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

FORM 10-K

(Mark One)

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

For the fiscal year ended December 31, 2024

OR

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

Commission File Number: 001-40295

ALIGNMENT HEALTHCARE, INC.
(Exact name of Registrant as specified in its Charter)

Delaware	**46-5596242**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
1100 W. Town and Country Road, Suite 1600 Orange, California	**92868**
(Address of principal executive offices)	**(Zip Code)**

Registrant's telephone number, including area code: (844) 310-2247

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

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, par value $0.001 per share	**ALHC**	The Nasdaq Stock Market LLC

Securities registered pursuant to Section 12(g) of the Act: **None**

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the Registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the Registrant was required to submit such files). Yes ☒ No ☐

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

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

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

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

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

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

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

The aggregate market value of voting shares held by non-affiliates of the Registrant was $973,520,748 as of June 30, 2024, the last business day of the Registrant's most recently completed second fiscal quarter (based on a closing price of $7.97 per share). This determination of affiliate status is not necessarily a conclusive determination for other purposes. The registrant has no non-voting common stock.

As of February 24, 2025, the registrant had 191,832,332 shares of common stock, $0.001 par value per share, outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required by Part III of this Annual Report, to the extent not set forth herein, is incorporated herein by reference from the registrant's definitive proxy statement relating to the Annual Meeting of Shareholders to be held in 2025, which definitive proxy statement shall be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year to which this Annual Report relates.

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FORWARD-LOOKING STATEMENTS

Throughout this annual report on Form 10-K (this "Annual Report"), we make "forward-looking statements" within the meaning of the U.S. Private Securities Litigation Reform Act of 1995. All statements other than statements of historical fact included in this Annual Report are forward-looking statements. Forward-looking statements give our current expectations relating to our financial condition, results of operations, plans, objectives, future performance and business. You can identify forward-looking statements by the fact that they do not relate strictly to historical or current facts. These statements may include words such as "anticipate," "estimate," "expect," "project," "plan," "intend," "believe," "may," "will," "should," "can have," "likely" and other words and terms of similar meaning. The forward-looking statements contained in this Annual Report are generally located in the material set forth under the heading *"Management's Discussion and Analysis of Financial Condition and Results of Operations"* but may be found in other locations as well. These statements are based upon management's current expectations, assumptions and estimates and are not guarantees of timing, future results or performance. All forward-looking statements are subject to risks and uncertainties that may cause actual results to differ materially from those that we expected, including:

- our history of net losses, and our ability to achieve or maintain profitability in an environment of increasing expenses;
- the effect of our relatively limited operating history on investors' ability to evaluate our current business and future prospects;
- the viability of our growth strategy and our ability to realize expected results;
- our ability to attract new members and to successfully enter into new markets;
- the quality and pricing of our products and services;
- our ability to maintain a high rating for our plans on the Five Star Quality Rating System;
- our ability to develop and maintain satisfactory relationships with care providers that service our members;
- our ability to manage our growth effectively, execute our business plan, maintain high levels of service and member satisfaction or adequately address competitive challenges;
- our ability to compete in the healthcare industry;
- the impact on our business of security breaches, loss of data or other disruptions causing the compromise of sensitive information or preventing us from accessing critical information;
- the impact on our business of disruptions in our disaster recovery systems or management continuity planning;
- the cost of legal proceedings and litigation, including intellectual property and privacy disputes;
- our dependence on reimbursements by the Centers for Medicare and Medicaid Services ("CMS") and premium payments by individuals;
- other risks associated with being a government contractor;
- the impact on our business of the healthcare services industry becoming more cyclical;
- our ability to manage acquisitions, divestitures and other significant transactions successfully;
- our ability to maintain, enhance and protect our reputation and brand recognition;
- our ability to effectively invest in, implement improvements to and properly maintain the uninterrupted operation and data integrity of our information technology and other business systems;
- our ability to obtain, maintain, protect and enforce intellectual property protection for our technology;
- the potential adverse impact of claims by third parties that we are infringing on, misappropriating or otherwise violating their intellectual property rights;
- the impact of any restrictions on our use of or ability to license data or our failure to license data and integrate third-party technologies;
- our dependence on our senior management team and other key employees;
- the concentration of our health plans in a limited number of U.S. states;
- our management team's limited experience managing a public company;
- our ability to generate sufficient cash flow to service all of our indebtedness and the potential impact of certain affirmative and negative covenants in our term loan agreement on our business;
- the impact of shortages of qualified personnel and related increases in our labor costs;

- the risk that our records may contain inaccurate or unsupportable information regarding risk adjustment scores of members;
- our ability to accurately estimate incurred but not reported medical expenses;
- the impact of negative publicity regarding the managed healthcare industry;
- the impact of weather and other factors beyond our control on our clinics, the centers out of which our external providers operate, and the facilities that host our AVA platform (as defined below);
- the impact on our business of renegotiation, non-renewal or termination of risk agreements with hospitals, physicians, nurses, pharmacists and medical support staff;
- risks associated with estimating the amount of liabilities that we recognize under our risk agreements with providers;
- our ability to respond to general economic conditions, including but not limited to, increased inflation and higher interest rates;
- risks associated with an economic downturn, including pressure on governmental budgets and reduced spending for health and human service programs;
- our ability to develop and maintain proper and effective internal control over financial reporting;
- the impact of state and federal efforts to reduce Medicare spending;
- our ability to comply with applicable federal, state and local rules and regulations, including those relating to data privacy and security; and
- other factors disclosed in the section entitled "Risk Factors" and elsewhere in this Annual Report.

We derive many of our forward-looking statements from our operating budgets and forecasts, which are based on many detailed assumptions. While we believe that our assumptions are reasonable, we caution that it is very difficult to predict the impact of known factors, and it is impossible for us to anticipate all factors that could affect our actual results. Important factors that could cause actual results to differ materially from our expectations, or cautionary statements, are disclosed under the sections entitled *"Risk Factors"* and *"Management's Discussion and Analysis of Financial Condition and Results of Operations"* in this Annual Report.

All written and oral forward-looking statements attributable to us, or persons acting on our behalf, are expressly qualified in their entirety by these cautionary statements as well as other cautionary statements that are made from time to time in our other SEC filings and public communications. You should evaluate all forward-looking statements made in this Annual Report in the context of these risks and uncertainties.

We caution you that the important factors referenced above may not contain all of the factors that are important to you. In addition, we cannot assure you that we will realize the results or developments we expect or anticipate or, even if substantially realized, that they will result in the consequences or affect us or our operations in the way we expect. The forward-looking statements included in this Annual Report are made only as of the date hereof. We undertake no obligation to update or revise any forward-looking statement as a result of new information, future events or otherwise, except as otherwise required by law.

MARKET AND INDUSTRY DATA

Unless otherwise indicated, information in this Annual Report concerning economic conditions, our industry, our markets and our competitive position is based on a variety of sources, including information from independent industry analysts and publications, as well as our own estimates and research. This information involves a number of assumptions and limitations, and you are cautioned not to give undue weight to such estimates. While we believe the information presented in this Annual Report is generally reliable, forecasts, assumptions, expectations, beliefs, estimates and projects involve risk and uncertainties and are subject to change based on various factors, including those described under *"Forward-Looking Statements"* and *"Risk Factors."*

Throughout this Annual Report, all references to "Net Promoter Score" or "NPS" are to a measure of satisfaction widely used in the healthcare industry. We calculate NPS based on responses to member surveys, conducted by a third-party administrator (either telephonically or online) that selects a random sample of members to participate. The surveys ask the consumer to rank, on a scale of one to 10, how likely the member would be to recommend Alignment to a friend or relative. We assign the designation of "Promoter" to respondents who provide a score of 9 or 10, the designation of "Neutral" to respondents who provide a score of 7 or 8, and the designation of "Detractor" to respondents who provide a score of 0 to 6. We then subtract the percentage of Detractors from Promoters to determine our overall Net Promoter Score. We believe that this method of calculation aligns with industry standards and that this metric is meaningful for investors because of the correlation between Net Promoter Score and consumer satisfaction.

Throughout this Annual Report, all references to the "Five-Star Rating System" or "Star rating" are to a measure used by the CMS to rate the performance of Medicare Advantage and Part D plans. Although subject to change, Medicare Advantage Plans are currently rated on how well they perform in five different categories: (1) staying healthy: screenings, tests, and vaccines, (2) managing chronic (long-term) conditions, (3) member experience with health plan, (4) member complaints and changes in the health plan's performance,

and (5) health plan customer service. Similarly, Part D plans are currently rated on how well they perform in four different categories: (1) drug plan customer service, (2) member complaints and changes in the drug plan's performance, (3) member experience with the drug plan, and (4) drug safety and accuracy of drug pricing. Ratings range from one to five stars, with five being the highest and one being the lowest. Plans are rated in each individual measure within the categories noted above and also at the category level. Medicare also assigns Medicare Advantage plans one summary star rating to summarize the plan's performance on the Medicare Advantage measures, and assigns Part D plans a similar summary star rating. Medicare Advantage-Part D combined plans are also given an overall rating, which combines performance all measures. All ratings are reported at the contract level.

BASIS OF PRESENTATION

We historically operated as a Delaware limited liability company under the name Alignment Healthcare Holdings, LLC. On March 17, 2021, Alignment Healthcare Holdings, LLC converted into a Delaware corporation pursuant to a statutory conversion and changed its name to Alignment Healthcare, Inc. As a result of this conversion, Alignment Healthcare Partners, LP, a Delaware limited partnership ("Alignment Partners") and the sole unitholder of Alignment Healthcare Holdings, LLC, became the sole holder of shares of common stock of Alignment Healthcare, Inc. (the "Corporate Conversion").

Prior to the closing of our initial public offering ("IPO"), (i) Alignment Healthcare, Inc. effected an approximately 1 for 260 split of its common stock (the "Stock Split") and (ii) Alignment Partners merged with and into Alignment Healthcare, Inc., with Alignment Healthcare, Inc. surviving the merger (the "Company Merger"). Pursuant to the Company Merger, the partners of Alignment Partners received all of the then-outstanding shares of common stock of Alignment Healthcare, Inc. in exchange for their units in Alignment Partners. The Stock Split and Company Merger are collectively referred to herein as the "Corporate Reorganization." Except as disclosed in this Annual Report, the consolidated financial statements and selected historical consolidated financial data and other financial information included in this Annual Report are those of Alignment Healthcare, Inc. and its subsidiaries and give effect to the Corporate Conversion and the Corporate Reorganization.

Unless the context otherwise requires, the terms "Alignment," the "Company," "our company," "we," "us" and "our" in this annual report refer to Alignment Healthcare Holdings, LLC, its consolidated subsidiaries and its affiliated medical groups, for all periods prior to the Corporate Conversion and to Alignment Healthcare, Inc., its consolidated subsidiaries and its affiliated medical groups, for all periods following the Corporate Conversion.

We are a holding company and our sole asset is the capital stock of our wholly owned subsidiaries, including Alignment Healthcare USA, LLC.

PART I

Item 1. Business.

Our Mission: Improve Healthcare, One Senior at a Time

Alignment Healthcare was founded in 2013 with one mission: improve healthcare, one senior at a time. We pursue this mission by focusing on our core values:

- always put the senior first;
- support the doctor;
- use data and technology to revolutionize care; and
- act with a serving heart.

We created Alignment after our own families faced frustrating experiences within the fragmented healthcare system. Without an advocate to create an integrated, high quality healthcare experience for them, our loved ones were left to navigate a care delivery and insurance landscape fraught with confusion and complexity. Seniors across the country are systemically and disproportionately impacted by the lack of care coordination, transparency and clear information. Furthermore, they are disadvantaged by misaligned incentives that dominate today's healthcare system. As one of our most vulnerable populations, seniors across America need and deserve better. We put our combined decades of healthcare experience to work to create the Alignment model, incorporating best practices learned over our years serving seniors. Through the combination of this experienced, mission-driven team with purpose-built technology, we have found a way to address the unmet health and wellness needs of seniors. We aim to bring this senior-first healthcare experience to millions in the United States, become the most trusted senior healthcare brand in the country, and ultimately "do well by doing good."

Alignment's Virtuous Cycle is a Distinct Competitive Advantage

Our model is based on a flywheel concept, referred to as our "virtuous cycle," which reflects our unique ability to manage healthcare expenditures while maintaining quality and member satisfaction — a distinct and sustainable competitive advantage.

To execute upon this concept, we start by ingesting medical and demographic data through our proprietary AVA technology platform. AVA's predictive algorithms provide unique insights into each member and identify those most at risk of an acute event. Our information-enabled care model is then combined with clinical engagement by our employed clinical teams known as Care Anywhere to improve healthcare outcomes for our members. For example, our high-touch clinical model proactively manages chronic conditions and assists with post-discharge care navigation to reduce unnecessary hospital admissions and readmissions, which in turn improves health outcomes and quality while lowering overall costs. We then reinvest medical cost savings into richer coverage and benefits, which propels growth in revenue and membership while maintaining margin discipline. The strength of our model is further reinforced by delivering a premium member experience. Our concierge and a clinical service hotline is available 24/7 at no additional cost to our members and our state-of-the-art in-house call centers provide us with more consistency and control over member-facing functions.

Our virtuous cycle, based on the principle of doing well by doing good, is highly repeatable and a core tenet of our ability to continue to expand in existing and new markets in the future. The five-year compounded growth rate through December 31, 2024 of revenue and the number of members enrolled in our HMO and PPO contracts ("Health Plan Membership") is 29% and 31%, respectively.

Our Results: Predictable, Recurring Revenue Positioned for Long-Term Growth

To achieve our mission of improving healthcare for one senior at a time, we have developed a business model with a predictable, recurring revenue stream that provides significant visibility into our financial growth trajectory. We generally contract directly with CMS as a licensed Medicare Advantage plan and receive a recurring per member per month ("PMPM") payment in exchange for bearing the responsibility of our members' healthcare outcomes and expenditures. These contractual arrangements, combined with the fact that the majority of our net membership growth occurs effective on January 1 of a calendar year after the annual enrollment period ("AEP"), provide a higher degree of visibility to our full-year projected revenue early in the calendar year, subject to our ability to model for in-year member growth, as well as revenue PMPM, which in turn depends on member health and mortality trends.

We believe that Medicare Advantage is unique in that it allows one entity to influence the entirety of a senior's healthcare through a single, direct-to-consumer product. Our platform is designed to maximize the benefits of Medicare Advantage, with all stakeholders being rewarded as we improve the clinical outcomes and experience for our members. We believe that the outcomes below clearly demonstrate the success of our unique consumer-centric platform by delivering on the promise of our virtuous cycle.

Our ability to deliver lower healthcare costs while improving the consumer's experience is a unique competitive advantage. In 2024, we achieved a net promoter score (NPS) for our Care Anywhere members of greater than 78 versus the industry average of 40 and had 98% of our members enrolled in a plan with a CMS star rating of 4 stars or above. From a clinical standpoint, we achieved a hospitalization rate of approximately 152 hospitalizations per every 1,000 at-risk members, which is approximately 39% lower than the 2019 Medicare FFS performance in our markets. This differentiation has led to our demonstrated ability to rapidly scale, as evidenced by the expansion

of our model to 53 markets across five states covering approximately 209,900 Health Plan Members as of January 1, 2025 and more than 83% of gross sales sourced through plan switchers from a competing Medicare Advantage plan. We believe we have proven that our model is highly predictable and repeatable across different markets and will enable strong growth on a national level as we pursue our vision of becoming the most trusted senior healthcare brand in the country.

We anticipate further investments in our business as we expand into new markets and continue to offer additional innovative product offerings and supplemental benefits to attract new members.

Our Technology: AVA® Provides Timely and Actionable Insights

AVA empowers Alignment's employees and provider partners with timely and actionable information to improve the health experience and outcomes of Alignment's members.

Our position in the healthcare ecosystem as a Medicare Advantage plan affords us differentiated access to large amounts of member data. We applied our clinical and technical expertise to build AVA, a proprietary platform that forms the backbone of our care delivery efforts, whether done through provider partners or directly through our care teams. AVA is a highly sophisticated engine that ingests longitudinal data from more than 200 sources to provide an accurate assessment of each member and actionable information to care teams in real time. When triggered by relevant data, AVA delivers prescriptive insights that guide providers' workflows to deliver personalized care to members. Examples of workflows include ordering a prescription, alerting a caregiver, transferring information from a lab to a doctor, and developing a treatment plan.

We and our provider partners use this data every day to power care interventions that may be missed in traditional healthcare relationships. AVA improves the care outcomes and care experience of our members, while also providing everyone in their ecosystem — from doctors to nurses — real-time data and operational indicators to deliver the right care, to the right member at the right time.
AVA incorporates high security controls around member data, and it is subject to regular vulnerability tests and strict authorization protocols. It also uses machine learning and artificial intelligence to help predict various scenarios such as hospital admission and re-admission risk, member satisfaction, disenrollment risk and various disease propensity scores and how to best intervene. These models are based on hundreds of thousands of historical outcomes, which have shaped their predictions and accuracy, and are constantly updated with new data sets, enabling them to get smarter and more effective.

Additional details on AVA's capabilities include:

- **Consumer Experience:** AVA offers a digital ecosystem that enables our members and their support system to get the information and care they need, when and how they need it. With their AVA-powered member portal and mobile app, seniors have many self-service capabilities and can get 24/7 care, send secure messages to their concierge and care teams, check their rewards and ACCESS On-Demand Concierge Card balance, and view their health history, including medical claims history, pharmacy, and benefits data.

- **Internal Care Delivery:** Our ability to efficiently and effectively deliver care via our internal care teams is critical to improving outcomes and managing costs. AVA is vital in our ability to identify and manage our highest risk, most complex members, and to ensure that every intervention opportunity is optimized by the most relevant and effective data available.

- **External Providers:** AVA transforms care delivery by shifting the paradigm from "silos of care" to physicians and payors working together as partners through technology-enablement. Medical group leaders, doctors and front-line administrative staff are provided comprehensive information to streamline and support the coordination of member care. AVA provider applications drive workflows and action lists to improve member outcomes at a lower cost and lower visit frequency. Providers are given access to AVA applications to track utilization, gaps in clinical care, and health risk assessments. This data is utilized to prioritize which members to see, and which members may benefit from various health engagement strategies.

- **Health Plan Operations:** By leveraging a single source of accurate information, we foster improved cross-functional communication and execution across our key value drivers. With the support of AVA our operational leaders can make faster, data-driven decisions, which leads to improved outcomes and greater efficiencies as we grow our membership base.

- **Growth Operations:** We are able to create greater brand differentiation in the market with our external brokers and our internal sales team by providing them best-in-class digital solutions such as the AVA Broker Portal and mobile app. These tools streamline application submission and management, client management, commission tracking, and a variety of self-service capabilities specifically for Medicare Advantage.

When paired with our operational expertise, we believe AVA is integral to our ability to drive our operations and business outcomes consistently across markets. AVA provides us with the flexibility to adapt our operating models to meet the needs of local communities and providers, while achieving high-quality, low-cost care in each market. From driving workflows to enabling smarter interventions, we believe AVA is a significant competitive advantage that allows us to deliver information-enabled healthcare at scale.

Our Clinical Model: Proactively Managing Member Care to Improve Outcomes and Reduce Cost

We engage regularly with members as part of their daily lives and proactively manage their chronic conditions to improve outcomes and reduce cost.

Our clinical model is designed specifically for seniors and is managed across multiple disciplines (medical, social, psychological, pharmaceutical and functional) and sites of care (home, inpatient, outpatient, virtual and others). Our internal care teams and external providers use AVA to coordinate high-quality care for members and manage the complexity of the healthcare system. Given the prevalence of comorbidities within our chronically ill members, coordination across a multi-disciplinary care team is vital to providing a medical and behavioral care plan that drives improved outcomes.

Our care delivery model creates a highly personalized experience that is unique to each member. Using insights from AVA, we organize members into four categories to provide optimized care: healthy, healthy utilizer, pre-chronic and chronic. The data below represents a sample of our population stratification from 2024.

Healthy: The typical member in the "healthy" category requires low levels of medical care. Healthy members comprise approximately 71% of our membership base but account for only 5% of the institutional claims submitted.

Healthy Utilizer: The typical member in the "healthy utilizer" category is an otherwise healthy senior who has had isolated or unexpected health challenges requiring significant medical care. Healthy utilizers comprise approximately 8% of our membership base and account for 16% of the institutional claims submitted.

Pre-Chronic: The typical member in the "pre-chronic category" is identified as high-risk by AVA but has yet to incur significant healthcare expenditures. We also refer to these members as on the "launching pad," and by deploying our targeted care programs towards this population we work to prevent or slow their increasing acuity levels. Pre-chronic members comprise approximately 8% of our membership but account for only 1% of the institutional claims submitted. Our active approach to monitoring gaps in care and acting before emerging health problems worsen is reflective of the culture of care embedded in our organization, and our focus on being a persistent advocate for our members.

Chronic: The typical member in the "chronic" category is generally a complex patient with multiple chronic conditions in need of significant, coordinated care. Chronic members comprise 13% of our membership but account for 78% of the institutional claims submitted.

Care Anywhere: Proactive, Coordinated Care Delivers Results

While the majority of healthy and healthy utilizer members' care needs are managed by our network of local community providers in conjunction with our support and oversight, our pre-chronic and chronic members are in our *Care Anywhere* program. *Care Anywhere* is an advanced clinician-driven model of care that is staffed by Alignment-employed physicians, advanced practice clinicians, case managers, social workers and behavioral health coaches to assure execution of cross-functional care plans. Unlike many managed care plans, we have built these services in-house to provide valuable, high-quality care to members for free, which complement the care provided by our provider partners for their most challenging and resource-intensive patients.

Key features of the *Care Anywhere* program include proactive outreach; 24/7 access; highly detailed personalized care plans; and enhanced coordination of care and social needs. Standardized care programs are targeted to seniors based on their underlying conditions, such as chronic heart failure or chronic obstructive pulmonary disorder, which are then personally tailored based on each individual's underlying circumstances. We proactively engage with this high-risk group of seniors based on their preferences for care delivery, which is typically in their homes or through telephonic and video consultations.

We believe, based on data gathered and analyzed using AVA, that our *Care Anywhere* program creates several benefits for our high-risk, complex members: improved quality of life, high patient satisfaction, reductions in unnecessary emergency room visits and inpatient care, and lower re-admission rates. This also allows us to establish a more direct relationship with seniors, building member loyalty and brand recognition. Our *Care Anywhere* program has an NPS score greater than 78, underscoring the positive impact it has on our most vulnerable members.

Our collective investment in our care model and technology platform has produced strong clinical outcomes for our seniors. In 2024, we achieved a hospitalization rate of approximately 152 hospitalizations per every 1,000 at-risk members, which is approximately 39% lower than the 2019 Medicare FFS performance in our markets. Further, we have achieved approximately 152-159 inpatient admissions per thousand on our at-risk membership for the last seven years in a row, despite our significant membership growth over that period of time.

Regulation

Our operations and those of our affiliated entities are subject to extensive federal, state and local governmental laws and regulations. These laws and regulations require us to meet various standards relating to, among other things, reports to CMS, personnel qualifications, maintenance of proper records and quality assurance programs and patient care. The majority of our regulation and oversight comes from CMS, which regulates almost every aspect of our business, including our provider network, benefits, member enrollment, risk adjustment program, plan offerings, claims payments, quality improvement programs, and appeals and grievances. We

have entered into standard form agreements with CMS pursuant to Sections 1851 through 1859 and Sections 1860D-1 through 1860D-43 of the Social Security Act ("SSA"), pursuant to which we have agreed to operate our plans in accordance with applicable laws and regulations and CMS has agreed to make payments to us under the SSA. Each CMS contract has a one-year term expiring on December 31 of the applicable calendar year and is subject to annual one-year renewal terms. Under the contracts we are obligated to provide our members basic benefits and services covered by Part A and Part B of the original Medicare Program, any applicable supplemental benefits we elect to provide in our final benefit and price bid proposals approved by CMS, and prescription drugs. The CMS contracts further require us to develop our annual benefit and price bid proposals and submit to CMS all related information on premiums, benefits and cost sharing by no later than the first Monday in June prior to the commencement of the subsequent calendar year to which they apply, in accordance with the CMS regulations. Each CMS contract may be terminated by mutual consent or by CMS or by us for cause. We are required to accept new enrollments, make enrollments effective, process voluntary disenrollments and limit involuntary disenrollments in accordance with the CMS regulations. Generally, to enroll or remain enrolled in one of our Medicare Advantage plans, an individual must be a U.S. citizen or lawfully present in the United States, be entitled to Medicare under Part A and enrolled in Part B, reside in the service area covered by the plan, complete and sign the required election forms to enroll and agree to abide by the rules of the Medicare Advantage plan into which he or she is enrolled or intends to enroll. Such agreements also provide for member and provider protections and marketing requirements, as well as recordkeeping and reporting requirements, all with reference to applicable laws and regulations. If any of our operations or those of our affiliated professional medical corporations are found to violate applicable laws or regulations, or if we otherwise fail to adhere to our contracts with CMS, 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:

- termination of one or more of our Medicare Advantage plans or contracts;
- suspension of our marketing of and/or enrollment into our Medicare Advantage plans;
- civil monetary penalties;
- refunds of amounts received in violation of law or applicable Medicare Advantage requirements dating back to the applicable statute of limitation periods;
- loss of our required government certifications;
- loss of our licenses required to operate our clinics and in-house care delivery programs;
- criminal or civil liability, fines, damages or monetary penalties for violations of healthcare fraud and abuse laws, including the Stark Law, the Anti-Kickback Statute, the FCA and the Civil Monetary Penalties Law and/or state analogs to these federal enforcement authorities, or other regulatory requirements;
- enforcement actions by governmental agencies and/or state law claims for monetary damages by patients who believe their health information has been used, disclosed or not properly safeguarded in violation of federal or state patient privacy laws, including the Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (the "HITECH Act"), and their implementing regulations (collectively known as "HIPAA")
- mandated changes to our practices or procedures that significantly increase operating expenses or decrease our revenue;
- imposition of and compliance with corporate integrity agreements that could subject us to ongoing audits and reporting requirements, as well as increased scrutiny of our business practices which could lead to potential fines, among other things;
- termination of various relationships and/or contracts related to our business, including provider arrangements;
- changes in and reinterpretation of rules and laws by a regulatory agency or court, such as state corporate practice of medicine laws, that could affect the structure and management of our business and our affiliated physician-owned professional medical groups;
- negative adjustments to government payment models including, but not limited to, Parts A, B and D benefits; and
- harm to our reputation, which could negatively impact our business relationships, our ability to attract and retain patients and physicians, our ability to obtain financing and our access to new business opportunities, among other things.

We expect that our industry will continue to be subject to substantial regulation, the scope and effect of which are difficult to predict. See "*Risk Factors—Risks Related to Regulation.*"

In addition to the SSA, CMS regulations, and our contractual obligations, we must also comply with a variety of other laws:

HIPAA, HITECH Act and Other Laws, Rules and Regulations Related to Data Privacy; Security and Protection

We are subject to data privacy and protection and breach notification laws and regulations that apply to the collection, transmission, storage and use of protected health information ("PHI"), and other types of personal data or personally identifiable information ("PII"), which among other things, impose certain requirements relating to the privacy and security of such PII. The legislative and regulatory landscape for privacy and data protection continues to evolve, and there has been an increasing focus on privacy and data protection issues with the potential to affect our business. Failure to comply with any of these laws and regulations could result in enforcement action against us, including fines, public censure, claims for damages by affected individuals, damage to our reputation and loss of

goodwill. Ongoing efforts to comply with evolving laws and regulations may be costly and require ongoing modifications to our policies, procedures and systems.

The use of individually identifiable health data by our business is regulated at federal and state levels. These laws and rules are changed frequently by legislation or administrative interpretation. Various state laws address the use and maintenance of individually identifiable health information. HIPAA includes administrative provisions directed at simplifying electronic data interchange through standardizing transactions, establishing uniform healthcare provider, payer, and employer identifiers, and establishing regulations aimed at protecting confidentiality and security of patient and member data. The rules preempt all inconsistent state laws unless the state law is more privacy-protective. These regulations, in addition to other state laws, set standards for the security of electronic health information, including requirements that insurers provide customers with notice regarding how their individually identifiable health information is used.

The US Department of Health and Human Services, Office for Civil Rights announced on December 27, 2024, and published in the Federal Register on January 6, 2025, a Notice of Proposed Rulemaking proposing extensive modifications to the HIPAA security standards. If finalized, these modifications and could entail significant additional compliance obligations and costs for HIPAA-regulated covered entities and business associates.

HIPAA imposes mandatory penalties for certain violations. In 2024, penalties for violations of HIPAA and its implementing regulations started at $141 per violation and could not exceed approximately $71,162 per violation, subject to a cap of approximately $2.1 million for violations of the same standard in a single calendar year. However, a single breach incident can result in violations of multiple standards. The penalty amounts listed above are also due for inflation adjustments in 2025.

HIPAA also authorizes state attorneys general to file suit on behalf of their residents for statutory damages of up to $25,000. While HIPAA does not create a private right of action allowing individuals to sue in civil court for violations of HIPAA, its standards have been used as the basis for duty of care in state civil suits such as those for negligence or recklessness in the misuse or breach of PHI.

In addition, the HITECH Act mandates that the Secretary of the Department of Health and Human Services ("HHS") conduct periodic compliance audits of HIPAA-regulated covered entities and business associates for compliance with HIPAA's privacy and security standards. It also tasks HHS with establishing a methodology whereby harmed individuals who were the victims of breaches of unsecured PHI may receive a percentage of any civil monetary penalty fine paid by the violator.

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

We also publish statements to our members and partners that describe how we handle and protect PHI. If federal or state regulatory authorities or private litigants consider any portion of these statements to be untrue, we may be subject to claims of deceptive practices, which could lead to significant liabilities and consequences, including, without limitation, costs of responding to investigations, defending against litigation, settling claims, and complying with regulatory or court orders.

Data privacy and security at the state level remains an evolving landscape. For example, California's California Consumer Privacy Act of 2018 ("CCPA"), which came into effect on January 1, 2020, has since been amended by the California Privacy Rights Act ("CPRA"), which became effective on January 1, 2023 and began enforcement on July 1, 2023. The CCPA, as amended by the CPRA, expands on the existing rights provided to California residents and will include rights to know, delete, correct, personal information; limit the use of sensitive personal information; and opt out of the sale of personal information or the sharing of personal information with third parties for purposes of cross-context behavioral advertising. There are also requirements for data processing and cybersecurity assessments, and contracting requirements for service providers, third parties, and contractors who receive and process information from the regulated "business." The CPRA amendment created a state agency, the California Privacy Protection Agency ("CPPA"), to enforce and implement the law. This agency will be able to finance operations through penalties issued and, with the CPRA's removal of the mandatory cure period from the CCPA, we will have less warning before compliance risk results in legal action. Additionally, the CCPA's exemption for personal information of personnel (including employees, job applicants, officers, and directors) and business-to-business contacts has been allowed to sunset. As a result, beginning on January 1, 2023, personal information of California resident personnel and business contacts became subject to the CCPA. This has created compliance obligations for our operations.

The CCPA and CPRA contain exemptions for medical information governed by the California Confidentiality of Medical Information Act, and for PHI collected by a covered entity or business associate governed by the privacy, security, and breach notification rule established pursuant to HIPAA. This exempts much of the data we process with respect to patients and plan members.

The CCPA has prompted a number of proposals for new federal and state-level privacy legislation. Such proposed legislation, if enacted, may add additional complexity, variation in requirements, restrictions and potential legal risk, require additional investment of resources in compliance programs, impact strategies and the availability of previously useful data and could result in increased compliance costs

and/or changes in business practices and policies. For example, the Virginia Consumer Data Protection Act, which became effective January 1, 2023, gives Virginia residents expanded rights to access and creates additional obligations on companies covered by the legislation and the Nevada Privacy Law, which became effective on October 1, 2019, requires businesses to give website users the option to opt-out of the sale of their data. State privacy laws also became effective in 2024 in Kentucky, Maryland, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, Oregon, Rhode Island, and Texas and have or will become effective in 2025 in Delaware, Iowa, Nebraska, New Hampshire, New Jersey, Tennessee, Minnesota, and Maryland. These state laws generally exempt HIPAA regulated covered entities and business associates, PHI, and/or personal information collected in the context of employment and business-to-business relationships.

While the CPRA/CCPA is an example of consumer privacy law, the NAIC's Insurance Data Security Model Law (the "Model Law") is a different type of law focused on securing insurance licensees' information systems. Versions of this Model Law have been passed in many states and are expected to be passed in more states in the coming years. Similar to HIPAA, the Model Law requires the implementation of technical, administrative, and physical information security practices and procedures and includes reporting requirements for data breaches. These Model Laws are typically enforced by state insurance regulators. We are not currently subject to any of these laws that have been adopted to date.

It is possible that applicable laws may be interpreted and applied in a manner that is inconsistent with our practices and our efforts to comply with the evolving data protection rules may be unsuccessful. We must devote significant resources to understanding and complying with this changing landscape. Failure to comply with laws regarding privacy and security of PHI and other PII could expose us to penalties under such laws. Any such failure to comply with data protection and privacy laws could result in government-imposed fines or orders requiring that we change our practices, claims for damages or other liabilities, regulatory investigations and enforcement action, litigation and significant costs for remediation.

As indicated above, there are numerous federal and state laws and regulations addressing patient and consumer privacy concerns, including notification requirements in the event of unauthorized access or theft of personal information. State statutes and regulations vary from state to state. Substantially all of our relevant member data is maintained on our technology platform, AVA, which aggregates and provides us with access to extensive member datasets, including individually identifiable PHI. Violations of HIPAA or applicable federal or state laws or regulations could subject us to significant criminal or civil penalties, including significant monetary penalties. Compliance with HIPAA and other privacy regulations requires significant and ongoing systems enhancements, training and administrative effort. See "*Risk Factors—Security breaches, loss of data and other disruptions could compromise sensitive information related to our business or our members, or prevent us from accessing critical information and expose us to liability, which could adversely affect our business and our reputation.*"

Our business and operations may also be subject to federal, state, and local consumer protection laws governing marketing communications, including the Telephone Consumer Protection Act ("TCPA"), which places restrictions on the use of automated tools and technologies to communicate with wireless telephone subscribers or communications services consumers generally and the CAN-SPAM Act, which regulates the transmission of marketing emails. In addition, certain of our businesses are also subject to the Payment Card Industry Data Security Standard ("PCI DSS"), which is a multifaceted industry security standard that is designed to protect credit card account data as mandated by payment brands and acquiring banks.

The Health Care Reform Law and Other Current or Future Legislative, Judicial or Regulatory Changes

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the "Health Care Reform Law") enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the Health Care Reform Law include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage premiums, the establishment of federally facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, and the introduction of plan designs based on set actuarial values. Some of these changes impact us and other entities that offer Medicare Advantage plans. In addition, the Health Care Reform Law established insurance industry assessments, including the Comparative Effectiveness Research Fee to fund the Patient-Centered Outcomes Research Institute.

Corporate Practice of Medicine and Other Laws

As a corporate entity, we are not licensed to practice medicine. Many states in which we operate through our subsidiaries limit the practice of medicine to licensed individuals or professional organizations comprised of licensed individuals, and business corporations generally may not exercise control over the medical decisions of physicians. Statutes, regulations and court decisions relating to the practice of medicine, fee-splitting between physicians and referral sources, and similar issues vary widely from state to state. The laws and regulations in these areas are complex, changing, and often subject to varying interpretations. The interpretation and enforcement of these laws vary significantly from state to state. Under business support agreements between certain of our subsidiaries and associated physician-owned professional groups, these groups retain sole responsibility for all medical decisions, as well as for hiring and managing physicians and other licensed healthcare providers, developing operating policies and procedures, implementing professional standards and controls, and maintaining malpractice insurance.

We, our in-house and externally engaged physicians and the facilities in which they operate are subject to various federal, state and local licensing and certification laws and regulations and accreditation standards and other laws, relating to, among other things, the adequacy of medical care, equipment, privacy of member information, physician relationships, personnel and operating policies and procedures.

Failure to comply with these licensing, certification and accreditation laws, regulations and standards could result in prior payments being subject to recoupment, requirements to make significant changes to our operations and can give rise to civil or, in extreme cases, criminal penalties. We routinely take the steps we believe are necessary to retain or obtain all requisite licensure and operating authorities.

In jurisdictions where the corporate practice of medicine is prohibited, we have historically operated by maintaining long-term business support services contracts with multiple associated professional medical entities that are wholly owned by physicians and, in turn, employ or contract with physicians to provide those professional medical services required by our members. Under these business support services agreements, our primary operating subsidiary performs only non-medical business support services, does not represent that it offers medical services and does not exercise influence or control over the practice of medicine by the physicians or the associated physician groups. In addition to the above business support services arrangements, we have certain contractual rights relating to the orderly transfer of equity interests in our associated physician practices through succession agreements and other arrangements with their physician equity holders. Such equity interests cannot, however, be transferred to or held by us or by any non-professional medical entity. Accordingly, neither we nor our direct subsidiaries directly own any equity interests in any of our associated physician practices.

Anti-Kickback, Physician Self-Referral and Other Fraud and Abuse Laws

A federal law commonly referred to as the "Anti-Kickback Statute" prohibits the offer, payment, solicitation, or receipt of any form of remuneration to induce, or in return for, the referral of Medicare or other governmental health program patients or patient care opportunities, or in return for the purchase, lease or order of items or services that are covered by Medicare or other federal governmental health programs. Because the prohibitions contained in the Anti-Kickback Statute apply to the furnishing of items or services for which payment is made in "whole or in part," the Anti-Kickback Statute could be implicated if any portion of an item or service we provide is covered by any of the state or federal health benefit programs described above. Violation of these provisions constitutes a felony criminal offense and applicable sanctions could include exclusion from the Medicare and Medicaid programs.

Section 1877 of the Social Security Act, commonly known as the "Stark Law," prohibits physicians, subject to certain exceptions described below, from referring Medicare or Medicaid patients to an entity providing "designated health services" in which the physician, or an immediate family member, has an ownership or investment interest or with which the physician, or an immediate family member, has entered into a compensation arrangement. These prohibitions, contained in the Omnibus Budget Reconciliation Act of 1993, commonly known as "Stark II," amended prior federal physician self-referral legislation known as "Stark I" by expanding the list of designated health services to a total of 11 categories. The professional groups with which we are contracted or affiliated provide one or more of these designated health services. Persons or entities found to be in violation of the Stark Law are subject to denial of payment for services furnished pursuant to an improper referral, civil monetary penalties, and exclusion from the Medicare and Medicaid programs.

A federal law commonly referred to as the "False Claims Act" prohibits the submission of a false or fraudulent claim to the government for payment or approval. *Qui tam* relators and/or the government may take the position that we submit certain data or information that could form the basis of a claim for payment, thus subjecting us to allegations under the False Claims Act. In such events, we could be subject to treble damages and per-claim penalties.

