Risk Factors Comparison 2024-02-27 to 2023-03-01 Form: 10-K

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Our business is subject to a number of risks, including risks that may prevent us from achieving our business objectives or may adversely affect our business, financial condition, cash flows, and results of operations that you should consider before making a decision to invest in our common stock. These risks include, but are not limited to, the following: Risks Related to Our Business • our history of net losses and the expectation that our expenses will increase in the future; • failure to identify and develop successful new geographies, physician partners and payors, or execute upon our growth initiatives; • success in executing our operating strategies or achieving results consistent with our historical performance; • medical expenses incurred on behalf of our members may exceed revenues we receive; • inability to secure contracts with MA payors; • inability to grow new physician partner relationships sufficient to recover startup costs; • availability of additional capital, on acceptable terms or at all, to support our business in the future; • significant reduction in our membership; • transition to a Total Care Model may be challenging for physician partners; • public health crises, such as COVID- 19, could adversely affect us; • inaccuracy in estimates of our members' risk adjustment factors, medical services expense, incurred but not reported claims, and earnings pursuant to payor contracts; • the impact of restrictive clauses or exclusivity provisions in some of our contracts with physician partners; • inability to hire and retain qualified personnel; • ability to realize the full value of our intangible assets; • security breaches, cybersecurity attacks, loss of data and other disruptions to our information systems; • ability to protect the confidentiality of our know- how and other proprietary and internally developed information; • reliance on our subsidiaries; • ESG issues; Risks Related to Our Reliance on Third Parties • reliance on a limited number of key payors; • the limited terms of contracts with our payors and our ability to renew them upon expiration; • reliance on payors for membership attribution and assignment, timely data and reporting accuracy and claims payment; • dependence on physician partners and other providers to effectively manage the quality and cost of care and perform obligations under payor contracts; • ability to obtain accurate and complete diagnosis data; • dependence on physician partners to document their services and any inaccuracies could result in overpayments, recoupments or liability under the federal FCA or through RADV audits (defined below); • reliance on third- party software, data, infrastructure and bandwidth; Risks Related to Our Industry and Government Programs • consolidation in the healthcare industry; • discontinuance or reductions in federal government healthcare programs' reimbursement rates or methodologies applied to derive reimbursement; • uncertain or adverse economic and macroeconomic conditions, including a downturn or decrease in government expenditures; • competition in our industry; • dependence on government performance standards and benchmarks; • government funding for healthcare programs is subject to statutory and regulatory changes, administrative rulings, interpretations of policy and determinations by intermediaries and governmental funding restrictions; • regulatory proposals directed at containing or lowering the cost of healthcare, including the ACO REACH Model, and our participation, voluntary or otherwise, in such proposed models; • federal and state investigations, audits and enforcement actions; • regulatory inquiries and corrective action plans imposed by our payors; • repayment obligations arising out of payor audits; • modification the methodology utilized to determine revenue associated with MA members; • negative publicity regarding the managed healthcare industry generally; Legal and Regulatory Risks • regulation of the healthcare industry at the federal, state and local levels and our ability to comply with applicable laws or regulations; • our and our physician partners' ability to comply with federal and state fraud and abuse laws, including physician incentive plan laws and regulations; • implication of laws and regulations regarding marketing, beneficiary inducements, telemarketing and use of protected health information; • our use, disclosure and processing of personally identifiable information, PHI, and de- identified data is subject to HIPAA and state patient confidentiality laws; • failure to obtain or maintain an insurance license, a certificate of authority or an equivalent authorization; • regulation of the corporate practice of medicine could restrict the manner in which we are permitted to conduct our business, and the failure to comply with such laws, or any changes to such laws or regulations or similar laws or regulations; • inadvertent employment or contract with an excluded person by us or our physician partners; • lawsuits not covered by insurance; • changes in tax laws and regulations, or changes in related judgments or assumptions; Risks Related to Our Indebtedness • incurrence of substantially more indebtedness, which could increase the risks created by our indebtedness; • restrictions and limitations in our agreements and instruments governing our indebtedness; Risks Related to Our Common Stock • dependence on our subsidiaries for cash to fund all of our operations and expenses; • our Certificate of Incorporation, Clayton, Dubilier & Rice, LLC (" CD & R ") and its affiliates and, in some circumstances, each of our directors and officers who is also a director, officer, employee, member or partner of CD & R and its affiliates, have no obligation to offer us corporate opportunities; • anti- takeover provisions in our Certificate of Incorporation and By- laws; • ability to achieve a return on your investment depends on appreciation in the price of our common stock; • exclusive forum provisions in our Certificate of Incorporation; and • material weakness in our internal control over financial reporting and our ability to remediate such material weakness. You should carefully consider each of the following risk factors and all of the other information set forth in this report. The ~~section below discusses~~ **risk factors generally have been separated into five groups: risks related to our business, risks related to our reliance on third parties, risks related to our industry and government programs, risks related to our indebtedness, and risks related to our common stock. Based on the information currently known to us, we believe that the following information identifies** the most significant risk factors **affecting our company in each of**

these categories of risks. However, the risks and uncertainties we face are not limited to those set forth in the risk factors described below. Additional risks and uncertainties not presently known to us or that ~~may~~ **we currently believe to be** ~~materially~~ -- **immaterial may also** adversely affect our business **. In addition** , **past financial performance may not be a reliable indicator of future performance and historical trends should not be used to anticipate** results **or trends in future periods. If any** of ~~operations~~ **the following risks** and **uncertainties develop into actual events, these events could have a material adverse effect on our business,** financial condition **or results of operations** . ~~Risks Related to Our Business~~ **In such a case, the trading price of our common stock could decline.** We have a history of net losses, we anticipate increasing expenses in the future, and we may not achieve or maintain profitability. We have incurred significant net losses in prior years and have a substantial accumulated deficit. We expect that our expenses will increase substantially in the foreseeable future and our losses may continue, in part as we invest in growing our business, expanding our management team, building relationships with physician partners and payors, developing new services and complying with the requirements associated with being a public company. These expenses may prove to be more significant than we currently anticipate, and we may encounter unforeseen expenses, difficulties, complications, delays and other unknown factors that may adversely affect our business. We may not succeed in sufficiently increasing our revenue to offset these expenses. Consequently, we may not be able to achieve and maintain profitability for the current or any future fiscal year. Our prior losses and potential for future losses have had and will continue to have an adverse effect on our stockholders' equity and working capital. Any failure by us to identify and develop successful new geographies, physician partners and payors and to successfully execute upon our growth initiatives and achieve required operational scale to support our growth may have a material adverse effect on our business, financial condition, cash flows, and results of operations. Our business depends on our ability to identify and develop successful geographies and relationships with physician partners and payors, and to successfully execute upon our growth initiatives to increase the profitability of our physician partners. In order to pursue our strategy successfully, we must effectively implement our platform, partnership and network model, including identifying suitable candidates and successfully building relationships with and managing integration of new physician partners and payors. We contract with a limited number of physician partners and rely on physician partners within each geography. Our growth initiatives in our existing geographies depend, in part, on our physician partners' ability to grow their practices through the addition of PCPs to increase their capacity to service Medicare patients, and to effectively meet increased patient demand. Our physician partners may encounter difficulties in recruiting additional PCPs to their practices due to many factors, including significant competition in their geographies. Accordingly, the loss or dissatisfaction of any physician partners, our inability to recruit and integrate physician partners into our model, or the failure of our physician partners to recruit additional PCPs or manage and scale capacity to timely meet patient demand, could substantially harm our brand and reputation, impact our competitiveness, inhibit widespread adoption of our platform, partnership and network model and impair our ability to attract new physician partners and maintain existing physician partnerships, both in new geographies and in geographies in which we currently operate, which could have a material adverse effect on our business, financial condition, cash flows, and results of operations. Further, our growth strategy depends, in part, on securing and integrating new high- caliber physician partners and expanding into new geographies in which we have little or no operating experience. Integration and other risks can be more pronounced for larger and more complicated relationships or relationships outside of our core business space, or if multiple relationships are pursued simultaneously. Additionally, new geographies may be characterized by stakeholder preferences for, and experience with, a Total Care Model, rates of MA enrollment, MA reimbursement rates, payor concentration and rates of unnecessary variability in and utilization of medical care that differ from those in the geographies where our existing operations are located. Likewise, new geographies into which we seek to expand may have laws and regulations that differ from those applicable to our current operations. As a young and rapidly growing company, we may be unfamiliar with the regulatory requirements in each geography that we enter, and we may be forced to incur significant expenditures to ensure compliance with requirements to which we ~~are~~ **may become** subject. If we are unable or unwilling to incur such costs, our growth in new geographies may be less successful than in our current geographies. Further, our growth to date has **significantly** increased the ~~significant~~ demands on our management, operational and financial systems, infrastructure and other resources. We must continue to improve our existing systems for operational and financial management, including our reporting systems, procedures and controls and management and mitigation of enterprise and operational risks. These improvements could require significant capital expenditures and place increasing demands on our management. We may not be successful in managing or expanding our operations, maintaining adequate financial and operating systems and controls, executing upon our growth initiatives and achieving required operational scale to support our growth. If we do not successfully manage these processes, our business, financial condition, cash flows, and results of operations could be harmed. We may be unsuccessful in executing our operating strategies, or we may not achieve results consistent with our historical performance. Our success is dependent on our ability to successfully execute upon defined operating strategies in our existing and future geographies. Such strategies include successfully growing our geographies through the addition of PCPs and our physician partners' capacity to serve new members, providing medical services for our members at appropriate levels of utilization and cost **while sufficient to achieve expected profitability** , and generating medical services revenue through appropriate and effective contracting strategies with our MA payors. We may not be successful in executing these strategies, or we may fail to implement such strategies in future markets as effectively as with our ~~initial~~ **current** markets. The failure to successfully execute upon such strategies or to produce results consistent with our historical results or the financial and operational models used in the analysis of our potential relationships may result in an inability to grow our business; may cause ongoing operating losses **or achievement of profitability levels that do not meet expectations** , asset write- offs, restructuring costs or other expenses; and may have a material adverse effect on our business, financial condition, cash flows, and results of operations. Further, as a young and rapidly growing company with a limited operating history, it is uncertain whether our platform, partnership and network model will achieve and sustain high levels of demand, physician and payor acceptance ~~and~~ **,**

market adoption **and profitability** . Due to our limited operating history, it is also difficult for us to evaluate our business compared to prior periods. If we do not develop, if we develop more slowly than we expect, if we encounter negative publicity or if our value propositions for physician partners, patients and payors do not drive sufficient member growth, the growth **and profitability** of our business will be harmed. Our success will depend to a substantial extent on our ability to demonstrate the value of our platform, partnership and network model to physicians and payors. ~~Our~~ **We believe our** ability to replicate the success of our model also enables us to attract and retain skilled physician partners. Accordingly, if we are unable to effectively manage our growth and replicate the success of our platform, partnership and network model in new geographies and with new partners, our business, financial condition, cash flows, and results of operations could be harmed. Amounts of medical expenses that are incurred on behalf of our members may exceed the amount of medical revenues we receive to provide care for such members. Under our agreements with our payors, we receive a PMPM- based capitation payment, and we assume financial risk for the expense of providing medical services on behalf of our physician partners. To the extent that utilization of medical services or the cost of providing such services increases beyond our expectations, the total cost to provide medical services to our members may exceed the corresponding amount of revenue we receive, which may result in losses **or profitability that does not meet expectations** and adversely impact our business, financial condition, cash flows, and results of operations. Additionally, factors that impact medical costs incurred by our members, and medical expenses we incur, may be subject to fluctuations which we may not be able to control. Such factors include the following: • Changes to the Medicare fee schedule or other rate schedules that serve as the basis for payments issued to hospitals, specialty and ancillary physicians and other providers; • Contractual rates paid to hospitals, specialty and ancillary physicians and other providers; • The utilization rates of healthcare services, including inpatient hospitalization, **outpatient procedures, high risk and chronic conditions and other services that result in medical expenses,** by our members; • Changes to member benefit **types, categories, and** levels established ~~annually~~ **and otherwise offered** by payors; and • The utilization rate and cost of pharmaceuticals or specialty drugs utilized by our members. Fluctuations in the magnitude of the hospital and physician network, including the discontinuation of a hospital or specialty or ancillary physician' s participation in our MA payors' provider network, could adversely impact our business, financial condition, cash flows, and results of operations. As we expand into new geographies, we may be unable to secure contracts with MA payors, or such contracts may be established at less favorable financial terms than are necessary to meet our financial targets. As we enter into new geographies, potential physician partners will typically provide care to members affiliated with one or more MA payors, in a structure other than a Total Care Model. Our ability to successfully operate in a market is dependent upon our ability to enter into contractual relationships with MA payors which have an existing presence in that market under a global risk structure. MA payors may take the position that it is not in their strategic or financial interests to enter into a contract with us, or they may have already established exclusive relationships with other value- based care providers or affiliates in a geography and, therefore, elect to not enter into a similar arrangement with us. Therefore, we may be unsuccessful in executing contractual relationships with MA payors, or such contracts may be established at financial terms which result in lower revenues or higher costs than we project or that are necessary to generate profits in a given geography. To the extent we are unsuccessful in establishing contractual relationships with MA payors in new geographies, or such relationships are established at less favorable terms than we project, we may not be able to successfully launch into a given geography, or the membership or revenue levels we are able to attain will be lower than our projections. We incur startup costs during the initial stages of development of our physician partner relationships and program initiatives, and if we are unable to maintain and grow these physician partner relationships or program initiatives over time, we may not recover these costs. We devote resources to the establishment of new physician partner relationships, including costs relating to physician recruiting to enhance access and support growth of the network, physician incentives to support the transition to a Total Care Model and operational support. Our startup investment in new physician partners can be significant and the associated revenue must be earned and sustained over time in order for us to recoup these costs. As our business grows, our physician partnership startup costs could outpace our buildup of recurring revenue if we do not achieve economies of scale, and we may be unable to achieve profitability until our revenues associated with new partnerships are more mature. We may never recoup our startup costs in a physician partner relationship, including as a result of such physician partner' s difficulty transitioning to a Total Care Model. **Similarly, if physicians join a physician partner following the initial implementation period for a new partner market and we are unable to manage the integration of such new physician into our Total Care Model, the new physician may not achieve expected improvements in patient outcomes and related profitability.** If we fail to achieve appropriate economies of scale, if we fail to manage or anticipate the evolution of the Total Care Model **throughout our markets** or if we fail to raise necessary capital to fund our startup costs, our business, financial condition, cash flows, and results of operations could be materially adversely affected. We also devote resources to establishing program initiatives to ensure a successful transition to a Total Care Model for members, physician partners and payors. Establishment of these program initiatives requires investments that may not be recouped. For example, investment in preventive care and incentivizing physician partners to complete annual wellness visits may increase our total medical services expense, particularly in the short term, and may fail to generate expected cost savings in the long term. If we fail to realize quality of care outcomes and projected revenues or cost savings due to effectively managed healthcare costs with these program initiatives, our business, financial condition, cash flows, and results of operations could be materially adversely affected. We may require substantial additional capital to support our business in the future, and this capital might not be available on acceptable terms, or at all. Our operations have consumed substantial amounts of cash since inception, and we expect to spend substantial amounts of cash for the foreseeable future. If our cash and cash equivalents and any cash generated from operations are not sufficient to meet our future cash requirements, we will need to access additional capital to fund our operations and our continued growth and expansion. We may seek to raise capital by, among other things, issuing additional shares of our common stock or other equity securities, issuing debt securities or borrowing funds under a credit facility. In the past, the securities and credit markets have experienced significant volatility

