re-pricing, where necessary, prior to payment.

In response to this material weakness, we focused on enhancing our pre-pay and post-pay claims quality assurance procedures and data mining capabilities. These capabilities have enabled early identification of overpayment issues so the issues can be addressed timely. Additionally, our provider data improvement initiatives have enhanced the accuracy of our provider rosters, determination of in-network versus out-of-network status, and alignment of providers to appropriate contracts and fee schedules. Finally, additional front-end claims review procedures implemented in the first quarter of fiscal year 2022 have resulted in improved claims payment accuracy, based on fee schedules agreed-upon with providers. While the Company has made significant progress in its remediation efforts, a material weakness remains relating to the Company's IFP business as of December 31, 2022, as noted above in Management's Annual Report on Internal Control over Financial Reporting.

In response to the material weakness in our internal control over financial reporting identified as of December 31, 2022, our management, with the oversight of the audit committee of our Board of Directors, will continue to dedicate resources and efforts to improve our internal control over financial reporting and continue to take actions to remediate the material weakness, including the reinforcement of the importance of performing control activities, assigning responsibility to perform those control activities timely, consistently and comprehensively, and addressing issues of non-compliance timely. This will also include performing control activities over the run out of the IFP business in 2023 due to the discontinuation of the IFP business effective December 31, 2022.

Once the applicable controls have operated for a sufficient period of time, management will test the design and operating effectiveness of the controls to determine if the material weakness has been remediated.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of Bright Health Group, Inc.

Opinion on Internal Control over Financial Reporting

We have audited the internal control over financial reporting of Bright Health Group, Inc. and subsidiaries (the "Company") as of December 31, 2022, based on criteria established in *Internal Control — Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). In our opinion, because of the effect of the material weakness identified below on the achievement of the objectives of the control criteria, the Company has not maintained effective internal control over financial reporting as of December 31, 2022, based on criteria established in *Internal Control — Integrated Framework (2013)* issued by COSO.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated financial statements as of and for the year ended December 31, 2022, of the Company and our report dated March 16, 2023, expressed an unqualified opinion on those financial statements.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Annual Report on Internal Control over Financial Reporting as of December 31, 2022. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Material Weaknesses

A material weakness is a deficiency, or a combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the company's annual or interim financial statements will not be prevented or detected on a timely basis. The following material weakness has been identified and included in management's assessment: The Company identified a material weakness in the control activities component of internal

control over financial reporting as defined by the COSO framework. Specifically, multiple deficiencies constituted a material weakness, in the aggregate, relating to deploying control activities through internal control policies that establish what is expected and procedures that put policies into action. The material weakness was considered in determining the nature, timing, and extent of audit tests applied in our audit of the consolidated financial statements as of and for the year ended December 31, 2022, of the Company, and this report does not affect our report on such financial statements.

/s/ Deloitte & Touche LLP

Minneapolis, Minnesota

March 16, 2023

ITEM 9B. OTHER INFORMATION

None.

ITEM 9C. DISCLOSURE REGARDING FOREIGN JURISDICTIONS THAT PREVENT INSPECTIONS

Not applicable.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Information regarding our executive officers is provided in Part I under the heading "Information About our Executive Officers."

BOARD OF DIRECTORS AND CORPORATE GOVERNANCE

Board of Directors

Our business and affairs are managed under the direction of our Board. Our Board currently consists of 12 members. Our amended and restated certificate of incorporation provides that our Board will initially be classified and will transition to an annually elected Board through a gradual phase-out process. At the 2024 annual meeting of stockholders and each annual meeting of stockholders thereafter, all directors shall be elected to hold office for a one-year term expiring at the next annual meeting of stockholders. Pursuant to such procedures, effective as of the conclusion of the 2024 annual meeting of stockholders, the Board will no longer be classified and directors shall no longer be divided into three classes.

Presented below is information with respect to our four Class II director nominees to be elected as directors at this year's Annual Meeting, our Class I directors and our Class III directors. The information presented below for each director includes the specific experience, qualifications, attributes and skills that led us to the conclusion that such director should serve on the Board.

Class II Directors – Terms expire in 2023

Linda Gooden, age 69, has served as a director since November 2020. Ms. Gooden has served over 30 years in various senior leadership roles with Lockheed Martin Corporation ("Lockheed"), most recently as Executive Vice President, Information Systems & Global Solutions ("IS&GS") from 2007 to 2013. Under her leadership as Executive Vice President of IS&GS, Lockheed expanded systems integration, security and transformation capabilities beyond government customers to international and commercial markets. She also served as Lockheed's Deputy Executive Vice President, Information and Technology Services from October to December 2006 and its President, Information Technology from 1997 to December 2006. In her role as President of Lockheed's IT division, Ms. Gooden founded and grew the business over a 10-year period to become a multi-billion dollar business. In the past eight years, Ms. Gooden has served on the Board of General Motors Company, The Home Depot, Inc., Automatic Data Processing, Inc., WGL Holdings, Inc. and Washington Gas & Light Company, a subsidiary of Alta Gas.

We believe that Ms. Gooden contributes to our Board her executive and boardroom experience at numerous publicly-held companies and her extensive experience with information technology and information security matters.

Jeffery R. Immelt, age 67, has served as a director since April 2020. Since 2018, Mr. Immelt has served as a venture partner on the technology and healthcare investing teams for New Enterprise Associates, a venture capital firm. From 2001 to 2017, Mr. Immelt served as the Chairman and Chief Executive Officer of General Electric Company. Mr. Immelt joined General Electric in 1982 and held various roles within the company before assuming his position as Chief Executive Officer. Mr. Immelt currently serves on the boards of Collective Health, Inc., Twilio Inc., where he is also a member of the compensation committee, Desktop Metal, Inc., where he is also a member of the audit committee, and Bloom Energy Cooperation, where he is also a member of the audit committee.

We believe Mr. Immelt contributes to our Board his executive and boardroom experience at numerous publicly-held companies.

Manuel Kadre, age 57, has served as a director since November 2020. Mr. Kadre is Chairman and Chief Executive Officer of MBB Auto Group, a premium luxury retail automotive group with a number of dealerships in the Northeast, a position he has held since 2012. Prior to his current role, Mr. Kadre was the Chief Executive Officer of Gold Coast Caribbean Importers, LLC from July 2009 until 2014. From 1995 until July 2009, Mr. Kadre served in various roles, including President, Vice President, General Counsel and Secretary, for CC1 Companies, Inc., a distributor of beverage products in markets throughout the Caribbean. Mr. Kadre is currently a member of the board of directors of Florida Free Trade Area of the Americas, Miami International Airport Blue Ribbon Aviation Panel and Florida Self-Insurers Guaranty Association, and is Chairman of the United Way Alexis de Tocqueville Society. Mr. Kadre serves as Chairman of the Board of Republic Services, Inc. and serves on the boards of directors of The Home Depot, Inc., Mednax Services, Inc. and the Board of Trustees of the University of Miami.

We believe Mr. Kadre contributes to our Board his significant chief executive and senior management experience leading large companies, as well as his experience as a director of companies, including service as chairman and lead independent director of three public companies.

Stephen Kraus, age 46, has served as a director since March 2016. Mr. Kraus has served as an investment professional at Bessemer Venture Partners, a venture capital firm, since 2004 and has been a partner since 2011. Mr. Kraus currently serves on the boards of directors of various privately held companies. Mr. Kraus also serves as an advisor to various organizations, including but not limited to Boston Children's Hospital and the Harvard Business School's Center for Entrepreneurship, and on the investment committees of various organizations, including but not limited to Blue Cross Blue Shield of Massachusetts.

We believe Mr. Kraus is qualified to serve on our Board due to his experience as a venture capitalist and his service on the boards of directors of other healthcare companies.

Class I Directors - Terms expire in 2024

Naomi Allen, age 49, has served as a director since February 2020. Since October 2019, Ms. Allen has served as the Chief Executive Officer and Co-founder of Brightline, Inc. From April 2018 until October 2019, Ms. Allen served as the Chief Growth Officer at Livongo Health, Inc., overseeing key strategic growth initiatives. Prior to Livongo Health, Inc., Ms. Allen was a category designer at Play Bigger from February 2017 to April 2018. Prior to joining Play Bigger, Ms. Allen was on sabbatical from December 2015 until February 2017, and also held various executive positions at Castlight Health, Inc. from April 2008 until December 2015.

We believe Ms. Allen contributes to our Board because of her experience advising healthcare companies as an executive officer.

Matthew G. Manders, age 61, has served as a director since March 2022. Mr. Manders served as the president of Cigna Corporation's ("Cigna") Government and Solutions organization from January 2021 through December 2021, building on his successful 30-plus-year career with the company. From November 2018 to January 2021, Mr. Manders served as the President of Cigna's Strategy and Solutions organization. Prior those roles, he served as Cigna's President of Government & Individual Programs & Group Insurance from February 2017 to November 2017, and as President US Markets from June 2014 to February 2017. Mr. Manders has served as a Trustee of Eisenhower Fellowships since 2013, is the Chair of its Administration and Finance Committee, and is a member of its Audit, Compensation and Executive Committees.

We believe Mr. Manders contributes to our Board because of his financial expertise and his experience supervising healthcare companies as an executive officer.

Adair Newhall, age 44, has served as a director since May 2017. Mr. Newhall is a Partner at StepStone Group, which acquired Greenspring Associates in 2021, where he served in various position since January 2015. Prior to Greenspring Associates, Mr. Newhall served as a principal at Domain Associates, LLC from August 2009 until December 2014. Prior to joining Domain Associates, LLC, Mr. Newhall worked in the business development group at Esprit Pharma, Inc., where he assisted with multiple product acquisitions and the subsequent sale of the company to Allergan plc. Before that, Mr. Newhall worked at ESP Pharma, Inc., which was acquired by PDL BioPharma, Inc. Mr. Newhall currently serves on the Board of Crown Laboratories, Inc. and is a board observer at Aetion, Inc. and Paladina Health LLC.

We believe Mr. Newhall contributes to our Board through his experience investing in and advising healthcare companies, as well as his experience as a director of companies.

Andrew Slavitt, age 56, has served as a director since August 2021. He previously served as a director of the Company form April 2018 until January 2021, when he was appointed as President Biden's White House Senior Advisor for the COVID-19 response effort. Mr. Slavitt is the founder and General Partner of Town Hall Ventures, which invests in healthcare innovations in vulnerable communities, a position he has held since 2018. Prior to that, he served as the Acting Administrator for the Centers for Medicare & Medicaid Services from 2015 to 2017, and as Group Executive Vice President of Optum, UnitedHealth Group's health services platform, from 2012 to 2014. From 2006 through 2011, Mr. Slavitt was the CEO of OptumInsight (formerly Ingenix), a UnitedHealth Group subsidiary. He serves on the Board of Directors of private companies Cityblock Health, Inc. and Equality Health, LLC, is co-chair of the Future of Healthcare Initiative at the Bipartisan Policy Center, and previously served as a director of Capella Education Company, an education services company (formerly Nasdaq: CPLA). Mr. Slavitt received his MBA from Harvard Business School and Bachelor of Arts and Bachelor of Science degrees from the University of Pennsylvania.

Mr. Slavitt brings to our Board of Directors extensive executive and leadership experience in the healthcare industry. His leadership at Centers for Medicare & Medicaid Services and within the healthcare insurance industry provides a valuable perspective to our Board.

Class III Directors - Terms expire in 2024

Robert J. Sheehy, age 65, is one of our co-founders and served as Chief Executive Officer from September 2015 until April 2020, and served as our Executive Chairman from April 2020 to May 2021. From 1986 to 2008, Mr. Sheehy held various executive positions at UnitedHealth Group, Inc., including as Chief Executive Officer of UnitedHealthcare, Inc. Mr. Sheehy currently serves on the Board of Directors for Radiology Partners, Inc. and the University of Michigan Health System. Following UnitedHealth Group, Inc. Mr. Sheehy served as an Operating Partner at Genstar Capital LLC, an Executive Partner at Flare Capital Partner, and a Strategic Advisor at Cimarron Healthcare Capital. Mr. Sheehy also continues to serve as an Executive Partner at Flare Capital Partners.

We believe that Mr. Sheehy brings leadership and a wealth of experience in healthcare to the Board, as well as knowledge of regulations and issues facing healthcare providers and medical companies.

G. Mike Mikan, age 51, has served as our Chief Executive Officer and President since April 2020. Mr. Mikan joined as our Vice Chairman and President in January 2019. Prior to joining Bright Health, Mr. Mikan served as Chairman and Chief Executive Officer of Shot-Rock Capital, LLC, a private investment firm, from January 2015 until December 2018. From January 2013 until December 2014, he served as President of ESL Investments, Inc. Mr. Mikan served as the Interim Chief Executive Officer of Best Buy Co., Inc. from April 2012 until September 2012. From November 1998 through February 2012, he served in various executive positions at UnitedHealth Group, Inc., including as Chief Financial Officer and as Chief Executive Officer of UnitedHealth Group's Optum subsidiary. Mr. Mikan serves as a director of AutoNation, Inc.

We believe that Mr. Mikan contributes to our Board his management experience and expertise in the healthcare sector.

Kedrick D. Adkins Jr., age 70, has served as a director since February 2020. Mr. Adkins served as the Chief Financial Officer for the Mayo Clinic from 2014 through his retirement at the end of 2017. He also served as the President of Integrated Services of Trinity Health Care from 2007 to 2014. Prior to his service at Trinity Health Care, Mr. Adkins had a 30-year tenure at Accenture, a global management consulting firm. Mr. Adkins is a certified public accountant. Mr. Adkins currently serves as a director and member of the audit committee for ProAssurance Corporation. Mr. Adkins currently serves on the Advisory Board of Welsh, Carson, Anderson & Stowe, an investment firm specializing in healthcare and technology, and the board of directors for CHRISTUS Health, the University of Michigan Hospital System, and Medical Memory, a medical technology startup.

We believe Mr. Adkins contributes to our Board his experience as an executive at major healthcare companies as well as his experience in boardrooms for healthcare companies.

Mohamad Makhzoumi, age 43, has served as a director since March 2016. Mr. Makhzoumi is a General Partner and Head of Global Healthcare at New Enterprise Associates, where he has served in various positions since 2005. Prior to joining New Enterprise Associates, Mr. Makhzoumi served as an associate at Summit Partners, L.P. and as an analyst at UBS Group AG, concentrating on leveraged finance and sponsor-led transactions. Mr. Makhzoumi currently serves on the board of directors of private companies Aetion, Inc., American Pathology Partners, Inc., Collective Health, Inc., Comprehensive Pharmacy Services, Inc., Nuvolo Technologies Corp, and Radiology Partners, Inc.

We believe Mr. Makhzoumi contributes to our Board his extensive experience investing in and advising healthcare companies, as well as his experience as a director of companies.

Corporate Governance

Our business and affairs are managed under the direction of our Board. Our Board currently consists of 12 directors divided into three classes. The Board and its committees meet throughout the year on a set schedule and hold special meetings and act by written resolution from time to time, as appropriate. For the year ended December 31, 2022, our Board held ten meetings. Our Audit Committee, Compensation and Human Capital Committee ("Compensation Committee"), and Nominating and Corporate Governance Committees held four, four, and one meeting(s), respectively, during 2022. In 2022, each director attended at least 75% of the meetings of the Board during such director's tenure and substantially all of the total number of meetings held by any of the committees of the Board on which the director served. Members of our Board are encouraged to attend our annual meetings of stockholders.

Board Leadership Structure

Our Board is led by Mr. Sheehy, the Chairman of the Board. Mr. Kadre, our Lead Director, provides effective independent oversight of management. Our Board selects its Chairperson and the Company's Chief Executive Officer in the manner it considers in the best interests of the Company, and thus has no policy with respect to the separation of the offices of Chairperson and Chief Executive Officer. The Board believes that this issue should be considered periodically as part of the succession planning process, however, and that it is in the best interests of our company to make a determination regarding this issue each time it appoints a new Chief Executive Officer. Accordingly, the Board may determine that it is appropriate in the future to combine the roles of Chairperson and Chief Executive Officer.

When the Chairperson of the Board is not independent, our Board elects a Lead Director. The Lead Director helps coordinate the efforts of the independent and non-management directors in the interest of ensuring that objective judgment is brought to bear on sensitive issues involving the management of the Company and, in particular, the performance of senior management. The Lead Director presides at Board meetings at which the Chairperson is not present and, among other things, collaborates with our Chief Executive Officer on Board matters, and acts as a liaison between the independent directors, on one hand, and stockholders or the Chairperson, on the other.

Role of Board of Directors in Risk Oversight

The Board has extensive involvement in the oversight of risk management related to us and our business and accomplishes this oversight through the regular reporting by the Audit Committee. Through its regular meetings with management, including the finance, legal and internal audit functions, the Audit Committee reviews and discusses all significant areas of our business and summarizes for the Board all areas of risk and the appropriate mitigating factors.

Committees of the Board of Directors

The standing committees of our Board consist of an Audit Committee, a Compensation and Human Capital Committee and a Nominating and Corporate Governance Committee.

Our Chief Executive Officer and other executive officers regularly report to the non-executive directors and the Audit, the Compensation, and the Nominating and Corporate Governance Committee to ensure effective and efficient oversight of our activities and to assist in proper risk management and the ongoing evaluation of management controls. The internal audit function reports functionally and administratively to our Chief Financial Officer and directly to the Audit Committee. We believe that the leadership structure of our Board provides appropriate risk oversight of our activities.

Audit Committee

The members of our Audit Committee are Kedrick Adkins, who serves as the Chair, Manuel Kadre and Linda Gooden, each of whom qualifies as an independent director under the NYSE corporate governance standards and independence requirements of Rule 10A-3 of the Exchange Act. Our Board has determined that Kedrick D. Adkins, Manuel Kadre and Linda Gooden each qualifies as an "audit committee financial expert" as such term is defined in Item 407(d)(5) of Regulation S-K.

The purpose of the Audit Committee is to prepare the audit committee report required by the SEC to be included in our proxy statement and to assist our Board in overseeing and monitoring (1) the quality and integrity of our financial statements, including oversight of our accounting and financial reporting processes, internal controls and financial statement audits, (2) our compliance with legal and regulatory requirements, (3) our independent registered public accounting firm's qualifications, performance and independence, (4) our corporate compliance program, including our code of conduct and anti-corruption compliance policy, and investigating possible violations thereunder, (5) our risk management policies and procedures and (6) the performance of our internal audit function.

Our Board has adopted a written charter for the Audit Committee, which is available on our website investors.brighthealthgroup.com.

Compensation and Human Capital Committee

The members of our Compensation Committee are Jeffery R. Immelt, who serves as the Chair, Mohamad Makhzoumi and Manuel Kadre, each of whom meets the NYSE's independence requirements applicable to compensation committee members.

The purpose of the Compensation Committee is to assist the Board in discharging its responsibilities relating to, among other things, (1) setting our compensation program and the compensation of our executive officers and directors, (2) administering our incentive and equity-based compensation plans and (3) preparing the Compensation Committee report required to be included in our proxy statement under the rules and regulations of the SEC.

Our Board has adopted a written charter for the Compensation Committee, which is available on our website investors.brighthealthgroup.com.

Compensation Committee Interlocks and Insider Participation

None of our current or former executive officers or employees currently serves, or has served during our last completed fiscal year, as a member of our Compensation Committee and, during that period, none of our executive officers served as a member of the compensation committee (or other committee serving an equivalent function) of any other entity whose executive officers served as a member of our Board. No member of our Compensation Committee has a material interest in any transaction described in the section titled "Certain Relationships and Related Party Transactions" below.

Nominating and Corporate Governance Committee

The members of our Nominating and Corporate Governance Committee are Manuel Kadre, who serves as the Chair, Stephen Kraus and Naomi Allen, each of whom qualifies as an independent director.

The purpose of our Nominating and Corporate Governance Committee is to assist our Board in discharging its responsibilities relating to (1) identifying individuals qualified to become new board members, consistent with criteria approved by the Board, (2) reviewing the qualifications of incumbent directors to determine whether to recommend them for reelection and selecting, or recommending that the Board select, the director nominees for the next annual meeting of stockholders, (3) identifying board members qualified to fill vacancies on any committee of the Board and recommending that the Board appoint the identified member or members to the applicable committee, (4) reviewing and recommending to the Board corporate governance principles applicable to us, (5) overseeing the evaluation of the Board and management and (6) handling such other matters that are specifically delegated to the committee by the Board from time to time.

Our Board has adopted a written charter for the Nominating and Corporate Governance Committee, which is available on our website investors.brighthealthgroup.com.

Background and Experience of Directors; Board Diversity

In accordance with our Corporate Governance Guidelines, the Nominating and Corporate Governance Committee is responsible for reviewing the qualifications of potential director candidates and recommending for the Board's selection those candidates to be nominated for election to the Board, subject to any obligations and procedures governing the nomination of directors to the Board that may be set forth in any stockholders agreement or investor rights agreement to which the Company is party.

The Nominating and Corporate Governance Committee is expected to consider (a) minimum individual qualifications, including strength of character, mature judgment, industry knowledge or experience and an ability to work collegially with the other members of the Board and (b) all other factors it considers appropriate, which may include age, diversity of background, existing commitments to other businesses, service on other boards of directors or similar governing bodies of public or private companies or committees thereof, potential conflicts of interest with other pursuits, legal considerations such as antitrust issues, corporate governance background, financial and accounting background, executive compensation background and the size, composition and combined expertise of the existing Board.

The Board is expected to monitor the mix of specific experience, qualifications and skills of its directors in order to assure that the Board, as a whole, has the necessary tools to perform its oversight function effectively in light of the Company's business and structure.

Stockholder Communications Policy

Stockholders and other interested parties may communicate directly and confidentially with the Board or the independent directors by sending a letter addressed to the intended recipients, c/o Corporate Secretary, 8000 Norman Center Drive, Suite 900, Minneapolis, Minnesota 55437. The secretary will review such communications and, if appropriate, forward them only to the intended recipients. Communications that do not relate to the responsibilities of the intended recipients as

directors of Bright Health (such as communications that are commercial or frivolous in nature) will not be forwarded. In addition, communications that appear to be unduly hostile, intimidating, threatening, illegal or similarly inappropriate will not be forwarded.

Stockholder Recommendations of Director Candidates

Stockholders who would like to recommend a director candidate for consideration by our Nominating and Corporate Governance Committee must send notice to Bright Health Group, Inc., Attn: Corporate Secretary, 8000 Norman Center Drive, Suite 900, Minneapolis, Minnesota 55437, by registered, certified or express mail, and provide us with a brief biographical sketch of the recommended candidate, a document indicating the recommended candidate's willingness to serve if elected, and evidence of the stock ownership of the person recommending such candidate. The Nominating and Corporate Governance Committee or its chair will then consider the recommended director candidate in accordance with the same criteria applied to other director candidates, including those described in our corporate governance guidelines and the charter of the Nominating and Corporate Governance Committee.

Hedging Transactions

Pursuant to our Insider Trading Policy, we prohibit our employees, directors and officers from engaging in any transactions (including prepaid variable forward contracts, equity swaps, collars and exchange funds) that are designed to hedge or offset any decrease in the market value of the Company's equity securities. Additionally, directors, officers and other employees are prohibited from holding our securities in a margin account or otherwise pledging our securities as collateral for a loan without first obtaining pre-clearance from our General Counsel or his or her designee. None of our executive officers or directors pledged any of our securities during 2022.

Code of Conduct

We have adopted a Code code of Conduct ethics applicable to all employees, our principal executive officer and other senior financial officers, who include our principal financial officer, principal accounting officer, controller and directors that addresses legal and ethical issues that may be encountered in carrying out their duties and responsibilities, including the requirement to report any conduct they believe to be a violation persons performing similar functions. The code of the Code of Conduct. The ethics, entitled Code of Conduct, is available posted under "Governance" on the Investor Relations section of our website investors.brighthealthgroup.com. at www.neuehealth.com. For information about how to obtain the Code of Conduct, see Part I, Item 1, "Business." If our Board were to amend our Code of Conduct or waive any provision of our Code of Conduct for a director or executive officer of the Company, we We intend to satisfy the SEC's disclosure requirements regarding amendments to, or waivers of, the code of ethics for our disclosure obligations with respect to any such waiver or amendment senior financial officers by posting such information on our website set forth indicated above.

Delinquent Section 16 (a) Reports The remaining information required by this item will be included under the headings "Corporate Governance" and "Proposal 1 – Election of Directors" in our definitive proxy statement for our 2024 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

Section 16(a) of the Exchange Act requires our executive officers, directors and persons who beneficially own more than 10% of our common stock to file initial reports of ownership and reports of changes in ownership with the SEC. Such executive officers, directors and greater than 10% beneficial owners are required by the regulations of the SEC to furnish us with copies of all Section 16(a) reports they file.

Based solely upon a review of copies of reports on Forms 3 and 4 and amendments thereto filed electronically with the SEC during, and reports on Form 5 and amendments thereto filed electronically with the SEC with respect to, the year ended December 31, 2022, and based further upon written representations received by us with respect to the need to file reports on Form 5, no persons filed late reports required by Section 16(a) of the Exchange Act during the year ended December 31, 2022 other than (i) a late Form 4 for Jeffrey Scherman for a transaction on March 7, 2022 and (ii) a late Form 4 for Jeffrey Scherman for a transaction on May 9, 2022.

ITEM 11. EXECUTIVE AND DIRECTOR COMPENSATION

EXECUTIVE COMPENSATION

COMPENSATION DISCUSSION AND ANALYSIS

This The information required in response to this item will be included under the headings "Executive and Director Compensation, Discussion and Analysis provides an overview of our executive compensation philosophy, the overall objectives of our executive compensation program, and each material element of compensation for the fiscal year ended December 31, 2022, which we also refer to as 2022.

We have provided this information for each person who served as our principal executive officer, our principal financial officer and our two most highly compensated executive officers employed in 2022 (other than our principal executive officers and our principal financial officer), all of whom we refer to collectively as our Named Executive Officers. We have also included this information for two former executive officers who would have been included based on their compensation for 2022 if they had continued to serve as executive officers at the end of the fiscal year.

Our Named Executive Officers for 2022 were:

- G. Mike Mikan, *President and Chief Executive Officer*
- Cathy Smith, *Chief Financial and Administrative Officer*
- Jeff Cook, *Chief Operating Officer*
- Jeff Craig, *General Counsel*

- Michael Carson, *Former Chief Executive Officer-Bright HealthCare*
- Sam Srivastava, *Former Chief Executive Officer" "Executive Compensation – NeueHealth*

Compensation Philosophy and Objectives

As a healthcare company, we operate in a highly competitive business environment, which is characterized by rapidly changing market requirements and the emergence of new market entrants. To succeed in this environment, we must continually develop and refine new and existing products and services and demonstrate an ability to quickly identify and capitalize on new business opportunities. We recognize that our success in this environment is in large part dependent on our ability to attract and retain talented employees. Therefore, we maintain, and modify as necessary, an executive compensation and benefits program designed to attract, retain, and incentivize a highly talented, deeply qualified, and committed team of executive officers to share our vision and desire to work toward these goals.

We endeavor to create and maintain compensation programs that reward performance and serve to align the interests of our executive officers and stockholders. Pursuant to our compensation philosophy, we seek to attract, retain and engage the best talent by:

- Fostering a pay-for-performance culture, where compensation is directly linked to company and individual goal achievement;
- Providing "Total Rewards" (which includes compensation, benefits, work-life balance, recognition, and perquisites) that are competitive with the external market and reward performance that supports our mission, vision and values (Be Brave. Be Brilliant. Be Accountable. Be Inclusive. Be Collaborative.);
- Awarding equity compensation that supports sustained performance and growth and aligns with the long-term interests of our stockholders; and
- Ensuring equal pay for work of equal value, so that differences in pay are based on factors such as job, experience, education, performance and location.

Our Compensation Committee continues to be guided by this philosophy. We intend to continue to evaluate Interlocks and Insider Participation" and "Compensation Committee Report" in our philosophy and objectives and compensation programs as circumstances require, and, at a minimum, our Compensation Committee will review our executive compensation philosophy and objectives annually.

Process for Setting Compensation

Role of Compensation Committee and Management Team

The Compensation Committee is responsible for overseeing our executive compensation program, as well as determining and approving the compensation of our Chief Executive Officer and other Named Executive Officers.

Annual Compensation Review. The Compensation Committee reviews the compensation levels definitive proxy statement for our executive officers annually. For executive officers other than our Chief Executive Officer, our Compensation Committee considers input from our Chief Executive Officer regarding such executive officers' responsibilities, performance and compensation. Specifically, our Chief Executive Officer recommends changes to base salary, target levels for cash incentive awards, incentive and equity awards and advises the Compensation Committee regarding the executive compensation program's ability to attract, retain and motivate talented executive officers. These recommendations reflect compensation levels that our Chief Executive Officer believes are qualitatively commensurate with an executive officer's individual qualifications, experience, responsibility level, functional role, knowledge, skills, and individual performance, as well as the performance of our business. The Compensation Committee considers our Chief Executive Officer's recommendations but may adjust components of compensation up or down as it determines in its discretion. The Compensation Committee makes the final compensation and equity decisions for all the executive officers.

Role of Compensation Consultant

The Compensation Committee engages Willis Towers Watson ("WTW") as its executive compensation consultant to advise on the establishment and review of our compensation programs, related policies and marketplace compensation trends. The Compensation Committee reviewed the independence of WTW under NYSE and SEC rules. Based on its review and information provided by WTW regarding the provision of its services, fees, policies and procedures, presence (if any) of any conflicts of interest, ownership of Bright Health stock, and other relevant factors, the Compensation Committee concluded that the work of WTW has not raised any conflicts of interest and deemed them to be an independent advisor to the Compensation Committee. The executive compensation consultant reports directly to the Committee and does not provide any additional services to management.

Use of Competitive Data

For purposes of comparing our executive compensation against the competitive market, the Compensation Committee established market pay references using multiple third party published surveys including:

- Equilar Top 25 Executive Compensation Survey
- Mercer IHP and Executive Compensation Survey
- Radford Technology and Life Sciences Survey

For each Named Executive Officer, the Compensation Committee sets annual base salary and the target level of annual and long-term incentives, with the intention that such target amounts, together with base salary, provide market competitive total annual target compensation. The target compensations levels for our Named Executive Officers are not intended to align with a specific percentile of the market surveys. These comparisons are part of the total mix of information used to evaluate base salary, short-term and long-term incentive compensation for each Names Executive Officer.

The Compensation Committee, with input from our independent compensation consultant, did not establish a peer group for 2022, but intends to again evaluate whether an appropriate executive officer compensation peer group can be established for any market-based analysis conducted during 2023.