Many states also have enacted laws similar in scope and purpose to the Anti-Kickback Statute and, in more limited instances, the Stark Law, that are not limited to services for which Medicare or Medicaid payment is made. In addition, most states have statutes, regulations, or professional codes that restrict a physician from accepting various kinds of remuneration in exchange for making referrals. These laws vary from state to state and have seldom been interpreted by the courts or regulatory agencies. In states that have enacted these statutes, we believe that regulatory authorities and state courts interpreting these statutes may regard federal law under the Anti-Kickback Statute and the Stark Law as persuasive.

State Regulation of Insurance-Related Products

Laws in each of the states in which we operate our business license and regulate entities that offer health plans to residents of that state. The products we offer are sold under licenses issued by the applicable insurance regulators. However, for entities offering Medicare Advantage plans, federal law preempts all state laws and regulations except those relating to licensing and financial solvency.

Certain of our licensed insurance subsidiaries are also subject to regulation under state insurance holding company regulations. These regulations generally require, among other things, prior approval and/or notice of new products, rates, benefit changes, and certain material transactions, including dividend payments, purchases or sales of assets, intercompany agreements, and the filing of various financial and operational reports. The amount of dividends that may be paid to us by these insurance subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements. We continue to maintain our levels of aggregate excess statutory capital and surplus in our state-regulated operating subsidiaries. Dividends from our non-insurance companies are generally not restricted by departments of insurance. See "*Risk Factors—Risks Related to Regulation—State Regulation of Insurance-Related Products*."

Intellectual Property

We believe that our intellectual property rights are valuable and critical to our business stability and growth. We rely on a combination of trademarks, copyrights, trade secrets, know-how license agreements and confidentiality procedures, non-disclosure agreements, employee disclosure and invention assignment agreements and other contractual rights to establish and protect our proprietary rights.
We do not have any issued patents with respect to our AVA platform, and we are not currently pursuing any patent applications.
We intend to pursue additional intellectual property protection to the extent we believe it would be beneficial and cost effective.

Competition

The U.S. healthcare insurance industry is highly competitive. Our competitors vary by local market and include other managed care companies, national insurance companies, HMOs and PPOs. Many of our competitors have a larger membership base and/or greater financial resources than we do. In addition, other companies may enter our markets in the future, including emerging competitors in the Medicare Advantage program or competitors in the delivery of healthcare services. We believe that barriers to entry in our markets are not substantial, so the addition of new competitors can occur relatively easily, and customers enjoy significant flexibility in moving between competitors. Contracts for the sale of our products are generally tied to an annual bidding process with CMS. While health plans compete on the basis of many factors, including service and the quality and depth of provider networks, we expect that price and Star ratings will continue to be significant bases of competition. In addition to the challenge of controlling healthcare costs, we face intense competitive pressure to contain premium prices. Factors such as business consolidations, strategic alliances, legislative reform and marketing practices create pressure to contain premium price increases, despite being faced with increasing medical costs. The primary competitive factors for our industry include, but are not limited to, the following:

- premium price;
- Star ratings;
- breadth and richness of benefits, such as maximum out-of-pocket, deductibles, co-pays, Part B rebates, in addition to others;
- diversity of services and products offered, particularly ones that address the social determinants of health;
- breadth of network access;
- level of member engagement;
- level of member satisfaction;
- the quality of the member experience provided, including member service;
- care delivery and health outcomes;
- costs of care;
- ability to recruit and retain skilled employees and clinicians;
- brand identity and reputation; and
- regulatory compliance

Environmental, Social and Governance and Human Capital

Environmental, Social and Governance

We are committed to implementing meaningful environmental, social, and governance ("ESG") practices. Our goal is to drive sustainable business growth while balancing our responsibilities to shareholders, employees, members, and the greater community. The three pillars to our ESG approach are the following:

- ***Serving People*** – Our employees are our most valuable asset, and we are dedicated to providing them with a safe, diverse, and inclusive workplace. See "*—Employees and Human Capital Resources*" below. We are also dedicated to serving our members with the utmost care and concern for their safety and health and strive to support our health care providers with the tools and resources needed to provide the best care.
- ***Serving the Environment*** – Our company is focused on reducing its carbon footprint by implementing energy-efficient practices, reducing water and waste, and exploring renewable energy sources.
- ***Serving Responsibly*** – We are committed to maintaining a high level of transparency and accountability across our operations. Our Board of Directors includes a strong and diverse mix of experienced business leaders and is committed to providing effective oversight of the Company's activities.

In 2022, we released our inaugural ESG report and created an ESG Steering Committee comprised of cross-functional leaders representing every department within the Company. Our aim is to continue fortifying each pillar and to operate with transparency in a way that always puts seniors first, and respects all people, communities, conditions, and environments.

Employees and Human Capital Resources

We are focused on building a company that is transforming health care by putting seniors first, and our employees are critical to our success. Our Human Capital strategy focuses on meeting business objectives by attracting, developing, engaging, and retaining a high-performing, diverse workforce. As of December 31, 2024, we had 1,679 full-time employees in addition to seasonal employees who assist with the Medicare AEP.

Each year, we conduct an employee survey to further enhance employee engagement and productivity. We also implement rigorous employee training protocols to help ensure our teams operate with rigor, ethics and compliance in mind.

We recognize that an inclusive workplace is crucial as we scale and build our high-performing team. All aspects of our inclusive culture continue to be embedded in each aspect of our processes, programs, and structures that drive our talent lifecycle: attraction, recruitment, onboarding, development, and retention efforts. Our efforts to recruit for excellence are reflected in the composition of our current employee workforce and Board of Directors, which are comprised of a diverse group of highly qualified individuals that represent top talent in the industry. As of December 31, 2024:

- 74% of our employees were female;
- 65% of our employees were ethnically diverse;
- 20% of our executive team was ethnically diverse;
- 10% of our executive team was female;
- 22% of our Board of Directors was ethnically diverse; and
- 44% of our Board of Directors was female.

The future success of our company will depend, in part, on our continued ability to attract, develop and retain the best talent as we grow and scale the organization. Our talent acquisition and management strategies are designed to ensure that we create and develop a pipeline of outstanding physicians, clinical employees, and business leaders. A key component of our corporate sustainability and success is learning and development. We are intentional in our efforts to provide all employees opportunities to grow. Our training and development programs for employees focus on enhancing and developing talent within the company. All of our employees can access the training of their choice on-demand through our learning and development platform. We are currently designing additional training programs and resources for both new hires and longer-tenured employees that will educate them on critical functional areas of within the organization.

Our compensation and incentive plans are designed to attract, retain, and reward employees by granting cash-based performance and stock-based awards. By motivating individuals to achieve business objectives and perform to the best of their abilities, they support the success of the company and the increase of stockholder value. We also provide comprehensive medical benefits, a positive work/life balance, generous paid time off, and health and wellness programs. We regularly evaluate each aspect of compensation and benefits to ensure they align with the market and our peers.

Our current workforce model embraces working in a hybrid-remote fashion. Our workforce strategy enhances our ability to attract the best talent nationally, allowing us to serve our members where they live and continue to provide our employees with a healthy work-life balance.

Our board of directors believes that human capital management is an essential component of our continued growth and success. Management regularly reports to our board for input on important decisions related to human capital, including corporate culture, safety, compliance, talent management, organizational development, compensation, and benefits.

Corporate Information

We were originally formed as a Delaware limited liability company under the name Alignment Healthcare Holdings, LLC in 2013. In March 2021, we completed the Corporate Conversion and Corporate Reorganization and changed our name to Alignment Healthcare, Inc. During the same month, we completed our initial public offering and our common stock began trading on the Nasdaq Global Select Market under the symbol "ALHC."

Our principal executive office is located at 1100 W. Town & Country Rd., Suite 1600, Orange, CA 92868 and our phone number is (844) 310-2247. Our website address is www.alignmenthealth.com. The information contained on, or that can be accessed through, our website is not incorporated by reference into this filing and you should not consider any information contained on, or that can be

accessed through, our website as part of this filing. We are a holding company and all of our business operations are conducted through our subsidiaries and affiliated medical groups.

Our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K and, if applicable, amendments to those reports filed or furnished pursuant to Section 13(a) of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), are available free of charge on or through our website, https://www.alignmenthealth.com, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the Securities and Exchange Commission, or the SEC. The SEC's website, https://www.sec.gov, contains reports, proxy and information statements, and other information regarding issuers that file electronically with the SEC.

Item 1A. Risk Factors.

Our business involves a high degree of risk. You should carefully consider the risks and uncertainties described below, together with all of the other information contained in this Annual Report on Form 10-K, including our consolidated financial statements and the related notes thereto, before making a decision to invest in our common stock. The risks and uncertainties described below are not the only ones we face. Additional risks and uncertainties that we are unaware of, or that we currently believe are not material, may also become important factors that affect us. If any of the following risks occur, our business, financial condition, operating results and prospectus could be materially and adversely affected. In that event, the price of our common stock could decline, and you could lose all or part of your investment.

Risk Factors Summary

The following are the principal risks that are applicable to our business and the shares of our common stock. Such risks are discussed in more detail below, and you should read this Risk Factors section in its entirety before deciding whether to invest in our common stock.

- We have a history of net losses and may be unable to achieve or maintain profitability.
- Our relatively limited operating history makes it difficult to evaluate our current business and future prospects.
- Our growth strategy may not prove viable and we may not realize expected results.
- If we are unable to attract new members, our revenue growth will be adversely affected.
- If we do not design and price our products properly and competitively, cannot develop new products and implement clinical initiatives, lower costs, and appropriately document members' risk profile, or if our benefits expense estimates are inadequate, our profitability may be materially adversely affected.
- We may not be successful in maintaining or improving our Star ratings in future years, which may have a direct and substantial adverse impact on our revenue.
- If we fail to develop and maintain satisfactory relationships with care providers, our business may be adversely affected.
- As a government contractor, we risk the potential loss of CMS contracts, suspension from the Medicare Advantage program, changes to premiums paid to Medicare Advantage plans, changes to provisions for risk sharing under Medicare Part D and governmental audits and investigations, among others.
- If we fail to manage our growth effectively, we may be unable to execute our business plan, maintain high levels of service and member satisfaction or adequately address competitive challenges.
- The loss or renegotiation of certain key contracts with large independent physician associations ("IPAs"), hospitals or other provider networks, to serve our membership base could negatively impact our results.
- Security breaches, loss of data and other disruptions could compromise sensitive business or member information, or prevent access to critical information and expose us to liability.
- Disruptions in our disaster recovery systems or management continuity planning could limit our ability to operate our business effectively and adequately care for our members.
- Our business depends on our ability to effectively invest in, implement improvements to and properly maintain the uninterrupted operation and data integrity of our information technology platform.
- We may be subject to legal proceedings and litigation, including intellectual property and privacy disputes.
- Our business may be impacted if the healthcare services industry becomes more cyclical.
- If we are not able to maintain, enhance and protect our reputation and brand recognition, including through the maintenance and protection of trademarks, our business and results of operations will be harmed.
- If we are unable to obtain, maintain, protect and enforce sufficiently broad intellectual property protection, including for our trade secrets, know-how and other proprietary and internally developed information, the value of our technology could be adversely affected.

- Third parties may initiate legal proceedings alleging intellectual property rights violations, the outcome of which would be uncertain and could have a material adverse effect on our business.
- Any restrictions on our use of, or ability to license, data, or our failure to license data and integrate third-party technologies, could have a material adverse effect on our business.
- We depend on our senior management team and other key employees, and the loss of one or more of these employees or an inability to attract and retain other highly skilled employees could harm our business.
- We have limited experience serving as a direct contracting entity with CMS under the ACO REACH program and may not be able to realize the expected benefits thereof.
- Our plans are concentrated in a limited number of U.S. states and we may not be able to establish new geographic presences.
- Competition for physicians and nurses, shortages of qualified personnel or other factors could increase our labor costs and adversely affect our revenue, profitability and cash flows.
- Our records may contain inaccurate or unsupportable information regarding risk adjustment scores of members, which could cause misstatements of revenue and subject us to penalties.
- Inaccurate estimates of incurred but not reported medical expense could adversely affect our results.
- Negative publicity regarding our industry generally could adversely affect our results of operations or business.
- Medicare Advantage funding reductions could adversely affect our results of operations.
- The healthcare industry is highly competitive, and this competition may have a material adverse effect on our business operations and financial position.
- If we are unable to offer new and innovative products and services or fail to keep pace with industry advances, technology and needs, our members may terminate memberships.
- We are a holding company with no operations of our own, and we depend on our subsidiaries for cash.
- We may be required to maintain higher statutory capital levels for our existing operations or may become subject to additional capital reserve requirements as we pursue new business opportunities.
- New laws or changes in laws or their application could increase our cost of doing business.
- We must adapt to changes in the healthcare industry and related regulations or our business may be harmed.
- Losing the services of the physicians who own our associated physician practices could jeopardize our contractual arrangements.
- Our existing indebtedness could adversely affect our business and growth prospects, particularly in an environment of rising interest rates.
- Our failure to raise additional capital or generate cash flows could reduce our ability to compete successfully.
- Our lead sponsor has significant control over our business activities, and their interests may conflict with ours or yours in the future.
- The requirements of being a public company may strain our resources and distract our management.
- Provisions of our corporate governance documents could make an acquisition of us more difficult.
- The exclusive forum provision in our certificate of incorporation may have the effect of discouraging lawsuits against our directors and officers.
- An active, liquid trading market for our common stock may not be sustained.
- Our operating results and stock price may be volatile, including as a result of economic or industry-wide factors that are beyond our control.
- A significant portion of our total outstanding shares may be sold into the market in the near future.
- Future sales of substantial amounts of common stock, or the possibility of such sales, could adversely affect stock price.

Risks Related to Our Business

We have a history of net losses, we anticipate increasing expenses in the future, and we may not be able to achieve or maintain profitability.

We have incurred net losses on an annual basis since our inception, including a net loss of $128.1 million and $148.2 million for the years ended December 31, 2024 and December 31, 2023. As of December 31, 2024, we had an accumulated deficit of $1,008.3 million.

We expect our aggregate costs will increase substantially in the foreseeable future as we expect to invest heavily in increasing our member base, growing our provider networks, expanding our operations geographically, engaging in expanded marketing and outreach efforts, enhancing our technology, hiring additional employees, operating as a public company and acquiring companies or assets complementary to our business. These efforts may prove more expensive than we currently anticipate, and we may not succeed in increasing our revenue sufficiently to offset these higher expenses. In addition, even if we are successful in increasing our membership and consequently increasing our total revenues from premiums earned, we may not successfully and effectively predict, price and manage the medical costs of our members. To date, we have financed our operations principally from the sale of our equity, revenue from the CMS and the incurrence of indebtedness. We may not generate positive cash flow from operations or profitability in the future.

We have encountered and will continue to encounter risks and difficulties frequently experienced by growing companies in rapidly changing industries, including increasing expenses as we continue to grow our business. In addition to the expected costs to grow our business, we also expect to incur additional legal, accounting and other expenses as we continue to operate as a public company. Moreover, the investments we intend to make into growing our company may be more costly than we expect, and if we do not achieve the benefits anticipated from these investments, or if the realization of these benefits is delayed, they may not result in increased revenue or growth in our business. If our growth rate were to decline significantly or become negative, it could adversely affect our financial condition and results of operations. Furthermore, even if we achieve profitability in the future, we may not be able to sustain profitability in subsequent periods. If we are not able to maintain positive cash flow in the long term, we may require additional financing, which may not be available on favorable terms or at all and/or which would be dilutive to our stockholders. If we are unable to successfully address these risks and challenges as we encounter them, our business, results of operations and financial condition would be adversely affected. Our failure to achieve or maintain profitability could negatively impact the value of our common stock.

Our relatively limited operating history makes it difficult to evaluate our current business and future prospects and increases the risk of your investment.

Our relatively limited operating history makes it difficult to evaluate our current business and prospectus and plan for our future growth. We were founded in 2013, with most of our growth occurring in recent years. We have encountered and will continue to encounter significant risks and uncertainties frequently experienced by new and growing companies in heavily regulated and rapidly changing industries, such as determining appropriate investments for our limited resources, scaling our model and technology platform, attracting and retaining members, efficiently navigating and complying with evolving regulations, hiring, integrating, training and retaining skilled personnel, identifying and reaching agreements with reliable healthcare service providers, competing against more established competitors, unforeseen expenses and challenges in forecasting accuracy. Although we have successfully expanded our footprint outside of California and intend to continue to expand into new markets, new plans we provide or new markets we enter may not prove successful. If we are unable to increase our member enrollment, scale our platform, maintain a low cost structure, identify, reach and successfully maintain agreements with reliable healthcare service providers, successfully manage our third-party medical costs or successfully expand the range of services and benefits we offer to members, our revenue and our ability to achieve and sustain profitability would be impaired. Additional risks include our ability to effectively manage growth, process, store, protect and use personal data in compliance with governmental regulation, contractual obligations and other legal obligations related to privacy and security and manage our obligations as a healthcare plan. If our assumptions regarding these and other similar risks and uncertainties, which we use to plan our business, are incorrect or change as we gain more experience operating our business or due to changes in our industry, or if we do not address these challenges successfully, our operating and financial results could differ materially from our expectations and our business could suffer.

Our growth strategy may not prove viable and we may not realize expected results.

Our business strategy is to grow rapidly by expanding our service offerings through an array of non-traditional benefits and continuing to build out and attract network relationships in our existing markets. We also intend to expand into new markets, leveraging our AVA technology platform, which has been designed to scale and allow us to provide a predictable and replicable member experience across new markets. Our strategy hinges on our ability to satisfy our members in our existing markets, achieve and maintain high Star ratings for our plans, submit successful bids to CMS for new plans and/or in new markets, attract new members, form alliances with primary care providers, and hire physicians, nurses and other medical support staff for our in-house care delivery programs, among other factors. We also seek growth opportunities through strategic acquisitions and vertical integration, as well as through joint ventures or other strategic arrangements. We cannot guarantee that we will be successful in pursuing our growth strategy. If we fail to evaluate and execute new business opportunities properly, we may not achieve anticipated benefits and may incur increased costs.

Our growth strategy involves a number of risks and uncertainties, including that:

- we may not be able to successfully enter into contracts with local providers in existing or new markets on terms favorable to us or at all. In addition, we compete for provider relationships with many other health care plans, some of whom may have greater resources than we do. This competition may intensify due to the ongoing consolidation in the healthcare industry, which may increase our costs to pursue such opportunities;
- we may not be able to maintain and improve the satisfaction levels of our members, which could lead to decreased ratings for some of our plans in the Five Star Quality Rating System and consequently to loss of the economic incentives associated with high Star ratings, which could negatively impact our revenues;

- we may not be able to enroll or retain a sufficient number of new members to execute our growth strategy, and we may incur substantial costs to enroll new members but may be unable to enroll a sufficient number of new members to offset those costs;
- we may not be able to realize the value of our AVA technology platform;
- we may not be able to hire or otherwise engage sufficient numbers of physicians and other staff and may fail to integrate our employees, particularly our medical personnel, into our in-house care model;
- we may not be successful in maintaining our reputation and brand in our existing markets or in establishing our reputation and brand with new members or into new markets;
- we may be unsuccessful in identifying or in executing key strategic joint ventures or other arrangements to facilitate our entry into new markets;
- when expanding our business into new states, we may be required to comply with laws and regulations that may differ from states in which we currently operate;
- when expanding into new markets, we may face competition with greater knowledge of such local markets;
- expansion into new offerings or new markets, or the acquisition of complementary businesses or assets, may require us to raise additional capital, which may not be available on desirable terms or at all; and
- depending upon the nature of the local market, we may not be able to implement our business model in every local market that we enter, which could negatively impact our revenues and financial condition.

Pursuing our growth strategy requires significant capital expenditures, the allocation of valuable management resources, and the hiring of additional personnel, and may strain our operations, and our financial and management controls and reporting systems and procedures. For a variety of reasons, we may not succeed in achieving scale, improving our operating efficiency or gaining operating leverage. Moreover, we have experienced and may in the future continue to experience attrition, which may further exacerbate these challenges. If we are unable to effectively execute our growth strategy and manage our growth, our results of operations and financial condition could be materially and adversely affected.

If we are unable to attract new members, our revenue growth will be adversely affected.

We currently derive substantially all of our revenue from CMS contracts related to our Medicare Advantage health plans. To increase our revenue, we must grow by expanding the number of members under our plans in the markets in which we currently operate and in the new markets that we intend to enter. In order to support such growth, we must continue to enroll and retain a sufficient number of new members. We have experienced significant member growth since we commenced operations; however, we may not be able to maintain this growth, and our member base could decrease rapidly or shrink over time. Even if we are successful in achieving and maintaining growth, doing so may be more costly than we anticipate, and if we are not able to manage our costs, our results could be materially adversely affected.

We are focused on the Medicare-eligible population and face competition from other plans in the enrollment of Medicare-eligible potential members. If we are unable to obtain CMS contracts for new plans or in new markets and convince the Medicare-eligible population of the benefits of our plans, or if potential or existing members prefer a plan offered by one of our competitors, we may not be able to effectively implement our growth strategy. Our ability to attract new members will depend on a variety of factors, including the following:

- our ability to create new plans and/or ancillary benefits;
- our ability to achieve and maintain high Star ratings for each of our plans;
- our ability to effectively promote our plans in our existing markets and the new markets we intend to enter;
- our allocation of management and financial resources toward efforts to grow our membership in certain markets;
- the extent to which eligible beneficiaries shop for MA plans in the markets we enter;
- our ability to establish relationships with provider groups and other key market constituencies;
- our competitor's products and pricing strategies;
- our ability to establish and grow our reputation and brand in new and existing markets;
- the extent to which the overall pool of MA-eligible beneficiaries continues to grow and the extent to which the historical trend of increased MA market penetration continues;
- if our strategic partners terminate or fail to renew our current contracts or we fail to enter into contracts with new strategic partners; and
- regulatory changes affecting the overall pool of MA-eligible beneficiaries and our ability to navigate the applicable regulatory requirements.

In addition, our growth strategy is partially dependent on beneficiaries electing to move from fee-for-service to one of our Medicare Advantage plans, or electing to move from their current Medicare Advantage plan and selecting us as their Medicare Advantage plan. In certain instances, original Medicare or other insurers' MA plans may be more attractive to a consumer than our MA plans. For example, though our PPO members are enrolled in plans that enable them to visit any doctor participating in Medicare who will see them, our HMO plans have restrictions on the network of doctors that HMO members can see, and in some markets other providers participating in Medicare may choose to see no MA members or only MA members participating in specific plans. It is also possible that original Medicare or other insurers' MA plans may offer broader physician networks in particular markets or highly competitive benefits, in which case those plans may be more attractive to some consumers than our MA plans. When the time to choose an MA plan comes, newly Medicare-eligible consumers may also choose to continue with their current insurer which was offered by their employer instead of transitioning to one of our plans.

For a majority of individuals, plan enrollment selections for Medicare Advantage are made during an annual enrollment period from October into December of each year; therefore, our ability to grow our member population is dependent in substantial part on our ability to successfully enroll members during the annual enrollment period and to convince such individuals not to subsequently change that election. If our ability to market and sell our MA plans is constrained during an enrollment period for any reason, such as technology failures, reduced allocation of resources, any inability to timely employ, license, train, certify and retain employees and contractors and agents to sell plans, interruptions in the operation of our website or systems, or disruptions caused by other external factors, such as natural disasters or civic disorder, we could acquire fewer new members than expected or suffer a reduction in the number of our existing members.

Our inability to enroll new members and retain existing members would harm our ability to execute our growth strategy and may have a material adverse effect on our business operations and financial position.

If we do not design and price our products properly and competitively, if we are unable to develop new products and implement clinical initiatives to provide a better healthcare experience for our members, lower costs, and appropriately document the risk profile of our members, or if our estimates of benefits expense are inadequate, our profitability may be materially adversely affected.

We use a substantial portion of our revenues to pay the costs of healthcare services delivered to our members by third-party providers. These costs include claims payments, capitation payments to providers (predetermined amounts paid to cover services), administrative costs and various other costs incurred to provide health insurance coverage to our members. These costs also include estimates of future payments to hospitals and other providers for medical care provided to our members. Generally, premiums in the healthcare business are fixed for one-year periods and we are required by federal law to spend a fixed amount of these premiums on healthcare services, covered benefits and quality improvement efforts. Accordingly, costs we incur in excess of our benefit cost projections generally are not recovered in the contract year through higher premiums and our ability to enhance the profitability of our plans depends in significant part on our ability to estimate the costs of our future benefit claims and other expenses. We make these estimates using actuarial methods and assumptions based upon claim payment patterns, medical inflation, historical developments, including claim inventory levels and claim receipt patterns, and other relevant factors. We also record benefits payable for future payments. We continually review estimates of future payments relating to benefit claims costs for services incurred in the current and prior periods and make necessary adjustments to our reserves, including premium deficiency reserves where appropriate. However, these estimates involve extensive judgment and have considerable inherent variability that is sensitive to claim payment patterns and medical cost trends. Many factors may and often do cause actual healthcare costs to exceed what was estimated and used to set our premiums. These factors may include:

- increased use of medical facilities and services;
- increased cost of such services;
- increased use or cost of prescription drugs, including specialty prescription drugs;
- the introduction of new or costly treatments, including new technologies;
- the extent to which providers in our network follow appropriate care recommendations and carry out effective care coordination and care management;
- our membership mix;
- the extent to which members decline to seek out appropriate preventative care or follow their physicians' care and healthful living recommendations;
- variances in actual versus estimated levels of cost associated with new products, benefits or lines of business, product changes or benefit level changes;
- changes in the demographic characteristics of an account or market;
- changes or reductions of our utilization management functions such as preauthorization of services, concurrent review or requirements for physician referrals;
- catastrophes, including acts of terrorism, public health epidemics, or severe weather (e.g., hurricanes and earthquakes), which may increase both use and cost of medical services and cause members to delay obtaining services, affecting their long-term health;

- medical cost inflation; and
- government mandated benefits, member eligibility criteria, or other legislative, judicial, or regulatory changes.

Key to our operational strategy is the implementation of clinical initiatives that we believe provide a better healthcare experience for our members, lower the cost of healthcare services delivered to our members, and appropriately document the risk profile of our members. Our profitability and competitiveness depend in large part on our ability to leverage our technology platform, AVA, to optimize and appropriately manage healthcare costs by, among other things, proactively managing member care.

Increases or decreases in staff and provider-related expenses, any costs associated with exiting products, additional investment in new products and in the expansion of clinical and technological capabilities as part of our integrated care delivery model, investments in health and well-being product offerings, acquisitions, new taxes and assessments, and implementation of regulatory requirements may increase our operating expenses. Any failure to adequately price our products or estimate sufficient benefits payable or effectively manage our operating expenses may result in a material adverse effect on our results of operations, financial position, and cash flows.

Premium increases, introduction of new product designs, and our relationships with our providers in various markets, among other issues, could also affect our membership levels. Other actions that could affect membership levels include our possible exit from or entrance into markets, or the termination of a large contract. If we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets to keep or increase our market share, if membership does not increase as we expect, if membership declines, or if we lose membership with favorable medical cost experience while retaining or increasing membership with unfavorable medical cost experience, our results of operations, financial position, and cash flows may be materially adversely affected.

We may not be successful in maintaining or improving our Star ratings in future years, which may have a direct and substantial adverse impact on our revenue.

CMS measures the quality of Medicare Advantage plans through a Five Star Quality Rating System. The Star Rating system considers various measures adopted by CMS, including, among others, quality of care, preventative services, chronic illness management and member satisfaction. The achievement of Star ratings of 4-Star or higher qualifies Medicare Advantage plans for an increase in the benchmark against which they bid (potentially increasing premium payments). As of January 1, 2025, approximately 98% of our members are enrolled in rated plans that have a 4.0 Star rating or greater for the 2025 rating year / 2026 payment year. However, we may not be able to maintain or improve upon these Star ratings in future years. Failure to maintain satisfactory quality and performance measures may negatively affect our premium rates, impede our ability to compete for new business in existing or new markets or result in the termination of our contracts, or affect our ability to enter into new CMS contracts or expand the service area of current health plans. Star ratings are an important component of how MA beneficiaries select an MA plan, both during each annual enrollment period and throughout each year. Low Star ratings may reduce our membership, if members choose to enroll in higher-rated plans.

Various factors may make it difficult for us to maintain or increase our Star ratings. For example, there are numerous providers that serve our plans, and we engage multiple third-party vendors to provide supplemental plan benefits. We may have limited success in obtaining quality health care outcomes and satisfactory member experiences from these providers and vendors. As a result of our dependence upon these relationships, we may have limited ability to directly influence the overall quality rating of our plans. Additionally, our higher concentration of minority members and members residing in socioeconomically disadvantaged neighborhoods generally may make it more difficult for us to achieve and maintain high Star ratings as compared to our competitors, given the well-documented health disparities among different minority and socioeconomic groups. CMS has attempted to address some of this disparity, but the efforts may not work as intended or be sufficient to address the difficulties of serving varying member populations.

CMS updates and makes changes to the Star ratings annually. Changes implemented by CMS with respect to the Five Star Quality Rating System have, in the past, and could, in the future, negatively impact our Star ratings. For example, in rating year 2024, CMS removed performance outliers from the calculation of non-Consumer Assessment of Healthcare Providers and Systems ("non-CAHPS data") measure rating cut points using the Tukey outlier deletion method. This change increased cut points overall, making it more difficult to achieve and maintain high Star ratings. In the 2025 Star ratings, only seven MA-Part D contracts earned a 5-star rating, a significant decrease from 31 in 2024, 57 in 2023, and 74 in 2022.

Additionally, CMS continues to make changes to Star Ratings methodology that could negatively impact our Star Ratings in future years. For example, in April 2024, CMS finalized changes to the measures used in the Star ratings, the calculation of the Categorical Adjustment Index and the Health Equity Index for contracts undergoing consolidation, and the weights assigned to certain measures. These and future adjustments to the Star rating methodology may have a negative impact on our Star ratings.

In addition, audits of our performance for past or future periods may result in downgrades to our Star ratings. For example, if a CMS audit finds that a particular issue of noncompliance impacts the data source for a Star measure, the Star measure may be reduced if the data set is deemed inaccurate or biased. Accordingly, our plans may receive a lower Star rating and may not be eligible for full level quality bonus payments, which could adversely affect the benefits we can offer, reduce membership and/or reduce profit margins. Also, CMS has the authority to terminate contracts that have had a rating of less than three Stars for three consecutive years, whereas Medicare Advantage plans with five Stars are permitted to conduct enrollment throughout almost the entire year. Because low quality ratings can potentially lead to the termination of one or more of our contracts we may not be able to prevent the potential termination of a plan or a shift of members to other plans based upon quality issues, which could, in turn, have a material adverse effect on our business, results of operations, financial condition and cash flows.

If we fail to develop and maintain satisfactory relationships with care providers to service our members, our business may be adversely affected.

Our success requires that we maintain and grow our provider networks and contract with providers and medical facilities in new markets in order to meet CMS requirements relating to network adequacy. We contract with a variety of physicians, nurses, hospitals, clinics and other third-party providers to deliver healthcare and related services to our members. Our plans encourage or require our customers to use these contracted providers. A key component of our integrated care delivery strategy is to increase the number of providers who share medical cost risk with us or have financial incentives to deliver high quality medical services in a cost-effective manner. In order to retain our members and attract additional membership, our provider networks, including those physicians participating in Medicare and willing to see our patients but with whom we have not contracted, must be not only adequate, but attractive, providing Medicare-eligible beneficiaries access to the providers and facilities that they want.

In any particular market, providers could refuse to contract with us, demand higher payments, or take other actions that could result in higher healthcare costs for us, less desirable outcomes for members or difficulty meeting regulatory or accreditation requirements, including network adequacy requirements. In some markets, certain providers, particularly hospitals, physician specialty groups, physician/hospital organizations, or multi-specialty physician groups, may have significant market positions and negotiating power. In addition, physician or practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, may compete with us in certain circumstances. If these providers refuse to contract with us, use their market position to negotiate unfavorable contracts with us or place us at a competitive disadvantage, or do not enter into contracts with us that encourage the delivery of quality medical services in a cost-effective manner, our ability to market products or to be profitable in those areas may be adversely affected.

In some situations, we have capitation contracts with individual or groups of primary care providers and specialists for an actuarially determined, fixed fee per month to provide a basket of required medical services to our members. The inability of providers to properly manage costs under these capitation arrangements could result in the financial instability of these providers and the termination of their relationship with us. In addition, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts could result in a disruption in the provision of services to our members or a reduction in the services available to our members. The financial instability or failure of a primary care provider to pay other providers for whom they have taken professional risk for services rendered could lead those other providers to demand payment from us even though we have made our regular fixed payments to the primary care provider. Providers with whom we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Even if we contract with sufficient numbers of providers in our markets, we may be required, from time to time, to work with providers with whom we do not contract and who are not included in our networks. This can increase our medical costs, as there is no pre-negotiated rate that we pay the provider and no incentive for the provider to control costs.

Our ability to develop and maintain satisfactory relationships with providers and facilities may also be negatively impacted by factors not associated with us, such as changes in Medicare programs and other pressures on healthcare providers, including consolidation activity among hospitals, physician groups, and other healthcare providers. We may be unable to contract with new providers, facilities and other entities in our current markets or new markets in which we enter or renew any contracts we maintain with existing providers or facilities on favorable terms, if at all. If we are unable to enter into new contracts or maintain contracts with providers or facilities in certain markets, we may be unable to meet network adequacy requirements, which would prevent us from serving such markets and could have a material adverse effect on our business, financial condition and results of operations.

If we fail to manage our growth effectively, we may be unable to execute our business plan, maintain high levels of service and member satisfaction or adequately address competitive challenges.

We have experienced, and may continue to experience, rapid growth and organizational change, which has placed, and may continue to place, significant demands on our management and our operational and financial resources. Additionally, our organizational structure may become more complex as we improve our operational, financial and management controls, as well as our reporting systems and procedures. We may require significant capital expenditures and the allocation of valuable management resources to grow and change in these areas. We must rapidly scale our technology platform, effectively increase our headcount and expand our provider networks, and we must continue to effectively train and manage our employees and partners. We will be unable to manage our business effectively if we are unable to alleviate the strain on resources caused by growth in a timely and successful manner. If we fail to effectively manage our anticipated growth and change, the quality of our services may suffer, which could negatively affect our brand and reputation and harm our ability to attract and retain members and employees.

In addition, as we expand our business, it is important that we continue to maintain a high level of member service and satisfaction. As our member base continues to grow, we will need to expand our product and service offerings and our network of partners to provide personalized member service. If we are not able to continue to provide high quality products, benefits and medical care with high levels of member satisfaction, our reputation, as well as our business, results of operations and financial condition could be adversely affected.

The healthcare industry is highly competitive. There are many other healthcare plans and healthcare service providers, many of which have a longer operating history and substantially more resources, and there are few barriers to entry in the healthcare industry. This competition may have a material adverse effect on our business operations and financial position.

We compete directly with national, regional and local Medicare Advantage organizations for members and healthcare providers. Competition in our markets involves rapidly changing technologies, diverse and evolving regulatory requirements and industry expectations, new product offerings and constantly changing member and physician preferences and user requirements. We currently face competition from a range of companies, including other incumbent MA providers and health insurance companies. Many of the other companies currently providing health insurance coverage and healthcare services, particularly national insurers such as United Health, Aetna, Humana and Cigna, have been in business longer and/or have substantially more resources than we do. Other companies could enter the healthcare industry in the future and divert some or all of our business. We also face competition from traditional Medicare.

Our ability to compete successfully varies from location to location and depends on a number of factors, including the number of competing plans in the local market and the types of services available at local clinical facilities, the demographics of each market and our ability to generate offerings that meet the needs of that population, our local reputation for providing quality care to members, the commitment and expertise of the providers in our network and our in-house medical staff, our local service offerings and community programs and the cost of care in each locality. If we are unable to attract members, our revenue and profitability will be adversely affected. Some of our competitors may have greater recognition and may be more established in particular communities than we are, and they may have greater financial and other resources than we have. Competing Medicare Advantage plans may also offer different programs or services than we do, which, combined with the foregoing factors, may result in our competitors being more attractive to our current members or potential members. While health plans compete on the basis of many factors, including service and the quality and depth of provider networks, we expect that price will continue to be a significant basis of competition. Furthermore, while we budget for improvements in our products and services to keep them competitive in their respective markets, to the extent that competitive forces cause related expenditures to increase in the future, our financial condition may be negatively affected. In addition, in certain instances our relationships with providers are not exclusive and our competitors have established or could seek to establish relationships with such providers. Additionally, as we expand into new geographies, we may encounter competitors with stronger relationships or recognition in the community in such new geography, which could give those competitors an advantage in retaining current members and obtaining new members, which may have a material adverse effect on our business operations and financial position.

Our failure to compete effectively may result in fewer plans being offered; a reduction in plan benefits; reduced services; a loss of existing members or inability to grow membership; fewer physician users; reduced revenues; lower gross margins; and loss of market share. Any failure to meet and address these factors would harm our business, results of operations and financial condition.

We have entered into certain key contracts with large independent physician associations, hospitals and other provider networks to serve our membership base. The loss or renegotiation of any of these contracts could negatively impact our results.

Our provider network includes key contracts with certain large independent physician associations ("IPAs"), hospitals and other provider networks, which are critical to serving our membership base. Although we typically seek to enter into contracts spanning three or more years, after a specified period, certain of these contracts, including existing contracts with some of our largest IPA partners, hospitals or other providers, may terminate by their own terms or through notice of non-renewal. In the ordinary course of business, including in connection with renewals or extensions of these agreements, we engage in active discussions and renegotiations with these counterparties in respect of the solutions we provide and the terms of our agreements. The loss of any of our largest IPA partnerships, hospitals or other provider networks or the renegotiation of any of these contracts could adversely affect our results of operations, as this may alter the attractiveness of our provider network, result in more out-of-network claims costs and/or increase the payments we make to these counterparties.

Security breaches, loss of data and other disruptions could compromise sensitive information related to our business or our members, or prevent us from accessing critical information and expose us to liability, which could adversely affect our business and our reputation.

In the ordinary course of our business, we collect, store, process, transfer, disclose and otherwise use sensitive data, including PHI and PII relating to our employees, members and others. We also process and store, and use third-party service providers to process and store, substantial amounts of sensitive information, including intellectual property, confidential information and other proprietary business information. We manage and maintain such sensitive data and information utilizing a combination of on-site systems, managed data center systems and cloud-based computing center systems.