and disruption. The availability of credit, from virtually all types of lenders, has at times been limited. In the event we need access to additional capital to pay our operating expenses, fund subsidiary surplus requirements, make payments on or refinance our indebtedness, pay capital expenditures, or fund acquisitions, our ability to obtain such capital may be limited and the cost of any such capital may be significant, particularly if we are unable to access ~~the~~ **our** credit facility agreement ~~we executed in February 2021~~ (as amended by the First Amendment to Credit Agreement, dated as of March 1, 2021 **and the Second Amendment to Credit Agreement, dated as of May 25, 2023** , the " ~~Secured~~ Credit ~~Facilities~~ **Facility** "). Our access to additional financing will depend on a variety of factors such as prevailing economic and credit market conditions, the general availability of credit, the overall availability of credit to our industry, our credit ratings and credit capacity and perceptions of our financial prospects. Similarly, our access to funds may be impaired if regulatory authorities or rating agencies take negative actions against us. If one or any combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and in such case, we may not be able to successfully obtain sufficient additional financing on favorable terms, within an acceptable timeframe, or at all. ~~Financings~~ **Financing** , if available, may be on terms that restrict our operational flexibility, dilute the economic or voting rights of our stockholders or reduce the market price of our common stock. If we require new sources of financing but they are insufficient or unavailable, we would be required to modify our operating plans to take into account the limitations of available funding, which would harm our ability to maintain or grow our business. Significant reduction in our membership could have an adverse effect on our business, financial condition, cash flows, and results of operations. A significant reduction in membership could adversely affect our business, financial condition, cash flows, and results of operations because our payor contracts compensate us on a per- member basis. Many factors that could cause such a reduction are outside our control. Factors that could contribute to a reduction in membership include: • failure to obtain new physician partners or members or to retain existing physician partners or members; • decision by a payor ~~to~~ not **to** renew the existing contractual agreement upon termination of such contract; • low quality of care by our physician partners, including as a result of our failure to provide **sufficient implementation in our Total Care Model,** tools and information to deliver high- quality care; • alternative care opportunities that are more attractive than those provided by our physician partners; • premium increases, benefit revisions or other similar changes, which cause our current payor relationships to be less attractive to members than other alternatives, including traditional Medicare or MA plans with which we do not maintain a relationship; • negative publicity, through social media, news coverage or otherwise, related to us, our physician partners, payors or MA; • failure of our payors to maintain their annual ratings awarded by CMS to health plans which measure the quality of health services received by beneficiaries enrolled in MA based on various calculated quality metrics (" STAR ratings "), which leads to members disenrolling from such payors; and • federal and state regulatory changes. We contract with a limited number of payors, and our membership is dependent on such payors attracting and retaining members. In addition, if a payor fails to renew its contract with us or members disenroll from such payor, the members such payor attributes to our platform could transition to another payor which is not on our platform, which could have a material adverse effect on our business, financial condition, cash flows, and results of operations. We may also fail to address factors within our control that could contribute to a reduction in enrollment, including providing our physician partners **with sufficient implementation in our Total Care Model, as well as** ~~the~~ **other** tools and information to provide high- quality care. The transition to a Total Care Model may be challenging for physician partners. The transition to a Total Care Model may be challenging for our physician partners, and fully capitated or other provider- risk arrangements have had a history of financial challenges for physicians. It may take time for physician partners to acclimate to a capitation model, and some physician partners may not be successful at transitioning to a Total Care Model **. Similarly, if physicians join a physician partner following the initial implementation period for a new partner market and we are unable to manage the integration of such new physician into our Total Care Model, the new physician may not achieve expected improvements in patient outcomes and related profitability** . If we are not able to attract or retain physician partners who are successful at transitioning to a Total Care Model, our business, financial condition, cash flows, and results of operations could be materially adversely affected. ~~The spread of~~ **Public health crises** , **such as** ~~and response to,~~ COVID- 19, ~~potential new variants of~~ **could adversely affect us. Public health crises (such as the** COVID- 19 ~~and entirely new pandemics~~ **pandemic** ~~may adversely affect us~~ **) could cause unexpected changes in utilization of healthcare services, which could impact our business, results of operations, financial condition, liquidity and cash flows** . **In particular, we have experienced, and may in the future experience, financial or operational impacts as a result of** COVID- 19 ~~continues to~~ **or other public health crises which may be material, including:** ~~impact~~ **impacts** ~~the United States~~ **on our medical costs** and ~~the rest~~ **medical services revenue, therefor affecting our total cost** of ~~the world and the pandemic~~ **care; increased delayed costs** ~~has~~ **as** ~~led~~ **a result of our enrolled members being unable** to **see** ~~significant economic disruption. Although the~~ **their PCPs or long term complications of** COVID- 19 ~~public~~ **; labor shortages; complete or partial closure of partner medical care facilities; and inability to implement clinical initiatives to manage** ~~health~~ **healthcare** ~~emergency is set to end on May 11, 2023,~~ **costs and chronic conditions of our enrolled members and appropriately document** ~~the~~ **their** ~~spread of~~ **risk profiles. Additionally,** COVID- 19 **has impacted** and ~~its~~ **could continue to** impact **our ability to accurately project medical cost trends. The impact of COVID- 19** on the worldwide economy and the healthcare industry underscores risks we face related to **public health crises and** pandemics. **Additionally** ~~Governmental and non- governmental organizations may not effectively combat the spread and severity of COVID- 19~~ , **future public health crises or** ~~potential new variants of COVID- 19 and entirely new~~ pandemics ~~, increasing the potential for harm for our members. If the spread of COVID- 19, potential new variants of COVID- 19, and entirely new pandemics are not contained, the medical services revenue we receive~~ may ~~prove to be insufficient to cover the cost of healthcare services delivered to our enrolled members, which could~~ increase ~~significantly as a result of higher utilization rates of medical facilities and services and other increases in associated medical claims and related costs. Over time, we may also experience increased costs or decreased revenues if, as a result of our enrolled members being unable to see their PCPs due to actions taken to mitigate the spread of COVID- 19, potential new variants of COVID- 19 and~~

~~entirely new pandemics, we are unable to implement clinical initiatives to manage healthcare costs and chronic conditions of our enrolled members and appropriately document their risk profiles. In addition,~~ the clinical disease burdens of our members ~~may increase~~ over time ~~and ,~~ reduce preventative care to manage their existing clinical conditions ~~. The spread of COVID- 19, potential new variants of COVID- 19~~ and **cause members to defer** ~~entirely new pandemics, or actions including the~~ **other** ~~efficacy~~ **care and elective procedures into future periods resulting in unexpected increased medical expense in such future periods** , **all** ~~ability to administer or extent~~ of **which may** ~~adoption of applicable vaccines, could have material~~ **materially** and ~~adverse~~ **adversely impact** ~~effects on our ability to operate effectively, including as a result of the complete or~~ **our business** ~~partial closure of facilities or labor shortages. Disruptions in public and private infrastructure, including communications~~ , financial **condition** ~~services and supply chains~~ , ~~could materially~~ **cash flows,** and **results of** ~~adversely disrupt our normal business~~ operations ~~. The rapid development and fluidity of COVID- 19 precludes any prediction as to the ultimate impact on us of COVID- 19, potential new variants of COVID- 19, and entirely new pandemics. We are continuing to monitor the spread of COVID- 19, potential new variants of COVID- 19, and entirely new pandemics, changes to our payors' benefit coverages, the ongoing costs and business impacts of dealing with the pandemic, including the potential costs associated with administering vaccines, and related risks, as well as potential costs associated with provision of care to our members suffering from COVID- 19~~ . The magnitude and duration of any pandemic and its ultimate impact on us are uncertain, but such impacts could be material to our business, financial condition, cash flows, and results of operations. Our estimates of our members' risk adjustment factors, medical services expense, incurred but not reported claims **,** and earnings pursuant to payor contracts could be inaccurate. Medical services revenue related to our members is based on clinical disease conditions identified and documented by physicians during patient visits during the preceding calendar year, as well as other factors such as the age and gender of the member, which is summarized in a risk- adjustment factor assigned to each member. To estimate the related amount of revenue that will ultimately be realized for the periods presented, we estimate our members' risk adjustment factors based on our knowledge of members' health status, which is in turn based on physicians' clinical assessment and documentation of members' health status, existing risk adjustment factors and applicable Medicare guidelines. These factors may not be predictive of our members' risk adjustment factors, or we may otherwise fail to accurately estimate such score, which could cause our revenue estimates for the relevant **or forecasted** ~~period~~ **periods** to be inaccurate. We establish liabilities on our balance sheet for the amount of medical services that have been incurred but not reported (" IBNR ") or paid as of the given balance sheet date. IBNR estimates are developed using actuarial methods and are based on many variables, including the utilization of healthcare services, historical payment patterns, cost trends, **the timing of the receipt and accuracy of claims data and other information from our payors,** product mix, seasonality, changes in membership and other factors. These estimation methods and the resulting reserves are periodically reviewed and updated. COVID- 19 has also resulted in fluctuations in our medical expenses and increased challenges in accurately estimating the amount of medical expenses which have been incurred by our members. Given the numerous uncertainties inherent in such estimates, our actual medical claims liabilities for a particular quarter or other period **, including for forecasted periods,** could differ significantly from the amounts estimated and reserved for that quarter or period. Our actual medical claims liabilities have varied and will continue to vary from our estimates, particularly in times of significant changes in utilization, medical cost trends and populations and geographies served. If our actual liability for claims payments is higher than previously estimated, our earnings in any particular quarter ~~or~~ **,** annual period **or forecasted periods** could be negatively affected. Our estimates of IBNR liabilities may be inadequate in the future, which would negatively affect our results of operations for the relevant time period **or for forecasted periods** . Furthermore, if we are unable to accurately estimate adequate IBNR levels, our ability to take timely corrective actions may be limited, further exacerbating the extent of the negative impact on our results **of operations for completed periods or forecasted periods** . When we enter into a new physician partner relationship or when we prepare operating and financial forecasts, we and our payors estimate medical services expense. Our medical services expense may exceed our or our payors' estimates, which may result in our establishing unfavorable financial terms in our contractual agreements with our payors, or may result in our payors' actuarial projections submitted to CMS being inaccurate. In either case, we may incur higher medical expenses than we anticipated or in excess of the revenues we receive, which could in turn have a material adverse effect on our business, financial condition, cash flows, and results of operations. Additionally, we cannot be certain that the stop- loss coverage we maintain to protect us against certain severe or catastrophic medical claims currently is or will be adequate or available to us in the future or that the cost of such stop- loss coverage will not limit our ability to obtain it. Restrictive clauses in some of our contracts with physician partners may prohibit us from establishing new RBEs within certain geographies in the future, and as a result may limit our growth. Most of our contracts with our physician partners include restrictive provisions that, among other things, preclude us from establishing new RBEs within certain geographies in the future. These restrictive provisions typically preclude us or our RBEs from contracting to provide a Total Care Model in specific geographic areas other than through the relevant RBE, and in certain circumstances may limit the providers with which the RBE may contract. Any contracts with restrictive provisions may limit our ability to conduct business with certain potential partners, including partnering with or providing services to other physicians or purchasing services from other physicians within certain time periods, and in certain regions. Accordingly, these restrictive provisions may limit growth and prevent us from entering into long- term relationships with potential partners and could cause our business, financial condition, cash flows, and results of operations to be harmed. Exclusivity provisions in some of our agreements with physician partners could subject us to investigations or litigation. Most of our contracts with our physician partners contain restrictive provisions that preclude our physician partners from providing specified services for the duration of our contracts. Such provisions could be the subject of investigations and enforcement actions by regulatory authorities and litigation by payors or physicians operating in the geographic areas where such contracts exist. Any such investigations, enforcement actions or litigation could require us to take actions that would adversely affect our business, financial condition, cash flows, and results of operations or could require us to

pay substantial amounts of money. Additionally, defending against these lawsuits and proceedings may involve significant expense and diversion of management' s attention and resources from other matters. We rely on our management team and key employees **,** and our business, financial condition, cash flows, and results of operations could be harmed if we are unable to **hire and** retain qualified personnel. Our success depends, in part, on the skills, working relationships and continued services of our senior management team and other key personnel. **Our** ~~All of our~~ employees are " at- will " employees or have offer letters or employment agreements that allow their employment to be terminated by us or them at any time, for any reason and without notice, subject, in certain cases, to severance payment rights. In order to **hire,** retain **,** and motivate valuable employees, in addition to salary and cash incentives, we provide stock options and restricted stock units that either vest over time or are based on the performance against predetermined financial targets. The value to employees of these stock options is significantly affected by movements in our stock price that are substantially outside our control. The compensation and benefits we provide to our employees, together with the value of stock options and restricted stock units that we have granted, may at any time be insufficient to counteract offers from other organizations. The departure of key personnel could adversely affect the conduct of our business, financial condition, cash flows, and results of operations. In such **an** event, we would be required to hire other personnel to manage and operate our business, and we may not be able to employ a suitable replacement for the departing individual at favorable terms, or at all. Competition for qualified personnel in our field is intense due to the limited number of individuals who possess the skills and experience required by our industry, particularly with respect to a Total Care Model. As a result, as we enter new geographies, it may be difficult for us to hire additional qualified personnel with the necessary skills to work in such geographies. If our hiring efforts in new or existing geographies are not successful, our business will be harmed. In addition, we have experienced employee turnover and expect to continue to experience employee turnover in the future. Continued increased competition for, or a shortage of, qualified personnel due to pandemics, general labor market conditions, low levels of unemployment, or general inflationary pressures, may require that we enhance our pay and benefits package to compete effectively for such personnel. **Additionally** ~~We may not be able to retain our current key personnel or attract~~ , **new** ~~train, integrate, or retain other highly skilled personnel in the future. New~~ hires require significant training and, in most cases, take significant time before they achieve full productivity. New employees may not become as productive as we expect, and we may be unable to hire or retain **, train or integrate** sufficient numbers of qualified individuals **. Further, if we are unable to develop and maintain our desired corporate culture, we may be unable to attract and retain qualified and key personnel** . If our retention efforts are not successful or our employee turnover rate increases in the future, our business, financial condition, cash flows, and results of operations will be harmed. We may never realize the full value of our intangible assets, which could cause us to record impairments that may negatively affect our financial condition and results of operations. We have a significant amount of intangible assets on our balance sheet, and we may never realize the full value of such assets. In addition to our annual goodwill impairment test in the fourth quarter, our intangible assets, including goodwill, are subject to impairment tests when events or circumstances indicate that the carrying value of the asset, or related group of assets, may not be recoverable. There are several factors that may be considered a change in circumstances indicating that the carrying value of our intangible assets, including goodwill may not be recoverable, including macroeconomic conditions, industry considerations, our overall financial performance (including an analysis of our current and projected cash flows), revenue and earnings, a sustained decrease in our share price and other relevant entity- specific events (including changes in strategy, physicians, members or litigation). Where the carrying value of the asset, or related group of assets, is not recoverable, we would record an impairment charge that may negatively impact our financial condition and results of operations. Any future impairments could be significant and have a material adverse effect on our business, financial condition, cash flows, and results of operations. Security breaches, cybersecurity attacks, loss of data and other disruptions to our ~~data platforms~~ **information systems** could compromise sensitive information related to our business and expose us to liability, which could adversely affect our operations, financial condition, cash flows and results of operation ~~. In the ordinary course of our business, we collect, store, use and disclose sensitive data, including what the law defines as PHI and other types of personal or identifying information. Our member information is encrypted but not always de- identified~~ . We manage and maintain our business and data through a combination of data center systems and cloud- based computing center systems. We are highly dependent on information technology networks and systems, including the internet, to securely **access,** process, transmit and store this information. We utilize third- party service providers for important aspects of the **access,** collection, storage and transmission of PHI and other sensitive information and, therefore, we may be unable to control the use of such information or the security protections employed by such third parties. The security of our technology platform and other aspects of our services, including those provided or facilitated by our third- party service providers, is important to our operations and business strategy because of the sensitivity of the PHI and other confidential information we and our providers **access,** collect, store, process and transmit. Our information technology and infrastructure, and that of our third- party service providers, may be vulnerable to various forms of attacks by hackers or to viruses, other technical failures or breaches due to third- party action, or due to employee and contractor negligence, error or malfeasance. We may also experience cybersecurity and other breach incidents that may remain undetected for an extended period of time. Because the techniques used to obtain unauthorized access or to otherwise disrupt computer systems change frequently and generally are not identified until they are launched against a target, we or our third- party service providers may be unable to implement adequate preventative measures or effectively respond to breaches in a timely fashion. Examples of currently known data security threats facing us and our third- party service providers include **, but are not limited to,** ransomware, phishing, business email compromise and credential stuffing **. Additionally, cyber threats and the techniques used in cyberattacks change, develop and evolve rapidly, including from emerging technologies, such as advanced forms of AI and quantum computing** . The risk of cyberattacks has also increased and will continue to increase in connection with Russia' s invasion of Ukraine. In light of the Ukraine war and other geopolitical events and dynamics, including ongoing tensions with North Korea, Iran and other states, state- sponsored parties or their supporters may launch retaliatory cyberattacks

