BRIDGE INVESTMENT GROUP

BRIDGE SENIOR LIVING

BRIDGE PROPERTY MANAGEMENT

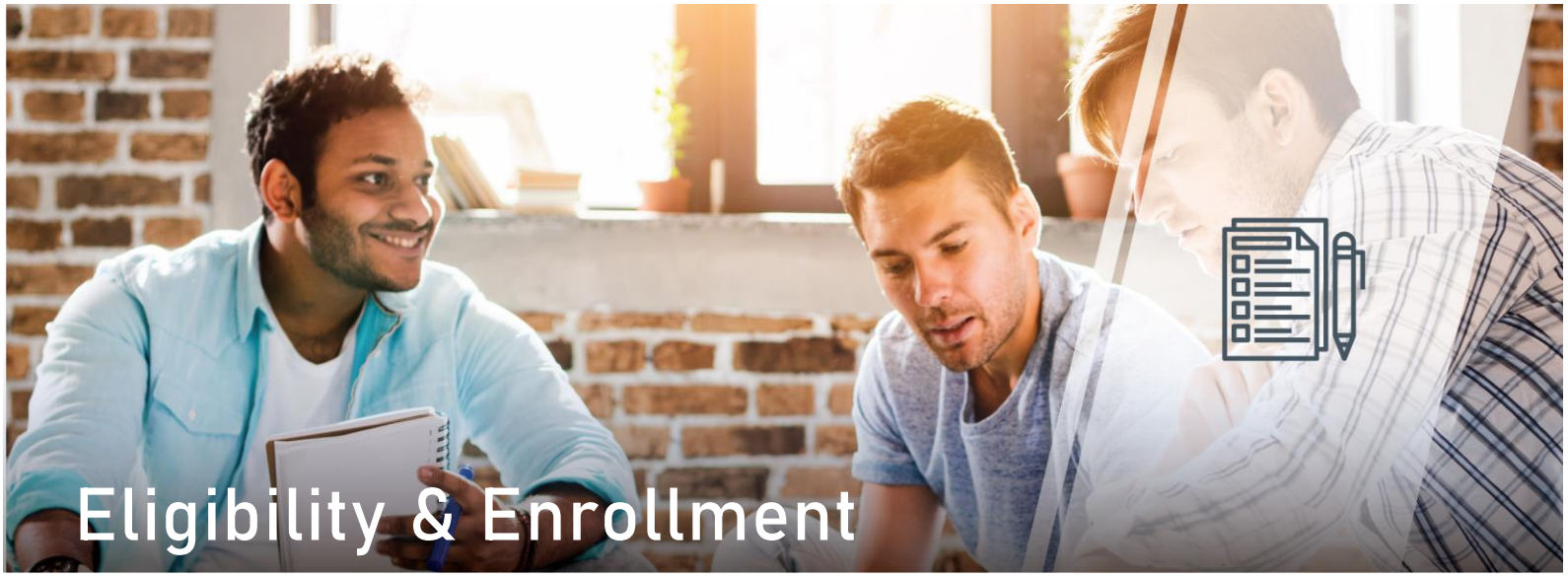
BRIDGE COMMERCIAL REAL ESTATE

2023

Benefits Information Guide

Welcome to your 2023 Benefits Plan Year. Bridge Investment Group is proud to offer a range of employee benefit plans to help protect you in the case of illness or injury. This Benefits Information Guide is a comprehensive tool designed to familiarize you with the plans and programs you and your family can enroll in for the plan year. If you have any questions regarding your benefits, please contact Human Resources.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 2 months, Federal law gives you more choices about your prescription drug coverage. Please see page 35 for more details.



Eligibility & Enrollment

Who can Enroll?

If you are an employee regularly working a minimum of 30 hours per week, you are eligible to participate in the benefits program. Eligible employees may also choose to enroll family members, including a legal spouse/ registered domestic partner (as legally defined under state and local law) and eligible children.

An employee may be unable to pay for and/or receive employer contributions on a pre-tax basis for the cost of the benefits of an employee's state registered domestic partner that does not meet the definition of the employee's tax dependent under IRC Section 152.

When Does Coverage Begin?

Regular, full-time employees: You are eligible to enroll on your date of hire, but your coverage will not be effective until the first of the month following your hire date. Your enrollment choices remain in effect through the end of the benefits plan year, January 1, 2023 – December 31, 2023.

TIP

If you miss the enrollment deadline, you may not enroll in a benefit plan unless you have a change in status during the plan year. Please review details on IRS qualified change in status events for more information.

How do I Enroll?

Open Enrollment Steps for Mobile

Select Your Benefits

From your Home page:

1. Tap the **Inbox** icon .
2. Tap the **Open Enrollment Change** task.
3. Tap **Let's Get Started** and answer any configured questions.
4. Answer the tobacco use question and tap **Save**.
5. The Benefits page displays. Select a category.
6. For each category, **Select** or **Waive** your choice. Your current elections will default.
7. Tap **Details** to review plan information and contact information for the provider.
8. Tap **Edit** to modify your coverage, if needed.

Complete Your Enrollment

1. Tap **View Summary**.
2. Scroll down to review your benefit elections and upload any required documentation in the Attachments section.
3. Select the **I Accept** checkbox to confirm your electronic signature, if needed.
4. Tap **Submit**. A confirmation page displays.
5. Tap **Close** to return to your Inbox. Optionally, tap the **View 2023 Benefits Statement** button to view a confirmation of your submitted elections.

Open Enrollment Steps for Desktop

Select Your Benefits

From your Home page:

1. Select the **Inbox** icon .
2. Choose the **Open Enrollment Change** task.
3. Select **Let's Get Started**.
4. Answer the Health Questionnaire for Tobacco Use and select **Continue**. Select **Continue** again to proceed with benefit selection.
5. Select **Manage** to update your medical elections. Select **Enroll** to enroll in a new benefit plan.
6. Choose **Select** or **Waive** for each medical election. Your current elections default.
7. Choose the **Plan Details** links to review.
8. Modify your coverage, if needed.
9. Select **Confirm and Continue**.

Complete Your Enrollment

10. Select the Review and Sign button to complete your enrollment.
11. Scroll to the bottom of the page. Select the I Accept checkbox to confirm your electronic signature, if required.
12. Enter comments, as needed.
13. Select Submit. A confirmation page displays.
14. Optionally, select the View 2023 Benefits Statement button to view the benefits statement.
15. Select the PDF icon to generate a PDF version for your records.
16. Select Done to complete the task.

TIP

- **If you have login issues, please email humanresources@bridgeig.com.**
- **Before you start the enrollment process, have your dependent/beneficiary information ready, such as a Social Security number and date of birth.**
- **As you go through the enrollment process, your selections will display and add up on the benefits summary tracker to the right!**

Do I Have to Enroll?

Although the federal penalty requiring individuals to maintain health coverage has been reduced to $0, some states have their own state-specific individual mandates.

To avoid paying the penalty in some states, you can obtain health insurance through our benefits program or purchase coverage elsewhere, such as coverage from a State or Federal Health Insurance Exchange.

For information regarding Health Care Reform and the Individual Mandate, please contact Human Resources or visit www.cciio.cms.gov. You can also visit www.coveredca.com to review information specific to the Covered California State Health Insurance Exchange.

You may elect to "waive" medical/dental/and/or vision coverage if you have access to coverage through another plan. To waive coverage, please log in to the Paycom site and waive benefits. It is important to note that if you waive our medical coverage, you must maintain medical/health coverage through another source. It is also important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans would be during the 2023 Open Enrollment, with changes being effective on January 1, 2024 or if a qualifying status change occurs.

What if My Needs Change During the Year?

You are permitted to make changes to your benefits outside of the open enrollment period if you have a qualified change in status as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change within 30 days of the qualified event. Change in status examples include:

- Marriage, divorce or legal separation.
- Birth or adoption of a child.
- Death of a dependent.
- You or your spouse's/registered domestic partner's loss or gain of coverage through our organization or another employer.
- An employee (1) is expected to average at least 30 hours of service per week, (2) has a change in status where he/she will reasonably be expected to average less than 30 hours of service per week (even if he/she remains eligible to be enrolled in the plan); and (3) intends to enroll in another plan that provides Minimum Essential Coverage (no later than the first day of the second month following the month of revocation of coverage).
- You enroll, or intend to enroll, in a Qualified Health Plan (QHP) through the State Marketplace or Federal Exchange and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare or state health insurance programs, you must submit the request for change within 60 days. For a complete explanation of qualified status changes, please refer to the "Legal Information Regarding Your Plans" contents.

If you want benefits in 2023, you must enroll. 2022 benefits will NOT roll over to 2023.

Accolade

To assist you and your family in navigating the healthcare system and maximizing your benefits, the services offered by Accolade can assist with healthcare issues and treatment decisions. Accolade can also help resolve time-consuming claims and other concerns.

Health Assistant Support

- Explain coverage and coordinate benefits.
- Research and resolve insurance claims and medical billing issues.
- Health Assistants can help you find a doctor, specialist or healthcare facility that meet your needs based on location, gender, language and more.
- Facilitate any required pre-authorizations for medical services, Durable Medical Equipment and prescription drugs.
- Research ways to reduce prescription drug and other costs.
- Facilitate the transfer of medical records between physicians.
- Help find a provider within network for the best rates.

Nurse and Expert Medical Decision Support

- Answer questions about symptoms, medical diagnoses and review treatment options.
- Research and identify the latest, most advanced approaches to care.
- Coordinate clinical services related to all aspects of medical care.
- Identify top experts and Centers of Excellence across the country for initial consults and second opinions.
- Discuss the cost and quality of medical services to help members make informed decisions about options for care (e.g., PCP, urgent care, ER) and help employees prepare for doctor visits, review results and plan future actions.
- 2nd.MD. Accolade's expert medical Opinion service can help coordinate a second opinion about a diagnosis, treatment option, a surgery or even a medication you may be prescribed to take.