We are highly dependent on information technology networks and systems, including the internet, to securely process, transmit and store this sensitive data and information. Security breaches of this infrastructure, including physical or electronic break-ins, computer viruses, ransomware, attacks by hackers and other malicious actors and similar breaches, and employee or contractor error, negligence or malfeasance, can create system disruptions, shutdowns or unauthorized disclosure or modifications of such sensitive data or information, causing PHI or other PII to be accessed or acquired without authorization or to become publicly available. We utilize a third-party operated 24x7 security operations center that continuously monitors the security and privacy posture of our systems and have implemented the HITRUST Alliance's Common Security Framework as part of our certification by HITRUST; however, we cannot provide assurance that these measures will protect us from all cybersecurity threats and risks. As our third-party service providers

manage important aspects of the collection, storage, processing and transmission of employee, user and member information, and other confidential and sensitive information, we rely on them to perform functions that have material cybersecurity risks. Because of the sensitivity of the PHI, other PII and other sensitive information we and our service providers collect, store, transmit, and otherwise process and use, the security of our technology platform and other aspects of our services, including those provided or facilitated by our third-party service providers, are important to our operations and business strategy. Measures taken to protect our systems, those of our contractors or third-party service providers, or the PHI, other PII, or other sensitive information we or contractors or third-party service providers process or maintain (including our requirement that our third-party service providers enter into business associate agreements or other required security agreements, if applicable), may not adequately protect us from the risks associated with the collection, storage, processing and transmission of such sensitive data and information. For example, we may be required to expend significant capital and other resources, such as in the performance of ongoing risk assessments of our and our third-party service providers' information systems, to protect against security breaches or to alleviate problems caused by security breaches. Because cyber-attacks are becoming more sophisticated and frequent and the techniques used to obtain unauthorized access or to sabotage systems change frequently and generally are not identified until they are launched against a target, despite the implementation of security measures, we or our third-party service providers may be unable to anticipate these techniques or to implement adequate protective measures.

A security breach or privacy violation that leads to disclosure or unauthorized use or modification of, or that prevents access to or otherwise impacts the confidentiality, security, or availability of, member information, including PHI or other PII, or other sensitive information we or our contractors or third-party service providers maintain or otherwise process, could harm our reputation and brand, compel us to comply with breach notification laws, and cause us to incur significant costs for remediation, fines, penalties, providing notification to individuals. We would need to identify and implement measures intended to repair or replace systems or technology and to prevent future occurrences, and we could face potential increases in insurance premiums. This is of particular risk when considering tight integration with third-party service providers who manage or provide parts of our information systems. If we are unable to prevent or mitigate such security breaches or privacy violations or implement satisfactory remedial measures, or if it is perceived that we have been unable to do so, our operations could be disrupted, we may be unable to provide access to our systems, and we could suffer a loss of members. We may also suffer loss of reputation, adverse impacts on member and investor confidence and financial loss, and we would be exposed to the risk of governmental investigations or other actions, regulatory or contractual penalties, and other claims and liabilities, including liability under laws and regulations that protect the privacy of member information or other personal information, such as HIPAA. In addition, security breaches and other inappropriate access to, or acquisition or processing of, information can be difficult to detect, and any delay in identifying such incidents or in providing any notification of such incidents may lead to increased harm.

Any such breach or interruption of our systems or those of any of our third-party service providers could also result in the compromise of our trade secrets and other proprietary information, which could adversely affect our business and competitive position. While we maintain insurance covering certain security and privacy damages and claim expenses, we may not carry insurance or maintain coverage sufficient to compensate for all liability and in any event, insurance coverage would not address the reputational damage that could result from a security incident.

Our service offering is driven by our core operating technology platform, AVA, allowing us to access and analyze comprehensive member data quickly, generating insights and alerts using such data and making recommendations to members and practitioners. AVA and the other systems or networks used in our business may experience an increase in attempted cyber-attacks, targeted intrusion, ransomware and phishing campaigns seeking to take advantage of shifts to employees and healthcare providers working remotely using their household or personal internet networks.

A data breach could result in incorrect or delayed medical recommendations and prescriptions, missed alerts and missed opportunities to intervene for our members on a timely basis. Unauthorized access, loss or dissemination could also disrupt our operations, including our ability to perform our services, access member health information, collect, process, and prepare company financial information, provide information about our current and future services and engage in other member and clinician education and outreach efforts. Any of the foregoing could have a material adverse effect on our business, results of operations and financial condition.

Disruptions in our disaster recovery systems or management continuity planning could limit our ability to operate our business effectively and adequately care for our members.

Our information technology systems facilitate our ability to conduct our business. The functioning of AVA, our technology platform, is critical to our ability to adequately care for our members and drive health outcomes. While we have disaster recovery systems and business continuity plans in place and such plans are reviewed annually as part of our third-party HITRUST certification, there may be disruptions in our disaster recovery systems or the failure of these systems to operate as expected. Such events could, depending on the magnitude of the problem, adversely affect our operating results and the health of our members by limiting our capacity to effectively monitor and control our operations. Despite our implementation of a variety of security measures, our information technology systems could be subject to physical or electronic break-ins or disruptions from unauthorized tampering, fires, power loss, telecommunication failures or any weather-related disruptions where our headquarters is located or at locations that host portions of our technology platform. In addition, in the event that a significant number of our personnel were unavailable in the event of a disaster, our ability to effectively conduct business and adequately care for our members could be adversely affected.

As a government contractor, we are exposed to risks that may materially adversely affect our business, including the potential loss of CMS contracts, significant changes to the Medicare Advantage and/or Part D programs, potential suspension from participating in

the Medicare Advantage program, changes to the risk-adjustment model used to determine the premiums paid to Medicare Advantage plans, changes to provisions for risk sharing under Medicare Part D and risks related to governmental audits and investigations, among others.

A significant portion of our revenue relates, directly or indirectly, to the Medicare Advantage program, which accounted for substantially all of our total revenue for the year ended December 31, 2024. Participating in the Medicare Advantage program exposes us to various risks, as described further below.

- As of January 1, 2025, under our contracts with CMS, we provided health insurance coverage to approximately 209,900 individual Medicare Advantage members. Our continued participation in the Medicare Advantage program through these and other contracts is not guaranteed. Our CMS contracts are subject to annual renewal, and CMS must also annually approve our bids for the plans we intend to offer under each contract. The loss of these and other CMS contracts or significant changes to the terms thereof may have a material adverse effect on our business, results of operations and financial condition.
- Either Congress or CMS may at any time enact significant changes to the Medicare Advantage program, and these changes may materially impact our profitability. For example, there may be changes to the amount or calculation of our premium payments, the mandated member benefits, or member eligibility criteria without corresponding increases in our premium payments, or the timing of payments. We have no control over these changes, including when or how frequently they are made. In addition, CMS annually establishes benchmark payment rates for Medicare Advantage organizations, and these rates may decrease or not keep pace with our expected medical costs. Any of these, or other, changes to the Medicare Advantage program and our payment rates may have a material adverse effect on our business, results of operations and financial condition.
- CMS may terminate our Medicare Advantage contracts if there is credible evidence that we have committed or participated in false, fraudulent, or abusive activities, including the submission of false or fraudulent data. Additionally, we may be subject to scrutiny under the federal False Claims Act (the "FCA") for the alleged submission of fraudulent information. As a recipient of federal money, we may be subject to qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that the recipient submitted false claims to the government. Litigation of this nature is filed under seal to allow the government an opportunity to investigate and to decide if it wishes to intervene and assume control of the litigation. If the government does not intervene, the lawsuit is unsealed, and the individual may continue to prosecute the action on his or her own.
- CMS uses a risk-adjustment model which adjusts premiums paid to Medicare Advantage organizations according to the health status of covered members. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 and the Benefits Improvement and Protection Act of 2000 ("BIPA"), generally pays more where a plan's membership has higher expected costs. Under this model, amounts paid to Medicare Advantage organizations are based, in part, on actuarially determined bids, which include a process whereby our prospective payments are based on our estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of our enrolled membership. Under the risk-adjustment methodology, all Medicare Advantage organizations must collect and submit the data from hospital inpatient, hospital outpatient, and physician services to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to Medicare Advantage organizations, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program. In certain cases, we rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on these providers to document appropriately all medical data, including the diagnosis data submitted with claims, and we rely on our technology platform to aggregate, organize, interpret and report such data. In addition, we conduct medical record reviews as part of our data and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model. These compliance efforts include the internal contract level audits described in more detail below, as well as ordinary course reviews of our internal business processes.

  CMS and the Office of the Inspector General of Health and Human Services ("HHS-OIG"), are continuing to perform audits of various companies' selected Medicare Advantage contracts related to this risk adjustment diagnosis data. We refer to these audits as Risk-Adjustment Data Validation Audits ("RADV audits"). RADV audits review medical records in an attempt to validate provider medical record documentation and coding practices which influence the calculation of premium payments to Medicare Advantage organizations.

  In 2012, CMS released a "Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation (RADV) Contract-Level Audits." The payment error calculation methodology provided that, in calculating the economic impact of audit results for a Medicare Advantage contract, if any, the results of the RADV audit sample would be extrapolated to the entire Medicare Advantage contract. Additionally, the estimated payment error rate identified during the audit would be compared to a similar audit of the government's traditional FFS Medicare program. We refer to the process of accounting for errors in fee-for-service claims as the "FFS Adjuster." This comparison of RADV audit results to the FFS error rate is necessary to

determine the economic impact, if any, of RADV audit results because the government used the traditional fee-for-service Medicare program data set, including any attendant errors that are present in that data set, to estimate the costs of various health status conditions and to set the resulting adjustments to Medicare Advantage plans' payment rates in order to establish actuarial equivalence in payment rates as required under the Medicare statute. CMS already makes other adjustments to payment rates based on a comparison of coding pattern differences between Medicare Advantage plans and traditional fee-for-service Medicare program data (such as for frequency of coding for certain diagnoses in Medicare Advantage plan data versus the traditional fee-for-service Medicare program dataset).

CMS released a final rule on January 30, 2023, which changes both the use of extrapolation and the application of the FFS Adjuster. Specifically, CMS will not extrapolate audit results for any audits covering payment years prior to 2018. Additionally, CMS will not apply any FFS Adjuster in RADV audits. These changes are expected to have a material impact on Medicare Advantage organizations, including us. In November 2024, CMS announced it had initiated the payment year 2018 RADV audits, and it expects to begin issuing the audit findings in mid-calendar year 2026, including instructions on how the overpayments will be collected as part of the audit.

In addition, as part of our internal compliance efforts, we routinely perform ordinary course reviews of our internal business processes related to, among other things, our risk coding and data submissions in connection with the risk-adjustment model. These reviews may also result in the identification of errors and the submission of corrections to CMS, that may, either individually or in the aggregate, be material. As such, the result of these reviews may have a material adverse effect on our results of operations, financial position, or cash flows.

- Our CMS contracts that cover members' prescription drugs under Medicare Part D contain provisions for risk sharing and certain payments for prescription drug costs for which we are not at risk. These provisions, certain of which are described below, affect our ultimate payments from CMS.

  Our losses or gains are limited by risk corridor provisions which compare costs targeted in our annual bids to our allowable costs under the plan, limited to actual costs that were incurred for the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to us or require us to refund to CMS a portion of the premiums we received (known as a "risk corridor"). We estimate and recognize an adjustment to premiums revenue related to the risk corridor payment settlement based upon pharmacy claims experience. The estimate of the settlement associated with these risk corridor provisions requires us to consider factors that may not be certain, including member eligibility differences with CMS.

  Reinsurance and low-income cost subsidies represent payments from CMS in connection with the Medicare Part D program. Reinsurance subsidies represent payments for CMS's portion of claims costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent payments from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. A reconciliation and settlement of CMS's prospective subsidies against actual prescription drug costs we paid, as well as other factors, is made after the end of the applicable year.

  Settlement of the reinsurance and low-income cost subsidies as well as the risk corridor payment is based on a reconciliation made approximately nine months after the close of each calendar year. This reconciliation process requires us to submit claims data necessary for CMS to administer the program. Our claims data may not pass CMS's claims edit processes due to various reasons, including discrepancies in eligibility or classification of low-income members. To the extent our data does not pass CMS's claim edit processes, we may bear the risk for all or a portion of the claim which otherwise may have been subject to the risk corridor provision or payment which we would have otherwise received as a low-income subsidy or reinsurance claim. In addition, in the event the settlement represents an amount CMS owes us, there is a negative impact on our cash flows and financial condition as a result of financing CMS's share of the risk. The opposite is true in the event the settlement represents an amount we owe CMS.

- We are also subject to various other governmental audits and investigations. Under state laws, we are audited by state departments of insurance for financial and contractual compliance and by state departments of health. Audits and investigations, including audits of risk adjustment data, are also conducted by state attorneys general, CMS, HHS-OIG, the Office of Personnel Management, the Department of Justice ("DOJ") and the Department of Labor. Findings from these audits and investigations could result in, among other things, the loss of licensure or the right to participate in the Medicare Advantage or other programs, a limitation on our ability to market or sell products, a suspension on our ability to enroll new members, a requirement to refund money to the government, the imposition of fines, penalties and other civil and criminal sanctions, or changes in our business practices. The outcome of any current or future governmental or internal investigations cannot be accurately predicted, nor can we predict any resulting penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities. Nevertheless, it is possible that any such outcome of litigation, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on our results of operations, financial position, and cash flows. Responding to subpoenas, investigations and other lawsuits, claims and legal proceedings as well as defending ourselves in such matters would divert management's attention and cause us to

incur significant legal expense. Negative findings or terms and conditions that we might agree to accept as part of a negotiated resolution of pending or future legal or regulatory matters could result in, among other things, substantial financial penalties or awards against us, substantial payments made by us, required changes to our business practices, exclusion from future participation in the Medicare Advantage Programs and, in certain cases, criminal penalties, any of which could have a material adverse effect on us. Certain of these matters could also affect our reputation. In addition, disclosure of any adverse investigation or audit results or sanctions could negatively affect our industry or our reputation in various markets and make it more difficult for us to sell our products and services.

The Inflation Reduction Act of 2022 contains several provisions that affect the Part D program. These changes may require us to change our prescription drug offerings, reduce our profitability, and otherwise impact our financial performance.

The Inflation Reduction Act of 2022 ("IRA"), signed into law on August 16, 2022, reflects an ongoing effort to control prescription drug costs and reduce spending by the federal government. The IRA contains several provisions that impact the Part D program and that may influence our benefit design and profitability. For example, beginning in 2024, Part D plans were required to eliminate member cost-sharing in the catastrophic phase of the benefit, and beginning in 2025, the coverage gap phase was eliminated. Part D plans must now also implement a cap on member out-of-pocket spending of $2,000. These changes have the potential to increase the financial responsibility of Part D plan sponsors. Furthermore, beginning in 2025, Part D plans must offer enrollees the option to pay out-of-pocket prescription drug costs in the form of capped monthly payments instead of all at once at the pharmacy. This may increase administrative burdens for plans by requiring new payment tracking systems and risk management strategies. These changes may significantly alter the plans that we offer and may adversely affect our business, results of operations and financial condition.

We may be subject to legal proceedings and litigation, including intellectual property and privacy disputes, which are costly and could materially harm our business and results of operations.

We may be party to lawsuits and legal proceedings in or outside of the normal course of business, whether initiated by third parties or by us. These matters are often expensive and disruptive to normal business operations. We may face allegations, lawsuits and regulatory inquiries, audits and investigations regarding the denial of healthcare benefit payments, compensation or non-acceptance or termination of provider contracts, medical malpractice (based on our medical necessity decisions or brought against us on the theory that we are liable for providers' alleged malpractice) or professional liability (in connection with the delivery of healthcare and related services to the public). We may initiate litigation or administrative proceedings, including, without limitation, to address regulatory matters or to protect our intellectual property. We may be subject to class-action lawsuits, shareholder derivative suits, or other litigation arising from alleged violations of federal or state securities laws or of Delaware corporate law. We may also face *qui tam* allegations or lawsuits brought by individuals who seek to sue on behalf of the government including, among other allegations, resulting from coding and review practices under the Medicare Advantage risk-adjustment model.

We also may be subject to lawsuits under the FCA and comparable state laws for submitting allegedly fraudulent or otherwise inappropriate risk adjustment or Stars data. These lawsuits, which may be initiated by government authorities as well as private party relators, can involve significant monetary damages, fines, attorney fees and the award of bounties to private plaintiffs who successfully bring these suits, as well as to the government programs. In recent years, government oversight and law enforcement have become increasingly active and aggressive in investigating and taking legal action against potential fraud, waste and abuse. Fraud, waste, and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, fraudulent coding practices, billing for unnecessary medical and/or other covered services, improper marketing and violations of patient privacy rights. The DOJ and the Department of Health and Human Services Office of Inspector General ("OIG"), have recently increased their scrutiny of healthcare payers and providers, and Medicare Advantage insurers, under the federal FCA, in particular, and there have been a number of investigations, prosecutions, convictions and settlements in the healthcare industry. The FCA provides for treble damages and significant mandatory minimum penalties for each false claim or statement. Healthcare plans and providers thus often seek to resolve these types of allegations through settlement for significant and material amounts, including in circumstances where they do not acknowledge or admit liability, to avoid the uncertainty of treble damages that may be awarded in litigation proceedings. Such settlements often contain additional compliance and reporting requirements as part of a consent decree or settlement agreement, including, for example, corporate integrity agreements.

Additionally, we may face allegations, lawsuits and regulatory inquiries, audits and investigations regarding data privacy and security, labor and employment, consumer protection and intellectual property infringement, misappropriation or other violation, including claims related to patents, publicity, trademarks, copyrights and other intellectual property or proprietary rights. We may also face allegations or litigation related to our acquisitions, securities issuances or business practices, including public disclosures about our business.

Litigation and regulatory proceedings may be protracted and expensive, and the results are difficult to predict. Certain of these matters may include speculative claims for substantial or indeterminate amounts of damages and include claims for injunctive relief. Additionally, our litigation costs could be significant. Adverse outcomes with respect to litigation or any of these legal proceedings may result in significant settlement costs or judgments, penalties and fines, or require us to modify our services or require us to stop serving certain members or geographies, all of which could negatively impact our geographical expansion and revenue growth. We may also become subject to periodic audits, which would likely increase our regulatory compliance costs and may require us to change our business practices, which could negatively impact our revenue growth. Managing legal proceedings, litigation and audits, even if we achieve favorable outcomes, is time-consuming and diverts management's attention from our business. Accordingly, such proceedings could harm our reputation, business, financial condition, results of operations and the market price of our common stock.

Although we maintain third-party professional liability insurance coverage and managed care errors and omissions policies, it is possible that claims against us may exceed the coverage limits of our insurance policies. Even if any professional liability loss is covered by an insurance policy, these policies typically have substantial deductibles for which we are responsible. Professional liability claims in excess of applicable insurance coverage could have a material adverse effect on our business, financial condition and results of operations. In addition, any professional liability claim brought against us, with or without merit, could result in an increase of our professional liability insurance premiums. Insurance coverage varies in cost and can be difficult to obtain, and we cannot guarantee that we will be able to obtain insurance coverage in the future on terms acceptable to us or at all. If our costs of insurance and claims increase, then our earnings could decline.

Our business may be adversely impacted if the healthcare services industry becomes more cyclical.

In the past, healthcare utilization generally has trended upward over time, regardless of minor fluctuations in the U.S. economy. We believe this trend may change, however, as consumers have been given more decision-making and spending responsibility. In turn, we believe members are making healthcare purchases on a more discretionary basis, especially for elective procedures. This could result in a more cyclical trend in healthcare utilization over the coming years and may cause short-term volatility in our operating results.

Any failure by us to manage acquisitions, joint ventures, divestitures and other significant transactions successfully may have a material adverse effect on our results of operations, financial position, and cash flows.

As part of our business strategy, we engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures, and outsourcing transactions and may enter into agreements relating to such transactions in order to further our business objectives. Such transactions may not always align properly with our strategic objectives and may not deliver the expected benefits within the timeframes anticipated or at all. In order to pursue our acquisition strategy successfully, we must identify suitable candidates for and successfully complete transactions, some of which may be large and complex, and manage post-closing issues such as the integration of acquired companies or employees. Integration and other risks can be more pronounced for larger and more complicated transactions, transactions outside of our core business space, or if multiple transactions are pursued simultaneously. Delays or difficulties in aligning key integration elements may result in operational disruptions, decreased productivity, and the failure to realize anticipated synergies, leading to a negative impact on financial performance. Moreover, the failure to successfully integrate acquired entities and businesses or failure to produce results consistent with the financial model used in the analysis of our acquisitions, investments, joint ventures or strategic alliances may cause asset write-offs, restructuring costs or other expenses and may have a material adverse effect on our results of operations, financial position, and cash flows. Acquisitions and joint ventures may expose us to legal and regulatory risks, including compliance with antitrust laws, contractual obligations, and other regulatory requirements. Failure to navigate these complexities may result in legal disputes, regulatory scrutiny, or financial penalties. If we fail to identify and successfully complete transactions that further our strategic objectives, we may be required to expend additional resources to expand our business organically.

If we are not able to maintain, enhance and protect our reputation and brand recognition, including through the maintenance and protection of trademarks, our business and results of operations will be harmed.

We believe that maintaining and enhancing our reputation and brand recognition is critical to our relationships with both members and providers and to our ability to attract new members. The promotion of our brand may require us to make substantial investments and we anticipate that, as our market becomes increasingly competitive, these marketing initiatives may become increasingly difficult and expensive. Moreover, our current marketing efforts to date have been limited to certain geographic regions and markets where our business operates to facilitate the efficient use of resources. If we grow nationally, we will need to spend additional resources to build strong national brand recognition and our efforts may not be effective. Our marketing activities may not be successful or yield increased revenue, and to the extent that these activities yield increased revenue, the increased revenue may not offset the expenses we incur and our results of operations could be harmed.

Any factor that diminishes our reputation or that of our management, including failing to meet the expectations of or provide quality service to our members, or any adverse publicity or litigation involving or surrounding us or our management, could make it substantially more difficult for us to attract new members and retain existing members. Similarly, because our existing members often act as references for us with prospective new members, any existing member that questions the quality of our care could impair our ability to secure additional new members. In addition, negative publicity resulting from any adverse government audit could injure our reputation. If we do not successfully maintain and enhance our reputation and brand recognition, our business may not grow and we could lose our relationships with members or providers, which would harm our business, results of operations and financial condition.

The registered or unregistered trademarks or trade names that we own may be challenged, infringed, circumvented, diluted, declared generic, lapsed or determined to be infringing on or dilutive of other marks. We may not be able to protect our rights in these trademarks and trade names, which we need in order to build name recognition with members, providers and other partners. In addition, third parties may in the future file for registration of trademarks similar or identical to our trademarks. If they succeed in registering or developing common law rights in such trademarks, and if we are not successful in challenging such third-party rights, we may not be able to use these trademarks to commercialize our technologies in certain relevant jurisdictions. If we are unable to establish name recognition based on our trademarks and trade names, we may not be able to compete effectively and our brand recognition, reputation and results of operations may be adversely affected.

Our business depends on our ability to effectively invest in, implement improvements to and properly maintain the uninterrupted operation and data integrity of our information technology platform and other business systems.

Our business is highly dependent on maintaining effective information systems, including our AVA platform, as well as the integrity and timeliness of the data we use to serve our members, support our in-house care teams and external providers and operate our business. Because of the large amount of data that we collect and manage, it is possible that hardware failures or errors in our systems could result in data loss or corruption or cause the information that we collect to be incomplete or contain inaccuracies that our in-house care teams, external providers and other partners regard as significant. If our data were found to be inaccurate or unreliable due to fraud or other error, or if we, or any of the providers we engage, were to fail to maintain information systems and data integrity effectively, we could experience operational disruptions that may impact our members, in-house care teams and external providers and other partners and hinder our ability to provide products and services, retain and attract members, manage our member risk profiles, report timely and accurate financial results and maintain regulatory compliance, among other things.

Natural disasters or widespread civic disruptions could also cause our third-party data center hosting facilities and cloud computing platform providers, which are critical to our infrastructure, to shut down their business, experience security incidents that impact our business, delay or disrupt performance or delivery of services, or experience interference with the supply chain of hardware required by their systems and services, any of which could materially adversely affect our business. Limitations on access or disruptions to services provided by some of the external care providers upon which our platform and business operations rely could interrupt our ability to provide our platform, decrease the productivity of our workforce and provider networks, and significantly harm our business operations, financial condition and results of operations.

Our information technology strategy and execution are critical to our continued success because our technology platform is at the center of our business model. We must continue to invest in long-term solutions that will enable us to anticipate member needs and expectations, enhance the member experience, act as a differentiator in the market and protect against cybersecurity risks and threats. Our success is dependent, in large part, on maintaining the effectiveness of existing technology systems and continuing to deliver and enhance technology systems that support our business processes in a cost-efficient and resource-efficient manner. Increasing regulatory and legislative changes will place additional demands on our information technology infrastructure that could have a direct impact on resources available for other projects tied to our strategic initiatives. In addition, continued trends toward greater member engagement and increased regulatory scrutiny in healthcare require new and enhanced technologies. Connectivity among technologies is becoming increasingly important. We must also develop new systems to meet current market standards and keep pace with continuing changes in information processing technology, evolving industry and regulatory standards and member needs. Failure to do so may present compliance challenges and impede our ability to deliver products and services in a competitive manner. Further, because system development projects are long-term in nature, they may be more costly than expected to complete and may not deliver the expected benefits upon completion. Our failure to effectively invest in, implement improvements to and properly maintain the uninterrupted operation and data integrity of our information technology and other business systems could adversely affect our business, financial condition and results of operations.

If we are unable to obtain, maintain, protect and enforce intellectual property protection for our technology or if the scope of our intellectual property protection is not sufficiently broad, others may be able to develop and commercialize technology substantially similar to ours, and our ability to successfully commercialize our technology may be adversely affected.

Our business depends on internally developed technology and content, including software, databases, confidential information and know-how, such as the AVA platform, the protection of which is crucial to the success of our business. We rely on a combination of trademark, trade secret and copyright laws and confidentiality procedures and contractual provisions to protect our intellectual property rights in our internally developed technology and content. We may, over time, increase our investment in protecting our intellectual property through additional trademark, patent and other intellectual property filings that could be expensive and time-consuming. Effective trademark, trade secret, copyright and other intellectual property protection is expensive to develop and maintain, both in terms of initial and ongoing registration requirements and the costs of defending our rights. These measures, however, may not be sufficient to offer us meaningful protection. Additionally, we do not currently hold a patent or other registered or applied for intellectual property protection for AVA. If we are unable to protect our intellectual property and other proprietary rights, particularly with respect to AVA, our competitive position and our business could be harmed, as third parties may be able to commercialize and use technologies and software products that are substantially the same as ours without incurring the development and licensing costs that we have incurred. Any of our owned or licensed intellectual property rights could be challenged, invalidated, circumvented, infringed, misappropriated or otherwise violated, our trade secrets and other confidential information could be disclosed in an unauthorized manner to third parties, or our intellectual property rights may not be sufficient to permit us to take advantage of current market trends or otherwise to provide us with competitive advantages, which could result in costly redesign efforts, discontinuance of certain offerings or other competitive harm.

Monitoring unauthorized use of our intellectual property is difficult and costly. From time to time, we seek to analyze our competitors' services, and may in the future seek to enforce our rights against potential infringement, misappropriation or other violation. However, the steps we have taken to protect our intellectual property rights may not be adequate to prevent infringement, misappropriation or other violation of our intellectual property. We may not be able to detect unauthorized use of, or take appropriate steps to enforce, our intellectual property rights. Any inability to meaningfully protect our intellectual property rights could result in harm to our ability to compete and reduce demand for our technology. Moreover, our failure to develop and properly manage new intellectual property could adversely affect our market positions and business opportunities. Also, some of our services rely on technologies and software developed

by or licensed from third parties, and we may not be able to maintain our relationships with such third parties or enter into similar relationships in the future on reasonable terms or at all.

Uncertainty may result from changes to intellectual property legislation and from interpretations of intellectual property laws by applicable courts and agencies. Accordingly, despite our efforts, we may be unable to obtain, maintain, protect and enforce the intellectual property rights necessary to provide us with a competitive advantage. Our failure to obtain, maintain, protect and enforce our intellectual property rights could therefore have a material adverse effect on our business, financial condition and results of operations.

If we are unable to protect the confidentiality of our trade secrets, know-how and other proprietary and internally developed information, the value of our technology could be adversely affected.

We may not be able to protect our trade secrets, know-how and other internally developed proprietary information, including in relation to the AVA platform, adequately. Although we use reasonable efforts to protect this internally developed information and technology, our employees, consultants and other parties (including independent contractors and companies with which we conduct business) may unintentionally or willfully disclose our trade secrets or other proprietary information or technology to competitors. Enforcing a claim that a third party illegally disclosed or obtained and is using any of our internally developed information or technology is difficult, expensive and time-consuming, and the outcome is unpredictable. In addition, courts outside the United States are sometimes less willing to protect trade secrets, know-how and other proprietary information. We rely, in part, on non-disclosure, confidentiality and assignment-of-invention agreements with our employees, independent contractors, consultants and companies with which we conduct business to protect our trade secrets, know-how and other intellectual property and internally developed information. We may fail to enter into such agreements with all applicable parties, and such agreements may not be self-executing, or they may be breached and we may not have adequate remedies for such breach. Moreover, third parties may independently develop similar or equivalent proprietary information or reverse-engineer or otherwise gain access to our trade secrets, know-how and other internally developed information. Any of the foregoing could have a material adverse effect on our business, financial condition and results of operations.

Any restrictions on our use of, or ability to license, data, or our failure to license data and integrate third-party technologies, could have a material adverse effect on our business, financial condition and results of operations.

We depend upon licenses from third parties for some of the technology and data used in AVA, our core operating technology platform. We may be unsuccessful in maintaining those licenses, and in such an event, it is possible that alternative technology may not be available for license on favorable terms or at all. Moreover, we expect that we may need to obtain additional licenses from third parties in the future in connection with the development of our applications. In addition, we obtain a portion of the data that we use from government entities, public records, external healthcare providers and other partners. We believe that we have all rights necessary to use the data that is incorporated into our services. We cannot, however, assure you that our licenses for information will allow us to use that information for all potential or contemplated applications.

In addition, our ability to continue to offer an integrated healthcare experience to our members depends on maintaining AVA, which is partially populated with data disclosed to us by our members, the physicians in our network and our other partners with their consent. If these members, physicians and other partners revoke their consent for us to maintain, use, de-identify and share this data, consistent with applicable law, our data assets could be degraded.

In the future, data providers could withdraw their data from us or restrict our usage for any reason, including if there is a competitive reason to do so, if legislation is passed restricting the use of the data or if judicial interpretations are issued restricting use of the data that we currently use to support our services. In addition, data providers could fail to adhere to our quality control standards in the future, causing us to incur additional expense to appropriately utilize the data. If a substantial number of data providers were to withdraw or restrict their data, or if they fail to adhere to our quality control standards, and if we are unable to identify and contract with suitable alternative data suppliers and integrate these data sources into our service offerings, our ability to provide appropriate services to our members would be materially adversely impacted, which could have a material adverse effect on our business, financial condition and results of operations.

We also integrate into our internally developed applications and use third-party software to support our technology infrastructure. Some of this software is proprietary and some is open-source software. These technologies may not be available to us in the future on commercially reasonable terms or at all and could be difficult to replace once integrated into our own internally developed applications. Most of these licenses can be renewed only by mutual consent and may be terminated if we breach the terms of the license and fail to cure the breach within a specified period of time. Our inability to obtain, maintain or comply with any of these licenses could delay development until equivalent technology can be identified, licensed and integrated, which would harm our business, financial condition and results of operations.

Our third-party licenses are generally non-exclusive and our competitors may obtain the right to use any of the data and technology covered by these licenses to compete directly with us. Our use of third-party technologies exposes us to increased risks, including, but not limited to, risks associated with the integration of new technology into our solutions, the diversion of our resources from development of our own internally developed technology and our inability to generate revenue from licensed technology sufficient to offset associated acquisition and maintenance costs. In addition, if our data suppliers choose to discontinue support of the licensed technology in the future, we might not be able to modify or adapt our own solutions.

Our use of "open-source" software could adversely affect our ability to offer our products and services and subject us to possible litigation.

We may use open-source software in connection with our services. Companies that incorporate open-source software into their technologies have, from time to time, faced claims challenging the use of open-source software and/or compliance with open-source license terms. As a result, we could be subject to suits by parties claiming ownership of what we believe to be open-source software or claiming noncompliance with open-source licensing terms. Some open-source software licenses require users who distribute software containing open-source software to publicly disclose all or part of the source code to such software and/or make available any derivative works of the open-source code, which could include valuable proprietary code of the user, on unfavorable terms or at no cost. While we monitor the use of open-source software and try to ensure that none is used in a manner that would require us to disclose our internally developed source code, including that of our AVA platform, or that would otherwise breach the terms of an open-source agreement, such use could inadvertently occur, in part because open-source license terms are often ambiguous. In addition to risks related to license requirements, use of certain open-source software can lead to greater risks than use of third-party commercial software, as open-source licensors generally do not provide warranties or controls on the origin of software which, thus, may contain security vulnerabilities, such as the Log4j vulnerability in November 2021, or infringing or broken code. Any requirement to publicly disclose our internally developed source code or pay damages for breach of contract could have a material adverse effect on our business, financial condition and results of operations and could help our competitors develop services that are similar to or better than ours.

We depend on our senior management team and other key employees, and the loss of one or more of these employees or an inability to attract and retain other highly skilled employees could harm our business.

Our success depends largely upon the continued services of our senior management team and other key employees. We rely on our leadership team's deep expertise and industry experience in the areas of operations, product development, provision of medical services, information technology and security, marketing, and general and administrative functions. From time to time, there may be changes in our executive management team resulting from the hiring or departure of executives, which could disrupt our business. Our employment agreements with our executive officers and other key personnel do not require them to continue to work for us for any specified period and, therefore, they could terminate their employment with us at any time. Furthermore, volatility in our stock price may affect our ability to attract and retain replacements should key personnel depart.

The loss of one or more of the members of our senior management team, or other key employees, could cause disruptions in or harm to our business, and replacing any such employees would entail significant time and cost. In particular, the loss of the services of our founder and Chief Executive Officer, John Kao, could significantly delay or prevent the achievement of our strategic objectives. We currently do not have "key person" insurance on any of our employees.

Competition for highly qualified personnel is intense, especially for technology specialists and for physicians, nurses and other medical professionals who are experienced in providing care services to older adults. We have, from time to time, experienced, and we expect to continue to experience, difficulty in hiring and retaining employees with appropriate qualifications. Many of the other Medicare Advantage plans and healthcare organizations with which we compete for experienced personnel have greater resources than we have. If we hire employees from competitors or other companies or healthcare providers, their former employees may attempt to assert that these employees or we have breached certain legal obligations, resulting in a diversion of our time and resources. If we fail to attract new personnel or fail to retain and motivate our current personnel, our business and future growth prospects could be harmed.

Our membership is concentrated in a limited number of U.S. states, and so we are subject to risks associated with our geographic concentration, including unanticipated changes in population morbidity, which could significantly increase utilization rates and medical costs.

A substantial portion of our revenue is driven by CMS payments in connection with our health plans in California, North Carolina, Nevada, Arizona and Texas, with over 94% of our members concentrated in California as of December 31, 2024. As a result, our exposure to many of the risks described herein is not mitigated by a diversification of geographic focus. Unfavorable changes in healthcare or other benefit costs or reimbursement rates or increased competition in these areas or any other geographic area where our membership becomes concentrated in the future could therefore have a disproportionately adverse effect on our operating results. Furthermore, due to the concentration of our operations in these states and in California in particular, our business may be adversely affected by economic, health or other conditions that disproportionately affect these states as compared to other states (e.g., outbreaks of infectious disease) or by natural disasters such as major earthquake, wildfire or hurricane. Any of these factors could have a significant impact on the health of a large number of our covered members, access to care may be more difficult and proposed responses, including telehealth, may not be available. Moreover, regulatory changes undertaken in response to such events could require us to cover health care costs for members for which we would not typically be responsible.

To continue to diversify our operations we will have to expand to other regions of the United States, which will require us to devote resources to identifying and exploring such perceived opportunities. We may not be able to continue to successfully expand our operations in any new geographic markets and so we may remain subject to the risks presented by our geographic concentration.

Our management team has limited experience managing a public company.

Most members of our management team have limited experience managing a publicly traded company, interacting with public company investors and complying with the increasingly complex laws pertaining to public companies. Our management team may not successfully or efficiently manage us as a public company that is subject to significant regulatory oversight and reporting obligations under the federal securities laws and the continuous scrutiny of securities analysts and investors. These obligations and constituents require significant attention from our senior management and could divert their attention away from the day-to-day management of our business, which could adversely affect our business, results of operations and financial condition.

Competition for physicians and nurses, shortages of qualified personnel or other factors could increase our labor costs and adversely affect our revenue, profitability and cash flows.

Although we primarily contract with external providers for care delivery, we also employ physicians and other healthcare professionals to deliver in-house care. Our in-house care delivery operations are dependent on the efforts, abilities and experience of those employees. We compete with healthcare providers, hospitals, clinics, networks and other facilities in attracting physicians, nurses and medical staff to support our in-house care delivery capabilities and in recruiting and retaining qualified management and support personnel to be responsible for the daily operations of our clinical care teams.

In some markets, the lack of availability of clinical personnel, such as nurses, social workers and mental health professionals, is a significant operating issue facing all healthcare providers and others seeking to employ such personnel. Any shortage of personnel may require us to continue to enhance wages and benefits to recruit and retain qualified personnel or to contract for more expensive temporary personnel. We also depend on the available labor pool of semi-skilled and unskilled workers in each of the markets in which we operate. Our failure to recruit and retain qualified clinical and other medical personnel could have a material adverse effect on our business, financial condition and results of operations.

Any union activity that may occur among our clinical staff in the future could contribute to increased labor costs. Certain proposed changes in federal labor laws and the National Labor Relations Board's modification of its election procedures could increase the likelihood of employee unionization attempts. Although none of our employees are currently represented by a collective bargaining agreement, to the extent a significant portion of our employee base unionizes, it is possible our labor costs could increase materially.

If our labor costs increase, we may not be able to offset these increased costs. Because a significant percentage of our revenue consists of fixed, prospective payments, our ability to pass along increased labor costs is limited. In particular, if labor costs rise at an annual rate greater than our net annual payments from CMS, our results of operations and cash flows will likely be adversely affected.

If our records, including those submitted to us by our external providers, contain inaccurate or unsupportable information regarding risk adjustment scores of members, we might overstate or understate our revenue and be subject to various penalties.