Executive Compensation Practices

We incorporated the following executive compensation and governance principles when making decisions on compensation for the Named Executive Officers in 2022, which we believe are based on industry leading practices. We avoid practices that do not align with the goals of the Company and our stockholders.

What We Do	What We Don't Do
• *Pay-for-performance*: A significant portion of the total compensation for our Named Executive Officers is designed to encourage focus on both our short-term and long-term strategic, financial, and operational success and to reward outstanding individual performance. • *Align incentives with stockholders*: Our executive compensation program is designed to focus our Named Executive Officers on our key strategic, financial and operational goals that will translate into long-term value-creation for our stockholders. • *Limited perquisites*: We provide limited, reasonable perquisites that we believe are consistent with our overall compensation philosophy. • *Clawback policy:* We maintain a robust clawback policy providing the Compensation Committee the ability to cover incentive compensation from any Named Executive Officer in the event of certain restatements of financial results. • *Change in control:* We require a 'double trigger' of both a change in control of the Company and resulting loss of employment. • *Ownership guidelines*: We maintain stock ownership guidelines in order to increase alignment with stockholders.	• *No supplemental retirement plans*: We do not maintain any supplemental retirement plans. • *No tax gross-ups*: We do not provide tax gross-ups under our change in control provisions or deferred compensation programs. • *Repricing*: We prohibit re-pricing of underwater stock options without stockholder approval. • *No hedging or pledging:* We prohibit Named Executive Officers from hedging or pledging Company stock to discourage misalignment between our executives and the Company and its stockholders. • *No uncapped incentive plans*: All of our incentive plans have maximum payouts to avoid excessive risk taking.

Say on Pay

At the 2022 2024 Annual Meeting of Stockholders, 97% of the votes were cast in favor of the advisory vote to approve executive compensation. The Compensation Committee considers the results of the Say on Pay advisory vote from the previous year when reviewing the elements of our executive compensation program Shareholders, and determined not to make changes to the compensation design in 2023 based on the overall support of our executive compensation program.

Elements of 2022 Compensation Program

We provide our executive officers with a mix of pay that reflects our belief that executive compensation should be tied to an appropriate balance of both short- and long-term performance. The primary elements of our executive compensation program are base salary, annual cash incentive, equity-based compensation and certain employee benefits and perquisites. Brief descriptions of each principal element of our executive compensation program are summarized in the following table and described in more detail below. Bright's executive compensation program such required information is designed to provide compensation to our executives for performance on corporate financial and strategic objectives as well as individual performance and level of responsibility.

Compensation Element	Description	Objectives
Base Salary	Fixed compensation provided for service during the fiscal year	Provide a competitive, fixed level of cash compensation to attract and retain talented and skilled executives Rewards the scope of the job, experience, and performance
Annual Cash Incentive	At-risk compensation based on company financial and strategic objectives. Discretionary annual cash incentive determined after considering financial and individual performance	Retain and motivate executives to achieve or exceed financial goals and company objectives without taking excessive risks.

Equity Awards	Equity-based compensation that is subject to vesting based on continued employment or tied to specific performance objectives	The value of equity is directly related to the appreciation in value delivered to our stockholders over time, aligning the interests of our executives with those of our stockholders Promotes long-term retention of talent
Employee Benefits and Perquisites	Participation in all broad-based employee health and welfare programs and retirement plans	Aid in retention of key executives in a highly competitive market for talent by providing an overall market competitive benefits package

Base Salary

Base salaries compensate our Named Executive Officers for fulfilling the requirements of their respective positions and are intended to reflect the scope of their responsibilities, performance, skills and experience as well as competitive market practices. The base salaries of our Named Executive Officers are reviewed annually incorporated herein by our Compensation Committee.

For 2022, our Board approved new hire base salaries of $600,000 for Mr. Cook, $850,000 for Mr. Carson and a promotion base salary of $425,000 for Mr. Craig. Our Compensation Committee reviewed market compensation data from the surveys cited above with references reflecting annual revenues comparable to the Company's estimated annual revenues and made no base salary increase in 2022 to Mr. Mikan or Ms.Smith.

The following table summarizes the base salaries for 2021 and 2022 of the Named Executive Officers who remained employed with us on December 31, 2022. The actual salary amounts earned by such Named Executive Officers for 2022 are reported in the Summary Compensation Table below.

Name	Fiscal Year End 2022 Base Salary ($)	Fiscal Year End 2021 Base Salary ($)	Percentage Increase (%)
G. Mike Mikan	1,300,000	1,300,000	-
Cathy Smith	650,000	650,000	-
Jeff Cook	600,000	-	-
Jeff Craig	425,000	231,000	84

2022 Discretionary Annual Cash Incentive Plan ("AIP")

We believe it is important to motivate our key leaders to achieve our short-term performance goals by linking a portion of their annual cash compensation to the achievement of our approved operating plan by providing the opportunity to earn a discretionary annual cash individual incentive award if the approved operating plan is achieved. We provide a discretionary annual cash incentive award opportunity to key members of management, including our Named Executive Officers, under the terms and conditions of our annual incentive plan for 2022. The AIP supports the Company's compensation philosophy by providing market-competitive incentive compensation designed to reward employees for Company profitability, individual performance, and overall collaboration.

The incentive provided to a participant under the AIP is termed an "individual incentive award" or "IIA" and refers to the amount that may be awarded to a participant as a cash award. The AIP sets out the terms under which an individual incentive award may be granted and payable to a participant.

The AIP is interpreted and administered by the Compensation Committee. The actions of the Compensation Committee are final and binding on all persons, including the participants and any beneficiary. The Compensation Committee, in its sole discretion, has the power, subject to, and within the limitations of, the express provisions of the AIP to: (i) determine from time to time which employees of the Company will be designated as eligible to participate in the AIP and the terms under which they will be entitled to participate; (ii) establish, change and adjust, in its sole discretion, an eligible employee's individual incentive award; and (iii) interpret all plan provisions and decide all disputes concerning eligibility and payment under the AIP.

An employee must satisfy the following requirements in order to be granted an individual incentive award:

- *Minimum Service*. The employee must have been employed by the Company for at least two consecutive months ending on the last day of the fiscal year in which the individual incentive award is granted.

- *Employment*. To be eligible to be granted an individual incentive award, the employee must have been employed by the Company continuously until the incentive award payment date.

An overall AIP pool is determined by the Compensation Committee based on (i) each eligible employee's annual earnings, multiplied by (ii) the employee's target individual incentive award amount, multiplied by (iii) the company performance factor (based on achievement of our operating plan). A participant's incentive award takes into consideration individual, team and Company performance results. At the end of each fiscal year, our Compensation Committee determines, in its discretion, the individual incentive award amount for our Chief Executive Officer and our other Named Executive Officers.

Individual incentive awards are paid as cash awards on a date that is after the end of the fiscal year in which the individual incentive award is granted. For 2022 awards, 50% of the anticipated awards were paid in January 2023 and the balance was paid in March 2023. Individual incentive awards are prorated for time employed during the fiscal year.

Determination of 2022 Individual Incentive Awards under our AIP

For 2022, the Compensation Committee approved the following financial and strategic metrics that they believed best incent our executives to execute on the Company's strategy and drive performance:

- gross revenue;
- adjusted EBITDA;
- medical cost ratio;
- transitioning to a fully aligned care delivery in Florida and Texas; and
- achieving specified technology milestones.

When determining the 2022 Individual Incentive Awards, the Compensation Committee evaluated the Company's overall execution against these performance metrics, as well as the execution of our updated business model to exit the Affordable Care Act Marketplace as an insurer at the end of 2022, thereby ceasing offering of IFP products nationwide and MA products outside of California. Although performance against the metrics as a whole suggested a performance factor of 130% of target, in light of the Company's significant transition in 2022, its failure to meet certain performance metrics, and the need to continue to implement our restructuring plan and align expenses with our updated business model, the Compensation Committee approved a performance factor of 100% of target.

The following table summarizes the amount paid to each Named Executive Officer under the AIP in 2022 (other than Mr. Srivastava, who was not eligible for a bonus as he left the Company in May 2022), as compared to the target opportunity.

Name	2022 Base Salary Paid ($)	Target IIA (%)	Target IIA Amount ($)	Actual IIA Paid ($)(1)
G. Mike Mikan	1,300,000	130	1,690,000	1,690,000
Cathy Smith	650,000	90	585,000	585,000
Jeff Cook(2)	300,000	90	540,000	540,000
Jeff Craig	380,231	50	190,115	190,115
Michael Carson(3)	418,462	90	765,000	765,000

(1) Individual incentive awards under the AIP in 2022 were calculated by multiplying each Named Executive Officer's 2022 actual salary paid by the target individual incentive award percentage by the 100% performance factor described above as adjusted based on individual performance.

(2) Mr. Cook's target incentive award was based on a full year's earnings in accordance with his offer letter.

(3) Mr. Carson's target incentive award was based on a full year's earnings, in accordance with our severance plan and his offer letter.

Long-Term Equity Incentive Compensation

We use equity awards to incentivize and reward our executive officers, including our Named Executive Officers, for long-term corporate performance based on the value of our common stock and, thereby, to align the interests of our executive officers with those of our stockholders. Equity awards have been granted pursuant to the terms of our 2016 Stock Incentive Plan, as amended (the "2016 Equity Plan") and the 2021 Omnibus Incentive Plan, which became effective June 5, 2021 (the "2021 Equity Plan"). No further awards will be granted under the 2016 Equity Plan. However, all outstanding awards granted under the 2016 Equity Plan will continue to be governed by the existing terms of the 2016 Equity Plan and the applicable award agreements.

We use equity awards in the form of restricted stock units ("RSUs") and stock options to deliver long-term incentive compensation opportunities to our executive officers, including the Named Executive Officers, and to address special situations as they may arise from time to time.

The Compensation Committee determines the amount of annual equity awards for our executive officers after taking into consideration the recommendations of our Chief Executive Officer (except with respect to his own long-term incentive compensation), the external market benchmarks, outstanding equity holdings of each executive officer, criticality of position and individual performance (both historical and expected future performance).

In 2022, the Compensation Committee adopted an Equity Award Policy that provides that annual equity awards shall be granted on the third business day after the Company's release of its annual earnings for the previous fiscal year, subject to limited exceptions.

2022 Option Grants to Named Executive Officers

On March 7, 2022, the Compensation Committee authorized annual equity grants to our Named Executive Officers (other than Messrs. Cook and Carson, whose employment had not yet commenced). Except in the case of Mr. Craig, the 2022 annual equity grants were 50% non-qualified stock options and 50% restricted stock units. The 2022 grants to all Named Executive Officers were as follows:

Name	Number of Options Granted	Number of RSUs Granted
G. Mike Mikan	3,458,367	1,815,642
Cathy Smith	1,489,758	782,123
Jeff Cook (1)	—	1,142,132
Jeff Craig (2)	—	139,665
Michael Carson (1)	1,113,861	571,066
Sam Srivastava	478,851	251,397

(1) Mr. Cook and Mr. Carson's equity grants were made on August 15, 2022 to coincide with the commencement of their employment.

(2) Mr. Craig was not a Named Executive Officer at the time of the annual grant and thus his grant was based on his then current role of Vice President, Senior Managing Counsel.

Other Compensation

Retirement Benefits

We maintain the Bright Health Management, Inc. 401(k) Plan (the "401(k) plan"), which is intended to be qualified under Section 401(a) of the Code, with the 401(k) plan's related trust intended to be tax exempt under Section 501(a) of the Code. Our 401(k) plan provides eligible employees, including the Named Executive Officers, with an opportunity to save for retirement on a tax-advantaged basis. Under our 401(k) plan, eligible employees may defer eligible compensation subject to applicable annual contribution limits imposed by the Code. As a tax-qualified retirement plan, contributions to the 401(k) plan and earnings on those contributions are not taxable to the employees until distributed from the plan. Employees who are at least 18 years old and have completed three months of service are eligible to join the 401(k) plan immediately. Eligible participants of the 401(k) plan may contribute any amount up to 100% of their pay, with a maximum of $20,500 for 2022, and eligible participants who are 50 years or older may qualify to make additional pre-tax or "catch-up" deferrals of up to $6,500. The Roth 401(k) deferral option gives participants the flexibility to designate all or part of their 401(k) elective deferrals as Roth contributions, all of which are made with after-tax dollars. We make a safe harbor matching contribution equal to 100% of each eligible participant's first 2% of compensation and 50% of the next 4% of compensation for a maximum company match of 4%. Participants are fully vested in the matching contribution after 1 year of service.

Health and Welfare Benefits

We provide various employee benefit programs to our Named Executive Officers, including medical, dental, vision, employee assistance program, flexible spending accounts, health savings accounts, lifestyle spending accounts, disability insurance, supplemental income replacement plans and life and accidental death and dismemberment insurance. These benefit programs are available to all of our full-time employees. We design our employee benefits programs to be affordable and competitive in relation to the market, as well as compliant with applicable laws and practices. We adjust our employee benefits programs as needed based upon regular monitoring of applicable laws and practices and the competitive market.

Perquisites and Other Benefits

We provide employer matching contributions under the 401(k) plan to all participating employees, including our Named Executive Officers. In 2022, Mr. Mikan was permitted a limited amount of personal use of the Company's leased aircraft upon approval by the Chair of the Compensation Committee. We do not reimburse any taxes for imputed income associated with any such personal travel. All future practices with respect to perquisites or other personal benefits will be approved and subject to periodic review by our Compensation Committee.

No Pension Benefits

Other than with respect to our 401(k) plan, our employees, including the Named Executive Officers, do not participate in any plan that provides for retirement payments and benefits, or payments and benefits that will be provided primarily following retirement.

No Nonqualified Deferred Compensation

During 2022, none of our Named Executive Officers contributed to, or earn any amounts with respect to, any defined contribution or other plan sponsored by us that provides for the deferral of compensation on a basis that is not tax-qualified.

Compensation Policies and Practices

Ownership Guidelines

Our Stock Ownership Guidelines (the “Guidelines”) are designed to align our directors' and executives' interests with our stockholders' interests and to encourage directors and executives to make decisions that will be in our long-term best interests—through all industry cycles and market conditions. The Guidelines require non-employee directors and executive officers to achieve and maintain ownership of our shares equal to five times base salary for the CEO, three times base salary for all other executive leadership team members and three times the annual cash retainer for non-employee directors. The ownership requirement is based on the participant's base salary or annual retainer (as applicable) and the average daily closing share price for the previous 12 months through October 31 of each calendar year.

During any year in which a participant is not in compliance with the ownership requirement, the Compensation Committee may require such participant to retain at least 50% of net shares delivered through our equity incentive plans (“net shares” means the shares remaining after deducting shares for the payment of taxes and, in the case of stock options, after deducting shares for payment of the exercise price of stock options). reference.

Clawback Policy

Pursuant to our Clawback Policy for executive officers, the Compensation Committee may recover cash-based and performance-based-equity incentive compensation paid to any current or former officer (as defined by Rule 16a-1(f) of the Exchange Act) in the event of a restatement of our financial results caused by or contributed to by such officer's fraud, willful misconduct, or gross negligence if the incentive compensation received by such officer exceeded the amount that such officer would have received based on the restated financial results.

Policy on Hedging and Prohibited Transactions

Our Insider Trading Policy prohibits employees, non-employee directors and related persons from engaging in any transactions (including prepaid variable forward contracts, equity swaps, collars and exchange funds) that are designed to hedge or offset any decrease in the market value of the Company’s equity securities. Additionally, directors, officers and other employees are prohibited from holding our securities in a margin account or otherwise pledging our securities as collateral for a loan without first obtaining pre-clearance from our General Counsel or his or her designee.

Compensation Policies as they relate to Risk Management

The Compensation Committee believes that our compensation programs are appropriately designed to provide a level of incentives that does not encourage our executive officers and employees to take unnecessary risks in managing their business operations or functions and in carrying out their employment responsibilities. Specifically:

- a substantial portion of our executive officers' compensation is performance-based, consistent with our approach to executive compensation;
- our annual incentive award program is designed to reward annual financial and/or strategic performance in areas considered critical to our short and long-term success;
- our long-term incentive awards are directly aligned with long-term stockholder interests through their link to our stock price and multi-year ratable vesting schedules; and
- our executive stock ownership guidelines further provide a long-term focus by requiring our executives to personally hold significant levels of our stock.

The Compensation Committee believes that the various elements of our executive compensation program sufficiently incentivize our executives to act based on the sustained long-term growth and performance of our company.

Severance Arrangements and Change in Control Vesting

Effective January 1, 2021, our Board adopted the Bright Health Management Inc. Severance Benefits Plan (amended effective as of June 1, 2021, the “2021 Severance Plan”) (as described in further detail below under “Potential Payments upon Termination or Change in Control”), which supersedes the severance provisions of the employment agreements for all the Named Executive Officers except for Mr. Mikan, who is entitled to severance benefits pursuant to his employment agreement. We provide these severance benefits in order to offer an overall compensation package that is competitive with that offered by the companies with whom we compete for executive talent. Severance benefits allow our executives to focus on our objectives without concern for their employment security in the event of a termination.

Mr. Mikan’s employment agreement, (amended as September 23, 2021) provides for severance benefits and accelerated vesting of a portion of his equity awards (as described in further detail below under “Potential Payments upon Termination or Change in Control”).

Tax and Accounting Implications

Our Board operates its compensation programs with the good faith intention of complying with Section 409A of the Code. We account for equity-based payments with respect to our long-term equity incentive award programs in accordance with the requirements of FASB Accounting Standards Codification Topic 718, Compensation — Stock Compensation, or FASB ASC Topic 718.

COMPENSATION AND HUMAN CAPITAL COMMITTEE REPORT

The Compensation and Human Capital Committee reviewed and discussed with management of the Company the foregoing Compensation Discussion and Analysis. Based on such review and discussion, the Compensation and Human Capital Committee has recommended to the Board that the Compensation Discussion and Analysis be included in this Annual Report on Form 10-K for the fiscal year ended December 31, 2022.

Respectfully submitted by:

Jeffery R. Immelt, Chair
Mohamad Makhzoumi

Manuel Kadre

Notwithstanding any statement in any of our filings with the SEC that might incorporate part or all of any filings with the SEC by reference, including this Proxy Statement, the foregoing Compensation and Human Capital Committee Report is not incorporated into any such filings.

2022 SUMMARY COMPENSATION TABLE

The following table summarizes the total compensation earned by our Named Executive Officers in the fiscal years ended December 31, 2022 and 2021.

Name and Principal Position	Year	Salary ($)	Bonus ($) (1)	Stock Awards ($) (2)	Option Awards ($)(3)	All Other Compensation ($)(4)	Total ($)
G. Mike Mikan	2022	1,300,000	1,690,000	3,249,999	3,249,236	503,934	9,993,169
CEO	2021	1,033,077	1,275,850	94,815,000	83,679,502	10,420	180,813,849
Cathy Smith	2022	650,000	585,000	1,400,000	1,399,671	14,780	4,049,451
CFO and CAO	2021	578,269	494,420	16,191,000	12,887,760	10,420	30,161,869
Jeff Cook(5)	2022	300,000	540,000	2,250,000	— —	6,100	3,096,100
COO							
Jeff Craig(6)	2022	380,231	190,115	250,000	—	12,200	832,546
General Counsel							
Michael Carson(7)	2022	418,462	765,000	1,125,000	1,125,056	105,373	3,538,891
Former CEO, Bright HealthCare							
Sam Srivastava(8)	2022	247,692	—	450,000	449,894	12,200	1,159,786
Former CEO, NeueHealth	2021	504,423	359,401	14,301,000	12,887,760	8,700	28,061,284

(1) The amounts reported in this column represent individual incentive awards awarded pursuant to our AIP in 2022. These awards are discussed in further detail under “Compensation Discussion and Analysis—Elements of 2022 Compensation Program—2022 Discretionary Cash Incentive Plan (“AIP”).” Mr. Carson was paid an individual incentive award that was not pro-rated, in accordance with our severance plan and his offer letter.

(2) Represents the aggregate grant date fair value of RSU grants made during each fiscal year, as calculated in accordance with accounting guidance applicable for the type of award, disregarding an estimate of forfeitures. For RSUs, fair value was calculated using the closing price of our common stock on the date of grant. The valuation assumptions used in determining such amounts are described in note 13 to our audited consolidated financial statements in this Form 10-K.

(3) The amounts reported in this column reflect the grant date fair value of the option awards granted to our Named Executive Officers calculated in accordance with Financial Accounting Standards Board Accounting Standards Codification Topic 718. The valuation assumptions used in determining such amounts are described in note 13 to our audited consolidated financial statements in this Form 10-K.

(4) All Other Compensation includes an employer matching contribution by the Company under the 401(k) plan for each named executive officer, and parking costs for Messrs. Mikan and Ms. Smith. All Other Compensation also includes $367,647 reimbursed to Mr. Mikan for life insurance premiums in 2022. The Company did not reimburse Mr. Mikan for life insurance premiums in 2021 but made two reimbursements in 2022 that related to 2021 and 2022. For Mr. Mikan, All Other Compensation also includes an incremental cost of $121,507 for use of the leased aircraft, which amount includes variable operating costs, fuel changes and landing fees and does not include fixed operating costs that do not change based on usage. Mr. Carson received $93,173 of severance payments in 2022

(5) Mr. Cook joined the Company on May 17, 2022.

(6) Mr. Craig was promoted into his role as General Counsel and Corporate Secretary on March 18, 2022.

(7) Mr. Carson joined the Company on May 17, 2022 and left the Company on December 2, 2022.

(8) Mr. Srivastava left the Company on May 11, 2022.

GRANTS OF PLAN BASED AWARDS IN 2022

The following table provides information with regards to each grant of plan-based awards made to a Named Executive Officer under any plan during the fiscal year ended December 31, 2022. For additional information regarding equity incentive plan awards, see “Long-Term Equity Incentive Compensation.”

Name	Grant Date	Approval Date	Estimated Future Payouts under Equity Incentive Plan awards[1]			All Other Stock Awards: Number of Shares of Stock or Units (#)[1]	All Other Option Awards: Number of Securities Underlying Options (#)[1]	Exercise or Base Price of Option Awards ($/share)	Grant Date Fair Value of Stock and Option Awards ($)[2]
			Threshold (#)	Target (#)	Maximum (#)				
G. Mike Mikan	3/7/2022	3/7/2022	—	—	—	1,815,642	3,458,367	1.79	6,499,235
Cathy Smith	3/7/2022	3/7/2022	—	—	—	782,123	1,489,758	1.79	2,799,671
Jeff Cook	8/15/2022	8/15/2022	—	—	—	1,142,132	—		2,250,000
Jeff Craig	3/7/2022	3/7/2022	—	—	—	139,665	—		250,000
Michael Carson	8/15/2022	8/15/2022	—	—	—	571,066	1,113,861	1.97	2,250,056
Sam Srivastava	3/7/2022	3/7/2022	—	—	—	251,397	478,851	1.79	899,895

(1) The vesting schedule applicable to each award is set forth in the “— Outstanding Equity Awards at Fiscal Year End Table.”

(2) The amounts reported in this column do not reflect the actual economic value realized by the Named Executive Officer. The amounts reported in this column represent the grant date fair value of the awards granted to each of the Named Executive Officers in 2022 calculated in accordance with FASB Accounting Standards Codification Topic 718. The valuation assumptions used in determining such amounts are described in note 13 to our audited consolidated financial statements in this Form 10-K.

NARRATIVE DISCLOSURE TO SUMMARY COMPENSATION TABLE AND GRANTS OF PLAN- BASED AWARDS TABLE

Information regarding the elements of our executive compensation program for 2022 is provided above under “Compensation Discussion and Analysis.” The following is a discussion of material factors necessary to obtain an understanding of information disclosed under “—2022 Summary Compensation Table” and “Grants of Plan-Based Awards in 2022” that is not otherwise discussed in the Compensation Discussion and Analysis.

Employment Agreement

Pursuant to Mr. Mikan’s amended and restated employment agreement, effective as of September 23, 2021 (the “Mikan Employment Agreement”), Mr. Mikan serves as our President, Chief Executive Officer and Vice Chair of our Board. Mr. Mikan is entitled to a base salary of $1,300,000, which may be increased at the discretion of the Board. In addition, he is eligible to participate in the AIP, pursuant to which he has a target individual incentive opportunity equal to 130% of his annual base salary. The Mikan Employment Agreement also provides that Mr. Mikan is entitled to reimbursement from the Company up to $100,000 annually for the costs of a life insurance policy (plus the amount of any incremental tax liabilities resulting from such reimbursement). The reimbursement for premiums in 2021 and 2022 were both made in 2022.

Pursuant to the Mikan Employment Agreement, Mr. Mikan is also entitled the severance and change of control benefits described below under “—Potential Payments Upon Termination or Change in Control.”

Personal Aircraft Use

In 2022, Mr. Mikan was permitted a limited amount of personal use of the Company’s leased aircraft upon approval by the Chair of the Compensation Committee. We do not reimburse any taxes for imputed income associated with any such personal travel. All future practices with respect to perquisites or other personal benefits will be approved and subject to periodic review by our Compensation Committee.

OUTSTANDING EQUITY AWARDS AT 2022 FISCAL YEAR END

The following table provides information with regard to each outstanding equity award held by the Named Executive Officers on December 31, 2022. The market value of the RSUs and PSUs is based on the closing market price of our stock on December 30, 2022, which was $0.65.

Outstanding Equity Awards at Fiscal Year End Table

	Option Awards[1]					Stock Awards				

Name	Grant Date	Number of Securities Underlying Unexercised Options # Exercisable	Number of Securities Underlying Unexercised Options # Unexercisable	Option Exercise/ Grant Price	Option Expiration Date	Grant Date	Number of Shares or Units of Stock That have not vested (#)[2]	Market Value of Shares or Units of Stock That have not vested ($)	Equity Incentive Plan Awards: Number of Unearned Shares or Units That Have Not vested (#)[3]	Equity Incentive Plan Awards: Market Value of Unearned Shares or Units That Have Not vested ($)
G. Mike Mikan	1/23/2019	11,059,687	235,313	$ 1.04	1/23/2029	6/28/2021	0	0	7,350,000	4,776,765
	2/19/2020	3,708,123	1,526,877	$ 1.77	2/19/2030	12/14/2021	7,000,000	4,549,300	0	0
	11/19/2020	859,374	790,626	$ 2.30	11/19/2030	3/7/2022	1,815,642	1,179,986	0	0
	2/10/2021	3,580,632	4,321,656	$ 2.30	2/10/2031					
	3/7/2022	0	3,458,367	$ 1.79	3/7/2032					
Cathy Smith	11/4/2019	1,004,250	690,627	$ 1.77	11/4/2029	6/28/2021	0	0	1,050,000	682,395
	2/19/2020	237,498	175,002	$ 1.77	2/19/2030	12/14/2021	1,700,000	1,104,830	0	0
	11/19/2020	225,000	225,000	$ 2.30	11/19/2030	3/7/2022	782,123	508,302	0	0
	2/19/2021	450,000	750,000	$ 2.30	2/19/2031					
	3/7/2022	0	1,489,758	$ 1.79	3/7/2032					
Jeff Cook						8/15/2022	1,142,132	742,272	0	0
Jeff Craig	5/28/2020	13,125	9,375	$ 1.77	5/28/2030	3/7/2022	139,665	90,768	0	0
	11/19/2020	8,124	6,876	$ 2.30	11/19/2030					
	2/19/2021	11,250	18,750	$ 2.30	2/19/2031					
	3/5/2021	7,185	7,815	$ 2.30	3/5/2031					
Michael Carson[4]	8/15/2022	0	1,113,861	$ 1.97	8/15/2032	8/15/2022	571,066	371,136		

(1) 25% of these option awards vest on the one year anniversary of the vesting commencement date, and 1/48th of the options vest each month for three years thereafter. 3,600,000 options granted to Mr. Mikan on January 23, 2019 were transferred to Mikan Family Enterprise, LLC in 2021, all of which are exercisable.

(2) 60% of the RSUs granted on December 14, 2021 vest on the 2nd anniversary of the grant date and 40% on the 3rd anniversary of the grant date.

(3) The PSUs listed in this column vest if the following performance conditions are met: (a) if a price per share goal is achieved before June 28, 2027 and the Named Executive Officer remains employed through such date, the corresponding PSUs vest, and (b) if a price per share goal is achieved after such date, the corresponding PSUs shall vest upon the achievement of such price per share goal. As of December 31, 2022, the price per share goal had not been achieved with respect to any such PSUs.

(4) Pursuant to the 2021 Severance Plan, these awards are subject to continued time-based vesting for 78 weeks following the date of Mr. Carson's separation.

OPTION EXERCISES AND STOCK VESTED

Our Named Executive Officers did not exercise any options in 2022. No stock awards held by our Named Executive Officers vested in 2022.

POTENTIAL PAYMENTS UPON TERMINATION OR CHANGE IN CONTROL

Each Named Executive Officer is entitled to potential payments and benefits in connection with a qualifying termination of employment or a change in control. The information below describes and estimates potential payments and benefits to

which the Named Executive Officers would be entitled under existing arrangements if a qualifying termination of employment or change in control occurred on December 30, 2022. These arrangements include:

- the 2021 Severance Plan;
- the 2016 Plan and the 2021 Plan; and
- Mr. Mikan's employment agreement.

These benefits are in addition to benefits available generally to salaried employees. Due to the number of factors that affect the nature and amount of any benefits provided upon the events discussed below, any actual amounts paid or distributed may be different from those estimated below. Factors that could affect these amounts include the timing during the year of any such event and our valuation at that time. There can be no assurance that a qualifying termination or change in control would produce the same or similar results as

those described below if any assumption used to prepare this information is not correct in fact. We have calculated the acceleration value of all equity awards using the market value of shares of our common stock of $0.65 as of December 30, 2022.

2021 Severance Plan

The 2021 Severance Plan provides severance benefits to all the Named Executive Officers except Mr. Mikan, who is entitled to severance benefits pursuant to his employment agreement, described below. The 2021 Severance Plan is administered by our Chief People Officer (or such other person or persons as determined by our Board). Each Named Executive Officer, other than Mr. Mikan, is eligible to severance benefits if such employee is terminated for reasons determined by the administrator to be an "involuntary termination" of employment by the Company for reasons beyond the participant's control or by the participant for Good Reason, defined below.

For purposes of the 2021 Severance Plan, a participant's termination of employment is not an involuntary termination if such termination is:

- a termination by the Company or affiliate for Cause, defined below;
- a voluntary termination by a participant other than for Good Reason;
- a termination by the participant prior to the date specified by the Company for a participant's involuntary termination of the participant's active employment with the Company; or
- a termination on account of the participant's death or disability.