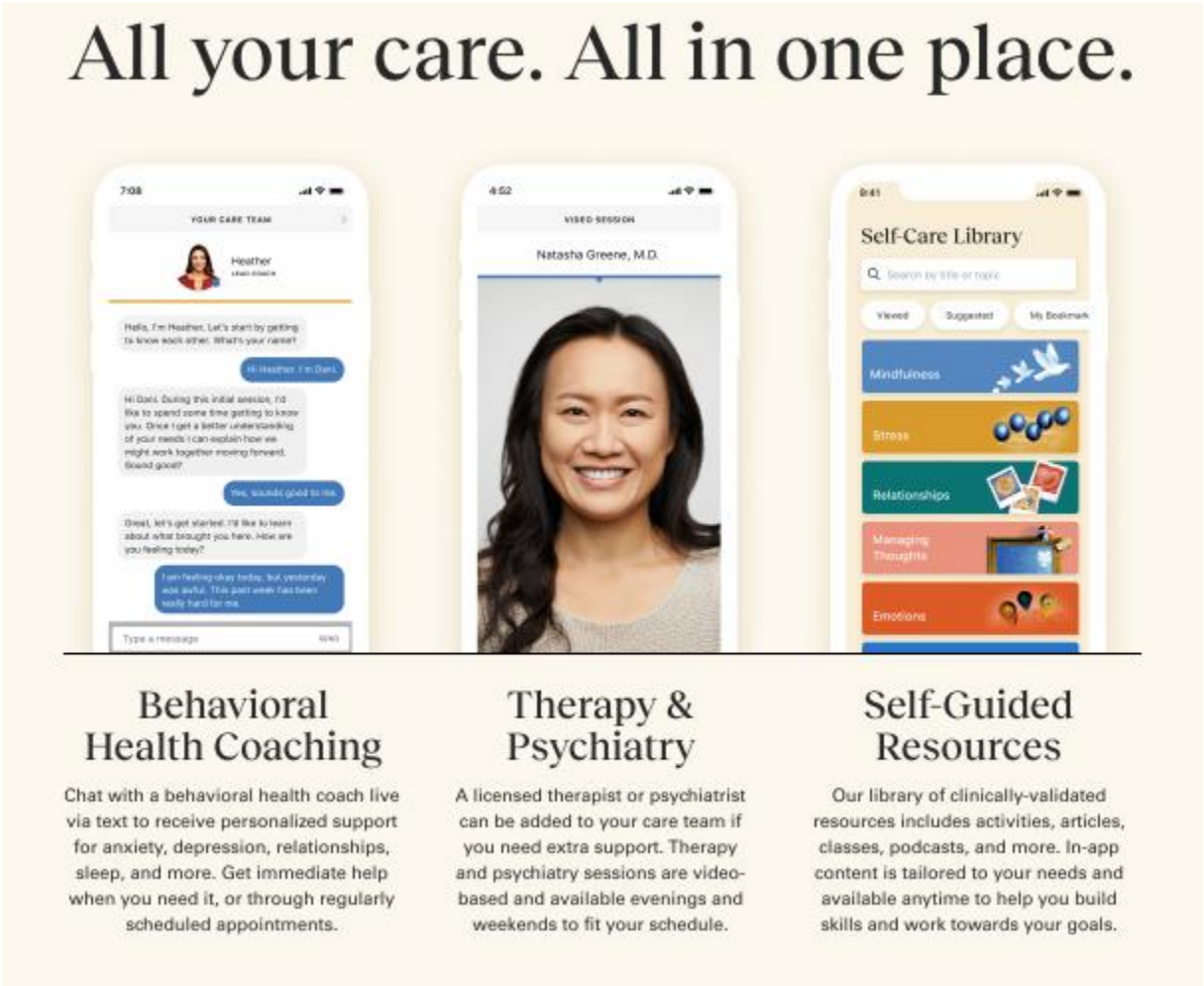
TIP

Get in Touch!

Contact Accolade Monday through Friday – 8:00AM-8:00PM (phone), 8:00AM-11:00PM (messaging) EST toll-free at 866.336.0790 or by visiting the Accolade member portal at member.accolade.com

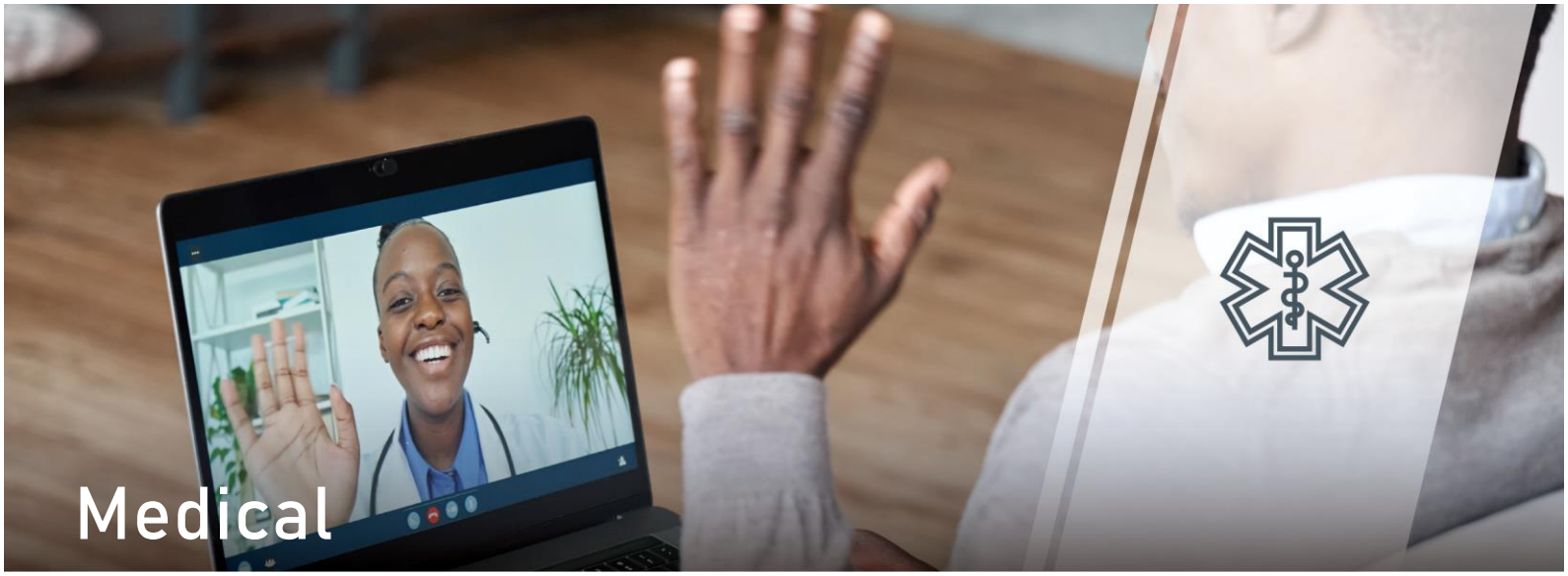
Ginger

In-the-moment care for every emotion. Ginger is the world's first integrated mental healthcare system where coaches, therapists, and psychiatrists work as a team to coordinate the best, personalized care right from your smartphone, whenever you need it. Get access to Behavioral Health Coaching, Therapy & Psychiatry, and Self-Guided Resources all on your smartphone!



Ready to get started?

Download the Ginger Emotional Support app, tap "Create account," then "My Organization." Follow the instructions and you're all set! Have a question? Email Ginger at help@ginger.com.



Medical

What are my options?

Use the chart below to compare medical plan options and determine which would be the best for you and your family.

	HDHP	PPO
	UMR	**UMR**
Required to select and use a Primary Care Physician (PCP)	No	No
Seeing a Specialist	No referral required	No referral required
Deductible Required	Yes	Yes, in most cases
Claims Process	PPO network providers will submit claims. You submit claims for other services.	PPO network providers will submit claims You submit claims for other services
Compatible with your Health Savings Account (HSA)	Yes	No

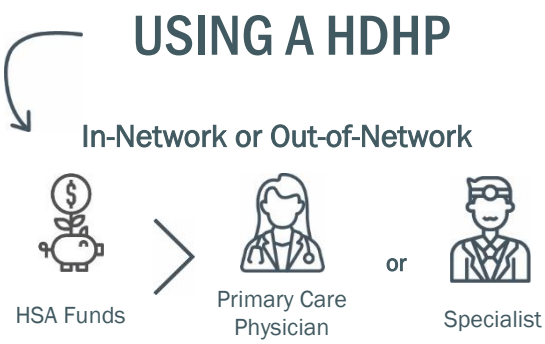
Please note, the above examples are used for general illustrative purposes only. Please consult with your Human Resources department for more specific information as it relates to your specific plan.

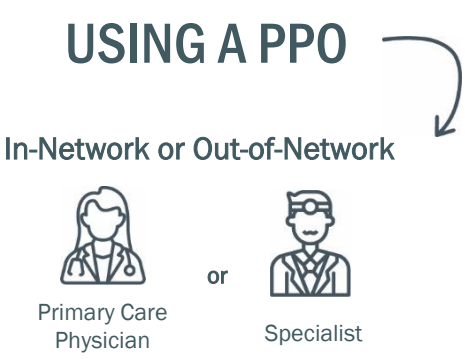
TIP

Medical Services Covered in Full

The federal Health Care Reform law now requires insurance companies to cover preventive care services in full, saving you money and helping you maintain your health. Preventive services may include annual check-ups, well-baby and child visits and certain immunizations and screenings.

To confirm that your preventive care services and lab work are covered in network, refer to your plan documents.