~~, and may attempt to cause supply chain disruptions,~~ or carry out other geopolitically motivated retaliatory actions that may adversely disrupt or degrade our operations and may result in data compromise. State- sponsored parties have, and will continue, to conduct cyberattacks to achieve their goals that may include espionage, monetary gain, disruption, and destruction. ~~To accomplish their goals, state- sponsored parties and other cyber criminals have used, and may continue to use, various attack vectors and methods as discussed above.~~ We ~~, like most companies today,~~ are subject to cybersecurity attacks and may experience cybersecurity incidents in the future. Such breaches of our infrastructure or information, or that of our third- party providers, whether as a result of physical break- ins, computer viruses, cyberattacks, or employee **, vendor** or contractor error, negligence or malfeasance, can create system disruptions, shutdowns or unauthorized **access, use,** disclosure or modification of sensitive information, including PHI. As a result, such data security breaches could result in the loss of data or inappropriate use of information. Any interruption in access to member information, unauthorized access to information, improper disclosure or other loss of information could also result in federal ~~or~~ **,** state **, or foreign** government investigations and liability under laws and regulations that protect the privacy of member information, such as HIPAA, potentially resulting in damages and regulatory penalties. See " Business — Healthcare and Other Applicable Regulatory Matters — Federal and State Privacy and Security Requirements " in Item 1 above **. Although we have implemented preventative measures, as described in Item 1C of this Annual Report, such measures may not be sufficient to prevent, mitigate or offset a cyber incident** . Sustained or repeated system failures could damage our reputation and reduce the attractiveness of our platform, partnership and network model to members and physician partners, possibly resulting in contract terminations and reductions in revenue. Additionally, the detection, prevention and remediation of known or unknown security vulnerabilities, including those arising from third- party hardware or software, may result in additional material direct or indirect costs. Any or all of these issues could adversely affect our ability to attract new physician partners and members, cause existing physician partners to fail to renew their agreements with us, cause existing members to disenroll or switch their coverage to non- contracted payors and result in reputational damage. Our general liability or data security insurance policies may not be adequate to cover all potential claims to which we are exposed and may not be adequate to indemnify us for the liability that may be imposed or the losses associated with such events, and in any case, such insurance may not cover all of the specific costs, expenses and losses we could incur in responding to and remediating a security breach. If we are unable to protect the confidentiality of our know- how and other proprietary and internally developed information, our operations could be adversely affected. Our business depends on internally developed information, including our databases, confidential information ~~and~~ **,** know- how **and brand** , the protection of which is crucial to the success of our business. We may not be able to protect our know- how and other internally developed information, including clinical and analytical outcomes generated from data we collect from physician partners, payors and other relevant sources. Our physician partners, employees, consultants and other parties (including independent contractors and companies with which we conduct business) may unintentionally or willfully disclose our information to competitors. Enforcing a claim that a third party illegally disclosed or obtained and is using any of our internally developed information is difficult, expensive and time- consuming, and the outcome is unpredictable. In addition, courts outside the ~~United States~~ **U. S.** are sometimes less willing to protect know- how and other proprietary information. We rely, in part, on non- disclosure or confidentiality agreements with our physician partners, independent contractors, consultants and companies with which we conduct business to protect our know- how and internally developed information. These agreements may not be self- executing, or they may be breached and we may not have adequate remedies for such breach. ~~Moreover, third~~ **Third** parties may independently develop similar or equivalent proprietary information or otherwise gain access to our know- how and other internally developed information. **Further, we have registered trademarks and filed other trademark applications that are meaningful to our business and brand.** Our failure to protect the confidentiality of our know- how **, brand** and other proprietary and internally developed information could have a material adverse effect on our business, financial condition, cash flows, and results of ~~operations. We may be responsible for certain liabilities in connection with the disposition of our California Operations. In February 2021, we completed the divestiture of our California Operations. We will continue to be responsible for any liabilities arising from the business that were incurred prior to the closing date of the transaction, including the payment of claims for medical services incurred prior to the effective date of each transaction, a liability for unrecognized tax benefits for which we are indemnified and other contingent liabilities that we currently believe are remote. See " Note 20. Discontinued Operations " in our audited consolidated financial statements included elsewhere in this report. We may not be successful in managing the risks associated with the divestiture of our California~~ operations. Our subsidiaries' lack of performance or ability to fund their operations could require us to fund such losses. If our subsidiaries suffer losses due to their lack of performance, our physician partners' failure to perform under their contracts or other reasons, we may be required to fund such losses or our subsidiaries may **subject to allegations of** breach **of** their payor contracts or **may** incur regulatory consequences. We have in the past chosen to or been required to, and may in the future choose to or be required to, fund our subsidiaries' losses. If unfunded, such losses have in the past, and could in the future, result in substantial doubt related to such subsidiary' s ability to continue operating as a going concern, and the contractual and regulatory consequences of such failure could have a material adverse effect on our business, financial condition, cash flows, and results of operations. ~~Risks Related to~~ **ESG issues may impact our business, our financial outcomes, and our reputation. Various stakeholders, including regulators, investors, physician partners, payors, and employees are increasingly concerned with ESG issues, including climate change and sustainability; diversity, equity, and inclusion; data privacy and security; and human capital management.** Our ~~Reliance~~ **actions and disclosures related to these and other ESG issues may impact our reputation and relationships with various stakeholder groups. Further, current and future mandated reporting requirements** on ~~Third Parties~~ **ESG topics, including climate-related disclosures, may impact our reporting and compliance costs, and require a significant time investment. Our failure to fulfill ESG disclosure requirements and to meet current and future commitments may result in litigation, liability, negative financial outcomes, and reputational damage.** We are economically dependent on maintaining our

contracts with a limited number of key payors. We contract with a limited number of key payors, and we are economically dependent on maintaining our contracts with such payors. See " Note 3. Concentration of Credit Risk " in our ~~audited consolidated~~ **Consolidated** ~~financial~~ **Financial** ~~statements~~ **Statements** included elsewhere in this ~~report~~ **Report** . As a result, our key payors may have increased bargaining power, and we may be required to accept less favorable contractual terms with them. Because we rely on a limited number of payors for a significant portion of our revenue, we depend on their creditworthiness. Our payors are subject to a number of risks including reductions in payment rates from governmental programs, higher than expected healthcare costs and lack of predictability of financial results when entering into new lines of business, particularly with high- risk populations. If the financial condition of our payors declines, our credit risk could increase. Should one or more of our significant payors declare bankruptcy, be declared insolvent or otherwise be restricted by state or federal laws or regulation from continuing in some or all of their operations, such payor may be unable to reimburse us for expenses incurred in managing patient care, and the members such payor attributes to our platform could transition to another payor who is not on our platform, which could have a material adverse effect on our business, financial condition, cash flows, and results of operations. Future consolidation of payors in the healthcare industry could reduce the number of payors even further, increasing these risks. Our contracts with our payors are for limited terms and may not be renewed upon their expiration. Our contracts with payors generally have terms of one to three years and are typically renewed for one- year periods unless terminated in accordance with the terms of such agreements. In the ordinary course of business, we engage in active discussions and renegotiations with our payors ~~in~~ **with** respect of the services we collectively provide and the terms of our payor agreements. As our payors' businesses respond to market dynamics and financial pressures, and as our payors make strategic business decisions ~~in~~ **with** respect of the lines of business they pursue and programs in which they participate, certain of our payors have sought, and we expect that in the future additional payors will, from time to time, seek to renegotiate or terminate their contracts with us. These negotiations could result in reductions to the economic terms and changes to the scope of services contemplated by our existing payor contracts and consequently could negatively impact our revenues, business and prospects and render our assumptions, estimates and reserves inaccurate. If any of our contracts with our payors is terminated, we may experience a reduction in the number of members attributed to our platform, which may result in a reduction of our revenues and may have a material adverse effect on our business. ~~We have in the past, with~~ **With** respect to certain of our discontinued operations, ~~and~~ **we** may ~~in the future,~~ recognize impairment charges for such terminations. If a payor does terminate or elects not to renew its relationship with us, our ability to retain members associated with that payor is limited. We and our physician partners must comply with the CMS Medicare Marketing Guidelines regarding communication and information provided to members, which limits the types of permissible communications that may be made to members. In addition, in Ohio, we are contractually prohibited from forming our own health plan, which effectively prohibits us from directly marketing to members in accordance with the CMS Medicare Marketing Guidelines. Additionally, if a payor with which we contract for these services loses its Medicare contract or CMS decides to discontinue its MA or commercial plans, decides to contract with another company to provide capitated care services to its members or decides to directly provide care, our contract with that payor could be at risk and we could lose revenue. Additionally, payors with whom we currently contract in a particular geography may not maintain their government- awarded contracts in future years. Moreover, our inability to maintain our agreements with payors, in particular with key payors such as Humana, Aetna and United Healthcare, with respect to their MA members or to negotiate favorable terms for those agreements in the future, could result in the loss of patients and could have a material adverse effect on our business, financial condition, cash flows, and results of operations. We rely on our payors for membership attribution and assignment, **timely** data and reporting accuracy and claims payment. We rely on our payors for membership attribution and assignment, **timely** data and reporting accuracy and claims payment, and if our payors do not adequately fulfill these functions, fewer members may be attributed to our platform or we may not receive complete and accurate information necessary to effectively manage our business **and forecast our expected profitability** . We receive payments from payors based on the number of assigned or attributed members participating in Medicare, which can be based upon complex attribution algorithms provided by our payors that may not be accurate. Additionally, payors may choose to assign specific member populations to specialty risk- bearing organizations, which would decrease the number of members attributed to us. We may not be reimbursed for members that payors fail to assign or attribute to us, which could result in lost margin and disruption to member care. Such a failure could materially reduce our revenues and have a material adverse effect on our business, financial condition, cash flows, and results of operations. Payors also regularly provide us an array of data associated with patients attributed to our physician partners, including information related to revenue and risk adjustment factors for our members, and details associated with amounts paid by payors for medical services rendered to our members. To the extent a payor does not provide us with **timely,** complete or accurate data ~~sets~~ related to our members, or if we are unable to effectively ingest the information that payors provide to us, we and our physician partners may not be able to effectively ensure our members' disease burdens are identified and may not be able to effectively operate our business **or forecast our expected profitability** . In addition, we are exposed to various risks related to our incentive programs with our payors, including those in which the payor typically has not delegated claims payment services to us. If our payors do not timely and accurately process claims and reimburse us for all covered members, are unable to contract with providers at market- based rates, change their utilization management methodologies, or are unable to secure an adequate network of specialists, our business, financial condition, cash flows, and results of operations could be adversely impacted. We are dependent on physician partners and other providers to effectively manage the quality and cost of care and perform obligations under payor contracts. Our success depends upon our continued ability to collaborate with and expand a network of high- caliber physician partners who can provide high quality of care, improve clinical outcomes and effectively manage healthcare costs, which are key drivers of our profitability. While the precise terms of each relationship vary, we do not ~~directly~~ employ our physician partners. Accordingly, our physician partners could demand an increased payment arrangement or take other actions, or fail to take actions, that could result in higher medical costs, lower quality of care for our