Severance pay under the 2021 Severance Plan will be paid to our eligible Named Executive Officers for 52 or 78 weeks (the "Severance Period"). Severance pay will generally be paid at regular payroll intervals following the participant's last day worked. Ms. Smith, Mr. Cook, and Mr. Carson are entitled to 78 weeks of base pay plus an amount equal to 1.5 times their target individual incentive award, paid over the Severance Period. Mr. Craig is entitled to 52 weeks of base pay plus an amount equal to 1.0 times his target individual incentive award, paid over the Severance Period.

In addition, the 2021 Severance Plan provides that our Named Executive Officers are entitled to elect and pay for 12 or 18 months of continued coverage under the Company's group medical, dental and/or vision plans pursuant to COBRA, in accordance with ordinary plan practices. If a participant was enrolled in the Company's group medical, dental and/or vision plans at the time of the participant's termination of employment and timely elects continuation coverage under COBRA, the Company will, on a monthly basis, directly pay for the amount of the COBRA coverage cost for medical plan coverage that is in excess of the cost of coverage payable by an active employee of the Company for the "benefit subsidy period." The benefit subsidy period begins immediately following the month active employee coverage terminates on account of the participant's termination of employment.

Eligible Named Executive Officers will also be paid a prorated portion of the individual incentive award, if any, payable in accordance with the terms of the applicable Company AIP for the calendar year in which the participant's termination of employment occurs (other than any requirement that participant remain employed through the end of the calendar year or at the time of payment), with such proration based on the full calendar months of the participant's employment during such year. The prorated individual incentive award will be based on Company performance impacting individual incentive award eligible employees and will be paid at the time the Company pays the individual incentive award to other employees, but not later than March 15th of calendar year following the end of the calendar year in which the participant's employment terminated. In accordance with the terms of his employment, Mr. Carson's individual incentive award was not pro-rated during his first year of employment.

In addition, the 2021 Severance Plan provides that our eligible Named Executive Officers are entitled to continued vesting of any unvested outstanding equity awards subject to time-based vesting during the Severance Period.

In the event of a termination of employment within 12 months following the occurrence of a Change in Control, defined below, the following provisions will apply to eligible Named Executive Officers:

- The severance pay will be paid in a single lump sum as soon as practicable, but not later than 60 days, following the participant's termination of employment.
- The individual incentive award will be equal to 100% of the participant's target individual incentive award amount, and will be paid in a lump sum within 60 days following the participant's termination of employment.
- Any unvested outstanding equity award subject to time-based vesting will vest in full at the time of the participant's termination of employment.

In order to be entitled to any severance benefits under the 2021 Severance Plan, a participant must sign a release of claims and restrictive covenant agreement, which will include non-competition, non-solicitation and non-disparagement provisions.

Under the 2021 Severance Plan, the Company may recover, or "claw back," from a participant any amounts previously paid pursuant to the 2021 Severance Plan if, following such payment, the administrator becomes aware of circumstances existing on the date of payment that could reasonably have been grounds for the participant's termination of employment for Cause or if the participant violates the terms of the restrictive covenant agreement and/or release of claims.

Pursuant to the 2021 Severance Plan:

- "Cause" means that in the Company's exclusive judgment, (i) conduct or statements that violate the Company's employee and member relations standards, including those which require that Company employees treat each other with dignity and respect, (ii) violation of the Company's standards, policies, or individual directives, regarding the prohibition of unlawful discrimination, harassment or retaliation, (iii) unsatisfactory attendance, conduct, or performance, (iv) violation of the Company's standards of conduct, (v) violation of any Company or regulatory standard regarding protection of confidential information, and trade secrets, (vi) refusal to satisfactorily perform the duties, responsibilities and obligations of an employee's position, (vii) dishonesty or other breach of an employee's duty of loyalty affecting the Company or any customer, vendor or other Company employee, (viii) use of alcohol or prohibited substances in a manner that adversely affects the employee's performance of the employee's duties, responsibilities, and obligations as a Company employee, (ix) the employee's conviction of any crime which has a nexus with the employee's position, (x) commission of any other willful or intentional act the Company believes may injure the reputation, business or business relationships of the Company and/or the employee, (xi) the existence of

any court order or settlement agreement prohibiting the employee's continued employment with the Company, (xii) insubordination, (xiii) violation of any statutory or regulatory standard applicable to the Company, or violation of any Company policy or procedure, which adversely affects the Company's legal rights.

- "Good Reason" means, without the express written consent of the participant:

  (a) the assignment to the participant of any duties that results in a material diminution in such participant's position, authority or responsibilities or any other substantial adverse change in such position, authority or responsibilities, that results in a reduction of the participant's grade level, excluding an isolated, insubstantial and inadvertent action not taken in bad faith and which is remedied by the Company as set forth below;

  (b) the material diminution in the participant's total compensation (including Base Salary and incentive pay), other than (i) an insubstantial and inadvertent failure remedied by the Company as set forth below, or (ii) a reduction in compensation which is applied to all similarly situated employees of the Company in the same dollar amount or percentage; or

  (c) the Company's requiring the participant to be based or to perform services at any office or location that is in excess of 50 miles from the principal location of the participant's work, except for travel reasonably required in the performance of the participant's responsibilities.

Before a termination by the participant will constitute termination for Good Reason, (i) the participant must give the Company written notice of the termination within sixty (60) calendar days of the initial occurrence of the event that constitutes Good Reason, (ii) the Company is provided an opportunity to remedy the event or events constituting Good Reason within thirty (30) days after receipt of the notice from the participant, (iii) the Company fails to cure the event or

events constituting Good Reason, and (iv) the participant terminates employment within sixty (60) days of the end of the Company's cure period.

2016 Plan and 2021 Plan

The 2016 Equity Plan provides that upon a participant's termination of service, the Board may, in its sole discretion (which may be exercised at any time on or after the date of grant, including following such termination) cause options (or any part thereof) then held by such participant to terminate, to vest and become exercisable, or to continue to vest and become exercisable or to remain exercisable following such termination of service, and restricted stock awards, restricted stock units or other share-based awards then held by such participant to terminate, vest or become free of restrictions and conditions to payment, as the case may be, following such termination of service, in each case in the manner determined by the Board; however (a) no Option may remain exercisable beyond its expiration date and (b) any such action adversely affecting any outstanding incentive award may not be effective without the consent of the affected participant.

In connection with a change in control, unless provision is made in connection with the change in control in the sole discretion of the parties to the change in control for the assumption or continuation by the successor entity of incentive awards theretofore granted, all outstanding incentive awards granted under this 2016 Equity Plan, whether or not exercisable or vested, as the case may be, will be canceled and terminated and that in connection with such cancellation and termination the holder of any vested incentive award will receive for each share of common stock subject to such incentive award a cash payment (or the delivery of shares of stock, other securities or a combination of cash, stock and securities with a fair market value (as determined by the Board in good faith) equivalent to such cash payment) equal to the difference, if any, between the consideration received by stockholders of the Company in respect of a share of common stock in connection with such change in control and the purchase price per share, if any, under the incentive award, multiplied by the number of shares of common stock subject to such incentive award that were vested at the time of cancellation (or in which such incentive award is denominated); however, if such product is zero ($0) or less or to the extent that the incentive award is not then vested or exercisable, the incentive award may be canceled and terminated without payment therefor. If any portion of the consideration pursuant to a change in control may be received by holders of shares of common stock on a contingent or delayed basis, the Board may, in its sole discretion, determine the fair market value per share of such consideration as of the time of the change in control on the basis of the Board' good faith estimate of the present value of the probable future payment of such consideration. The 2016 Equity Plan further provides that no incentive award may include the acceleration of the vesting or exercisability of such incentive award in connection with a change in control, unless such acceleration provision is approved by the Board.

In connection with any change in control under the 2021 Equity Plan, the Compensation Committee may, in its sole discretion, provide for any one or more of the following: (i) a substitution or assumption of awards, or to the extent the surviving entity does not substitute or assume the awards, full acceleration of vesting of, exercisability of, or lapse of restrictions on, as applicable, any awards, provided that (unless the applicable award agreement provides for different treatment upon a change in control) with respect to any performance-vested awards, any such acceleration will be based on (A) the target level of performance if the applicable performance period has not ended prior to the date of such change in control and (B) the actual level of performance attained during the performance period of the applicable performance period has ended prior to the date of such change in control; and (ii) cancellation of any one or more outstanding awards and payment to the holders of such awards that are vested as of such cancellation (including any awards that would vest as a result of the occurrence of such event but for such cancellation) the value of such awards, if any, as determined by the Compensation Committee (which value, if applicable, may be based upon the price per share of common stock received or to be received by other holders of our common stock in such event), including, in the case of options and stock appreciation rights, a cash payment equal to the excess, if any, of the fair market value of the shares of common stock subject to the option or stock appreciation right over the aggregate exercise price or strike price thereof.

Potential Payments to Mr. Mikan

Mr. Mikan is not entitled to any cash severance payments upon termination due to death, disability, or for Cause (as defined in the Mikan Employment Agreement).

Pursuant to the Mikan Employment Agreement, if the Company terminates Mr. Mikan's employment without Cause or Mr. Mikan voluntarily terminates his employment for Good Reason, then subject to his continued material compliance with the Mikan Employment Agreement and his timely execution, without revocation, of an effective release of claims in favor of the Company and its affiliates, the Company will pay him an amount equal to (x) two times the sum of his then applicable annual base salary, (y) two times the then applicable target annual individual incentive award payment and (z) the full year target annual individual incentive award for the year in which he was terminated, less all applicable

withholdings and deductions. The payment of the severance amount will be in substantially equal installments in accordance with the Company's payroll practice over 24 months commencing within 60 days after the termination date.

In addition, Mr. Mikan will receive health and welfare benefits continuation for 24 months following the termination date. Finally, the number of unvested equity awards granted to him under the Company's equity incentive plans as of the termination date which would have vested over the 24 month period commencing on the termination date (assuming continued employment throughout such period) in accordance with the terms of the applicable grant agreements will automatically vest in full.

The Mikan Employment Agreement also provides that in the event that the Mr. Mikan's employment is terminated involuntarily or Mr. Mikan voluntarily terminates his employment for Good Reason within 24 months of a Change of Control, Mr. Mikan shall receive a lump sum equal to (x) two times the sum of his then applicable annual base salary, (y) two times the then applicable target annual individual incentive award payment and (z) the full year target annual individual incentive award for the year in which he was terminated, less all applicable withholdings and deductions. In addition, Mr. Mikan will receive full acceleration of vesting on all outstanding equity awards, provided that the Special IPO PSU Grant will only be accelerated to the extent then vested.

The Mikan Employment Agreement further provides that in the event of Mr. Mikan's death, a number of unvested equity awards granted to him under the Company's equity incentive plans will become vested as follows: (i) if, at the time of his death, fewer than one half of the equity awards have vested, then such number of shares will become vested in full automatically such that one half of the equity awards will be vested; and (ii) if, at the time of his death, one half or more of the equity awards have vested, then the number of unvested equity awards as of the date of his death which would have vested over the twelve month period commencing on the date of his death (assuming continued employment throughout such period) in accordance with the terms of the applicable grant agreements will automatically vest in full.

Definitions

Under the Mikan Employment Agreement, "Cause" is defined as one or more of the following: (i) a material breach of the Mikan Employment Agreement by the executive and the executive's failure to cure such breach within 10 business days following written notice by the Company; (ii) a breach of the executive's duty of loyalty to the Company; (iii) the indictment or charging of the executive of, or the plea by the executive of nolo contendere to, a felony or a misdemeanor involving moral turpitude or other willful act or omissions causing material harm to the standing and reputation of the Company; (iv) the executive's repeated failure to perform in any material respect his duties under the Mikan Employment Agreement, and the executive's failure to cure such failures within 10 business days following written notice by the Company; (v) theft, embezzlement, or willful misappropriation of funds or property of the Company by the executive; (vi) a material violation by the executive of the Company's written employment policies, and the executive's failure to cure such violation within 10 business days following written notice by the Company; or (vii) failure to cooperate with a bona fide internal investigation or an investigation by regulatory or law enforcement authorities, after being instructed by the Company to cooperate, or the willful destruction or willful failure to preserve documents or other materials known to be relevant to such investigation or the inducement of others to fail to cooperate or to produce documents or other materials in connection with such investigation. Notwithstanding the foregoing, the executive will not be deemed to have been terminated for Cause unless and until there has been delivered to executive a written statement, executed by the Chairman of our Board (after reasonable notice to the executive and an opportunity for the executive to be heard by the Board), stating that in the good faith opinion of the Chairman of our Board the executive was guilty of conduct constituting "Cause" as set forth above and specifying the particulars thereof in reasonable detail.

Under the Mikan Employment Agreement, "Good Reason" means the executive's voluntary termination of employment with the Company or the acquiror following the occurrence of any of the following without the executive's written consent: (i) a material reduction or change in job duties, responsibilities or requirements inconsistent with the executive's position, provided that a mere change in title following a sale of the Company will not constitute For Good Reason, so long as the executive is assigned to a position that is substantially equivalent to the position held prior to the Change of Control terms of job duties, responsibilities and requirements; (ii) a material reduction in the executive's compensation; (iii) the executive's refusal to relocate the principal place for performance of his duties to a location more than 50 miles from the location at which he performed his duties at the time of the sale of the Company.

The following tables provide, for the specified Named Executive Officers, as of December 31, 2022, the potential severance amount they are eligible for under the scenarios discussed above.

Potential Payments to Mr. Mikan upon Termination

Benefit	Termination other than in connection with Change of Control ($)	Death ($)	Termination within 24 months of Change of Control ($)
Cash Severance	7,670,000	—	7,670,000
Health Benefits(1)	52,143	—	—
Accelerated Equity Awards	5,335,957 (2)	2,864,643 (3)	5,729,286 (4)
Total	13,058,100	2,864,643	13,399,286

(1) Calculated by multiplying 100% of the employer and employee monthly premiums payable with respect to the health care coverage elected by the executive as of December 30, 2022, by 24.

(2) Continued vesting of Mr. Mikan's 8,210,428 unvested RSUs for an additional 24 months would have an estimated value of $5,335,957. In addition, continued vesting of Mr. Mikan's unvested options for an additional 24 months would have an estimated value of $0 on December 31, 2022. PSUs are excluded since vesting was uncertain as of December 30, 2022.

(3) Since less than 50% of Mr. Mikan's December 14, 2021 and March 7, 2022 RSU awards were vested as of December 31, 2022, 50% of his equity awards would vest as of that date. 4,407,821 unvested RSUs would have an estimated value of $2,864,643 if vested. In addition, vesting of Mr. Mikan's unvested options would have an estimated value of $0 on December 30, 2022. PSUs are excluded since vesting was uncertain as of December 30, 2022.

(4) An acceleration of Mr. Mikan's 8,815,642 unvested RSUs would have an estimated value of $5,729,286. In addition, an acceleration of Mr. Mikan's unvested options would have an estimated value of $0 on December 30, 2022. PSUs are excluded since vesting was uncertain as of December 31, 2022.

Potential Payments to other Named Executive Officers Who Remained employed on December 30, 2022

Payment Type	Cathy Smith	Jeff Craig	Jeff Cook
Termination other than in connection with Change of Control			
Cash Severance	$ 2,437,500	$ 850,000	$ 2,250,000
Health Benefits(1)	$ 26,725	$ 17,206	$ 26,725
Additional Equity Vesting	$ 1,001,766 (2)	$ 30,256 (3)	$ 247,423 (4)
Total	$ 3,465,991	$ 897,462	$ 2,524,148
Termination within 12 months of a Change of Control			
Cash Severance	$ 2,437,500	$ 850,000	$ 2,250,000
Health Benefits	$ 26,725	$ 17,206	$ 26,725
Accelerated Equity Awards	$ 1,613,132 (5)	$ 90,768 (6)	$ 742,272 (7)
Total	$ 4,077,357	$ 957,974	$ 3,018,997

(1) In the case of an involuntary termination without Cause or for Good Reason, calculated by multiplying 100% of the employer and employee monthly premiums payable with respect to the health care coverage elected by the executive as of December 30, 2022, by 18 for Ms. Smith and Mr. Cook and by 12 for Mr. Craig.

(2) An additional 18 months vesting of Ms. Smith's unvested RSUs would include 1,541,415 RSUs for an estimated value of $1,001,766 on December 30, 2022. PSUs are excluded since vesting is not time based.

(3) An additional 12 months vesting of Mr. Craig's unvested RSUs would include 46,555 RSUs for an estimated value of $30,256 on December 30, 2022.

(4) An additional 18 months vesting of Mr. Cook's unvested RSUs would include 380,710 RSUs for an estimated value of $247,423 on December 30, 2022.

(5) An acceleration of Ms. Smith's 2,482,123 unvested RSUs would have an estimated value of $1,613,132 on December 30, 2022. PSUs are excluded since vesting is not time-based.

(6) An acceleration of Mr. Craig's 139,665 unvested RSUs would have an estimated value of $90,768.

(7) An acceleration of Mr. Cook's 1,142,132 unvested RSUs would have an estimated value of $742,272.

CEO Pay Ratio

As required by Section 953(b) of the Dodd-Frank Wall Street Reform and Consumer Protection Act, we are providing the following information about the relationship between the annual total compensation of our median employee and the annual total compensation of our CEO. Our identified median compensated employee was $71,500 and Mr. Mikan's compensation was $9,993,169. Accordingly, our CEO to median employee pay ratio is 140:1.

To determine our median compensated employee, we reviewed our employee population, consisting of approximately 2,840 full-time U.S. employees who were employed by us as of December 31, 2022. To identify our median compensated employee from the selected employee population, we used total annualized base pay, plus the target bonus percent to determine total cash compensation for all full-time employees. We then determine equity value and the employer-paid health insurance contributions.

DIRECTOR COMPENSATION

Our Corporate Governance Guidelines provide for compensation for our non-employee directors' services, in recognition of their time and skills. Directors who are also our officers or employees do not receive additional compensation for serving on the Board. Annual compensation for our non-employee directors comprises cash and stock-based equity compensation. Under our director compensation policy, each non-employee director is entitled to an annual cash retainer of $80,000 (other than any non-employee Chairman of the Board, who is entitled to an additional $100,000 cash retainer) and an annual RSU award having a fair market value of $175,000 as of the date of grant. In addition, the Audit Committee chair receives an additional cash retainer of $25,000, the Compensation Committee Chair receives an additional cash retainer of $20,000 and the chair of the Nominating and Corporate Governance Committee receives an additional cash retainer of $15,000. All other committee members receive an additional cash retainer of $10,000. Amounts are paid pro rata for any partial year of service.

DIRECTOR COMPENSATION TABLE FOR 2022

The following table contains information concerning the compensation of our non-employee directors in 2022. Messrs. Mikan and Sheehy did not receive any additional compensation for services as a director in 2022.

Name	Fees Earned or Paid in Cash ($)	RSU Awards ($)(1)	Total ($)

Kedrick D. Adkins Jr	105,000	175,000	280,000
Naomi Allen	90,000	175,000	265,000
Linda Gooden	90,000	175,000	265,000
Jeffrey R. Immelt	100,000	175,000	275,000
Manuel Kadre	115,000	175,000	290,000
Stephen Kraus	67,500	175,000	242,500
Mohamed Makhzoumi	90,000	175,000	265,000
Adair Newhall	80,000	175,000	255,000
Andrew Slavitt	80,000	175,000	255,000
Matthew Manders(2)	66,600	218,750	285,350

(1) 95,109 RSUs were granted to each independent director on May 13, 2022. 100% of the RSUs vest on the first anniversary of the grant date.

(2) Mr. Manders received a grant which was pro-rated for his partial service in the prior year.

As of December 31, 2022, non-executive directors held the following options and RSUs:

Name	Options	RSUs
Kedrick D. Adkins Jr	540,000	95,109
Naomi Allen	540,000	95,109
Linda Gooden	540,000	95,109
Jeffrey R. Immelt	540,000	95,109
Manuel Kadre	540,000	95,109
Andrew Slavitt	280,404	95,109
Stephen Kraus		95,109
Mohamed Makhzoumi		95,109
Adair Newhall		95,109
Matthew Manders		118,886

Directors Stock Ownership Policy

In November 2021, our Board adopted a stock ownership policy for our non-employee directors. The policy requires each non-employee director to hold shares of Company common stock having an aggregate market value of at least three times their annual cash retainer.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT

The following table sets forth information about the beneficial ownership of our common stock as of March 1, 2023 for:

- each person or group known to us who beneficially owns more than 5% of our common stock;
- each of our directors;
- each of our Named Executive Officers; and
- all of our directors, director nominees and executive officers as a group.

The number of shares and percentages of beneficial ownership set forth below are based on the 630,331,300 shares of our common stock issued and outstanding as of March 1, 2023. Beneficial ownership for the purposes of the following table is determined in accordance with the rules and regulations of the SEC. A person is a “beneficial owner” of a security if that person has or shares “voting power,” which includes the power to vote or to direct the voting of the security, or “investment power,” which includes the power to dispose of or to direct the disposition of the security or has the right to acquire such powers within 60 days. Securities that can be so acquired are deemed to be outstanding for purposes of computing such person’s ownership percentage, but not for purposes of computing any other person’s percentage. Under these rules, more than one person may be deemed to be a beneficial owner of the same securities and a person may be deemed to be a beneficial owner of securities as to which such person has no economic interest.

Unless otherwise noted in the footnotes to the following table, and subject to applicable community property laws, the persons named in the table have sole voting and investment power with respect to their beneficially owned common stock. Except as otherwise indicated in the footnotes below, the address of each beneficial owner is c/o Bright Health Group, Inc., 8000 Norman Center Drive, Suite 900, Minneapolis, Minnesota 55437.

Name of Beneficial Owner	Shares	Percent
5% OR MORE BENEFICIAL OWNERS:		
New Enterprise Associates and affiliated funds(1)	368,001,007	47.2 %
Bessemer Venture Partners and affiliated funds(2)	85,998,211	13.5 %
StepStone Group LP and affiliated funds(3)	43,517,440	6.9 %
DIRECTORS, DIRECTOR NOMINEES AND NAMED EXECUTIVE OFFICERS		
G. Mike Mikan(4)	22,425,906	3.4 %
Catherine R. Smith(5)	4,116,667	*
Jeff Craig(6)	101,240	*
Jeff Cook	—	*
Robert J. Sheehy(7)	23,681,357	3.7 %
Kedrick D. Adkins Jr(8)	427,500	*
Naomi Allen(9)	427,500	*
Linda Gooden(10)	281,250	*
Jeffery R. Immelt(11)	991,762	*
Manuel Kadre(12)	1,691,250	*
Steve Kraus(2)(13)	—	*
Mohamad Makhzoumi(1)(14)	368,001,007	47.2 %
Matthew G. Manders	—	*
Adair Newhall(15)	43,566,134	6.9 %
Andrew Slavitt(16)	10,584,352	1.7 %
ALL DIRECTORS, DIRECTOR NOMINEES AND EXECUTIVE OFFICERS AS A GROUP (15 persons)	476,295,925	58.4 %

* Indicates beneficial ownership of less than 1%.

(1) The following information is based on a Schedule 13D as amended, filed by New Enterprise Associates 15, L.P. and other reporting persons named therein. Consists of (i) 107,041,762 shares of common stock held by New Enterprise Associates 15, L.P., or NEA 15, (ii) 3,494,244 shares of common stock held by NEA 15 Opportunity Fund, L.P., or NEA 15 OF, (iii) 47,925,199 shares of common stock held by New Enterprise Associates 16, L.P., or NEA 16, (iv) 23,983,073 shares of common stock held by New Enterprise Associates 17, L.P., or NEA 17, (v) 25,817,487 shares of common stock held by NEA BH SPV, L.P., or BH SPV and (vi) 9,891,858 shares of common stock held by NEA BH SPV, II L.P., or BH SPV II. Also includes 51,667,555 shares of common stock issuable as of March 1, 2023 upon conversion of an aggregate of 200,000 shares of Series A Convertible Perpetual Preferred Stock held by NEA 17 and NEA 18 Venture Growth Equity, L.P., or NEA 18 VGE, and 98,179,829 shares of common stock issuable as of March 1, 2023 upon conversion of an aggregate of 137,700 shares of Series B Convertible Perpetual Preferred Stock held by NEA 17 and NEA 18 VGE. The shares directly held by NEA 15 are indirectly held by NEA Partners 15, L.P., or NEA Partners 15, the sole general partner of NEA 15, NEA 15 GP, LLC, or NEA 15 LLC, the sole general partner of NEA Partners 15, and each of the individual managers of NEA 15 LLC. The individual managers, or collectively, the NEA 15 Managers, of NEA 15 LLC are Forest Baskett, Anthony A. Florence, Jr., Mohamad Makhzoumi, Scott D. Sandell and Peter Sonsini. The NEA 15 Managers share voting and dispositive power with regard to the shares held by NEA 15. The shares directly held by NEA 15 OF are indirectly held by NEA Partners 15-OF, L.P., or NEA Partners 15-OF, the sole general partner of NEA 15 OF, NEA 15 LLC, the sole general partner of NEA Partners 15-OF, and each of the NEA 15 Managers. The NEA 15 Managers share voting and dispositive power with regard to the shares held by NEA 15 OF. The shares directly held by NEA 16 are indirectly held by NEA Partners 16, L.P., or NEA Partners 16, the sole general partner of NEA 16, NEA 16 GP, LLC, or NEA 16 LLC, the sole general partner of NEA Partners 16, and each of the individual managers of NEA 16 LLC. The individual managers, or collectively, the NEA 16 Managers, of NEA 16 LLC are Forest Baskett, Ali Behbahani, Carmen Chang, Anthony A. Florence, Jr., Mohamad Makhzoumi, Scott D. Sandell, Paul Walker, and Peter Sonsini. The NEA 16 Managers share voting and dispositive power with regard to the shares held by NEA 16. The shares directly held by NEA 17 are indirectly held by NEA Partners 17, L.P., or NEA Partners 17, the sole general partner of NEA 17, NEA 17 GP, LLC, or NEA 17 LLC, the sole general partner of NEA Partners 17, and each of the individual managers of NEA 17 LLC. The individual managers, or collectively, the NEA 17 Managers, of NEA 17 LLC are Forest Baskett, Ali Behbahani, Carmen Chang, Anthony A. Florence, Jr., Edward Mathers, Mohamad Makhzoumi, Scott D. Sandell, Paul Walker, Rick Yang, and Peter Sonsini. The NEA 17 Managers share voting and dispositive power with regard to the shares held by NEA 17. The shares directly held by NEA 18 VGE are indirectly held by NEA Partners 18 VGE, L.P., or NEA Partners 18 VGE, the sole general partner of NEA 18 VGE, NEA 18 VGE GP, LLC, or NEA 18 VGE LLC, the sole general partner of NEA Partners 18 VGE, and each of the individual managers of NEA 18 VGE LLC. The individual managers, or collectively, the NEA 18 VGE Managers, of NEA 18 VGE LLC are Ali Behbahani, Carmen Chang, Anthony A. Florence, Jr., Edward Mathers, Mohamad Makhzoumi, Scott D. Sandell, Paul Walker, Rick Yang, and Peter Sonsini. The NEA 18 VGE Managers share voting and dispositive power with regard to the shares held by NEA 18 VGE. The shares directly held by BH SPV are indirectly held by NEA BH SPV GP, LLC ,or SPV LLC, the sole general partner of BH SPV, and each of the NEA 17 Managers. The NEA 17 Managers share voting and dispositive power with regard to the shares held by BH SPV. The shares directly held by BH SPV II are indirectly held by SPV LLC, the sole general partner of BH SPV II, and each of the NEA 17 Managers. The NEA 17 Managers share voting and dispositive power with regard to the shares held by BH SPV II. All indirect holders of the above referenced shares disclaim beneficial ownership of all applicable shares except to the extent of their actual pecuniary interest therein. The address for the above referenced entities is 1954 Greenspring Drive, Suite 600, Timonium, Maryland 21093.

(2) The following information is based on a Schedule 13G filed by Deer X & Co. Ltd. and other reporting persons named therein. Consists of (i) 35,891,981 shares of common stock held by Bessemer Venture Partners IX L.P., or Bessemer IX, (ii) 28,754,956 shares of common stock held by Bessemer Venture Partners IX Institutional L.P., or Bessemer Institutional, (iii) 2,090,325 shares of common stock held by Bessemer Venture Partners Century Fund L.P., or Bessemer Century, (iv) 13,189,833 shares of common stock held by Bessemer Venture Partners Century Fund Institutional L.P., or Bessemer Century Institutional and (v) 10,629 shares of common stock issuable held by 15 Angels II LLC, or 15 Angels (together with Bessemer IX, Bessemer Institutional, Bessemer Century and Bessemer Century Institutional, the "Bessemer Entities"). Also includes 6,060,487 shares of common stock issuable as of March 1, 2023 upon conversion of an aggregate of 8,500 shares of Series B Convertible Perpetual Preferred Stock held by Bessemer IX, Bessemer Institutional, Bessemer Century, Bessemer Century Institutional and 15 Angels. 15 Angels is wholly owned by Bessemer Venture Partners VIII Institutional L.P., or Bessemer VIII Institutional. Deer VIII & Co. L.P., or Deer VIII L.P. is the general partner of Bessemer VIII Institutional. Deer VIII & Co. Ltd., or Deer VIII Ltd., is the general partner of Deer VIII L.P. Robert P. Goodman, David Cowan, Jeremy Levine, Byron Deeter and Robert M. Stavis are the directors of Deer VIII Ltd. and hold the voting and dispositive power for 15 Angels. Deer IX & Co. L.P., or Deer IX L.P., is the general partner of Bessemer IX and Bessemer Institutional. Deer IX & Co. Ltd., or Deer IX Ltd., is the general partner of Deer IX L.P. David Cowan, Byron Deeter, Adam Fisher, Robert P. Goodman, Jeremy Levine and Robert M. Stavis are the directors of Deer IX Ltd. and hold the voting and dispositive power for Bessemer IX and Bessemer Institutional. Investment and voting decisions with respect to the shares held by Bessemer IX and Bessemer Institutional are made by the directors of Deer IX Ltd. acting as an investment committee. Deer X & Co. L.P., or Deer X L.P., is the general partner of Bessemer Century and Bessemer Century Institutional. Deer X & Co. Ltd., or Deer X Ltd., is the general partner of Deer X L.P. Pursuant to a proxy arrangement between Deer X L.P. and Deer IX L.P., Deer IX L.P., its general partner Deer IX Ltd., and the aforementioned directors of Deer IX Ltd. make voting decisions with respect to the shares of the Company held by Bessemer Century and Bessemer Century Institutional. Such voting decisions are made by the directors of Deer IX Ltd. acting as an investment committee. Mr. Kraus disclaims beneficial ownership of the securities held by the Bessemer Entities except to the extent of his pecuniary interest, if any, in such securities by virtue of his indirect interest in the Bessemer Entities. The address for each of these entities is c/o Bessemer Venture Partners, 1865 Palmer Avenue, Suite 104, Larchmont, New York 10538.