Plan Highlights	PPO $750	PPO $1,000	PPO $3,000	PPO $5,000
	In-network Choice Plus	In-network Choice Plus	In-network Choice Plus*	In-network Choice Plus
Annual Calendar Year Deductible				
Individual	$750	$1,000	$3,000	$5,000
Family	$1,500	$2,000	$6,000	$10,000
Maximum Calendar Year Out-of-pocket (1)				
Individual	$1,500	$3,000	$6,000	$5,000
Family	$3,000	$6,000	$12,000	$10,000
Professional Services				
Primary Care Physician (PCP)	$25 copay	$25 copay	$30 copay	$30 copay
Specialist	$50 copay	$50 copay	$55 copay	$60 copay
Telehealth Visit	PCP Copay	PCP Copay	PCP Copay	PCP Copay
Preventive Care Exam	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Diagnostic X-ray and Lab	PCP Copay	PCP Copay	PCP Copay	PCP Copay
Complex Diagnostics (MRI/CT Scan)	10% after deductible	15% after deductible	20% after deductible	0% after deductible
Chiropractic Services	$25 copay	$25 copay	$30 copay	$30 copay
Hospital Services				
Inpatient	10% after deductible	15% after deductible	20% after deductible	0% after deductible
Outpatient Surgery	10% after deductible	15% after deductible	20% after deductible	0% after deductible
Urgent Care	$100 copay	$100 copay	$100 copay	$100 copay
Emergency Room	$300 copay	$300 copay	$300 copay	$300 copay
Mental Health & Substance Abuse				
Inpatient	10% after deductible	15% after deductible	20% after deductible	0% after deductible
Outpatient	10% after deductible	15% after deductible	20% after deductible	0% after deductible
Retail Prescription Drugs (30-day supply)				
Tier 1	$10 copay	$10 copay	$10 copay	$10 copay
Tier 2	$20 copay	$20 copay	$25 copay	$25 copay
Tier 3	$50 copay	$50 copay	$50 copay	$50 copay
Tier 4	$250 copay	$250 copay	$250 copay	$250 copay
Mail Order Prescription Drugs (90-day supply)				
Tier 1	$20 copay	$20 copay	$20 copay	$20 copay
Tier 2	$40 copay	$40 copay	$50 copay	$50 copay
Tier 3	$100 copay	$100 copay	$100 copay	$100 copay
Tier 4	$500 copay	$500 copay	$500 copay	$500 copay

(1) Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

***The same plan design is available with the Options PPO network instead of the Choice Plus PPO Network. The Option PPO Network has poorer provider discounts and is therefore only recommended for those employees seeing care with University of Utah facilities.**

For definitions of many of the terms used above, please see the glossary on page 34.

Plan Highlights	PPO $6,500	HDHP $3,000	HDHP $4,000	HDHP $6,500
	In-network Choice Plus	In-network Choice Plus	In-network Choice Plus	In-network Choice Plus
Annual Calendar Year Deductible				
Individual	$6,500	$3,000	$4,000	$6,500
Family	$13,000	$6,000	$8,000	$13,000
Maximum Calendar Year Out-of-pocket [1]				
Individual	$8,550	$6,000	$7,050	$6,500
Family	$17,100	$12,000	$14,100	$13,000
Professional Services				
Primary Care Physician (PCP)	$30 copay	10% after deductible	20% after deductible	0% after deductible
Specialist	$60 copay	10% after deductible	20% after deductible	0% after deductible
Telehealth Visit	PCP copay	$49 until deductible, then 10% coinsurance	$49 until deductible, then 20% coinsurance	$49 until deductible, then 0% coinsurance
Preventive Care Exam	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Diagnostic X-ray and Lab	PCP copay	10% after deductible	20% after deductible	0% after deductible
Complex Diagnostics (MRI/CT Scan)	30% after deductible	10% after deductible	20% after deductible	0% after deductible
Chiropractic Services	$30 copay	10% after deductible	20% after deductible	0% after deductible
Hospital Services				
Inpatient	30% after deductible	10% after deductible	20% after deductible	0% after deductible
Outpatient Surgery	30% after deductible	10% after deductible	20% after deductible	0% after deductible
Urgent Care	$100 copay	10% after deductible	20% after deductible	0% after deductible
Emergency Room	30% after deductible	10% after deductible	20% after deductible	0% after deductible
Mental Health & Substance Abuse				
Inpatient	30% after deductible	10% after deductible	20% after deductible	0% after deductible
Outpatient	30% after deductible	10% after deductible	20% after deductible	0% after deductible
Retail Prescription Drugs (30-day supply)				
Tier 1	$10 copay	10% after deductible	20% after deductible	0% after deductible
Tier 2	$25 copay	10% after deductible	20% after deductible	0% after deductible
Tier 3	$50 copay	10% after deductible	20% after deductible	0% after deductible
Tier 4	$250 copay	10% after deductible	20% after deductible	0% after deductible
Mail Order Prescription Drugs (90-day supply)				
Tier 1	$20 copay	10% after deductible	20% after deductible	0% after deductible
Tier 2	$50 copay	10% after deductible	20% after deductible	0% after deductible
Tier 3	$100 copay	10% after deductible	20% after deductible	0% after deductible
Tier 4	$500 copay	10% after deductible	20% after deductible	0% after deductible

[1] Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider. Out-of-network plan designs and benefits are outlined in the benefit summaries online.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Cost Breakdown

The rates below are effective January 1, 2023 – December 31, 2023.

Coverage Level	Per-Pay Deduction	Per-Pay Deduction
	With Wellness	**Without Wellness**
PPO $750		
Employee Only	$95.25	$108.21
Employee and Spouse/Registered Domestic Partner	$217.77	$243.70
Employee and Child(ren)	$222.33	$235.29
Employee and Family	$335.02	$360.95
PPO $1,000		
Employee Only	$78.71	$91.67
Employee and Spouse/Registered Domestic Partner	$187.33	$213.25
Employee and Child(ren)	$194.20	$207.16
Employee and Family	$293.25	$319.18
PPO $3,000		
Employee Only	$58.94	$71.90
Employee and Spouse/Registered Domestic Partner	$150.93	$176.86
Employee and Child(ren)	$160.58	$173.54
Employee and Family	$243.33	$269.25
PPO $5,000		
Employee Only	$50.06	$63.02
Employee and Spouse/Registered Domestic Partner	$134.60	$160.52
Employee and Child(ren)	$145.48	$158.45
Employee and Family	$220.92	$246.84
PPO $6,500		
Employee Only	$20.20	$33.16
Employee and Spouse/Registered Domestic Partner	$79.64	$105.56
Employee and Child(ren)	$94.71	$107.68
Employee and Family	$145.52	$171.45
HDHP $3,000		
Employee Only	$34.73	$47.69
Employee and Spouse/Registered Domestic Partner	$106.37	$132.30
Employee and Child(ren)	$119.41	$132.38
Employee and Family	$182.20	$208.13
HDHP $4,000		
Employee Only	$2.85	$15.81
Employee and Spouse/Registered Domestic Partner	$47.70	$73.63
Employee and Child(ren)	$65.20	$78.17
Employee and Family	$101.71	$127.63
HDHP $6,500		
Employee Only	**FREE**	$12.97
Employee and Spouse/Registered Domestic Partner	$38.79	$64.72
Employee and Child(ren)	$56.97	$69.94
Employee and Family	$89.49	$115.41

Prescription Drug Coverage

Many FDA-approved prescription medications are covered through the benefits program. Important information regarding your prescription drug coverage is outlined below:

- The DisclosedRx plan covers generic formulary, brand-name formulary, non-formulary brand, and specialty drugs.
- Generic drugs are required by the FDA to contain the same active ingredients as their brand-name counterparts.
- A brand-name medication is protected by a patent and can only be produced by one specified manufacturer.
- Although you may be prescribed non-formulary prescriptions, these types of drugs are not on the insurance company's preferred formulary list.
- Specialty medications most often treat chronic or complex conditions and may require special storage or close monitoring.

For a current version of the prescription drug list(s), go to disclosedrx.com

WHY PAY MORE?

There are a few ways you can save money when using the Prescription Drug Plan:

Mail Order

Save time and money by utilizing a mail order service for maintenance medications. A 90-day supply of your medication will be shipped to you, instead of a typical 30-day supply at a walk-in pharmacy.

Shop Around

Some pharmacies, such as those at warehouse clubs or discount stores, may offer less expensive prescriptions than others. By calling ahead, you may determine which pharmacy provides the most competitive price.

GoodRx - Compare prices, print free coupons, and save up to 80% on your prescriptions. For complete details, please visit www.goodrx.com.

Walgreens Savings Program – For Complete details, please visit www.walgreens.com and search *Prescription Savings Club.* There you will find over 400 generic prescription drugs at discount prices, medications offered in all drug classes covering most common and chronic health conditions, pet prescriptions, and more!

Explore Over-the-Counter Options

For common ailments, over-the-counter drugs may provide a less expensive option that serves the same purpose as prescription medications.

DisclosedRx
The Fully Disclosed PBM™

How to Find a Provider

UMR

1. Go to www.umr.com
2. Login or create an account
3. Select “Find a provider”
4. Search for the UnitedHealthcare Choice Plus Network network by using the alphabet navigation or type the network names into the search box.
5. For medical providers, choose “Search for a medical provider”. For behavioral health providers (including counseling and substance abuse) select “View directory of behavioral health providers”.

United Healthcare Choice Plus PPO

The United Healthcare online provider directories include network hospitals, primary physicians and specialists. The following information is available:

- Provider name, address and phone number
- Hospital affiliation
- Board Certification
- UnitedHealth Premium Quality & Cost Efficiency designations that highlight physicians by quality of care cost standards in their specialty
- Office language capabilities (English, Spanish, etc.)
- Maps and directions to each office
- Average costs for care in your area and how
- different providers compare to the local average
- Provider ID number

Please verify that the provider is still in the network prior to our next visit and before receiving any services. Remember, if you do not log in or create an account, you may get search results showing healthcare facilities and professionals that are not in your plan’s network.

Telehealth Services

With telehealth, you can connect with leading board-certified physicians for many non-emergency illnesses through the internet or telephone. By leveraging these virtual visits, you can avoid emergency rooms and urgent care centers and quickly refill your prescriptions so you can get back on your feet in no time.