members, harm to our reputation or create difficulty meeting regulatory or other requirements. Likewise, our physician partners could take actions contrary to our instructions, requests, policies or objectives or applicable law, or could have economic or business interests or goals that are or become inconsistent with our own. Further, our physician partners may not engage with our platform **sufficiently** to assist in improving overall quality of care and management of healthcare costs, which could produce results that are inconsistent with our estimates and financial models and negatively impact our growth. In addition to receiving care from our physician partners, our members also receive care from an array of hospitals, specialists ~~and~~ **,** ancillary **, and other** providers who typically contract directly with our payors. Similar to our physician partner relationships, we do not ~~directly~~ employ providers from whom our members receive care. As such, we cannot guarantee the quality and efficiency of services from such providers, over which we have no control. Members who receive poor quality healthcare from such providers may be dissatisfied with our physician partners, which would have a negative impact on member satisfaction and retention. Any of these consequences could adversely impact our business, financial condition and results of operations. We could also experience significant losses if the expenses incurred to deliver healthcare services to our attributed members exceed revenues we receive from payors in respect of our attributed members. Under a capitation contract, a payor typically prospectively pays periodic capitation payments representing a prospective budget from which our physician partnerships manage healthcare expenses on behalf of the population enrolled with that physician partnership. To manage total medical services expense, we rely on our physician partners' ability to improve clinical outcomes, implement clinical initiatives to provide a better healthcare experience for our members and accurately and sufficiently document the risk profile of our members. While our contracts vary, generally, if the cost of medical care provided exceeds the corresponding capitation revenue we receive we may realize operating deficits, which are typically not capped, and could lead to substantial losses **or otherwise impair our profitability** . Difficulties in obtaining accurate and complete diagnosis data could have adverse consequences. The accurate and complete coding and documentation of diagnosis data underlying our members' existing disease conditions is important because our contracts with payors require the submission of complete and correct encounter data. Such data includes members' medical information, as documented by physicians, other medical professionals and hospitals, and is used by payors to attribute membership and reimburse healthcare providers for the services rendered. The accurate and complete coding and documentation of diagnosis is also important because the CMS risk adjustment model adjusts reimbursement for members with existing qualifying diagnoses. Additionally, in geographies in which payors adjudicate claim payments to the provider network, we rely on providers to submit accurate diagnosis information and other encounter data to payors. To the extent we or providers in our network fail to submit diagnosis data underlying our members' existing disease condition, we may receive less medical services revenue than is necessary to provide healthcare services for such members. Furthermore, we project our medical services revenue in part based upon the data submitted and expected to be submitted to CMS. Failure by us or our provider network to submit complete and accurate diagnosis information or encounter data may result in inaccuracies in our projections of medical services revenue, or in other estimation processes. We may be held liable for inaccuracies or deficiencies in the submitted encounter data and potentially could be subject to financial penalties imposed by government authorities and breach of contract claims by payors. We have experienced, and may in the future experience, challenges in obtaining complete and accurate encounter data due to difficulties with our internal compliance and monitoring systems receiving and processing data from multiple systems, with physicians and third- party vendors submitting claims in a timely fashion and in the proper format, and with payors properly recording and coordinating such submissions. We may not be successful in collecting accurate and complete encounter data, correcting inaccurate or incomplete encounter data and developing systems that allow us to receive and process data from multiple systems. Further, it may be prohibitively expensive or impossible for us to collect or reconstruct historical encounter data. We depend on physician partners to accurately, timely and sufficiently document their services, and their failure to do so could result in nonpayment for services rendered or allegations of fraud. If any diagnosis information or encounter data are inaccurate or incorrect, claims or encounter data submissions to payors may not be compliant, resulting in potential overpayments, possible recoupments and **possible** liability under the federal **FCA** ~~False Claims Act~~ or through RADV audits. Our revenue will be negatively impacted if our physician partners or our network providers, including hospitals and specialist physicians, fail to accurately, timely and sufficiently document their services or if our internal compliance and monitoring programs fail to ensure that documentation is complete, timely and accurate. We rely upon physician partners to accurately, timely and sufficiently complete medical record documentation and assign appropriate reimbursement codes for their services. We also rely on our internal compliance and monitoring systems to ensure that documentation is complete, timely and accurate. However, we do not ~~directly~~ employ or control our physician partners, and accordingly any adverse effects on us regarding their noncompliance with documentation requirements are uncertain and unpredictable. Reimbursement is conditioned upon, in part, physician partners providing the correct procedure and diagnosis codes and properly documenting the services themselves, including the level of service provided and the medical necessity for the services. If our affiliated physicians have provided incorrect or incomplete documentation or selected inaccurate reimbursement codes, or if our internal compliance and monitoring procedures to ensure complete, timely and accurate submission of data are ineffective, this could result in nonpayment for services rendered or lead to allegations of billing fraud. See " Business — Healthcare and Other Applicable Regulatory Matters — Health Care Fraud Statute. " In addition, CMS and the ~~U. S. Department of Health and Human Services (" HHS ")~~ Office of Inspector General perform audits of selected MA contracts related to risk adjustment diagnosis data. In these Risk- Adjustment Data Validation Audits (" RADV audits "), the government reviews medical records to determine whether physician medical record documentation and coding practices are compliant, which can result in the recovery of payments **and other monetary penalties** from managed care organizations if errors are identified and influence the calculation of premium payments by CMS to MA plans. Disclosure of any adverse investigation or audit results or sanctions could negatively affect our reputation and make it more difficult to attract members, physician partners and payors. Additionally, exception rates of existing documentation identified through a RADV audit may be extrapolated to an overall population of members attributed to a payor,

which may result in a reduction of our revenues. The DOJ has brought a number of investigations and actions under the federal **FCA** ~~False Claims Act~~ against both physicians and payors, including MA plans, for alleged falsification of diagnosis codes under the risk- adjustment methodology. The Medicare Risk Adjustment Factor (" RAF ") scores attributable to members determine, in part, the revenue to which health plans and, in turn, we are entitled for the provision of medical care to such members. The data submitted to CMS by each health plan is based, in part, on medical charts and diagnosis codes submitted to health plans. Each health plan generally relies on us and our physician partners to maintain accurate medical records and appropriately document clinical diagnoses associated with medical services provided to members. If our physician partners have provided incorrect or incomplete documentation or selected inaccurate reimbursement codes, or if our internal compliance and monitoring systems fail to ensure that documentation is complete and accurate, we could be subject to potential civil and criminal penalties, including exclusion from government healthcare programs, such as Medicare, that constitute a substantial percentage of our total revenues. Furthermore, in some proceedings involving MA plans, there have been allegations that certain financial arrangements with providers violate other fraud and abuse laws, such as the federal Anti- Kickback Statute. While we believe that our data recordation practices and relationships with providers comply with applicable laws and regulations, such arrangements may be subject to audits, reviews and investigation, ~~which~~ **and the government may disagree with our position. Furthermore, an audit, review or investigation** may result in substantial costs and may divert management' s attention and resources. A health plan may seek repayment from us should CMS make any payment adjustments as a result of its audits or hold us liable for any penalties owed to CMS for inaccurate or unsupportable RAF scores provided by us or our affiliated physicians. We could, further, be liable for substantial penalties to the government under the **FCA** ~~False Claims Act~~ for each false claim, plus up to three times the amount of damages caused by each false claim, which can be as much as the amounts received directly or indirectly from the government for each such false claim. In addition, payors may disallow, in whole or in part, requests for reimbursement based on determinations that certain amounts are not covered, services provided were not medically necessary, or supporting documentation was not adequate. Retroactive adjustments may change amounts realized from payors and result in recoupments or refund demands, affecting revenue already received. Any of these consequences of inaccurate data recordation could have a material adverse effect on our business, financial condition cash flows and results of operations. Furthermore, a health plan may be randomly selected or targeted for review by CMS and the outcome of such a review may result in a material adjustment in our revenue and profitability, even if the information we submitted to the plan is accurate and supportable. We rely on third- party software and data to operate our business and provide services to our members and physician partners, and any restrictions on our use of, or ability to license, such third- party resources could adversely affect our business, financial condition, cash flows, and results of operations. We rely on software licensed from third parties, as well as data received from third parties, including government agencies, in order to operate our business. These licenses are generally commercially available on varying terms. It is possible that the licenses and rights necessary to use the software and data necessary for the provision of our services may not continue to be available on commercially reasonable terms, or at all, or that our use of such software or data may be restricted. Our suppliers of data may increase restrictions on our use of such data, fail to adhere to our quality- control standards or otherwise satisfactorily perform services or otherwise change the terms upon which we can access such data. Any loss of the right to use or receive any of this software or data could significantly increase our expenses and otherwise result in delays in the provision of our services until supplemental data is able to be obtained, or equivalent technology is either developed by us, or, if available from another source, is identified, obtained and integrated. In the future, we may need to obtain additional licenses from third parties in connection with our growth into new geographies or provision of new or supplemental services, and such additional licenses may not be available on commercially reasonable terms, or at all. Furthermore, our use of additional or alternative third- party software or data requires us to enter into license agreements with third parties, and integration of new third- party software may require significant work and require substantial investment of our time and resources. Also, the software we license is complex and may contain errors or failures that are not detected until after the software is introduced or updated and new versions are released. In addition, it is possible that hardware failures or errors in the third- party software we use could result in data loss or corruption or cause the information to be incomplete or contain inaccuracies. Any undetected errors, defects or corruption in third- party software or data could prevent the deployment or impair the functionality of our software, delay new updates or enhancements to our services, result in a failure of our services and injure our reputation. We have limited control over such third- party providers, and these third parties may not continue to invest the appropriate levels of resources to maintain and enhance the capabilities of their software, continue to collect and disseminate relevant data, or even remain in business. Integration of software provided by various third parties is also less reliable than an owned, fully integrated network, which we do not have. Any failure or interruption in the services provided by these third parties could negatively impact our ability to operate, relationships with members and physician partners and adversely affect our business, financial condition, cash flows, and results of operations. We rely on third- party internet infrastructure and bandwidth providers for our operations, and any failure or interruption in the services provided by these third parties could negatively impact our ability to operate and our relationships with members and physician partners and adversely affect our business, financial condition, cash flows, and results of operations. Our ability to aggregate and evaluate member, physician partner, payor and other relevant data to facilitate our operations, including to process and adjudicate claims payments, provide data analytics and store data, depends on the development and maintenance by third parties of the internet infrastructure we use to operate our business. We rely on internal systems as well as third- party bandwidth and telecommunications equipment providers and other service providers to maintain and operate our internet- based services. This includes maintenance of a reliable network backbone with the necessary speed, data capacity, bandwidth capacity and security. Our services are designed to operate without interruption. However, we may experience future interruptions and delays in services and availability from time to time. In the event of an interruption or a catastrophic event with respect to one or more of the systems we use, we may experience an extended period of system unavailability, which could negatively impact our relationship with

members, physician partners and payors. To operate without interruption, both we and our service providers must guard against: • damage from fire, power loss, natural disasters and other events outside our control; • communications failures; • software and hardware errors, failures and crashes; • data security breaches, ransomware attacks, computer viruses, hacking, denial- of-service attacks and similar disruptions; and • other potential interruptions. If any of the foregoing occur, our reputation, operations and financial results may be materially adversely impacted. Further, any failure of or by the systems we use to handle the volume of use, either by us or others on such systems, or any increased volume of use, could significantly harm our business. We have limited control over our third- party internet infrastructure and bandwidth providers, and, as a result, limited ability to independently address problems with services they provide. Any errors, failures, interruptions or delays experienced in connection with these providers' services could negatively impact our relationships with members, physician partners or payors. ~~Risks Related to Our Industry and Government Programs~~ Consolidation in the healthcare industry could have a material adverse effect on our business, financial condition, cash flows, and results of operations. Many healthcare industry participants, including physician groups and payors, are consolidating to create larger and more integrated healthcare delivery systems with greater bargaining power, given their market share. We expect regulatory and economic conditions to result in additional consolidation. Physician groups or payors that have consolidated and are not already part of our network may try to use their increased bargaining power to negotiate better terms upon which to join our network. Consolidation may also result in the acquisition or future development by our partners or unaffiliated third parties of products and services that compete with us. Finally, consolidation may result in physician groups merging with, or being acquired by, each other or by health plans or other types of providers such as hospitals, and such groups may not have a need for our services which could reduce our market opportunity. Any of these potential results of consolidation could have a material adverse effect on our business, financial condition, cash flows, and results of operations. Substantially all of our total revenues relate to federal government healthcare programs, and reductions in their reimbursement rate or methodology applied to derive reimbursement, or discontinuation of such healthcare programs, would adversely affect our business, financial condition, cash flows, and results of operations. Substantially all of our total revenues relate to federal government healthcare coverage programs. The MA program accounted for substantially all of our revenues for our immediately preceding fiscal years. ~~Additionally, we began participating in the Direct Contracting Model in April 2021.~~ While the ~~DCE~~ **ACO** ' s are not consolidated, they still have an impact on our profitability ~~. Additionally, in February 2022, the CMS Innovation Center announced that it is redesigning the Direct Contracting model and renaming it the ACO REACH Model. The CMS Innovation Center concurrently introduced a Request for Applications (" RFA ") for a new cohort to begin the model on January 1, 2023, and it announced that all current Direct Contracting model participants that meet ACO REACH requirements would be permitted to continue participating in the ACO REACH model as ACOs. The ACO REACH requirements outlined thus far include the development and implementation of a robust health equity plan to identify and better serve underserved communities; the requirement that at least 75 % control of each ACO' s governing body be held by participating providers or their designated representatives (compared to 25 % during the first two Performance Years of the Direct Contracting model); and the requirement that there be at least two beneficiary advocates on the governing board (at least one Medicare beneficiary and at least one consumer advocate), both of whom must hold voting rights. We began our participation in the ACO REACH Model in January 2023, and these new requirements have not had a material impact on our current or future participation in this program, or inhibited our ability to continue and grow our participation in the model. In addition, the CMS Innovation Center announced that ACO REACH would include technical adjustments to the model' s parameters, including changes to benchmark calculations. The overall effect of these changes has been minimal thus far~~ . The policies and decisions made by the federal government regarding these programs have a substantial impact on our profitability. We cannot predict changes to these programs, and we may be unable to adapt our business to such changes, either at all or in relation to our competitors. On an annual basis, CMS issues a final rule to establish the MA county-level benchmark payment rates for the following calendar year. Rates we receive from payors may be reduced as a result of annual reimbursement changes, changes to the risk- adjustment methodology (including revisions to the FFS normalization rate, coding intensity adjustment or other elements of the methodology) for the services we provide or other changes to the CMS reimbursement model. Any reductions in rates that we receive from payors could have a significant adverse impact on our revenue and financial results. We cannot predict the nature of future changes. The final impact of the MA rates can vary from any estimate we may have and may be further impacted by the relative growth of our MA patient volumes across markets as well as by the benefit plan designs submitted by the health plans. It is possible that we may underestimate the impact of the changes in MA rates on our business, which could have a material adverse effect on our business, financial condition, cash flows, and results of operations. In addition, our MA revenues may continue to be volatile in the future, which could have a material adverse impact on our business, financial condition, cash flows, and results of operations. The rates we or our payors pay to physician partners are generally based on the Medicare FFS schedule, which is subject to change and outside our control. Increases in the Medicare FFS schedule could cause us or our payors to modify our physician partner reimbursement methodology in ways that we cannot predict, which would result in increases to our medical services expenses. There are sometimes wide variations in the established reimbursement rates per member as a result of, among other things, members' risk status, acuity levels and age, plan benefit design and geography. As the composition of our membership base changes, due to programmatic, competitive, regulatory, benefit design, economic or other changes, there is a corresponding change to our premium revenue, costs and margins, which could have a material adverse effect on our business, financial condition, cash flows, and results of operations. The financial aspects of the ACO REACH Model are set forth in an agreement between the ACO and CMS. CMS has the right to amend the agreement without the consent of the ~~DCE~~ **ACO** for good cause or as necessary to comply with applicable federal or state law, regulatory requirements, accreditation standards or licensing guidelines or rules. We cannot predict whether CMS will amend such agreements and, if CMS amends such agreements, the impact such amendments may have on the financial aspects of our participation in the model, including, but not limited to, risk adjustment