(3) The following information is based on a Schedule 13D/A filed by StepStone Group LP and other reporting persons named therein. Consists of (i) 5,358,000 shares of common stock held by StepStone VC Global Partners VII-A, L.P. ("StepStone VII-A"), (ii) 516,912 shares of common stock held by StepStone VC Global Partners VII-C, L.P. ("StepStone VII-C"), (iii) 21,059,052 shares of common stock held by StepStone VC Opportunities IV, L.P. ("StepStone IV"), (iv) 2,290,572 shares of common stock held by StepStone Master G, L.P. ("StepStone Master"), (v) 8,246,418 shares of common stock held by AU Special Investments, L.P. ("AU"), (vi) 3,305,300 shares of common stock held by StepStone VC Opportunities VI, L.P. ("StepStone VI"), (vii) 188,884 shares of common held by StepStone VC Opportunities VI-D, L.P. ("StepStone VI-D"), (viii) 969,477 shares of common stock held by StepStone VC Opportunities V, L.P. ("StepStone V") and (ix) 85,529 shares of common stock held by StepStone VC Opportunities V-D, L.P ("StepStone V-D"). Also includes 1,488,205 shares of common stock issuable as of March 1, 2023 upon conversion of an aggregate of 2,100 shares of Series B Convertible Perpetual Preferred Stock held by StepStone V, StepStone V-D, StepStone VI and StepStone VI-D. StepStone Group LP ("StepStone") is the investment manager of several direct shareholders of Bright Health Group, Inc., including StepStone VII-A, StepStone VII-C, AU, StepStone IV, StepStone VI, StepStone VI-D, StepStone Master, StepStone V, and StepStone V-D (collectively, the "StepStone Funds"). StepStone has voting, investment and dispositive power over the shares held by the StepStone Funds pursuant to each StepStone Fund's limited partnership agreement and certain investment management agreements to which StepStone and such StepStone Funds are parties. The address for StepStone and the StepStone Funds is 4225 Executive Square, Suite 1600, La Jolla, CA 92037.

(4) Consists of (i) 18,220,692 options held by Mr. Mikan that are exercisable within 60 days of March 1, 2023, (ii) 605,214 restricted stock units that vest within 60 days of March 1, 2023 and (iii) 3,600,000 options held by Mikan Family Enterprise, LLC that are exercisable within 60 days of March 1, 2023.

(5) Consists of (i) 142,623 shares of common stock, (ii) 2,813,337 options held by Ms. Smith that are exercisable within 60 days of March 1, 2023, (iii) 260,707 restricted stock units that vest within 60 days of March 1, 2023 and (iv) 900,000 shares of common stock held by The Smith Family Grantor Retained Annuity Trust. Catherine R. Smith and Ryan T. Smith are the sole trustees of The Smith Family Grantor Retained Annuity Trust and have voting and investment power over the shares of common stock held by The Smith Family Grantor Retained Annuity Trust.

(6) Consists of (i) 7,500 shares of common stock, (ii) 47,185 options that are exercisable within 60 days of March 1, 2023 and (iii) 46,555 restricted stock units that vest within 60 days of March 1, 2023.

(7) Consists of (i) 3,626,121 options that are exercisable within 60 days of March 1, 2023 held by Mr. Sheehy and (ii) 20,055,236 shares of common stock held by the Robert J. Sheehy Revocable Trust. Robert J. Sheehy is the sole trustee of the Robert J. Sheehy Revocable Trust and has voting and investment power over the shares of common stock and Series A preferred stock held by the Robert J. Sheehy Revocable Trust.

(8) Consists of 427,500 options that are exercisable within 60 days of March 1, 2023.

(9) Consists of 427,500 options that are exercisable within 60 days of March 1, 2023.

(10) Consists of 281,250 options that are exercisable within 60 days of March 1, 2023.

(11) Consists of (i) 598,012 shares of common stock and (ii) 393,750 options that are exercisable within 60 days of March 1, 2023.

(12) Consists of (i) 1,070,112 shares of common stock, (ii) 326,250 options that are exercisable within 60 days of March 1, 2023, (iii) 294,888 shares of common stock held by the Kadre Family Partnership, L.P. of which Mr. Kadre is the general partner.

(13) Does not include 85,998,211 shares beneficially owned by the Bessemer Entities, as described under footnote (2). Mr. Kraus is a director of Deer X Ltd. and has an indirect, passive economic interest in the shares held by Bessemer IX, Bessemer Institutional and 15 Angels. Mr. Kraus disclaims beneficial ownership of the securities held by the Bessemer Entities except to the extent of his pecuniary interest, if any, in such securities by virtue of his indirect interest in the Bessemer Entities.

(14) Consists of shares held by NEA 15, NEA 15 OF, NEA 16, NEA 17, NEA 18 VGE, BH SPV and BH SPV II described under footnote (1), over which Mr. Makhzoumi shares voting and dispositive power. Mr. Makhzoumi has no voting or dispositive power with regard to any shares held by NEA. In addition, Mr. Makhzoumi disclaims beneficial ownership of above-referenced shares held by entities affiliated with NEA described in footnote (1) except to the extent of his actual pecuniary interest therein.

(15) Consists of (i) 48,694 shares of common stock held by The 2016 Adair Newhall Trust in respect of which Mr. Newhall is one of three trustees and (ii) shares held by the StepStone funds described under footnote (3), over which Mr. Newhall shares voting and dispositive power. Mr. Newhall disclaims beneficial ownership of the above-referenced shares held by the StepStone Funds except to the extent of his actual pecuniary interest therein.

(16) Consists of (i) 166,887 shares of common stock, (ii) 280,404 options that are exercisable within 60 days of March 1, 2023 and (iii) 450,000 shares of common stock held by Slavitt Holdings LLC. Mr. Slavitt is the sole manager and member of Slavitt Holdings LLC and has voting and investment power over the shares of common stock held by Slavitt Holdings LLC. Also includes 2,454,972 shares held by Town Hall Ventures II LP and 4,237,497 shares held by Town Hall Ventures LP, in respect of each of which Mr. Slavitt serves as a managing member and its General Partner. Also includes 2,994,592 shares of common stock issuable as of March 1, 2023 upon conversion of 4,200 shares of Series B Convertible Perpetual Preferred Stock held by Town Hall Ventures II LP. Mr. Slavitt disclaims beneficial ownership over the shares held by the Town Hall entities except to the extent of his pecuniary interest therein.

Securities Authorized for Issuance Under Equity Compensation Plans

Information about our common stock that may be issued under our equity compensation plans as of December 31, 2022 December 31, 2023, was as follows:

Plan Category	Plan Category	Number of Securities to be Issued Upon Exercise of Outstanding Options and Rights(1)	Weighted-Average Exercise Price per Share of Outstanding Options and Rights(2)	Number of Securities Available for Future Issuance Under Equity Compensation Plans(3)	Plan Category	Number of Securities to be Issued Upon Exercise of Outstanding Options and Rights(1)	Weighted-Average Exercise Price per Share of Outstanding Options and Rights(2)	Number of Securities Available for Future Issuance Under Equity Compensation Plans(3)
Equity compensation plans approved by shareholders	Equity compensation plans approved by shareholders	112,358,000	$ 1.82	18,050,748				

(1) Includes grants of stock options and restricted stock units (which may be time-based or market-based) granted under the 2021 Incentive Plan and the 2016 Incentive Plan.
(2) Includes weighted-average exercise price per share of outstanding stock options only.
(3) Consists of shares of common stock available for future issuance under the 2021 Incentive Plan as of December 31, 2022 December 31, 2023. Excludes securities to be issued upon exercise of outstanding options and rights. Shares available under the 2021 Incentive Plan may be granted as future awards in the form of stock options, stock appreciation rights, restricted shares, restricted stock units and other equity-based awards.

The remaining information required by this item will be included under the heading “Security Ownership of Certain Beneficial Owners and Management” in our definitive proxy statement for our 2024 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED PARTY TRANSACTIONS, AND DIRECTOR INDEPENDENCE

Registration Rights Agreement The information required by this item will be included under the headings “Certain Relationships and Related Party Transactions” and “Corporate Governance” in our definitive proxy statement for our 2024 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

We are party to a registration rights agreement with certain of our stockholders including New Enterprise Associates, Bessemer Venture Partners, StepStone, Town Hall Ventures, and certain subsidiaries of Cigna and certain of their respective affiliates. Each of New Enterprise Associates, Bessemer Venture Partners and StepStone beneficially owned more than 5% of our outstanding common stock as of the Record Date.

The registration rights agreement, as amended, contains provisions that entitle the stockholder parties thereto to certain rights to have their securities registered by us under the Securities Act. New Enterprise Associates and Bessemer Venture Partners will be entitled to three “demand” registrations in the aggregate, subject to certain limitations. In addition, the stockholder parties to the registration rights agreement, including New Enterprise Associates, Bessemer Venture Partners, StepStone, and certain subsidiaries of Cigna are

entitled to customary “piggyback” registration rights. The registration rights agreement provides that we will pay certain expenses of the stockholder parties relating to such registrations and indemnify them against certain liabilities which may arise under the Securities Act.

Investment Agreement

On October 10, 2022, we entered into an Investment Agreement (the “Investment Agreement”) with affiliates of New Enterprise Associates, Bessemer Venture Partners, StepStone Group LP, and Town Hall Ventures (the “Purchasers”), among others, relating to the issuance and sale by the Company to the Purchasers of 175,000 shares of the Company's Series B Convertible Perpetual Preferred Stock, par value $0.0001 per share (the “Series B Preferred Stock”), for a purchase price of $1,000 per share. Pursuant to the Investment Agreement, the Purchasers acquired 152,500 shares of the Series B Preferred Stock for an aggregate purchase price of $152.5 million. The terms of the Preferred Stock are set forth in the Certificate of Designations designating the Preferred Stock, a copy of which is attached as an exhibit to our Annual Report on Form 10-K for the year ended December 31, 2022. We granted the Purchasers registration rights in respect of the Preferred Stock and any shares of common stock issued upon conversion thereof.

Certain of our directors have current or former relationships with New Enterprise Associates, Bessemer Venture Partners, StepStone, and Townhall Ventures. For information about these relationships see the section titled “Board of Directors and Corporate Governance-Board of Directors”.

Related Persons Transaction Policy

Our Board has adopted a written policy on transactions with related persons, which we refer to as our “related person policy.” Our related person policy requires that all “related persons” (as defined in paragraph (a) of Item 404 of Regulation S-K) must promptly disclose to our general counsel any “related person transaction” (defined as any transaction that is anticipated would be reportable by us under Item 404(a) of Regulation S-K in which we were or are to be a participant and the amount involved exceeds $120,000 and in which any related person had or will have a direct or indirect material interest) and all material facts with respect thereto. Our general counsel will communicate that information to our Board or to a duly authorized committee thereof. Our related person policy provides that no related person transaction entered into will be executed without the approval or ratification of our Board or a duly authorized committee thereof. It will be our policy that any directors interested in a related person transaction must recuse themselves from any vote on a related person transaction in which they have an interest.

Director Independence

Pursuant to the corporate governance listing standards of the NYSE, a director employed by us cannot be deemed to be an independent director. Each other director will qualify as independent only if our Board affirmatively determines that he or she has no material relationship with us, either directly or as a partner, stockholder or officer of an organization that has a relationship with us. Ownership of a significant amount of our stock, by itself, does not constitute a material relationship.
The Board has affirmatively determined that each of our directors, other than G. Mike Mikan and Robert J. Sheehy, qualifies as independent in accordance with the NYSE rules. In making its independence determinations, our Board considered and reviewed all information known to it (including information identified through directors’ questionnaires).

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

FEES BILLED BY DELOITTE & TOUCHE LLP

The Audit Committee has direct oversight information required by this item will be included under the heading “Disclosure of the independent registered public accounting firm that audits our financial statements, including their appointment, compensation and evaluation. The Audit Committee has appointed Deloitte & Touche LLP as our independent registered public accounting firm for the year ending December 31, 2023. Services provided Fees Paid to the Company and its subsidiaries by Deloitte & Touche LLP for the year ended December 31, 2021 are described below and under “Audit Committee Report.”

Fees and Services

The following table summarizes the aggregate fees for professional audit services and other services rendered by Deloitte & Touche LLP for the years ended December 31, 2022 and 2021:

	2022	2021
Audit Fees(1)	$ 3,737,356	$ 3,243,831
Audit-Related Fees(2)	$ —	$ 490,021
Tax Fees(3)	$ 74,830	$ 60,375
Total	$ 3,812,186	$ 3,794,227

(1) The Audit fees listed above for 2022 were billed in connection with the audit of our annual consolidated financial statements Independent Registered Public Accounting Firm" in our 2022 definitive proxy statement for our 2024 Annual Report, the reviews Meeting of our interim consolidated financial statements included in our quarterly reports on Forms 10-Q Shareholders, and other professional services related to our statutory audits. The Audit fees listed above for 2021 were billed in connection with the audit of our annual consolidated financial statements in our 2021 Annual Report, the reviews of our interim consolidated financial statements included in our quarterly reports on Forms 10-Q and other professional services related to our statutory audits, including in relation to our registration statement on Form S-1.

(2) Audit-Related fees listed above include due diligence services for acquisitions during 2021.

(3) Tax fees listed above consist of professional fees primarily for tax compliance services.

In considering the nature of the services provided such required information is incorporated herein by the independent auditor, the Audit Committee determined that such services are compatible with the provision of independent audit services. The Audit Committee discussed these services with the independent auditor and Bright Health management to determine that they are permitted under the rules and regulations concerning auditor independence promulgated by the SEC to implement the Sarbanes-Oxley Act of 2002, as well as the American Institute of Certified Public Accountants.

AUDIT COMMITTEE PRE-APPROVAL POLICIES AND PROCEDURES

The Audit Committee has adopted a policy that requires advance approval of all audit services as well as non-audit services, regardless of cost, to the extent required by the Exchange Act and the Sarbanes-Oxley Act of 2002. Unless the specific service has been previously pre-approved with respect to that year, the Audit Committee must approve the permitted service before the independent auditor is engaged to perform it. The Audit Committee may consider the amount or range of estimated fees as a factor in determining whether a proposed service would impair the registered public accounting firm's independence. Requests or applications to provide services that require separate approval by the Audit Committee will be submitted to the Audit Committee by both the independent registered public accounting firm and the Company's Chief Financial Officer or the Chief Accounting Officer and must include a joint statement as to whether, in their view, the request or application is consistent with the SEC's and the Public Company Accounting Oversight Board ("PCAOB")'s rules on registered public accounting firm independence. reference.

PART IV

ITEM 15. EXHIBITS, FINANCIAL STATEMENT SCHEDULES

The following documents are filed as part of this report:

(a) 1. *Financial Statements.* The financial statements are included under Item 8 of this report:

- Report of Independent Registered Public Accounting Firm.
- Consolidated Balance Sheets as of December 31, 2022 December 31, 2023 and 2021. 2022.
- Consolidated Statements of Income (Loss) for the years ended December 31, 2022, 2021 December 31, 2023 and 2020. 2022.
- Consolidated Statements of Comprehensive Income (Loss) for the years ended December 31, 2022, 2021 December 31, 2023 and 2020. 2022.
- Consolidated Statements of Changes in Redeemable Preferred Stock and Shareholders' Equity (Deficit) for the years ended December 31, 2022, 2021 December 31, 2023 and 2020. 2022.
- Consolidated Statements of Cash Flows for years ended December 31, 2022, 2021 December 31, 2023 and 2020. 2022.
- Notes to the Consolidated Financial Statements.

2. *Financial Statement Schedules.* The following statement schedule of the Company is included in Item 15(c)

- Schedule I - Condensed Financial Information of Registrant (Parent Company Only).

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore have been omitted.

(b) *Exhibits*. See Exhibit Index, which is incorporated by reference as if fully set forth herein.

EXHIBIT INDEX

Exhibit Number	Description
3.1	Ninth Amended and Restated Certificate of Incorporation of Bright Health Group, NeueHealth, Inc. (incorporated by reference to Exhibit 4.1 filed with the Registrant's Registration Statement on Form S-8 filed on June 28, 2021)
3.2	Certificate of Amendment to the Ninth Amended and Restated Certificate of Incorporation of NeueHealth, Inc. (incorporated by reference to Exhibit 3.1 filed with the Registrant's Current Report on Form 8-K filed on May 25, 2023)
3.3	Certificate of Amendment to the Ninth Amended and Restated Certificate of Incorporation of NeueHealth, Inc. (incorporated by reference to Exhibit 3.1 filed with the Registrant's Current Report on Form 8-K filed on January 24, 2024)
3.4	Certificate of Designations of Series A Convertible Perpetual Preferred Stock of Bright Health Group, NeueHealth, Inc. (incorporated by reference to Exhibit 3.1 filed with the Registrant's Current Report on Form 8-K filed on January 3, 2022)
3.3 3.5	Certificate of Amendment to the Certificate of Designations of Series A Convertible Perpetual Preferred Stock of Bright Health Group, NeueHealth, Inc. (incorporated by reference to Exhibit 3.1 filed with the Registrant's Current Report on Form 8-K filed on October 18, 2022)
3.4 3.6	Certificate of Designations of Series B Convertible Perpetual Preferred Stock of Bright Health Group, NeueHealth Inc. (incorporated by reference to Exhibit 3.2 filed with the Registrant's Current Report on Form 8-K filed on October 18, 2022)
3.5 3.7	Fourth Amended and Restated Bylaws of Bright Health Group, NeueHealth, Inc. (incorporated by reference to Exhibit 4.2 3.2 filed with the Registrant's Registration Statement Current Report on Form S-8 8-K filed on June 28, 2021 January 24, 2024)
4.1	Description of the Registrant's Securities Registered Pursuant to Section 12 of the Securities Exchange Act of 1934 (incorporated by reference to Exhibit 4.14.1 filed with the Registrant's Annual Report on Form 10-K filed on March 18, 2022)
4.2	Form of Warrant to Purchase Shares of Common Stock (included in Exhibit 10.2) (incorporated by reference to Exhibit 4.1 filed with the Registrant's Current Report on Form 8-K filed on October 5, 2023)
10.1	Credit Agreement, dated as of March 1, 2021 August 4, 2023, among NeueHealth, Inc. (f/k/a Bright Health Group, Inc.), JPMorgan Chase Bank, N.A., New Enterprise Associates, Inc. and the financial institutions from time to time party thereto as Administrative Agent and Collateral Agent, lenders, and the other lenders and parties from time to time party thereto (incorporated by reference to Exhibit 10.1 filed with the Registrant's Registration Statement Current Report on Form S-1 8-K filed on May 19, 2021 August 7, 2023)

10.2	Incremental Amendment No. 1, dated as of August 2, 2021 October 2, 2023, among NeueHealth, Inc. (f/k/a Bright Health Group, Inc.), the other Loan Parties party thereto, the Lenders party thereto NEA 18 Venture Growth Equity, L.P. and JPMorgan Chase Bank, N.A., as administrative agent.California State Teachers' Retirement System (incorporated by reference to Exhibit 10.1 filed with the Registrant's Registrant's Current Report on Form 8-K filed on August 2, 2021 October 5, 2023)
10.3	Warrantholders Agreement, dated as of August 4, 2023, among NeueHealth, Inc. (f/k/a Bright Health Group, Inc.) and the Holders named therein (incorporated by reference to Exhibit 10.3 filed with the Registrant's Current Report on Form 8-K filed on August 7, 2023)
10.4	Warrantholders Agreement, dated as of October 2, 2023, among NeueHealth, Inc. (f/k/a Bright Health Group, Inc.) and California State Teachers' Retirement System (incorporated by reference to Exhibit 10.2 filed with the Registrant's Current Report on Form 8-K filed on October 5, 2023)
10.5	Investment Agreement, dated December 6, 2021, by and between NeueHealth, Inc. (f/k/a Bright Health Group, Inc.) and Cigna Health & Life Insurance Company and New Enterprise Associates 17, L.P. (incorporated by reference to Exhibit 10.1 filed with the Registrant's Registrant's Current Report on Form 8-K filed on December 6, 2021 December 7, 2021)
10.4 10.6	Bright Health Insurance Company of Florida Repayment Plan Approval and Letter of Agreement, dated September 14, 2023, by and between the Centers for Medicare and Medicaid Services and Bright Health Insurance Company of Florida (incorporated by reference to Exhibit 10.2 filed with the Registrant's Current Report on Form 8-K filed on September 19, 2023)
10.7	Bright Health Insurance Company of Illinois Repayment Plan Approval and Letter of Agreement, dated September 14, 2023, by and between the Centers for Medicare and Medicaid Services and Bright Health Insurance Company of Illinois (incorporated by reference to Exhibit 10.3 filed with the Registrant's Current Report on Form 8-K filed on September 19, 2023)
10.8	Bright Health Insurance Company of Texas Repayment Plan Approval and Letter of Agreement, dated September 14, 2023, by and between the Centers for Medicare and Medicaid Services and Bright Health Insurance Company of Texas (incorporated by reference to Exhibit 10.4 filed with the Registrant's Current Report on Form 8-K filed on September 19, 2023)
10.9	Bright Health Insurance Company Repayment Plan Approval and Letter of Agreement, dated September 14, 2023, by and between the Centers for Medicare and Medicaid Services and Bright Health Insurance Company (incorporated by reference to Exhibit 10.1 filed with the Registrant's Current Report on Form 8-K/A filed on September 19, 2023)
10.10*	Addendum to Bright Health Insurance Company Repayment Plan Approval and Letter of Agreement, dated March 11, 2024, by and between the Centers for Medicare and Medicaid Services and Bright Health Insurance Company.
10.11	Bright Health Management Inc. Severance Benefits Plan and Summary Plan Description (incorporated by reference to Exhibit 10.7 filed with the Registrant's Registration Statement on Form S-1 filed on June 15, 2021)
10.5† 10.12†	NeueHealth, Inc. (f/k/a Bright Health Group, Inc.) Amended and Restated 2021 Omnibus Incentive Plan, effective as of June 5, 2021 May 4, 2023 (incorporated by reference to Exhibit 10.8 10.2 filed with the Registrant's Registration Statement Registrant's Quarterly Report on Form S-1/A 10-Q filed on June 15, 2021) May 10, 2023
10.6† 10.13†	Form of Stock Option Agreement under the NeueHealth, Inc. (f/k/a Bright Health Group, Inc.) 2021 Omnibus Incentive Plan (incorporated by reference to Exhibit 10.9 filed with the Registrant's Registration Statement on Form S-1/A filed on June 5, 2021)

10.7†	10.14†	Form of Restricted Stock Unit Agreement under the NeueHealth, Inc. (f/k/a Bright Health Group, Inc.) 2021 Omnibus Incentive Plan (incorporated by reference to Exhibit 10.10 filed with the Registrant's Registration Statement on Form S-1/A filed on June 4, 2021)
10.8†	10.15†	Form of Executive Performance Stock Unit Agreement under the NeueHealth, Inc. (f/k/a Bright Health Group, Inc.) 2021 Omnibus Incentive Plan (2021 Executive Leadership Team PSUs)(incorporated by reference to Exhibit 10.11 filed with the Registrant's Registration Statement on Form S-1/A filed on June 4, 2021)
10.9†	10.16†	Form of Executive Performance Stock Unit Agreement under the NeueHealth, Inc. (f/k/a Bright Health Group, Inc.) 2021 Omnibus Incentive Plan (incorporated by reference to Exhibit 10.6 filed with the Registrant's Quarterly Report on Form 10-Q filed on August 11, 2021)
10.10†	10.17†	NeueHealth, Inc. (f/k/a Bright Health Group, Inc. (formerly known as Bright Health Inc.) 2016 Stock Incentive Plan (as amended through December 21, 2020) (incorporated by reference to Exhibit 10.4 filed with the Registrant's Registration Statement on Form S-1 filed on May 19, 2021)
10.11†	10.18†	Form of Stock Option Agreement under the NeueHealth, Inc. (f/k/a Bright Health Group, Inc. (formerly known as Bright Health Inc.) 2016 Stock Incentive Plan (incorporated by reference to Exhibit 10.5 filed with the Registrant's Registration Statement on Form S-1 filed on May 19, 2021)
10.12†	10.19†	Amended and Restated Employment Agreement, effective as of September 23, 2021, between Bright Health Management, Inc. and George L. Mikan III (incorporated by reference to Exhibit 10.15 filed with the Registrant's Annual Report on Form 10-K filed on March 18, 2022)
10.13†	10.20†	Employment offer letter, dated as of December 19, 2019, between Cathy Smith and Bright Health (incorporated by reference to Exhibit 10.13 filed with the Registrant's Registration Statement on Form S-1 filed on May 19, 2021)
10.14†	10.21†	Employee Confidentiality, Assignment of Inventions and Non-Competition Agreement, effective as of January 7, 2020 between Cathy Smith and Bright Health Management, Inc. (incorporated by reference to Exhibit 10.18 filed with the Registrant's Registration Statement on Form S-1 filed on May 19, 2021)
10.15†	10.22†	Form of Restricted Stock Unit Agreement under the NeueHealth, Inc. (f/k/a Bright Health Group, Inc.) 2021 Omnibus Incentive Plan (incorporated by reference to Exhibit 10.1 filed with the Registrant's Current Report on Form 8-K filed on December 20, 2021)
10.16†	10.23†	Form of Indemnification Award for Directors and Officers (incorporated by reference to Exhibit 10.7 filed with the Registrant's Quarterly Report on Form 10-Q filed on August 11, 2021)
10.17†	10.24†	Bright Health Management Inc. Annual Incentive Plan (formerly known as Bright Health Inc.) (incorporated by reference to Exhibit 10.6 filed with the Registrant's Registration Statement on Form S-1 filed on May 19, 2021)
10.19†	10.25†	Employment offer letter, dated as of May 4, 2022, between Jeff Cook and Bright Health
10.20	10.26	Form of Executive Separation Agreement (incorporated by reference to Exhibit 10.2 filed with the Registrant's Quarterly Report on Form 10-Q filed on May 12, 2022)
10.21	10.27	Investment Agreement, dated October 10, 2022, by and between NeueHealth, Inc. (f/k/a Bright Health Group, Inc.) and the purchasers parties thereto (incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K filed on October 11, 2022).

10.22 10.28	Third Amended and Restated Registration Rights Agreement, dated as of October 17, 2022, by and among NeueHealth, Inc. (f/k/a Bright Health Group, Inc.) and the other parties named therein (incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K filed on October 18, 2022).
10.23 10.29†	Amendment No. 3, dated as of November 8, 2022, among Bright Health Group, Inc., the other Loan Parties party thereto, the Lenders party thereto and JPMorgan Chase Bank, N.A., as administrative agent (incorporated by reference to Exhibit 10.1 filed with the Registrant's Current Report on Form 8-K filed on November 9, 2022)
10.24	Limited Waiver and Consent, dated as of February 28, 2023, among Bright Health Group, Inc., the other loan parties party thereto, the lenders party thereto and JPMorgan Chase Bank, N.A., as administrative agent (incorporated by reference to Exhibit 10.1 to the Registrant's current report on From 8-K filed on March 1, 2023.
10.25*	Amendment No. 2, dated as of November 20, 2021, among Bright Health Group, Inc., the other Loan Parties party thereto, the Lenders party thereto and JPMorgan Chase Bank, N.A., as administrative agent
10.26*†	Form of Restricted Stock Unit Agreement under the NeueHealth, Inc. (f/k/aBright Health Group, Inc.) 2021 Omnibus Incentive Plan (2022)
10.27*† 10.30†	Form of Stock Option Agreement under theNeueHealth, Inc. (f/k/a Bright Health Group, Inc.) 2021 Omnibus Incentive Plan (2022)
10.31*†	Executive Employment Agreement between Centrum Medical Holdings, LLC and Tomas Orozco, effective August 9, 2021 and filed herewith
10.32†	Consulting agreement, dated May 9, 2023, between Catherine R. Smith and Bright Health Group, Inc. (incorporated by reference to Exhibit 10.3 to the Registrant's Quarterly Report on Form 10-Q filed on May 10, 2023)
21.1*	Subsidiaries of the Registrant
23.1*	Consent of Deloitte & Touche LLP
31.1*	Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2*	Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1*	Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 (1)
32.2*	Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 (1)
97.1*	Incentive Compensation Clawback Policy of NeueHealth, Inc.
101*	The following financial information from our Annual Report on Form 10-K for the year ended December 31, 2022 December 31, 2023, filed with the SEC on March 16, 2023 March 28, 2024, formatted in Inline Extensible Business Reporting Language ("iXBRL")
104*	Cover Page Interactive Data File (formatted as Inline XBRL and embedded within Exhibit 101)

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* Filed herewith.

† Management contract or compensatory plan or arrangement.

(1) The certifications in Exhibit 32.1 to this Annual Report on Form 10-K shall not be deemed "filed" for purposes of Section 18 of the Securities Exchange Act of 1934, as amended, and shall not be incorporated by reference into any filing or other document pursuant to the Securities Act of 1933, as amended, except as shall be expressly set forth by specific reference in such filing or document.

(c) Financial Statement Schedule. Schedule I - Condensed Financial Information of Registrant (Parent Company Only).

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM ON FINANCIAL STATEMENT SCHEDULE

To the shareholders and the Board of Directors of Bright Health Group, NeueHealth, Inc.

We have audited the consolidated financial statements of Bright Health Group, NeueHealth, Inc. and subsidiaries (the "Company" "Company") as of December 31, 2022 December 31, 2023 and 2021 2022 and for each of the three two years in the period ended December 31, 2022, and the Company's internal control over financial reporting as of December 31, 2022 December 31, 2023, and have issued our report thereon dated March 16, 2023, March 28, 2024, which contained an unqualified opinion on those consolidated financial

statements and included an explanatory paragraph regarding going concern, and an adverse opinion on the Company's internal control over financial reporting due to the identification of a material weakness.concern.