Telehealth can be used for:

General Health Issues

Certain Specialty Services

Prescription

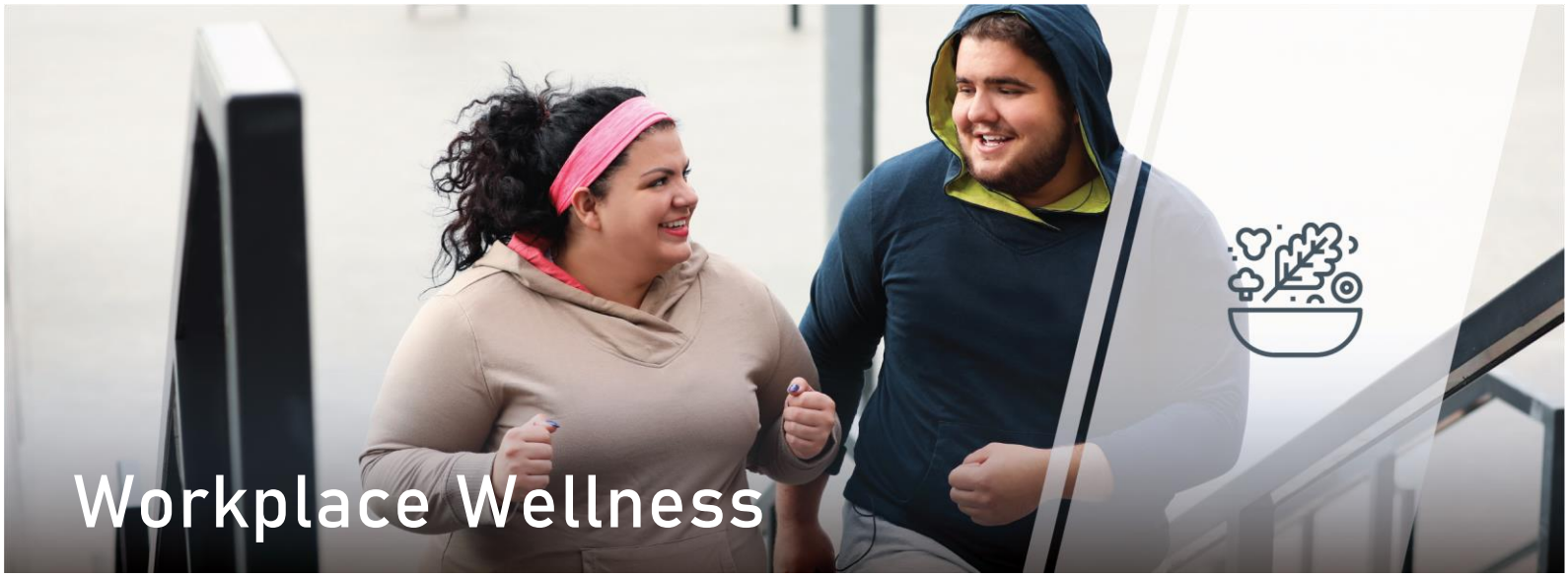
If your telehealth doctor prescribes you medication, Teledoc will ensure you are able to conveniently pick up your prescription in your local area. You may also use mail-order services for delivery of your prescription.

Through Teledoc, telehealth services will cost your Primary Care Physician copay for the UMR PPO plans and a $49 fee for the UMR HDHP plans for you and for all dependents on your health plan.

Start your eVisit today!

- By Phone: 800.835.2362
- Online: www.teladoc.com. Click “set up account.”
- Download Teledoc’s mobile app and click “Activate Account”.

Teladoc®



Workplace Wellness

Why Wellness?

Healthy, active lifestyles can help reduce the risk of chronic disease and may lower your annual health care costs. We care about your total well-being and encourage all employees to engage in our Wellness Program at no-cost.

Bridge Investment Group Preventive Care Initiative

Bridge Investment Group Preventive Care Initiative includes a variety of educational resources and opportunities for participation throughout the year. Employees and their dependents that voluntarily participate and receive a preventive age/gender/risk-appropriate screening from your physician will receive a premium discount.

Activity	Requirements
Receive a preventive age/gender/risk-appropriate screening from your physician	**Provide the completed Preventive Care Form to your HR team by June 30, 2023**

Incentives & How They are Applied

Employees and spouses are both encouraged to participate. If you choose to complete a preventive visit and **submit the Preventive Care Form by June 30th, 2023** you will receive a $25 per month medical premium discount for employee only enrollments, and/or employee + child(ren) coverage. If you enroll with a spouse and they also complete the form, you will receive a $50 per month medical premium discount ($25 each for completing the form).

If you and/or your spouse elect to complete the preventive care initiative during open enrollment and you do not submit the form by the above deadline, you will no longer receive the discounts and will be **retroactively charged** the discounted amount that was earned previously throughout the year.

Preventive services may include, but are not limited to, a general wellness exam, mammogram, colonoscopy, pap smear, etc.,

Please note: Alternative standards are made available to anyone that is interested in earning rewards but medically unable to complete the programs. Some prizes may be taxable to the recipient (e.g., gift cards). Review the Bridge Investment Group Preventive Care Initiative for program details, and contact HR with any questions.

Spending Accounts

Health Savings Account (HSA)

What is it?

By enrolling in one of the UMR high-deductible health plans, you will have access to a Health Savings Account (HSA), which provides tax advantages and can be used to pay for qualified health care expenses, such as your deductible, copayments, and other out-of-pocket expenses.

What are the benefits?

Administered by HealthEquity, an HSA accumulates funds that can be used to pay current and future health care costs.

- You can contribute to your HSA on a pre-tax basis, for federal tax purposes, or you can contribute on a post-tax basis and take the deduction on your tax return.
- Generally, HSA funds can grow on a tax-free basis, subject to state law.[1]
- An HSA reduces your taxable income and may allow you to make tax-free withdrawals from the account when paying for qualified health care expenses (tax regulations vary by state).
- Because you own the HSA, there are no "Use it or Lose it" provisions, so unused HSA funds roll over from year-to-year, and can be used to reimburse future eligible out-of-pocket expenses.
- You may enjoy lower monthly premium payments as compared to traditional PPO medical plans.
- Because you own the HSA, the money in your account is yours to keep if you leave the company.
- Bridge Investment Group contributes towards your HSA if you enroll in one of the HDHP plan options: $37.50 per paycheck for employee-only coverage, and $50.00 per paycheck for family coverage.

How do I qualify for an HSA?

The IRS has guidelines regarding who qualifies for an HSA. You are considered eligible if:

- You are covered under a qualified medical plan.
- You are not enrolled in non-qualified health insurance outside of Bridge Investment Group's HDHP plan.
- You are not enrolled in Medicare.
- You are not claimed as a dependent on someone else's tax return (excluding a spouse).
- You are not enrolled in a general Health Care Flexible Spending Account (Health FSA) or general Health Reimbursement Arrangement (HRA).

* If you are 65 and delay Medicare enrollment, please be aware that when you do apply, Medicare Part A coverage will be retroactive for 6 months. You will need to stop contributing to your HSA six months before Medicare is effective to avoid potential penalties.

** Veterans with a service-connected disability may contribute to an HSA regardless of receiving VA benefits.

How do I get started?

If you're ready to activate your HSA, you can do so by:

- Visiting www.healthequity.com.
- Follow the registration directions to get started.

Once the HSA is activated, you can manage and access your account at any time by visiting www.healthequity.com. If questions arise regarding account activation, contact HealthEquity or visit www.healthequity.com. Consult your tax advisor for taxation information or advice.

(1) Please consult your tax advisor for applicable tax laws in your state.

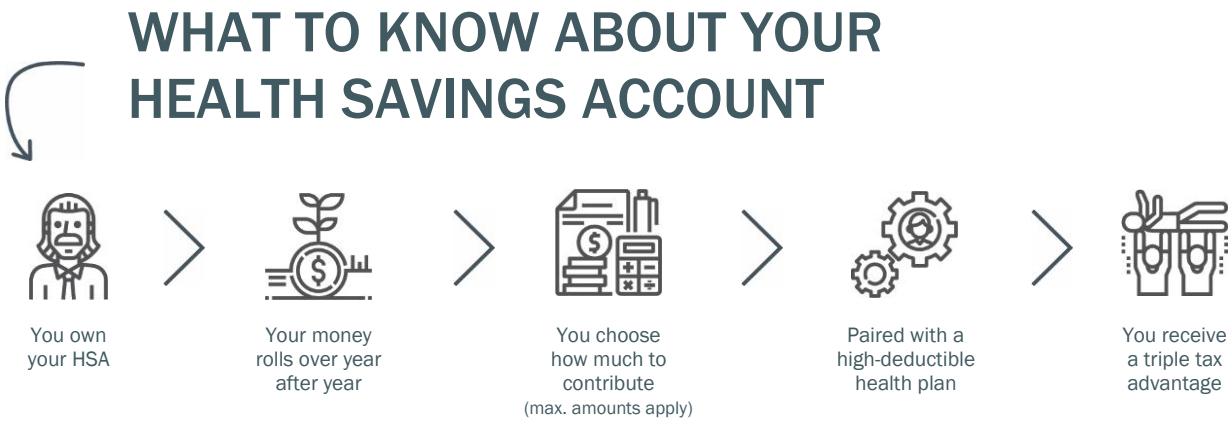
A few rules you need to know:

- For 2023, the maximum contribution limit for employee and employer contributions in an employee's HSA account is $3,850 if you are enrolled in the HSA-PPO for employee-only coverage, and $7,750 for employees with dependent coverage.
- An additional catch-up contribution of $1,000 is also available to account holders who are age 55 or older.
- It's important to monitor your contributions to avoid going over the IRS limit, as contributions in excess of the IRS limit are subject to standard income tax rates, plus a 6% excise tax.
- There is a 20% penalty for using HSA funds on non-qualified health care expenses if you are under age 65. For more details about what are considered qualified health care expenses, visit www.healthequity.com.
- You may not be able to contribute to your HSA if you are entitled to Medicare. However, funds accumulated before Medicare entitlement may be used to reimburse your qualified medical expenses.
- You may not contribute to your HSA if you are covered under any medical benefits plan which is not an HSA-qualified high deductible medical plan (e.g., a spouse's non-HDHP medical plan, a general purpose Health Care FSA, or Medicare). However, you may be covered by a Limited Purpose Health Care FSA, or an FSA which can be used after your HDHP deductible is met.
- Typically, the maximum amount an employee is eligible to contribute to an HSA per calendar year is based upon a **pro-rata** portion of the number of months an employee is eligible to contribute to an HSA. For example, an employee would normally be able to contribute 4/12 of the maximum annual limit in his/her first year of enrollment into the HSA plan, if the employee first joins the HSA plan on September 1. However, under the full contribution rule, an employee is allowed to contribute the maximum annual amount, regardless of the number of months he/she was eligible to contribute to an HSA in the first year, if he/she is eligible to contribute to an HSA on December 1 of the first year and continues to be eligible to contribute to an HSA until December 31 of the following year (i.e., for the entire subsequent year).