The RAF scores attributable to our members determine, in part, the revenue to which we are entitled for the provision of medical care to our members. The data we submit to CMS is based, in part, on medical charts and diagnosis codes that our in-house clinical staff and our external providers prepare and submit to us. We generally rely on our in-house and externally engaged physicians to appropriately document and support such RAF data in our medical records. We also rely on our in-house and externally engaged physicians to appropriately code claims for medical services provided to members. If the providers do not provide us with accurate and supportable coding and diagnosis information, we may not be able to accurately estimate our revenue and medical costs associated with providing care to our members. If the data suggests the members are sicker than they actually are, we may overstate our revenue and overstate our costs. If the data suggests the members are healthier than they actually are, we may understate our revenue and underestimate our costs. Erroneous and/or unsupported submissions could result in a correction or retroactive adjustment in later periods. This corrected or adjusted information may be reflected in financial statements for periods subsequent to the period in which the revenue was recorded. We might also need to refund a portion of the revenue that we received, which refund, depending on its magnitude, could have a material adverse effect on our business, financial condition and results of operations.

Additionally, CMS audits Medicare Advantage organizations for documentation to support RAF-related payments for members. The Medicare Advantage organizations ask providers to submit the underlying documentation for members that they serve. It is possible that claims associated with members with higher RAF scores could be subject to more scrutiny in a CMS or plan audit. CMS may impose penalties as a result of its audits. In addition, we could be liable for penalties to the government under the FCA that range from $5,500 to $11,000 (adjusted for inflation) for each false claim, plus up to three times the amount of damages caused by each false claim, which can be as much as the amounts received directly or indirectly from the government for each such false claim. On February 12, 2024, the DOJ issued a final rule announcing adjustments to FCA penalties, under which the per claim penalty range was increased to a range from $13,946 to $27,894 for penalties assessed after February 12, 2024 with respect to violations occurring after November 2, 2015. CMS has indicated that, for some audits of plan years beginning with 2018, payment adjustments will not be limited to RAF scores for the specific Medicare Advantage enrollees for which errors are found but may also be extrapolated to the entire Medicare Advantage plan membership.

In addition to the provisions of the FCA, which provide for civil enforcement, the federal government can use several criminal statutes to prosecute persons who are alleged to have submitted false or fraudulent claims for payment to the federal government.
Our health plans 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.

A failure to accurately estimate incurred but not reported medical expense could adversely affect our results of operations.

Member care costs include estimates of future medical claims that have been incurred by the members but for which the provider has not yet billed. These claim estimates are made utilizing actuarial methods and are continually evaluated and adjusted by management, based upon our historical claims experience and other factors, including an independent assessment by a nationally recognized actuarial firm. Adjustments, if necessary, are made to medical claims expense and capitated revenues when the assumptions used to determine our claims liability change and when actual claim costs are ultimately determined.

Due to the inherent uncertainties associated with the factors used in these estimates and changes in the patterns and rates of medical utilization, materially different amounts could be reported in our financial statements for a particular period under different conditions or using different, but still reasonable, assumptions. It is possible that our estimates of this type of claim may be inadequate in the future. In such event, our results of operations could be adversely impacted. Further, the inability to estimate these claims accurately may also affect our ability to take timely corrective actions, further exacerbating the extent of any adverse effect on our results of operations.

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 Medicare Advantage 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 products and services;
- increasing the regulatory, including compliance, burdens under which we operate which, in turn, may negatively impact the manner in which we provide products and services and increase our costs of providing products and services;
- adversely affecting our ability to market our products or services through the imposition of further regulatory restrictions regarding the manner in which plans and providers market to and communicate with Medicare Advantage enrollees; or
- adversely affecting our ability to attract and retain members.

Federal reductions in Medicare Advantage funding could adversely affect our financial condition and results of operations.

The majority of our revenues come from the government-subsidized Medicare Advantage program. Medicare Advantage is a federally administered program financed in part by federal funds. The federal government has instituted measures aimed at controlling the growth of and/or reducing healthcare spending, including Medicare Advantage spending. We are exposed to financial risks associated with contracting with the federal government, including but not limited to our dependence upon Congress and CMS' robustly funding the Medicare Advantage program and the impact that delays in government payments could have on our operating cash flow and liquidity.

For example, future levels of funding for Medicare Advantage may be affected by continuing government efforts to contain healthcare costs and may further be affected by federal budgetary constraints. Congress periodically considers reducing or reallocating the amount of money the federal government spends on healthcare programs including the Medicare Advantage program, and CMS annually sets the rates and other financial factors that influence the amount of money Medicare Advantage organizations receive from the government. Furthermore, Medicare remains subject to the automatic spending reductions imposed by the Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012 ("sequestration"), subject to a 2% cap, which has been extended several times, most recently by the Consolidated Appropriations Act of 2023, and is effective through 2032 with respect to Medicare benefit payments (i.e., all payments for programs and activities under Title XVIII of the Social Security Act). Adverse economic conditions may put pressures on federal budgets as tax and other federal revenues decrease while the population that is eligible to participate in Medicare Advantage programs increases, creating more need for funding. This may require Congress and/or CMS to seek to reduce Medicare Advantage spending, which may result in reductions in funding for the Medicare Advantage program or contraction of covered benefits. A reduction (or less than expected increase), a protracted delay, or a change in allocation methodology in government funding for Medicare Advantage, as well as termination of one or more CMS contracts, may materially and adversely affect our results of operations, financial position and cash flows.

In addition, if another federal government shutdown were to occur for a prolonged period of time, CMS payment obligations, including its obligations under the Medicare Advantage program, may be delayed. If CMS fails to make payments on a timely basis, our business could suffer, and our financial position, results of operations or cash flows may be materially affected.

Delays in obtaining, or failure to obtain or maintain, governmental approvals, or moratoria imposed by regulatory authorities, could adversely affect our revenues or membership, increase costs or adversely affect our ability to bring new products and services to market as forecasted.

The centers out of which our external providers operate and the facilities that host our AVA platform may be negatively impacted by weather and other factors beyond our control.

Our results of operations may be adversely impacted by adverse conditions affecting the centers out of which our external care providers operate, and the facilities that host our AVA platform, including severe weather events such as tornadoes and widespread winter storms, natural disasters such as earthquakes and fires, public health concerns such as infectious disease outbreaks, violence or threats of violence or other factors beyond our control. Any of these events could cause disruption of member scheduling, displacement of our members, employees and care teams, or force certain of our providers' centers, or facilities that host our AVA platform to close temporarily. In certain geographic areas, we have a large concentration of clinics, external provider facilities, and facilities that host our AVA platform that may be simultaneously affected by adverse weather conditions or other events. Our future operating results may be adversely affected by these and other factors that disrupt the operation of the centers out of which our external providers operate and the facilities that host our AVA platform.

If we are unable to offer new and innovative products and services or our products and services fail to keep pace with advances in industry standards, technology and our members' needs, our members may terminate or fail to renew their membership with us and our revenue and results of operations may suffer.

Our success depends on providing innovative, high-quality, customizable products and services that elevate our members' healthcare experience and outcomes. If we cannot adapt to rapidly evolving industry standards, technology and increasingly sophisticated and varied members' needs, our existing product and service offerings could become undesirable, obsolete or harm our reputation. In order to remain competitive, we must continue to invest significant resources in our personnel and technology in a timely and cost-effective manner in order to enhance our existing products and services and introduce new high-quality products and services that existing members and potential members will want. We are continually involved in a number of projects to develop new products and services, including the further refinement of our proprietary AVA platform. If our innovations are not responsive to the needs of our existing members or potential new members, are not appropriately timed with market opportunity, are not effectively brought to market or significantly increase our operating costs, we may lose existing members or be unable to enroll new members and our results of operations may suffer.

We are a holding company with no operations of our own, and we depend on our subsidiaries for cash.

Currently, we are a holding company and do not have any material assets or operations other than ownership of equity interests of our subsidiaries. Our operations are conducted almost entirely through our subsidiaries, and our ability to generate cash to meet our obligations or to pay dividends is highly dependent on the earnings of, and receipt of funds from, our subsidiaries through dividends, administrative expenses or intercompany loans. The ability of our subsidiaries to generate sufficient cash flow from future operations to allow us and them to make scheduled payments on our obligations will depend on their future financial performance, which will be affected by a range of economic, competitive and business factors, many of which are outside of our control. We cannot assure you that the cash flow and future earnings of our operating subsidiaries will be adequate for our subsidiaries to service their debt obligations. If our subsidiaries do not generate sufficient cash flow from future operations to satisfy corporate obligations, we may have to: undertake alternative financing plans (such as refinancing), restructure debt, sell assets, reduce or delay capital investments, or seek to raise additional capital. We cannot assure you that any such alternative refinancing would be possible, that any assets could be sold, or, if sold, of the timing of the sales and the amount of proceeds realized from those sales, that additional financing could be obtained on acceptable terms, if at all, or that additional financing would be permitted under the terms of our various debt instruments then in effect. Our inability to generate sufficient cash flow to satisfy our obligations, or to refinance our obligations on commercially reasonable terms, would have an adverse effect on our business, financial condition and results of operations. Furthermore, we and our subsidiaries may incur substantial additional indebtedness in the future that may severely restrict or prohibit our subsidiaries from making distributions, paying dividends or making loans to us.

Our ability to obtain funds from certain of our licensed subsidiaries is restricted by state insurance regulations.

Our MA plans are operated through regulated insurance subsidiaries in various states. These subsidiaries are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital or tangible net equity, as defined by each state. The states in which our subsidiaries operate regulate the payment of dividends, loans, administrative expense reimbursements or other cash transfers to us, and limit investments to approved securities. The amount of dividends that may be paid to us by these insurance subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. In some states, prior notification is provided before paying a dividend even if approval is not required. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements. We continue to maintain our levels of aggregate excess statutory capital and surplus in our state-regulated operating subsidiaries. Dividends from our non-insurance companies are generally not restricted by governmental departments of insurance. In the event that our subsidiaries are unable to provide sufficient capital to fund our obligations and allow us to pursue our objectives, our results of operations, financial position, and cash flows may be materially adversely affected.

If we are required to maintain higher statutory capital levels for our existing operations or if we are subject to additional capital reserve requirements as we pursue new business opportunities, our cash flows and liquidity may be adversely affected.

One or more of the states in which our MA plan subsidiaries operate may raise the statutory capital or tangible net equity level we are required to maintain from time to time. Many states have adopted risk-based capital requirements based on guidelines adopted by the National Association of Insurance Commissioners, which tend to be, although are not necessarily, higher than existing statutory capital requirements. Regardless of whether a state in which we may operate has adopted risk-based capital requirements, the state departments of insurance can require our regulated insurance subsidiaries to maintain minimum levels of statutory capital or tangible net equity in excess of amounts required under the applicable state laws if they determine that maintaining additional statutory capital or tangible net equity, as applicable, is in the best interests of our beneficiaries. Any other changes in these requirements could materially increase our statutory capital requirements. In addition, as we continue to expand our plan offerings in new states, add new beneficiaries, or pursue new business opportunities, we may be required to maintain additional statutory capital. In any case, our available funds could be materially reduced, which could harm our ability to implement our business strategy.

We have limited experience serving as a participant in the ACO REACH model with CMS and may not be able to realize the expected benefits thereof.

The CMS Center for Medicare and Medicaid Innovation ("CMMI") implemented a direct contracting model, intended to create value-based payment arrangements directly with Direct Contracting Entities ("DCEs"), which is part of CMS's strategy to drive broader healthcare reform and accelerate the shift from original Medicare toward value-based care models. A key aspect of direct contracting is providing new opportunities for a variety of different DCEs to participate in value-based care arrangements in Medicare fee-for-service. Effective January 1, 2023, CMS replaced the DCE program with the "ACO Realizing Equity, Access, and Community Health Model" or "ACO REACH" model and designated participating entities as Accountable Care Organizations ("ACOs").

Our participation in the CMMI program began on April 1, 2021 and, as of January 1, 2025, we had approximately 6,650 members in our arrangement with our clinician partners in California and Nevada. Our participation in the ACO REACH program is subject to annual CMS approval, and our contracts are not guaranteed to be renewed in future years. Prior to April 1, 2021, we had no experience participating in CMMI's programs and, as such, our ACO business is in the early stages of development. We are subject to the risks inherent to the launch of any new business, including the risks that we may not generate sufficient returns to justify our investment and that it may take longer or be more costly to achieve the expected benefits from this new program. In particular, we may be unable to achieve risk-like patient economics on original Medicare patients. Moreover, our financial performance under the ACO REACH model may not be similar to our performance under the DCE model.

CMMI is constantly evaluating the ACO REACH program and may revise the applicable rules and design at any time, and such changes may have a significant impact on our ability to carry out our business. Certain CMMI model methodologies, including but not limited to, allowed provider classes, beneficiary alignment, benchmark establishment, and risk score modeling, are subject to continued evaluation. For example, the ACO REACH model requires participants to meet several provisions on promoting health equity, including the creation of a health equity plan, and will introduce a health equity benchmark adjustment to payments to help support care delivery and coordination in underserved areas. ACO REACH also requires that doctors and other health care providers make up 75% of governing or voting rights on the participating accountable care organization's board. These and other requirements could materially impact our profitability.

In 2024, we entered into a management services and risk management agreement with a third-party healthcare company. The third party will be responsible for arranging and controlling the health care services provided to the ACO members, and for providing certain management and support services with respect to ACO operations. The third party will also assume specified upside and downside financial risk relative to the ACO's performance. Due to our reliance on this third party, we may face the risk that it will fail to successfully manage the health care of these members and that it will incur significant financial losses. Although the third party is contractually liable for such losses and was required to obtain a security instrument and to provide a cash reserve backstopping such losses, there is a possibility that losses could exceed the aggregate amount of the security instrument and cash reserve. If that were to occur, we may be responsible for the excess losses.

The ACO REACH model may not be successful and may ultimately be discontinued, including as a result of decreased political support for value-based care or the ACO REACH model, or we may be unable to expand our total addressable market in the manner that we expect. Ultimately, our participation in the ACO REACH model may not be profitable to us initially or at all.

If we are unable to maintain the minimum required number of beneficiaries served by our ACO REACH model, we may become ineligible to participate in the program.

As with the DCE model, CMS requires ACO REACH participants to maintain at least 5,000 aligned Medicare fee-for-service beneficiaries prior to the start of each performance year. If for any year we fail to satisfy the minimum beneficiary alignment requirements, CMS may take remedial action, including imposition of a corrective action plan or termination of our participation in the program. Any adverse action that curtails or eliminates our ability to participate in the program may have an adverse effect on our business, financial condition and results of operations. Additionally, because preliminary performance year benchmarks are calculated prospectively for each performance year before the prior performance year is complete, CMS may retroactively adjust performance year

benchmarks based on the finalized quality performance scores achieved by the ACO, which will impact the reimbursements achieved in the model.

We are subject to risks associated with delegating services and functions to vendors, including supplemental benefit providers and third-party brokers.

We rely on a number of vendors and other third parties to perform various functions and fulfill our obligations to CMS and members. Our ability to operate our business depends on the performance of, and continued contracts with, these vendors. The functions performed by our major vendors include, but are not limited to, information technology support, claims processing, pharmaceutical benefit management, supplemental benefits (e.g., our "black card" benefit, vision benefits, transportation benefits) and other business process outsourcing. We also rely in part on third-party brokers for the marketing and sale of our insurance plans and on our IPAs, which perform certain functions on our behalf.

Our ability to operate our business depends on the performance of these third parties. Their performance may be compromised, degraded or interrupted for a variety of reasons, some of which are outside of our control, and they may fail to meet agreed-upon service level standards. For example, if a vendor becomes disqualified by CMS from providing services in connection with a Medicare Advantage plan, we would be unable to continue to use their services. Our vendors could also experience changes in their financial health or disruptions to their own operations. We do not directly control their actions and they could violate applicable laws, rules, and regulations. In the event that these third parties render poor performance or are unwilling or unable to perform services for us in accordance with our contract and legal requirements, we may face operational difficulties, increased expenses, penalties, fines, sanctions or litigation. Although we may be able to force the vendor to indemnify us for some or all of our losses, the vendor may not ultimately be liable in contract or tort for other losses and our business and reputation may suffer nonetheless. Disputes arising from contractual disagreements, service-level disputes or changes in vendor terms and conditions may impact our ability to maintain stable and cost-effective relationships with third-party vendors.

Our reliance on third-party vendors may directly and adversely impact our health plan membership. To the extent a vendor's inadequate performance impacts our members, their satisfaction with our health insurance plans and customer service may be diminished.

Additionally, in the event that one of our agreements with a key third party terminates, we may have a difficult time bringing the contracted services in-house or contracting with another vendor. Identifying a replacement vendor, negotiating an agreement with the vendor, and transitioning services to the vendor takes significant time and resources. We may be unable to enter into agreements with replacement vendors on favorable terms, or at all. Any loss of a key vendor relationship could result in a service disruption or unavailability and harm our ability to continue to develop, maintain, and improve our products.

Risks Related to Regulation

Our business activities are subject to substantial government regulation. New laws or regulations, or legislative, judicial, or regulatory changes in existing laws or regulations or their manner of application could increase our cost of doing business and may have a material adverse effect on our results of operations; our financial position; and our cash flows.

The Health Care Reform Law and Other Current or Future Legislative, Judicial or Regulatory Changes

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the "Health Care Reform Law") enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the Health Care Reform Law include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage premiums, the establishment of federally facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, and the introduction of plan designs based on set actuarial values. Some of these changes impact us and other entities that offer Medicate Advantage plans.

It is reasonably possible that the Health Care Reform Law and related regulations, as well as other current or future legislative, judicial or regulatory changes, including restrictions on our ability to manage our provider network or otherwise operate our business, or restrictions on profitability, including reviews by regulatory bodies that may compare the profitability of various products within our Medicare Advantage business and require that they remain within certain ranges of each other, increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments to us, may have a material adverse effect on our results of operations (including restricting revenue, enrollment and premium growth in certain products and market segments, restricting our ability to expand into new markets, increasing our medical and operating costs, further lowering our payment rates and increasing our expenses associated with assessments), our financial position and our cash flows.

Additionally, potential legislative changes or judicial determinations, including activities to repeal or replace the Health Care Reform Law or declare all or certain portions of the Health Care Reform Law unconstitutional, creates uncertainty for our business, and we cannot predict when, or in what form, such legislative changes or judicial determinations may occur.

Health Insurance Portability and Accountability Act, the Health Information Technology for Economic and Clinical Health Act and Other Laws, Rules and Regulations Related to Data Privacy

We are subject to data privacy and protection laws and regulations that apply to the collection, transmission, storage and use of PHI and other PII, which among other things, impose certain requirements relating to the privacy, security and transmission of PII. The legislative and regulatory landscape for privacy and data protection continues to evolve, and there has been an increasing focus on privacy and data protection issues with the potential to affect our business. Failure to comply with any of these laws and regulations could result in enforcement action against us, including fines, public censure, claims for damages by affected individuals, damage to our reputation and loss of goodwill, any of which could have a material adverse effect on our business, financial condition, results of operations or prospects. Ongoing efforts to comply with evolving laws and regulations may be costly and require ongoing modifications to our policies, procedures and systems.

The use of individually identifiable health data by our business is regulated at federal and state levels. These laws and rules are changed frequently by legislation or administrative interpretation. Various state laws address the use and maintenance of PII. Among these state laws, which we describe in more detail below, we are most substantially affected by the California Consumer Privacy Act, which uniquely among general consumer privacy laws did not exempt employee information, business contact information, and only maintains narrow exemptions for data subject to HIPAA or the Gramm-Leach-Bliley Act. We may need to change the way we create, receive, maintain or transmit PII to comply with these state laws.

HIPAA includes administrative provisions directed at simplifying electronic data interchange through standardizing transactions, establishing uniform healthcare provider, payer, and employer identifiers, and establishing regulations aimed at protecting confidentiality and security of patient and member data. The rules preempt all inconsistent state laws unless the state law is more privacy-protective.

These regulations, in addition to other state laws, set standards for the security of electronic health information, including requirements that insurers provide customers with notice regarding how their PHI is used. Compliance with HIPAA regulations requires us to regularly monitor security risk, implement and regularly review administrative, technical and physical safeguards to protect electronic health information, and provide workforce training, among other administrative efforts. HIPAA can also expose us to additional liability for violations by our business associates (*e.g.,* entities that provide services to health plans and providers).

The US Department of Health and Human Services, Office for Civil Rights announced on December 27, 2024, and published in the Federal Register on January 6, 2025, a Notice of Proposed Rulemaking proposing extensive modifications to the HIPAA security standards. If finalized, these modifications could entail significant additional compliance obligations and costs for HIPAA-regulated covered entities and business associates.

HIPAA imposes mandatory penalties for certain violations. In 2024, penalties for violations of HIPAA and its implementing regulations started at $141 per violation and could not exceed approximately $71,162 per violation, subject to a cap of approximately $2.1 million for violations of the same standard in a single calendar year. However, a single breach incident can result in violations of multiple standards. Additionally, the penalty amounts listed above are also due for inflation adjustments in 2025.

HIPAA also authorizes state attorneys general to file suit on behalf of their residents for statutory damages of up to $25,000. While HIPAA does not create a private right of action allowing individuals to sue in civil court for violations of HIPAA, its standards have been used as the basis for duty of care in state civil suits such as those for negligence or recklessness in the misuse or breach of PHI.

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

We also publish statements to our members and partners that describe how we handle and protect PHI. If federal or state regulatory authorities or private litigants consider any portion of these statements to be untrue, we may be subject to claims of deceptive practices, which could lead to significant liabilities and consequences, including, without limitation, costs of responding to investigations, defending against litigation, settling claims, and complying with regulatory or court orders. Any of the foregoing consequences could have a material adverse impact on our business and our financial results.

Data privacy and security at the state level remains an evolving landscape. For example, CCPA, which came into effect on January 1, 2020, requires companies that process information on California residents to make disclosures to consumers about their data collection, use and sharing practices, allow consumers to opt out of certain data sharing with third parties and provides a cause of action for data breaches. In addition, on November 3, 2020, California voters approved amendments to the CCPA, known as the CPRA, which significantly modifies the CCPA, including by expanding consumers' rights with respect to certain personal information and creating a state agency, the California Privacy Protection Agency ("CPPA"), to oversee implementation and enforcement efforts. The CPPA is able to finance operations through penalties issued and with the CPRA's removal of the mandatory cure period from CCPA, we will have less warning before compliance risk results in legal action. The CPRA's amendments became effective on January 1, 2023. The CCPA

contains exemptions for medical information governed by the California Confidentiality of Medical Information Act, and for PHI collected by a covered entity or business associate governed by the privacy, security, and breach notification rule established pursuant to HIPAA.

The CPPA has released for public comment draft regulations on risk assessments, cybersecurity assessments, and automated decision-making technologies, which close on February 19, 2025. These regulations are the final components of the CPRA's amendments to the CCPA, which granted the CPPA the authority to pass additional regulations. These regulations in their draft form contain substantial new compliance obligations with respect to PII we process.

The CCPA has prompted a number of proposals for new federal and state-level privacy legislation. Such proposed legislation, if enacted, may add additional complexity, variation in requirements, restrictions and potential legal risk, require additional investment of resources in compliance programs, impact strategies and the availability of previously useful data and could result in increased compliance costs and/or changes in business practices and policies. For example, the Virginia Consumer Data Protection Act, which became effective January 1, 2023, gives Virginia residents expanded rights to access and creates additional obligations on companies covered by the legislation, and the Nevada Privacy Law, which became effective on October 1, 2019, requires businesses to give website users the option to opt-out of the sale of their data, but is otherwise significantly more narrow than the other laws mentioned. As of February 1, 2025, general State privacy laws are in effect in California, Colorado, Connecticut, Utah, Texas, Oregon, Virginia, Montana, New Jersey, Delaware, Iowa, Nebraska, and New Hampshire. Additional general state privacy laws have been passed and will go into effect in 2025 in Tennessee, Minnesota, and Maryland, and in 2026, in Indiana, Kentucky, and Rhode Island.

While the CPRA/CCPA is an example of consumer privacy law, the NAIC's Model Insurance Data Security Law (the "Model law") is a different type of law focused on securing insurance licensees' information systems. Versions of this Model Law have been passed in many states and are expected to be passed in more states in the coming years. Similar to HIPAA, the Model Law requires the implementation of technical, administrative, and procedural information security practices and procedures and includes reporting requirements for data breaches. These Model Laws exist in a majority of states and are typically enforced by state insurance regulators.

It is possible that applicable laws may be interpreted and applied in a manner that is inconsistent with our practices and our efforts to comply with the evolving data protection rules may be unsuccessful. We must devote significant resources to understanding and complying with this changing landscape. Failure to comply with laws regarding privacy and security of PHI and other PII could expose us to penalties under such laws. Any such failure to comply with data protection and privacy laws could result in government-imposed fines or orders requiring that we change our practices, claims for damages or other liabilities, regulatory investigations and enforcement action, litigation and significant costs for remediation, any of which could adversely affect our business. Even if we are not determined to have violated these laws, government investigations into these issues typically require the expenditure of significant resources and generate negative publicity, which could have an adverse effect on our business, financial condition and results of operations.

As indicated above, there are numerous federal and state laws and regulations addressing patient and consumer privacy concerns, including notification requirements in the event of unauthorized access or theft of personal information. State statutes and regulations vary from state to state. Violations of HIPAA or applicable federal or state laws or regulations could subject us to significant criminal or civil penalties, including significant monetary penalties. We cannot yet fully determine the impact these or future laws, rules, regulations and industry standards may have on our business or operations. Any such laws, rules, regulations and industry standards may be inconsistent among different jurisdictions, subject to differing interpretations or may conflict with our current or future practices. Additionally, our customers may be subject to differing privacy laws, rules and legislation, which may mean that they require us to be bound by varying contractual requirements applicable to certain other jurisdictions. Adherence to such contractual requirements may impact our collection, use, processing, storage, sharing and disclosure of various types of information and may mean we become bound by, or voluntarily comply with, self-regulatory or other industry standards relating to these matters that may further change as laws, rules and regulations evolve. Complying with these requirements and changing our policies and practices may be onerous and costly, and we may not be able to respond quickly or effectively to regulatory, legislative and other developments. These changes may in turn impair our ability to offer our existing or planned features, products and services and/or increase our cost of doing business. As we expand our customer base, these requirements may vary from customer to customer, further increasing the cost of compliance and doing business.

Our business and operations may also be subject to federal, state, and local consumer protection laws governing marketing communications, including the Telephone Consumer Protection Act, "TCPA", which places restrictions on the use of automated tools and technologies to communicate with wireless telephone subscribers or communications services consumers generally and the CAN-SPAM Act, which regulates the transmission of marketing emails. Under the TCPA, entities using an automatic telephone dialing system to send communications must obtain prior express consent for non-marketing communications and prior express written consent for marketing communications. The TCPA has a private right of action, allowing individuals who have received unsolicited communications (phone calls, text messages or faxes) made using an "automatic telephone dialing system" to seek statutory damages of $500 per violation, or $1,500 if the violation was made willfully or knowingly. Despite our compliance efforts, we could nevertheless be forced to defend private class actions or government enforcement based on the communications we send to members.

In addition, certain of our businesses are also subject to the PCI DSS, which is a multifaceted industry security standard that is designed to protect credit card account data as mandated by payment brands and acquiring banks. We rely on vendors to assist us with PCI matters and to ensure PCI compliance. Despite our compliance efforts, we may become subject to claims that we have violated the PCI DSS or other requirements of the payment card brands, based on past, present, or future business practices, which could have an adverse impact on our business and reputation, subject us to fines and/or have a negative impact on our ability to accept credit card payments.

As described above, substantially all of our relevant member data is maintained on our technology platform, AVA, which aggregates and provides us with access to extensive member datasets, including individually identifiable PHI. As a result, any breach of our technology platform could expose us to substantial liability under HIPAA, the HITECH Act and other applicable laws, regulations or rules. See "*Risk Factors—Security breaches, loss of data and other disruptions could compromise sensitive information related to our business or our members, or prevent us from accessing critical information and expose us to liability, which could adversely affect our business and our reputation.*"

Corporate Practice of Medicine and Other Laws

As a corporate entity, we are not licensed to practice medicine. Many states in which we operate through our subsidiaries limit the practice of medicine to licensed individuals or professional organizations comprised of licensed individuals, and business corporations generally may not exercise control over the medical decisions of physicians. Statutes, regulations and court decisions relating to the practice of medicine, fee-splitting between physicians and referral sources, and similar issues vary widely from state to state. While we endeavor to comply with state corporate practice of medicine laws and regulations as we interpret them, the laws and regulations in these areas are complex, changing, and often subject to varying interpretations. The interpretation and enforcement of these laws vary significantly from state to state.

Under business support services agreements between certain of our subsidiaries and affiliated physician-owned professional groups, these groups retain sole responsibility for all medical decisions, as well as for hiring and managing physicians and other licensed healthcare providers, developing operating policies and procedures, implementing professional standards and controls, and maintaining malpractice insurance. Regulatory authorities and other parties may assert that, despite the business support services agreements and other arrangements through which we operate, we are engaged in the prohibited corporate practice of medicine or that our arrangements constitute unlawful fee-splitting. Penalties for violations of the corporate practice of medicine or fee-splitting laws vary by state and may result in physicians being subject to disciplinary action, as well as to forfeiture of revenue from payors for services rendered. For business entities such as us, violations may also bring both civil and, in more extreme cases, criminal liability for engaging in medical practice without a license, our agreements could be found legally invalid and unenforceable (in whole or in part) or we could be required to restructure our contractual arrangements.

We, our in-house and externally engaged physicians and the facilities in which they operate are subject to various federal, state and local licensing and certification laws and regulations and accreditation standards and other laws, relating to, among other things, the adequacy of medical care, equipment, privacy of member information, physician relationships, personnel and operating policies and procedures. Failure to comply with these licensing, certification and accreditation laws, regulations and standards could result in prior payments being subject to recoupment, requirements to make significant changes to our operations and can give rise to civil or, in extreme cases, criminal penalties. We routinely take the steps we believe are necessary to retain or obtain all requisite licensure and operating authorities. While we have made reasonable efforts to substantially comply with federal, state and local licensing and certification laws and regulations and standards as we interpret them, the agencies that administer these programs may find that we have failed to comply in some material respects. If this were to occur, we could be subject to civil and/or criminal penalties, or we could be required to close or limit our operations at relevant sites.

In jurisdictions where the corporate practice of medicine is prohibited, we have historically operated by maintaining long-term business support contracts with multiple associated professional medical entities that are wholly owned by physicians and, in turn, employ or contract with physicians to provide those professional medical services required by our members. Under these business support services agreements, our primary operating subsidiary performs only non-medical business support services, does not represent that it offers medical services and does not exercise influence or control over the practice of medicine by the physicians or the associated physician groups. In addition to the above business support services arrangements, we have certain contractual rights relating to the orderly transfer of equity interests in our associated physician practices through succession agreements and other arrangements with their physician equity holders. Such equity interests cannot, however, be transferred to or held by us or by any non-professional medical entity. Accordingly, neither we nor our direct subsidiaries directly own any equity interests in any of our physician practices. In the event that any of the physician owners of our associated physician practices fail to comply with the business support services arrangement, if any business support services arrangement is terminated and/or we are unable to enforce our contractual rights over the orderly transfer of equity interests in any of our associated physician practices, such events could have a material adverse effect on our business, results of operations, financial condition and cash flows.

It is possible that a state regulatory agency or a court could determine that our agreements with physician equity holders of our associated physician practices and the way we carry out these arrangements as described above, either independently or coupled with the business support services agreements with such associated physician practices, are in violation of prohibitions on the corporate practice of medicine. As a result, these arrangements could be deemed invalid. Such a determination could force a restructuring of our business support services arrangements with the affected practices, which might include revisions of the business support services agreements, including a modification of the services fee and/or establishing an alternative structure that would permit us to contract with a physician network without violating prohibitions on the corporate practice of medicine. Such a restructuring may not be feasible, or it may not be possible to accomplish it within a reasonable time frame without a material adverse effect on our business, results of operations, financial condition and cash flows. Additionally, a number of states have recently introduced or are planning to introduce legislation that would significantly increase the level of scrutiny that similarly structured organizations would face and could introduce additional penalties on business support services organizations similar to ours.

Anti-Kickback, Physician Self-Referral and Other Fraud and Abuse Laws

A federal law commonly referred to as the "Anti-Kickback Statute" prohibits the offer, payment, solicitation, or receipt of any form of remuneration to induce, or in return for, the referral of Medicare or other governmental health program patients or patient care opportunities, or in return for the purchase, lease or order of items or services that are covered by Medicare or other federal governmental health programs. Because the prohibitions contained in the Anti-Kickback Statute apply to the furnishing of items or services for which payment is made in "whole or in part," the Anti-Kickback Statute could be implicated if any portion of an item or service we provide is covered by any of the state or federal health benefit programs described above. Violation of these provisions constitutes a felony criminal offense and applicable sanctions could include exclusion from the Medicare and Medicaid programs.

Section 1877 of the Social Security Act, commonly known as the "Stark Law," prohibits physicians, subject to certain exceptions described below, from referring Medicare or Medicaid patients to an entity providing "designated health services" in which the physician, or an immediate family member, has an ownership or investment interest or with which the physician, or an immediate family member, has entered into a compensation arrangement. These prohibitions, contained in the Omnibus Budget Reconciliation Act of 1993, commonly known as "Stark II," amended prior federal physician self-referral legislation known as "Stark I" by expanding the list of designated health services to a total of 11 categories. The professional groups with which we are contracted or affiliated provide one or more of these designated health services. Persons or entities found to be in violation of the Stark Law are subject to denial of payment for services furnished pursuant to an improper referral, civil monetary penalties, and exclusion from the Medicare and Medicaid programs.

A federal law commonly referred to as the "False Claims Act" prohibits the submission of a false or fraudulent claim to the government for payment or approval. *Qui tam* relators and/or the government may take the position that we submit certain data or information that could form the basis of a claim for payment, thus subjecting us to allegations under the False Claims Act. In such events, we could be subject to treble damages and per-claim penalties.

Many states also have enacted laws similar in scope and purpose to the Anti-Kickback Statute and, in more limited instances, the Stark Law, that are not limited to services for which Medicare or Medicaid payment is made. In addition, most states have statutes, regulations, or professional codes that restrict a physician from accepting various kinds of remuneration in exchange for making referrals. These laws vary from state to state and have seldom been interpreted by the courts or regulatory agencies. In states that have enacted these statutes, we believe that regulatory authorities and state courts interpreting these statutes may regard federal law under the Anti-Kickback Statute and the Stark Law as persuasive.

In addition, these laws are subject to modification and changes in interpretation, and are enforced by authorities vested with broad discretion. We continually monitor developments in this area. If we or our third parties with which we contract fail to comply with these laws, or if these laws are interpreted in a manner contrary to our interpretation or are reinterpreted or amended, or if new legislation is enacted with respect to healthcare fraud and abuse, illegal remuneration, or similar issues, we may be required to restructure our affected operations to maintain compliance with applicable law and/or be subject to liability. Such restructuring may not be possible or, if possible, may have a material adverse effect on our results of operations, financial position, or cash flows.

Environmental

We are subject to various federal, state, and local laws and regulations relating to the protection of human health and the environment. If an environmental regulatory agency finds any of our facilities to be in violation of environmental laws, penalties and fines may be imposed for each day of violation and the affected facility could be forced to cease operations. We could also incur other significant costs, such as cleanup costs or claims by third parties, as a result of releases of hazardous substances or violations of, or other liabilities under, environmental laws. Although we believe that our environmental practices, including waste handling and disposal practices, are in material compliance with applicable laws, future claims or violations, or changes in environmental laws, could have a material adverse effect on our results of operations, financial position or cash flows.

State Regulation of Insurance-Related Products

Laws in each of the states in which we operate our business license and regulate entities that offer health plans to residents of that state. The products we offer are sold under licenses issued by the applicable insurance regulators. However, for entities offering Medicare Advantage plans, federal law preempts all state laws and regulations except those relating to licensing and financial solvency.

With respect to state regulation of financial solvency, certain of our licensed insurance subsidiaries are subject to regulation under state insurance holding company regulations. These regulations generally require, among other things, prior approval and/or notice of certain material transactions, including dividend payments, purchases or sales of assets, intercompany agreements, and the filing of various financial and operational reports. The amount of dividends that may be paid to us by these insurance subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements. We continue to maintain our levels of aggregate excess statutory capital and surplus in our state-regulated operating subsidiaries. Dividends from our non-insurance companies are generally not restricted by departments of insurance.

If any of our plans or operations are found to violate these or other applicable government 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 one or more of our plans;
- refunds of amounts received in violation of law or applicable payment program requirements dating back to the applicable statute of limitation periods;
- loss of our required government certifications;
- loss of our licenses required to operate our clinics and in-house care delivery programs;
- criminal or civil liability, fines, damages or monetary penalties for violations of healthcare fraud and abuse laws, including the federal Anti-Kickback Statute, Stark Law and FCA, or other failures to meet regulatory requirements;
- enforcement actions by governmental agencies and/or state law claims for monetary damages by members who believe their PHI has been used, disclosed or not properly safeguarded in violation of federal or state patient privacy laws, including HIPAA and the Privacy Act of 1974;
- mandated changes to our practices or procedures that significantly increase operating expenses;
- imposition of and compliance with corporate integrity agreements that could subject us to ongoing audits and reporting requirements as well as increased scrutiny of our billing and business practices which could lead to potential fines, among other things;
- termination of various relationships and/or contracts related to our business, including joint venture arrangements, medical director agreements, real estate leases and consulting agreements with physicians; and
- harm to our reputation which could negatively impact our business relationships, affect our ability to attract and retain members and physicians, affect our ability to obtain financing and decrease access to new business opportunities, our ability to develop relationships with providers, among other things.

If we are unable to effectively adapt to changes in the healthcare industry, including changes to laws and regulations regarding or affecting the U.S. healthcare reform, our business may be harmed.

Due to the importance of the healthcare industry in the lives of all Americans, federal, state, and local legislative bodies frequently pass legislation and promulgate regulations relating to healthcare reform or that affect the healthcare industry. As has been the trend in recent years, it is reasonable to assume that there will continue to be increased government oversight and regulation of the healthcare industry in the future. We cannot predict the ultimate content, timing or effect of any new healthcare legislation or regulations, nor is it possible at this time to estimate the impact of potential new legislation or regulations on our business. It is possible that future legislation enacted by Congress or state legislatures, or regulations promulgated by regulatory authorities at the federal or state level, could adversely affect our business or could change the operating environment of our clinical staff and external providers. It is possible that the changes in Medicare, Medicaid or other governmental healthcare program reimbursements may serve as precedent to possible changes in other payors' reimbursement policies in a manner adverse to us. Similarly, changes in the private payor reimbursements could lead to adverse changes to Medicare, Medicaid and other governmental healthcare programs, which could have a material adverse effect on our business, financial condition and results of operations.