The financial statement schedule of the Company listed in the Index at Item 15 has been subjected to audit procedures performed in conjunction with the audit of the Company's Company's consolidated financial statements. The financial statement schedule is the responsibility of the Company's Company's management. Our responsibility is to express an opinion on the Company's financial statement schedule based on our audits. In our opinion, the financial statement schedule, when considered in relation to the consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

March 28, 2024

/s/ Deloitte & Touche LLP

Minneapolis, Minnesota

March 16, 2023

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
Bright Health Group, NeueHealth, Inc.
Parent Company Condensed Balance Sheets

		As of December 31,	
		2022	2021
	As of December 31,		
	2023		
Assets	**Assets**		
Current assets:	Current assets:		
Current assets:			
Current assets:			
Cash and cash equivalents			
Cash and cash equivalents			
Cash and cash equivalents	Cash and cash equivalents	**$ 335**	$ 971
Short-term investments	Short-term investments	**1,619**	1,119
Investment in subsidiaries	Investment in subsidiaries	**1,037,067**	1,301,937
Other assets		**73**	2,885
Prepaids and other assets			
Total assets	**Total assets**	**1,039,094**	1,306,912
Liabilities, Redeemable Preferred Stock and Shareholders' Equity (Deficit)			
Liabilities, Redeemable Preferred Stock and Shareholders' Deficit			
Liabilities, Redeemable Preferred Stock and Shareholders' Deficit			
Liabilities, Redeemable Preferred Stock and Shareholders' Deficit			
Current liabilities:	Current liabilities:		
Current liabilities:			
Current liabilities:			
Related-party payable, net			
Related-party payable, net			

	As of December 31,	
	2023	2022

Related-party payable, net	Related-party payable, net	**4,527**	988
Short-term borrowings	Short-term borrowings	**303,947**	155,000
Other current liabilities	Other current liabilities	**6,264**	2,469
Total current liabilities			
Long-term borrowings			
Total liabilities	**Total liabilities**	**314,738**	158,457
Commitments and contingencies (Note 15)			
Redeemable Series A preferred stock, $0.0001 par value; 750,000 and — shares authorized in 2022 and 2021, respectively; 750,000 and — shares issued and outstanding in 2022 and 2021, respectively		**747,481**	—
Redeemable Series B preferred stock, $0.0001 par value; 175,000 shares authorized in 2022 and 2021, respectively; 175,000 and — shares issued and outstanding in 2022 and 2021, respectively		**172,936**	—
Commitments and contingencies (Note 14)			
Commitments and contingencies (Note 14)			
Commitments and contingencies (Note 14)			
Redeemable Series A preferred stock, $0.0001 par value; 750,000 shares authorized in 2023 and 2022; 750,000 shares issued and outstanding in 2023 and 2022			
Redeemable Series B preferred stock, $0.0001 par value; 175,000 shares authorized in 2023 and 2022; 175,000 shares issued and outstanding in 2023 and 2022			
Shareholders' equity (deficit):	Shareholders' equity (deficit):		
Common stock, $0.0001 par value; 3,000,000,000 and 3,000,000,000 shares authorized in 2022 and 2021, respectively; 630,271,508 and 628,622,872 shares issued and outstanding in 2022 and 2021, respectively		**63**	63
Shareholders' equity (deficit):			
Shareholders' equity (deficit):			
Common stock, $0.0001 par value; 3,000,000,000 shares authorized in 2023 and 2022; 8,053,576 and 7,878,394 shares issued and outstanding in 2023 and 2022*, respectively			
Common stock, $0.0001 par value; 3,000,000,000 shares authorized in 2023 and 2022; 8,053,576 and 7,878,394 shares issued and outstanding in 2023 and 2022*, respectively			
Common stock, $0.0001 par value; 3,000,000,000 shares authorized in 2023 and 2022; 8,053,576 and 7,878,394 shares issued and outstanding in 2023 and 2022*, respectively			
Additional paid-in capital	Additional paid-in capital	**2,972,271**	2,861,243

Retained earnings (deficit)	Retained earnings (deficit)	**(3,156,395)**	(1,700,851)
Treasury stock, at cost, 2,522,148 shares at December 31, 2022 and 2021		**(12,000)**	(12,000)
Treasury stock, at cost, 31,526 shares at December 31, 2023 and 2022			
Total shareholders' equity (deficit)	**Total shareholders' equity (deficit)**	**(196,061)**	1,148,455
Total liabilities, redeemable preferred stock and shareholders' equity (deficit)	**Total liabilities, redeemable preferred stock and shareholders' equity (deficit)**	**$1,039,094**	$1,306,912

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
Bright Health Group, NeueHealth, Inc.
Parent Company Condensed Statements of Income (Loss) and Comprehensive Income (Loss)

		For the Years Ended December 31,		
		2022	**2021**	**2020**

	For the Years Ended December 31,		
	2023	**2023**	**2022**
Revenue:	**Revenue:**		
Investment income			
Investment income			
Investment income	Investment income	**$ (36)**	$ 30	$ 26
Total revenue	**Total revenue**	**(36)**	30	26
Operating costs:	**Operating costs:**			
Operating costs:				
Operating costs:				
Operating costs				
Operating costs				
Operating costs	Operating costs	**112,867**	69,170	5,867
Total operating costs	**Total operating costs**	**112,867**	69,170	5,867
Interest expense	Interest expense	**12,822**	7,732	—
Warrant expense				
Loss before income taxes and equity in net loss of subsidiaries	Loss before income taxes and equity in net loss of subsidiaries	**(125,725)**	(76,872)	(5,841)
Income tax expense (benefit)	Income tax expense (benefit)	**43**	17	—
Loss before equity in net loss of subsidiaries	Loss before equity in net loss of subsidiaries	**(125,768)**	(76,889)	(5,841)

Equity in net loss of subsidiaries	Equity in net loss of subsidiaries	**(1,329,776)**	(1,107,973)	(242,601)
Net loss	**Net loss**	**(1,455,544)**	(1,184,862)	(248,442)
Unrealized investment holding (losses) gains	Unrealized investment holding (losses) gains	**(5,267)**	(6,163)	1,556
Unrealized investment holding (losses) gains				
Unrealized investment holding (losses) gains				
Less: reclassification adjustments for investment (losses) gains	Less: reclassification adjustments for investment (losses) gains	**(4,173)**	(402)	112
Other comprehensive (loss) income	**Other comprehensive (loss) income**	**(1,094)**	(5,761)	1,444
Comprehensive loss	**Comprehensive loss**	**$(1,456,638)**	$(1,190,623)	$(246,998)
Comprehensive loss				
Comprehensive loss				

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
Bright Health Group, NeueHealth, Inc.
Parent Company Condensed Statements of Cash Flows

		For the Years Ended December 31,		
		2022	2021	2020
	For the Years Ended December 31,			
	2023			
Net cash provided by (used in) operating activities	**Net cash provided by (used in) operating activities**	**(5,910)**	(4,888)	(168)
Cash flows from investing activities:	**Cash flows from investing activities:**			
Purchases of investments				
Purchases of investments				
Purchases of investments	Purchases of investments	**(500)**	—	(1,119)
Proceeds from sales, paydown, and maturities of investments.	Proceeds from sales, paydown, and maturities of investments.	**—**	—	1,191
Capital contributions to operating subsidiaries	Capital contributions to operating subsidiaries	**(1,064,595)**	(607,699)	(480,869)

		For the Years Ended December 31,	
		2023	2022

Business acquisition, net of cash acquired	Business acquisition, net of cash acquired	**(310)**	(431,791)	(230,331)
Net cash used in investing activities	**Net cash used in investing activities**	**(1,065,405)**	(1,039,490)	(711,128)
Cash flows from financing activities:	**Cash flows from financing activities:**			
Proceeds from issuance of preferred stock	Proceeds from issuance of preferred stock	**920,417**	—	711,200
Proceeds from issuance of preferred stock	Proceeds from issuance of preferred stock			
Proceeds from issuance of common stock	Proceeds from issuance of common stock	**1,315**	11,390	1,241
Proceeds from short-term borrowings	Proceeds from short-term borrowings	**303,947**	355,000	—
Repayments of short-term borrowings	Repayments of short-term borrowings	**(155,000)**	(200,000)	—
Payments for debt issuance costs		**—**	(3,391)	—
Proceeds from IPO		**—**	887,328	—
Payments for IPO offering costs		**—**	(6,686)	—
Proceeds from long-term borrowings				
Net cash provided by financing activities	**Net cash provided by financing activities**	**1,070,679**	1,043,641	712,441
Net increase (decrease) in cash and cash equivalents	**Net increase (decrease) in cash and cash equivalents**	**(636)**	(737)	1,145
Cash and cash equivalents – beginning of year	Cash and cash equivalents – beginning of year	**971**	1,708	563
Cash and cash equivalents – end of year	Cash and cash equivalents – end of year	**$ 335**	$ 971	$ 1,708

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
Bright Health Group, NeueHealth, Inc.
Notes to Condensed Financial Statements

NOTE 1. BASIS OF PRESENTATION

The Bright Health Group, NeueHealth, Inc. (the "Parent Company") condensed financial statements should be read in conjunction with our consolidated financial statements. The condensed financial statements include the activity of the Parent Company and reflect its subsidiaries using the equity method of accounting. Under the equity method, the investment in consolidated subsidiaries is stated at cost plus equity in undistributed earnings of consolidated subsidiaries.

NOTE 2. SUBSIDIARY TRANSACTIONS

Investment in Subsidiaries: The Parent Company's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries.

Dividends and Capital Distributions: Cash There were no cash dividends from unregulated subsidiaries included in the Cash Flows from Operating Activities in the Parent Company Condensed Statements of Cash Flows were $— million, $— million and $65.1 million for the years ended December 31, 2022, 2021December 31, 2023 and 2020, respectively. 2022.

NOTE 3. SHORT-TERM BORROWINGS

Discussion of short-term borrowings can be found in Note 11 5 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements. Statements and Supplementary Data."

NOTE 4. LONG-TERM BORROWINGS & COMMON STOCK WARRANTS

Discussion of long-term borrowings and common stock warrants can be found in Note 6 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

NOTE 4. 5. COMMITMENTS AND CONTINGENCIES

Certain regulated subsidiaries are guaranteed by the Parent Company in the event of insolvency.

For a summary of commitments and contingencies, see Note 17 14 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements. Statements and Supplementary Data."

ITEM 16. FORM 10-K SUMMARY

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this Annual Report to be signed on its behalf by the undersigned, thereunto duly authorized.

NeueHealth, Inc.

Bright Health Group, Inc.

Date: March 16, 2023 March 28, 2024

By: /s/ G. Mike Mikan

Name: G. Mike Mikan

Title: Chief Executive Officer and President

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed by the following persons on behalf of the registrant in the capacities indicated on March 16, 2023 March 28, 2024.

SIGNATURE	TITLE
/s/ G. Mike Mikan G. Mike Mikan	Chief Executive Officer, President and Director (Principal Executive Officer)
/s/ Catherine R. Smith Jay Matushak Catherine R. Smith Jay Matushak	Chief Administrative and Financial Officer (Principal Financial Officer)
/s/ Jeffrey J. Scherman Jeffrey J. Scherman	Chief Accounting Officer (Principal Accounting Officer)
/s/ Robert J. Sheehy Robert J. Sheehy	Chairman
/s/ Kedrick D. Adkins Jr. Kedrick D. Adkins Jr.	Director
/s/ Naomi Allen Naomi Allen	Director
/s/ Linda Gooden Linda Gooden	Director
/s/ Jeffery Jeffrey R. Immelt Jeffery Jeffrey R. Immelt	Director
/s/ Manuel Manual Kadre Manuel Kadre	Director
/s/ Steve Kraus Steve Kraus	Director
/s/ Mohamad Makhzoumi Mohamad Makhzoumi	Director
/s/ Matthew Manders Matthew Manders	Director
/s/ Adair Newhall Adair Newhall	Director
/s/ Andrew M. Slavitt Andrew M. Slavitt	Director

Exhibit 10.10

ADDENDUM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
7500 Security Boulevard, Mail Stop WB-22-75
Baltimore, Maryland 1244-1850

To: Jay Matushak, President, Chief Financial Officer
Jeff Craig, Secretary
Bright Health Insurance Company
Payee ID A1025001 (HIOS ID BHIC-CO-31070)
jcraig@brighthealthgroup.com

Date: March 8, 2024

RE: Bright Health Insurance Company (BHIC-CO) Addendum to Repayment Plan Approval and Letter of Agreement

Dear Messrs. Matushak and Craig:

On February 16, 2024, BHIC-CO requested a repayment plan to pay the outstanding 2022 benefit year risk adjustment charges on BHIC-CO's August 16, 2023 initial invoices totaling **$163,394,891.07**.

For CMS to implement the 18-month payment plan, you must:

1. **Sign and submit this letter to provide your written understanding and agreement to the terms of this Letter of Agreement concerning the 18-month repayment plan CMS approved (the "Repayment Plan") no later than 11:59 p.m. ET on March 11, 2024.** The signed Letter of Agreement must be sent to CCIIOInvoices@cms.hhs.gov.

2. **Pay the lump sum payment of $5,000,000 no later than 11:59 p.m. ET on March 11, 2024.** Payment must be submitted electronically. To submit payment, you must visit www.pay.gov and then select and complete the CMS Health Insurance Marketplace and Premium Stabilization Programs Payment Form.

CMS has attached the installment payment and amortization schedule which reflects the most recent invoice balance, setting forth the 18-month installment payment amounts and due dates. By entering into this Letter of Agreement as shown by your signature below, you agree that the Repayment Plan is incorporated fully into this Letter of Agreement, and that this Letter of Agreement, along with the attached revised installment and amortization schedule, constitute the entire agreement ("the Agreement") between CMS and BHIC-CO concerning repayment of the referenced debt under the Repayment Plan, subject to all applicable laws, rules, and regulations.

As outlined in the schedule, CMS will assess interest at the rate provided for under 45 C.F.R. § 30.18. **You will be charged an interest rate of 11.5%,** which is the interest rate that was established on the initial invoices for 2022 benefit year risk adjustment charges. Each installment payment will be due on the 15th of each month over the course of 18 months, except that any payment due date that falls on a holiday or weekend will be due the next following business day.

If you fail to make the lump sum payment outlined in this addendum or submit the addendum signed agreement, the Repayment Plan will revert to the Repayment Plan set forth in the original September 14, 2023 Letter of Agreement. Failure to make timely payment in accordance with the Repayment Plan, or entering into liquidation, rehabilitation, or early pre-liquidation, constitute default. In the event of default, CMS will initiate debt collection, and the full balance of the debt will become immediately due and payable.

You are permitted to make early payment, or to pay off the entire debt early, without penalty. Any early payment will be applied to the principal balance, but in that event, the monthly installment payment amounts would not change unless notified by CMS.

If you have any questions concerning the repayment plan, please contact CMS at CCIIOInvoices@cms.hhs.gov.

Sincerely,

/s/ Elizabeth E. Parish -S

Elizabeth Parish
Director, Payment Policy and Financial Management Group (PPFMG)
Center for Consumer Information and Insurance Oversight (CCIIO)
Centers for Medicare & Medicaid Services (CMS)
U.S. Department of Health and Human Services (HHS)

ATTESTATION

I attest that I am legally and financially able to obligate Bright Health Insurance Company, HIOS ID BHIC-CO-31070, and agree to terms of the Agreement as set forth above, including all attachments and all documents incorporated herein.

Jeffery Craig

First and Last Name

Secretary

Title

Bright Health Insurance Company

Company

612-238-1321

Phone Number

jcraig@brighthealthgroup.com

Email

8000 Norman Center Drive, Suite 900, Minneapolis, MN 55437

Address

/s/ Jeff Craig

Signature (Electronic Signature permitted)

3/11/2024

Date Signed

cc: Michael Conway
Colorado Insurance Commissioner
Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Exhibit 10.19 10.30

May 4, 2022

Jeff Cook
9449 Sagrada Park Fort Worth, TX 76126

Dear Jeff,

Welcome and congratulations!

We are so excited to offer you the opportunity to join our team and help us advance our mission! This offer is an expression of our confidence in you, which is manifested in your attitude, potential, and demonstrated experience. We look forward to a satisfying employment relationship and mutual commitment to living our values and delivering on better healthcare for our members.

This letter contains the details of your employment, including salary and benefits, along with some legalese to make sure that we agree. **This offer is subject to Compensation Committee approval.** Please do not hesitate to follow up with any questions. We look forward to your response and the opportunity to Make Healthcare Right. Together.

SUMMARY OFFER (details below)

In the role of **President – NeueHealth**, you will be expected to fulfill the duties and responsibilities listed in your job description. We will make sure to keep it updated and on file, working with you and your manager to ensure it reflects your role.

Position - President, NeueHealth
Manager - Mike Mikan
Annual Base Salary - 600,000
Bonus Target - 90% of base salary
Equity Grant - $2,250,000
Signing Bonus - $250,000
Anticipated Start Date - TBD
Employee Benefits - Full Participation
Classification - ExemptExecution Version

INITIAL COMPENSATION

If you accept this offer, you will receive base salary of **$600,000** on an annualized basis. Your salary will be paid in accordance with the Company's normal payroll procedures.

You will be eligible to receive an annual (calendar year) incentive bonus of up to **90%** of your base salary based on evaluation of your achievement of certain corporate and individual performance goals. The bonus will **not** be prorated during your first year of employment and will be paid no later than March 15th each calendar year. To be eligible for a bonus, you must be employed prior to November 1st of the bonus calendar year and also be employed on the date that the bonus is paid.

We are pleased to offer you a signing bonus of THIS EXECUTIVE EMPLOYMENT AGREEMENT (the "$250,000 Agreement. This bonus will be paid out on your first scheduled pay date after 90 days of employment. The signing bonus") is taxable, made and all regular payroll taxes will be withheld. If you leave Bright Health (either voluntarily or if terminated for cause) within 12 months of your date of hire, you will be responsible for reimbursing the company for the portion of the signing bonus you have been paid.

BENEFITS

As a full-time employee of Bright Health, you are eligible to participate in our company-sponsored benefit plans. We offer the following coverages, some paid in part by Bright Health: medical, dental, vision, flexible spending account, commuter, and life & disability. In addition, employees may enroll in our 401k plan following 90 days of employment. The Company may change these benefits from time to time. You are entitled to paid time off "PTO" according to our current Company policies and subject to the approval of your immediate supervisor.

EQUITY AWARD

As part of your offer, we are providing you with an opportunity to own equity in Bright Health Group and participate in the growth of Bright Health Group. This comes in the form of Restricted Stock Units ("RSUs") and Stock Options. We will recommend that our Board of Directors grant you an equity award in the amount of **$2,250,000** at the next quarterly meeting after you start your employment. This award will be made up of 100% RSUs. The total number of Stock Options and RSUs will be determined based on the fair market value of Bright Health Group stock at the time of grant.

Both the Stock Options and RSUs will vest annually over 3 years (1/3, 1/3, 1/3), and vesting will begin after 12 months following the grant date. After your Stock Options vest, you will have earned the right to buy the number of shares that have vested at the price determined on the grant date. The grants will be subject to the terms and conditions of the Company's 2021 Stock Incentive Plan and standard Stock Option and RSU Agreements.

You will be eligible to participate in the annual equity program with discretionary grants based on your role in the company. As President – NeueHealth, your 2023 target would be approximately **$900,000**. This award will be made up of 50% RSUs and 50% Stock Options. The total number of Stock Options and RSUs will be determined based on the fair market value of Bright Health Group stock at the time of grant.

EMPLOYMENT RELATIONSHIP

This offer of employment is contingent upon successful completion of your background and reference checks and your ability to provide us with documents deemed acceptable by the USCIS (United States Citizenship & Immigration Services) to demonstrate your identity and eligibility to work in the United States. Please call if you have any questions about what documents are acceptable to the USCIS.

This offer of employment is contingent upon you receiving a waiver of your non-competition agreement with your current employer. As a condition of your employment, you are also required to sign and return to us - before your first day of employment - and to comply with the terms of the Employee Confidentiality, Assignment of Inventions and Non-Competition Agreement ("Agreement"). That

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Agreement requires, among other provisions, your assignment of rights to any invention made during your employment at the Company (subject to limited exceptions), non-disclosure of Company proprietary information, and a restriction on certain aspects of your conduct during the one year following termination of your employment.

We also require that, if you have not already done so, you disclose to the Company any and all agreements relating to your prior employment that may affect your eligibility to be employed by the Company or limit the manner in which you may be employed. As more fully described in the Agreement, we understand that any such agreements will not prevent you from performing the duties of your position and you represent that such is the case. Similarly, you agree not to bring any third-party confidential information to the Company, including that of your former employer, and that in performing your duties for the Company you will not in any way utilize any such information.

Finally, although Bright Health strives to maintain long-term successful relationships with its employees, this offer of employment is not for a definite period of time and will be at-will employment. You will be free to resign at any time, for any reason or for no reason. Similarly, the Company will be free to conclude its employment relationship with you at any time, with or without cause or notice, for any lawful reason. Your at-will employment status may not be modified other than in writing and signed by an authorized officer of the Company.

CONCLUSION

This letter and the enclosed Agreement set forth the initial terms of your employment with the Company, and supersede any prior representations or agreements including, but not limited to, any representations made during your recruitment, interviews or pre-employment negotiations, whether written or oral. This letter, the enclosed Agreement, and your employment will be governed by the laws of Minnesota.

To accept the Company's offer, please sign and date this letter in the space provided below. We look forward to your favorable reply and to working with you at Bright Health.

Very truly yours,

/s/ Stacy Conti

Stacy Conti
Chief People Officer

Enclosures: Employee Confidentiality, Assignment of Inventions and Non-Competition Agreement

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ACKNOWLEDGEMENT AND ACCEPTANCE

By signing below, I accept the offer to join Bright Health and the mission to Make Healthcare Right. Together!

I acknowledge that I have read, understand, and agree to the above offer of employment letter, and the enclosed Employee Confidentiality and Assignment of Inventions Agreement and Non-Competition Agreement, successful completion of background check and references.

Name: Jeff Cook Signature:

AMENDMENT NO. 2 dated entered into as of November 20, 2021 (this July 1, 2021 and made effective as of August 9, 2021 (the "Amendment Effective Date"), among BRIGHT HEALTH GROUP, INC. by and between Centrum Medical Holdings, LLC, a Delaware limited liability company (the "Company"), the other LOAN PARTIES party hereto, the LENDERS party hereto and JPMORGAN CHASE BANK, N.A., in its capacity as administrative agent Tomas Orozco (the "Administrative Agent Executive").

Reference is made

RECITALS:

WHEREAS, the Company desires to employ Executive pursuant to the Credit Agreement dated as terms of March 1, 2021 (as amended by the First Amendment dated as of August 2, 2021, this Agreement; and as further amended, supplemented or otherwise modified from time

WHEREAS, Executive desires to time prior be so employed pursuant to the date hereof, the "Credit Agreement"), among the Company, the Lenders party thereto and the Administrative Agent. Capitalized terms used and not otherwise defined herein shall have the meanings assigned to them in the Credit of this Agreement.

The Company has requested, and the Administrative Agent and the Lenders party hereto agree, in accordance with Section 15.1 of the Credit Agreement, to amend the Credit Agreement on the terms and subject to the conditions set forth herein.

AGREEMENT:

NOW, THEREFORE, in consideration of the based upon these premises, and covenants contained herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto, intending to be legally bound do hereby agree as follows:

A. Amendment

. Subject to upon the satisfaction terms and conditions of Executive's employment with the conditions precedent Company that are set forth in Section 3 hereof:

a. the defined term "Letter of Credit Commitment" in Section 1.1 of the Credit Agreement is hereby amended in its entirety to read as follows:

""Letter of Credit Commitment" means, (a) with respect to each Issuing Bank set forth on Annex A, the amount set forth opposite such Issuing Bank's name on Annex A or such other amount as may from time to time be agreed between the Company and the applicable Issuing Bank or (b) in

the case of any other Issuing Bank, such amount as may be agreed among such Issuing Bank, the Company and the Administrative Agent."; herein,

a. 1.Effectiveness/Employment and TermSection 2.3.2 .

1.1 This Agreement constitutes a binding obligation of the Credit Agreement is hereby amended (i) by replacing the text "$50,000,000" in such Section with "$75,000,000" and (ii) by replacing the text of clause (ii) thereof with the text "the portion of the LC Exposure attributable to Letters of Credit issued by any Issuing Bank will not exceed the Letter of Credit Commitment of such Issuing Bank, unless otherwise agreed by the such Issuing Bank"; and

b. Annex A of the Credit Agreement is hereby amended by increasing the "Letter of Credit Commitment" amount with respect to JPMorgan Chase Bank, N.A. from $10,714,500 to $35,714,500 and increasing the total amount of Letter of Credit Commitments from $50,000,000 to $75,000,000 (it being understood that the Letter of Credit Commitment of each other Issuing Bank shall remain unchanged).

B. Representations and Warranties

. The Company represents and warrants that parties as of the date hereof hereof. The term of employment under this Agreement shall commence on the Effective Date and shall expire upon the Amendment Effective Date:

a. After giving effect to this Amendment, later of (a) December 31, 2025 or (b) the representations final exercise by (i) RRD Healthcare, LLC of its put option, or (ii) Medical Practice Holding Company, LLC of its call option, in connection with that certain Amended and warranties contained in Section 9 Restated Limited Liability Company Agreement of the Credit Company, dated as of even date hereof, subject to earlier termination pursuant to Section 6.

1.2 The Company agrees to employ Executive and Executive agrees to be employed by the Company pursuant to the terms of this Agreement, and for the period commencing on the Effective Date until 11:59 pm Eastern Time on January 14, 2022 (the "Initial Title Term"), as the Company's EVP of IFP/ACA Clinics and President of IFP Clinics, reporting solely to the Chief Executive Officer, and for the remainder of the term of the agreement following the Initial Title Term, as the Company's Chief Executive Officer, reporting solely to the Board of Managers of the Company (the "Board"), to perform the duties assigned to Executive by the Company in accordance with Section 2.

2.Duties. Executive will perform all duties customarily incident to Executive's position and such duties that are true properly assigned to Executive by the Company the from time to time. Except as set forth herein, Executive shall devote Executive's entire professional time, attention and correct (i) effort to the affairs of the Company and its affiliates and shall use Executive's reasonable best efforts to promote the interests and success of the Company; provided, however, Executive may serve on civic or charitable boards or committees, deliver lectures, fulfill speaking engagements and manage personal investments, provided that such activities do not individually or in the case aggregate materially interfere with, and are otherwise not materially inconsistent with, the performance of the representations and warranties qualified as to materiality, in all respects and (ii) otherwise, in all material respects; except in the case of any such representation and warranty that expressly relates to a prior date, in which case Executive's duties under this Agreement.

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such representation and warranty3.Compensation.

3.1 Base Salary. As consideration payable to Executive for performing the duties described in Section 2 hereof, the Company shall pay to Executive an annualized base salary of $650,000 (the "Base Salary"), payable in regular installments in accordance with Company's ordinary payroll practices. If the Board of Managers determines (in its sole discretion) to increase Executive's Base Salary, the Base Salary as so increased shall be so true the new Base Salary for all purposes of this Agreement. Executive's Base Salary for any partial year shall be based upon the actual number of days elapsed in such year.

3.2 Bonus Compensation.

3.2.1 Annual Bonus. For each fiscal year completed during Executive's employment under this Agreement, Executive will be eligible to earn an annual cash bonus. Executive's target annual cash bonus will be an amount up to 50% of Executive's Base Salary (the "Bonus"), with the actual amount of any such Bonus to be determined by the Board in its good faith discretion, based on satisfaction of performance criteria related to the Executive's performance and correct on the Company's achievement of financial, operational and as performance targets and other objectives to be established by the Board or a duly constituted committee thereof in good faith. Annual bonuses shall be paid at the same time the Company pays the bonus to other similarly situated employees. In order to earn and receive any Bonus hereunder, Executive must be employed through the end of such prior date.

b. After giving effect to this Amendment, no Default or Event of Default has occurred the calendar year measurement period and is continuing.

C. Conditions to Effectiveness

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This Amendment shall become effective on the first date (the "the Bonus is paid. Executive's Bonus for any partial calendar year shall be based upon the actual number of days elapsed in such calendar year.

3.2.2 Amendment Effective Date Promotion Incentive"). Within ten (10) calendar days of the expiration of the Initial Term, Executive shall receive a single lump-sum cash payment of $1,250,000, payable on the Company's next regular payroll payment date subject to withholding.

3.3 Taxes and Other Applicable Deductions. From all compensation paid to Executive, the Company shall withhold all applicable sums for all state, federal and local taxes, and such other amounts as are necessary and applicable or agreed to by Executive.

4.Executive Benefits. In addition to the Base Salary and Bonus, Executive and his covered dependents shall be entitled to all standard benefits normally provided by the Company to its similarly situated executive officers, which may be sponsored, developed or established by the Administrative Agent shall have received (a) a certificate, dated Company from time to time in the Amendment Effective Date and signed by a Responsible Officer sole discretion of the Company, confirming that including, without limitation, the representations and warranties benefits set forth in this Section 2 hereof are true and correct in all respects, and (b) executed counterparts 4.

4.1. Medical Coverage. The Company shall provide a standard medical benefit package, as offered to other employees of the Company or any Related Company (as defined herein), throughout the term of this Amendment by (i) Agreement. Notwithstanding the foregoing, until such time as the Company (ii) each can provide Executive with comprehensive PPO coverage, Executive shall receive a tax-free medical insurance allowance in the amount of the other Loan Parties, (iii) the Administrative Agent and (iv) the Required Lenders.

The Administrative Agent shall notify the Company and the Lenders of the Amendment Effective Date and such notice shall be conclusive and binding.

A. Fees and Expenses

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The Company agrees to reimburse the Administrative Agent for its reasonable and documented out-of-pocket expenses incurred by it in connection with this Amendment, including the reasonable fees, charges and disbursements of Cravath, Swaine & Moore LLP, counsel for the Administrative Agent.

A. Counterparts

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This Amendment may be executed in any number of counterparts and by different parties hereto in separate counterparts, each of which when so executed shall be deemed to be an original and all of which taken together shall constitute one and the same agreement. The words "execution", "signed", "signature", "delivery", and words of like import in or relating to this Amendment and/or any document to be signed in connection with this Amendment and the transactions contemplated hereby shall be deemed to include Electronic Signatures, deliveries or the keeping of records in electronic form, each of which shall be of the same legal effect, validity or enforceability as two thousand US Dollars ($2,000) a manually executed signature, physical delivery thereof or the use of a paper-based recordkeeping system, as the case may be.

A. month. Reaffirmation by Loan Parties

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Each of the Loan Parties, as debtor, grantor, pledgor, guarantor, assignor, or in any other similar capacity in which such Loan Party grants liens or security interests in its property or acts as a guarantor, hereby (a) ratifies and reaffirms all of its payment and performance obligations, contingent or otherwise, under each of the Loan Documents to which it is a party (after giving effect hereto) and (b) to the extent such Loan Party granted liens on or security interests in any of its property pursuant to any such Loan Document as security for, or guaranteed, the Obligations under the Loan Documents, ratifies and reaffirms such grant of security interests and liens and such guarantee and confirms and agrees that such security interests and liens hereafter secure all of the Obligations as amended hereby.