TIP

How do I manage my HSA?

- **The most convenient way to pay for qualified expenses is to utilize the debit card**
- **You can also use your own cash or a personal credit card and reimburse yourself through your online HSA account**
- **It is recommended that you keep receipts of HSA purchases, should you ever be audited by the IRS**
- **View the status of your claims and check your HSA balance at https://healthequity.com**



Flexible Spending Accounts (FSA)

A flexible spending account with NBS lets you use pre-tax dollars to cover eligible health care and dependent care expenses. There are different types of FSAs that help to reduce your taxable income when paying for eligible expenses for yourself, your spouse, and any eligible dependents, as outlined below:

FSA Type	Detail
Health Care FSA	• Can reimburse for eligible health care expenses not covered by your medical, dental and vision insurance. • Maximum contribution for 2023 is $3,050. • If you enrolled in the HDHP Medical plans, you can have a **Limited Purpose FSA** that allows you to use the funds for dental and vision expenses only.
Dependent Care FSA	• Can be used to pay for a child's (up to the age of 13) child care expenses and/or care for a disabled family member in the household, who is unable to care for themselves. • Maximum contribution for 2023 is $5,000. • This benefit has a 75 day grace period after the end of the plan year.

What are the benefits?

- Your taxable income is reduced and your spendable income increases!
- Save money while keeping you and your family healthy.

How do I use it?

You must enroll in the FSA program within 30 days of your hire date or during annual open enrollment. At this time, you must establish an annual contribution amount within the maximum limit. Once enrolled, you will have online access to view your FSA balance, check on a reimbursement status, and more. Visit www.nbsbenefits.com to access National Benefit Services online portal.

- **The IRS has a strict "use it or lose it" rule. You will forfeit any funds left in your account after the end of the plan year.**
- **The plan does allow you to roll over up to $610 to the next plan year.**

A few rules you need to know:

- Although the FSA plan year runs from January 1, 2023 through December 31, 2023 you have extra time after the end of the plan year (March 31, 2024) to seek reimbursement for health care expenses incurred during the plan year. January 1, 2023 through December 31, 2023. This reimbursement period is called an annual run-out period.

For more details about using an FSA, contact Human Resources.

Supplemental Health

Critical Illness Coverage

Critical Illness coverage offered on a voluntary basis through UnitedHealthcare pays you a lump sum benefit if you are diagnosed with a covered illness or condition. All benefits are paid directly to you and you may use the funds as you see fit.

What can Critical Illness coverage pay for?

- Medical expenses, such as copays, deductibles or co-insurance.
- Wellness benefit pays $50 per covered person, per year, for completing a covered wellness exam.
- Everyday expenses such as groceries and utilities.
- Alternative treatments.
- Lodging and travel to a specialist

- **What are examples of covered illnesses or conditions?**
- Cancer.
- Heart Attack.
- Stroke
- Kidney Failure.
- Organ Transplant.

Here's an example of how Critical Illness coverage can help support you

Denise is 45 years old and had a heart attack. She was out of work for a couple of months recovering and although she had disability insurance, it didn't cover all of her lost income and medical bills. Thankfully, Denise had a $10,000 Critical Illness policy. She filed her claim and received her cash benefit so that she could pay her bills and medical expenses. With her Critical Illness policy, Denise had peace of mind and was able to focus on improving her health.

Please note the above is an illustration only and does not reflect your plans actual benefits. Please refer to the plan documents for more detailed information.

100% Employee-paid

If you elect the voluntary Critical Illness plan, 100% of the cost is deducted through payroll deductions. Per Pay Period post-tax rates are outlined are dependent on the benefit amount you select.

Benefit options

Election	Benefit Amounts & Guaranteed Issue
Employee	$10,000, $20,000 or $30,000 (All Guaranteed Issue)
Spouse	Up to 50% of Employee benefit election (All Guaranteed Issue)
Child(ren)	Up to 50% of Employee benefit election (All Guaranteed Issue)

Critical Illness Plan Semi-Monthly Cost

Age Range	Option 1: EE $10,000 / SP $5,000 / CH $2,500			
	Employee Only	Employee+Spouse	Employee+Child(ren)	Employee+Spouse+Child(ren)
	Uni Tobacco	Uni Tobacco	Uni Tobacco	Uni Tobacco
Under 25	$0.90	$1.13	$1.04	$1.26
25 - 29	$1.15	$1.50	$1.29	$1.64
30 - 34	$1.40	$1.90	$1.54	$2.04
35 - 39	$1.90	$2.65	$2.04	$2.79
40 - 44	$2.90	$4.13	$3.04	$4.26
45 - 49	$4.50	$6.48	$4.64	$6.61
50 - 54	$6.65	$9.38	$6.79	$9.51
55 - 59	$9.40	$12.88	$9.54	$13.01
60 - 64	$13.35	$18.50	$13.49	$18.64
65 - 69	$18.35	$25.45	$18.49	$25.59
70 - 74	$11.43	$16.54	$11.56	$16.68
75 +	$11.40	$19.74	$11.54	$19.88

Age Range	Option 2: EE $20,000 / SP $10,000 / CH $5,000			
	Employee Only	Employee+Spouse	Employee+Child(ren)	Employee+Spouse+Child(ren)
	Uni Tobacco	Uni Tobacco	Uni Tobacco	Uni Tobacco
Under 25	$1.80	$2.25	$2.08	$2.53
25 - 29	$2.30	$3.00	$2.58	$3.28
30 - 34	$2.80	$3.80	$3.08	$4.08
35 - 39	$3.80	$5.30	$4.08	$5.58
40 - 44	$5.80	$8.25	$6.08	$8.53
45 - 49	$9.00	$12.95	$9.28	$13.23
50 - 54	$13.30	$18.75	$13.58	$19.03
55 - 59	$18.80	$25.75	$19.08	$26.03
60 - 64	$26.70	$37.00	$26.98	$37.28
65 - 69	$36.70	$50.90	$36.98	$51.18
70 - 74	$22.85	$33.08	$23.13	$33.35
75 +	$22.80	$39.48	$23.08	$39.75

Age Range	Option 3: EE $30,000 / SP $15,000 / CH $7,500			
	Employee Only	Employee+Spouse	Employee+Child(ren)	Employee+Spouse+Child(ren)
	Uni Tobacco	Uni Tobacco	Uni Tobacco	Uni Tobacco
Under 25	$2.70	$3.38	$3.11	$3.79
25 - 29	$3.45	$4.50	$3.86	$4.91
30 - 34	$4.20	$5.70	$4.61	$6.11
35 - 39	$5.70	$7.95	$6.11	$8.36
40 - 44	$8.70	$12.38	$9.11	$12.79
45 - 49	$13.50	$19.43	$13.91	$19.84
50 - 54	$19.95	$28.13	$20.36	$28.54
55 - 59	$28.20	$38.63	$28.61	$39.04
60 - 64	$40.05	$55.50	$40.46	$55.91
65 - 69	$55.05	$76.35	$55.46	$76.76
70 - 74	$34.28	$49.61	$34.69	$50.03
75 +	$34.20	$59.21	$34.61	$59.63

Hospital Protection

Planned or unplanned, a trip to the hospital can be unsettling, especially if your primary medical insurance doesn't cover the majority of your costs. Hospital Insurance offered on a voluntary basis through UnitedHealthcare pays out cash to you or your family to offset both medical and non-medical bills resulting from a hospital stay. There is no pre-existing condition period and no separate waiting period for Maternity Hospitalizations.

How can Hospital insurance help?

The cash benefits can be used to pay for services or expenses your traditional medical plan might not cover. Since benefits are paid directly to you, you choose how to use them. Here are a few examples:

- Copayments.
- Deductibles.
- Transportation expenses.
- Child care.
- Lodging expenses for a companion.
- Lost income.

Here's an example of how Hospital Insurance can help support you

Meet Trevor. Trevor had some complications from gallbladder removal surgery, which resulted in a 5-day hospital stay. Through his primary medical insurance, Trevor owed a $500 deductible and $3,000 in co-insurance. With the help of his Hospital Insurance coverage, which paid a $1,000 1st day confinement benefit plus $150 for each additional day, he was only out of pocket $1,900 instead of $3,500.

Out-of-Pocket Expenses	Hospital Indemnity Plan Benefits
$500 deductible	$1,000 1st day Hospital Confinement benefit
$3,000 co-insurance	$150/day x 4 additional days = $600
Total: $3,500	**Total benefits paid to Trevor: $1,600**

Please note the above is an illustration only and does not reflect your plans actual benefits. Please refer to the plan documents for more detailed information.

100% Employee-paid

If you elect the voluntary Hospital Insurance plan, 100% of the cost is deducted through payroll deductions. Per Pay Period post-tax rates are outlined below:

Election & Per-Pay Costs	Option 1	Option 2	Option 3
Employee Only	$2.80	$4.47	$6.14
Employee + Spouse	$5.91	$9.71	$13.52
Employee + Child(ren)	$5.01	$8.37	$11.73
Family	$8.64	$14.53	$20.42

Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. To learn more or to obtain a full schedule of benefits access the Paycom app or see Human Resources.

Accident Insurance Plan

Accident Insurance offered on a voluntary basis through UnitedHealthcare provides coverage for specific injuries and treatments resulting from a covered off-the-job accident. The amount of the benefit paid depends on the type of injury and care received.

How can Accident Insurance help?

Since benefits are paid directly to you, you choose how to use them, such as paying medical bills, subsidizing lost income, or covering everyday expenses.

What are some common covered benefits?

- Emergency room visit.
- Ambulance
- Doctor visits.
- Hospital admission.
- Surgery.
- Medical equipment.
- Outpatient therapy.
- Diagnostic imaging.