The policies and decisions of the federal and state governments regarding the Medicare Advantage program in which we participate have a substantial impact on our profitability. These governmental policies and decisions, which we cannot predict with certainty, directly shape the revenues given to us under the Medicare Advantage program, the eligibility and enrollment of our members, the services we provide to our members, and our administrative, healthcare services, and other costs associated with the Medicare Advantage program. Legislative or regulatory actions, such as changes to the Medicare Advantage program, those resulting in a reduction in payments to us, an increase in our cost of administrative and healthcare services, or additional fees, taxes or assessments, may have a material adverse effect on our results of operations, financial position, and cash flows. For example, CMS recently finalized new regulations requiring Utilization Management (UM) committees to include a health equity expert and conduct an annual analysis of prior authorization impacts on enrollees with social risk factors, with the findings publicly posted on their website. These changes expand upon recently imposed requirements for UM committees and the annual review of UM policies, further increasing the regulatory burden on MA plans. Additionally, CMS implemented stricter regulations on Third-Party Marketing Organizations (TPMOs), prohibiting the sharing or resale of personal beneficiary data without prior written consent, which may limit outreach efforts and reduce lead generation and enrollment opportunities for MA plans. CMS's focus on marketing activities coincides with an apparent increased DOJ interest, as well. In recent years, the DOJ has launched investigations into whether marketing and recruiting practices of Medicare Advantage Organizations and their downstream providers violate the FCA.

While we believe that we have structured our agreements and operations in material compliance with applicable healthcare laws and regulations, we may be unable to successfully address changes in the current regulatory environment. In addition, some of the healthcare laws and regulations applicable to us are subject to limited or evolving interpretations, and a review of our business or operations by a court, law enforcement or a regulatory authority might result in a determination that could have a material adverse effect on us.

Furthermore, the healthcare laws and regulations applicable to us may be amended or interpreted in a manner that could have a material adverse effect on our business, prospects, results of operations and financial condition.

New federal restrictions on plans that CMS believes resemble dual-eligible special needs plans and new state-level restrictions on actual dual-eligible special needs plans may restrict the types and number of plans that we can offer, thus potentially adversely impacting our membership, revenue and/or profitability.

Medicare Advantage organizations may offer dual-eligible special needs plans ("D-SNPs"), which are plans that may only enroll beneficiaries who are eligible for both Medicare and Medicaid. D-SNPs must meet additional statutory and regulatory requirements that are intended to address certain challenges faced by the dually eligible population. According to CMS, some Medicare Advantage organizations offer plans that are not D-SNPs but that are designed to attract primarily dual-eligible beneficiaries ("D-SNP look-alike plans"). In 2020, CMS issued a final rule to restrict the offering of D-SNP look-alike plans. Specifically, CMS will not enter into a contract for a new Medicare Advantage plan that is not a special needs plan and is projected to enroll more than 80% dual-eligible members. Moreover, CMS will not renew a contract for such plans unless the plan has been active for less than a year and enrolls 200 or fewer members. There may be additional CMS restrictions on D-SNP plans and their enrollment, as CMS recently finalized a policy that would, among other things, lower the threshold to seventy percent (70%) in 2025 and sixty percent (60%) in 2026. Additionally, the California Department of Healthcare Services has adopted regulatory changes limiting the availability of D-SNP contracts. Since contract year 2024, DHCS will only contract with new D-SNPs that are affiliated with a Medi-Cal managed care plan. Furthermore, beginning in contract year 2025, existing D-SNPs without such affiliations will be prohibited from enrolling new members. These regulatory developments are likely to restrict the types of plans we can offer and the membership mix we can maintain in our plans. To the extent we have to offer enhanced benefits to attract or retain dual-eligible members in certain plans, the profitability of such plans may be impacted. These regulatory developments may accordingly have an adverse impact on our membership, financial condition, results of operations and cash flows.

If we lost the services of the licensed physicians who own our associated physician practices for any reason, the contractual arrangements with our associated physician practices could be in jeopardy.

As described above, because of regulations preventing the corporate practice of medicine, certain of our associated physician practice groups that operate our clinics are wholly owned or primarily owned by physicians employed by us. Although we retain certain rights regarding the succession of ownership of the associated practices through succession agreements and other arrangements with their physician equity holders, if current owners died, were incapacitated or otherwise were no longer affiliated with us, there could be a material adverse effect on the relationship between us and the associated physician practices and, therefore, our business operations could be adversely affected.

The contractual arrangements we have with our associated physician practices are not as secure as direct ownership of such entities.

As described above, because of laws prohibiting the corporate practice of medicine, we enter into contractual arrangements to manage certain of our affiliated physician practices. If we were to hold the equity of such physician practices directly, we would be able to exercise our rights as an equity holder directly to effect changes in the boards of directors of those entities, which could effect changes at the management and operational level. In contrast, under our current contractual arrangements with our associated physician groups, we may not be able to directly change the members of the boards of directors of these entities and would have to rely on the entities and the entities' equity holders to perform their obligations in order to exercise our control over the entities. If any of these affiliated entities or their equity holders fail to perform their respective obligations under the contractual arrangements, we may have to incur substantial costs and expend additional resources to enforce such arrangements.

Changes in tax laws may adversely affect us, and the Internal Revenue Service or a court may disagree with tax positions taken by us, which may result in adverse effects on our financial condition or the value of our common stock.

There can be no assurance that future tax law changes will not increase the rate of the corporate income tax significantly, impose new limitations on deductions, credits or other tax benefits, or make other changes that may adversely affect our business, cash flows or financial performance. Executive or Congressional actions could materially increase our tax obligations and significantly impact our effective tax rate in the period such guidance is issued or such actions take effect, and in future periods. In addition, it may be the case that the Internal Revenue Service (the "Service") has yet to issue guidance on a number of important issues regarding the changes made by recent or future legislation. In the absence of such guidance, we may take positions with respect to a number of unsettled issues. There is no assurance that the Service or a court will agree with the positions taken by us, in which case tax penalties and interest may be imposed that could adversely affect our business, cash flows or financial performance.

Risks Related to Our Indebtedness and our Capital Requirements

Our existing indebtedness could adversely affect our business and growth prospects.

On November 22, 2024 we completed the sale of $330.0 million of our 4.25% Convertible Senior Notes (the "Convertible Notes"). The Convertible Notes were issued pursuant to an indenture, dated as of November 22, 2024, between the Company and U.S. Bank Trust Company, National Association, as trustee. The Convertible Notes are senior, unsecured obligations of the Company, and interest will be

payable semi-annually in arrears at a rate of 4.25% per annum beginning on May 15, 2025. The Convertible Notes will mature on November 15, 2029, unless earlier repurchased, redeemed or converted in accordance with their terms.

The Convertible Notes have an initial conversion rate of 62.4 shares of common stock per $1,000 principal amount of the Convertible Notes (subject to adjustment for certain events). This represents an initial conversion price of approximately $16.04 per share. The initial conversion price of the Convertible Notes represents a premium of approximately 25% to the closing price of the our common stock on November 14, 2024.

Our indebtedness under the Convertible Notes, or any additional indebtedness we may incur, could require us to divert funds identified for other purposes for debt service and impair our liquidity position. If we cannot generate sufficient cash flow from operations to service our debt, we may need to refinance our debt, dispose of assets or issue equity to obtain necessary funds. We do not know whether we will be able to take any of these actions on a timely basis, on terms satisfactory to us or at all.

Our indebtedness under the Convertible Notes and any other indebtedness we may incur, and the cash flow needed to satisfy our debt, have other important consequences, including:

- limiting funds otherwise available for financing our capital expenditures by requiring us to dedicate a portion of our cash flows from operations to the repayment of debt and the interest on this debt;
- placing us at a competitive disadvantage to our competitors that are not as highly leveraged; and
- making us more vulnerable in the event of a downturn in our business.

Moreover, our indebtedness may increase our vulnerability to any generally adverse economic and industry conditions, and we and our subsidiaries may, subject to the limitations in the terms of our existing and future indebtedness, incur additional debt, secure existing or future debt, or recapitalize our debt. If we incur additional indebtedness, the risks related to our business would increase and our ability to service or repay our indebtedness may be adversely impacted. In addition, developments in tax policy, such as the disallowance of tax deductions for interest paid on outstanding indebtedness, could have an adverse effect on our liquidity and our business, financial conditions and results of operations.

We expect to use cash flow from operations to meet current and future financial obligations, including funding our operations, debt service requirements and capital expenditures. The ability to make these payments depends on our financial and operating performance, which is subject to prevailing economic, industry and competitive conditions and to certain financial, business, economic and other factors beyond our control.

We may not be able to generate sufficient cash flow to service all of our indebtedness and may be forced to take other actions to satisfy our obligations under such indebtedness, including refinancing such indebtedness, which may not be successful.

Our ability to make scheduled payments or to refinance outstanding debt obligations depends on our financial and operating performance, which will be affected by prevailing economic, industry and competitive conditions and by financial, business and other factors beyond our control. We may not be able to maintain a sufficient level of cash flow from operating activities to permit us to pay the principal, premium, if any, and interest on our indebtedness. Any failure to make payments of interest and principal on our outstanding indebtedness on a timely basis would likely result in penalties or defaults, which would also harm our ability to incur additional indebtedness.

If our cash flows and capital resources are insufficient to fund our debt service obligations, we may be forced to reduce or delay capital expenditures, sell assets, seek additional capital or seek to restructure or refinance our indebtedness. Any refinancing of our indebtedness could be at higher interest rates and may require us to comply with more onerous covenants. We may not be able to obtain sufficient funds to enable us to repay or refinance our debt obligations on commercially reasonable terms, or at all, and accordingly may not be successful and may not permit us to meet our scheduled debt service obligations. In the absence of such cash flows and resources, we could face substantial liquidity problems and might be required to sell material assets or operations to attempt to meet our debt service obligations. If we cannot meet our debt service obligations, the holders of our indebtedness may accelerate such indebtedness and, to the extent such indebtedness is secured, foreclose on our assets. In such an event, we may not have sufficient assets to repay all of our indebtedness.

We may not have the ability to raise the funds necessary to settle conversions of our convertible notes, repurchase our convertible notes upon a fundamental change, or repay our convertible notes in cash at their maturity, and our future debt may contain limitations on our ability to pay cash upon conversion or repurchase of our convertible notes.

We will need to make cash payments (a) if holders of the Convertible Notes require us to repurchase all, or a portion of, their Convertible Notes before the maturity date upon the occurrence of a fundamental change (e.g., a change of control of Alignment Healthcare, Inc.) or (b) to repay the Convertible Notes in cash at their maturity unless earlier converted, repurchased or redeemed. If our cash provided by operating activities, together with our existing cash, cash equivalents, and investments, and existing sources of financing, are inadequate to satisfy these obligations, we will need to obtain third-party financing, which may not be available to us on commercially reasonable terms or at all, to meet these payment obligations. Under the terms of the Convertible Notes, we also have the option to settle the amount of our conversion obligation in cash, shares of our common stock or a combination of cash and shares, at our

election. If we are unable to settle such obligations in cash, we would be required to settle such obligations by delivering shares of our common stock, which may have a significant dilutive impact on our stockholders.

If a takeover transaction constitutes a make-whole fundamental change under the Indenture, we may be required to increase the conversion rate for holders who convert their notes in connection with such takeover. In either case, and in other cases, our obligations under the Convertible Notes and the Indenture could increase the cost of acquiring us or otherwise discourage a third party from acquiring us or removing incumbent management, including in a transaction that holders of the Convertible Notes or holders of our common stock may view as favorable.

In addition, our ability to repurchase or to pay cash upon conversion of the Convertible Notes may be limited by law, regulatory authority, or agreements governing our future indebtedness. Our failure to repurchase the Convertible Notes at a time when the repurchase is required by the Indenture or to pay cash upon conversion of the Convertible Notes as required by the Indenture would constitute a default under the indenture. A default under the Indenture or the fundamental change itself could also lead to a default under agreements governing our future indebtedness, if any. If the payment of the related indebtedness were to be accelerated after any applicable notice or grace periods, we may not have sufficient funds to repay the indebtedness and repurchase the Convertible Notes or to pay cash upon conversion of the Convertible Notes.

Our failure to raise additional capital or generate cash flows necessary to expand our operations and invest in new technologies in the future could reduce our ability to compete successfully and harm our results of operations.

We may need to raise additional funds, and we may not be able to obtain additional debt or equity financing on favorable terms or at all. Our need for additional capital will depend on our business needs, requirements and opportunities, including to develop and enhance new and existing products and services, enter new markets, further develop our infrastructure, and comply with any statutory, regulatory or contractual capital and liquidity requirements. In addition, we intend to assess strategic acquisitions as the opportunities arise, some of which may be material to our operations. Our ability to obtain additional capital will depend on our development efforts, business plans, investor demand, operating performance, the condition of the capital markets, and other factors. If we raise additional equity financing or additional convertible note financing, our security holders may experience significant dilution of their ownership interests. The equity securities we issue may also have rights, preferences, or privileges senior to the rights of existing stockholders. If we engage in additional debt financing, we may be required to accept terms that restrict our ability to incur additional indebtedness, force us to maintain specified liquidity or other ratios or restrict our ability to pay dividends or make acquisitions.

If we need additional capital and cannot raise it on acceptable terms, or at all, we may not be able to, among other things:

- develop and enhance our member services;
- maintain or expand our marketing efforts;
- maintain our presence in certain existing markets or enter new markets as currently planned, or at all;
- continue to expand our organization;
- hire, train and retain employees;
- respond to competitive pressures or unanticipated working capital requirements; or
- pursue acquisition opportunities.

If we are unable to obtain adequate financing or financing on terms satisfactory to us when we require it, our ability to continue to support our business growth and to respond to business challenges could be significantly limited or impaired.

Risks Related to Our Common Stock

Our operating results and stock price may be volatile, including as a result of factors that are beyond our control.

Our quarterly operating results are likely to fluctuate in the future. In addition, securities markets worldwide, and public companies in the healthcare and technology industry in particular, have experienced, and are likely to continue to experience, significant price and volume fluctuations. This market volatility, as well as general economic, market or political conditions, could subject the market price of our shares to wide price fluctuations regardless of our operating performance. Our operating results and the trading price of our shares may fluctuate in response to various factors, including:

- market conditions in our industry or the broader stock market;
- actual or anticipated fluctuations in our quarterly or annual financial and operating results;
- our announcement of actual results for a fiscal period that are higher or lower than revenue or earnings guidance or our announcement of revenue or earnings guidance that is higher or lower than expected;
- introduction of new solutions or services by us or our competitors;
- issuance of new or changed securities analysts' reports or recommendations;
- sales, or anticipated sales, of large blocks of our stock;

- additions or departures of board members, management or other key personnel;
- regulatory or political developments, including those related to Medicare;
- litigation and governmental investigations;
- changing economic conditions;
- investors' perception of us;
- events beyond our control, such as earthquakes, epidemics, weather and war; and
- any default on our indebtedness.

These and other factors, many of which are beyond our control, may cause our operating results and the market price and demand for our shares to fluctuate substantially. Fluctuations in our quarterly or annual operating results could limit or prevent investors from readily selling their shares and may otherwise negatively affect the market price and liquidity of our shares. In addition, in the past, when the market price of a stock has been volatile, holders of that stock have sometimes instituted securities class action litigation against the company that issued the stock. If any of our shareholders brought a lawsuit against us, we could incur substantial costs defending the lawsuit. Such a lawsuit could also divert the time and attention of our management from our business, which could significantly harm our profitability and reputation. Further, we provide indemnification for our officers and directors for certain claims in connection with such litigation. Large indemnity payments would adversely affect our business, results of operations, and financial condition.

Our actual operating results may not meet or exceed our guidance and investor expectations, which would likely cause our stock price to decline.

From time to time, we may release guidance in our earnings releases, earnings conference calls or otherwise, regarding our future performance that represent our management's estimates as of the date of release. If given, this guidance, which will include forward-looking statements, will be based on projections prepared by our management. Projections are based upon a number of assumptions and estimates that, while presented with numerical specificity, are inherently subject to significant business, economic and competitive uncertainties and contingencies, many of which are beyond our control. Our actual results could differ materially from such projections. Factors that could cause or contribute to such differences include, but are not limited to, those identified in this *"Risk Factors"* section. The principal reason that we expect to release guidance is to provide a basis for our management to discuss our business outlook with analysts and investors. With or without our guidance, analysts and other investors may publish expectations regarding our business, financial performance and results of operations. Guidance is necessarily speculative in nature, and it can be expected that some or all of the assumptions of the guidance furnished by us will not materialize or will vary significantly from actual results. If our actual performance does not meet or exceed our guidance or investor expectations, the trading price of our common stock may decline.

An active, liquid trading market for our common stock may not be sustained.

Although our common stock is currently listed on the Nasdaq Stock Market under the symbol "ALHC," an active trading market for our shares may not be sustained. Accordingly, if an active trading market for our common stock is not maintained, the liquidity of our common stock would be limited, and holders of our common stock may not be able to sell their shares when desired. Moreover, the prices that they may obtain for their shares would be adversely affected. An inactive market may also impair our ability to raise capital to continue to fund operations by issuing shares and may impair our ability to acquire other companies or technologies by using our shares as consideration.

Our Lead Sponsor holds a substantial percentage of our outstanding common stock and has the ability to significantly influence our management, business plans and policies and the election of our directors, and their interests may conflict with ours or the holders of our common stock in the future.

As of December 31, 2024, funds managed by General Atlantic, L.P. ("Lead Sponsor") beneficially owned approximately 31.9% of our outstanding common stock, which means that, based on its percentage voting power, the Lead Sponsor has the ability to significantly influence the vote of all matters submitted to a vote of our shareholders, including the election of the members of our board of directors (the "Board") and all other corporate decisions. Accordingly, the Lead Sponsor has significant influence with respect to our management, business plans and policies, including the appointment and removal of our officers, decisions on whether to raise future capital and amending our charter and bylaws, which govern the rights attached to our common stock. In particular, for so long as the Lead Sponsor continues to own a significant percentage of our stock, the Lead Sponsor is able to exert substantial influence over any proposed change of control of us or a change in the composition of our Board and could effectively preclude any unsolicited acquisition of us. The concentration of ownership could deprive holders of an opportunity to receive a premium for their shares of common stock as part of a sale of us and ultimately might affect the market price of our common stock.

In addition, we have entered into an Amended and Restated Stockholders Agreement with the Lead Sponsor that provides the Lead Sponsor the right to designate: (i) four of the nominees for election to our Board for so long as General Atlantic beneficially owns at least 35% of our common stock then outstanding; (ii) three of the nominees for election to our Board for so long as the Lead Sponsor beneficially owns less than 35% but at least 25% of our common stock then outstanding; (iii) two of the nominees for election to our Board for so long as the Lead Sponsor beneficially owns less than 25% but at least 15% of our common stock then outstanding; and (iv)

one of the nominees for election to our Board for so long as the Lead Sponsor beneficially owns less than 15% but at least 5% of our common stock then outstanding. The Lead Sponsor may also assign such rights to its affiliates.

The Lead Sponsor and its affiliates engage in a broad spectrum of activities, including investments in the healthcare industry generally. In the ordinary course of their business activities, the Lead Sponsor and its affiliates may engage in activities where their interests conflict with our interests or those of our other stockholders, such as investing in or advising businesses that directly or indirectly compete with certain portions of our business or are suppliers or customers of ours. Our certificate of incorporation provides that none of the Lead Sponsor, any of its affiliates or any director who is not employed by us (including any non-employee director who serves as one of our officers in both his director and officer capacities) or its affiliates will have any duty to refrain from engaging, directly or indirectly, in the same business activities or similar business activities or lines of business in which we operate. The Lead Sponsor also may pursue acquisition opportunities that may be complementary to our business and, as a result, those acquisition opportunities may not be available to us. In addition, each of the Lead Sponsor may have an interest in pursuing acquisitions, divestitures and other transactions that, in its judgment, could enhance its investment, even though such transactions might involve risks to holders of our common stock.

Future sales and issuances by us of our common stock could result in additional dilution to you and could cause the price of our common stock to drop significantly. Additionally, a significant portion of our total outstanding shares may be sold into the market in the future. This could also cause the market price of our common stock to drop significantly, even if our business is doing well.

As of December 31, 2024, we had 191,778,639 outstanding shares of common stock. We also had $330 million in aggregate principal amount of convertible notes outstanding that could be converted into additional shares of common stock. From time to time in the future, we may issue additional shares of our common stock or securities convertible into our common stock pursuant to a variety of transactions, including acquisitions. The issuance by us of additional shares of our common stock or securities convertible into our common stock would dilute the ownership of our existing stockholders and may cause the price of our common stock to drop significantly.

Moreover, sales of a substantial number of shares of our common stock in the public market by the existing holders thereof could occur at any time. The Lead Sponsor is entitled, under a registration rights agreement, to require us to register shares owned by it for public sale in the United States. Additionally, we have registered shares of common stock that we may issue under our equity compensation plans. Subject to the satisfaction of vesting conditions, such shares can be freely sold in the public market upon issuance. Sales by these holders, or the perception in the market that the holders of a large number of shares intend to sell shares, could reduce the market price of our common stock. These factors could also make it more difficult for us to raise additional funds through future offerings of our shares of common stock or other securities.

Conversion of our convertible notes may dilute the percentage of ownership of our stockholders and could negatively impact the trading prices of our common stock.

Upon conversion of the Convertible Notes, we have the option to pay or deliver, as the case may be, cash, shares of our common stock, or a combination of cash and shares, at our election. If we elect to settle conversions of the Convertible Notes by delivering shares of our common stock (or a combination of cash and shares), or if we are otherwise required to do so because we do not have the funds available to settle such conversions in cash, the conversion of some or all of the Convertible Notes may have a significant dilutive impact on our stockholders and could negatively impact the trading prices of our common stock. In addition, if we elect to settle our conversion obligation in shares of our common stock (or a combination of cash and shares), any sales in the public market of our shares issuable upon such conversion could adversely affect prevailing market prices of our common stock.

Our outstanding convertible notes may impact the trading price of our common stock.

We believe that many investors in, and potential purchasers of, convertible debt instruments employ, or seek to employ, a convertible arbitrage strategy with respect to these instruments. Investors that employ a convertible arbitrage strategy with respect to convertible debt instruments typically implement that strategy by selling short the common stock underlying the convertible instrument and dynamically adjusting their short position while they hold the instrument. The implementation of this strategy by investors in the Convertible Notes, as well as related market regulatory actions, could have a significant impact on the trading prices of our common stock, and the trading prices and liquidity of the Convertible Notes. The price of our common stock and the Convertible Notes could also be affected by possible sales of our common stock by investors who view the Convertible Notes as more attractive means of equity participation in us.

If securities or industry analysts do not publish research or reports about our business, if they adversely change their recommendations regarding our shares or if our results of operations do not meet their expectations, our stock price and trading volume could decline.

The trading market for our shares is influenced by the research and reports that industry or securities analysts publish about us or our business. We do not have any control over these analysts. If one or more of these analysts cease coverage of us or fail to publish reports on us regularly, we could lose visibility in the financial markets, which in turn could cause our stock price or trading volume to decline. Moreover, if one or more of the analysts who cover us downgrade our stock, or if our results of operations do not meet their expectations, our stock price could decline.

We may issue shares of preferred stock in the future, which could make it difficult for another company to acquire us or could otherwise adversely affect holders of our common stock, which could depress the price of our common stock.

Our certificate of incorporation authorizes us to issue one or more series of preferred stock. Our Board has the authority to determine the preferences, limitations and relative rights of the shares of preferred stock and to fix the number of shares constituting any series and the designation of such series, without any further vote or action by our shareholders. Our preferred stock could be issued with voting, liquidation, dividend and other rights superior to the rights of our common stock. The potential issuance of preferred stock may delay or prevent a change in control of us, discouraging bids for our common stock at a premium to the market price, and materially adversely affect the market price and the voting and other rights of the holders of our common stock.

We have no current plans to pay regular cash dividends on our common stock for the foreseeable future.

We do not anticipate paying any regular cash dividends on our common stock for the foreseeable future. Any decision to declare and pay dividends in the future will be made at the discretion of our Board and will depend on, among other things, our results of operations, financial condition, cash requirements, contractual restrictions and other factors that our Board may deem relevant. In addition, our ability to pay dividends is, and may be, limited by covenants of existing and any future outstanding indebtedness we or our subsidiaries incur. Therefore, any return on investment in our common stock is solely dependent upon the appreciation of the price of our common stock on the open market, which may not occur.

Provisions of our corporate governance documents could make an acquisition of us more difficult and may prevent attempts by our shareholders to replace or remove our current management, even if beneficial to our shareholders.

Our certificate of incorporation and bylaws and the Delaware General Corporation Law (the "DGCL") contain provisions that could make it more difficult for a third-party to acquire us, even if doing so might be beneficial to our shareholders. Among other things, these provisions:

- provide that any amendment, alteration, rescission or repeal of our certificate of incorporation or our bylaws by our stockholders will require the affirmative vote of the holders of at least 66 2/3% in voting power of all the then-outstanding shares of our stock entitled to vote thereon, voting together as a single class;
- allow us to authorize the issuance of undesignated preferred stock, the terms of which may be established and the shares of which may be issued without shareholder approval, and which may include supermajority voting, special approval, dividend, or other rights or preferences superior to the rights of stockholders;
- provide for a classified board of directors with staggered three-year terms;
- prohibit stockholder action by written consent; and
- establish advance notice requirements for nominations for elections to our Board or for proposing matters that can be acted upon by stockholders at stockholder meetings, provided, however, that at any time the Lead Sponsor beneficially own, in the aggregate, at least 40% of our common stock then outstanding, such advance notice provision will not apply to the Lead Sponsor.

Our certificate of incorporation contains a provision that provides us with protections similar to Section 203 of the DGCL, and prevents us from engaging in a business combination with a person who acquires at least 15% of our common stock for a period of three years from the date such person (excluding the Lead Sponsor and any of its direct or indirect transferees and any group as to which such persons are a party) acquired such common stock, unless Board or stockholder approval is obtained prior to the acquisition. These provisions could discourage, delay or prevent a transaction involving a change in control of our company. These provisions could also discourage proxy contests and make it more difficult for stockholders to elect directors of their choosing and cause us to take other corporate actions they desire, including actions that they may deem advantageous, or negatively affect the trading price of our common stock. In addition, because our Board is responsible for appointing the members of our management team, these provisions could in turn affect any attempt by our stockholders to replace current members of our management team.

These and other provisions in our certificate of incorporation, bylaws and Delaware law could make it more difficult for stockholders or potential acquirers to obtain control of our Board or initiate actions that are opposed by our then-current Board, including delay or impede a merger, tender offer or proxy contest involving our company. The existence of these provisions could negatively affect the price of our common stock and limit opportunities for our stockholders to realize value in a corporate transaction.

The provision of our certificate of incorporation requiring exclusive forum in the Court of Chancery of the State of Delaware or the federal district courts of the United States for certain types of lawsuits may have the effect of discouraging lawsuits against our directors and officers.

Pursuant to our certificate of incorporation, unless we consent in writing to the selection of an alternative forum, the Court of Chancery of the State of Delaware will be the sole and exclusive forum for (1) any derivative action or proceeding brought on our behalf, (2) any action asserting a claim of breach of a fiduciary duty owed by any of our directors, officers or other employees to us or our shareholders, (3) any action asserting a claim against us arising pursuant to any provision of the DGCL, our certificate of incorporation or our bylaws or (4) any other action asserting a claim against us that is governed by the internal affairs doctrine; provided that for the avoidance of doubt, the forum selection provision that identifies the Court of Chancery of the State of Delaware as the exclusive forum for certain

litigation, including any "derivative action", will not apply to suits to enforce a duty or liability created by the Securities Act, the Exchange Act or any other claim for which there is exclusive federal or concurrent federal and state jurisdiction. Additionally, unless we consent in writing to the selection of an alternative forum, the federal district courts of the United States of America shall be the exclusive forum for the resolution of any complaint asserting a cause of action arising under the Securities Act. Although we believe these exclusive forum provisions benefit us by providing increased consistency in the application of Delaware law and federal securities laws in the types of lawsuits to which each applies, the exclusive forum provisions may limit a stockholder's ability to bring a claim in a judicial forum that it finds favorable for disputes with us or any of our directors, officers or stockholders, which may discourage lawsuits with respect to such claims. Our stockholders will not be deemed to have waived our compliance with the federal securities laws and the rules and regulations thereunder as a result of our exclusive forum provisions. Further, in the event a court finds any such exclusive forum provision contained in our certificate of incorporation to be unenforceable or inapplicable in an action, we may incur additional costs associated with resolving such action in other jurisdictions, which could harm our business, operating results and financial condition. Our certificate of incorporation further provides that any person or entity purchasing or otherwise acquiring any interest in shares of our capital stock is deemed to have notice of and consented to the provisions of our certificate of incorporation described above. The forum selection clauses in our certificate of incorporation may have the effect of discouraging lawsuits against us or our directors and officers and may limit our shareholders' ability to obtain a favorable judicial forum for disputes with us.

General Risk Factors

Economic downturn or unstable market and economic conditions, including rising rates of inflation, may have serious adverse consequences on our business, financial condition and share price.

The global economy, including credit and financial markets, has experienced extreme volatility and disruptions, including severely diminished liquidity and credit availability, declines in consumer confidence, declines in economic growth, increases in unemployment rates, increases in inflation rates, higher interest rates and uncertainty about economic stability. Any such volatility and disruptions, or a general sustained economic downturn, may have adverse consequences on us or the third parties on whom we rely. Increased inflation rates, for example, have previously and may in the future adversely affect us by increasing our costs, including interest rates applicable to outstanding indebtedness, labor and employee benefit costs and increasing medical expenses. Additionally, if the equity and credit markets deteriorate, including as a result of natural disaster or due to political unrest or war, it may make any necessary debt or equity financing more difficult to obtain in a timely manner or on favorable terms, more costly or more dilutive. During periods of economic downturn or high unemployment, governmental entities often experience budget deficits as a result of increased costs and lower than expected tax collections. Budget deficits at federal, state and local government entities have decreased, and may continue to decrease, spending for health and human service programs, including Medicare and similar programs, which represents the most significant revenue source for us. Any of these negative economic conditions could have a material adverse effect on our business, results of operations and financial condition.

Our corporate culture has contributed to our success, and if we cannot maintain this culture as we grow, we could lose the innovation, creativity and teamwork fostered by our culture and our business may be harmed.

We believe that our culture has been and will continue to be a critical contributor to our success. We expect to continue to hire aggressively as we expand, and we believe our corporate culture has been crucial in our success and our ability to attract highly skilled personnel. If we do not continue to develop our corporate culture or maintain and preserve our core values of always putting the senior first, supporting doctors, using data and technology to revolutionize healthcare and acting with a serving heart, as we grow and evolve, we may be unable to foster the innovation, curiosity, creativity, focus on execution, teamwork and the facilitation of critical knowledge transfer and knowledge sharing we believe we need to support our growth. Our anticipated headcount growth and our transition from a private company to a public company may result in a change to our corporate culture, which could harm our business.

The requirements of being a public company may strain our resources and distract our management, which could make it difficult to manage our business.

As a public company, we incur legal, accounting and other expenses that we did not previously incur. We are subject to the reporting requirements of the Exchange Act and the Sarbanes-Oxley Act of 2002 (the "Sarbanes-Oxley Act"), the listing requirements of and other applicable securities rules and regulations. Compliance with these rules and regulations will continue to increase our legal and financial compliance costs, make some activities more difficult, time-consuming or costly and increase demand on our systems and resources. The Exchange Act requires that we file annual, quarterly and current reports with respect to our business, financial condition and results of operations. The Sarbanes-Oxley Act requires, among other things, that we establish and maintain effective internal controls and procedures for financial reporting, as discussed further below. Furthermore, the need to establish the corporate infrastructure demanded of a public company may divert our management's attention from implementing our growth strategy, which could prevent us from improving our business, financial condition and results of operations. We have made, and will continue to make, changes to our internal controls and procedures for financial reporting and accounting systems to meet our reporting obligations as a public company. However, the measures we take may not be sufficient to satisfy our obligations as a public company. In addition, these rules and regulations increase our legal and financial compliance costs and make some activities more time-consuming and costly. For example, these rules and regulations make it more difficult and more expensive for us to obtain director and officer liability insurance, and we may be required to incur substantial costs to maintain the same or similar coverage. These additional obligations could have a material adverse effect on our business, financial condition and results of operations.

In addition, changing laws, regulations and standards relating to corporate governance and public disclosure are creating uncertainty for public companies, increasing legal and financial compliance costs and making some activities more time consuming. These laws, regulations and standards are subject to varying interpretations, in many cases due to their lack of specificity and, as a result, their application in practice may evolve over time as new guidance is provided by regulatory and governing bodies. This could result in continuing uncertainty regarding compliance matters and higher costs necessitated by ongoing revisions to disclosure and governance practices. We have invested, and will continue to invest, resources to comply with evolving laws, regulations and standards, and this investment may result in increased general and administrative expenses and a diversion of our management's time and attention from revenue-generating activities to compliance activities. If our efforts to comply with new laws, regulations and standards differ from the activities intended by regulatory or governing bodies due to ambiguities related to their application and practice, regulatory authorities may initiate legal proceedings against us and there could be a material adverse effect on our business, financial condition and results of operations.

As a result of becoming a public company, we are obligated to develop and maintain proper and effective internal control over financial reporting in order to comply with Section 404 of the Sarbanes-Oxley Act. We are continuing to develop and refine our disclosure controls and other procedures that are designed to ensure that information required to be disclosed by us in the reports that we will file with the SEC is recorded, processed, summarized, and reported within the time periods specified in SEC rules and forms and that information required to be disclosed in reports under the Exchange Act is accumulated and communicated to our principal executive and financial officers. We are also continuing to improve our internal control over financial reporting, which includes hiring additional accounting and financial personnel to implement such processes and controls. In order to maintain and improve the effectiveness of our disclosure controls and procedures and internal control over financial reporting, we have expended, and anticipate that we will continue to expend, significant resources, including accounting-related costs and significant management oversight. These internal controls may not be determined to be effective, which may adversely affect investor confidence in us and, as a result, the value of our common stock.

We are required by Section 404 of the Sarbanes-Oxley Act to furnish a report by management on, among other things, the effectiveness of our internal control over financial reporting. If during the evaluation and testing process we identify one or more material weaknesses or significant deficiencies in our internal control over financial reporting, our management may be unable to assert that our internal control over financial reporting is effective. In addition, if we fail to achieve and maintain the adequacy of our internal controls, as such standards are modified, supplemented or amended from time to time, we may not be able to ensure that we can conclude on an ongoing basis that we have effective internal controls over financial reporting in accordance with Section 404 of the Sarbanes-Oxley Act.

Additionally, our independent registered public accounting firm is required to formally attest to the effectiveness of our internal control over financial reporting. Even if our management concludes that our internal control over financial reporting is effective, our independent registered public accounting firm may issue a report that is qualified if it is not satisfied with our controls or the level at which our controls are documented, designed, operated or reviewed.

If we are not able to comply with the requirements of Section 404 of the Sarbanes-Oxley Act, our independent registered public accounting firm may issue an adverse opinion due to ineffective internal controls over financial reporting, and we may be subject to sanctions or investigation by regulatory authorities, such as the SEC. As a result, there could be a negative reaction in the financial markets due to a loss of confidence in the reliability of our financial statements. In addition, we may be required to incur costs in improving our internal control system and the hiring of additional personnel. Any such action could negatively affect our results of operations and cash flows.

Our business could be negatively impacted by environmental, social and corporate governance matters or our reporting of such matters.

There is an increasing focus from certain investors, employees, partners, and other stakeholders concerning ESG matters. We may be, or be perceived to be, not acting responsibly in connection with these matters, which could negatively impact us. Moreover, the SEC has proposed, and may continue to propose, certain mandated ESG reporting requirements, which, if approved, would significantly increase our compliance and reporting costs and may also result in disclosures that certain investors or other stakeholders deem to negatively impact our reputation and/or that harm our stock price. A lack of reporting on ESG matters could result in certain investors declining to invest in our common stock.

Third parties may initiate legal proceedings alleging that we are infringing, misappropriating or otherwise violating their intellectual property rights, the outcome of which would be uncertain and could have a material adverse effect on our business, financial condition and results of operations.

Our commercial success depends on our ability to develop and commercialize our products and services and use our internally developed technology without infringing the intellectual property or proprietary rights of third parties. Intellectual property disputes can be costly to defend and may cause our business, operating results and financial condition to suffer. As the market for healthcare in the United States expands and more patents are issued, the risk increases that there may be patents issued to third parties that relate to our technology of which we are not aware or that we must challenge in order to continue our operations as currently or in the future contemplated. Whether merited or not, we may face allegations that we, our partners or parties indemnified by us have infringed, misappropriated or otherwise violated the patents, trademarks, copyrights, trade secrets or other intellectual property rights of third parties. Such claims may be made by competitors seeking to obtain a competitive advantage or by other parties. Additionally, in recent years, individuals and groups have begun purchasing intellectual property assets for the purpose of making such claims and attempting to extract settlements from

companies like ours. We may also face allegations that our employees have misappropriated the trade secrets or other intellectual property or proprietary rights of their former employers or other third parties.

It may be necessary for us to initiate litigation to defend ourselves in order to determine the scope, enforceability, validity or ownership of third-party intellectual property or proprietary rights, or to establish our respective rights. We may not be able to successfully settle or otherwise resolve such adversarial proceedings or litigation. If we are unable to successfully settle future claims on terms acceptable to us we may be required to engage in or to continue claims, regardless of whether such claims have merit, that can be time-consuming, divert management's attention and financial resources and be costly to evaluate and defend. Results of any such litigation are difficult to predict and may require us to stop commercializing or using our technology, obtain licenses, modify our services and technology while we develop non-infringing substitutes or incur substantial damages, settlement costs or face a temporary or permanent injunction prohibiting us from marketing or providing the affected products and services. If we require a third-party license, it may not be available on reasonable terms or at all, and we may have to pay substantial royalties and upfront or ongoing fees, or grant cross-licenses to our own intellectual property rights. Such licenses may also be non-exclusive, which could allow competitors and other parties to use the subject technology in competition with us. We may also have to redesign our services so they do not infringe, misappropriate or otherwise violate third-party intellectual property rights, which may not be possible or may require substantial monetary expenditures and time, during which our technology may not be available for commercialization or use. Even if we have an agreement to indemnify us against such costs, the indemnifying party may be unable to uphold its contractual obligations. If we cannot or do not obtain a third-party license to the infringed technology at all, license the technology on reasonable terms or obtain similar technology from another source, our revenue and earnings could be adversely impacted.