models used to set benchmarks, the rate book, capitation payment mechanisms and the calculation of shared savings and losses. Furthermore, changes to Medicare (including the ACO REACH Model) or MA, such as if CMS were to scale back models or cut MA payments, could have a significant adverse impact on our membership levels, revenue and financial results. Changes in individual plan dynamics, such as changes in benefits provided by the payors, premiums charged by the payors or our payors' STAR ratings, could also adversely impact us. Uncertain or adverse economic **and macroeconomic** conditions, including a downturn or decrease in government expenditures, could have a material adverse effect on our business, financial condition, cash flows, and results of operations. Historically, government budget limitations have resulted in reduced spending. The existing federal deficit and continued deficit spending by the federal government and significant economic pressure on state budgets have the potential to lead to reduced government expenditures, including for government- funded programs in which we participate such as Medicare. Any sustained failure to identify and respond to these trends could have a material adverse effect on our business, financial condition, cash flows, and results of operations. Unfavorable economic conditions could also impact enrollment in MA plans with our payors, cause our payors to change the benefits structure that is offered to our members or weaken our ability to raise additional capital on acceptable terms. For example, unfavorable economic conditions could cause our payors to reduce the benefits that are offered to our members and could result in the cancellation by certain members of our payors' products and services, which would reduce our overall membership, premiums and fee revenues. Any reduction in membership, premiums or fee revenues would, in turn, adversely affect the financial position of physician practice groups **. In addition, the current macroeconomic environment is characterized by high inflation, supply chain challenges, labor shortages, high interest rates, foreign currency exchange volatility and volatility in global capital markets. Such adverse macroeconomic conditions may also affect our physician partners' or payors' operations and financial condition, which may in turn cause our physician partners or payors to elect not to renew their services agreements or affect their ability to pay amounts owed to us in a timely manner or at all, or adversely affect prospective partners' or payors' ability or willingness to enter into services agreements with us** . We operate in a competitive industry, and if we are not able to compete effectively, our business, financial condition, cash flows, and results of operations will be harmed. Our industry is competitive and we expect it to attract increased competition, which could make it difficult for us to succeed. We currently face competition in various aspects of our business, including in offering a favorable reimbursement structure for physician partners and potential physician partners and attracting payors and physician partners who are not contracted with us, from a range of companies that provide a Total Care Model under different care models that could attract patients, providers and payors, including hospitals, managed service organizations and provider networks and data analysis consultants. Further, individual physicians who are contracted within our network may affiliate with our competitors. Competition from hospitals, managed service organizations and provider networks and data analysis consultants, payors and other parties could result in payors changing the benefit structure that is offered to our members, which could negatively impact our profitability and market share. **We compete against other providers of value- based care** ~~Our primary competitors include ChenMed, Oak Street Health, Optum and VillageMD~~ , in addition to numerous local provider networks, hospitals and health systems. Moreover, large, well- financed payors have in some cases developed their own managed services tools and may provide these services to their physicians and patients at discounted prices, or may seek to expand their relationships with additional competing physicians or physician networks, including in geographic areas we serve. This may result in a more competitive environment and increased challenges to grow at the rates we have projected. We expect that competition will continue to increase as a result of consolidation in the healthcare industry and increased demand for a Total Care Model. Some of our competitors may have greater name recognition, particularly in local geographies, longer operating histories, superior products or services and significantly greater resources than we do. Further, our current or potential competitors may be acquired by or partner with third parties with greater available resources than we have. As a result, our competitors may be able to respond more quickly and effectively than we can to new or changing opportunities, technologies, standards or customer requirements and may have the ability to initiate or withstand substantial benefits structure and premium competition. In addition, current and potential competitors have established, and may in the future establish, cooperative relationships with providers of complementary services, technologies or services to increase the attractiveness of their services. Accordingly, new competitors or alliances may emerge that have greater market share, a larger customer base, better data aggregation systems, greater marketing expertise, greater financial resources and larger marketing teams than we have, which could put us at a competitive disadvantage. Our competitors could also be better positioned to serve certain segments of the healthcare delivery industry, which could create additional pressure on the premiums that our payors are able to charge. If we are unable to successfully compete, our business, financial condition, cash flows, and results of operations could be materially adversely affected. Our compensation and reputation are dependent on government performance standards and benchmarks, some of which depend on factors outside our control. We contract with payors that participate in government healthcare programs and, as a result, are required to satisfy certain conditions, performance standards and benchmarks which we may not be able to control. For example, as part of the ACA, the level of reimbursement each MA plan receives from CMS is dependent, in part, upon the quality rating of the plan. Such ratings impact the percentage of any cost savings rebate and any bonuses earned by such health plan. The CMS STAR rating system considers various measures, including, among others, quality of care, preventive services, chronic illness management and customer satisfaction. Agreements with certain of our payors may condition amounts paid to us based upon improvements to contracted payors' STAR ratings. ~~Certain flexibilities~~ **Further, on April 12, 2023 CMS published a Final Rule (the " 2023 Final Rule ")** that ~~allowed plans to score higher on STAR ratings to counteract financial pressures caused by the COVID- 19 pandemic are no longer in effect. Further, the 2022 Proposed Rule~~ sets forth several ~~proposals~~ **provisions** that would, among other things, impact the STAR ratings program, including: (i) developing a health equity index to reward contracts that obtain a high measure- level score for the subset of enrollees with specified social risk factors, (ii) reducing the weight of patient experience / complaints and access measures, and (iii) removing select measures. If we are not eligible for quality bonuses or if we contract with payors who

experience a reduction in their STAR ratings, we may experience a negative impact on our revenues, which could materially and adversely affect the marketability of our platform, partnership and network model to physicians, our membership levels and our business, financial condition, cash flows, and results of operations. Further, our payors' STAR ratings are based on the services they provide to their overall contracted attributed membership in a defined geography. As a result, even if we effectively engage and manage our membership, changes in such payors' STAR ratings are outside our control. Furthermore, CMS has terminated MA plans that have had a low- quality rating for three consecutive years. Low- quality ratings can potentially lead to the termination of certain plans with which we contract, or a shifting of beneficiaries to alternative plans with higher STAR ratings, which could in turn have a material adverse effect on our business, financial condition, cash flows, and results of operations. Government funding for healthcare programs is subject to statutory and regulatory changes, administrative rulings, interpretations of policy and determinations by intermediaries and governmental funding restrictions, all of which could materially impact program coverage and reimbursements for both institutional and professional services. The healthcare industry in the ~~United States~~ **U. S.** is undergoing significant structural change and is rapidly evolving. Such changes could ultimately result in substantial changes in Medicare coverage and reimbursement, as well as changes in coverage or amounts paid by private payors, which could have an adverse impact on our revenues from those sources. The frequent enactment of, changes to or interpretations of laws and regulations relating to healthcare could, among other things: force us to restructure our relationships with payors and physician partners within our network; require us to implement additional or different programs and systems; restrict revenue and member growth; increase our medical and administrative costs; impose additional capital and surplus requirements; increase or change our liability to members in the event of malpractice by our physician partners and potentially increase, or add new, criminal, civil and administrative penalties that could be imposed on us in the event our operations were found to be non- compliant with new or existing laws and regulations. In addition, changes in political party or administrations at the state or federal level may change the attitude towards healthcare programs and result in changes to the existing legislative or regulatory environment. Government funding for healthcare programs is subject to statutory and regulatory changes, administrative rulings, interpretations of policy and determinations by intermediaries and governmental funding restrictions, all of which could materially impact program coverage and reimbursement levels. Various legislative, judicial and executive efforts have made the status of federal healthcare program funding and many other aspects of the U. S. healthcare system, particularly the status of reforms implemented under the ACA, unclear. Budget pressures often lead the federal government to reduce or impose limitations on reimbursement rates, which has in the past resulted, and could in the future result, in substantial reductions in our revenue and operating margins. There is also uncertainty regarding both MA payment rates and beneficiary enrollment, which, if reduced, would adversely affect our overall revenues and net income. Each year, CMS issues a final rule to establish the MA benchmark payment rates for the following calendar year. Any reduction to such benchmark rates may have a material adverse effect on our business, financial condition, cash flows, and results of operations. We may be further impacted by the relative growth of our MA patient volumes across geographies. However, MA enrollment may not continue to grow at the same rate it has over the last decade. Further, we may not capture a material portion of enrollments, particularly since MA enrollment is increasingly concentrated amongst a small group of payors. Uncertainty over MA payment rates and enrollment presents a continuing risk to our business, particularly in recent years, as MA payment rates have been subjected to increased scrutiny. We are unable to determine how any future federal spending cuts or other industry changes and reform will affect Medicare reimbursement and, accordingly, our business. There likely will continue to be legislative and regulatory proposals at the federal level directed at containing or lowering the cost of healthcare that, if adopted, could have a material adverse effect on our business, financial condition, cash flows, and results of operations. Our inability to keep pace with changes in government regulations and the healthcare industry could constrain our ability to grow and could have a material adverse effect on our business, financial condition, cash flows, and results of operations. Regulatory proposals directed at containing or lowering the cost of healthcare, including the ~~Direct Contracting~~ **ACO REACH** Model, and our participation, voluntary or otherwise, in such proposed models, could impact our business, financial condition, cash flows and operations. The CMS Innovation Center continues to test an array of alternative payment models that could impact our business, financial condition, cash flows and operations. For example, the CMS Innovation Center has created the ~~Direct Contracting~~ **ACO REACH** Model to allow a variety of different organizations called ~~DCEs~~ **ACOs** to negotiate directly with the government to manage traditional Medicare beneficiaries and share in the savings and losses generated from managing such beneficiaries. We, in conjunction with some of our physician partners, began participating in the ~~Direct Contracting~~ **ACO REACH** Model in certain geographies in ~~2021~~ **2023** . The ~~Direct Contracting~~ **ACO REACH** Model' s economic structure, including risk adjustment methodologies, quality reporting and model timelines, has been built upon CMS' experience with other programs, including MA and the Medicare Shared Savings Program, but also has new elements, such as a risk adjustment model developed specifically for use in the ~~Direct Contracting~~ **ACO REACH** Model. Likewise, the ~~Direct Contracting~~ **ACO REACH** Model rate book is based on the same methodology used for the MA rate book but has been modified in light of the characteristics of the ~~Direct Contracting~~ **ACO REACH** Model. Because the ~~Direct Contracting~~ **ACO REACH** Model is a new and evolving program, we are unable to determine how the ~~Direct Contracting~~ **ACO REACH** Model, or other alternative payment models promulgated by the CMS Innovation Center, will affect Medicare reimbursement and capitation benchmarks. For example, if the CMS Innovation Center fails to ensure the long- term predictability of revenue under the ~~Direct Contracting~~ **ACO REACH** Model, such reimbursement instability could adversely impact our business, financial condition, cash flows and operations. Additionally, if the CMS Innovation Center fails to streamline incentive program requirements for physicians across payment models, such conflicting requirements may impose additional compliance burdens on our affiliated physician partners' practices, which may have a material adverse effect on process, quality and efficiency. We are unable to predict how states will regulate ~~DCEs~~ **ACOs** and our participation in the ~~Direct Contracting~~ **ACO REACH** Model. For example, certain states in which we operate may require ~~DCEs~~ **ACOs** to obtain specific licensure to participate in the ~~Direct Contracting~~ **ACO REACH** Model and

assume risk directly from CMS, which may require us to maintain certain levels of tangible net equity, meet working capital requirements, or expend significant resources on operational development. Alternatively, CMS may choose to limit additional new ~~DCE~~ **ACO** entrants in future years to those who attend to underserved communities or are controlled by provider entities ~~. Additionally, in February 2022, the CMS Innovation Center announced that it is redesigning the Direct Contracting model and renaming it the ACO REACH Model. The CMS Innovation Center concurrently introduced a RFA for a new cohort to begin the model on January 1, 2023, and it announced that all current Direct Contracting model participants that meet ACO REACH requirements would be permitted to continue participating in the ACO REACH model as ACOs. The ACO REACH requirements outlined thus far include the development and implementation of a robust health equity plan to identify and better serve underserved communities; the requirement that at least 75 % control of each ACO' s governing body be held by participating providers or their designated representatives (compared to 25 % during the first two Performance Years of the Direct Contracting model); and the requirement that there be at least two beneficiary advocates on the governing board (at least one Medicare beneficiary and at least one consumer advocate), both of whom must hold voting rights. We began our participation in the ACO REACH Model in January 2023, and these new requirements have not had a material impact on our current or future participation in this program, or inhibited our ability to continue and grow our participation in the model. In addition, the CMS Innovation Center announced that ACO REACH would include technical adjustments to the model' s parameters, including changes to benchmark calculations. The overall effect of these changes has been minimal thus far~~ . There likely will continue to be regulatory proposals directed at containing or lowering the cost of healthcare that, if adopted, could have a material adverse effect on our business, financial condition, cash flows, and results of operations, including with respect to our contractual relationships with providers and payors. We, as well as our physician partners and affiliates, have in the past, and could in the future, be subject to federal and state investigations, audits and enforcement actions. ~~Expansion of federal~~ **Federal** , state and payor enforcement activity could adversely affect our business, financial condition, cash flows, and results of operations. Due to our payors' participation in government and private healthcare programs, we are from time to time involved in inquiries, reviews, audits and investigations by governmental agencies and private payors of our business practices, including assessments of our compliance with coding, billing and documentation requirements and compliance with rules governing delegation of insurance functions, ranging from claims management to utilization review. In this regard, both federal and state government agencies have active civil and criminal enforcement efforts against healthcare companies and their executives and managers. These investigations could also be initiated by private whistleblowers. Responding to audit and investigative activities can be costly and disruptive to our business, even when the allegations are without merit. If we are subject to an audit or investigation, a finding could be made that we have violated relevant state or federal legal standards in our operations or in how we have structured our arrangements and relationships or that we or our affiliates have erroneously billed or were incorrectly reimbursed. At the conclusion of such audits or investigations, we may be required to repay such agencies or payors, and may be subjected to pre- payment reviews, which can be time- consuming and result in non- payment or delayed payments for the services we or our affiliates provide. We may also be subject to financial sanctions **, exclusion,** or **may be** required to modify our operations. Investigations, audits or enforcement actions with respect to our physician partners could have an adverse effect on us. We do not directly employ or control our physician partners, and accordingly any adverse effects on us regarding such government activities are outside our control and are uncertain and unpredictable. We may be subject to regulatory inquiries and corrective action plans imposed by our payors and may be required to contribute a material amount of risk- bearing capital to our local operating subsidiaries. We may be subject to regulatory inquiries and corrective action plans imposed by our payors and we may be audited by payors and regulatory bodies. In some cases, payors and regulatory bodies have required us to contribute a material amount of risk- bearing capital to our local operating subsidiaries in the form of letters of credit or restricted deposits, and we expect that payors and regulatory bodies will continue to require us to contribute risk- bearing capital going forward. There is also a risk that such risk- bearing capital amounts may be increased in the future as a result of regulatory changes, changes in performance by our local operating subsidiaries and physician partners and expansion of our business. Repayment obligations arising out of payor audits, such as CMS RADV audits, can be significant and adversely impact reimbursement rates. Our payors are subject to audit by government health plans, including, but not limited to, CMS, in connection with the MA program. CMS and the HHS Office of Inspector General perform RADV audits, which can result in the recovery of payments from managed care organizations if errors are identified and influence the calculation of premium payments by CMS to MA plans. In addition, certain of our payor contracts incorporate language that enables payors to recoup funding from us in the event that CMS requires payment under ~~an~~ **a** RADV audit. As a result of such audits and contracts, our payors may demand recoupments or adjustments from us, bring recovery proceedings against us, require us to submit and implement corrective action plans, or terminate agreements with our physician partners. The results of RADV audits could also adversely impact the compensation we receive from payors, which could have a material adverse effect on our revenue. Disclosure of any adverse audit results could also negatively affect our reputation and make it more difficult to attract members, physician partners and payors. CMS may modify the methodology utilized to determine revenue associated with MA members, including but not limited to the CMS Risk Adjustment Processing System for calculating risk adjustment factors, which could adversely impact us. Changes to how CMS calculates revenues associated with MA members, as well as members' risk adjustment factors under the MA program, could adversely impact our revenues or understate risk adjustment factors for our members, causing us to be underpaid relative to expenses incurred, especially for members with severe or chronic medical conditions. CMS is currently phasing in the process of calculating risk adjustment factors using diagnosis data from the Encounter Data System (" EDS ") rather than using diagnosis data from the CMS Risk Adjustment Processing System (" RAPS "). The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. Conversely, the EDS process requires MA plans to submit all encounter data, and CMS will apply the risk adjustment filtering logic to determine the risk adjustment factors. The phase- in from RAPS to EDS could result in different