Covered Event/Injury	Option 1	Option 2	Option 3
Ambulance (ground)	$200	$300	$400
Emergency room care	$100	$150	$200
Accident Physician's Treatment	$100	$150	$200
Dislocations & Fractures	Up to $4,500	Up to $6,000	Up to $9,000
Hospital Confinement	$175 ICU - $500	$250 ICU - $750	$325 ICU - $1,000
Wellness Benefit	$50 per person per year	$50 per person per year	$50 per person per year

Here's an **example** of how Accident Insurance can help support you

Kathy's daughter, Molly, plays soccer. During a recent game, she collided with a player, was knocked unconscious and taken to the emergency room (ER) by ambulance. The ER doctor diagnosed a concussion and a broken tooth. He ordered an x-ray scan to check for facial fractures due to swelling. Molly was released to her primary care physician for follow-up treatment and her dentist repaired her broken tooth with a crown. Thanks to Accident Insurance, Kathy will receive $1,100 to help pay for Molly's expenses associated with her accident.

Please note the above is an illustration only and does not reflect your plans actual benefits. Please refer to the plan documents for more detailed information.

100% Employee-paid

If you elect the voluntary Accident Insurance plan, 100% of the cost is deducted through payroll deductions.
Per Pay Period post-tax rates are outlined below:

Election & Per-Pay Cost	Option 1	Option 2	Option 3
Employee Only	$2.55	$3.33	$4.37
Employee + Spouse	$3.94	$5.18	$6.84
Employee + Child(ren)	$4.64	$6.35	$8.56
Family	$7.11	$9.69	$13.06

Your Dental PPO Plan

You and your eligible dependents have the opportunity to enroll in a Dental Preferred Provider Organization (PPO) plan offered by MetLife.

Using the Plan

The Dental PPO plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice.

Plan Highlights	MetLife Dental PPO	
	In-Network	**Out-of-Network**
Calendar Year Deductible		
Individual	$50	
Family	$150	
Annual Maximum	$1,450 per covered person	
Preventive	Covered 100%	Covered 100% of Reasonable & Customary
Basic Services	Covered 100% after deductible	Covered 100% of Reasonable & Customary after deductible
Major Services	Covered 60% after deductible	Covered 60% of Reasonable & Customary after deductible
Orthodontia Services		
Child up to age 19	50%	50%
Lifetime Maximum	$1,200	$1,200

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Election	Per-Pay Costs
Employee Only	$3.88
Employee + Spouse	$18.31
Employee + Child(ren)	$21.24
Family	$29.60

TIP

Choose your Primary Care Dentist

When using a Dental PPO plan, you can receive services from dental providers both in and out of your insurance network. However, you'll receive better coverage when you use an in-network dentist. To determine whether your dentist is in or out of your insurance network, go to www.metlife.com/dental and search the PDP Plus Network , or call MetLife

Vision Plan

Vision coverage is offered by MetLife as a Preferred Provider Organization (PPO) plan. As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount. To locate an in-network vision provider, visit www.metlife.com

Plan Highlights

MetLife Vision PPO

	In-Network	Out-of-Network Reimbursement
Exam – Every 12 months	$10 copay	Up to $45
Lenses – Every 12 months		
Single	$10 copay	Up to $30
Bifocal	$10 copay	Up to $50
Trifocal	$10 copay	Up to $65
Lens Options: standard Plastic Scratch Coating, UV Treatment, Solid & Gradient Tint	$0 copay	Applied to the allowance for corrective lens
Frames – Every 24 months		
Frames	$150 Allowance + 20% off balance over $150	Up to $70
Contacts – Every 12 months, in lieu of lenses & frames		
Medically Necessary	$0 copay	Up to $210
Elective	$130 Allowance	Up to $105

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Election	Per-Pay Costs
Employee Only	$2.55
Employee + Spouse	$4.82
Employee + Child(ren)	$5.07
Family	$7.38

TIPS

Tips for having an excellent view

Get regular eye exams. Allow your eyes to rest from the computer screen. Wear sunglasses to protect your eyes from bright light.Wear safety goggles whenever necessary.

Life and Disability

Basic Life and AD&D

In the event of your passing, Life Insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your Accidental Death & Dismemberment (AD&D) coverage may apply.

Paid for in full by Bridge Investment Group, the benefits outlined below are provided by MetLife.

- Basic Life Insurance of $20,000
- AD&D of $20,000
- Please note, benefits may reduce when you reach age 65.

IRS Regulation: Employees can receive employer paid life insurance up to $50,000 on a tax-free basis and do not have to report the payment as income. However, an amount in excess of $50,000 will trigger taxable income for the "economic value" of the coverage provided to you.

Voluntary Life and AD&D

If you would like to supplement your employer paid insurance, additional Life and AD&D coverage for you and/or your dependents is available for purchase on a post-tax payroll deduction basis through MetLife.

- **For employees:** Increments of $10,000 - 5 times your annual earnings up to a $500,000 maximum with a guarantee issue benefit of $200,000 if you enroll in the plan within 30 days of your initial eligibility.
- **For your spouse:** Increments of $5,000 - 50% of the employee elected amount to a to a $250,000 maximum with a guarantee issue benefit of $50,000 if you enroll in the plan within 30 days of your initial eligibility.
- **For your child(ren):** $1,000 to $10,000.
- **Voluntary AD&D:** Coverage is available for purchase in the same amounts as voluntary life insurance amounts above.

Any amounts of insurance over the guarantee issue benefit are subject to review of good health by the insurance company. Insurance amounts subject to review will not be effective until the insurance company approves. If you do not enroll in the plan within the initial enrollment period, **any** amount of supplemental life insurance will require proof of good health, which is subject to approval by the insurance company before the insurance is effective. For more information regarding this plan, review the plan summary detail.

Please note: Benefits coverage may reduce when you reach age 65. Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill. Please refer to your Summary Plan Description for exclusions and further detail.

TIP

Both basic and voluntary life policies are portable, which means you have the option to continue your coverage if you leave Bridge.

Cost of Employee Voluntary Coverage

Age of Insured	Per Pay Period Rate per $1,000
Less than 30	$0.031
30–34	$0.040
35–39	$0.045
40–44	$0.084
45–49	$0.130
50–54	$0.197
55–59	$0.317
60–64	$0.526
65–69	$0.846
70+	$1.664
AD&D	**$0.009**

Cost of Spousal Voluntary Coverage

Age of Insured	Per Pay Period Rate per $1,000
Less than 30	$0.031
30–34	$0.040
35–39	$0.045
40–44	$0.084
45–49	$0.130
50–54	$0.197
55–59	$0.317
60–64	$0.526
65–69	$0.846
70+	$1.664
AD&D	**$0.012**

Dependent Child Coverage

Age of Insured	Per Pay Period Rate per $1,000
Less than 26	$0.079
AD&D	**$0.012**

TIP

Required! Are Your Beneficiaries Up to Date?

Beneficiaries are individuals or entities that you select to receive benefits from your policy.

- **You can change your beneficiary designation at any time.**
- **You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated.**
- **To select or change your beneficiary, access your Paycom app or contact Human Resources.**

Short & Long Term Disability

Added protection

Should you experience a non-work related illness or injury that prevents you from working, disability coverage acts as income replacement to protect important assets and help you continue with some level of earnings. Benefits eligibility may be based on disability for your occupation or any occupation.

Your Plans	Coverage Details
Short Term Disability (STD) Employee Paid	• Administered by MetLife, STD coverage provides a benefit equal to 60% of your base weekly earnings, up to $2,500 per week for a period up to 24 weeks - inclusive of the 14-day elimination period. • The plan begins paying these benefits at the time of disability/after you have been absent from work for 14 consecutive days.

Long Term Disability Coverage (LTD)
Employer Paid
	• If your disability extends beyond 180 days, the LTD coverage through MetLife can replace 60% of your base monthly earnings, up to maximum of $6,000 per month.
	• Your benefits may continue to be paid until you reach social security normal retirement age as long as you meet the definition of disability.
	  ○ You are unable to perform all the material and substantial duties of your regular occupation; and
	  ○ You have a 20% or more loss in your monthly earnings.

Pre-Existing Conditions

You may not be eligible for benefits if you have received treatment for a condition within 3 months prior to your effective date until you have been covered on the **Short Term Disability** policy for 6 months and until you have been covered for 12 months on the **Long Term Disability** policy.

Per Pay Period Voluntary STD rates are per $10 of benefit

Employee Age	Per Pay Period STD Cost
<25	$0.102
20-34	$0.102
35–39	$0.096
40–44	$0.099
45–49	$0.115
50–54	$0.131
55–59	$0.166
60–64	$0.200
65+	$0.229

Tax considerations

Because Long Term Disability coverage is an employer-paid benefit and is available for employees at no cost, any disability payments made to you will be taxable.

As an optional employee paid benefit, Short Term Disability coverage is available to you on a post-tax basis:

- **After-tax:** If you pay your disability coverage on an after-tax basis, you will not have to pay income taxes on any STD benefits you receive.
- **Please note:** Consult your tax advisor for additional taxation information or advice.

TIP

Facts and figures regarding disability

- One in seven people will be disabled for five years or more in their lifetime.
- 30% of people use disability coverage.
- Almost half (46%) of all foreclosures are caused by financial hardship due to disability.