From time to time, we may be subject to legal proceedings and claims in the ordinary course of business with respect to intellectual property. Some third parties may be able to sustain the costs of complex litigation more effectively than we can because they have substantially greater resources. Even if resolved in our favor, litigation or other legal proceedings relating to intellectual property claims may cause us to incur significant expenses, and could distract our technical and management personnel from their normal responsibilities. In addition, there could be public announcements of the results of hearings, motions or other interim proceedings or developments, and if securities analysts or investors perceive these results to be negative, it could have a material adverse effect on the price of our common stock. Moreover, any uncertainties resulting from the initiation and continuation of any legal proceedings could have a material adverse effect on our ability to raise the funds necessary to continue our operations. Any of the foregoing could have a material adverse effect on our business, financial condition and results of operations.

Item 1B. Unresolved Staff Comments.

None.

Item 1C. Cybersecurity.

Risk Management and Strategy

As we are a company that leverages data, technology and analytics to improve health care, we invest in long-term solutions to address current and foreseeable risks and threats to data security and privacy, while also enabling technological development that enhances the member experience. We recognize the critical importance of developing, implementing, and maintaining robust cybersecurity measures to safeguard our information systems and protect the confidentiality, integrity, and availability of our data.

We have designed and deployed a comprehensive cybersecurity risk management program that is embedded in our broader risk management framework, all of which is overseen by our Board of Directors. Our program is designed to include ongoing assessment of our critical assets; detection and analysis of potential threats; timely management of identified security risks; and prompt remediation planning and implementation. To successfully operate and monitor our security readiness, we maintain a data security and privacy team with substantial real-world experience to detect and respond to cybersecurity threats. Our multi-layered security is bolstered by technologies and partners and includes annual employee and vendor security awareness trainings, enhanced access control, data loss protection and vulnerability management, among other technical and process security controls. Our proprietary data architecture, AVA, incorporates high security controls around member data. Our information security program considers how attackers are using emerging technologies (such as artificial intelligence) to help inform our defensive tactics. Our team also regularly reviews emerging product technology to improve our capabilities.

In 2021, we received the externally validated HITRUST certification, the gold standard compliance framework in the health care industry. Through our data security and privacy program and policies, we adhere to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), other federal regulations and best-practices within the health care industry. Moreover, our risk analysis methodology is consistent with ISO 27001, the Federal Information Security Management Act and the U.S. Department of Commerce National Institute of Standards and Technology and Center for Internet Security Special Publication 800-66.

Our strict protection and security measures have resulted in zero security incident-related disruptions or downtime to our business continuity. However, there is no guarantee that a future security incident would not materially affect our business strategy, results of operations or financial condition. See "Risk Factors" beginning on page 13 of this Form 10-K.

Engagement of Third Parties

Our information security program is under nearly constant third-party review as part of Sarbanes-Oxley compliance and the HITRUST certification process, including independent third-party penetration testing of all information technology assets at least annually and assessment of our vulnerability to ransomware. Multiple industry-standard third-party tools are utilized to detect vulnerabilities. Alignment is a member of the Healthcare Information Sharing and Analysis Center (Health-ISAC) operated by the U.S. Department of Health and Human Services and the Department of Homeland Security and is affiliated with the FBI InfraGard program, providing deep, actionable intelligence regarding healthcare security and privacy threats and countermeasures. We continuously monitor the Health-ISAC reporting to anticipate and respond to potential threats.

Management of Third-Party Cyber-Risk

We rely on third-party vendors to provide supplemental benefits to our members and for a variety of other key business functions. Accordingly, our vendor onboarding process includes a comprehensive security assessment. Moreover, at least quarterly, we assess the risks from cybersecurity threats relating to each of our member-facing and other key third-party service providers with whom we share protected health information, personal identifying information and confidential information. We generally require our suppliers to adopt security-control principles based on industry-recognized standards and we seek audit rights over their security protocols.

Cybersecurity Governance

As a component of its general oversight over key risks to our business, our Board of Directors has established robust oversight mechanisms designed to ensure effective governance in managing risks associated with cybersecurity threats. As a technology-enabled Medicare Advantage platform, we have selected directors with backgrounds in technology and expertise in data privacy and cybersecurity matters, which represent important elements of our risk management strategy.

Our Audit Committee is responsible for the direct oversight of risks from cybersecurity threats. Members of the Audit Committee receive updates on at least a quarterly basis from senior management, including leaders from our information security, compliance and legal teams regarding matters of cybersecurity. Reports by management to the Audit Committee include existing and new cybersecurity risks, status updates regarding how management is addressing and/or mitigating those risks, cybersecurity and data privacy incidents (if any) and status on key information security initiatives. The Audit Committee's involvement ensures that cybersecurity considerations are integrated into the Company's broader strategic objectives. The Audit Committee conducts an annual review of the company's cybersecurity posture and the effectiveness of its risk management strategies. This review helps in identifying areas for improvement and ensuring the alignment of cybersecurity efforts with the overall risk management framework. As needed, this framework also includes consultations with our enterprise risk management committee, led by our Chief Compliance and Privacy Officer.

Alignment's cybersecurity organization is led by David MacLeod, our Chief Information Security Officer, who is responsible for the prevention, detection, mitigation, and remediation of cybersecurity incidents and reports to Robert Scavo, our Chief Information Officer, as well as to the Audit Committee. Mr. MacLeod has served as our CISO since December 2022, has over 26 years of diverse leadership experience in the healthcare information space (including over 20 years as a certified information systems security professional and chief information security officer) and holds advanced degrees in information technology management and computer science.

The CISO is continually informed about the latest developments in cybersecurity, including potential threats and innovative risk management techniques. The CISO implements and oversees processes for the regular monitoring of our information systems. This includes the deployment of advanced security measures and regular system audits to identify potential vulnerabilities. In the event of a cybersecurity incident, the CISO is equipped with a well-defined incident response plan. This plan includes immediate actions to mitigate the impact and long-term strategies for remediation and prevention of future incidents.

Item 2. Properties.

Our corporate office is located in Orange, California at 1100 W. Town and Country Rd, Suite 1600, where we lease approximately 47,321 square feet of office space under a lease that terminates in March 2030. We also have offices located in Raleigh, North Carolina; Las Vegas and Reno, Nevada; El Paso, Texas; Sahuarita, and Tucson, Arizona; and Tampa, Florida. We also have small clinics located in Milpitas, Modesto and Downey, California; and Raleigh, North Carolina. We believe that our properties are generally suitable to meet our needs for the foreseeable future. In addition, to the extent we require additional space in the future, we believe that it would be readily available on commercially reasonable terms.

Item 3. Legal Proceedings.

We are from time to time subject to, and are presently involved in, litigation and other legal proceedings. We believe that there are no pending lawsuits or claims that, individually or in the aggregate, may have a material effect on our business, financial condition or operating results. The results of any future claims or proceedings cannot be predicted with certainty, and regardless of the outcome, litigation can have an adverse impact on us because of defense and litigation costs, diversion of management resources, and other factors. For a discussion of our material legal actions, including those not in the ordinary course of business, see "Legal Proceedings" in Note 14 to the audited Consolidated Financial Statements included in Item 8. Financial Statements and Supplementary Data.

Item 4. Mine Safety Disclosures.

Not applicable.

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.

Market Information

Our common stock has been traded under the symbol "ALHC" on the Nasdaq Global Select Market since our initial public offering on March 26, 2021. Prior to that time, there was no public market for our common stock. As of February 20, 2025, there were approximately 54 holders of record of our common stock.

Dividend Policy

We currently intend to retain all available funds and any future earnings to fund the development and growth of our business and to potentially repay any indebtedness and, therefore, we do not anticipate paying any cash dividends in the foreseeable future. Additionally, because we are a holding company, our ability to pay dividends on our common stock may be limited by restrictions on the ability of our subsidiaries to pay dividends or make distributions to us. Any future determination to pay dividends will be at the discretion of our Board, subject to compliance with covenants in current and future agreements governing our and our subsidiaries' indebtedness, and will depend on our results of operations, financial condition, capital requirements and other factors that our Board may deem relevant. Our outstanding term loan restricts our ability to pay dividends. See the discussion of our term loan in "*Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Liquidity and Capital Resources*."

Securities Authorized for Issuance Under Equity Compensation Plans

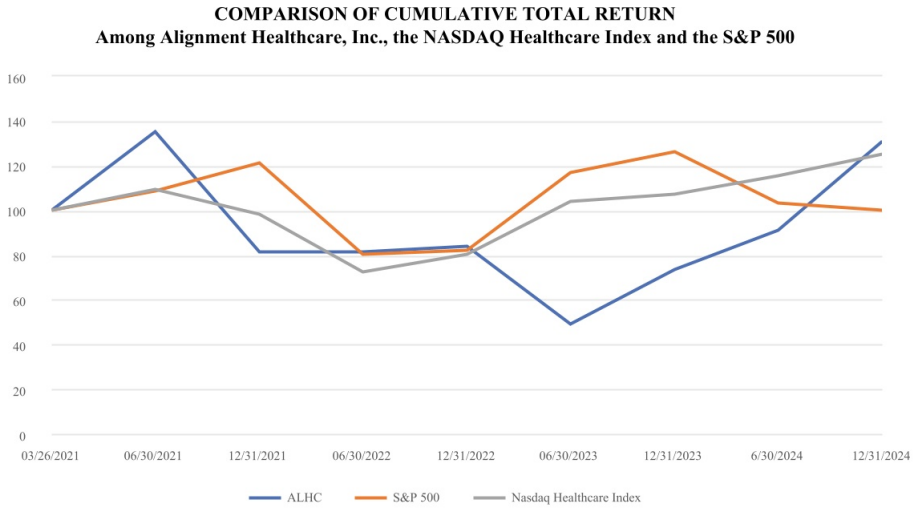
For information regarding securities authorized for issuance under our equity compensation plans, see Part III, Item 12, "Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters."

Performance Graph

This performance graph below shall not be deemed "soliciting material" or to be "filed" with the SEC for purposes of Section 18 of the Exchange Act, or otherwise subject to the liabilities under that Section, and shall not be deemed to be incorporated by reference into this Annual Report on Form 10-K or any other filing of Alignment Healthcare, Inc. under the Exchange Act or the Securities Act, whether made before or after the date hereof and irrespective of any general incorporation language in any such filing, except to the extent that we specifically incorporate this information by reference therein.

The graph set forth below compares the cumulative total stockholder return on our common stock between March 26, 2021 (the date our common stock commenced trading on the Nasdaq Global Select Market) and December 31, 2024, with the cumulative total return of (a) the Nasdaq Healthcare Index and (b) the S&P 500, over the same period. This graph assumes the investment of $100 on March 26, 2021 in our common stock, the Nasdaq Healthcare Index, and the Nasdaq S&P 500 and assumes the reinvestment of dividends, if any. The graph assumes our closing sales price on March 26, 2021 of $17.31 per share as the initial value of our common stock and not the initial offering price to the public of $18.00 per share.

The comparisons shown in the graph below are based upon historical data. We caution that the stock price performance shown in the graph below is not necessarily indicative of, nor is it intended to forecast, the potential future performance of our common stock.



	3/26/2021	6/30/2021	12/31/2021	6/30/2022	12/31/2022	6/30/2023	12/31/2023	6/30/2024	12/31/2024
Alignment Healthcare, Inc. (ALHC)	$ 100.00	$ 135.01	$ 81.22	$ 81.15	$ 83.64	$ 48.89	$ 73.21	$ 90.82	$ 130.66
Nasdaq Healthcare Index	100.00	109.16	98.09	72.42	80.10	103.86	107.24	102.98	99.77
S&P 500	100.00	108.52	121.18	80.04	81.87	116.88	126.26	115.29	125.00

Recent Sales of Unregistered Securities

None.

Use of Proceeds from Public Offering of Common Stock

On March 25, 2021, our Registration Statement on Form S-1 (SEC File No. 333-253824) for the initial public offering of 27,200,000 shares of common stock was declared effective by the Securities and Exchange Commission. Our common stock began trading on March 26, 2021 on Nasdaq under the ticker symbol "ALHC." The IPO closed on March 30, 2021, with us selling 21,700,000 shares of common stock and certain selling stockholders selling 5,500,000 shares of common stock, in each case at a price to the public of $18.00 per share. On April 6, 2021, pursuant to a partial exercise of the underwriters' over-allotment option, certain selling stockholders sold an additional 3,314,216 shares of common stock at the IPO price. In the aggregate, the IPO generated approximately $361.6 million in net proceeds for the Company, which amount is net of approximately $24.4 million in underwriters' discounts and commissions and offering costs of approximately $4.6 million. The IPO commenced on March 25, 2021 and terminated upon the partial exercise of the underwriters' over-allotment options as described above. The representatives of the several underwriters of the IPO were Goldman Sachs & Co. LLC and Morgan Stanley & Co. LLC.

There has been no material change in the use of proceeds described in the final IPO prospectus filed with the SEC on March 29, 2021. We may use a portion of our net proceeds to acquire or invest in complementary businesses, products, services or technologies.

Purchase of Equity Securities by the Issuer and Affiliated Purchasers

None.

Item 6. [Reserved]

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations.

The following discussion should be read in conjunction with the consolidated financial statements and accompanying notes, which appear elsewhere in this Annual Report on Form 10-K. This discussion contains forward-looking statements that involve risks and uncertainties. Our actual results could differ materially from those anticipated in these forward-looking statements as a result of various factors, including those discussed below and elsewhere in this Annual Report on Form 10-K. See Part I. Item 1A. Risk Factors and Cautionary Note Regarding Forward-Looking Statements. For discussion of 2022 items and year-over-year comparisons between 2023 and 2022 that are not included in this Form 10-K, refer to Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations" found in our Annual Report on Form 10-K for the year ended December 31, 2023, filed with the Securities and Exchange Commission on February 27, 2024.

Overview

Alignment is a next generation, consumer-centric platform designed to improve the healthcare experience for seniors. We deliver this experience through our Medicare Advantage plans, which are customized to meet the needs of a diverse array of seniors. Our innovative model of consumer-centric healthcare is purpose-built to provide seniors with care as it should be: high quality, low cost and accompanied by a vastly improved consumer experience. We combine a proprietary technology platform and a high-touch clinical model that enhances our members' lifestyles and health outcomes while simultaneously controlling costs, which allows us to reinvest savings back into our platform and products to directly benefit the senior consumer.

Our model is based on a flywheel concept, referred to as our "virtuous cycle," which reflects our unique ability to manage healthcare expenditures while maintaining quality and member satisfaction — a distinct and sustainable competitive advantage.

To execute upon this concept, we start by ingesting medical and demographic data through our proprietary AVA technology platform. AVA's predictive algorithms provide unique insights into each member and identify those most at risk of an acute event. Our information-enabled care model is then combined with clinical engagement by our employed clinical teams known as Care Anywhere to improve healthcare outcomes for our members. For example, our high-touch clinical model proactively manages chronic conditions and assists with post-discharge care navigation to reduce unnecessary hospital admissions and readmissions, which in turn improves health outcomes and quality while lowering overall costs. We then reinvest medical cost savings into richer coverage and benefits, which propels growth in revenue and membership while maintaining margin discipline. The strength of our model is further reinforced by delivering a premium member experience. Our concierge and a clinical service hotline is available 24/7 at no additional cost to our members and our state-of-the-art in-house call centers provide us with more consistency and control over member-facing functions.

Our virtuous cycle, based on the principle of doing well by doing good, is highly repeatable and a core tenet of our ability to continue to expand in existing and new markets in the future. The five-year compounded growth rate through December 31, 2024 of revenue and the number of members enrolled in our HMO and PPO contracts ("Health Plan Membership") is 29% and 31% respectively.

Medicare Advantage Background

Today, seniors are confronted with a healthcare landscape that is fragmented across disparate point solutions, tools and vendors, without an accessible, coordinated approach to comprehensive care delivery. Under the traditional Medicare fee-for-service ("FFS") model, seniors receive access to hospital insurance benefits ("Part A") and outpatient services ("Part B") directly from CMS. Original Medicare (Part A and B) does not include prescription drug coverage ("Part D"), and most seniors enrolled in original Medicare opt to obtain Part D and other protection for gaps in their coverage by purchasing costly Medicare supplement insurance plans. In contrast, Medicare Advantage plans are direct-to-consumer and provide a single point of care delivery for Part A, Part B and often Part D coverage. Medicare Advantage penetration of the Medicare market is rapidly increasing given the enhanced benefits and coverage that Medicare Advantage plans offer relative to traditional Medicare FFS. In 2024, approximately 54% of the Medicare eligible population, or approximately 33 million seniors, were enrolled in a Medicare Advantage plan. Industry projections have forecasted a continued increase in the Medicare Advantage penetration rate from approximately 54% to approximately 64% by 2033.

Medicare Advantage allows one entity to influence the entirety of a senior's healthcare through a singular, direct-to-consumer product. We contract with CMS under the Medicare Advantage program to provide health insurance coverage to Medicare eligible persons under HMO and PPO plans in exchange for a payment per member per month ("PMPM"). The PMPM payment varies based on geography, CMS Star ratings and certain population-specific risk factors. Under these value-based contracts, we assume the economic risk of funding our members' healthcare, supplemental benefits and related administration costs. By transferring the economic risk to managed care companies like Alignment, CMS has enabled us to focus on proactive, cross-disciplinary care targeted at improving health outcomes and lowering unnecessary healthcare expenditures.

The Medicare Advantage regulatory framework is designed to reward plans that achieve the triple aim of high-quality care, low costs and better experience. CMS payments to Medicare Advantage plans are allocated in each county or region based on a bidding system. Each plan submits a bid based on its estimated costs per enrollee for services covered under Medicare Parts A and B. Plans that have a low enough cost structure to bid under the benchmark are entitled to rebates, which enable those plans to offer enhanced supplemental benefits and medical coverage to their members, which in turn boosts membership growth and therefore revenue. CMS further measures Medicare Advantage beneficiaries' clinical outcomes and experience with their health plans and the healthcare system through a Five Star Quality Rating System. Medicare Advantage plans are eligible to receive additional economic incentives based on their Star rating.

Due to the competitive nature of CMS's bidding system, only those plans that are able to provide low cost and high-quality outcomes will be able to offer enhanced benefit options, which is critical to achieving sustainable membership and growth on a long-term basis.

Under the Medicare Advantage system, our members typically enroll with us for a one-year period that can be renewed on an annual basis, resulting in revenue that is principally based on a subscription-like PMPM recurring revenue model. This model provides us with significant visibility into our short-term financial performance, particularly given that the substantial majority of our members continue to choose Alignment after their initial selection year. Further, our HMO and PPO plans covered under Medicare Advantage contracts with CMS are generally renewed for a calendar year term, unless CMS notifies us of its decision not to renew by May 1 of the year in which the contract would end. When carefully managed, this annual renewal process provides a measure of stability and predictability to our short-term revenue streams, allowing us to focus on improving health quality outcomes and lowering healthcare expenditures for our population through enhanced member care on a long-term basis.

Factors Affecting Our Performance

Our proprietary technology platform, AVA, is a key element of our business with capabilities that we expect to impact our future performance. AVA enables us to personalize and manage our member relationships, care quality and experience, and to coordinate and manage risk with our provider partners. AVA's unified platform, analytical tools and data across the healthcare ecosystem enable us to produce consistent outcomes, unit economics and support new member growth. Additionally, our historical financial performance has been, and we expect our financial performance in the future will be, driven by our ability to:

- ***Capitalize on Our Existing Market Growth Opportunity:*** Our ability to attract and retain members to grow in our existing markets depends on our ability to offer a superior value proposition. We routinely take market share from large established players in highly competitive markets, a key source of our health plan membership growth in excess of the industry average. We believe that there are still significant opportunities for future growth even in our most mature markets where we have a 10-30% market share. According to CMS data, our approximately 209,900 Health Plan Members represent only 5% market share of Medicare Advantage enrollees in our markets.

- ***Drive Growth and Consistent Outcomes Through New Market Expansion:*** As part of our long-term growth strategy, we may enter new markets with the goal of building brand awareness across our key stakeholders to achieve meaningful market share over time. We intend to focus on markets with significant senior populations where we expect to be able to replicate our model most effectively. Our existing markets also feature a diverse array of membership profiles across ethnicities, income levels and acuity. Since 2020, we have expanded into 29 markets and four states.

- ***Provide Superior Service, Care and Consumer Satisfaction:*** We are highly focused on providing superior service and care to our members and on maintaining high levels of consumer satisfaction, which are key to our financial performance and growth. The CMS Five Star Quality Rating System provides economic incentives to Medicare Advantage plans that achieve higher Star ratings by (i) meeting certain care criteria (such as completing particular preventative screening procedures or ensuring proper follow-up care is provided for specific conditions or episodes) and (ii) receiving high member satisfaction ratings. These incentives impact financial performance in the year following the CMS Rating Year (for example, CMS's announcement of the 2025 Ratings occurred in the second half of 2024 and will impact our financial performance in 2026). In aggregate, more than 98% of our health plan members are enrolled in plans rated 4 stars and above, meaning the vast majority of members consistently receive a high-quality care experience, as defined under CMS star measurement criteria. Additionally, the California HMO plan has achieved a 4 star or greater rating for seven consecutive years.

- ***Effectively Manage the Quality of Care to Improve Member Outcomes:*** Our care delivery model is based on a clinical continuum through which we have created a highly personalized experience that is unique to each member depending on their personal health and circumstances. Utilizing data and predictive analytics generated by AVA, our clinical continuum separates seniors into four categories in order to provide optimized care for every stage of a senior's life: healthy, healthy utilizer, pre-chronic and chronic. We partner with our broader network of community providers to service members in our non-chronic categories, and we have developed a Care Anywhere program implemented by our internal clinical teams to care for our higher risk and/or chronically ill members. By investing in our members' care proactively, our model has consistently reduced unnecessary and costly care while improving the quality of our members' lifestyle and healthcare experience. By delivering superior care and preventing avoidable utilization of the healthcare system, we are able to reduce our claims expenditures in some of our largest medical expense categories, which translates to superior medical benefits ratio ("MBR") financial performance and ultimately the ability to offer richer products in the market.

- ***Achieve Superior Unit Economics:*** As our senior population ages, their healthcare needs become more frequent and complex. To combat the healthcare cost increases that typically result, we proactively look to (i) connect with our population early in their enrollment with Alignment to assess

their care needs, (ii) develop care plans and engage those members with more chronic, complex health challenges in our clinical model, and (iii) continue to monitor and evaluate our healthier members in a preventative fashion over time. Given the Medicare Advantage payment mechanism and the retention of the vast majority of our members who continue to choose Alignment after their initial selection year, we are able to focus our efforts on driving favorable long-term health outcomes for our entire population. As a result, our clinical model efforts have demonstrated the ability to lower the MBRs of our returning members. We believe this is evidence of our ability to manage the financial risk of our members as they age, and that these favorable underlying unit economic trends translate directly to our ability to continue to deliver a richer product to the marketplace. With this dynamic in mind, our consolidated MBR may be impacted year-to-year based on our pace of new member growth and mix of members by cohort. However, we believe our ability to sustain MBR performance improvement over time positions us well to invest in new member growth to drive long-term financial performance.

- ***Invest in our Platform and Growth:*** We plan to continue to invest in our business in order to further develop our AVA platform, pursue new expansion opportunities and create innovative product offerings. In addition, in order to maintain a differentiated value proposition for our members, we continue to invest in innovative product offerings and supplementary benefits to meet the evolving needs of the senior consumer. We anticipate further investments in our business as we expand into new markets and pursue strategic acquisitions, which we expect will primarily be focused on healthcare delivery groups in key geographies, standalone and provider-sponsored Medicare Advantage plans and other complementary risk bearing assets.
- ***Navigate Seasonality to our Business:*** Our operational and financial results will experience some variability depending upon the time of year in which they are measured. We experience the largest portion of member growth during the first quarter, when plan enrollment selections made during the annual enrollment period ("AEP") from October 15th through December 7th of the prior year take effect. As a result, we expect to see a significant percentage of our member growth occur on January 1 of a given calendar year. As the year progresses, our per-member revenue often declines as new members join us, typically with less complete or accurate documentation (and therefore lower risk-adjustment scores), and senior mortality disproportionately impacts our higher-acuity (and therefore greater revenue) members. Medical costs will vary seasonally depending on a number of factors, but most significantly the weather. Certain illnesses, such as the influenza virus, are far more prevalent during colder months of the year, which will result in an increase in medical expenses during these time periods. We therefore expect to see higher levels of per-member medical costs in the first and fourth quarters. The design of our prescription drug coverage (Medicare Part D) results in coverage that varies as a member's cumulative out-of-pocket costs pass through successive stages of a member's plan period, which begins annually on January 1 for renewals. We anticipate that, starting in 2025, the benefit redesign under the Inflation Reduction Act will result in much more moderate seasonality than we have experienced in past years. Members will still pass through the benefit phases, but our share of the total liability will be more consistent through each phase than it has been in the past. In addition, we expect our corporate, general and administrative expenses to increase in absolute dollars for the foreseeable future to support our growth. Due to the timing of many of these investments, including our primary sales and marketing season, we typically incur a greater level of investment in the second half of the year relative to the first half of the year.

Key Business Metrics

In addition to our financial information in accordance with accounting principles generally accepted in the United States of America ("U.S. GAAP"), we review a number of operating and financial metrics, including the following key metrics, to evaluate our business, measure our performance, identify trends affecting our business, formulate business plans and make strategic decisions.

	Year Ended December 31,		
(dollars in '000's, except percentages)	**2024**	**2023**	**% Change**
Health plan membership (at period end)	189,100	119,200	58.6 %
Medical benefits ratio	88.8 %	88.5 %	0.3 %
Revenues	$ 2,703,561	$ 1,823,630	48.3 %
Loss from Operations	$ (101,555)	$ (127,817)	20.5 %
Net loss	$ (128,071)	$ (148,173)	13.6 %
Adjusted EBITDA [(1)]	$ 1,339	$ (35,319)	103.8 %
Adjusted gross profit [(1)]	$ 302,607	$ 208,825	44.9 %

(1) See "Adjusted EBITDA" and "Adjusted Gross Profit" below for reconciliation to the most directly comparable financial measure calculated in accordance with GAAP and related disclosures.

Health Plan Membership

We define Health Plan Membership as the number of members enrolled in our HMO and PPO contracts as of the end of a reporting period. We believe this is an important metric to assess growth of our underlying business, which is indicative of our ability to consistently offer a superior value proposition to seniors. This metric excludes third-party payor members with respect to which we are at-risk for managing their healthcare expenditures, which represented 400 members as of December 31, 2024 and December 31, 2023. It also excludes approximately 8,300 and 7,300 ACO REACH members as of December 31, 2024 and December 31, 2023, respectively.

Adjusted Gross Profit and Medical Benefits Ratio

Adjusted gross profit is a non-GAAP financial measure that we define as loss from operations before depreciation and amortization, clinical equity-based compensation expense, clinical restructuring costs and selling, general, and administrative expenses. Adjusted gross profit is a key measure used by our management and Board to understand and evaluate our operating performance and trends before the impact of our consolidated selling, general and administrative expenses.

Adjusted gross profit should not be considered in isolation of, or as an alternative to, measures prepared in accordance with GAAP. There are a number of limitations related to the use of adjusted gross profit in lieu of loss from operations, which is the most directly comparable financial measure calculated in accordance with GAAP.

Our use of the term adjusted gross profit may vary from the use of similar terms by other companies in our industry and accordingly may not be comparable to similarly titled measures used by other companies.

Adjusted gross profit is reconciled as follows:

	Year Ended December 31,	
	2024	2023
(dollars in thousands)		
Loss from operations	$ (101,555)	$ (127,817)
Add back:		
Equity-based compensation (medical expenses)	4,930	7,541
Depreciation (medical expenses)	190	254
Restructuring costs (medical expenses) [1]	796	—
Depreciation and amortization [2]	26,872	21,414
Selling, general, and administrative expenses	371,374	307,433
Total add back	404,162	336,642
Adjusted gross profit	$ 302,607	$ 208,825

(1) Represents severance and related costs incurred as part of a corporate restructuring, that took place during 2024, designed to streamline our organizational structure and drive operational efficiencies

(2) Includes $0.6 million in impairment expense related to intangible assets that were written off during the year

We calculate our MBR by dividing total medical expenses, excluding depreciation, equity-based compensation and clinical restructuring costs, by total revenues in a given period. We believe our MBR is an indicator of our gross profit for our Medicare Advantage plans and demonstrates the ability of our clinical model to produce superior outcomes by identifying and providing targeted care to our high-risk members resulting in improved member health and reduced total population medical expenses. We expect that this metric may fluctuate over time due to a variety of factors, including our pace of new member growth given that new members typically join Alignment with higher MBRs, while our model has demonstrated an ability to improve MBR for a given cohort over time.

When we determine, on an annual basis, whether we have satisfied the CMS minimum Medical Loss Ratio of 85%, adjustments are made to the MBR calculation to include certain additional expenses related to improving the quality of care provided, and to exclude certain taxes and fees, in each case as permitted or required by CMS and applicable regulatory requirements.

Adjusted EBITDA

Adjusted EBITDA is a non-GAAP financial measure that we define as net loss before interest expense, income taxes, depreciation and amortization expense, acquisition expenses, certain litigation costs, gains or losses on right of use ("ROU") assets, gains or losses on sale of property and equipment, restructuring costs, equity-based compensation expense and loss on extinguishment of debt. Adjusted EBITDA is a key measure used by our management and our Board to understand and evaluate our operating performance and trends, to prepare and approve our annual budget and to develop short and long-term operating plans. In particular, we believe that the exclusion of the amounts eliminated in calculating Adjusted EBITDA provides useful measures for period-to-period comparisons of our business, as we do not consider the excluded items to be part of our ongoing results of operations. Given our intent to continue to invest in our

platform and the scalability of our business in the short to medium-term, we believe Adjusted EBITDA over the long term will be an important indicator of value creation.

Adjusted EBITDA should not be considered in isolation of, or as an alternative to, measures prepared in accordance with GAAP. There are a number of limitations related to the use of Adjusted EBITDA in lieu of net loss, which is the most directly comparable financial measure calculated in accordance with GAAP.

Our use of the term Adjusted EBITDA may vary from the use of similar terms by other companies in our industry and accordingly may not be comparable to similarly titled measures used by other companies.

Adjusted EBITDA is reconciled as follows:

	Year Ended December 31,	
	2024	2023
(dollars in thousands)		
Net loss	$ (128,071)	$ (148,173)
Less: Net loss attributable to noncontrolling interest	36	156
Adjustments:		
Interest expense	23,547	21,231
Depreciation and amortization [1]	27,062	21,668
Income tax expense (benefit)	21	(22)
Equity-based compensation [2]	71,132	66,835
Acquisition expenses [3]	26	977
Litigation costs [4]	2,069	2,298
(Gain) loss on ROU assets [5]	143	(289)
Gain on sale of property and equipment	(9)	—
Restructuring costs [6]	2,363	—
Loss on extinguishment of debt	3,020	—
Adjusted EBITDA	$ 1,339	$ (35,319)

(1) Includes $0.6 million in impairment expense related to intangible assets that were written off during the year

(2) Represents equity-based compensation related to grants made in the applicable year, as well as equity-based compensation related to the timing of the IPO, which includes previously issued stock appreciation rights ("SARs") liability awards, modifications related to transaction vesting units, and grants made in conjunction with the IPO

(3) Represents acquisition-related fees, such as legal and advisory fees, that are non-capitalizable

(4) Represents certain litigation costs considered outside of the ordinary course of business based on the following considerations which we assess regularly: (i) the frequency of similar cases that have been brought to date, or are expected to be brought within two years, (ii) complexity of the case, (iii) nature of the remedies sought, (iv) litigation posture of the Company, (v) counterparty involved, and (vi) the Company's overall litigation strategy

(5) Represents gains or losses related to ROU assets that were terminated or subleased in the respective period

(6) Represents severance and related costs incurred as part of a corporate restructuring, that took place during 2024, designed to streamline our organizational structure and drive operational efficiencies

Results of Operations

We operate and manage our business as a single reporting and operating segment, which is to provide healthcare services to our seniors. The components of our results of operations are as follows:

Revenues

Our revenue is comprised of earned premiums and other revenue. We receive and record premium revenue on a monthly basis from the federal government based on our contract with CMS. In accordance with this arrangement, we assume the responsibility for the outcomes and the economic risk of funding our members' healthcare, supplemental benefits and related administration costs. We recognize premium revenue in the month that members are entitled to receive healthcare services, and premiums collected in advance are deferred. The monthly premium that we receive under our contract with CMS includes a PMPM which is adjusted based on certain risk factors derived from medical diagnoses for our members. The adjustments are estimated by projecting the ultimate annual premium and are recognized ratably during the year, with adjustments in each period to the amount of revenue recognized to reflect changes in the estimated ultimate premium. Premiums are also recorded net of estimated uncollectible amounts and retroactive membership adjustments.

Our recognized premium revenue for the Alignment Health Plans is subject to a minimum annual medical loss ratio ("MLR") of 85%. The MLR represents medical costs as a percentage of premium revenue. The Code of Federal Regulations defines what specifically constitutes medical expenses and premium revenue for the MLR test, and if the minimum MLR is not met, we are required to remit a portion of the premiums back to the federal government. The amount remitted, if any, is recognized as an adjustment to premium revenues in the consolidated statement of operations. The amounts payable under this provision were immaterial at December 31, 2024 and December 31, 2023.

The premiums we receive from CMS for our members are based on the annual bid that we submit to CMS. These payments represent revenues for providing healthcare coverage, including Medicare Part D benefits. Under the Medicare Part D program, members receive standard drug benefits. We may also provide enhanced benefits at our own expense. We recognize revenue for providing this insurance coverage in the month that members are entitled to receive healthcare services. Our CMS payment related to Medicare Part D is subject to risk sharing through the Medicare Part D risk corridor provisions. See "*—Critical Accounting Estimates—Revenue"* below.

Our capitation revenue consists primarily of capitated fees for medical care services provided by us under arrangements with our third-party payors and from CMS related to our ACO REACH entity. In 2024, we entered into a management services and risk management agreement with a third-party healthcare company. The third-party is responsible for arranging and controlling the health care services provided to the ACO members, and for providing certain management and support services with respect to ACO operations. The third-party also assumes specified upside and downside financial risk relative to the ACO's performance. As a result of this arrangement, revenue is recorded on a net basis within other revenue on the consolidated statement of operations for the year ended December 31, 2024.

Expenses

Medical Expenses. Medical expenses include claim payments, capitation payments, pharmacy costs net of rebates, allocations of certain centralized expenses, supplemental benefits, internal care delivery expenses and various other costs incurred to provide health insurance coverage to members, as well as estimates of future payments to hospitals and others for medical care previously provided to our members. Medical expenses also include clinical depreciation and restructuring costs, as discussed above.

We have contracts with a network of hospitals, physicians, and other providers and compensate those providers and ancillary organizations based on contractual arrangements or CMS Medicare compensation guidelines. We pay these contracting providers either through fee-for-service arrangements in which the provider is paid negotiated rates for specific services provided, or through capitation payments, which represent monthly contractual fees disbursed for each member regardless of medical services provided to the member. We are ultimately responsible for the entirety of the cost of healthcare services related to our member population, in addition to supplemental benefits that we provide to our seniors.

Capitation-related expenses are recorded on an accrual basis during the coverage period. Expenses related to fee-for-service contracts are recorded in the period in which the related services are dispensed.

Pharmacy costs represent payments for members' prescription drug benefits, net of rebates from drug manufacturers. Receivables for such manufacturer rebates are included in accounts receivable in the consolidated balance sheet.

Selling, General and Administrative Expenses. Selling, general and administrative expenses consist of (i) personnel expenses including salaries, bonuses, equity-based compensation expense and benefits for non-clinical employees; (ii) all corporate technology, occupancy costs and allocated overhead costs; (iii) professional and outside services, including external vendors and professional services; (iv) costs associated with administering our contracts with CMS, including claims adjudication, member and concierge services, provider engagement, and other health plan functions; and (v) central and community-based advertising costs to generate greater awareness, engagement and retention among our current and prospective members, as well as the infrastructure required to support all of our marketing efforts and ongoing commission payments. These expenses also include restructuring costs, as discussed above, and certain growth expenditures, including business development and various new market expansion activities. Our investments in our sales, marketing and other growth activities are an important component of our selling, general and administrative expenses in a typical year given our desire to continue to grow on an accelerated trajectory. We anticipate continuing to invest heavily in our growth efforts in the near future, which we believe will be an important driver of long-term value creation.

Depreciation and Amortization. Depreciation and amortization expenses are primarily attributable to our capital investment and consist of fixed asset depreciation, amortization of intangibles considered to have definite lives and amortization of capitalized internal-use software costs.

Other Expense

Interest Expense. Interest expense consists primarily of interest payments on our outstanding borrowings under our Term Loan (as defined below), as well as interest related to the convertible notes that were issued in November 2024. See "*—Liquidity and Capital Resources.*"

Other (Income) Expenses. Other (income) expenses consist primarily of gains or losses on the disposition of assets, as well as gains and losses related to subleased ROU assets.

The following table sets forth our consolidated statements of operations data for the periods indicated:

	Year Ended December 31,	
	2024	2023
(dollars in thousands)		
Revenues:		
Earned premiums	$ 2,671,931	$ 1,800,933
Other	31,630	22,697
Total revenues	2,703,561	1,823,630
Expenses:		
Medical expenses	2,406,870	1,622,600
Selling, general, and administrative expenses	371,374	307,433
Depreciation and amortization	26,872	21,414
Total expenses	2,805,116	1,951,447
Loss from operations	(101,555)	(127,817)
Other expenses:		
Interest expense	23,547	21,231
Other (income) expenses, net	(72)	(853)
Loss on extinguishment of debt	3,020	—
Total other expenses	26,495	20,378
Loss before income taxes	(128,050)	(148,195)
Provision for income tax expense (benefit)	21	(22)
Net loss	$ (128,071)	$ (148,173)
Less: Net loss attributable to noncontrolling interest	36	156
Net loss attributable to Alignment Healthcare, Inc.	$ (128,035)	$ (148,017)

The following table sets forth our consolidated statements of operations data expressed as a percentage of total revenues for the periods indicated:

	Year Ended December 31,	
	2024	2023
(% of revenue)		
Revenues:		
Earned premiums	99 %	99 %
Other	1	1
Total revenues	100	100
Expenses:		
Medical expenses	89	89
Selling, general and administrative expenses	14	17
Depreciation and amortization	1	1
Total expenses	104	107
Loss from operations	(4)	(7)
Other expenses:		
Interest expense	1	1
Other (income) expenses, net	—	—
Loss on extinguishment of debt	—	—
Total other expenses	1	1
Loss before income taxes	(5)	(8)
Provision for income taxes	—	—
Net loss	(5)	(8)
Less: Net loss attributable to noncontrolling interest	—	—
Net loss attributable to Alignment Healthcare, Inc.	(5)%	(8)%

Revenues

	Year Ended December 31,		Change	
	2024	2023	$	%
(dollars in thousands)				
Revenues:				
Earned premiums	$ 2,671,931	$ 1,800,933	$ 870,998	48.4 %
Other	31,630	22,697	8,933	39.4 %
Total revenues	$ 2,703,561	$ 1,823,630	$ 879,931	48.3 %

Earned Premiums. Earned premium revenues were $2,671.9 million and $1,800.9 million for the years ended December 31, 2024 and 2023, respectively, an increase of $871.0 million or 48.4%. The increase was primarily driven by growth in our Health Plan membership, which increased 58.6% between December 31, 2024 and December 31, 2023. The increase was offset by a decrease in ACO REACH revenue due to the change from gross to net revenue treatment. ACO REACH revenue decreased $125.2 million, or 101.0%, for the year ended December 31, 2024 compared to the year ended December 31, 2023.