A. Governing Law; Amendment of Right to Trial by Jury, Etc

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THIS AMENDMENT AND ANY CLAIM, CONTROVERSY, DISPUTE OR CAUSE OF ACTION ARISING UNDER OR RELATED TO THIS AMENDMENT SHALL BE GOVERNED BY, AND CONSTRUED IN ACCORDANCE WITH, THE SUBSTANTIVE LAWS OF THE STATE OF NEW YORK WITHOUT REGARD TO CHOICE OF LAW

DOCTRINES. 4.2 Dental Coverage. The Company shall provide a standard dental benefit package, as offered to other employees of the Company or any Related Company, throughout the term of this Agreement.

5. Business Expenses. The Company will reimburse Executive, within thirty (30) days following submission by Executive to the Company of appropriate supporting documentation, for Executive's usual and customary business expenses incurred in the course of Executive's employment in accordance with the Company's applicable policies and procedures, including expenditure limits and substantiation requirements, in effect from time to time regarding reimbursement of expenses incurred by similarly situated employees of the Company, its affiliates and subsidiaries; provided that all claims for reimbursement (accompanied by supporting documentation) are submitted to the Company within ninety (90) days following the date such expenses are incurred.

6. Termination. Notwithstanding any other provision of this Agreement, the provisions of Sections 15.4, 15.6, 15.7, 15.15, 15.20 this Section 6 shall exclusively govern Executive's rights under this Agreement upon termination of employment with the Company.

6.1 Termination Without Cause. Company may terminate Executive without Cause at any time upon prior written notice to Executive. Upon the Company's termination of employment without Cause, subject to Section 6.5, Company will pay to Executive (a) the amount of any unpaid salary owed through the date of termination and 15.24 (b) any unreimbursed expenses pursuant to Section 5 for expenses incurred in the performance of Executive's duties hereunder prior to termination (such payments collectively referred to herein as, the "Accrued Benefits").

6.2 Mutual Agreement/Resignation without Good Reason/Death or Disability. Executive's employment shall terminate upon the occurrence of either of the Credit following events:

a. Mutual Agreement/Resignation without Good Reason. The Company and Executive shall mutually agree to termination of this Agreement in writing or Executive shall resign without Good Reason (as defined herein); provided that Executive shall be obligated to give the Company at least one hundred twenty (120) days' advance written notice of any resignation without Good Reason. Upon Executive's termination of employment due to mutual agreement, or the resignation of employment by Executive without Good Reason, the Company will pay to Executive the Accrued Benefits.

b. The Death of Executive; Termination by Company Due toExecutive's Disability. "Disability" for purposes of this Agreement shall be the inability of Executive to materially perform his duties hereunder, with or without an accommodation, due to a physical or mental condition for a period of at least one hundred twenty (120) consecutive calendar days, or any longer period required by law, as reasonably determined by Company and Executive. Upon Executive's termination of employment for death or Disability, Company will pay to Executive the Accrued Benefits.

6.3 Termination for Cause. Executive's employment may be terminated by the Company for "Cause" upon the occurrence of any of the following events:

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a. Executive's conviction of or the entering of a guilty plea or plea of no contest with respect to a felony involving theft or misappropriation against the Company;

b. Executive's conviction or the entering of a guilty plea or plea of no contest with respect to a crime involving fraud, dishonesty or moral turpitude or embezzlement against the Company;

c. Executive commits an intentional and material act (i) to defraud the Company or any affiliate or (ii) of embezzlement against the Company or any affiliate, each of which are hereby incorporated determined in good faith by reference the Company;

d. Executive's breach of a fiduciary duty owed to the Company, which Executive has failed to cure within thirty (30) days of receiving written notice from the Board specifying such breach; or (ii) is of such a serious nature and degree so as to be incompatible with continued employment;

e. Executive's repeated (i.e., more than once) refusal to follow (or cause the Company to follow) the lawful direction of the Board or any duly authorized designee thereof Executive has failed to cure within thirty (30) days of receiving written notice from the Board specifying such refusal;

f. a material breach of the provisions of any written code of conduct or policy of the Company, as amended from time to time, of which Executive has been informed or has knowledge and which Executive has failed to cure within thirty (30) days of receiving written notice from the Board specifying such breach; or (ii) is of such a serious nature and degree so as to be incompatible with continued employment;

g. Executive willfully impedes or endeavors to improperly influence, obstruct or impede an investigation or fails to materially cooperate with an investigation in each case authorized by the Company or being conducted pursuant to a legal process to which the Company is subject, following notice and a reasonable opportunity to cure; or

h. Executive's material or intentional breach of this Agreement; and which Executive has failed to cure within thirty (30) days of receiving written notice from the Board specifying such breach; or (ii) is of such a serious nature and degree so as to be incompatible with continued employment.

Upon the Company's termination of Executive's employment pursuant to this Section 6.3, Company will pay to Executive (a) the amount of any unpaid Base Salary owed through the date of termination and (b) any unreimbursed expenses pursuant to Section 5 for expenses incurred in the performance of Executive's duties hereunder prior to termination, and Company will have no other liability to Executive hereunder (except for any vested benefits under any employee benefit plans or programs).

6.4 Termination for Good Reason. Executive may voluntarily resign Executive's employment for "Good Reason" upon the occurrence of any of the following events:

a. a material breach by the Company of this Agreement;

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b. without Executive's consent, a relocation of the Executive's place of employment by more than thirty (30) miles from the Company's offices as of the Effective Date;

c. a material and permanent reduction in Executive's authority or responsibilities; or

d. a material reduction in Executive's Base Salary (i.e., a reduction that is in excess of 10% of Executive's then-current Base Salary), except for across-the-board salary reductions similarly affecting the senior management of the Company after consultation with Executive.

Notwithstanding the foregoing, no event shall constitute Good Reason unless and until Executive shall have notified the Board in writing describing the event that constitutes Good Reason and then, if the Good Reason event is curable, only if the Company shall fail to cure such event within thirty (30) days following its receipt of such written notice.

Upon Executive's termination of employment for Good Reason, subject to Section 6.5, Company will pay to Executive the Accrued Benefits.

6.5 Severance Compensation and Other Obligations.

a. If Executive's employment is terminated by the Company without Cause under Section 6.1, or by Executive for Good Reason under Section 6.4, then, subject to Executive's continued compliance with the provisions of Section 7 and Section 8 of this Agreement, and provided Executive has signed the Separation Agreement and Release in the form of Exhibit A to this Agreement ("Release"), Company shall pay Executive as severance compensation ("Severance") a total amount equal to (i) Executive's then-current Base Salary for an eighteen (18) month period (such period, the "Severance Period"), paid in substantially equal installments in accordance with Company's normal payroll payment dates subject to applicable tax withholding, subject to Section 23(b)*plus* (ii) any Bonus Executive otherwise would have earned and received under Section 3 of this Agreement in respect of the calendar year in which Executive's employment is discontinued had Executive's employment otherwise continued through the date on which the Bonus would have been earned, to be determined in the same manner and paid at the same time as set forth in full herein, mutatis mutandis Section 3.

A. b. Headings

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The headings terms of this AmendmentSection 6.5 shall survive any termination of this Agreement.

7. Restricted Activities.

7.1 Preliminary Statement. Executive acknowledges that by virtue of Executive's duties under this Agreement, Executive shall become aware of sensitive and confidential information of the Company, and shall develop contacts and relationships which Executive otherwise would not have had access to or developed.

Executive further acknowledges

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that such information and relationships would give Executive an unfair competitive advantage should Executive compete with the Company. Executive further acknowledges that Executive may also become aware of certain confidential information relating to the Company and certain of its subsidiaries (each, a "Related Company" and collectively, the "Related Companies") and will develop certain contacts and relationships with clients or customers of the Company or a Related Company which would give Executive an unfair competitive advantage if Executive should compete with the Company or any such Related Company. Accordingly, Executive agrees that Executive shall not, directly or indirectly, whether alone or as a partner, officer, director, investor, employee, agent, member or shareholder of any other entity or corporation (other than the Company or any of the Related Companies), without the prior written consent of the Company, violate any of the covenants (the "Covenants") set forth in this Section 7.

7.2 Covenant Not to Divulge Confidential Information. During the term of Executive's employment with the Company, whether pursuant to this Agreement or otherwise, and after termination of Executive's employment with the Company, Executive shall not, without the prior written consent of the Board, (i) use any Confidential Information of or concerning the Company or the Related Companies except for the Company's or a Related Company's benefit or (ii) disclose or divulge to any third party any Confidential Information relating to the Company or the Related Companies, except for the Company's or a Related Company's benefit or as otherwise required by law. "Confidential Information" shall mean information concerning the Company or any Related Company. Notwithstanding the immediately preceding sentence, Confidential Information shall not include (a) any information that is, or becomes, generally available to the public (unless such availability occurs as a result of the Executive's breach of any portion of this Section 7.2), (b) any information that is lawfully acquired by Executive from sources which are for purposes not prohibited from disclosing such information by a legal, contractual or fiduciary obligation or any information that is independently developed by or on behalf of reference only Executive without use of Confidential Information.

7.3 Covenant Not to Compete or Interfere with Business Relationships. During the term of Executive's employment with the Company, and continuing until the end of the Severance Period (the "Restricted Period"), Executive shall not engage in the following activities:

a. Executive shall not, within the Restricted Geographic Area, engage in any activity competitive with the Company or any Related Company. "Restricted GeographicArea" shall mean any state in which the Company or any Related Company is providing management services to, or operating, a medical practice as of the termination date of Executive's employment under this Agreement.

b. Executive shall not solicit or hire (for Executive or on behalf of a third party) any person who is then, or within one hundred eighty (180) days prior to termination of this Agreement was, an employee, service provider, or contractor (including, without limitation, any Contract Physicians) of the Company or any Related Company; provided, however, that that the general solicitation by the Executive conducted, directly or indirectly, in newspapers, trade journals, the Internet, or by any similar media shall not be deemed to limit, amplify be an attempt to induce, attempt to induce, or modify attempt to hire any officer, manager, director, or employee of any member of the Company or any Related Company or cause any such person to leave the employ of any member of the Company or any Related Company or otherwise interfere with any relationship

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between any such person and any member of the Company or any Related Company in contravention of, or be deemed to otherwise violate, this Section 7.3. "Contract Physicians" shall include those physicians with whom the Company or any Related Company then has a contract, or which have actively been recruited by the Company or any Related Company within one hundred eighty (180) days prior to termination of this Agreement.

c. Executive shall not induce or attempt to induce any person or entity doing business with the Company or any Related Company, to terminate such relationship, or engage in any other activity detrimental to Company or any Related Company.

d. Executive shall not, within the Restricted Geographic Area, be employed by nor have any financial relationship (except as the holder of not more than one percent (1%) of the outstanding stock of a publicly held company) with any entity which directly or indirectly performs any competitive activity which Executive is individually prohibited from performing under the terms of this Amendment, nor affect Agreement (a "Competing Entity").

e. Notwithstanding the meaning hereof. restrictions specified in this Section 7, nothing herein shall be construed to prohibit Executive from owning, solely as a passive investment, the securities of an entity which are not publicly traded provided that such entity is not engaged in a principal business of providing physician services to patients.

A. 7.4 Effect Construction. The Covenants are essential elements of Amendment; References this Agreement. The period of time during which Executive is prohibited from engaging in the business practices described in any Covenant shall be extended by any length of time during which Executive is in breach of such Covenant. The Company and Executive agree that the Covenants are appropriate and reasonable when considered in light of the nature and extent of the business conducted by the Company. However, if a court of competent jurisdiction determines that any portion of the Covenants, including without limitation, the specific time period, scope or geographical area, is unreasonable or against public policy, then such Covenants shall be considered divisible as to time, scope, and geographic area and the maximum time period, scope or geographic area which is determined to be reasonable and not against public policy shall be enforced.

7.5 Remedies. The parties agree that if Executive breaches any Covenant, the Company or the Related Companies, as applicable, may suffer irreparable damages. Executive agrees that (i) damages at law will be difficult to measure and an insufficient remedy to the Credit Agreement Company or a Related Company in the event that Executive violates the terms of this Section 7 and (ii) the Company and the Related Companies shall be entitled to seek injunctive relief to enforce the provisions of this Section 7 without proving actual damages, which injunctive relief shall be in addition to any other rights or remedies available to the Company or the Related Companies. No remedy shall be exclusive of any other, and neither application for nor obtaining injunctive or other relief shall preclude any other remedy available, including money damages. The non-prevailing party shall pay the prevailing party all of its all costs and expenses, including reasonable attorneys' fees and costs, incurred relating to the enforcement of the terms of this Section 7, associated with litigation, including, if any, in appellate proceedings. Executive acknowledges and agrees that the Related Companies are intended beneficiaries of the Covenants

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Except and shall have the same rights and remedies as expressly set the Company to enforce the Covenants.

8. Inventions and Intellectual Property. Executive acknowledges that all developments, including, without limitation, inventions, patentable or otherwise, discoveries, improvements, patents, trade secrets, designs, reports, computer software, flow charts and diagrams, procedures, data, documentation, ideas and writings and applications thereof relating to the present or planned business of the Company or any Related Company that, alone or jointly with others, Executive may conceive, create, make, develop, reduce to practice or acquire during the term of this Agreement in connection with Executive's performance of his duties under this Agreement (collectively, the "Developments") are works made for hire and shall remain the sole and exclusive property of the Company, and Executive hereby assigns to the Company all of Executive's right, title and interest in and to all such Developments. All related items, including, but not limited to, memoranda, notes, lists, charts, drawings, records, files, computer software, programs, source and programming narratives and other documentation (and all copies thereof) made or compiled by Executive, or made available to Executive, concerning the business or planned business of the Company or any Related Company shall be the property of the Company and shall be delivered to the Company promptly upon the termination of this Agreement. The provisions of this Section 8 shall survive the termination of this Agreement.

9. Death. If Executive dies before the date on which all amounts owing to the Executive hereunder are paid in full, the Company shall pay to Executive's estate (or such other recipient as designated from time to time by Executive in writing) such remaining amounts when and as such amounts were otherwise payable to Executive. After receiving the payments provided under this Section 9, Executive and Executive's estate shall have no further rights against the Company for Compensation under this Agreement.

10. Assignment and Binding Effect. Executive may not sell, assign, transfer, or otherwise convey any of Executive's rights or delegate any of Executive's duties under this Agreement without the prior written consent of the Company. This Agreement shall be binding upon and inure to the benefit of the parties and their respective legal successors, permitted assigns, heirs, representatives and beneficiaries.

11. Entire Agreement and Modification. This Agreement sets forth herein, the entire understanding of the parties with respect to the subject matter hereof, supersedes all existing agreements between them concerning such subject matter, and may be modified only by a written instrument duly executed by both parties.

12. Waiver. The failure of a party to insist upon strict adherence to any term of this Amendment Agreement on one or more occasions shall not be considered a waiver or deprive that party of the right thereafter to insist upon strict adherence to that term or any other term of this Agreement. Any waiver must be in writing. Any waiver by implication any party of a breach of any provision of this Agreement shall not operate as or otherwise limit, impair, constitute be construed to be a waiver of any other breach of such provision or otherwise affect of any breach of any other provision of this Agreement.

13. Governing Law; Submission to Jurisdiction; Waiver of Jury Trial; Limitations Period.

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a. This Agreement shall be governed by and construed in accordance with the rights and remedies internal laws of the Administrative Agent, State of Florida without giving effect to any Lender choice or conflict of law provision or rule (whether of the State of Florida or any Issuing Bank under other jurisdiction).

b. ANY LEGAL SUIT, ACTION OR PROCEEDING ARISING OUT OF OR BASED UPON THIS AGREEMENT, THE OTHER TRANSACTION DOCUMENTS OR THE TRANSACTIONS CONTEMPLATED HEREBY OR THEREBY MAY ONLY BE INSTITUTED IN THE FEDERAL COURTS OF THE UNITED STATES OF AMERICA LOCATED IN THE STATE OF FLORIDA, AND EACH PARTY IRREVOCABLY SUBMITS TO THE EXCLUSIVE JURISDICTION AND VENUE OF SUCH COURTS IN ANY SUCH SUIT, ACTION OR PROCEEDING. SERVICE OF PROCESS, SUMMONS, NOTICE OR OTHER DOCUMENT BY MAIL TO SUCH PARTY'S ADDRESS SET FORTH HEREIN SHALL BE EFFECTIVE SERVICE OF PROCESS FOR ANY SUIT, ACTION OR OTHER PROCEEDING BROUGHT IN ANY SUCH COURT. THE PARTIES IRREVOCABLY AND UNCONDITIONALLY WAIVE ANY OBJECTION TO THE LAYING OF VENUE OF ANY SUIT, ACTION OR ANY PROCEEDING IN SUCH COURTS AND IRREVOCABLY WAIVE AND AGREE NOT TO PLEAD OR CLAIM IN ANY SUCH COURT THAT ANY SUCH SUIT, ACTION OR PROCEEDING BROUGHT IN ANY SUCH COURT HAS BEEN BROUGHT IN AN INCONVENIENT FORUM.

c. EACH PARTY ACKNOWLEDGES AND AGREES THAT ANY CONTROVERSY WHICH MAY ARISE UNDER THIS AGREEMENT OR THE OTHER TRANSACTION DOCUMENTS IS LIKELY TO INVOLVE COMPLICATED AND DIFFICULT ISSUES AND, THEREFORE, EACH SUCH PARTY IRREVOCABLY AND UNCONDITIONALLY WAIVES ANY RIGHT IT MAY HAVE TO A TRIAL BY JURY IN RESPECT OF ANY LEGAL ACTION ARISING OUT OF OR RELATING TO THIS AGREEMENT, THE OTHER TRANSACTION DOCUMENTS OR THE TRANSACTIONS CONTEMPLATED HEREBY OR THEREBY. EACH PARTY TO THIS AGREEMENT CERTIFIES AND ACKNOWLEDGES THAT (A) NO REPRESENTATIVE OF ANY OTHER PARTY HAS REPRESENTED, EXPRESSLY OR OTHERWISE, THAT SUCH OTHER PARTY WOULD NOT SEEK TO ENFORCE THE FOREGOING WAIVER IN THE EVENT OF A LEGAL ACTION, (B) SUCH PARTY HAS CONSIDERED THE IMPLICATIONS OF THIS WAIVER, (C) SUCH PARTY MAKES THIS WAIVER VOLUNTARILY, AND (D) SUCH PARTY HAS BEEN INDUCED TO ENTER INTO THIS AGREEMENT BY, AMONG OTHER THINGS, THE MUTUAL WAIVERS AND CERTIFICATIONS IN THIS SECTION 13(c).

14. Notices. All notices, requests, demands and other communications made with respect to this Agreement shall be in writing, and either personally delivered, sent by registered or certified mail (postage prepaid) or sent by overnight courier service, and shall be deemed to be effective on (a) the Credit Agreement day that such writing is delivered if delivered in person, (b) the next Business Day following delivery to a nationally recognized overnight courier, if delivered by overnight courier or any agreement (c) if given by registered or document relating thereto, and except certified mail, five (5) business days after being deposited in the mail. All such notices shall be addressed as expressly follows, or to such other address as a party may from time to time indicate in writing to the other, as provided in this Amendment, Section 14:

If to Company, to:

Centrum Medical Holdings, LLC c/o Bright Health Group, Inc.

8000 Norman Center Drive, Suite 1200
Minneapolis, MN 55437 Attn: General Counsel

If to Executive, to:
Tomas Orozco 9370 SW 98th St.
Miami, Florida 33176

15. Severability. In the event that any provision in this Agreement shall be found by a court, arbitrator, referee or governmental authority of competent jurisdiction to be invalid, illegal or unenforceable, such provision shall be construed and enforced as if it had been narrowly drawn so as not alter, modify, amend to be invalid, illegal or unenforceable, and the validity, legality and enforceability of the remaining provisions of this Agreement shall not in any way affect be effected or impaired thereby, and if any provision is inapplicable to any person or circumstance, it shall nevertheless remain applicable to all other persons and circumstances.

16. Headings. The headings in this Agreement are solely for convenience of reference and shall be given no effect in the construction or interpretation of this Agreement.

17. Confidentiality. The terms and conditions of this Agreement are confidential and neither party to this Agreement shall disclose the existence or content of this Agreement to any individual or entity, except (a) to such party's tax, legal or accounting advisors, (b) as necessary for such party to perform its obligations under this Agreement, (c) to enforce such party's rights under this Agreement, (d) in connection with due diligence activities related to any potential transaction involving the Company or (e) as may otherwise be required by law, without the express written consent of the terms, conditions, obligations, covenants other party.

18. Counterparts. This Agreement may be executed in one or agreements contained in the Credit Agreement or any such other agreement or document, more counterparts, each of which will be deemed an original, but all of which are ratified and affirmed in all respects and shall continue in full force and effect. This Amendment shall together will constitute a Loan Document for all purposes of the Credit Agreement one and the other Loan Documents. On and after the Amendment Effective Date, each reference in the Credit same instrument. The exchange of executed copies of this Agreement to "this Agreement", "hereunder", "hereof" or words of like import referring to the Credit Agreement shall mean and be a reference to the Credit Agreement as amended hereby. Nothing herein shall entitle the Company to a consent to, or a waiver, extension, amendment, modification by facsimile, PDF transmission or other change reasonable form of electronic transmission will constitute effective execution and delivery of this Agreement.

19. Enforcement Costs. If any legal action or other proceeding is brought, for the enforcement of any of the terms or conditions obligations, covenants or agreements contained in the Credit of this Agreement, or because of an alleged dispute, breach, or default, in connection with any agreement or document relating thereto of the provisions of this Agreement, the prevailing party in such action shall be entitled to recover from the non-prevailing party the costs it incurred in such action including, but not limited to, reasonable attorneys' fees (including costs and fees incurred on appeal), in addition to any similar or different circumstances. other relief to which such party may be entitled.

[Remainder 20. Survival. Termination of page left intentionally blank] this Agreement shall not terminate any continuing obligation(s) of the parties under this Agreement, and the parties hereby agree that such obligation(s) shall survive termination, unless the context of the obligation(s) requires otherwise.

21. Compliance with other Agreements. Executive represents and warrants that the execution of this Agreement and Executive's performance of Executive's obligations hereunder will not conflict with, or result in a breach of any provision of, or result in the termination of, or constitute a default under, any agreement to which Executive is a party or by which Executive is or may be bound.

22. No Rule of Construction. This Agreement shall be construed to be neither against nor in favor of any party hereto based upon any party's role in drafting this Agreement, but rather in accordance with the fair meaning hereof.

23. Compliance With IRC 409A.

a. Application of IRC Section 409A. To the extent of any compliance issues or ambiguous terms, this Agreement shall be construed in such a manner so as to comply with the requirements of Section 409A of the Internal Revenue Code ("IRC" or "Code"), and the rules set forth in this Section 23(a) shall apply with respect to any payments that may be subject to Section 409A of the Code notwithstanding any other provision of this Agreement.

b. Timing of Payments. Notwithstanding the applicable provisions of this Agreement regarding the timing of payments, any payment due hereunder which is contingent upon receipt of the Release described in Section 6.5 shall be made, if at all, in accordance with this Section 23(b), and only if Executive has delivered to the Company a properly executed Release for which all legally mandated revocation rights of the Executive have expired prior to the sixtieth (60th) day following the date of termination. Any such payment shall be made after receipt of such executed and irrevocable Release within such sixty (60) period, unless otherwise scheduled to be made after such period pursuant to the terms of this Agreement; provided, however, if the sixty (60) day period for such payments begins in one taxable year of Executive and ends in a second taxable year of Executive, any payments otherwise payable within such sixty (60) day period will be made in the second taxable year. Any payments due after such sixty (60) period shall be payable in accordance with their regularly scheduled payment date. All payments hereunder are subject to any required delay pursuant to Section 23(c), if applicable.

c. "Specified Executive" Delay in Payment. Notwithstanding anything herein to the contrary, (i) if at the time of Executive's termination of employment with the Company Executive is a "specified employee" as defined in Section 409A of the Code and the deferral of the commencement of any payments or benefits otherwise payable hereunder as a result of such termination of employment is necessary in order to prevent any accelerated or additional tax under Section 409A of the Code, then the Company will defer the commencement of the payment of any such payments or benefits hereunder (without any reduction in such payments or benefits ultimately paid or provided to Executive) until the date that is six months following Executive's termination of employment with the Company (or the earliest date as is permitted under Section 409A of the Code) and (ii) if any other payments of money or other benefits due to Executive hereunder could cause the application of an accelerated or additional tax under Section 409A of

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the Code, such payments or other benefits shall be deferred if deferral will make such payment or other benefits compliant under Section 409A of the Code, or otherwise such payment or other benefits shall be restructured, to the extent possible, in a manner, determined by the Board, that does not cause such an accelerated or additional tax. The Company shall consult with Executive in good faith regarding the implementation of the provisions of this Section 23; provided that neither the Company nor any of its employees or representatives shall have any liability to Executive with respect thereto. For purposes of Section 409A of the Code, the right to a series of installment payments under this Agreement shall be treated as a right to a series of separate payments and references herein to Executive's termination of employment shall refer to Executive's "separation from service" within the meaning of the default provisions of Treas. Reg. § 1.409A-1(h).

d. Expenses; In-Kind Benefits. To the extent that reimbursements or other in- kind benefits under this Agreement constitute nonqualified deferred compensation, (i) all expenses or other reimbursements hereunder shall be made on or prior to the last day of the taxable year following the taxable year in which such expenses were incurred by Executive, (ii) any right to reimbursement or in- kind benefits shall not be subject to liquidation or exchange for another benefit, and (iii) no such reimbursement, expenses eligible for reimbursement, or in-kind benefits provided in any taxable year shall in any way affect the expenses eligible for reimbursement, or in-kind benefits to be provided, in any other taxable year.

[remainder intentionally left blank; signatures on following page]

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[Signature Page – Executive Employment Agreement]

IN WITNESS WHEREOF, the parties hereto have caused executed this Amendment to be duly executed as of Executive Employment Agreement on the date first above written. written above.

BRIGHT HEALTH GROUP, INC., COMPANY: Centrum Medical Holdings, LLC, a Delaware limited liability company as the Company

By: /s/ Cathy R Smith Rodolfo Rodriguez-Duret
Name: Cathy R Smith Rodolfo Rodriguez-Duret
Title: EVP CFO/CAO Authorized Representative

BRIGHT HEALTH MANAGEMENT, INC. BRIGHT HEALTH SERVICES, INC.
MEDICAL PRACTICE HOLDING
COMPANY, LLC
BRIGHTHEALTH NETWORKS, LLC
PHYSICIANS PLUS ACO, LLC
PINEAPPLE ACO, LLC
PHYSICIANS PLUS, LLC
PHYSICIANS PLUS OF FLORIDA, LLC
PHYSICIANS PLUS OF CALIFORNIA, LLC EXECUTIVE: Tomas Orozco

NEUEHEALTH LLC,
as Guarantors

By: Cathy R Smith
Name: Cathy R Smith
Title: EVP CFO/CAO DocuSign Envelope ID: 248E1835-B6F9-4617-B954-176BC2671507

JPMORGAN CHASE BANK, N.A.,
as Administrative Agent and Lender [Signature Page – Executive Employment Agreement]

By: /s/ Joon Hur IN WITNESS WHEREOF, the parties hereto have executed this Executive Employment Agreement on the date first written above.
Name: Joon Hur
Title: Executive Director COMPANY: Centrum Medical Holdings, LLC, a Delaware limited liability company

BARCLAYS BANK PLC,
as Lender

By: /s/ Jake Lam _____
Name: Jake Lam
Title: Assistant Vice President

GOLDMAN SACHS LENDING PARTNERS LLC,
as Lender

By: /s/ Dan Martis
Name: Dan Martis Rodolfo Rodriguez-Duret
Title: Authorized Signatory

MORGAN STANLEY SENIOR FUNDING, INC.,
as Lender

By: /s/ David White
Name: David White
Title: Authorized Signatory Representative

BANK OF AMERICA, N.A.,
as Lender

By: EXECUTIVE: /s/ Joseph L. Corah Tomas Orozco

Name: Joseph L. Corah
Title: Director EXHIBIT A

SEPARATION AGREEMENT AND RELEASE

This Separation Agreement and Release (this "Release Agreement") is made between Centrum Medical Holdings, LLC ("Company") and Tomas Orozco ("you") as follows:

1. **Severance**. Company will pay you Severance in accordance with Section 6.5 of your Executive Employment Agreement with Company. The Severance does not constitute "compensation" for purposes of determining any contributions or benefits provided under any 401(k) or other Company benefit plan.

RESTRICTED STOCK UNIT GRANT NOTICE UNDER THE BRIGHT HEALTH GROUP, INC. 2021 OMNIBUS INCENTIVE PLAN

Bright Health Group, Inc. (the "

2. **Company Release of All Claims**". In exchange for the Severance, you, for yourself and any person or representative claiming through you, release and forever discharge Company, its parent company, subsidiaries, affiliates, successors and assigns and their past and present managers, officers, members, employees, agents, attorneys, benefit plans and plan administrators, sureties and insurers (collectively "Releasees"), pursuant from all claims, liabilities, commissions, demands, costs, attorney fees, causes of action and damages, including all consequential and incidental damages, whether known or unknown, arising out of or relating to its 2021 Omnibus Incentive Plan, as it may be amended your Executive Employment Agreement with Company or your employment with Company, including without limitation all claims for personal injury, defamation, breach of contract, breach of the implied covenant of good faith and restated from time to time (the "fair dealing, privacy violations, rehire or reemployment rights, wrongful discharge, wages, commissions, salary or other compensation (except for salary under Plan Section 3.1"), hereby grants of the Executive Employment Agreement owed through the employment termination date for all quarters ended prior to the Participant employment termination date and a pro rata amount for the portion of any quarter that has not yet ended as of the employment termination date), violation of due process or civil rights and violation of any federal, state or local statute, law or ordinance and the common law, including without limitation violation of the Employee Retirement Income Security Act, the Age Discrimination in Employment Act, Title VII of the Civil Rights Act, the Family and Medical Leave Act, the Americans with Disabilities Act, the Equal Pay Act, the Sarbanes-Oxley Act, the Lilly Ledbetter Fair Pay Act, the Uniformed Services Employment and Re-employment Rights Act (including the right to reinstatement under USERRA), the Indiana Civil Rights Law, and/or any federal, state or local law regarding discrimination, harassment, retaliation, compensation or employee benefits. You also waive any right to monetary recovery should any administrative or governmental agency or any other person or entity pursue any claims on your behalf.