risk adjustment factors from each dataset as a result of plan processing issues, CMS processing issues and filtering logic differences between RAPS and EDS. Such changes in risk adjustment factors could have a material adverse effect on our business, financial condition, cash flows, and results of operations. CMS may annually adjust other components of the methodology utilized to determine revenues associated with MA members, including but not limited to the fee for service normalization factor, coding intensity adjustment or corridors utilized to determine calculations contributing to rebate amounts or STAR ratings. Such revisions could result in a reduction of our revenues. Our revenues could be further reduced by budget reconciliation bills, which could increase the MA coding intensity adjustment. Negative publicity regarding the managed healthcare industry generally could adversely affect our results of operations or business. Negative publicity regarding the managed healthcare industry generally, or the MA program in particular, may result in increased regulation and legislative review of industry practices that further increase our costs of doing business and adversely affect our results of operations or business by: • requiring us to change our platform and services; • increasing the regulatory, including compliance, burdens under which we operate, which, in turn, may negatively impact the manner in which we provide services and increase our costs; • adversely affecting our ability to market our services through the imposition of further regulatory restrictions regarding the manner in which plans market to MA enrollees; or • adversely affecting our ability to attract and retain physician partners and have patients attributed to those physician partners. ~~Legal and Regulatory Risks~~ The healthcare industry is heavily regulated at the federal, state and local levels and government authorities may determine that we fail to comply with applicable laws or regulations and take actions against us. As a company involved in the healthcare industry with substantially all of our revenue derived from government programs, our business activities are subject to substantial governmental regulation. There are significant costs involved in complying with these laws and regulations. If we are found to have violated any applicable laws or regulations, we could be subject to civil or criminal damages, fines, sanctions or penalties, including exclusion from participation in government healthcare programs, such as Medicare, and we may be required to change our method of operations and business strategy. These consequences could be the result of our prior or current conduct, and prior to existing physician partners joining our network. We have in the past incurred, and may in the future incur, significant costs to defend ourselves if we become the subject of an investigation or legal proceeding alleging a violation of these laws and regulations. A federal, state or local government could determine that we are not operating in accordance with the law. Further, it is unknown, whether, when or how the laws, or the interpretation thereof, will change in the future and impact our business, financial condition, cash flows, and results of operations. In addition, some of the governmental and regulatory bodies that regulate us may consider enhanced or new regulatory requirements or may seek to exercise their supervisory or enforcement authority in new or more robust ways. Any of these possibilities, if they occur, could adversely affect us. Our operations are subject to extensive federal, state and local government laws and regulations, such as: • Federal and state laws, and related regulations, including the ~~CMPL~~ **fraud and abuse laws such as the FCA and Health Care Fraud Statute** , which impose civil and criminal liability on individuals or entities that knowingly submit false or fraudulent claims for payment, or knowingly make, or cause to be made, a false statement in order to have a false claim paid, including qui tam or whistleblower suits, and impose civil monetary penalties on entities that fail to disclose and repay known overpayments; • Federal and state anti- kickback laws, and related regulations, which generally prohibit ~~transactions~~ **arrangements** intended to induce or reward referrals for items or services reimbursable by a ~~federal~~ healthcare program; • Federal and state physician self- referral prohibition statutes, and related regulations, which generally prohibit physicians from referring a patient to an entity providing **certain** DHS if the physician (or his / her immediate family member) has a financial relationship with that entity; • Provisions of, and regulations enacted pursuant to, HIPAA, as amended, HITECH, and the American Recovery and Reinvestment Act of 2009, as well as similar or more stringent state laws, regarding the collection, use and disclosure of health information; • Provisions of, and regulations enacted pursuant to, the 21st Century Cures Act, regarding interoperability and prohibitions against information blocking; • Federal laws and regulations that require providers to enroll in the Medicare program before submitting any claims for services, to promptly report certain changes in operations to the agencies that administer these programs, and to re- enroll in these programs when changes in direct or indirect ownership occur or in response to revalidation requests from Medicare; • Federal and state laws that govern managed care organizations, such as our payors, and downstream contracted entities, such as our RBEs, including laws governing timely payment of claims, quality assurance, utilization review, credentialing, financial solvency, downstream transfers of risk and payor- provider contractual relationships; • State laws that govern the activities of third- party administrators and utilization review agents; **• Laws relating to competition and anticorruption;** and • State laws that prohibit general business entities from practicing medicine, controlling physicians' medical decisions or engaging in certain practices, such as splitting fees with physicians. These and other healthcare laws and regulations that may affect us are further described in " Business — Healthcare and Other Applicable Regulatory Matters " in Item 1. The laws and regulations applicable to our business are complex, changing and often subject to varying interpretations. As a result, we may not be able to adhere to all applicable laws and regulations. Any violation or alleged violation of any of these laws or regulations by us or our affiliates, or our physician partners or payors, could have a material adverse effect on our business, financial condition, cash flows, and results of operations. We may in the future be a party to various and material lawsuits, demands, claims, qui tam suits, government investigations and audits **or government enforcement actions** , of which any could result in, among other things, substantial financial penalties or awards against us, reputational harm, termination of relationships or contracts related to our business, mandated refunds, substantial payments made by us, required changes to our business practices, exclusion from future participation in Medicare and other healthcare programs and possible criminal penalties. If we are found in violation of applicable laws or regulations, we could suffer severe consequences that would have a material adverse effect on our business, results of operations, financial condition, cash flows, reputation and stock price, including: • suspension or termination of our participation in federal **or state** ~~healthcare~~ ---- **health care** programs; • criminal or civil liability, fines, damages or monetary penalties for violations of healthcare fraud and abuse laws, including the federal ~~False Claims Act~~ **FCA, Healthcare Fraud Statutes** , CMPL, Anti- Kickback Statute and Stark Law;

• enforcement actions by governmental agencies or claims for monetary damages by patients under federal or state patient privacy laws, including HIPAA; • enforcement actions by governmental agencies or monetary penalties for violations of the 21st Century Cures Act; • repayment of amounts received in violation of law or applicable payment program requirements, and related monetary penalties; • mandated changes to our practices or procedures that materially increase operating expenses; • imposition of corporate integrity agreements that could subject us to ongoing audits and reporting requirements as well as increased scrutiny of our billing and business practices; • termination of various relationships or contracts related to our business; and • harm to our reputation which could negatively affect our business relationships, decrease our ability to attract or retain patients and physicians, decrease access to new business opportunities and impact our ability to obtain financing, among other things. Responding to lawsuits and other proceedings as well as defending ourselves in such matters **may** ~~will continue to~~ require management' s attention and cause us to incur significant legal expense. It is also possible that criminal proceedings may be initiated against us or individuals in our business in connection with investigations by the federal government. We rely on our physician partners to comply with certain laws or regulations, including licensure and certification requirements to provide healthcare services, operate facilities or administer pharmaceuticals in the states in which we conduct business, and billing and coding compliance with respect to the provision of services. Although we provide some high- level training, and, if needed, supplemented clinical or coding staff as appropriate, to ensure that all health conditions are assessed and sufficiently documented by our physician partners and network providers, and we perform audits on this process, we do not as a general matter supervise or control our physician partners or network providers; accordingly, any adverse effects on us regarding their noncompliance are uncertain and unpredictable. If our physician alignment strategies with our physician partners — including the formation of risk and shared savings pools, making downstream payments and joint venture arrangements — are not in compliance with the state and federal fraud and abuse laws, including physician incentive plan laws and regulations, we could be subject to penalties. A central component of our clinical and operational strategy is to encourage alignment with our physician partners so as to incentivize them to increase the quality of care while appropriately managing overall costs and participate in various care management and care coordination programs. Such alignment is often achieved through the design of risk or other incentive pools, with gating quality metrics that participating physicians must first satisfy before being allowed to share in cost savings. In other instances, we may support the delivery of care through a number of means, such as the provision of additional capital to improve and enhance the delivery of quality of care and improve access to quality care or by entering into a joint venture with a physician partner and other healthcare entities. All such arrangements can implicate, and must be structured to be in compliance with, all applicable federal and state fraud and abuse laws including the federal Anti- Kickback Statute and the Stark Law. See " Business — Healthcare and Other Applicable Regulatory Matters — Federal and State Anti-Kickback Statutes " and " Business — Healthcare and Other Applicable Regulatory Matters — Stark Law " in Item 1. The laws and regulations are complex ~~,~~ and ~~we~~ **the interpretations of those laws continue to expand and evolve. We** may not be successful in structuring our arrangements in compliance with them. Should government regulatory or enforcement authorities find any arrangement to be out of compliance with such laws or regulations, then criminal, civil and administrative penalties could be imposed on us or on our physician partners and affiliated entities. In addition, all such arrangements can implicate, and must be structured in compliance with, state and federal laws and regulations that prohibit payors and their downstream entities from linking physician incentives to reducing or limiting necessary medical services to patients. Violation of such laws or regulations can subject payors to significant civil monetary penalties, as well as possible sanctions, such as suspension of the payor' s enrollment of patients, suspension of communication activities to potential patients and exclusion from government healthcare programs. Our failure to comply with these laws could cause us to be in breach of our agreements with payors, which could lead to significant financial penalties or termination of our contracts with payors, all of which could materially and adversely affect our business, financial condition, cash flows, and results of operations. Our business development and member engagement activities may implicate laws and regulations regarding marketing, beneficiary inducements, telemarketing and use of protected health information. Medicare product marketing and sales activities are regulated by CMS and the states in which we operate. Medicare Managed Care marketing requirements are outlined in the Medicare Marketing Guidelines, a sub-regulatory guidance document updated annually. CMS has oversight over all MA marketing materials and outreach activities. To maintain appropriate beneficiary safeguards while not impeding the physician- patient relationship, the Medicare Marketing Guidelines set forth acceptable activities in the healthcare setting. For example, payors may not allow contracted physicians to accept / collect scope of appointment forms but may allow contracted physicians to make available communication materials regarding MA plans in areas where care is being delivered. Notably, **the** ~~CMS' s 2022~~ **2023** ~~Proposed~~ **Final** Rule includes, among other things, significant new MA marketing requirements and modifications. ~~CMS' s proposals~~ **The 2023 Final Rule provisions** are a response to increased congressional and press attention to MA marketing practices, including a 2022 ~~US~~ **U. S.** Senate Finance Committee report that detailed deceptive marketing practices by MA plans; the report urged CMS to take action to protect Medicare beneficiaries. The ~~2022~~ **2023** ~~Proposed~~ **Final** Rule includes ~~more than 20~~ distinct changes to the marketing regulations as well as broad- ranging ~~proposals~~ **provisions** that address potentially misleading advertising **and require heightened broker oversight** . In addition, through our participation in the CMS **ACO REACH** ~~Innovation Center Direct Contracting~~ Model, we (either as ~~a DCE~~ **an ACO** or as a service provider to our physician partners who are participating in the model) must comply with provisions in the participation agreements with CMS regarding marketing and outreach activities. For example, ~~DCEs~~ **ACOs** must have their plans for marketing activities approved by CMS and are prohibited from engaging in some forms of marketing activities such as door- to- door solicitation. Similarly, state laws governing managed care organizations also address allowable marketing and enrollee communication practices. Marketing and outreach activities undertaken in the healthcare industry — whether undertaken by or on behalf of providers and payors — are subject to a complex web of laws and regulations designed to prevent fraud and abuse. See " Business — Healthcare and Other Applicable Regulatory Matters — Federal and State Anti- Kickback Statutes " and " Business — Healthcare and Other Applicable

Regulatory Matters — Civil Monetary Penalties Statute ” in Item 1. Our physician partners and the payors with which we contract risk violating applicable state and federal fraud and abuse laws — including the Anti- Kickback Statute and CMPL — and laws governing marketing and member outreach (e. g., the Medicare Marketing Guidelines). Failure to comply with such laws can lead to severe penalties, including sanctions, fees, civil monetary penalties, imprisonment and exclusion from participation in federal healthcare programs. The imposition of such penalties against our physician partners or the payors with which we contract, could have a material adverse effect on our business, financial condition, cash flows, and results of operations. Our business development and member engagement activities may implicate the TCPA, related Federal Communication Commission (“ FCC ”) orders and analogous state laws which impose significant restrictions on the ability to utilize telephone calls and text messages to mobile telephone numbers as a means of communication, when the prior consent of the person being contacted has not been obtained. See “ Business — Healthcare and Other Applicable Regulatory Matters — Consumer Protection Laws ” in Item 1. A determination that we, one of our affiliates, one of our vendors or one of our physician partners violated the TCPA or other communications- based statutes could expose us to significant damage awards that could, individually or in the aggregate, materially harm our business, financial condition, cash flows, and results of operations. Certain failures by our physician partners to comply with these laws could have an adverse effect on us. We do not directly employ or control our physician partners, and accordingly any adverse effects on us regarding their noncompliance are uncertain and unpredictable. These activities also implicate privacy laws, such as HIPAA and analogous state laws, which limit how we and our affiliates can use an individual’ s PHI in connection with marketing activities and member outreach activities. A violation of such laws could subject us to significant penalties. Our physician partners are subject to federal and state healthcare fraud and abuse laws and regulations. Our physician partners are subject to various federal and state laws pertaining to healthcare fraud and abuse, including, among others, the federal Anti- Kickback Statute, Stark Law and **FCA** ~~False Claims Act~~ and analogous state laws. See “ Business — Healthcare and Other Applicable Regulatory Matters ” in Item 1. Violations of these laws can occur under many different circumstances, including, for example, if a physician partner is engaging in prohibited financial and referral relationships with other physicians or providers; is improperly documenting and coding for services; is making prohibited internal referrals for certain services covered by the Stark Law or analogous state laws or is providing benefits to induce patients to self- refer. Depending on the circumstances, violations of these laws can be punishable by criminal and civil sanctions, including exclusion from participation in federal and state healthcare programs, as well as significant potential monetary liabilities. Should government authorities find that our physician partners have violated applicable law or regulations, our physician partners could be subject to criminal and civil penalties that could adversely affect our reputation and have a material adverse effect on our business, financial condition, cash flows, and results of operations. In addition, our physician partners are subject to federal, state and local licensing regulations relating to, among other things, professional credentialing, the ability to practice medicine, professional ethics and prescribing medication and controlled substances. See “ Business — Healthcare and Other Applicable Regulatory Matters — Other Laws and Regulations ” in Item 1. If our physician partners fail to obtain and maintain all necessary licenses, certifications, accreditations and other approvals and operate in compliance with applicable healthcare and other laws, their ability to provide medical services to members would be impaired. Given our reliance on anchor physician practices in some geographies, such noncompliance could materially and adversely affect our business, financial condition, cash flows, and results of operations. We do not directly employ or control our physician partners, and accordingly any adverse effects on us regarding their noncompliance with laws and regulations are uncertain and unpredictable. Our use, disclosure and processing of personally identifiable information, PHI, and de- identified data is subject to HIPAA and state patient confidentiality laws, and our failure to comply with those regulations or to adequately secure the information we hold could result in significant liability or reputational harm and, in turn, cause a material adverse effect on our members ~~and~~ **,** revenue **, and operations** . Numerous state ~~and~~ **,** federal **, and international** laws and regulations govern the collection, dissemination, use, privacy, confidentiality, security, availability, integrity and other processing of PHI and, more broadly, personally identifiable information whether or not related to healthcare. These laws and regulations include HIPAA, as amended by the HITECH Act. HIPAA establishes a set of national privacy and security standards for the protection of PHI by health plans, healthcare clearinghouses and certain healthcare providers, referred to as covered entities, and the business associates with which such covered entities contract for services. Components of our business are considered “ covered entities ” under HIPAA and others are considered “ business associates ” of our healthcare partners and payors. HIPAA requires covered entities and business associates to develop and maintain policies and procedures with respect to PHI that is used or disclosed, including the adoption of administrative, physical and technical safeguards to protect such information. HIPAA also implemented the use of standard transaction code sets and standard identifiers that covered entities must use when submitting or receiving certain electronic healthcare transactions, including activities associated with the billing and collection of healthcare claims. In addition to federal regulations issued under HIPAA, ~~some~~ **several** states have enacted their own data privacy and security statutes or regulations that govern the use and disclosure of a person’ s health information or records. Such state laws, if more stringent than HIPAA requirements, are not preempted by the federal requirements, and we are required to comply with them. See “ Business — Healthcare and Other Applicable Regulatory Matters — Federal and State Privacy and Security Requirements ” in Item 1. These and other laws and regulations affecting data security and data privacy **, including international laws and regulations relevant to our business,** are often uncertain, contradictory and subject to changing interpretations, and we expect new laws, rules and regulations regarding data privacy and information security to be proposed and enacted in the future. This complex, dynamic legal landscape creates significant compliance issues and potentially exposes us to expense, adverse publicity and liability. The regulatory framework for data privacy and security issues worldwide is evolving and is likely to remain in flux for the foreseeable future, so it is unclear how regulatory changes could impact our business or the costs of compliance, though the impacts and costs seem likely to increase. The general legal trend in the data privacy and security area is toward the broader adoption of more stringent laws and toward more aggressive enforcement. The data privacy and security measures we have