Source: www.affordableinsuranceprotection.com/disability_facts

Employee Assistance Program (EAP)

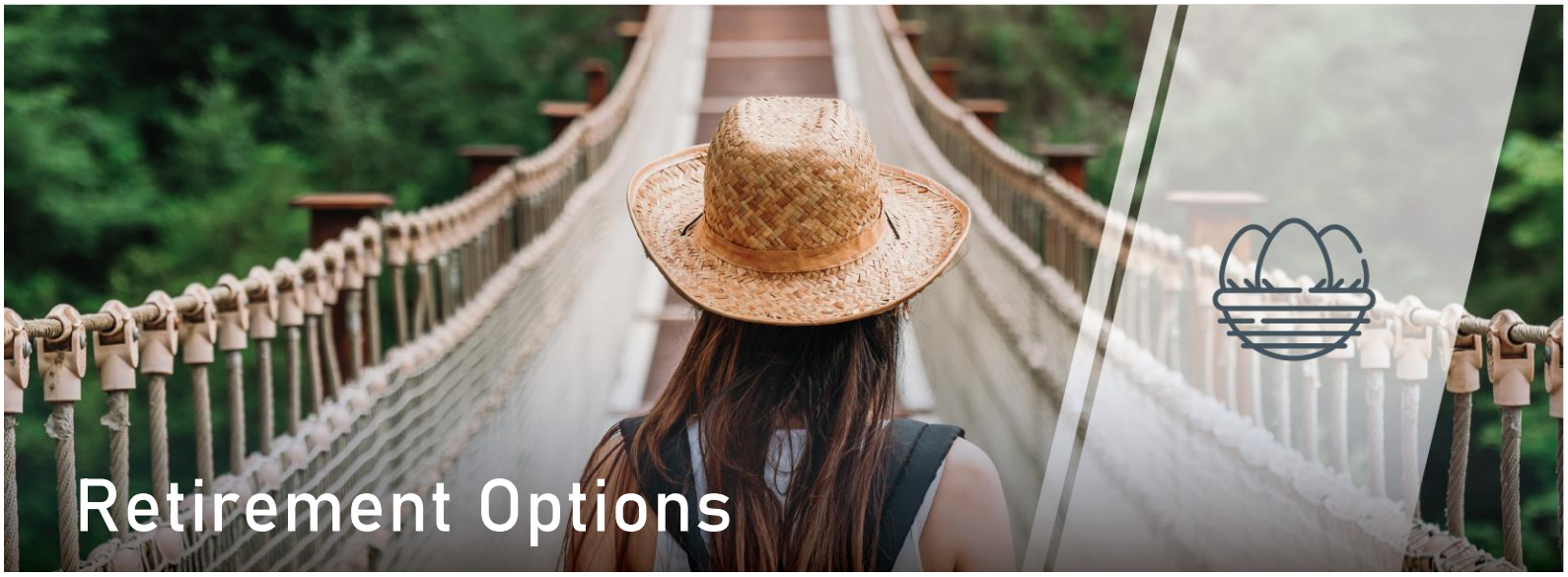
Bridge Investment Group understands that you and your family members might experience a variety of personal or work-related challenges. Through the MetLife EAP- LifeWorks US Inc.- you have access to resources, information, and counseling that are fully confidential and no cost to you.

Program Component	Coverage Details
Number of Sessions	5 face-to-face sessions per year per member per incident
How to Access	Phone or face-to-face sessions
Topics May Include	Mental Health Support: • Marital, relationship or family problems. • Bereavement or grief counseling. • Substance abuse and recovery. Community Support: • Childcare and eldercare. • Legal services and Identity theft. • Financial support. • Educational materials.
Who Can Utilize	All employees, dependents of employees, and members of your household

TIP

Get in touch:

- **By Phone: 888.319.7819 & for TDD 800.999.3004**
- **Online: metlifeeap.lifeworks.com**
- **Website username: : metlifeeap and Password: eap**



Retirement Options

Your 401(k) Plan Option

Your future financial success is at the forefront of our minds at Bridge Investment Group. While there are no 401k election requirements tied to open enrollment, we wanted to take this opportunity to showcase the many benefits of saving into our 401k plan.

Plan Highlights

- Bridge now matches dollar for dollar (100%) on the first 6% of wage contributed!
- You can control your portfolio or use the Target Date Funds to have it done for you
- Choice on when to pay taxes on the income you are saving

Education & Advice For You

- We have arranged for education and advice through our 401k advisors at OneDigital via:
  - The Financial Academy: Live monthly webinars and OnDemand access
  - Our 401k Home Base: Plan Highlights, contact information and timely insights
  - 1on1 Retirement & Investment Advice Opportunities
  - Super Backdoor Roth education for those maxing out their 401k contributions

BRIDGE INVESTMENT GROUP

All Assets Available Through the 401k Home Base QR Code Above

Core Decisions for Retirement Savings Success - Enrollment & Account Access

You are **eligible** to participate in the 401(k) after just 2 months with Bridge and will be automatically enrolled to save 4% of your wage at the beginning of the following month.

These 3 Core decisions will pave your path to success:

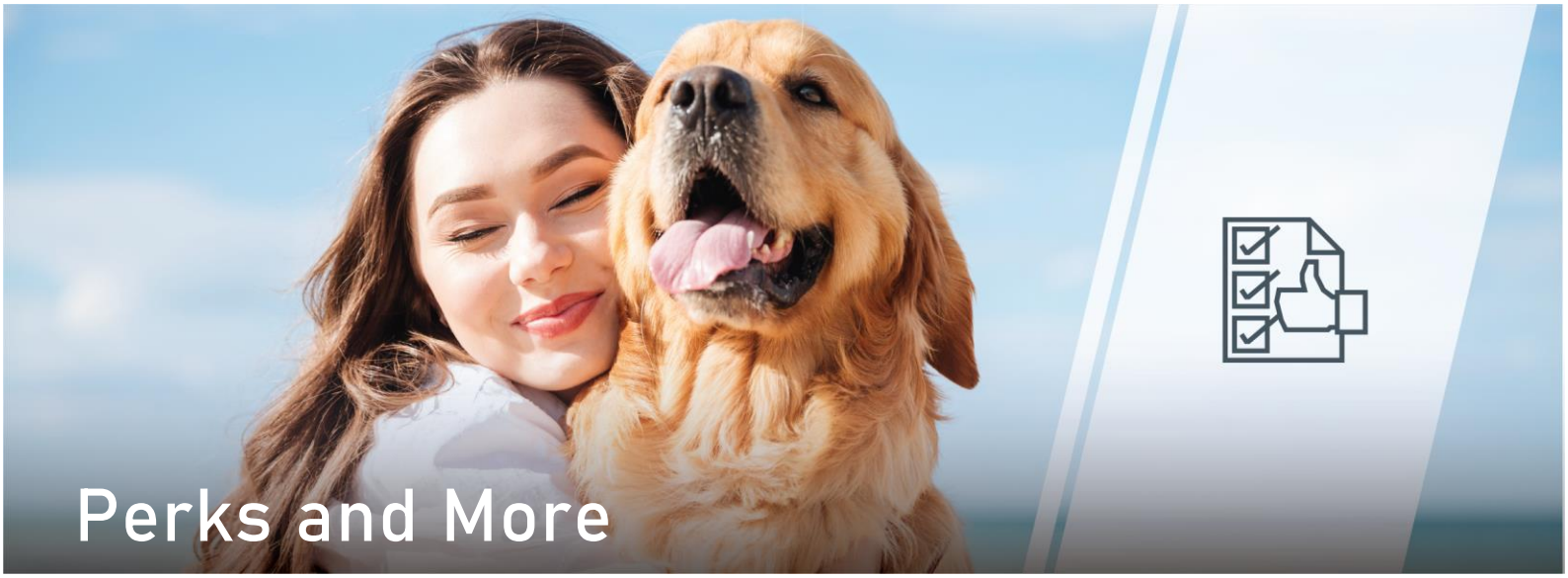
1. Decide how much to save…Experts suggest saving 15% of your wage will have you on track to retire at age 65. We suggest you save what you can afford with a minimum of 6% to get the full match. That's up to 6% free money!
2. Pay tax on the income you save for retirement today by making ROTH contributions or in the future by making Pre-Tax contributions? Good news is that you have choice and can in 2023. ($30,000 if you are age 50+)
3. Determine how to invest your assets. You can build your own portfolio from the available investments in the plan or use the Target Date funds designed to provide you an appropriate level of risk based on your age.

The automatic enrollment starts everyone at 4% but we would suggest setting an automatic increase to gradually increase until you are saving 9%. That plus the match will have you right on track!

Empower is the record keeper of our 401k and you can access your account at www.empowermyretirement.com or by calling them at (800) 338-4015. Transactions such as savings rate, Roth vs. Pre-Tax, Investing and name your beneficiary are all taken care of through Empower. Don't forget to download the app as well!

Our advisors from OneDigital are available to provide Investment & Retirement advice at RetireReady@OneDigital.com

Happy Savings!



Pet Insurance

For many of us, our pets are just as special and loved as our family members. That's why it's important we protect their health too! Our Pet Insurance benefit, offered by Nationwide, covers dogs, cats, birds with discount plans available for exotic animals. Some of the covered benefits for your pet may include allergies, diabetes, cut or bite wounds, infections, heart failure, skin cancer, and more.

Check out the plans on Nationwide's website at www.petinsurance.com/bridgeig or call 877.738.7874 to discuss the best coverage for your animal.

My Pet Protection Features

- Reimburses a significant percentage of vet bills - up to 70% - after a $250 deductible, up to $7,500 per calendar year
- No in or out of network – you are able to use any vet, including specialists and emergency providers
- Multiple Pet Discount of 5% for each additional insured up to 4 pets (10% for 4 pets or more) are available!

	Pet Protection
Accidents, Poisoning, Allergic Reactions	Included
Common Illnesses including Ear Infections, Vomiting & more	Included
Surgeries, Prescriptions and Hospitalizations	Included
Wellness Exams, Vaccinations, Routine Blood Tests	N/A
Spay/Neuter, Flea/Tick Prevention, Heartworm testing and prevention	N/A

TIP

You must go to the Nationwide website to finalize enrollment: www.petinsurance.com/bridgeig

PLEASE NOTE: If you are a current member, you may have certain benefits grandfathered and an option to keep them at current levels.

Nationwide®
is on your side

Legal Services

When you need guidance on personal legal matters, MetLife's services can provide you with access to a network of qualified attorneys. Whether you prefer telephonic or in-office consultation, you may receive guidance on topics such as debt matters, family law, preparation of wills, real estate matters, trusts, and more. Coverage for business or employment related legal concerns may not be offered. To learn more or begin coverage, contact MetLife at 800.821.6400 or visit www.members.legalplans.com.

Identity Theft

Bridge Investment Group offers protection for its employees from the hardships associated with identity theft. Through MetLife, employees can purchase industry-leading identity protection and fraud detection services on an individual basis, or for their families. To learn more or begin coverage, contact Human Resources.