It is understood and agreed that except for the exceptions set forth below the number of Restricted Stock Units (the "RSUs") set forth below.The RSUs are subject to all of the terms and conditions as set forth herein, in the Restricted Stock Unit this Release Agreement (attached hereto or previously provided to the Participant in connection with a prior grant) and in the Plan, Executive Employment Agreement with Company, this is a full and final release in complete settlement of all claims and rights of every nature and kind whatsoever which are incorporated herein in their entirety.By accepting the RSUs, you are agreeing to be bound by such Restricted Stock Unit Agreement.In the event the Participant does not accept the RSUs as directed by the Company within 90 days of receipt of written notice of the grant of the RSUs (which have or may be delivered via e-mail), the Company may, in its sole discretion, cancel the RSUs.Capitalized terms not otherwise defined herein shall have the meaning set forth in the Plan.

Participant:

Date of Grant:

Number of RSUs:

Vesting Start Date:

Vesting Schedule:Subject to the Participant's continued service with the against Company and its Subsidiaries on each applicable vesting date, other Releasees arising out of or relating to your Executive Employment Agreement with Company or your employment with Company. You represent and agree that, except as set forth below, the RSUs shall vest as follows: one third of the RSUs shall vest and be released to the Participant's captive broker account on each of the first three anniversaries of the Vesting Start Date.

Notwithstanding any of the foregoing, if a Change otherwise provided in Control occurs, and during the 24-month period following such Change in Control, the Participant's service is terminated by the Service Recipient without Cause or due to the Participant's resignation for Good Reason (as defined below), all unvested RSUs shall become fully vested upon the date of the Participant's Termination.

Definitions"Good Reason" shall have the meaning given to such term in any employment or consulting agreement between the Participant and the Service Recipient in effect at the time of the Participant's Termination. In the absence of any such employment or consulting agreement or the absence of any definition of "Good Reason" contained therein, "Good Reason" means the occurrence of one or more of the following events arising without the express written consent of the Participant, but only if the Participant notifies the Service Recipient in writing of the event within 60 days following the occurrence of the event, the event remains uncured after the expiration of 30 days from receipt of such notice, and the Participant resigns effective no later than 30 days following the Service Recipient's failure to cure the event: (i) a material diminution in the Participant's base salary or target bonus opportunity, (ii) the relocation of the Participant's principal place of employment or service to a location more than 35 miles from the Participant's then current principal place of employment or service, if a move to such other location materially increases the Participant's commute, or (iii) any material breach by the Company or the Service Recipient of this RSU Agreement or the Participant's offer letter or employment agreement with the Service Recipient.

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this Release Agreement and in the Executive Employment Agreement with Company, as of the date you signed this Release Agreement, you have been compensated for all hours worked, you have received all payments and benefits that you are entitled to receive, you have not suffered any personal injuries and/or disabilities related to your employment with Company for which you have not already filed a claim, and you have not filed or caused to be filed any claims against any of the Releasees arising out of or relating to your Executive Employment Agreement with Company or your employment with Company.

You agree that you will not file a lawsuit against Company and/or other Releasees as to any matter released under this Release Agreement. You agree that in the event that any such lawsuit is filed, the filing of a copy of this Release Agreement will constitute a full and complete defense.

RESTRICTED STOCK UNIT AGREEMENT UNDER THE BRIGHT HEALTH GROUP, INC. 2021 OMNIBUS INCENTIVE PLAN

Pursuant 3. **Confidentiality of Agreement**. You agree to the Restricted Stock Unit Grant Notice (the "Grant Notice") delivered to the Participant (as defined in the Grant Notice), and subject to keep the terms of this Restricted Stock Unit Release Agreement (this "RSU confidential and to not disclose any terms of this Release Agreement") to anyone other than your attorneys, spouse, significant other, financial consultant and Bright Health Group, Inc. 2021 Omnibus Incentive Plan, as it other advisors, and then only upon their agreement to keep such terms confidential for which you indemnify Company. You may be amended and restated from time to time (the "Plan"), Bright Health Group, Inc. (the "Company") and the Participant agree as follows.By accepting the RSUs listed in the Grant Notice (which is hereby incorporated into this RSU Agreement), you are agreeing to be bound by this RSU Agreement (including, without limitation, the restrictive covenants in Section 14 hereof), and the Plan, and acknowledge that you have been provided with a copy or electronic access to a copy of the Prospectus for the Plan.Capitalized terms not otherwise defined herein shall have the same meaning as set forth in the Plan.

1. **Grant of RSUs**.Subject to also disclose the terms and conditions set forth herein and in the Plan, the Company hereby grants to the Participant the number of RSUs provided in the Grant Notice (with each RSU representing an unfunded, unsecured right to receive one share of Common Stock).The Company may make one or more additional grants of RSUs to the Participant under this RSU Agreement by providing the Participant with a new Grant Notice, which may also include any terms and conditions differing from this RSU Release Agreement to the extent provided therein. Internal Revenue Service or a governmental agency upon request and to enforce this Release Agreement.

The 4. **Cooperation**. You agree that despite your termination from Company, reserves all rights you may have to cooperate with Company with respect to the granting matters of additional RSUs hereunder and makes no implied promise which you may have knowledge due to grant additional RSUs.

2. **Vesting**.Subject to the conditions contained herein and in the Plan, the RSUs shall vest as provided in the Grant Notice.
3. **Settlement of Vested RSUs**.Subject your employment, including but not limited to any election transition of your work responsibilities and any defense or prosecution of any claims, causes of action or charges brought against or by the Committee pursuant Company. You agree to Section 9(d)(ii) of the Plan, the cooperate reasonably with Company, will deliver including talking to the Participant, without charge, as soon as reasonably practicable (and, and/or meeting with Company representatives, employees, agents and attorneys and providing, if necessary, testimony in any event, within two forum; provided, however, the foregoing cooperation obligation shall not preclude you from engaging in other full-time employment or in any way interfere unreasonably with any such other employment or personal schedule. Company in turn agrees to provide reasonable notice to you should your cooperation in any matter be required and one-half months) following the applicable vesting date, one share of Common Stock for each vested RSU (as adjusted under the Plan, as applicable) which becomes vested hereunder and such vested RSU shall be cancelled upon such delivery.The Company shall either (a) deliver, or cause to be delivered, to the Participant a certificate or certificates therefor, registered in the Participant's name or (b) cause such shares of Common Stock to be credited to the Participant's account at the third-party plan administrator.Notwithstanding anything in this RSU Agreement to the contrary, the Company shall have no obligation to issue or transfer any shares of Common Stock as contemplated by this RSU Agreement unless and until such issuance or transfer complies with all relevant provisions

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of law and the requirements of any stock exchange on which the Company's shares of Common Stock are listed for trading.

4. **Treatment of RSUs Upon Termination**. Except as otherwise provided in the Grant Notice or as otherwise may be provided by the Committee, in the event of a Participant's Termination responsible for any reason prior reasonable costs incurred by you in connection with such cooperation. You agree that any failure to the time that provide such Participant's RSUs have vested, (A) all vesting with respect to such Participant's RSUs shall cease and (B) unvested RSUs shall be forfeited to the Company by the Participant for no consideration as of the date of such Termination.
5. **Conditions to Issuance of Common Stock**. The Company shall not be required to record the ownership by the Participant of shares of Common Stock issued upon the settlement of vested RSUs prior to fulfillment of all of the following conditions: (i) the obtaining of approval or other clearance from any federal, state, local or non-U.S. governmental agency which the Committee shall, in its reasonable and good faith discretion, determine to be necessary;(ii) the lapse of such reasonable period of time following the vesting of the RSUs as may otherwise be required by applicable law; and (iii)the execution and delivery to the Company, to the extent not so previously executed and delivered, of such other documents and instruments cooperation as may be reasonably required by the Committee.
6. **Participant**. Whenever the word "Participant" is used in any provision will be a breach of a material term of this RSU Agreement under circumstances where the provision should logically be construed to apply to the executors, the administrators, or the person or persons to whom the RSUs may be transferred in accordance with Section 14(b) of the Plan, the word "Participant" shall be deemed to include such person or persons.
7. **Non-Transferability**.The RSUs are not transferable by the Participant except to Permitted Transferees in accordance with Section 14(b) of the Plan. Except as otherwise provided herein, no assignment or transfer of the RSUs, or of the rights represented thereby, whether voluntary or involuntary, by operation of law or otherwise, shall vest in the assignee or transferee any interest or right herein whatsoever, but immediately upon such assignment or transfer the RSUs shall terminate and become of no further effect. The Participant further hereby agrees that the Participant shall, without further action on the part of the Participant, be bound by the provisions of the lock-up agreements executed by the executive officers of the Company to the same extent as if the Participant had directly executed such lock-up agreement himself or herself. Such lock-up agreement will provide that the Participant shall not, subject to certain customary exceptions, dispose of or hedge any shares of Common Stock or securities convertible into or exchangeable for shares of Common Stock during the period from the date of the final prospectus relating to initial public offering of the Company and continuing through the date one hundred eighty (180) days following the date of such prospectus, except with the prior consent of the representative(s) of the underwriters. Release Agreement.

1. 5. **Rights as Shareholder Injunctive Relief**. The Participant or a Permitted Transferee of the RSUs shall have no rights as a shareholder with respect In addition to any share other recovery allowed by law, Company will be entitled to a temporary restraining order, preliminary and permanent injunctive relief and such other equitable relief as appropriate for any breach by you of Common Stock underlying Section 3 or 4 of this Release Agreement without having to prove damages or post a RSU unless and until the Participant shall have become the holder of record or the beneficial owner of such share of Common Stock, and no adjustment shall be made for dividends or distributions bond or other rights in respect of such share of Common Stock for which the record date is prior to the date upon which the Participant shall become the holder of record or the beneficial owner thereof. security.

1. 6. **Tax Withholding No Admission of Wrongdoing**.The Participant is required to pay to Neither this Release Agreement nor the Company payment of any amounts under this Release Agreement will be construed as an admission of liability or the Service Recipient, and the Company shall have the right and is hereby authorized to withhold, any applicable withholding taxes in respect of the RSUs, their vesting or settlement or any payment or transfer with respect to the RSUs at the minimum applicable statutory rates, and to take such action as wrongdoing by Company.

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may be necessary 7. Representations and Acknowledgments.

a. Company has given you a period of at least twenty-one (21) days in which to consider this Release Agreement. If executed prior to the opinion end of this twenty-one (21) day period, you acknowledge that you voluntarily waive the balance of this period. You agree that changes to this Release Agreement, if any, whether material or immaterial, do not restart the running of the Committee twenty-one (21) day period.

b. Company advises you to satisfy consult with an attorney before signing this Release Agreement.

c. You acknowledge having had a full and fair opportunity to discuss all obligations aspects of this Release Agreement with your attorney, if you choose to do so, and that you have carefully read this Release Agreement, understand it, and are entering into it voluntarily and knowingly, which means no one is forcing or pressuring you to sign it.

d. By signing this Release Agreement, you acknowledge that no promises or representations have been made or relied upon regarding the subject matter contained in this Release Agreement apart from those expressly set forth in this Release Agreement.

e. This Release Agreement will not be effective or enforceable for a period of seven (7) days following the payment date of your signature below, during which time only, you may revoke this Release Agreement. This revocation must be in writing, signed by you and delivered or mailed so as to arrive within such withholding taxes (" seven (7) days to: the Board of Managers of the Company.

f. Withholding Taxes You have returned all Company property to Company.

g. "). You have not assigned any rights being released under this Release Agreement.

The Participant must make payment (i) h. Except as specifically set forth in cash by wire transfer a written agreement between you and the Company, you have no entitlement to further or (ii) to future employment with Company.

8. Miscellaneous.

a. This four (4) page Release Agreement and the extent permitted by applicable law, by delivery of a notice that Executive Employment Agreement constitute the Participant has placed a market sell order with a broker entire agreement between you and Company with respect to shares the subject matter of Common Stock then issuable upon vesting of the RSUs, this Release Agreement and that the broker has been directed supersede any prior or contemporaneous oral or written promises, agreements or representations between them as to pay a sufficient portion of the net proceeds of the sale to the Company in satisfaction of the Withholding Taxes; provided, that payment of such proceeds is then made to the Company upon settlement of such sale.The Committee may, in its sole discretion, allow such withholding obligation to be satisfied by any other method described in Section 14 of the Plan.

1. **Notice**.Every notice or other communication relating to this RSU Agreement between the Company and the Participant shall be in writing, and shall be mailed to or delivered to the party for whom it is intended at such address as may from time to time be designated by such party in a notice mailed or delivered to the other party as herein provided; provided, that, unless and until some other address be so designated, all notices or communications by the Participant to the Company shall be mailed or delivered to the Company at its principal executive office, to the attention of the Company's Compensation Department, and all notices or communications by the Company to the Participant may be given to the Participant personally or may be mailed to the Participant at the Participant's last known address, as reflected in the Company's records.Notwithstanding the above, all notices and communications between the Participant and any third-party plan administrator shall be mailed, delivered, transmitted or sent in accordance with the procedures established by such third-party plan administrator and communicated to the Participant from time to time.

1. **No Right to Continued Service**.This RSU Agreement does not confer upon the Participant any right to continue as an employee or other service provider to the Company or any of its Subsidiaries or Affiliates.

1. **Binding Effect**.This RSU Agreement shall be binding upon the heirs, executors, administrators and successors of the parties hereto.

1. **Waiver and Amendments**.Except subject matter, except as otherwise set forth stated in Section 13 of this Release Agreement or the Plan, Executive Employment Agreement. However, you agree that any waiver, alteration, amendment inventions, trade secrets, confidential information, fiduciary, non-solicitation, or modification of any of the terms of this RSU Agreement shall be valid only if made in writing and non-compete agreement signed by the parties hereto; provided, that any such waiver, alteration, amendment or modification is consented to on the Company's behalf by the Committee.No waiver by either of the parties hereto of their rights hereunder shall be deemed to constitute a waiver you during employment with respect to any subsequent occurrences or transactions hereunder unless such waiver specifically states that it is to be construed as a continuing waiver.

1. **Limited Restrictions on Certain Post-Employment Activities**. By accepting the RSUs, Participant specifically agrees to the restrictive covenants contained in this Section 14 (the "**Restrictive Covenants**") and Participant agrees that the Restrictive Covenants and the remedies described herein are reasonable and necessary to protect the legitimate interests of the Company. Participant also acknowledges the uncertainty of the law with respect to Restrictive Covenants and expressly stipulates that this RSU Agreement is to be given the construction that renders its provisions valid and enforceable to the maximum extent (not exceeding its express terms) possible under applicable law. Company, including Section 14(a) does not apply to the Participant if the Participant is employed in the state 7 of California or any other jurisdiction rendering your Executive Employment

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restrictive covenants invalid or unenforceable as Agreement with Company, will survive and will be complied with by you. This Release Agreement cannot be modified orally but only in a matter written document signed by you and an authorized representative of Company. This Release Agreement will be governed by the laws of the State of Florida (exclusive of its choice of law as of the date Participant signs this RSU Agreement, but only to such extent any restrictive covenant in Section 14(a) is unenforceable in Participant's employing jurisdiction. Section 14(a) also does not apply if Participant is employed in an occupation or a profession in a jurisdiction that limits or prohibits enforcement of any restrictive covenant as of the date Participant signs this RSU Agreement, but only to the extent any restrictive covenant in Section 14(a) is unenforceable in Participant's employing jurisdiction with respect to Participant's occupation or profession. rules).

a. **Limited Restriction on Competitive Activities**.Participant agrees that, during the term b. If any provision of employment with the Company and for a period of twelve (12) months after employment with the Company ends whether voluntarily or involuntarily, the Participant will not alone, this Release Agreement, in whole or in any capacity with another firm:

   i. be employed by, work as a consultant for, or directly or indirectly render services to, invest in or lend to any person, firm or corporation conducting business in any of the states (including the District of Columbia and all U.S. territories) in which the Company conducted business during Participant's employment, by engaging in research, development, manufacture, marketing, sales, administrative support or promotion of any products, services, or technology (whether commercially available or under development) that are competitive with any products, services, or technology of the Company of which the Participant had knowledge or responsibilities, including but not limited to the development, marketing, sales or administrative support of Company products, services, or technology, including the direct or indirect supervision of Company employees and consultants engaged in those activities;

   ii. engage in competitive conduct, disrupt, damage, impair, or interfere with the business of the Company whether by way of interfering with or disrupting the relationship of the Company with its clients, customers, representatives, vendors or suppliers;

   iii. directly or indirectly call upon or solicit any customer or supplier of the Company or induce, encourage or influence any customer or supplier to terminate or otherwise adversely modify its business relationship with the Company; or

   iv. directly or indirectly hire, solicit, or persuade any of the Company's employees, or former employees who worked for the Company during the twelve (12) months prior to the date of termination of Participant's employment, for the purpose of hiring them, engaging them as consultants, or inducing them to leave their employment with the Service Recipient, attempt to hire, solicit, or persuade or assist anyone else in the solicitation of such employees or former employees.Participant agrees that if Participant is approached by a current or former Company employee regarding potential employment, consultation, or contract, as described above, during the one-year restrictive period of non-solicitation, Participant must promptly (1) inform the employee or former employee of Participant's non-solicitation obligation described above and (2) refrain from engaging in any communication with the employee or former employee regarding potential employment, consultation, or contract.

b. Exceptions to the Foregoing Restrictions.The restrictions contained in this Section 14 of this RSU Agreement will not prevent the Participant from accepting employment with a

large diversified organization with separate and distinct divisions that do not compete, directly or indirectly, with the Company, as long as prior to accepting such employment the Company receives a written assurance from the Participant, satisfactory to the Company, to the effect that the Participant will not render any services to, or have any ability to provide strategic direction or oversight to, any division or business unit that competes, directly or indirectly, with the Company.During the restrictive period set forth in Section 14(a), the Participant will inform any new employer, prior to accepting employment, of the existence of this Agreement and provide such employer with a copy of this Agreement.

If any portion of this Section 14 part, is determined to be unlawful or unenforceable, in any respect, it shall the parties agree that such provision will be interpreted to be valid deemed modified, if possible, to the maximum extent for which it reasonably may be enforced, and enforced as so interpreted, all as determined by necessary to render such arbitrator in such action. Participant acknowledges the uncertainty of the law in this respect and expressly stipulates that this Agreement is to be given the construction that renders its provisions provision valid and enforceable to the maximum extent (not exceeding its express terms) permitted by law and, if not possible, under applicable law.

1. Remedies.Participant understands that violation it will be severed from this Release Agreement. In either event all remaining provisions of this RSU Release Agreement would result will remain in immediate full force and irreparable injury to effect.

c. The captions and headings of the Company; accordingly, Participant agrees that the Company has the right to obtain an injunction to specifically enforce the terms Sections of this Release Agreement are for convenience of reference only and are not to obtain any other legal be considered in construing this Release Agreement. This Release Agreement accurately sets forth the intent and understanding of each party. This Release Agreement will not be construed for or equitable remedies which may be available.Participant agrees that such injunctive relief shall be in addition to and not instead of any right to recover money damages.Further, if Participant violates this Agreement, Participant agrees that the Company will be entitled to an accounting, and to the repayment of all profits, compensation, commissions, fees, royalties, or other financial rewards which Participant or any other entity or person may realize against either party as a result of Participant's violations.Further, in the event Participant violates this RSU Agreement, Participant agrees to pay drafting hereof if there is any dispute over the meaning or intent of any of its provisions.

d. Payment of the Severance evidences Company's costs and attorneys' fees incurred in pursuing its rights with respect to the enforcement acceptance of this RSU Release Agreement.

2. No Restriction on Protected Activities. Nothing in this

e. This Release Agreement prohibits Participant from disclosing information in good faith to any governmental agency, legislative body, may be executed by facsimile or official regarding scanned signature, which is effective as an alleged violation of law or regulation or otherwise protected under applicable law, including, without limitation, the National Labor Relations Act, the Defend Trade Secrets Act, and any rule or regulation promulgated by the Securities and Exchange Commission, the National Labor Relations Board, the Equal Employment Opportunity Commission, or any other federal, state, or local government agency.original.

3. Forfeiture of RSUs. This Section 17 sets forth circumstances under which Participant shall forfeit all or a portion of the RSUs or be required to repay the Company for the value realized in respect of all or a portion of the RSUs.

a. Violation of Restrictive Covenants. If Participant violates any provision of the Restrictive Covenants set forth in Section 14, then any unvested RSUs shall be immediately and irrevocably forfeited without any payment therefor. In addition, for any RSUs that vested within one year prior to Participant's termination of employment with the Service Recipient or at any time after such termination of employment, the Participant shall be required, upon demand, to repay or otherwise reimburse the Company an amount having a value equal to the aggregate Fair Market Value of the shares of Common Stock underlying such RSUs Signed below on the date the RSUs became vested.

b. Detrimental Activity.In addition to the forgoing, and notwithstanding anything to the contrary contained herein or in the Plan, if the Participant has engaged in or engages in any Detrimental Activity, then the Committee may, in its sole discretion, take actions permitted under the Plan, including: (a) canceling the RSUs, or (b) requiring that the

Participant forfeit any gain realized on the disposition of any shares of Common Stock received in settlement of any RSUs, and repay such gain to the Company.In addition, if the Participant receives any amount in excess of what the Participant should have received under the terms of this RSU Agreement for any reason (including without limitation by reason of a financial restatement, mistake in calculations or other administrative error), then the Participant shall be required to repay any such excess amount to the Company.Without limiting the foregoing, all RSUs shall be subject to reduction, cancellation, forfeiture or recoupment to the extent necessary to comply with applicable law. "Detrimental Activity" means any, offset of the following: (i) unauthorized disclosure of any confidential or proprietary information of any member of the Company Group; (ii) any activity that would be grounds to terminate the Participant's employment or service with the Service Recipient for Cause; (iii) a breach by the Participant of any restrictive covenant by which such Participant is bound, including, without limitation, any covenant not to compete or not to hire or solicit, in any agreement with any member of the Company Group; or (iv) fraud, gross negligenceor conduct contributing to any financial restatements or irregularities, as determined by the Committee in its sole discretion.

c. In General. This Section 17 does not constitute the Company's exclusive remedy for Participant's violation of the Restrictive Covenants or commission of fraudulent conduct. As the forfeiture and repayment provisions are not adequate remedies at law, the Company may seek any additional legal or equitable remedy, including injunctive relief, for any such violations. The provisions in this Section 17 are essential economic conditions to the Company's grant of RSUs to Participant. By receiving the grant of RSUs hereunder, to the extent permissible under applicable law, Participant agrees that the Company may deduct from any amounts it owes Participant from time to time (such as wages or other compensation, deferred compensation credits, vacation pay, any severance or other payments owed following a termination of employment, as well as any other amounts owed to the Participant by the Company) to the extent of any amounts Participant owes the Company under this section. The provisions of this Section 17 and any amounts repayable by Participant hereunder are intended to be in addition to any rights to repayment the Company may have under Section 304 of the Sarbanes-Oxley Act of 2002, Section 954 of the Dodd-Frank Wall Street Reform and Consumer Protection Act, and other applicable law.

4. **Governing Law; Venue**.This RSU Agreement shall be construed and interpreted in accordance with the laws of the State of Delaware, without regard to the principles of conflicts of law thereof.Notwithstanding anything contained in this RSU Agreement, the Grant Notice or the Plan to the contrary, if any suit or claim is instituted by the Participant or the Company relating to this RSU Agreement, the Grant Notice or the Plan, the Participant hereby submits to the exclusive jurisdiction of and venue in the courts of Minneapolis, Minnesota.
5. **Award Subject to Plan**. The RSUs granted hereunder, and the shares of Common Stock issued to the Participant upon settlement of vested RSUs, are subject to the Plan and the terms of the Plan are hereby incorporated into this RSU Agreement. By accepting the RSUs, the Participant acknowledges that the Participant has received and read the Plan and agrees to be bound by the terms, conditions, and restrictions set forth in the Plan, this RSU Agreement, and the Company's policies, as in effect from time to time, relating to the Plan. In the event of a conflict between any term or provision contained herein and a term or provision of the Plan, the applicable terms and provisions of the Plan will govern and prevail. The provisions of this RSU Agreement shallbelow.

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survive the termination of this Award to the extent consistent with, or necessary to carry out, the purposes thereof.

6. **Section 409A**.It is intended that the RSUs granted hereunder shall be exempt from Section 409A of the Code pursuant to the "short-term deferral" rule applicable to such section, as set forth in the regulations or other guidance published by the Internal Revenue Service thereunder.
7. **Imposition of Other Requirements**.The Company reserves the right to impose other requirements on the Participant's participation in the Plan, on the RSUs and on any shares of Common Stock acquired under the Plan, to the extent the Company determines it is necessary or advisable for legal or administrative reasons, and to require the Participant to sign any additional agreements or undertakings that may be necessary to accomplish the foregoing.
8. **TransmissionAcknowledgement**. To the extent necessary, the Participant authorizes, agrees and unambiguously consents to the transmission by the Company or any other member of the Company Group of any of the Participant's personal data related to the Award for legitimate business purposes (including, without limitation, the administration of the Plan). The Participant confirms and acknowledges that the Participant gives this authorization and consent freely.
9. **Electronic Delivery and Acceptance**.The Company may, in its sole discretion, decide to deliver any documents related to current or future participation in the Plan by electronic means.The Participant hereby consents to receive such documents by electronic delivery and agrees to participate in the Plan through an on-line or electronic system established and maintained by the Company or a third party designated by the Company. In the event that any information regarding the RSUs provided to the Participant through the third-party stock plan administrator's web portal or otherwise conflicts with any of the terms and conditions of this RSU Agreement or the Plan (collectively, the "RSU Governing Documents"), the RSU Governing Documents shall control.READ BEFORE SIGNING

1. **Entire Agreement**.With the exception of any restrictive covenant contained in any other agreement between the Participant and the Service Recipient, the RSU Governing Documents constitute the entire agreement of the parties hereto in respect of the subject matter contained herein and supersede all prior agreements and understandings of the parties, oral and written, with respect to such subject matter._____ _____

Date Tomas Orozco

OPTION GRANT NOTICE
UNDER
BRIGHT HEALTH GROUP, INC.
2021 OMNIBUS INCENTIVE PLAN

Bright Health Group, Inc. (the "Company"), pursuant to its 2021 Omnibus Incentive Plan, as it may be amended and restated from time to time (the "Plan"), hereby grants to the Participant set forth below the number of Options (each Option representing the right to purchase one share of Common Stock) set forth below, at an Exercise Price per share as set forth below. The Options are subject to all of the terms and conditions as set forth herein, in the Option Agreement (attached hereto or previously provided to the Participant in connection with a prior grant) and in the Plan, all of which are incorporated herein in their entirety. By accepting the Options, you are agreeing to be bound by such Option Agreement and such Vesting Schedule. In the event the Participant does not accept the Options as directed by the Company within 90 days of receipt of written notice of the grant of these Options (which may be delivered via e-mail), the Company may, in its sole discretion, cancel these Options. Capitalized terms not otherwise defined herein shall have the meaning set forth in the Plan.

Participant:

Date of Grant:

Number of Options:

Exercise Price per Share:

Option Period Expiration Date:

Type of Option: **Non-Qualified Stock Option**

Vesting Start Date:

Vesting Schedule: Subject to the Participant's continued service with the Company and its Subsidiaries on each applicable vesting date, and except as set forth below, the Options shall vest as follows: one third of the Options shall vest and become exercisable on each of the first three anniversaries of the Vesting Start Date.

Notwithstanding any of the foregoing, if a Change in Control occurs, and during the 24-month period following such Change in Control, the Participant's service is terminated by the Service Recipient without Cause or due to the Participant's resignation for Good Reason (as defined below), all unvested Options shall become fully vested and exercisable upon the date of the Participant's Termination.

Definitions:

"Good Reason" shall have the meaning given to such term in any employment or consulting agreement between the Participant and the Service Recipient in effect at the time of the Participant's Termination. In the absence of any such employment or consulting agreement or the absence of any definition of "Good Reason" contained therein, "Good Reason" means the occurrence of one or more of the following events arising without the express written consent of the Participant, but only if

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the Participant notifies the Service Recipient in writing of the event within 60 days following the occurrence of the event, the event remains uncured after the expiration of 30 days from receipt of such notice, and the Participant resigns effective no later than 30 days following the Service Recipient's failure to cure the event: (i) a material diminution in the Participant's base salary

or target bonus opportunity, (ii) the relocation of the Participant's principal place of employment or service to a location more than 35 miles from the Participant's then current principal place of employment or service, if a move to such other location materially increases the Participant's commute, or (iii) any material breach by the Company or the Service Recipient of this Option Agreement or the Participant's offer letter or employment agreement with the Service Recipient.

OPTION AGREEMENT
UNDER
BRIGHT HEALTH GROUP, INC.
2021 OMNIBUS INCENTIVE PLAN

Pursuant to the Option Grant Notice (the "Grant Notice") delivered to the Participant (as defined in the Grant Notice), and subject to the terms of this Option Agreement (this "Option Agreement") and Bright Health Group, Inc. 2021 Omnibus Incentive Plan, as it may be amended and restated from time to time (the "Plan"), Bright Health Inc. (the "Company") and the Participant agree as follows. By accepting the Options listed in the Grant Notice (which is hereby incorporated into this Option Agreement), you are agreeing to be bound by this Option Agreement and the Plan, and acknowledge that you have been provided with a copy or electronic access to a copy of the Prospectus for the Plan. Capitalized terms not otherwise defined herein shall have the same meaning as set forth in the Plan.

1. **Grant of Option**. Subject to the terms and conditions set forth herein and in the Plan, the Company hereby grants to the Participant the number of Options provided in the Grant Notice (with each Option representing the right to purchase one share of Common Stock), at an Exercise Price per share as provided in the Grant Notice. The Company may make one or more additional grants of Options to the Participant under this Option Agreement by providing the Participant with a new Grant Notice, which may also include any terms and conditions differing from this Option Agreement to the extent provided therein. The Company reserves all rights with respect to the granting of additional Options hereunder and makes no implied promise to grant additional Options.

2. **Vesting**. Subject to the conditions contained herein and in the Plan, the Options shall vest as provided in the Grant Notice.

3. **Exercise of Options Following Termination**. Except as otherwise provided in the Grant Notice or as otherwise may be provided by the Committee, in the event of: (A) a Participant's Termination by the Service Recipient for Cause, all outstanding Options granted to such Participant shall immediately terminate and expire; (B) a Participant's Termination due to death or Disability, each outstanding unvested Option granted to such Participant shall immediately terminate and expire, and each outstanding vested Option shall remain exercisable for six months thereafter (but in no event beyond the expiration of the Option Period); (C) a Participant's Termination without Good Reason, each outstanding unvested Option granted to such Participant shall immediately terminate and expire, and each outstanding vested Option shall remain exercisable for ninety (90) days thereafter (but in no event beyond the expiration of the Option Period); and (D) a Participant's Termination for any other reason (including, for the avoidance of doubt, termination by the Service Recipient without Cause or by the Participant for Good Reason), each outstanding unvested Option granted to such Participant shall immediately terminate and expire, and each outstanding vested Option shall remain exercisable for ninety (90) days thereafter (but in no event beyond the expiration of the Option Period).