implemented may not adequately protect us from the risks associated with the storage and transmission of customer information and PHI. The security measures that we, and our third- party vendors and subcontractors, have in place to promote compliance with data privacy and data security laws may not protect our facilities and systems from data security breaches, acts of vandalism or theft, computer viruses, misplaced or lost data, programming and human errors, or other similar events. In the event that new data security laws are implemented, we may not be able to timely comply with such requirements, or such requirements may not be compatible with our current safeguards. Changing our safeguards could be time- consuming and expensive, and failure to timely implement required changes could subject us to liability for non- compliance. Under HIPAA, certain of our entities are directly liable for any data privacy and data security breaches that occur in our capacity as a covered entity. Under the HITECH Act, as business associates, our RBEs may also be directly liable under certain circumstances for data privacy and data security breaches and failures of our subcontractors. We from time- to- time experience security and privacy issues that require assessment of our duties and obligations under HIPAA, and we cannot guarantee that we will not face security or privacy breaches in the future. Additionally, the investigation and remediation of privacy breaches may result in additional material direct or indirect costs. We incur substantial costs related to ordinary- course compliance with HIPAA and the HITECH Act. Such compliance could also require us to change our practices in a manner adverse to our business. Failure to comply with any applicable standards regarding patient privacy, or data privacy and data security more generally, may subject us to penalties, including significant civil monetary penalties and, in some circumstances, criminal penalties. In addition, any such failures may injure our reputation and adversely affect our ability to retain customers and attract new customers. Even an unsuccessful challenge by regulatory authorities could result in adverse publicity and could require a costly response. Additionally, on December 1, 2022, **HHS** OCR issued guidance on the use of tracking technologies on websites and mobile applications, indicating that certain information collected from websites and applications may implicate HIPAA. Although HIPAA does not itself provide a private right of action, it is commonly cited in consumer actions that allege improper use and disclosure of sensitive patient data: use of tracking technologies, such as cookies, web beacons, and pixels, by covered entities or their business associates has recently been subject to class action lawsuits alleging improper disclosure of patient information. Any of the foregoing consequences could have a material adverse impact on our business, financial condition, cash flows, and results of operations. Certain failures or non- compliance by our physician partners under these laws could result in their being required as covered entities to report to governmental authorities and patients, implement expensive corrections and pay civil penalties. For example, we note that in 2019, the Office of Civil Rights announced the creation of its Right of Access Initiative, intended to support individuals' right of timely access to their health records. Since the creation of the Right of Access Initiative, there has been substantial enforcement activity related to covered entities' alleged failures to provide individuals with timely access to their health records. To the extent the physician partners' non- compliance with HIPAA rules and regulations impacts members who are attributed to our RBEs (e. g., through the loss of PHI or failure to provide timely access to health records), or otherwise implicates our data processing or billing operations, we could suffer reputational harm or a material adverse effect on our business, financial condition, cash flows, and results of operations. Failure to obtain or maintain an insurance license, a certificate of authority or an equivalent authorization allowing our participation in downstream risk- sharing arrangements with payors could subject us to significant penalties and adversely impact our operations. Regulation of downstream risk- sharing arrangements, including, but not limited to, global risk and other value- based arrangements, varies significantly from state to state. See " Business — Healthcare and Other Applicable Regulatory Matters — Federal and State Insurance and Managed Care Laws " in Item 1. We therefore expect ~~significant~~ uncertainty regarding whether our operations fall within the scope of certain laws or regulations. If a state in which we currently operate, or a new geography, views our participation in risk- sharing arrangements as the assumption of insurance risk, the arrangement may fall within the purview of state insurance or managed care laws. If so, in connection with our continued operations or our expansion into new geographies, we may be required to obtain a state insurance or managed care license (or some other type of registration) and comply with the state' s insurance or managed care laws and regulations. Such laws and regulations may subject us to significant oversight by state regulators in the form of periodic reporting and audits, required financial reserves and refraining from taking certain actions without prior regulatory approval. The majority of states do not explicitly address whether and in what manner the state regulates the transfer of risk by a payor to a downstream entity, and in such states, regulators may nonetheless interpret statutes and regulations to regulate such activity. If downstream risk- sharing arrangements are not regulated directly in a particular state, the state regulatory agency may nonetheless require oversight by the licensed payor as the party to such a downstream risk- sharing arrangement. Such oversight is accomplished via contract and may include the imposition of reserve requirements and reporting obligations. Failure to comply with these direct and indirect oversight laws can result in significant monetary penalties, administrative fines, fraud or misrepresentation charges, denial of future insurer applications or loss of membership or suspension of membership growth. Laws regulating the corporate practice of medicine could restrict the manner in which we are permitted to conduct our business, and the failure to comply with such laws, or any changes to such laws or regulations or similar laws or regulations could subject us to penalties and restructuring or have a material adverse effect on our consolidation of the accounts of our majority- owned subsidiaries. Some of the states in which we operate limit the practice of medicine to licensed individuals or professional organizations comprising licensed individuals, and lay business corporations generally may not exercise control over the medical decisions of physicians. Certain state regulatory bodies have taken the position that an arrangement that confers too much control over a physician practice to a non- medical professional entity may violate the corporate practice of medicine doctrine. See " Business — Healthcare and Other Applicable Regulatory Matters — Corporate Practice of Medicine " in Item 1. A violation of the corporate practice of medicine doctrine constitutes the unlawful practice of medicine, which is subject to fines and other legal consequences. Penalties for violating fee- splitting statutes or regulations may include medical license revocation, suspension, probation or other disciplinary actions. It is possible that a state regulatory agency or a court could determine that under applicable rules governing the corporate practice of medicine, we are violating the

corporate practice of medicine doctrine or that our arrangements constitute unlawful fee splitting. As a result, our arrangements could be deemed invalid, potentially resulting in a loss of revenues and an adverse effect on results of operations derived from such arrangements. We could be subject to civil or other legal consequences, and our agreements and the accompanying governance structures and arrangements could be found legally unenforceable (in whole or in part). Such a determination could force a restructuring of the arrangements with our RBEs and physician partners. Such a restructuring may not be feasible or **acceptable to our partners and** may not be accomplished within a reasonable time frame or on reasonable terms, any of which could have a material adverse effect on our business, financial condition, cash flows, and results of operations. We have been the subject of regulatory inquiries regarding our compliance with the corporate practice of medicine doctrine, and we cannot guarantee that we will not be subject to such inquiries in the future. Further, our financial statements are consolidated in accordance with applicable accounting standards and include the accounts of our majority- owned subsidiaries, including RBEs, classified as variable interest entities. Such consolidation for accounting or tax purposes does not, is not intended to, and should not be deemed to, imply or provide us any control over the medical or clinical affairs of such practices. In the event of a change in accounting standards promulgated by the Financial Accounting Standards Board (" FASB ") or in interpretation of its standards, or if there is an adverse determination by a regulatory agency or a court, or a change in state or federal law relating to the ability to maintain such agreements or arrangements, we may not be permitted to continue to consolidate the revenues, expenses, assets and liabilities of our majority- owned subsidiaries classified as variable interest entities, which could have a material adverse effect on our business, financial condition, cash flows, and results of operations. If we or our physician partners inadvertently employ or contract with an excluded person, we may face government sanctions. Individuals and entities can be excluded from participating in the Medicare program for violating certain laws and regulations, or for other reasons such as the loss of a license in any state, even if the person retains other licensure. This means that the excluded person or entity is prohibited from receiving payments for such person' s or entity' s services rendered to Medicare or MA beneficiaries, and if the excluded person is a physician, all services ordered (not just provided) by such physician are also non- covered and non-payable. Entities that employ or contract with excluded individuals are prohibited from billing the Medicare program for the excluded individual' s services and are subject to civil penalties if they do. We might inadvertently contract or do business with an excluded person or entity, such as a physician partner, contracted or employed physician, or any other contracted party, or with an excluded person who could become excluded in the future without our knowledge. If this occurs, we or our physician partnerships may be subject to substantial repayments and civil penalties. Physician partners are also expected to comply with these requirements. We do not directly control our physician partners, and accordingly any adverse effects on us regarding their noncompliance with these laws are uncertain and unpredictable. We may face lawsuits not covered by insurance and related expenses may be material. ~~Our failure~~ **The costs** to ~~avoid,~~ defend and ~~accrue~~ **pay any judgment** ~~for~~ **or settlement** ~~claims and litigation~~ could negatively impact our business, financial condition, cash flows, and results of operations. We are exposed to, and may become involved in, various litigation matters arising out of our business, including from time to time, actual or threatened lawsuits. Lawsuits for tort liabilities associated with managed care activities that we conduct in our managed care business are common in the healthcare industry. Common liability exposures we face include performance of utilization review, performance of credentialing and peer review, provider network contracting determinations, and vicarious liability for the conduct of affiliated providers. Liability exposures in the managed care industry in which we operate vary greatly by state. The status of tort reform, availability of non- economic damages or the presence or absence of other statutes, such as elder abuse or vulnerable adult statutes, influence the incidence and severity of managed care litigation. We may also be subject to other types of lawsuits, inquiries, audits, investigations or other proceedings, such as those initiated by our competitors, stockholders, employees, service providers, contractors or by government agencies, including when we terminate relationships with them, which could involve large claims and significant defense costs. Furthermore, lawsuits for tort liabilities arising out of business activities, including the acquisition of other businesses ~~or physician groups~~, also are common. Common liability exposures we face include interference with contract, interference with prospective economic advantage, violation of the Voidable Transactions Act, successor liability, and antitrust and unfair competition. The results of any such lawsuits, inquiries, audits, investigations or other proceedings cannot be predicted, and determining reserves for pending litigation or other matters requires significant judgment. Further, the defense of litigation, including fees of legal counsel, expert witnesses and related costs, is expensive and difficult to forecast accurately. Such costs may be unrecoverable even if we ultimately prevail in litigation and could consume a significant portion of our limited capital resources. To defend lawsuits or participate in other proceedings, it may also be necessary for us to divert ~~officers~~ **executives** and other employees from our normal business functions to gather evidence, give testimony and otherwise support litigation efforts. If any such proceeding is not resolved in our favor, we could face material judgments or awards against us. An unfavorable resolution of one or more of the proceedings in which we are involved now or in the future could have a material adverse effect on our business, financial condition, cash flows, and results of operations. We may also in the future find it necessary to file lawsuits to recover damages or protect our interests. The cost of such litigation could also be significant and unrecoverable, which could also deter us from aggressively pursuing even legitimate claims. All of our physician partners are required to carry medical malpractice insurance. We also currently maintain managed care errors and omissions insurance. We cannot be certain that our insurance coverage will be adequate to cover liabilities arising out of claims asserted against us, our affiliated professional organizations or our affiliated physicians. Liabilities incurred by us or our affiliates in excess of our insurance coverage, including coverage for professional liability and other claims, could have a material adverse effect on our business, financial condition, cash flows, and results of operations. Our insurance coverages generally must be renewed annually and may not continue to be available to us in future years at acceptable costs and on favorable terms, which could increase our exposure to litigation. Further, such coverage typically has substantial deductibles for which we would be responsible. ~~Risks~~ **Changes in tax laws and regulations, or changes in** ~~Related~~ **related judgments or assumptions could materially impact our financial condition and results of operation. We are subject** to