Other Revenues. Other revenues increased $8.9 million for the year ended December 31, 2024 compared to the year ended December 31, 2023. The increase is mainly attributable to an increase in the interest rate of our interest earning cash balances. Additionally, the change from gross to net revenue treatment for ACO REACH increased other revenues by $2.3 million.

Expenses

(dollars in thousands)	Year Ended December 31, 2024	Year Ended December 31, 2023	Change $	Change %
Expenses:				
Medical expenses	$ 2,406,870	$ 1,622,600	$ 784,270	48.3 %
Selling, general and administrative expenses	371,374	307,433	63,941	20.8 %
Depreciation and amortization	26,872	21,414	5,458	25.5 %
Total expenses	$ 2,805,116	$ 1,951,447	$ 853,669	43.7 %

Medical Expenses. Medical expenses were $2,406.9 million and $1,622.6 million for the years ended December 31, 2024 and 2023, respectively, an increase of $784.3 million, or 48.3%. The increase was driven primarily by the growth in Alignment Health Plan membership, which increased 58.6% between December 31, 2024 and December 31, 2023. Overall, medical expenses for the year ended December 31, 2024 grew at a slightly higher rate than earned premium revenues compared to the year ended December 31, 2023, primarily due to 2024 having a higher percentage of new members relative to returning members, richer member benefits and increases in unit costs. This increase was offset by lower inpatient admissions per thousand and the change from gross to net revenue treatment for ACO REACH.

Selling, General and Administrative Expenses. Selling, general and administrative expenses were $371.4 million and $307.4 million for the years ended December 31, 2024 and 2023, respectively, an increase of $63.9 million, or 20.8%. The increase was primarily due to an increase in ongoing investments and expenditures in network development, operations and sales and marketing to drive the growth of Alignment's Health Plan membership. Selling, general, and administrative expenses grew at a slower rate than revenue for the year ended December 31, 2024 compared to the year ended December 31, 2023 due to economies of scale gained from Alignment's 2024 membership growth.

Depreciation and Amortization. Depreciation and amortization expense was $26.9 million and $21.4 million for the years ended December 31, 2024 and 2023, respectively, an increase of $5.5 million, or 25.5%. The increase was primarily due to the amount and timing of our capital expenditures and the associated depreciation relative to 2023. Additionally, for the year ended December 31, 2024, we recorded amortization expense of $0.6 million related to the impairment of intangible assets associated with an inactive Medicare license that was terminated during the period.

Other Expenses

Interest expense. Interest expense was $23.5 million and $21.2 million for the years ended December 31, 2024 and 2023, respectively, an increase of $2.3 million or 10.8%. The increase in interest expense was partially due to an increase in the debt balance as a result of the $50.0 million drawdown of the Oxford Delayed Draw term loan in June 2024. Additionally, we experienced a higher interest rate on our debt balance during the majority of the year, which then decreased as a result of the issuance of the convertible notes and repayment of the Oxford term loan as discussed below. Prior to the repayment of the Oxford term loans, the average interest rate during 2024 was 11.77% compared to an average interest rate of 11.35% during the year ended December 31, 2023. The convertible notes have an interest rate of 4.25%.

Other (income) expenses, net. Other (income) expenses were $(0.1) million and $(0.9) million for the years ended December 31, 2024 and 2023, respectively, a decrease of $0.8 million. The decrease is primarily attributable to the timing of gains and losses related to ROU assets subleased during the respective periods.

Loss on extinguishment of debt. During the year ended December 31, 2024 we recorded a $3.0 million loss on extinguishment of debt due to the write-off of debt issuance costs related to the Oxford term loans repayment which is discussed below.

Liquidity and Capital Resources

General

To date, we have financed our operations principally through our IPO, private placements of our equity securities, revenues, certain term loans and convertible notes (described below). As of December 31, 2024, we had $470.7 million in cash, cash equivalents and short-term investments.

We operate as a holding company in a highly regulated industry. Alignment Healthcare, Inc., our parent company, is dependent upon dividends and administrative expense reimbursements from our subsidiaries, most of which are subject to regulatory restrictions. We maintain significant levels of aggregate excess statutory capital and surplus in our state-regulated operating subsidiaries. As of December 31, 2024, our operating parent company (an indirect wholly owned subsidiary of our parent company) had $212.3 million in cash, cash equivalents and short-term investments.

We may incur operating losses in the future due to the investments we intend to continue to make in expanding our operations and sales and marketing, in further developing our technology and due to the general and administrative costs we expect to incur in connection with continuing to operate as a public company. As a result, we may require additional capital resources to execute strategic initiatives to grow our business.

We believe that our liquid assets will be sufficient to fund our operating and organic capital needs for at least the next 12 months. Our assessment of the period of time through which our financial resources will be adequate to support our operations is a forward-looking statement and involves risks and uncertainties. Our actual results could vary because of, and our future capital requirements will depend on, many factors, including our growth rate, the timing and extent of spending to expand our presence in existing markets, expand into new markets, increase our sales and marketing activities and develop our technology. Additionally, in the future we may enter into arrangements to acquire or invest in complementary businesses, services and technologies, including intellectual property rights, which may also substantially increase our capital needs.

We have based this estimate on assumptions that may prove to be wrong, and we could use our available capital resources sooner than we currently expect. We may be required to seek additional equity or debt financing. In the event that additional financing is required from outside sources, we may not be able to raise it on terms acceptable to us or at all. If we are unable to raise additional capital when desired, or if we cannot expand our operations or otherwise capitalize on our business opportunities because we lack sufficient capital, our business, results of operations, and financial condition would be adversely affected.

Certain states in which we operate as a CMS-licensed Medicare Advantage company may require us to meet certain capital adequacy performance standards and tests. The National Association of Insurance Commissioners has adopted rules which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for healthcare coverage. The requirements take the form of risk-based capital ("RBC") rules, which may vary from state to state. Certain states in which our health plans or risk bearing entities operate have adopted the RBC rules. Other states in which our health plans or risk bearing entities operate have chosen not to adopt the RBC rules, but instead have designed and implemented their own rules regarding capital adequacy. As of December 31, 2024, our health plans or risk-bearing entities were in compliance with the minimum capital requirements.

Oxford Term Loan

On September 2, 2022 (the "Effective Date"), we, Alignment Healthcare USA, LLC, an indirect subsidiary of the Company (the "Borrower") and certain of our other subsidiaries (together with the Company and the Borrower, the "Borrower Parties") entered into a term loan agreement (the "Oxford Loan Agreement") with Oxford Finance LLC ("Oxford"), as administrative agent, collateral agent and a lender, and the other lenders from time to time party thereto (collectively, the "Lenders"), pursuant to which the Lenders have agreed to lend the Borrower an aggregate principal amount of up to $250.0 million in a series of term loans (the "Term Loans"). Pursuant to the Oxford Loan Agreement, the Borrower received an initial Term Loan of $165.0 million on the Effective Date and had the option to borrow up to an additional $85.0 million of Term Loans (such additional Term Loans, the "Delayed Draw Term Loans"). On June 14, 2024, we borrowed $50,000 in aggregate principal amount of the Delayed Draw Term Loans prior to the expiration date for such amount of the Delayed Draw Term Loans of June 30, 2024. Interest on the Term Loans was a variable rate equal to (i) the secured overnight financing rate administered by the Federal Reserve Bank of New York for a one-month tenor, subject to a floor of 1.00%, plus (ii) an applicable margin of 6.50%. The interest rate applied during the year ended December 31, 2024 ranged from 11.35% to 11.84%.

In connection with the issuance of the convertible senior notes, as noted below, we repaid all amounts outstanding under the term loans with Oxford Finance on November 22, 2024.

Convertible Senior Notes

On November 22, 2024 (the "Effective Date"), Alignment Healthcare Inc. (the "Company") completed the sale of $330.0 million of its 4.25% Convertible Senior Notes (the "Notes"). The Notes were issued pursuant to an indenture (the "Indenture"), dated as of November 22, 2024, between the Company and U.S. Bank Trust Company, National Association, as trustee (the "Trustee"). The Notes are senior, unsecured obligations of the Company, and interest will be payable semi-annually in arrears at a rate of 4.25% per annum beginning on May 15, 2025. The Notes will mature on November 15, 2029, unless earlier repurchased, redeemed or converted in accordance with their terms. The net cash proceeds from the sale of the Notes was approximately $321.1 million, after subtracting fees, discounts and estimated expenses in connection with the transaction.

Prior to the close of business on the business day immediately preceding August 15, 2029, the Notes will be convertible at the option of holders during certain periods, upon satisfaction of certain conditions. On or after August 15, 2029, the Notes will be convertible at any time until the close of business on the second scheduled trading day immediately preceding the maturity date. Upon conversion, the Notes may be settled in shares of Company common stock, cash or a combination of cash and shares of Company common stock, at the Company's election.

The Notes have an initial conversion rate of 62.4 shares of Company common stock per $1,000 principal amount of the Notes. The conversion rate will be subject to adjustment in certain events, including adjustment in the event of certain significant corporate transactions. This represents an initial conversion price of approximately $16.04 per share. The initial conversion price of the Notes represents a premium of approximately 25% to the closing price of the Company's common stock on November 14, 2024. The Company

has used the proceeds from the sale of the Notes to repay in full the $215.0 million aggregate principal amount, accrued interest and fees related to the Oxford term loans, as well as certain fees and expenses incurred in connection with the transaction.

The Indenture contains customary terms and covenants, including that upon certain events of default occurring and continuing, either the Trustee or the holders of at least 25% in principal amount of the outstanding notes may declare 100% of the principal of, and accrued and unpaid special interest, if any, on, all the notes to be due and payable.

The Company has recognized the Notes in their entirety as a liability on the consolidated balance sheet and no portion of the proceeds from the issuance of the convertible debt instrument was accounted for separately as an embedded conversion feature within stockholders' equity.

Cash Flows

The following table presents a summary of our consolidated cash flows from operating, investing and financing activities for the periods indicated.

	Year Ended December 31,	
(dollars in thousands)	**2024**	**2023**
Net cash provided by (used in) operating activities	$ 34,770	$ (59,187)
Net cash provided by (used in) investing activities	39,191	(147,263)
Net cash provided by financing activities	156,028	105
Net change in cash	229,989	(206,345)
Cash, cash equivalents and restricted cash at beginning of period	204,954	411,299
Cash, cash equivalents and restricted cash at end of period	$ 434,943	$ 204,954

Operating Activities

For the year ended December 31, 2024, net cash provided by operating activities was $34.8 million, an increase of $94.0 million compared to net cash used in operating activities of $59.2 million for the year ended December 31, 2023. The increase is mainly attributable to an increase in medical expenses payable as a result of the increased Health Plan membership growth during the year ended December 31, 2024 compared to the year ended December 31, 2023, as well as a decrease in our net loss over the same period.

Investing Activities

For the year ended December 31, 2024, net cash provided by investing activities was $39.2 million, an increase of $186.5 million compared to net cash used in investing activities of $147.3 million for the year ended December 31, 2023. The increase primarily relates to purchases of short-term treasury securities which were $379.1 million during the year ended December 31, 2023 compared to $82.2 million during the year ended December 31, 2024, a decrease of 296.9 million. The increase was partially offset by a decrease in maturities of short-term investments.

Financing Activities

For the year ended December 31, 2024, net cash provided by financing activities was $156.0 million, an increase of $155.9 million compared to net cash provided by financing activities of $0.1 million for the year ended December 31, 2023. The increase in net cash provided by financing activities is mainly attributable to cash received of $330.0 million in connection with the issuance of the convertible notes discussed above, as well as the $50.0 million draw down of the Oxford Delayed Draw term loan in June 2024. This was offset by the repayment of $215.0 million related to the Oxford term loans, as discussed above.

Material cash requirements from known contractual and other obligations

Our principal commitments consist of repayments of long-term debt, operating leases and certain purchase obligations. The following table summarizes our contractual and other obligations as of December 31, 2024:

	Payments due by Period				
	Total	Less than 1 year	1-3 year	3-5 years	More than 5 years
(dollars in thousands)					
Long term debt obligations[1]	$ 330,000	$ —	$ —	$ 330,000	$ —
Operating lease obligations	9,047	1,212	3,525	4,310	—
Purchase obligations[2]	50,069	14,695	19,536	13,533	2,305
Other obligations	—	—	—	—	—
Total	$ 389,116	$ 15,907	$ 23,061	$ 347,843	$ 2,305

(1) Represents the estimated full cash repayment upon maturity of the Convertible Senior Notes in November 2029. As discussed above, the Convertible Senior Notes can be repurchased, redeemed, or converted prior to maturity in accordance with their terms.

(2) Includes fixed, minimum and estimated payments under our existing contractual obligations that are legally enforceable and binding for goods and services. These obligations include agreements that are cancelable with the payment of an early termination penalty and other funding commitments that require fixed or minimum levels of service to be purchased with a specific timing established. Purchase obligations exclude agreements that are cancelable without penalty.

Not included in the table above are our medical expenses payable which are included within current liabilities in our financial statements included in this Annual Report on Form 10-K.

Critical Accounting Estimates

The discussion and analysis of our financial condition and results of operations are based upon our consolidated financial statements, which have been prepared in accordance with U.S. GAAP and include the accounts of our wholly owned subsidiaries and three variable interest entities ("VIEs") in California and North Carolina that meet the consolidation requirements for accounting purposes. All intercompany transactions have been eliminated in consolidation. Noncontrolling interest is presented within the equity section of our consolidated balance sheets.

Certain accounting policies involve significant judgments and assumptions by management, which have a material impact on the carrying value of assets and liabilities and the recognition of income and expenses. Management considers these accounting policies to be critical accounting policies. The estimates and assumptions used by management are based on historical experience and other factors, which are believed to be reasonable under the circumstances. The significant accounting policies which we believe are the most critical to aid in fully understanding and evaluating our reported financial results are described below. Refer to Note 2 "*Summary of Significant Accounting Policies*" to our audited consolidated financial statements for more detailed information regarding our critical accounting policies.

Revenue

Payments by CMS to health plans are determined through a competitive bidding process with CMS and are based on the cost of care in a local market and the average utilization of services by the member enrolled. These payments are subject to periodic adjustments under CMS's "risk adjustment model," which compensates health plans based on the health severity and certain demographic factors of each individual member. Members diagnosed with certain conditions are paid at a higher monthly payment than members who are healthier. Under this risk adjustment model, CMS calculates the risk adjustment payment using diagnosis data from hospital inpatient, hospital outpatient and physician treatment settings. We and healthcare providers collect, capture, and submit the necessary and available diagnosis data to CMS within prescribed deadlines. Both premium and capitation revenue (including Medicare Part D) are subject to adjustments under the risk adjustment model.

Throughout the year, we estimate risk adjustment payments based upon the diagnosis data submitted and expected to be submitted to CMS. The risk adjustment payments are recorded as an adjustment to premium and capitation revenue. Our risk adjustment data is also subject to review by the government, including audit by regulators.

Receivables, including risk adjusted premium due from the government or through third-party payors, pharmacy rebates, and other receivables, are shown net of allowances for estimated uncollectible accounts and retroactive membership adjustments.

Medical Expenses Payable

Medical expenses payable includes estimates of our obligations for medical care services that have been rendered on behalf of our members and the members of third-party payors, but for which claims have either not yet been received or processed, loss adjustment expense reserve for the expected costs of settling these claims, and for liabilities related to physician, hospital and other medical cost disputes.

We develop estimates for medical expenses incurred but not yet paid ("IBNP") which includes an estimate for claims incurred but not reported ("IBNR") and a payable for adjudicated claims. IBNR is estimated using an actuarial process that is consistently applied and centrally controlled. Medical expenses payable also includes an estimate for the costs necessary to process unpaid claims at the end of each period. We estimate IBNR liability using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors, such as cost trends and completion factors that are assessed based on historical data for payment patterns, product mix, seasonality, utilization of health care services, and other relevant factors.

Completion Factors. A completion factor is an actuarial estimate, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period adjudicated by us at the date of estimation. Completion factors are the most significant factors we use in developing our medical expenses payable estimates for periods prior to the most recent three months. Completion factors include judgments in relation to claim submissions such as the time from date of service to claim receipt, claim levels and processing cycles, as well as other factors. If actual claims submission rates from providers (which can be influenced by a number of factors, including provider mix and electronic versus manual submissions) or our claim processing patterns are different than estimated, our reserve estimates may be significantly impacted.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical expenses payable estimates for those periods as of December 31, 2024:

Completion Factors Increase (Decrease) in Factors	**Increase (Decrease) in Medical Expenses Payable**
	(in thousands)
(3)%	$ 24,600
(2)	16,400
(1)	8,200
1	(8,200)
2	(16,400)
3	(24,600)

Medical Cost Per Member Per Month Trend Factors. Medical cost PMPM trend factors are significant factors we use in developing our medical expenses payable estimates for the most recent three months. Medical cost trend factors are developed through a comprehensive analysis of claims incurred in prior months, provider contracting and expected unit costs, benefit design and a review of a broad set of health care utilization indicators. These factors include but are not limited to pharmacy utilization trends and inpatient hospital authorization data. A large number of factors can cause the medical cost trend to vary from our estimates, including: our ability and practices to manage medical and pharmaceutical costs, changes in level and mix of services utilized; mix of benefits offered, including the impact of co-pays and deductibles; changes in medical practices; and catastrophes, epidemics and pandemics, such as COVID-19.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical expenses payable estimates for the most recent two months as of December 31, 2024:

Medical Cost PMPM Quarterly Trend Increase (Decrease) in Factors	**Increase (Decrease) in Medical Expenses Payable**
	(in thousands)
(3)%	$ (6,300)
(2)	(4,200)
(1)	(2,100)
1	2,100
2	4,200
3	6,300

Each period, we re-examine previously established IBNR estimates based on actual claim submissions and other changes in facts and circumstances. As the IBNR estimates recorded in prior periods develop, we adjust the amount of the estimates and include the changes in estimates in medical expenses in the period in which the change is identified.

Actuarial Standards of Practice generally require that the IBNP estimates be adequate to cover obligations under moderately adverse conditions. Moderately adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of estimate.

In many situations, the claims amount ultimately settled will be different than the estimate that satisfies the Actuarial Standards of Practice. We include in our IBNP an estimate for medical claims liability under moderately adverse conditions, which represents the risk of adverse deviation of the estimates in its actuarial method of reserving.

We believe that medical expenses payable is adequate to cover future claims payments required. However, such estimates are based on knowledge of current events and anticipated future events. Therefore, the actual liability could differ materially from the amounts provided. The following tables provide information about incurred and paid claims development as of December 31, 2024:

	Cumulative Incurred Claims, net of reinsurance for the Years Ended December 31,		
	2022	2023	2024
Claims Incurred Year		*(in thousands)*	
2022	400,939	385,746	383,865
2023		492,315	484,951
2024			832,819
Total			$ 1,701,635

	Cumulative Claims paid, net of reinsurance for the Years Ended December 31,			Cumulative Number of Paid Claims[1]
	2022	2023	2024	
Claims Incurred Year		*(in thousands)*		
2022	315,187	383,419	382,467	389,689
2023		400,465	481,827	537,129
2024			670,471	909,451
Total			$ 1,534,765	

(1) Cumulative number of paid claims are presented in whole amounts

Substantially all of the claims incurred but not paid balance as of December 31, 2024 relate to the current year.

There is no single or common claim frequency metric used in the health care industry. We believe a relevant metric for our health insurance business is the cumulative number of claims paid for each incurred year. Claims that did not result in a liability are not included in the frequency metric.

Recent Accounting Pronouncements

See Note 2 to our audited consolidated financial statements "*Summary of Significant Accounting Policies—Recent Accounting Pronouncements Adopted*" for more information.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

Market risk represents the risk of loss that may impact our financial position due to adverse changes in financial market prices and rates. Our market risk exposure is primarily a result of exposure due to potential changes in interest rates and inflation.

Interest Rate Risk

As of December 31, 2024, we had $71.1 million of U.S. Treasury bills which were classified as held to maturity and had maturities less than twelve months. Due to the short-term duration of our investment portfolio and the low risk profile of our investments, we believe that our exposure to interest rate risk on these investments is not significant. We do not enter into investments for trading purposes.

In November 2024, we completed the sale of $330.0 million of 4.25% Convertible Senior Notes. Since the notes have a fixed annual interest rate, we have no financial or economic interest exposure associated with changes in interest rates. However, the fair value of fixed rate debt fluctuates when interest rates change. Additionally, the fair value of the Convertible Senior Notes can be impacted when the market price of our common stock fluctuates.

Inflation Risk

Based on our analysis of the periods presented, although we have experienced modest increases in unit costs and labor expenses, we believe that inflation has not had a material effect on our operating results. Nonetheless, if our costs were to become subject to

significant inflationary pressures, we may not be able to fully offset such higher costs through price increases. There can be no assurance that future inflation will not have an adverse impact on our operating results and financial condition.

Item 8. Financial Statements and Supplementary Data.

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the stockholders and the Board of Directors of Alignment Healthcare, Inc.:

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of Alignment Healthcare, Inc. and subsidiaries (the "Company") as of December 31, 2024 and 2023, the related consolidated statements of operations, changes in stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2024, and the related notes listed in the accompanying Index (collectively referred to as the "financial statements"). In our opinion, the financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2024 and 2023, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2024, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2024, based on criteria established in Internal Control — Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 27, 2025, expressed an unqualified opinion on the Company's internal control over financial reporting.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

Critical Audit Matter

The critical audit matter communicated below is a matter arising from the current-period audit of the financial statements that was communicated or required to be communicated to the audit committee and that (1) relate to accounts or disclosures that are material to the financial statements and (2) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the financial statements, taken as a whole, and we are not, by communicating the critical audit matter below, providing separate opinion on the critical audit matter or on the accounts or disclosures to which it relates.

Medical expenses payable – Incurred but not paid claims - Refer to Notes 2 and 7 to the financial statements

Critical Audit Matter Description

Medical expenses payable includes estimates of obligations for medical care services that have been rendered on behalf of members and the members of contracted third-party payors, but for which claims have either not yet been received or processed. These estimates are referred to as incurred but not yet paid (IBNP) claim liabilities, which totaled $168.4 million as of December 31, 2024, and includes an estimate for claims incurred but not reported (IBNR). The Company develops estimates for IBNR claim liability by using actuarial methods that requires management judgment in developing its estimates. These actuarial methods consider factors such as 1) historical data for payment patterns, 2) assumptions of cost trends related to the medical cost per member per month, and 3) completion factors to account for the time from date of service to claim receipt.

We identified the estimation of IBNR claim liability as a critical audit matter because of the significant assumptions made by management in estimating the liability. This required complex auditor judgment and an increased extent of effort, including the involvement of actuarial specialists in performing procedures to evaluate the reasonableness of management's methods, assumptions and judgments in developing the estimate of the IBNR claim liability.

How the Critical Audit Matter Was Addressed in the Audit

Our audit procedures related to the IBNR claim liability included the following, among others:

- We tested the effectiveness of controls over the Company's actuarial process for estimating the IBNR claim liability.

- We tested the underlying claims and membership data and other information that served as the basis for the actuarial analysis, to determine the inputs to the actuarial estimate were complete and accurate.

- With the assistance of actuarial specialists, we evaluated the reasonableness of the actuarial methods and assumptions used by management to estimate the IBNR claim liability by:

    - Performing an overlay of the historical claims data used in management's actuarial model to the data used in prior periods to determine whether there were material changes to the claims data tested in prior periods.

    - Performing a retrospective review comparing management's prior year estimate of the IBNR IBNP claim liability to claims processed in 2024 with dates of service in 2023 and prior.

    - Developing an independent estimate of the IBNR claim liability and compared our estimate to management's estimate. Our independent estimate included development of per member per month claims cost trends and completion factors using management's data, and comparison of these assumptions to current and historical claims trends and current industry benchmarks.

/s/ Deloitte & Touche LLP

Costa Mesa, California
February 27, 2025
We have served as the Company's auditor since 2019.

Alignment Healthcare, Inc.
Consolidated Balance Sheets
(amounts in thousands, except par value and share amounts)

	December 31, 2024	December 31, 2023
Assets		
Current Assets:		
Cash and cash equivalents	$ 432,859	$ 202,904
Accounts receivable (less allowance for credit losses of $0 at December 31, 2024 and 2023)	153,904	119,749
Investments - current	37,791	115,914
Prepaid expenses and other current assets	37,084	44,970
Total current assets	661,638	483,537
Property and equipment, net	67,139	51,901
Right of use asset, net	7,818	9,959
Goodwill	34,826	34,826
Intangible Assets, net	4,550	5,252
Other assets	6,092	6,405
Total assets	$ 782,063	$ 591,880
Liabilities and Stockholders' Equity		
Current Liabilities:		
Medical expenses payable	$ 289,788	$ 205,399
Accounts payable and accrued expenses	22,126	23,511
Accrued compensation	39,931	34,112
Total current liabilities	351,845	263,022
Long-term debt, net of debt issuance costs	321,428	161,813
Long-term portion of lease liabilities	7,835	8,974
Total liabilities	681,108	433,809
Commitments and Contingencies (Note 14)		
Stockholders' Equity:		
Preferred stock, $.001 par value; 100,000,000 shares authorized as of December 31, 2024 and 2023, respectively; no shares issued and outstanding as of December 31, 2024 and 2023	—	—
Common stock, $.001 par value; 1,000,000,000 shares authorized as of December 31, 2024 and December 31, 2023; 191,778,639 and 188,951,643 shares issued and outstanding as of December 31, 2024 and December 31, 2023, respectively	192	189
Additional paid-in capital	1,107,952	1,037,015
Accumulated deficit	(1,008,293)	(880,258)
Total Alignment Healthcare, Inc. stockholders' equity	99,851	156,946
Noncontrolling interest	1,104	1,125
Total stockholders' equity	100,955	158,071
Total liabilities and stockholders' equity	$ 782,063	$ 591,880

See accompanying notes to consolidated financial statements.

Alignment Healthcare, Inc.
Consolidated Statements of Operations
(amounts in thousands, except share and per share amounts)

	Year Ended December 31,		
	2024	2023	2022
Revenues:			
Earned premiums	$ 2,671,931	$ 1,800,933	$ 1,431,550
Other	31,630	22,697	2,609
Total revenues	2,703,561	1,823,630	1,434,159
Expenses:			
Medical expenses	2,406,870	1,622,600	1,249,879
Selling, general, and administrative expenses	371,374	307,433	295,646
Depreciation and amortization	26,872	21,414	17,273
Total expenses	2,805,116	1,951,447	1,562,798
Loss from operations	(101,555)	(127,817)	(128,639)
Other expenses:			
Interest expense	23,547	21,231	18,289
Other (income) expenses, net	(72)	(853)	176
Loss on extinguishment of debt	3,020	—	2,196
Total other expenses	26,495	20,378	20,661
Loss before income taxes	(128,050)	(148,195)	(149,300)
Provision for income tax expense (benefit)	21	(22)	339
Net loss	$ (128,071)	$ (148,173)	$ (149,639)
Less: Net loss attributable to noncontrolling interest	36	156	92
Net loss attributable to Alignment Healthcare, Inc.	$ (128,035)	$ (148,017)	$ (149,547)
Total weighted-average common shares outstanding - basic and diluted	190,793,552	186,214,784	181,212,757
Net loss per share attributable to Alignment Healthcare, Inc. - basic and diluted	$ (0.67)	$ (0.79)	$ (0.83)

See accompanying notes to consolidated financial statements.

Alignment Healthcare, Inc.
Consolidated Statements of Stockholders' Equity
(amounts in thousands, except par value and share amounts)

	Common Stock					
	Shares	Amount	Additional Paid-In Capital	Accumulated Deficit	Noncontrolling interest	Total
Balance at December 31, 2021	187,193,613	$ 187	$ 888,547	$ (582,694)	$ 15	$ 306,055
Net Loss	—	—	—	(149,547)	(92)	(149,639)
Issuance of common stock upon vesting of restricted stock units	456,509	—	—	—	—	—
Forfeitures	(370,107)	—	—	—	—	—
Equity-based compensation	—	—	81,718	—	—	81,718
Noncontrolling interest attributable to subsidiary	—	—	(85)	—	1,253	1,168
Balance at December 31, 2022	187,280,015	$ 187	$ 970,180	$ (732,241)	$ 1,176	$ 239,302
Net loss	—	—	—	(148,017)	(156)	(148,173)
Issuance of common stock upon vesting of restricted stock units	1,762,086	2	—	—	—	2
Forfeitures	(90,458)	—	—	—	—	—
Equity-based compensation	—	—	66,835	—	—	66,835
Noncontrolling interest attributable to subsidiary	—	—	—	—	105	105
Balance at December 31, 2023	188,951,643	$ 189	$ 1,037,015	$ (880,258)	$ 1,125	$ 158,071
Net loss	—	—	—	(128,035)	(36)	(128,071)
Issuance of common stock upon vesting of restricted stock units	2,885,424	3	—	—	—	3
Forfeitures	(6,270)	—	—	—	—	—
Shares withheld related to net restricted stock settlement	(69,820)	—	(350)	—	—	(350)
Equity-based compensation	—	—	71,132	—	—	71,132
Stock options exercised	17,662	—	155	—	—	155
Noncontrolling interest attributable to subsidiary	—	—	—	—	15	15
Balance at December 31, 2024	191,778,639	$ 192	$ 1,107,952	$ (1,008,293)	$ 1,104	$ 100,955

See accompanying notes to consolidated financial statements.

Alignment Healthcare, Inc.
Consolidated Statements of Cash Flows
(amounts in thousands)

	Year Ended December 31,		
	2024	2023	2022
Operating Activities:			
Net loss	$ (128,071)	$ (148,173)	$ (149,639)
Adjustments to reconcile net loss to net cash provided by (used in) operating activities:			
Provision for credit loss	123	91	150
(Gain) loss on right of use assets	143	(289)	510
Gain on sale of property and equipment	(9)	—	—
Depreciation and amortization	27,062	21,668	17,486
Amortization-debt issuance costs	1,293	1,254	1,850
Amortization-investment discount	(2,579)	(4,917)	—
Amortization of payment-in-kind interest	—	—	2,943
Loss on disposal of property and equipment	—	—	101
Equity-based compensation	71,132	66,835	81,718
Non-cash lease expense	1,764	2,318	2,811
Loss on extinguishment of debt	3,020	—	2,196
Changes in operating assets and liabilities:			
Accounts receivable	(34,278)	(26,950)	(34,377)
Prepaid expenses and other current assets	7,887	(2,863)	(14,356)
Other assets	60	(142)	(86)
Medical expenses payable	84,389	35,264	44,250
Accounts payable and accrued expenses	(1,460)	(6,347)	13,743
Accrued compensation	5,819	6,574	3,609
Lease liabilities	(1,525)	(3,510)	(4,214)
Payment-in-kind interest	—	—	(14,122)
Net cash provided by (used in) operating activities	34,770	(59,187)	(45,427)
Investing Activities:			
Purchase of business, net of cash received	—	—	(4,043)
Purchase of investments	(82,200)	(379,058)	(2,825)
Sale of property and equipment	14	—	—
Maturities of investments	162,795	267,790	2,425
Acquisition of property and equipment	(41,418)	(35,995)	(23,774)
Net cash provided by (used in) investing activities	39,191	(147,263)	(28,217)
Financing Activities:			
Repurchase of noncontrolling interest	—	—	(100)
Proceeds from long-term debt	380,000	—	165,000
Debt issuance costs	(8,792)	—	(5,196)
Repayment of long-term debt	(215,000)	—	(143,179)
Payment of employment taxes related to release of restricted stock	(350)	—	—
Proceeds from exercise of stock options	155	—	—
Contributions from noncontrolling interest holders	15	105	68
Net cash provided by financing activities	156,028	105	16,593
Net increase (decrease) in cash	229,989	(206,345)	(57,051)
Cash, cash equivalents and restricted cash at beginning of period	204,954	411,299	468,350
Cash, cash equivalents and restricted cash at end of period	$ 434,943	$ 204,954	$ 411,299
Supplemental disclosure of cash flow information:			
Cash paid for interest	$ 22,157	$ 19,165	$ 22,447
Supplemental non-cash investing and financing activities:			
Acquisition of property in accounts payable	$ 70	$ 59	$ 47
Purchase of business in accounts payable	$ —	$ —	$ 505
Debt issuance costs in accounts payable	$ 512	$ —	$ —

The following table provides a reconciliation of cash and restricted cash reported within the consolidated balance sheets to the total above:

	December 31, 2024	December 31, 2023	December 31, 2022
Cash and cash equivalents	$ 432,859	$ 202,904	$ 409,549
Restricted cash in other assets	2,084	2,050	1,750
Total	$ 434,943	$ 204,954	$ 411,299

See accompanying notes to consolidated financial statements.

Alignment Healthcare, Inc.
Notes to Consolidated Financial Statements
(amounts in thousands, except share amounts)

1. Organization

Alignment Healthcare, Inc. (collectively, "we" or "us" or "our" or the "Company"), is a next generation, consumer-centric health care platform that is purpose-built to provide seniors with high quality, affordable care with a vastly improved consumer experience. Enabled by our innovative technology and care delivery model, the Company focuses on improving outcomes in the Medicare Advantage sector. The Company's operations primarily consist of Medicare Advantage Plans in the states of California, North Carolina, Nevada, Arizona, Florida and Texas.

2. Summary of Significant Accounting Policies

Basis of Presentation

The accompanying consolidated financial statements and accompanying notes have been prepared in accordance with accounting principles generally accepted in the United States of America ("U.S. GAAP"). The consolidated financial statements include the accounts of the Company, our subsidiaries, and three immaterial variable interest entities in which we are the primary beneficiary. All intercompany transactions have been eliminated in consolidation. Noncontrolling interest is presented within the equity section of the consolidated balance sheets.

We have no components of other comprehensive income (loss), and accordingly, comprehensive income (loss) is the same as the net income (loss) for all periods presented.

Use of Estimates

The preparation of the consolidated financial statements requires management to make estimates and judgments that affect the amounts reported in the consolidated financial statements. Our significant estimates include, but are not limited to, the determination of medical expenses payable; the impact of risk adjustment provisions related to our Medicare contracts; collectability of receivables; valuation of related impairment recognition of long-lived assets, including goodwill and intangible assets; equity-based compensation expense; and contingent liabilities. Estimates and judgments are based upon historical information and on various other assumptions that are believed to be reasonable under the circumstances. Actual results could differ materially from those estimates and the impact of any change in estimates is included in earnings in the period in which the estimate is adjusted.

Segments

We have determined that our chief executive officer is the chief operating decision maker ("CODM") who regularly reviews financial operating results on a consolidated basis for purposes of allocating resources and evaluating financial performance. We operate and manage the business as one reportable segment and one operating segment, which is to provide healthcare services to our seniors. Factors used in determining the reportable segment include the nature of operating activities, our organizational and reporting structure, and the type of information reviewed by the CODM to allocate resources and evaluate financial performance. All of our assets are located in the United States.

The CODM assesses the Company's performance by using consolidated net loss which is reported on the consolidated statements of operations as net loss. This measure is used predominantly by the CODM in the annual budget and forecasting process. The CODM considers budget-to-actual variances on a quarterly basis when making decisions about the allocation of operating and capital resources for the Company.

In addition to net loss, the CODM is also provided information on certain significant segment expenses which are presented below:

	Year Ended December 31,		
	2024	2023	2022
Revenues:	$ 2,703,561	$ 1,823,630	$ 1,434,159
Expenses:			
Medical expenses (less depreciation and equity-based compensation)	2,401,750	1,614,805	1,240,538
Selling, general, and administrative expenses (less equity-based compensation)	305,172	248,139	223,056
Other segment expenses [1]	101,163	87,628	101,915
Interest expense	23,547	21,231	18,289
Net loss	$ (128,071)	$ (148,173)	$ (149,639)

(1) Other segment items included in segment net income includes equity-based compensation, depreciation and amortization in medical expense, other expenses (income), loss on extinguishment of debt, and provision for income taxes.

Fair Value Measurements

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Our current assets and current liabilities approximate fair value because of the short-term nature of these financial instruments. Financial instruments measured at fair value on a recurring basis were based upon a three-tier hierarchy as follows:

Level 1 - Quoted prices in active markets for identical assets or liabilities

Level 2 - Other inputs that are observable for the asset or liability, either directly or indirectly, for substantially the full term of the asset or liability

Level 3 - Unobservable inputs that reflect management's best estimate of what market participants would use in pricing the asset or liability at the measurement date

The fair value of cash, cash equivalents, restricted cash and U.S. Treasury bills was determined based on Level 1 inputs. The fair value of the convertible senior note and certificate of deposits, which are recorded in long-term debt and other assets in the consolidated balance sheets, respectively, were determined based on Level 2 inputs. There were no assets or liabilities measured at fair value using Level 3 inputs as of December 31, 2024 and December 31, 2023. Our long-term debt was reported at carrying value.

Revenue and Accounts Receivable

Earned premium revenue consisting of premium revenue and capitation revenue for the years ended December 31, 2024, 2023, and 2022 were as follows:

	Year Ended December 31,		
	2024	2023	2022
Premium	$ 2,666,813	$ 1,668,131	$ 1,372,334
Capitation	5,118	132,802	59,216
	$ 2,671,931	$ 1,800,933	$ 1,431,550

Premium revenue is derived monthly from the federal government based on our contracts with the Centers for Medicare and Medicaid Services ("CMS"). In accordance with these arrangements, we assume the responsibility for the outcomes and the economic risk of funding our members' health care, supplemental benefits and related administration costs. We recognize premium revenue in the month that members are entitled to receive health care services, and premiums collected in advance are deferred. The monthly reimbursement includes a fixed payment per member per month ("PMPM"), which is adjusted based on certain risk factors derived from medical diagnoses and conditions of our members. The adjustments are estimated by projecting the ultimate annual premium and are recognized ratably during the year, with adjustments each period to reflect changes in the estimated ultimate premium. Premiums are also recorded net of estimated uncollectible amounts and retroactive membership adjustments.