4. **Method of Exercising Options**. The Options may be exercised by the delivery of notice of the number of Options that are being exercised accompanied by payment in full of the Exercise Price applicable to the Options so exercised. Such notice shall be delivered to a third-party plan administrator as may be arranged for by the Company or the Committee from time to time for purposes of the administration of outstanding Options under the Plan. Payment of the aggregate Exercise Price may be made by paying in cash via wire transfer or using the method described in Section 7(d)(ii)(B) of the Plan.

5. **Issuance of Shares of Common Stock**. Following the exercise of an Option hereunder, as promptly as practical after receipt of such notification and full payment of such Exercise Price and any required income or other tax withholding amount (as provided in Section 10 hereof), the Company shall issue or transfer, or cause such issue or transfer, to the Participant the number of shares of Common Stock with respect to which the Options have been so exercised, and shall either (a) deliver, or cause to be delivered, to the Participant a certificate or certificates therefor, registered in the Participant's name or (b)

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cause such shares of Common Stock to be credited to the Participant's account at the third-party plan administrator.

6. **Conditions to Issuance of Common Stock**. The Company shall not be required to record the ownership by the Participant of shares of Common Stock purchased upon the exercise of the Options or portion therefore prior to fulfillment of all of the following conditions: (i) the obtaining of approval or other clearance from any federal, state, local or non-U.S. governmental agency which the Committee shall, in its reasonable and good faith discretion, determine to be necessary; (ii) the lapse of such reasonable period of time following the exercise of the Option as may otherwise be required by applicable law; and (iii) the execution and delivery to the Company, to the extent not so previously executed and delivered, of such other documents and instruments as may be reasonably required by the Committee.

7. **Participant**. Whenever the word "Participant" is used in any provision of this Option Agreement under circumstances where the provision should logically be construed to apply to the executors, the administrators, or the person or persons to whom the Options may be transferred in accordance with Section 14(b) of the Plan, the word "Participant" shall be deemed to include such person or persons.

8. **Non-Transferability**. The Options are not transferable by the Participant; provided, to the extent permitted by the Committee in accordance with Section 14(b) of the Plan, vested Options may be transferred to Permitted Transferees. Except as otherwise provided herein, no assignment or transfer of the Options, or of the rights represented thereby, whether voluntary or involuntary, by operation of law or otherwise, shall vest in the assignee or transferee any interest or right herein whatsoever, but immediately upon such assignment or transfer the Options shall terminate and become of no further effect.

9. **Rights as Shareholder**. The Participant shall have no rights as a shareholder with respect to any share of Common Stock covered by an Option unless and until the Participant shall have become the holder of record or the beneficial owner of such share of Common Stock, and no adjustment shall be made for dividends or distributions or other rights in respect of such share of Common Stock for which the record date is prior to the date upon which the Participant shall become the holder of record or the beneficial owner thereof.

10. **Tax Withholding**. Concurrently with the exercise of an Option, the Participant must pay to the Company any amount that the Company determines it is required to withhold under applicable federal, state or local or foreign tax laws in respect of the exercise or the transfer of the shares of Common Stock in connection therewith ("Withholding Taxes"). The Participant must make payment (i) in cash by wire transfer or (ii) to the extent permitted by applicable law, by delivery of a notice that the Participant has placed a market sell order with a broker with respect to shares of Common Stock then issuable upon exercise of the Options being so exercised, and that the broker has been directed to pay a sufficient portion of the net proceeds of the sale to the Company in satisfaction of the Withholding Taxes; provided, that payment of such proceeds is then made to the Company upon settlement of such sale. The Committee may, in its sole discretion, allow such withholding obligation to be satisfied by any other method described in Section 14 of the Plan.

11. **Notice**. Every notice or other communication relating to this Option Agreement between the Company and the Participant shall be in writing, and shall be mailed to or delivered to the party for whom it is intended at such address as may from time to time be designated by such party in a notice mailed or delivered to the other party as herein provided; provided, that, unless and until some other address be so designated, all notices or communications by the Participant to the Company shall be mailed or delivered to the Company at its principal executive office, to the attention of the Company's Compensation Department, and all notices or communications by the Company to the Participant may be given to the Participant personally or may be mailed to the Participant at the Participant's last known address, as reflected in the Company's records. Notwithstanding the above, all notices and communications between the Participant and any third-party plan administrator shall be mailed, delivered,

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transmitted or sent in accordance with the procedures established by such third-party plan administrator and communicated to the Participant from time to time.

12. **No Right to Continued Service**. This Option Agreement does not confer upon the Participant any right to continue as an employee or service provider to the Company or any of its Subsidiaries.

13. **Binding Effect**. This Option Agreement shall be binding upon the heirs, executors, administrators and successors of the parties hereto.

14.**Waiver and Amendments**. Except as otherwise set forth in Section 13 of the Plan, any waiver, alteration, amendment or modification of any of the terms of this Option Agreement shall be valid only if made in writing and signed by the parties hereto; provided, that any such waiver, alteration, amendment or modification is consented to on the Company's behalf by the Committee. No waiver by either of the parties hereto of their rights hereunder shall be deemed to constitute a waiver with respect to any subsequent occurrences or transactions hereunder unless such waiver specifically states that it is to be construed as a continuing waiver.

15. **Limited Restrictions on Certain Post-Employment Activities**. By accepting the Options, Participant specifically agrees to the restrictive covenants contained in this Section 15 (the "**Restrictive Covenants**") and Participant agrees that the Restrictive Covenants and the remedies described herein are reasonable and necessary to protect the legitimate interests of the Company. Participant also acknowledges the uncertainty of the law with respect to Restrictive Covenants and expressly stipulates that this Option Agreement is to be given the construction that renders its provisions valid and enforceable to the maximum extent (not exceeding its express terms) possible under applicable law. Section 15(a) does not apply to the Participant if the Participant is employed in the state of California or any other jurisdiction rendering restrictive covenants invalid or unenforceable as a matter of law as of the date Participant signs this Option Agreement, but only to such extent any restrictive covenant in Section 15(a) is unenforceable in Participant's employing jurisdiction. Section 15(a) also does not apply if Participant is employed in an occupation or a profession in a jurisdiction that limits or prohibits enforcement of any restrictive covenant as of the date Participant signs this Option Agreement, but only to the extent any restrictive covenant in Section 15(a) is unenforceable in Participant's employing jurisdiction with respect to Participant's occupation or profession.

(a) **Limited Restriction on Competitive Activities**. Participant agrees that, during the term of employment with the Company and for a period of twelve (12) months after employment with the Company ends whether voluntarily or involuntarily, the Participant will not alone, or in any capacity with another firm:

(i)be employed by, work as a consultant for, or directly or indirectly render services to, invest in or lend to any person, firm or corporation conducting business in any of the states (including the District of Columbia and all U.S. territories) in which the Company conducted business during Participant's employment, by engaging in research, development, manufacture, marketing, sales, administrative support or promotion of any products, services, or technology (whether commercially available or under development) that are competitive with any products, services, or technology of the Company of which the Participant had knowledge or responsibilities, including but not limited to the development, marketing, sales or administrative support of Company products, services, or technology, including the direct or indirect supervision of Company employees and consultants engaged in those activities;

(ii)engage in competitive conduct, disrupt, damage, impair, or interfere with the business of the Company whether by way of interfering with or disrupting the relationship of the Company with its clients, customers, representatives, vendors or suppliers;

(iii)directly or indirectly call upon or solicit any customer or supplier of the Company or induce, encourage or influence any customer or supplier to terminate or otherwise adversely modify its business relationship with the Company; or

(iv)directly or indirectly hire, solicit, or persuade any of the Company's employees, or former employees who worked for the Company during the twelve (12) months prior to the date of termination of Participant's employment, for the purpose of hiring them, engaging them as consultants, or inducing them to leave their employment with the Service Recipient, attempt to hire, solicit, or persuade or assist anyone else in the solicitation of such employees or former employees. Participant agrees that if Participant is approached by a current or former Company employee regarding potential employment, consultation, or contract, as described above, during the one-year restrictive period of non-solicitation, Participant must promptly (1) inform the employee or former employee of Participant's non-solicitation obligation described above and (2) refrain from engaging in any communication with the employee or former employee regarding potential employment, consultation, or contract.

(b) Exceptions to the Foregoing Restrictions. The restrictions contained in this Section 15 of this Option Agreement will not prevent the Participant from accepting employment with a large diversified organization with separate and distinct divisions that do not compete, directly or indirectly, with the Company, as long as prior to accepting such employment the Company receives a written assurance from the Participant, satisfactory to the Company, to the effect that the Participant will not render any services to, or have any ability to provide strategic direction or oversight to, any division or business unit that competes, directly or indirectly, with the Company. During the restrictive period set forth in Section 15(a), the Participant will inform any new employer, prior to accepting employment, of the existence of this Agreement and provide such employer with a copy of this Agreement.

If any portion of this Section 15 is determined to be unenforceable in any respect, it shall be interpreted to be valid to the maximum extent for which it reasonably may be enforced, and enforced as so interpreted, all as determined by such arbitrator in such action. Participant acknowledges the uncertainty of the law in this respect and expressly stipulates that this Option Agreement is to be given the construction that renders its provisions valid and enforceable to the maximum extent (not exceeding its express terms) possible under applicable law.

16. **Remedies**. Participant understands that violation of this Option Agreement would result in immediate and irreparable injury to the Company; accordingly, Participant agrees that the Company has the right to obtain an injunction to specifically enforce the terms of this Option Agreement, and to obtain any other legal or equitable remedies which may be available. Participant agrees that such injunctive relief shall be in addition to and not instead of any right to recover money damages. Further, if Participant violates this Agreement, Participant agrees that the Company will be entitled to an accounting, and to the repayment of all profits, compensation, commissions, fees, royalties, or other financial rewards which Participant or any other entity or person may realize as a result of Participant's violations. Further, in the event Participant violates this Option Agreement, Participant agrees to pay the Company's costs and attorneys' fees incurred in pursuing its rights with respect to the enforcement of this Option Agreement.

17. **No Restriction on Protected Activities**. Nothing in this Option Agreement prohibits Participant from disclosing information in good faith to any governmental agency, legislative body, or official regarding an alleged violation of law or regulation or otherwise protected under applicable law, including, without limitation, the National Labor Relations Act, the Defend Trade Secrets Act, and any rule or regulation promulgated by the Securities and Exchange Commission, the National Labor Relations Board, the Equal Employment Opportunity Commission, or any other federal, state, or local government agency.

18. **Forfeiture**. This Section 18 sets forth circumstances under which Participant shall forfeit all or a portion of any vested Options.

(a) **Violation of Restrictive Covenants**. If Participant violates any provision of the Restrictive Covenants set forth in Section 15, then any vested Options shall be immediately and irrevocably forfeited without any payment therefor.

(b) **Detrimental Activity**. In addition to the forgoing, and notwithstanding anything to the contrary contained herein or in the Plan, if the Participant has engaged in or engages in any Detrimental Activity, then the Committee may, in its sole discretion, take actions permitted under the Plan, including: (a) canceling the Options, or (b) requiring that the Participant forfeit any gain realized on the exercise of the Options or the disposition of any shares of Common Stock received upon exercise of the Options, and repay such gain to the Company. In addition, if the Participant receives any amount in excess of what the Participant should have received under the terms of this Option Agreement for any reason (including without limitation by reason of a financial restatement, mistake in calculations or other administrative error), then the Participant shall be required to repay any such excess amount to the Company. Without limiting the foregoing, all Options shall be subject to reduction, cancellation, forfeiture or recoupment to the extent necessary to comply with applicable law. "Detrimental Activity" means any, offset of the following: (i) unauthorized disclosure of any confidential or proprietary information of any member of the Company Group; (ii) any activity that would be grounds to terminate the Participant's employment or service with the Service Recipient for Cause; (iii) a breach by the Participant of any restrictive covenant by which such Participant is bound, including, without limitation, any covenant not to compete or not to hire or solicit, in any agreement with any member of the Company Group; or (iv) fraud, gross negligence or conduct contributing to any financial restatements or irregularities, as determined by the Committee in its sole discretion.

(c) **In General**. This Section 18 does not constitute the Company's exclusive remedy for Participant's violation of the Restrictive Covenants or commission of fraudulent conduct. As the forfeiture and repayment provisions are not adequate remedies at law, the Company may seek any additional legal or equitable remedy, including injunctive relief, for any such violations. The provisions in this Section 18 are essential economic conditions to the Company's grant of Options to Participant. By receiving the grant of Options hereunder, to the extent permissible under applicable law, Participant agrees that the Company may deduct from any amounts it owes Participant from time to time (such as wages or other compensation, deferred compensation credits, vacation pay, any severance or other payments owed following a termination of employment, as well as any other amounts owed to the Participant by the Company) to the extent of any amounts Participant owes the Company under this section. The provisions of this Section 18 and any amounts repayable by Participant hereunder are intended to be in addition to any rights to repayment the Company may have under Section 304 of the Sarbanes-Oxley Act of 2002, Section 954 of the Dodd-Frank Wall Street Reform and Consumer Protection Act, and other applicable law.

19. **Governing Law; Venue**. This Option Agreement shall be construed and interpreted in accordance with the laws of the State of Delaware, without regard to the principles of conflicts of law thereof. Notwithstanding anything contained in this Option Agreement, the Grant Notice or the Plan to the contrary, if any suit or claim is instituted by the Participant or the Company relating to this Option Agreement, the Grant Notice or the Plan, the Participant hereby submits to the exclusive jurisdiction of and venue in the courts of Minneapolis, Minnesota.

20. **Award Subject to Plan**. The Options granted hereunder, and the shares of Common Stock issued to the Participant upon exercise of the Options, are subject to the Plan and the terms of the Plan are hereby incorporated into this Option Agreement. By accepting the Options, the Participant acknowledges that the Participant has received and read the Plan and agrees to be bound by the terms, conditions, and restrictions set forth in the Plan, this Option Agreement, and the Company's policies, as in effect from time to time, relating to the Plan. In the event of a conflict between any term or provision contained herein and a term or provision of the Plan, the applicable terms and provisions of the Plan will govern and prevail. The provisions of this Option Agreement shall survive the termination of this Award to the extent consistent with, or necessary to carry out, the purposes thereof.

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21. **Imposition of Other Requirements**. The Company reserves the right to impose other requirements on the Participant's participation in the Plan, on the Options and on any shares of Common Stock acquired under the Plan, to the extent the Company determines it is necessary or advisable for legal or administrative reasons, and to require the Participant to sign any additional agreements or undertakings that may be necessary to accomplish the foregoing.

22. **Transmission Acknowledgement**. To the extent necessary, the Participant authorizes, agrees and unambiguously consents to the transmission by the Company or any other member of the Company Group of any of the Participant's personal data related to the Award for legitimate business purposes (including, without limitation, the administration of the Plan). The Participant confirms and acknowledges that the Participant gives this authorization and consent freely.

23. **Electronic Delivery and Acceptance**. The Company may, in its sole discretion, decide to deliver any documents related to current or future participation in the Plan by electronic means. The Participant hereby consents to receive such documents by electronic delivery and agrees to participate in the Plan through an on-line or electronic system established and maintained by the Company or a third party designated by the Company. In the event that any information regarding the Options provided to the Participant through the third-party stock plan administrator's web portal or otherwise conflicts with any of the terms and conditions of this Option Agreement or the Plan (collectively, the "Option Governing Documents"), the Option Governing Documents shall control.

24. **Entire Agreement**. The Option Governing Documents constitute the entire agreement of the parties hereto in respect of the subject matter contained herein and supersede all prior agreements and understandings of the parties, oral and written, with respect to such subject matter.

Exhibit 21.1

Name of Subsidiary	Jurisdiction of Incorporation or Organization
AssociatesMD Medical Group, Inc.	Delaware
Bright Health Charitable Foundation	Delaware
Bright Health Company of Arizona	Arizona
Bright Health Company of California, Inc.	California
Bright Health Company of Georgia	Georgia
Bright Health Company of North Carolina	North Carolina
Bright Health Company of South Carolina, Inc.	South Carolina
Bright Health Group, Inc.	Delaware
Bright Health Insurance Company	Colorado
Bright Health Insurance Company of Florida	Florida
Bright Health Insurance Company of Illinois	Illinois
Bright Health Insurance Company of New York	New York
Bright Health Insurance Company of Ohio, Inc.	Ohio
Bright Health Insurance Company of Tennessee	Tennessee
Bright Health Management, Inc.	Delaware
Bright Health Services, Inc.	Delaware
Bright HealthCare Company of Florida, Inc.	Florida
Bright HealthCare Insurance Company of Texas(1)	Texas
BrightHealth Networks, LLC	Delaware
Central Health Plan of California, Inc.	California
Centrum Health IP, LLC	Delaware
Centrum Medical Centers Center – Airport, LLC	Florida
Centrum Medical Group Center – East Hialeah, LLC	Florida
Centrum Medical Center – West Hialeah, LLC	Florida
Centrum Medical Center – Miami Gardens, LLC	Florida
Centrum Medical Center – South Dade, LLC	Florida
Centrum Medical Center - Westchester, LLC	Florida
Centrum Medical Center – Little Havana 27 Ave, LLC	Florida
Centrum Medical Center – Little Havana 12 Ave, LLC	Florida
Centrum Medical Centers of North Carolina, PLLC Coral Springs, LLC	North Carolina Florida
Centrum Medical Centers of Margate, LLC	Florida
Centrum Medical Centers of Davie, LLC	Florida
Centrum Medical Centers of Hallandale, LLC	Florida
Centrum Medical Centers of Lighthouse Point, LLC	Florida
Centrum Medical Centers of Fort Lauderdale, LLC	Florida
Centrum Medical Centers of Sheridan, LLC	Florida
Centrum Medical Centers of Miramar, LLC	Florida
Centrum Medical Center - Homestead, LLC	Florida

Centrum Medical Group, PLLC	Texas
Centrum Medical Holdings of Texas, LLC	Texas Delaware
Centrum Medical Holdings, LLC	Delaware
Centrum Pharmacy, LLC	Delaware
Centrum Specialty Network, LLC	Florida
DocSquad, LLC (dba Zipnosis)	Delaware
Med Care Centers, LLC	Florida
Med Care Express, LLC	Florida
Med Plan Clinic, LLC	Florida
Medcare Quality Medical Centers, LLC	Florida
Medical Practice Holding Company, LLC	Delaware
Medlife Wellness Centers, LLC	Florida
Medplan Holdings, LLC	Florida
NeueHealth Accountable Care, LLC	Delaware
NeueHealth Advantage ACO, LLC	Delaware
NeueHealth LLC	Delaware
NeueHealth Networks of Texas, Inc.	Texas
NeueHealth Community ACO, LLC	Delaware
NeueHealth Partner Services, LLC	Delaware
NeueHealth Partners of California, LLC	Delaware
NeueHealth Partners of Central Florida, LLC	Delaware
NeueHealth Partners of Florida RBE, LLC	Delaware
NeueHealth Partners of Florida, LLC	Florida
NeueHealth Partners Texas RBE, LLC	Delaware
NeueHealth Partners, LLC	Delaware
NeueHealth Premier ACO, LLC	Delaware
Premier Medical Associates of Florida Healthcare, P.A.	Delaware
Premier Medical Associates of Florida, LLC	Delaware
Premier Specialty Care, LLC	Delaware
True Health New Mexico, Inc.	New Mexico
Universal Care, Inc.	California

(1)On November 29, 2023, BrightHealthcare Insurance Company of Texas was placed into liquidation and the Texas Department of Insurance was appointed as receiver. The financial results of BrightHealthcare Insurance Company of Texas are included in the NeueHealth, Inc.'s consolidated results through November 28, 2023, the day prior to the date of the receivership. .

Exhibit 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in Registration Statement No. 333-257477 on Form S-8 of our reports dated March 16, 2023 March 28, 2024, relating to the financial statements of Bright Health Group, NeueHealth, Inc. and the effectiveness of Bright Health Group, Inc.'s internal control over financial reporting appearing in this Annual Report on Form 10-K for the year ended December 31, 2022 December 31, 2023.

/s/ Deloitte & Touche LLP
Minneapolis, Minnesota MN
March 16, 2023

28, 2024

EXHIBIT 31.1

CERTIFICATION OF THE CHIEF EXECUTIVE OFFICER
PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

Certifications

I, G. Mike Mikan, certify that:

1. I have reviewed this Annual report on Form 10-K of Bright Health Group, NeueHealth, Inc. (the "registrant");
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
   b) [Omitted]; Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: March 16, 2023 March 28, 2024

/s/ G. Mike Mikan

G. Mike Mikan

Vice Chairman, President and Chief Executive Officer

EXHIBIT 31.2

CERTIFICATION OF THE CHIEF FINANCIAL OFFICER
PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

Certifications

I, Catherine R. Smith, Jay Matushak, certify that:

1. I have reviewed this Annual report on Form 10-K of Bright Health Group, NeueHealth, Inc. (the "registrant");
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
   b) [Omitted]; Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: March 16, 2023 March 28, 2024

/s/ Catherine R. Smith Jay Matushak

Catherine R. Smith Jay Matushak

Chief Financial and Administrative Officer

Exhibit 32.1

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350, AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

Certification of Principal Executive Officer

In connection with the Annual Report report of NeueHealth, Inc. (the "Company") on Form 10-K of Bright Health Group, Inc. (the "Company") for the period ended December 31, 2022 December 31, 2023 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, G. Mike Mikan, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that: that to my knowledge:

(1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and
(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: March 16, 2023 March 28, 2024

/s/ G. Mike Mikan

G. Mike Mikan

Vice Chairman, President and Chief Executive Officer

Exhibit 32.2

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350, AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

Certification of Principal Financial Officer

In connection with the Annual Report report of NeueHealth, Inc. (the "Company") on Form 10-K of Bright Health Group, Inc. (the "Company") for the period ended December 31, 2022 December 31, 2023 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Catherine R. Smith, Jay Matushak, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that: that to my knowledge:

(1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and
(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: March 16, 2023 March 28, 2024

/s/ Catherine R. Smith Jay Matushak

Catherine R. Smith Jay Matushak

Chief Financial and Administrative Officer

Exhibit 97.1

NeueHealth, Inc.
Policies and Procedures

Incentive Compensation Clawback Policy

I. OVERVIEW

NeueHealth, Inc. (the "Company") has adopted this Incentive Compensation Clawback Policy (the "Policy") in order to help ensure that Incentive Compensation is paid or awarded based on accurate financial results and the correct calculation of performance against incentive targets.

II. COMPENSATION AND HUMAN CAPITAL COMMITTEE

The Compensation and Human Capital Committee (the "Committee") of the Board of Directors of the Company (the "Board") shall have full authority to interpret and enforce the Policy in accordance with its business judgment, except with regard to matters specifically reserved for Board approval by applicable law or by the Company's governance documents.

III. COVERED EMPLOYEES

The Policy applies to all current and former "officers" (as that term is defined in Rule 16a-1(f) under the Securities Exchange Act of 1934, as amended (the "Exchange Act")) of the Company, including at a minimum executive officers identified pursuant to Item 401(b) of Regulation S-K, and any other current and former employee of the Company and its subsidiaries designated by the Board or the Committee from time to time by notice to the employee (collectively, the "Covered Employees").

This Policy covers Incentive Compensation received by a person after beginning service as a Covered Employee and who served as a Covered Employee at any time during the performance period for that Incentive Compensation.

This Policy shall be binding upon and enforceable against all Covered Employees and their beneficiaries, heirs, executors, administrators or other legal representatives.

IV. CLAWBACK IN EVENT OF ACCOUNTING RESTATEMENT

In the event of an Accounting Restatement, the Company will recover reasonably promptly any Overpayment received by any Covered Employee during the three completed fiscal years immediately preceding the date on which the Company is required to prepare an Accounting Restatement, including transition periods resulting from a change in the Company's fiscal year as provided in Rule 10D-1 of the Exchange Act and applicable listing standards. Incentive Compensation is deemed "received" in the Company's fiscal period during which the Financial Reporting Measure specified in the Incentive Compensation award is attained, even if the payment or grant of the Incentive Compensation occurs after the end of that period.

a. Definition of Accounting Restatement.

For the purposes of this Policy, an "Accounting Restatement" means the Company is required to prepare an accounting restatement of its financial statements due to the Company's material noncompliance with any financial reporting requirements under the federal securities laws (including any required accounting restatement to correct an error in previously issued financial statements that is material to the previously issued financial statements, or that would result in a material misstatement if the error were corrected in the current period or left uncorrected in the current period).

The determination of the time when the Company is **"**required**"** to prepare an Accounting Restatement shall be made in accordance with applicable Securities and Exchange Commission (**"**SEC**"**) and national securities exchange rules and regulations.

An Accounting Restatement does not include situations in which financial statement changes did not result from material non-compliance with financial reporting requirements, such as, but not limited to

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retrospective: (i) application of a change in accounting principles; (ii) revision to reportable segment information due to a change in the structure of the Company's internal organization; (iii) reclassification due to a discontinued operation; (iv) application of a change in reporting entity, such as from a reorganization of entities under common control; (v) adjustment to provision amounts in connection with a prior business combination; and (vi) revision for stock splits, stock dividends, reverse stock splits or other changes in capital structure.

b. Definition of Incentive Compensation.

For purposes of this Policy, "Incentive Compensation" means any compensation that is granted, earned, or vested based wholly or in part upon the attainment of a Financial Reporting Measure, including, for example, bonuses or awards under the Company's short and long-term incentive plans, grants and awards under the Company's equity incentive plans, and contributions of such bonuses or awards to the Company's deferred compensation plans or other employee benefit plans. Incentive Compensation does not include awards which are granted, earned and vested without regard to attainment of Financial Reporting Measures, such as certain time-vesting awards, discretionary awards and awards based wholly on subjective standards, strategic measures or operational measures.

c. Definition of Financial Reporting Measures.

"Financial Reporting Measures**"** are those that are determined and presented in accordance with the accounting principles used in preparing the Company's financial statements (including non-GAAP financial measures) and any measures derived wholly or in part from such financial measures. For the avoidance of doubt, Financial Reporting Measures include stock price and total shareholder return. A measure need not be presented within the financial statements or included in a filing with the SEC to constitute a Financial Reporting Measure for purposes of this Policy.

V. CALCULATION OF OVERPAYMENT

The amount(s) to be recovered from the Covered Employee will be the amount(s) by which the Covered Employee's Incentive Compensation for the relevant period(s) exceeded the amount(s) that the Covered Employee otherwise would have received had such Incentive Compensation been determined based on the restated amounts contained in the Accounting Restatement (the "Overpayment"). All amounts shall be computed without regard to taxes paid.

For Incentive Compensation based on Financial Reporting Measures such as stock price or total shareholder return, where the amount of excess compensation is not subject to mathematical recalculation directly from the information in an Accounting Restatement, the Board will calculate the amount to be reimbursed based on a

reasonable estimate of the effect of the Accounting Restatement on such Financial Reporting Measure upon which the Incentive Compensation was received. The Company will maintain documentation of that reasonable estimate and will provide such documentation to the applicable national securities exchange.

VI. FORMS OF RECOVERY

The Committee shall determine, in its sole discretion, the method(s) for recovering reasonably promptly an Overpayment. For example, the Company shall have the right to demand that the Covered Employee pay the Company for, or forfeit, any Overpayment paid or awarded as a result of an Accounting Restatement. The Committee may also determine to reduce, cancel, or cause the forfeiture of any compensation otherwise due to recover the Overpayment, provided, that, any reduction, cancellation, or forfeiture of any compensation shall be in done in compliance with Section 409A of the Internal Revenue Code of 1986, as amended, and the Employee Retirement Income Security Act of 1974, as amended.

To the extent the Covered Employee refuses to pay to the Company an amount equal to the Overpayment, the Company shall have the right to sue for repayment and/or enforce the Covered Employee's obligation to make payment through the reduction or cancellation of outstanding and future compensation. Without limiting the Company's rights, to the extent any shares have been issued under vested awards or such shares have been sold by the Covered Employee, the Company shall have the right to cancel any other outstanding equity-based awards with a value equivalent to the Overpayment, as determined by the Committee.

VII. IMPRACTICALITY

The Company shall recover any excess Incentive Compensation in accordance with this Policy, except to the extent that certain conditions are met and the Committee or Board has determined that such recovery would be impracticable, all in accordance with Rule 10D-1 of the Exchange Act and the rules adopted by the NYSE.

VIII. NO INDEMNIFICATION

Subject to applicable law, the Company shall not indemnify, including by paying or reimbursing for premiums for any insurance policy covering any potential losses, any Covered Employees against the loss of any erroneously awarded Incentive Compensation.

IV. COMMITTEE DETERMINATION FINAL

Any determination by the Committee (or by any Officer of the Company to whom enforcement authority has been delegated) with respect to the Policy shall be final, conclusive and binding on all interested parties. It is intended that this Policy be interpreted in a manner that is consistent with the requirements of Section 10D of the Exchange Act and any applicable rules or standards adopted by the SEC or any national securities exchange on which the Company's securities are listed.

X. EFFECTIVE DATE

The effective date of this Policy, as amended, is October 27, 2023 (the "Effective Date"). This Policy applies to Incentive Compensation received by Covered Employees on or after the Effective Date that results from attainment of a Financial Reporting Measure based on or derived from financial information for any fiscal period ending on or after the Effective Date. Without limiting the scope or effectiveness of this Policy, Incentive Compensation granted or received by Covered Employees prior to the Effective Date remains subject to the Company's prior Incentive Compensation Clawback Policies. In addition, this Policy is intended to be and will be incorporated as an essential term and condition of any Incentive Compensation agreement, plan or program that the Company establishes or maintains.

XI. AMENDMENT

The Policy may be amended by the Board from time to time, and the Board shall amend this Policy as it deems necessary to reflect changes in regulations adopted by the SEC under Section 10D of the Exchange and to comply with any rules adopted by the NYSE.

VII. ENFORCEMENT AND NON-EXCLUSIVITY

The Committee intends that this Policy will be applied to the fullest extent of the law.[2] The Committee may require that any employment agreement or similar agreement relating to Incentive Compensation received on or after the Effective Date shall, as a condition to the grant of any benefit thereunder, require a Covered Employee to agree to abide by the terms of this Policy. Nothing in the Policy shall be viewed as limiting the right of the Company or the Committee to pursue recoupment under or as required by the Company's plans, awards and employment agreements or the applicable provisions of any law, rule or regulation (including, without limitation, Section 10D of the Exchange Act, or Section 304 of the Sarbanes-Oxley Act of 2002), or stock exchange listing requirement (and any future policy adopted by the Company pursuant to any such law, rule, regulation or requirement).

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