~~Our Indebtedness~~ **federal and state taxes in the U. S. and other countries in which we conduct business, and such laws and rates vary by jurisdiction. Although we believe our tax practices and provisions are reasonable, the final determination of tax audits and any related litigation, changes in the taxation of our activities and proposed changes in tax laws and regulations could cause the ultimate settlement of our tax liabilities to be materially different from our historical tax practices, provisions and accruals. If we receive an adverse ruling as a result of an audit, or we unilaterally determine that we have misinterpreted provisions of the tax regulations to which we are subject, there could be a material effect on our tax provision, net income or cash flows in the period or periods for which that determination is made, which could materially impact our financial results. Further, any changes in the taxation of our activities, including certain proposed changes in U. S. tax laws, may increase our effective tax rate and adversely affect our financial position and results of operations. In addition, liabilities associated with taxes are often subject to an extended or indefinite statute of limitations period. Therefore, we may be subject to additional tax liability, including penalties and interest for a particular year for extended periods of time.** Despite our indebtedness levels, we and our subsidiaries may incur substantially more indebtedness, which could increase the risks created by our indebtedness. We and our subsidiaries may incur substantial additional indebtedness in the future. The terms of **our** ~~the 2021~~ Credit ~~Agreement~~ **Facility** do not fully prohibit our subsidiaries from incurring additional debt. If our subsidiaries are in compliance with certain coverage ratios set forth in the agreements governing the Credit ~~Facilities~~ **Facility** , they may be able to incur substantial additional indebtedness, which could increase the risks created by our current indebtedness. In addition, subject to certain conditions and without the consent of the then- existing lenders, the loans under the Credit ~~Facilities~~ **Facility** may be expanded (or new term loan facilities, revolving credit facilities or letter of credit facilities added) by up to $ 50. 0 million plus an additional amount equal to the aggregate amount of certain prepayments, repayments and redemptions of term loans and / or permanent reduction in the revolving credit facilities. The agreements and instruments governing our indebtedness contain restrictions and limitations that could significantly impact our ability to operate our business. Our Credit ~~Facilities~~ **Facility** ~~contain~~ **contains** covenants that, among other things, restrict the ability of our subsidiary agilon health management, inc. (“ agilon management ”) and its subsidiaries to: • incur additional indebtedness and create liens; • pay dividends and make other distributions or to purchase, redeem or retire capital stock; • purchase, redeem or retire certain junior indebtedness; • make loans and investments; • enter into agreements that limit agilon management’ s or its subsidiaries’ ability to pledge assets or to make distributions or loans to us or transfer assets to us; • sell assets; • enter into certain types of transactions with affiliates; • consolidate, merge or sell substantially all assets; • make voluntary payments or modifications of junior indebtedness; and • enter into lines of business. agilon management and its subsidiaries account for substantially all of our assets and total liabilities. Consequently, the restrictions in the Credit ~~Facilities~~ **Facility** may prevent us from taking actions that we believe would be in the best interest of our business and may make it difficult for us to execute our business strategy successfully or effectively compete with companies that are not similarly restricted. We may also incur future debt obligations that might subject us to additional restrictive covenants that could affect our financial and operational flexibility. We may be unable to refinance our indebtedness, at maturity or otherwise, on terms acceptable to us or at all. The ability of agilon management to comply with the covenants and restrictions contained in the Credit ~~Facilities~~ **Facility** may be affected by economic, financial and industry conditions outside our control including credit or capital market disruptions. The breach of any of these covenants or restrictions could result in a default that would permit the applicable lenders to declare all amounts outstanding thereunder to be due and payable, together with accrued and unpaid interest. If we are unable to repay indebtedness, lenders having secured obligations, such as the lenders under the Credit ~~Facilities~~ **Facility** , could proceed against the collateral securing the indebtedness. This could materially and adversely affect our business, financial condition, cash flows, and results of operations, and could cause us to become bankrupt or insolvent. ~~Risks Related to Our Common Stock~~ agilon health is a holding company with no operations of its own, and it depends on its subsidiaries for cash to fund all of its operations and expenses, including to make future dividend payments, if any. Our operations are conducted entirely through our subsidiaries, and our ability to generate cash to fund our operations and expenses, to pay dividends or to meet debt service obligations is highly dependent on the earnings and the receipt of funds from our subsidiaries through dividends or intercompany loans. Deterioration in the financial condition, earnings or cash flow of agilon management and its subsidiaries for any reason could limit or impair their ability to pay such distributions. Many of these subsidiaries are subject to regulatory, contractual or other legal restrictions that may restrict such subsidiaries’ ability to pay dividends to us. To the extent our subsidiaries are restricted from making such distributions under applicable law or regulation or under the terms of our financing arrangements or are otherwise unable to provide funds to the extent of our needs, there could be a material adverse effect on our business, financial condition, cash flows, and results of operations. For example, we are currently contractually required, and may in the future be required by state laws or regulations, to maintain specific prescribed minimum amounts of capital in certain subsidiaries. When we enter into a new payor contract, we are typically required by the payor to contribute risk- bearing capital to the local operating subsidiary. This typically takes the form of letters of credit **, surety bonds,** or restricted deposits, or the payor may retain a percentage of the capitation payments due under the applicable contract. Risk-bearing capital required by payors varies by payor and geography. In addition, the agreements governing the Credit ~~Facilities~~ **Facility** significantly restrict the ability of our subsidiaries to pay dividends, make loans or otherwise transfer assets to us. Furthermore, our subsidiaries are permitted under the terms of the Credit ~~Facilities~~ **Facility** to incur additional indebtedness that may restrict or prohibit the making of distributions, the payment of dividends or the making of loans by such subsidiaries to us. If we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our ~~results of~~ business, financial condition, cash flows and results of operations could be materially and adversely affected. Under our Certificate of Incorporation, ~~the~~ CD & R ~~Investor~~ and its affiliates and, in some circumstances, each of our directors and officers who is also a director, officer, employee, member or partner of ~~the~~ CD & R ~~Investor~~ and its affiliates, have no obligation to offer us corporate opportunities. The policies relating to corporate opportunities and transactions with ~~the~~ CD & R ~~Investor~~ set forth in our

Certificate of Incorporation address potential conflicts of interest between agilon health, on the one hand, and ~~the~~ CD & R ~~Investor~~ and its officers, directors, employees, members or partners who are directors ~~or officers~~ of our company, on the other hand. In accordance with those policies, ~~the~~ CD & R ~~Investor~~ may pursue corporate opportunities, including acquisition opportunities that may be complementary to our business, without offering those opportunities to us. By becoming a stockholder in agilon health, you will be deemed to have notice of and have consented to these provisions of our Certificate of Incorporation. Although these provisions are designed to resolve conflicts between us and ~~the~~ CD & R ~~Investor~~ and its affiliates fairly, conflicts may not be resolved in our favor or be resolved at all. Anti- takeover provisions in our Certificate of Incorporation and By- laws could discourage, delay or prevent a change of control of our company and may affect the trading price of our common stock. Our Certificate of Incorporation and our By- laws include a number of provisions that may discourage, delay or prevent a change in our management or control over us that stockholders may consider favorable. For example, our Certificate of Incorporation and By- laws collectively: • authorize the issuance of " blank check " preferred stock that could be issued by ~~our~~ **the** ~~board~~ **Board** of ~~directors~~ **Directors (the " Board of Directors ")** to thwart a takeover attempt; • provide for a classified board of directors, which divides ~~our~~ **the** ~~board~~ **Board** of ~~directors~~ **Directors** into three classes, with members of each class serving staggered three- year terms, which prevents stockholders from electing an entirely new board of directors at an annual meeting; • limit the ability of stockholders to remove directors if ~~the~~ CD & R ~~Investor~~ ceases to beneficially own at least 40 % of the outstanding shares of our common stock; • provide that vacancies on ~~our~~ **the** ~~board~~ **Board** of ~~directors~~ **Directors**, including vacancies resulting from an enlargement of ~~our~~ **the** ~~board~~ **Board** of ~~directors~~ **Directors**, may be filled only by a majority vote of directors then in office; • prohibit stockholders from calling special meetings of stockholders if ~~the~~ CD & R ~~Investor~~ ceases to beneficially own at least 40 % of the outstanding shares of our common stock; • prohibit stockholder action by written consent, thereby requiring all actions to be taken at a meeting of the stockholders, if ~~the~~ CD & R ~~Investor~~ ceases to beneficially own at least 40 % of the outstanding shares of our common stock; • opt out of Section 203 of the Delaware General Corporation Law (the " DGCL "), which prohibits a publicly- held Delaware corporation from engaging in a " business combination " with an " interested stockholder " for a period of three years following the time the person became an interested stockholder, until ~~the~~ CD & R ~~Investor~~ ceases to beneficially own at least 5 % of the outstanding shares of our common stock; • establish advance notice requirements for nominations of candidates for election as directors or to bring other business before an annual meeting of our stockholders; and • require the approval of holders of at least 66 2 / 3 % of the outstanding shares of our common stock to amend our By- laws and certain provisions of our Certificate of Incorporation if ~~the~~ CD & R ~~Investor~~ ceases to beneficially own at least 40 % of the outstanding shares of our common stock. These provisions may prevent our stockholders from receiving the benefit from any premium to the market price of our common stock offered by a bidder in a takeover context or from changing our management and ~~board~~ **Board** of ~~directors~~ **Directors**. Even in the absence of a takeover attempt, the existence of these provisions may adversely affect the prevailing market price of our common stock if the provisions are viewed as discouraging takeover attempts in the future. Our Certificate of Incorporation and By- laws may also make it difficult for stockholders to replace or remove our management. Furthermore, the existence of the foregoing provisions, as well as the significant amount of common stock that ~~the~~ CD & R ~~Investor~~ owns, could limit the price that investors might be willing to pay in the future for shares of our common stock. These provisions may facilitate management entrenchment that may delay, deter, render more difficult or prevent a change in our control, which may not be in the best interests of our stockholders. We do not intend to pay dividends on our common stock for the foreseeable future and, consequently, your ability to achieve a return on your investment depends on appreciation in the price of our common stock. We do not intend to declare and pay dividends on our common stock for the foreseeable future. We currently intend to use our future earnings, if any, to repay debt, to fund our growth, to develop our business, for working capital needs and for general corporate purposes. Therefore, you are not likely to receive any dividends on your common stock for the foreseeable future, and the success of an investment in shares of our common stock depends upon any future appreciation in their value. There is no guarantee that shares of our common stock will appreciate in value or even maintain the price at which our stockholders have purchased their shares. Payments of dividends, if any, are at the sole discretion of ~~our~~ **the** ~~board~~ **Board** of ~~directors~~ **Directors** after taking into account various factors, including general and economic conditions, our financial condition and operating results, our available cash and current and anticipated cash needs, capital requirements, contractual, legal, tax and regulatory restrictions and implications of the payment of dividends by us to our stockholders or by our subsidiaries to us, and such other factors as ~~our~~ **the** ~~board~~ **Board** of ~~directors~~ **Directors** may deem relevant. In addition, our operations are conducted almost entirely through our subsidiaries. As such, to the extent that we determine in the future to pay dividends on our common stock, none of our subsidiaries will be obligated to make funds available to us for the payment of dividends. Further, the agreements governing the Credit ~~Facilities~~ **Facility** significantly restrict the ability of our subsidiaries to pay dividends or otherwise transfer assets to us, and we may enter into other credit agreements or borrowing arrangements in the future that restrict or limit our ability to pay cash dividends on our common stock. In addition, Delaware law imposes additional requirements that may restrict our ability to pay dividends to holders of our common stock ~~. We are no longer a " controlled company " within the meaning of the NYSE rules. However, we may continue to rely on exemptions from certain corporate governance requirements during a one- year transition period. From August 12, 2022, CD & R Investor no longer controlled a majority of the voting power of our outstanding common stock, and we ceased to be a " controlled company " within the meaning of the NYSE corporate governance standards. As a result, the NYSE rules require that we have a majority of independent directors on our board of directors within one year of the date we no longer qualified as a " controlled company, " have at least one independent director on each of the Compensation and Nominating and Governance Committees on the date we no longer qualified as a " controlled company, " at least a majority of independent directors on each of the Compensation and Nominating and Governance Committees within 90 days of such date and the Compensation and Nominating and Governance Committees composed entirely of independent directors within one year of such date and perform an annual performance evaluation of the Nominating and Governance and Compensation Committees. During~~

~~this transition period, we may continue to utilize the available exemptions from certain corporate governance requirements as permitted by the NYSE rules and we presently do not have a majority of independent directors, our Nominating and Governance Committee and Compensation Committees do not consist entirely of independent directors and such committees may not be subject to annual performance evaluations during the transition period. Accordingly, during the transition period, you will not have the same protections afforded to stockholders of companies that are subject to all of the corporate governance rules and requirements of the NYSE discussed herewith. Furthermore, a change in our board of directors and committee membership may result in a change in corporate strategy and operation philosophies, and may result in deviations from our current strategy~~ . Our Certificate of Incorporation designates the Court of Chancery of the State of Delaware as the sole and exclusive forum for certain litigation that may be initiated by our stockholders, which could limit our stockholders' ability to obtain a favorable judicial forum for disputes with us or our directors, officers or stockholders. Our Certificate of Incorporation provides that, unless we consent in writing to the selection of an alternative forum, the Court of Chancery of the State of Delaware will, to the fullest extent permitted by law, be the sole and exclusive forum for (i) any derivative action or proceeding brought on our behalf, (ii) any action or proceeding asserting a claim of breach of a fiduciary duty owed to us or our stockholders by any of our directors, officers, other employees, agents or stockholders, (iii) any action or proceeding asserting a claim arising out of or pursuant to or seeking to enforce any right, obligation or remedy under the DGCL, or as to which the DGCL confers jurisdiction on the Court of Chancery of the State of Delaware (including, without limitation, any action asserting a claim arising out of or pursuant to our Certificate of Incorporation or our By- laws) or (iv) any action or proceeding asserting a claim that is governed by the internal affairs doctrine, in each case subject to such Court of Chancery of the State of Delaware having personal jurisdiction over the indispensable parties named as defendants. It is possible that a court could find that the exclusive forum provisions described above are inapplicable for a particular claim or action or that such provision is unenforceable, and our stockholders will not be deemed to have waived our compliance with the federal securities laws and the rules and regulations thereunder. As permitted by Delaware law, our Certificate of Incorporation provides that, unless we consent in writing to the election of an alternative forum, the **U. S.** federal district courts ~~of the United States of America~~ will, to the fullest extent permitted by law, be the sole and exclusive forum for the resolution of any complaint asserting a cause of action arising under the Securities Act, the Exchange Act, and the rules and regulations thereunder. To the fullest extent permitted by law, by becoming a stockholder in our company, you will be deemed to have notice of and have consented to the provisions of our Certificate of Incorporation related to choice of forum. The choice of forum provision in our Certificate of Incorporation may limit our stockholders' ability to obtain a favorable judicial forum for disputes with us or any of our directors, officers, other employees, agents or stockholders, which could discourage lawsuits with respect to such claims. Additionally, a court could determine that the exclusive forum provision is unenforceable, and our stockholders will not be deemed to have waived our compliance with the federal securities laws and the rules and regulations thereunder. If a court were to find these provisions of our Certificate of Incorporation inapplicable to, or unenforceable in respect of, one or more of the specified types of actions or proceedings, we may incur additional costs associated with resolving such matters in other jurisdictions, which could adversely affect our business, financial condition, cash flows, and results of operations. We have identified **a** material ~~weaknesses~~ -- **weakness** in our internal control over financial reporting. If we are unable to remediate ~~these~~ **this** material ~~weaknesses~~ -- **weakness** , or if we experience additional material weaknesses in the future or otherwise fail to maintain an effective system of internal controls, we may not be able to accurately or timely report our financial results, in which case our business may be harmed, investors may lose confidence in the accuracy and completeness of our financial reports and, as a result, our common stock price may be adversely affected and we may be unable to maintain compliance with NYSE listing requirements. Our management is responsible for establishing and maintaining adequate internal control over financial reporting and for evaluating and reporting on our system of internal control. Our internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with U. S. GAAP. As a public company, we are required to comply with the Sarbanes- Oxley Act and other rules that govern public companies. In particular, we are required to certify our compliance with Section 404 of the Sarbanes- Oxley Act, which requires us to furnish annually a report by management on the effectiveness of our internal control over financial reporting. In addition, our independent registered public accounting firm is required to report on the effectiveness of our internal control over financial reporting. In connection with our year- end assessment of internal control over financial reporting, we identified **a** material ~~weaknesses~~ -- **weakness** in our internal control over financial reporting as of December 31, ~~2022~~ **2023** . For a discussion of our internal control over financial reporting and a description of the identified material ~~weaknesses~~ -- **weakness** , see Part II, Item 9A, " Controls and Procedures. " As further described in Item 9A " Controls and Procedures- Management' s Report on Internal Control Over Financial Reporting and Remediation of the Material ~~Weaknesses~~ -- **Weakness** in Internal Control Over Financial Reporting, " we are undertaking steps to improve our internal control over financial reporting. We expect that we will need to improve existing operational and financial systems, procedures and controls, and implement new ones, to manage our future business effectively. However, we may not be successful in making the improvements necessary to remediate the material ~~weaknesses~~ -- **weakness** identified by management or be able to do so in a timely manner, or be able to identify and remediate additional control deficiencies or material weaknesses in the future. Any implementation delays, or disruption in the transition to new or enhanced systems, procedures or controls, could harm our ability **to** record and report financial and management information on a timely and accurate basis. If our remedial measures are insufficient to address the material ~~weaknesses~~ -- **weakness** , or if significant deficiencies or material weaknesses in our internal control over financial reporting are discovered or occur in the future, it may adversely affect us.