Election	Per Pay Legal and ID Theft Protection
Individual	$14.10
Family	$17.10

Paid Time Off (PTO)*

PTO is available to support your work-life balance and accrues as follows:

Total Company	Days	Accrual Hours
0-5 years of Service	17	5.23
5-10 years of service	20	6.15
10-15 years of service	25	7.69
15+	30	9.23

*Some PTO plans will be grandfathered for individuals. If you have any questions, please contact your HR Business Partner.

Directory and Required Notices

Below, please find important contact information and resources for Bridge Investment Group.

Information Regarding	Contact Information	
Enrollment & Eligibility		
Human Resources: Online Enrollment Vendor: • Workday	801.506.1141 801.716.4500	benefits@bridgeig.com www.myworkday.com/bridgeigp/login.htmld
Healthcare Decision Support		
ACCOLADE Ginger Emotional Support	866.336.0790	myaccolade.com help@ginger.com
Medical Coverage		
UMR • PPO • HDHP with HSA **DisclosedRx** BIN: 021601 PCN: DRX	800.826.9781 888.589.3340	www.umr.com disclosedrx.com
Dental Coverage		
MetLife • PPO	800.942.0854	www.metlife.com/dental
Vision Coverage		
MetLife • PPO	855.638.3931	www.metlife.com/vision
Life, AD&D, Disability		
Met Life • Life & ADD • Short Term Disability • Long Term Disability	800.638.5433	www.metlife.com/BridgeInvestmentGroup
Worksite		
UHC • Accident, Critical Illness & Hospital		www.myuhc.com
Flexible Spending Accounts		
National Benefit Services	800.274.0503	www.nbsbenefits.com
Health Savings Account		
Health Equity	866.346.5800	www.healthequity.com
401(k) Retirement Plan Adviser		
Empower Retirement	800.338.4015	www.empowermyretirement.com
Employee Assistance Plan		
LifeWorks through MetLife	888.319.7819	metlifeeap.lifeworks.com
Pet Insurance		
Nationwide Pet Insurance	877.738.7874	www.petinsurance.com/bridgeig
Legal / Identity Theft		
MetLife Legal MetLife Identity Theft	800.821.6400	www.members.legalplans.com
Benefits Broker / Benefit Questions		
Lovitt & Touché, A Marsh & McLennan Insurance Agency LLC Claims Advocate	602.385.7066	mwigham@lovitt-touche.com

Glossary of Benefit-Related Terms

Co-Insurance The percentage of a covered expense the plan pays after the member has met any required deductible. The remaining percentage is the member's co-insurance.

Co-Payment A flat, predetermined fee usually paid at the time a health care service is provided.

Deductible An amount the member pays each year for covered health care expenses before a plan starts paying benefits. Typically, medical plans have an individual deductible and a family deductible. Once a family meets the family deductible, no additional individual deductibles will apply for the remainder of the calendar year.

Formulary A list of medications preferred by your plan.

Generic Prescription Drug Once the patent on a prescription drug expires, other manufacturers are allowed to produce the same drug under another name. These drugs are almost always less expensive than their brand name equivalents. Generic drugs are designed to have the same potency, efficacy and results as the brand name drug.

Maximum Benefit The highest benefit amount a plan will pay for a covered person during each plan year. Typically, dental plans have a maximum annual benefit per person.

Non-Preferred Prescription Drugs Drugs not included on a plan's list of preferred drugs.

Out-of-Pocket Maximum The maximum amount for an individual and/or family that the covered person will pay each year before the plan pays at 100% of contracted rates. The annual out-of-pocket is comprised of coinsurance, copayments and deductibles. Check specific plan information to see how the out-of-pocket maximum applies. Bridge Investment Group has a different out-of-pocket maximum for in-network care and out-of-network care.

Preauthorization Advance approval that a plan requires for certain health care services, such as non-emergency hospitalization, MRIs, CAT scans, and surgery. If a required preauthorization is not obtained, benefit payments may be denied and/or a penalty applied.

Preferred Brand Prescription Drug A pharmaceutical product that is trademarked by its originator or licensee. If the product is patented, there is usually only one source for that particular medication. Brand name drugs almost always cost more than generic.

Pre-Tax Deduction Deductions from an employee's gross pay. Pre-tax deductions often lower taxes paid.

Preventive Care Health care services aimed at keeping participants well (as opposed to treating disease or injuries). This includes care such as routine exams, disease screenings, well-child/adult care and immunizations. Wellness programs help manage health care costs by emphasizing prevention and early detection of health problems.

Qualifying Family Status Change A change in the employee's family or employment situation that, according to federal rules, allows him/her to make related benefit changes mid-year. Examples include getting married or divorced, changing from part-time to full-time status, etc. Generally, qualifying status changes affect the number of eligible dependents in the employee's family or his/her (or spouse's) eligibility for employer-sponsored benefits.

Guidelines/Evidence of Coverage

The benefit summaries listed on the previous pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the plan's Evidence of Coverage. The Evidence of Coverage or Summary Plan Description is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members' medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan's network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the plan's Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Summary Plan Description, the Evidence of Coverage or Summary Plan Description will prevail.

Medicare Part D
Creditable Coverage Notice

Important Notice from Bridge Investment Group
About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan while enrolled in Bridge Investment Group coverage as an active employee, please note that your Bridge Investment Group coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Bridge Investment Group coverage as a former employee.

You may also choose to drop your Bridge Investment Group coverage. If you do decide to join a Medicare drug plan and drop your current Bridge Investment Group coverage, be aware that you and your dependents may not be able to get this coverage back.

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 01/01/2023
Name of Entity/Sender: Bridge Investment Group
Contact--Position/Office: Human Resources Department
Address: 111 East Sego Lily Drive, Suite 400, Salt Lake City, UT 84070
Phone Number: 801.506.1141

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in Bridge Investment Group group health coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact Human Resources at 801.506.1141.

HIPAA Notice of Privacy Practices

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

Bridge Investment Group sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of Bridge Investment Group, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by Bridge Investment Group, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the Bridge Investment Group HIPAA Privacy Officer:

Bridge Investment Group
Attention: HIPAA Privacy Officer
Ginny Bennett
111 East Sego Lily Drive, Suite 400
Salt Lake City, UT 84070
801.506.1141

Effective Date

This Notice as revised is effective January 1, 2023.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment
We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment
We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations
We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates
We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law
We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety
We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors
For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment

purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation
If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans
If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities
We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement
We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors
We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research
We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You
When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives
We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
(2) treating such person as your personal representative could endanger you; or
(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members
With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations
Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy
You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend
If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in

writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures
You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period ABC Company has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA**.**

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

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

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid

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

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64

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

Phone: 1-877-438-4479

All other Medicaid

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

Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366

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

Hawki Phone: 1-800-257-8563

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

HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/

Phone: 1-800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx

Phone: 1-855-459-6328

Email: KIHIPP.PROGRAM@ky.gov

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

Phone: 1-877-524-4718

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

LOUISIANA – Medicaid

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

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

MAINE – Medicaid

Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: (617) 886-8102

MINNESOTA – Medicaid

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

Phone: 1-800-657-3739

MISSOURI – Medicaid

Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218

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

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT – Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA-Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone:1-800-432-5924 CHIP Phone:1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator at 801.506.1141.

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

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

Model General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

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

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

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed

later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

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

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Human Resources.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect

COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Bridge Investment Group
Attention: Ginny Bennett
Human Resources Department
111 East Sego Lily Drive, Suite 400
Salt Lake City, UT 84070
801.506.1141

HIPAA Notice of Availability of Notice of Privacy Practices

The Bridge Investment Group Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resources at 801.506.1141.

HIPAA Wellness Program Reasonable Alternative Standards Notice

Your group health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all eligible employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at benefits@bridgeig.com and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

EEOC Wellness Program Notice

Notice Regarding Wellness Program

Bridge Investment Group Preventive Care Initiative is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary preventive age/gender/risk-appropriate screening from your physician this year. You are not required to complete any medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of a $25 per month medical premium discount for employee only and or Employee + child(ren). If you enroll with a spouse, and they also complete the form, you will receive a $50 per month medical premium discount ($25 each for completing). Although you are not required to complete a preventive age/gender/risk-appropriate screening, only employees who do so will receive a medical premium discount.

You may request a reasonable accommodation or an alternative standard by contacting your Human Resources Department at benefits@bridgeig.com.

The results from your screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Bridge Investment Group may use aggregate information it collects to design a program based on identified health risks in the workplace, Bridge Investment Group Preventive Care Initiative will never disclose any of your personal information

either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are a registered nurse, a doctor, or a health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact your Human Resources Department at benefits@bridgeig.com.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you should not be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

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

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

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

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

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

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:

    - Cover emergency services without requiring you to get approval for services in advance (also known as “prior authorization”).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you’ve been wrongly billed, the following information and resources are available to help you understand your rights:

Assistance by telephone – You may contact the U.S. Department of Health & Human Services at (800) 985-3059 to discuss whether you may have any surprise billing protection rights for your situation.

Available online assistance – You can also visit the U.S. Centers for Medicare & Medicaid Services website to learn more about protections from surprise medical bills and for contact information for the state department of insurance or other similar agency/resource in your state to learn if you have any rights under applicable state law. Please click on your state in the map for contact information to appear.

Notice Regarding Availability of Health Insurance Exchange

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(Expires 6-30-2023)

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.12% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[2]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[2] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Bridge Investment Group		4. Employer Identification Number (EIN) 45-4084424
5. Employer address 111 East Sego Lily Drive, Suite 400		6. Employer phone number 801.506.1141
7. City Salt Lake City	8. State UT	9. ZIP Code 84070
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above)		12. Email address benefits@bridgeig.com

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

- As your employer, we offer a health plan to:

  ☒ All employees. Eligible employees are:

  Full-time regular employees working 30 hours or more per week

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are:

  Your legal Spouse or domestic partner (with affidavit), and dependent eligible children (up to age 26) or older who are or become disabled and dependent upon the employee.

  ☐ We do not offer coverage.

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

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums..

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