Capitation revenue consists primarily of capitated fees for medical care services provided by us under arrangements with third-party payors.

Under those arrangements with third-party payors, we receive a PMPM payment for a defined member population, and we are responsible for providing health care services to the member population over the contract period. We are solely responsible for the cost of health care services related to the member population and in some cases, we are financially responsible for the supplemental benefits provided by us to the members. We act as a principal in arranging for and controlling the services provided by our provider network and we are at risk for arranging and providing health care services.

The premium and capitation payments we receive monthly from CMS for our members are determined from our annual bid or similarly from third-party payors under our capitation arrangement. These payments represent revenues for providing health care coverage, including Medicare Part D benefits. Under the Medicare Part D program, our members and the members of the third-party payors receive standard drug benefits. We may also provide enhanced benefits at our own expense. We recognize premium or capitation revenue for providing this insurance coverage in the month that members are entitled to receive health care services and any premium or capitation collected in advance is deferred. Our CMS payment related to Medicare Part D is subject to risk sharing through the Medicare Part D risk corridor provisions.

In 2023, capitation revenue consisted primarily of revenue from CMS related to our participation in the CMS "ACO Realizing Equity, Access, and Community Health Model" or "ACO REACH" model, formerly the Direct Contracting Model ("DCE"). CMS serves as the claim adjudicator for institutional and specialists care, and directly pays for such fee for service claims. The ACO REACH entity

("ACO") is responsible for the cost of health care services related to the patient population attributed to the ACO by participating in 100% savings/losses via the risk share model and in some cases, are financially responsible for the supplemental benefits provided to the patients. In 2024, we entered into a management services and risk management agreement with a third-party healthcare company. The third-party is responsible for arranging and controlling the health care services provided to the ACO members, and for providing certain management and support services with respect to ACO operations. The third-party also assumes specified upside and downside financial risks relative to the ACO's performance. As a result of this arrangement, revenue is recorded on a net basis within other revenue on the consolidated statement of operations for the year ended December 31, 2024. Revenue recognized by the ACO for the years ended December 31, 2024 was $984.

Prior to 2024, the ACO acted as a principal in arranging for and controlling services provided directly by their contracts with primary care physicians, as well as services provided by preferred institutional care providers and specialists. Capitation payments for the ACO program are determined from an annual benchmark established by CMS. These payments, which are adjusted for variable considerations, represented revenue for providing health care services, including primary care as well as institutional and specialist care. The ACO recognized capitation revenue for providing these services in the period in which the performance obligations were satisfied by transferring services to the members. Revenue recognized by the ACO for the years ended, 2023 and 2022 was $123,972 and $50,946, respectively.

Interest income earned on our cash deposits and short-term investments is included within other revenue on the consolidated statements of operations. Interest income for the years ended December 31, 2024, 2023 and 2022 was $23,986, $19,586 and $1,010, respectively.

Revenue Adjustments

Payments by CMS to health plans are determined via a competitive bidding process with CMS and are based upon the cost of care in a local market and the average utilization of services by the member enrolled. These payments are subject to periodic adjustments under CMS' "risk adjustment model," which compensates health plans based on the health severity and certain demographic factors of each individual member. Members diagnosed with certain conditions are paid at a higher monthly payment than members who are healthier. Under this risk adjustment model, CMS calculates the risk adjustment payment using diagnosis data from hospital inpatient, hospital outpatient, and physician treatment settings. The Company and health care providers collect, capture, and submit the necessary and available diagnosis data to CMS within prescribed deadlines. Both premium and capitation revenues (including Medicare Part D) are subject to adjustments under the risk adjustment model.

Throughout the year, we estimate risk adjustment payments based upon the diagnosis data submitted and expected to be submitted to CMS. Those estimated risk adjustment payments are recorded as an adjustment to premium and capitation revenue. Our risk adjustment data is also subject to review by the government, including audit by regulators.

Our recognized premium revenue for our Medicare Advantage Plans in California, North Carolina, Nevada, Arizona, Texas and Florida are each subject to a minimum annual medical loss ratio ("MLR") of 85%. The MLR represents medical costs as a percentage of premium revenue. The Code of Federal Regulations defines what constitutes medical costs and premium revenue, including certain additional expenses related to improving the quality of care provided, and the exclusion of certain taxes and fees, in each case as permitted or required by CMS and applicable regulatory requirements. If the minimum MLR is not met, we are required to remit a portion of the premiums back to the federal government. The amount remitted, if any, is recognized as an adjustment to premium revenues in the consolidated statements of operations. The amounts payable under this provision were immaterial at December 31, 2024 and December 31, 2023.

Medicare Part D payments are also subject to a federal risk corridor program, which limits a health plan's overall losses or profit if actual spending for basic Medicare Part D benefits is much higher or lower than what was anticipated. Risk corridor is recorded within premium revenue. The risk corridor provisions compare costs targeted in our bids or third-party payors' bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS or third-party payors making additional payments to us or require us to refund a portion of the premiums we received. We estimate and recognize an adjustment to premium revenue related to these provisions based upon pharmacy claims experience. We record a receivable or payable at the contract level and classify the amount as current or long-term in our consolidated balance sheet based on the timing of expected settlement.

Variable consideration estimates related to ACO contract revenue are based on the most likely outcome method and that a significant reversal in the amount of cumulative revenue recognized would not occur.

Receivables, including risk adjusted premium due from the government or through third-party payors, pharmacy rebates, and other receivables, are shown net of allowances for credit losses and retroactive membership adjustments.

Cash and Cash Equivalents

Cash includes currency on hand with banks and financial institutions. We consider short-term investments with an original maturity of three months or less at the date of purchase to be cash equivalents. Carrying value approximates fair value due to the short-term maturity of the investments.

As of December 31, 2024 and 2023, cash equivalents were $32,494 and $22,232, respectively.

Investments

Investment securities are classified as held-to-maturity or available-for-sale at the time of purchase. Investment securities classified as held-to-maturity, which management has the positive intent and ability to hold to maturity, are reported at amortized cost. Investments with maturities of less than one year are classified as short-term.

Restricted and Other Long-Term Assets

Restricted assets are composed of restricted cash and investments in US Treasury bills and certificate of deposits. The Company intends to hold its investments until maturity; therefore, these investments are stated at amortized cost. Premiums and discounts, if any, are amortized or accreted as interest expense or income over the life of the related asset using the effective interest method. As of December 31, 2024 and 2023, all investments had maturities with less than 12 months.

Restricted assets are required to be maintained at a financial institution within certain states. Due to the nature of the state's requirements, these assets are classified as noncurrent assets regardless of the contractual maturity date.

Property and Equipment—Net

Property and equipment are carried at cost, net of accumulated depreciation. Expenditures for repairs and maintenance that do not improve or extend the life of the assets are expensed when incurred. Costs and the related accumulated depreciation are removed when property and equipment are sold or otherwise disposed of, and any resulting gains or losses are reflected in the consolidated statement of operations.

Software development activities typically consist of three phases: (1) planning, (2) application and infrastructure development, and (3) post implementation. Costs incurred in the planning and post implementation phases, including post-configuration training and repairs and maintenance, are expensed as incurred. Costs incurred in the application and infrastructure development phases, including significant enhancements and upgrades, are capitalized once the planning phase is completed and management authorizes the project to commence. Those costs include, but are not limited to, salaries and benefit expenses for employees who are directly associated with the development projects and outside contractor expenses. Software development costs that do not qualify for capitalization are expensed as incurred.

Depreciation expense is computed using the straight-line method generally based on the following estimated useful lives:

Description	Estimated Service Lives (years)
Computer and equipment	5
Office equipment and furniture	5-7
Software	3-5
Leasehold improvements	15 (or lease term, if shorter)

Depreciation expense related to property and equipment used to service our members or at our clinics are included within medical expenses in the consolidated statements of operations.

Leases

We determine if an arrangement is a lease at inception and evaluate each lease arrangement to determine whether the lease is an operating or financing lease. ROU assets and lease liabilities are recognized at commencement date based on the present value of the future minimum lease payments over the lease term. ROU assets include upfront payments, if any, and excludes lease incentives. The lease terms may include options to extend or terminate the lease when it is reasonably certain that we will exercise that option.

We utilize our incremental borrowing rate to determine the present value of the lease payments if an interest rate is not implicit in the lease. Expenses for our operating and finance leases are recognized on a straight-line basis over the lease term and are recorded as selling, general and administrative expenses for operating leases and as depreciation expense and interest expense for finance leases.

We elected practical expedients permitted under the transition guidance, which allowed the carryforward of historical lease classification, assessment on whether a contract was or contains a lease and allowed for a cumulative-effect adjustment as of January 1, 2020 and did not restate previously reported results in the comparative periods. We also elected to account for lease and non-lease components as a single lease component. Leases with an initial term of 12 months are not included within the ROU assets and lease liabilities and the associated lease payments are recognized in the consolidated statements of income on a straight-line basis over the lease term. Operating leases are included in ROU assets and lease liabilities are included in accounts payable and accrued expenses and long-term portion of lease liabilities on the consolidated balance sheets.

Goodwill and Intangible Assets

Intangible assets are classified into three categories: (1) goodwill, (2) indefinite-lived intangible assets, and (3) definite-lived intangible assets.

Goodwill and indefinite-lived intangible assets are not amortized. For definite-lived intangible assets, we determine the useful lives of intangible assets after considering each asset's specific facts and circumstances. Intangible assets that are determined to have definite lives are amortized on a straight-line basis over their useful lives.

Impairment

Goodwill and indefinite-lived assets are tested for impairment on an annual basis and more frequently if indicators of impairment are present. Impairment tests are performed, at a minimum, in the fourth quarter of each year supported by our long-range business plan and annual planning process.

When testing goodwill for impairment, we first perform a qualitative assessment. If the qualitative assessment indicates that it is more likely than not that the carrying value of a reporting unit exceeds the estimated fair value, then a quantitative assessment is performed. We may elect to bypass the qualitative assessment and proceed directly to the quantitative assessment.

If the quantitative test is needed, we determine an appropriate valuation technique to estimate the fair value of the reporting unit as of the testing date. We utilize the income approach and the market approach to assess the most appropriate fair value for the reporting unit. Changes in economic and operating conditions impacting assumptions used in our analyses could result in goodwill impairment in future periods.

When testing indefinite-lived intangible assets other than goodwill for impairment, we first perform a qualitative analysis to determine whether it is more likely than not that an asset has been impaired. If it is more likely than not that an asset has been impaired, an impairment is evaluated by comparing the estimated fair value of the asset to its carrying value. An impairment charge is recognized if the asset's estimated fair value is less than its carrying value.

Impairment of Long-Lived Assets

Long-lived assets consist of property and equipment and other finite-lived intangible assets. These assets are depreciated or amortized over their estimated useful life and are subject to impairment reviews. We periodically review long-lived assets whenever adverse events or changes in circumstances indicate the carrying value of the asset may not be recoverable.

We review these assets for impairment by comparing the sum of the expected future cash flows (undiscounted and without interest charges) to the carry value. If the sum of the estimated undiscounted future cash flows is less than the carrying value, an impairment determination is required. The amount of impairment is calculated by subtracting the fair value of the asset from the carrying value. An impairment charge, if any, is recognized within earnings from operations.

Medical Expenses

Medical expenses include claim payments, capitation payments, pharmacy costs net of rebates, allocations of certain centralized expenses, internal care delivery expenses and various other costs incurred to provide health insurance coverage and care to members, as well as estimates of future payments to hospitals and others for medical care and other supplemental benefits provided.

We have contracts with a network of hospitals, physicians, and other providers and compensate those providers and ancillary organizations based on contractual arrangements or CMS Medicare compensation guidelines. We pay these contracting providers either through fee-for-service arrangement in which the provider is paid negotiated rates for specific services provided or a capitation payment, which represent monthly contractual fees disbursed for each member regardless of medical services provided to the member. We are responsible for the entirety of the cost of health care services related to the member population, in addition to supplemental benefits provided by us to our seniors. In 2023, we also recorded claims expenses related to our institutional and specialist care related to our ACO program with CMS as we acted as the principal in the transaction. As discussed above, beginning in 2024, claims expense related to the ACO program is netted against ACO revenue as we act as the agent in these transactions.

Capitation-related expenses are recorded on an accrual basis during the coverage period. Expenses related to fee-for-service contracts are recorded in the period in which the related services are dispensed.

Pharmacy costs represent payments for members' prescription drug benefits, net of rebates from drug manufacturers. Receivables for such pharmacy rebates are included in accounts receivable in the consolidated balance sheet.

In August 2022, the Inflation Reduction Act ("IRA") was signed into law. The law intends to increase tax revenue and reduce Medicare costs through lower prescription drug prices, inflation rebates, and increased financial responsibility for certain drug manufacturers. The provisions of the law are set to take effect over the next seven years. There was an immaterial impact on our consolidated financial statements at December 31, 2024 and the 2025 bid pricing and budget reflect the expected impact the IRA will have on our business for fiscal year 2025.

Medical Expenses Payable

Medical expenses payable includes estimates of our obligations for medical care services that have been rendered on behalf of our members and the members of the third-party payors, but for which claims have either not yet been received or processed, loss adjustment expense reserve for the expected costs of settling these claims, and for liabilities related to physician, hospital, and other medical cost disputes.

We develop estimates for medical expenses incurred but not yet paid ("IBNP"), which includes an estimate for claims incurred but not reported ("IBNR") and a payable for adjudicated claims. IBNR is estimated using an actuarial process that is consistently applied and centrally controlled. Medical expenses payable also includes an estimate for the costs necessary to process unpaid claims at the end of each period. We estimate the IBNR liability using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors, such as cost trends and completion factors that are assessed based on historical data for payment patterns, product mix, seasonality, utilization of health care services, and other relevant factors. Each period, we re-examine previously established IBNR estimates based on actual claim submissions and other changes in facts and circumstances. As the IBNR estimates recorded in prior periods develop, we adjust the amount of the estimates and include the changes in estimates in medical expenses in the period in which the change is identified.

Actuarial Standards of Practice generally require that the IBNP estimates be adequate to cover obligations under moderately adverse conditions. Moderately adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of estimate. In many situations, the claims amount ultimately settled will be different than the estimate that satisfies the Actuarial Standards of Practice. We include in our IBNP an estimate for medical claims liability under moderately adverse conditions, which represents the risk of adverse deviation of the estimates in our actuarial method of reserving. We believe that medical expenses payable is adequate to cover future claims payments required. However, such estimates are based on knowledge of current events and anticipated future events. Therefore, the actual liability could differ materially from the amounts provided.

We reassess the profitability of contracts for providing coverage to members when current operating results or forecasts indicate probable future losses. A premium deficiency reserve is established in current operations to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceed related future premiums under contract and investment income. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with the method of acquiring, servicing, and measuring the profitability of such contracts. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established.

Part D Subsidies

We also receive advance payments each month from CMS related to Catastrophic Reinsurance, Coverage Gap Discount, and the Low-Income Member Cost Sharing Subsidy ("Subsidies"). Reinsurance subsidies represent funding from CMS for our portion of prescription drug costs, which exceed the member's out-of-pocket threshold or the catastrophic coverage level. Low-income cost subsidies represent funding from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Additionally, the Health Care Reform Law mandates consumer discounts of 75% on brand-name prescription drugs for Part D plan participants in the coverage gap. The majority of the discounts are funded by the pharmaceutical manufacturers, while we fund a smaller portion and administer the application of the total discount. In 2025, the IRA retires the Coverage Gap Discount Program and introduces the Manufacturer Discount Program. While CMS's share of the drug cost liability is expected to decline from Catastrophic Reinsurance and Low-Income Member Cost Sharing, prescription drug manufacturers are expected to experience increased liability. These program changes and the corresponding changes in prepayments were embedded in the 2025 bid pricing.

These Subsidies represent cost reimbursements under the Medicare Part D program and are recorded as deposits or payables. These Subsidies received in excess of, or less than, actual subsidized benefits paid are refundable to or recoverable from CMS through an annual reconciliation process following the end of the contract year. The amounts refundable to or recoverable from CMS, including risk corridor as discussed above, were recorded in the following accounts within the consolidated balance sheets:

	December 31, 2024		December 31, 2023	
	Risk Corridor	CMS Subsidies	Risk Corridor	CMS Subsidies
Current assets:				
Accounts receivable	$ 10,427	$ —	$ 1,120	$ —
Prepaid expenses and other current assets	—	25,782	—	28,134
Current liabilities:				
Medical expenses payable	$ —	$ 24,993	$ 16,776	$ 5,302

Shared Risk Reserve Arrangements

We established a fund (also referred to as "a pool") for risk and profit-sharing with various independent physician associations ("IPAs"). The pool enables us and our IPAs to share in the financial responsibility and/or upside associated with providing covered medical expenses to our members. The risk pool is based on a contractually agreed upon medical budget, typically based upon a percentage of revenue. If actual medical expenses are less than the budgeted amount, this results in a surplus. Conversely, if actual medical expenses are greater than the budgeted amount, this results in a deficit. We will distribute the surplus, or a portion thereof, to each IPA based upon contractual terms. Deficits are charged to shared risk providers' risk pool as per the contractual term and evaluated for collectability at each reporting period.

We record risk-sharing receivables and payables on a gross basis on the consolidated balance sheet. Throughout the year, we evaluate expected losses on risk-sharing receivables and record the resulting expected losses to the reserve. We systematically build and release reserves based on adequacy and its assessment of expected losses on a monthly basis. Credit loss associated with risk share deficit receivables are recorded within medical expense in the consolidated statements of operations. As of December 31, 2024 and December 31, 2023, we recorded an allowance for credit losses for substantially all of the risk-sharing receivable balance due to collection risk related to the balance. The risk-sharing payable is included within medical expenses payable on the consolidated balance sheet.

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash deposits and current and restricted investments with financial institutions. Accounts at each financial institution are insured by the Federal Deposit Insurance Corporation ("FDIC") up to certain limits. At December 31, 2024 and December 31, 2023, there was $469,373 and $316,977, respectively, in excess of FDIC-insured limits.

Income Taxes

We account for income taxes using the asset and liability method. Deferred tax assets and liabilities are determined based on temporary differences between the bases used for financial reporting and income tax reporting purposes based on the enacted tax rates and laws that will be in effect at the time such temporary differences are expected to reverse.

The recognition of deferred tax assets requires an assessment to determine the realization of such assets. Realization refers to the incremental benefits achieved through the reductions in future taxes payable or refunds receivable from the deferred tax assets, assuming that the underlying deductible differences and carryforwards are the last items to enter into the determination of future taxable income. We establish a valuation allowance for tax assets when it is more likely than not that they will not be realized, based on all available positive and negative evidence.

We account for uncertainty in income taxes using a "more-likely-than-not" recognition threshold. We consider many factors when evaluating and estimating our tax positions and tax benefits, which may require periodic adjustments, and which may not accurately reflect actual outcomes. Interest and penalties related to uncertain tax benefits are recognized as a component of interest expense and income tax expense, respectively, in the consolidated statement of operations.

Member Acquisition Costs

Member acquisition costs primarily relate to internal and external broker commission costs. These member acquisition costs related to our health services contract with our members are expensed as incurred and are recorded as selling, general and administrative expenses. These short-term health services contract typically have a one-year term and may be canceled by the member.

Advertising Expenses

The Company expenses the costs of advertising as incurred. Advertising expenses were $5,756, $6,956, and $7,958, for the years ended December 31, 2024, 2023, and 2022, respectively, and were reported as selling, general and administrative expenses.

Equity-Based Compensation

Equity-based compensation expense is measured and recognized based on the grant date fair value of the awards. The grant date fair value of stock options is estimated using the Black-Scholes option pricing model. The grant date fair value of restricted stock units ("RSUs") and restricted stock awards ("RSAs") is estimated based on the fair value of our underlying common stock on the date of grant.

The Black-Scholes option pricing model requires the use of highly subjective assumptions, including the award's expected term, the fair value of the underlying common stock, the expected volatility of the price of the common stock, risk-free interest rates, and the expected dividend yield of the common stock. The assumptions used to determine the fair value of the stock-based awards are management's best estimates and involve inherent uncertainties and the application of judgment. The expected term represents the period the stock-based awards are expected to be outstanding. As we do not have sufficient historical experience for determining the expected term of the stock option awards granted, we utilize the simplified method available under U.S. GAAP. As we do not have a substantial trading history,

volatility assumptions were developed using a combination of the Company's historical volatility and the historical volatilities of a set of peer companies, adjusted for debt-equity leverage. Equity-based compensation expense for awards with service-based vesting only is recognized on a graded vesting schedule over the requisite service period of the awards, which is generally four years.

Equity-based compensation expense for RSU awards with performance-based vesting is recognized over the requisite service period on a graded vesting schedule and is only recognized when the Company concludes that it is probable that the performance condition(s) will be achieved. At each reporting period, the Company reassesses the probability of achieving the performance criteria. Determining whether the performance criteria will be achieved involves judgment, and the estimate of share-based compensation expense may be revised periodically based on changes in the probability of achieving the performance criteria. Revisions are reflected in the period in which the estimate is changed. We account for forfeitures as they occur.

Equity-based compensation is recorded within selling, general and administrative expenses, and medical expenses based on the function of the applicable employee and non-employee.

Net Loss per Share

Net loss per share is calculated based on net loss attributable to Alignment Healthcare, Inc.'s shareholders. The following table sets forth the computation of basic and diluted net loss per share for the years ended December 31, 2024, 2023, and 2022:

	Year Ended December 31,		
	2024	2023	2022
Numerator:			
Net loss	$ (128,071)	$ (148,173)	$ (149,639)
Less: Net loss attributable to noncontrolling interests	36	156	92
Net loss attributable to Alignment Healthcare, Inc.	$ (128,035)	$ (148,017)	$ (149,547)
Denominator:			
Total weighted-average common shares outstanding - basic and diluted	191,150,693	188,420,487	187,227,877
Less: Restricted shares of common stock	(357,141)	(2,205,703)	(6,015,120)
Total weighted-average common shares outstanding, net of restricted shares of common stock - basic and diluted	190,793,552	186,214,784	181,212,757
Net loss per share:			
Net loss per share - basic and diluted	$ (0.67)	$ (0.79)	$ (0.83)

Basic net loss per share is the same as diluted net loss per share for periods presented as the inclusion of all potentially dilutive shares would have been anti-dilutive.

In addition to the restricted shares of common stock, we also excluded the following potential common shares, presented based on amounts outstanding at each period end, from the computation of diluted net loss per share as of December 31, 2024, 2023, 2022:

	December 31,		
	2024	2023	2022
Stock options	8,762,481	9,135,879	10,603,493
Restricted stock units	21,419,556	17,774,830	8,728,936
Convertible senior notes	25,720,959	—	—
Total	55,902,996	26,910,709	19,332,429

Recently Adopted Accounting Pronouncements

In November 2023, the FASB issued Accounting Standards Update ("ASU") No. 2023-07 around segment disclosures. The new standard requires a public entity to disclose significant segment expenses and other segment items on an annual and interim basis and provide, in interim periods, all disclosures about a reportable segment's profit or loss and assets that are currently required annually. Additionally, it requires a public entity to disclose the title and position of the Chief Operating Decision Maker. The ASU does not change how a public entity identifies its operating segments, aggregates them, or applies the quantitative thresholds to determine its reportable segments. The guidance was for annual periods beginning with the Company's fiscal year 2024, and in interim periods within the Company's fiscal year

2025. The Company adopted the requirements of this ASU within our segment disclosure in Note 2 Summary of Significant Accounting Policies above. The adoption only impacted our disclosures with no impact to our results of operations, cash flows or financial condition.

Recent Accounting Pronouncements Issued

In November 2024, the FASB issued ASU 2024-04 "*Debt with Conversion and Other Options*", which improves and clarifies the requirements for determining whether certain settlements of convertible debt instruments should be accounted for an as induced conversion. ASU 2024-04 is effective for annual periods beginning after December 15, 2025 (and interim reporting periods within those annual reporting periods). The Company is currently evaluating the impact of this ASU on its financial statements.

Additionally, in November 2024, the FASB issued ASU 2024-03 "*Disaggregation of Income Statement Expenses*", which improve income statement presentation and disclosures related to expenses. It requires a public entity to disaggregate key expense categories such as employee compensation, depreciation and intangible asset amortization within its financial statements. ASU 2024-03 is effective for annual periods beginning with the Company's fiscal year 2027, and interim periods within the Company's fiscal year 2028, with early adoption permitted. The Company is currently evaluating the impact of this ASU on its disclosures of income statement expenses.

In December 2023, the FASB issued ASU 2023-09 *"Income Taxes (Topic 740): Improvements to Income Tax Disclosures*", which requires public entity to disclose, on an annual basis, a tabular rate reconciliation using both percentages and currency amounts, broken out into specified categories with certain reconciling items further broken out by nature and jurisdiction to the extent those items exceed a specified threshold. In addition, all entities are required to disclose income taxes paid, net of refunds received disaggregated by federal, state/local, and foreign and by jurisdiction if the amount is at least 5% of total income tax payments, net of refunds received. For public entities, the new standard is effective for annual periods beginning after December 15, 2024, with early adoption permitted. An entity may apply the amendments in this ASU prospectively by providing the revised disclosures for the period ending December 31, 2025 and continuing to provide the pre-ASU disclosures for the prior periods, or may apply the amendments retrospectively by providing the revised disclosures for all period presented. We expect this ASU to only impact our disclosures with no impacts to our results of operations, cash flows, and financial condition.

3. Fair Value

The following tables present the carrying value and fair value of these financial instruments as of December 31, 2024 and 2023:

	December 31, 2024			
		Fair Value		
	Carrying Value	Level 1	Level 2	Level 3
US Treasury bills	$ 71,120	$ 71,135	$ —	$ —
Certificate of deposits	2,321	—	2,321	—
Total	$ 73,441	$ 71,135	$ 2,321	$ —

	December 31, 2023			
		Fair Value		
	Carrying Value	Level 1	Level 2	Level 3
U.S. Treasury bills	$ 117,337	$ 117,310	$ —	$ —
Certificate of deposits	1,755	—	1,755	—
Total	$ 119,092	$ 117,310	$ 1,755	$ —

The carrying value of long-term debt represents the outstanding balance, net of unamortized debt issuance costs. As of December 31, 2024 and 2023, the fair value of our long-term debt approximates the carrying value.

Our nonfinancial assets and liabilities, which include goodwill, intangible assets, property, and equipment, are not required to be measured at fair value on a recurring basis. However, on a periodic basis, or whenever events or changes in circumstances indicate that their carrying value may not be recoverable, we assess these assets for impairment. We recorded an impairment charge related to intangible assets during the year ended December 31, 2024. No such impairment resulted during the years ended December 31, 2023 and 2022. Please refer to Note 6 Goodwill and Intangible Assets for more information on the impairment charge.

U.S. Treasury Securities Investments

As of December 31, 2024, the Company had $37,791 of investments in U.S. Treasury bills which were classified as held to maturity and carried at amortized cost. These investments are included in short-term investments in the consolidated balance sheets as the original

maturities are greater than three months and less than twelve months. The Company has the intent and ability to hold these securities to maturity and gross unrecognized gains were $16.

As of December 31, 2024, the Company had $32,296 of investments in U.S. Treasury bills with an original maturity of less than three months. These investments are considered cash equivalents and are included in cash and cash equivalents in the consolidated balances sheets.

Restricted Investments

Restricted investments are composed of investments in U.S. Treasury bills and certificates of deposits and are included within other assets in the consolidated balance sheets. As of December 31, 2024 and December 31, 2023, the Company had $1,033 and $1,423 of restricted investments in U.S. Treasury bills and $2,321 and $1,755 of restricted investments in certificates of deposits, respectively. The Company has the intent and ability to hold these investments until maturity; therefore, these investments are stated at amortized cost. Restricted investments are required to be maintained at a financial institution within certain states. As of December 31, 2024 and December 31, 2023, these investments had maturities with less than 12 months. Due to the nature of the state's requirements, these assets are classified as noncurrent assets regardless of the contractual maturity date.

4. Accounts Receivable

Accounts receivable consisted of the following as of December 31, 2024 and 2023:

	December 31, 2024	December 31, 2023
Government receivables	$ 26,338	$ 35,529
Pharmacy rebate receivables	111,813	75,894
Other receivables	15,753	8,326
Total accounts receivable	153,904	119,749
Allowance for credit losses	—	—
Accounts receivable, net	$ 153,904	$ 119,749

The allowance for expected credit losses for accounts receivable is based primarily on past collections experience relative to the length of time receivables are past due. However, when available evidence reasonably supports an assumption that future economic conditions will differ from current and historical payment collections, an adjustment is reflected in the allowance for expected credit losses. We record pharmacy rebates and other receivables based on contractual terms and expected collections and our estimation process for contractual allowances for such balances generally results in an allowance for balances outstanding greater than 90 days or if expected credit risks are known.

Receivables and any associated allowance are written off only when all collection attempts have failed and such amounts are determined unrecoverable. We regularly review the adequacy of these allowances based on a variety of factors, including age of the outstanding receivable and collection history. When circumstances related to specific collection patterns change, estimates of the recoverability of receivables are adjusted. Because substantially all of our receivable amounts are readily determinable and a large portion of our creditors are governmental authorities, our allowance for credit losses is insignificant.

We recorded credit losses related to accounts receivable of $123, $91, and $150 during the years ended December 31, 2024, 2023, and 2022, respectively. The amounts were recorded in selling general, and administrative expenses in the consolidated statements of operations.

5. Property and Equipment

Property and equipment consisted of the following as of December 31, 2024 and 2023:

	December 31, 2024	December 31, 2023
Computers and equipment	$ 12,569	$ 11,447
Office equipment and furniture	4,341	4,396
Software	179,336	148,864
Leasehold improvements	6,231	6,347
Construction in progress	14,049	4,532
Subtotal	216,526	175,586
Less accumulated depreciation	(149,387)	(123,685)
Property and equipment-net	$ 67,139	$ 51,901

Depreciation expense for the year ended December 31, 2024 was $26,360 of which $190 was included in medical expenses. Depreciation expense for the years ended December 31, 2023 and 2022 was $21,442 and $17,100, respectively, of which $254 and $213, respectively, was included in medical expenses.

6. Goodwill and Intangible Assets

Intangible assets consisted of the following as of December 31, 2024 and 2023:

	December 31, 2024			
	Gross Carrying Value	Accumulated Amortization	Net Carrying Value	Weighted Average Life
Goodwill	$ 34,826	$ —	$ 34,826	—
License (indefinite lived)	4,550	—	4,550	—
Plan member relationships	2,700	(2,700)	—	9 years
Other	633	(633)	—	2 - 10 years
Total	$ 42,709	$ (3,333)	$ 39,376	

	December 31, 2023			
	Gross Carrying Value	Accumulated Amortization	Net Carrying Value	Weighted Average Life
Goodwill	$ 34,826	$ —	$ 34,826	—
License (indefinite lived)	4,967	—	4,967	—
Plan member relationships	2,700	(2,700)	—	9 years
Other	1,050	(765)	285	2- 10 years
Total	$ 43,543	$ (3,465)	$ 40,078	

Amortization expense relating to intangible assets for the years ended December 31, 2024, 2023, and 2022, was $702, $226, and $386, respectively. Included within the amortization balance for the years ended December 31, 2024 was $645 in impairment charges related to intangible assets that were written off related to an inactive Medicare license that was terminated during the period.

There were no impairment charges related to goodwill and intangible assets for the years ended December 31, 2023 and 2022.

7. Medical Expenses Payable

The following table is a detail of medical expenses payable as of December 31, 2024 and 2023:

	December 31, 2024	December 31, 2023
Claims incurred but not paid	$ 168,357	$ 95,664
Capitation and risk-sharing payable	52,016	50,894
Other	69,415	58,841
Medical expenses payable	$ 289,788	$ 205,399

Each period, we re-examine previously established outstanding claims reserve estimates based on actual claims submissions and other changes in facts and circumstances. As more complete claim information becomes available, we adjust the amount of the estimates and include the changes in estimates in claim costs in the period in which the change is identified. Substantially, all of the total claims paid by us are known and settled within the first year from the date of service, and substantially, all remaining claim amounts are paid within a three-year period.

The following table presents components of the change in medical expenses payable as of December 31, 2024, 2023, and 2022 :

	December 31, 2024	December 31, 2023	December 31, 2022
Claims incurred but not paid - beginning balance	$ 95,664	$ 88,813	$ 77,073
Incurred related to:			
Current year	832,819	492,315	400,939
Prior years	(9,245)	(14,555)	(15,402)
Total incurred, net of reinsurance	823,574	477,760	385,537
Payments related to:			
Current year	670,471	400,465	315,187
Prior years	80,410	70,444	58,610
Total payments, net of reinsurance	750,881	470,909	373,797
Claims incurred but not paid - ending balance	168,357	95,664	88,813
Capitation payable, risk-sharing payable, and other	121,431	109,735	81,322
Total medical expenses payable	$ 289,788	$ 205,399	$ 170,135

We re-examine previously established outstanding claims reserve estimates based on actual claims submissions and other changes in facts and circumstances. We recognized a favorable prior year development, excluding provision for adverse deviation, of $7,052, $10,996, and $11,179 for the years ended December 31, 2024, 2023, and 2022, respectively. The favorable prior year development incurred in 2024, 2023 and 2022 was primarily due to better-than-expected claims recoveries and actual claims expense being less than expected.

The following tables provide information about incurred and paid claims development as of December 31, 2024:

	Cumulative Incurred Claims, Net of Reinsurance For the Years Ended December 31,		
	2022	2023	2024
Claims Incurred Year		*(in thousands)*	
2022	$ 400,939	385,746	383,865
2023		492,315	484,951
2024			832,819
Total			$ 1,701,635

	Cumulative Claims Paid, Net of Reinsurance For the Years Ended December 31,			Cumulative Number of Paid Claims[1]
	2022	2023	2024	
Claims Incurred Year		*(in thousands)*		
2022	$ 315,187	383,419	382,467	389,689
2023		400,465	481,827	537,129
2024			670,471	909,451
Total			$ 1,534,765	

(1) Cumulative number of paid claims are presented in whole amounts

Substantially all of the claims incurred but not paid as of December 31, 2024 relate to the current year.

There is no single or common claim frequency metric used in the health care industry. We believe a relevant metric for our health insurance business is the cumulative number of claims paid for each incurred year. Claims that did not result in a liability are not included in the frequency metric.

8. Long-Term Debt

Long-term debt is recorded at carrying value in the consolidated balance sheets. The carrying value of long-term debt outstanding, net of unamortized debt issuance costs, consisted of the following as of December 31, 2024 and 2023:

	December 31, 2024	December 31, 2023
Long-term debt	$ 330,000	$ 165,000
Less unamortized debt issuance costs	(8,572)	(3,187)
Long-term debt-net of amortization	321,428	161,813
Less current portion of long-term debt	—	—
Long-term debt - net of current portion	$ 321,428	$ 161,813

Oxford Term Loan

On September 2, 2022 (the "Effective Date"), we, Alignment Healthcare USA, LLC, an indirect subsidiary of the Company (the "Borrower") and certain of our other subsidiaries entered into a term loan agreement (the "Oxford Loan Agreement") with Oxford Finance LLC, as administrative agent, collateral agent and a lender, and the other lenders from time to time party thereto (collectively, the "Lenders"), pursuant to which the Lenders have agreed to lend the Borrower an aggregate principal amount of up to $250,000 in a series of term loans (the "Term Loans"). Pursuant to the Oxford Loan Agreement, the Borrower received an initial Term Loan of $165,000 on the Effective Date and had the option to borrow up to an additional $85,000 of Term Loans. On June 14, 2024, we borrowed $50,000 in aggregate principal amount of the Delayed Draw Term Loans prior to the expiration date for such amount of the Delayed Draw Term Loans of June 30, 2024. Interest on the Term Loans was a variable rate equal to (i) the secured overnight financing rate administered by the Federal Reserve Bank of New York for a one-month tenor, subject to a floor of 1.00%, plus (ii) an applicable margin of 6.50%. The interest rate applied during the year ended December 31, 2024 ranged from 11.35% to 11.84%.

In connection with the issuance of the convertible senior notes, as noted below, we repaid all amounts outstanding under the terms loans with Oxford Finance on November 22, 2024.

Convertible Senior Notes

On November 22, 2024, the Company completed the sale of $330,000 of our 4.25% Convertible Senior Notes (the "Notes"). The Notes were issued pursuant to an indenture (the "Indenture"), dated as of November 22, 2024, between the Company and U.S. Bank Trust Company, National Association, as trustee (the "Trustee"). The Notes are senior, unsecured obligations of the Company, and interest will be payable semi-annually in arrears at a rate of 4.25% per annum beginning on May 15, 2025. The Notes will mature on November 15, 2029, unless earlier repurchased, redeemed or converted in accordance with their terms. The net cash proceeds from the sale of the Notes was approximately $321,100, after subtracting fees, discounts and estimated expenses in connection with the transaction.

Prior to the close of business on the business day immediately preceding August 15, 2029, the Notes will be convertible at the option of holders during certain periods, upon satisfaction of certain conditions. On or after August 15, 2029, the Notes will be convertible at any time until the close of business on the second scheduled trading day immediately preceding the maturity date. Upon conversion, the

Notes may be settled in shares of Company common stock, cash or a combination of cash and shares of Company common stock, at the Company's election.

The Notes have an initial conversion rate of 62.4 shares of Company common stock per $1,000 principal amount of the Notes. The conversion rate will be subject to adjustment in certain events, including adjustment in the event of certain significant corporate transactions. This represents an initial conversion price of approximately $16.04 per share. The initial conversion price of the Notes represents a premium of approximately 25% to the closing price of the Company's common stock on November 14, 2024. The Company has used the proceeds from the sale of the Notes to repay in full the $215,000 aggregate principal amount, accrued interest and fees related to the Oxford term loans, as well as certain fees and expenses incurred in connection with the transaction.

The Indenture contains customary terms and covenants, including that upon certain events of default occurring and continuing, either the Trustee or the holders of at least 25% in principal amount of the outstanding notes may declare 100% of the principal of, and accrued and unpaid special interest, if any, on, all the notes to be due and payable.

The Company has recognized the Notes in their entirety as a liability on the consolidated balance sheet and no portion of the proceeds from the issuance of the convertible debt instrument was accounted for separately as an embedded conversion feature within stockholders' equity.

Future maturities under the term loan as of December 31, 2024 are as follows:

Period Ending December 31,	Amount
2025	—
2026	—
2027	—
2028	—
2029	330,000
Total	$ 330,000

9. Income Taxes

The reconciliation of income tax expense recorded in the consolidated statement of operations and amounts computed at the statutory federal income tax rate for the years ended December 31, 2024, 2023 and 2022, were as follows:

	December 31, 2024		December 31, 2023		December 31, 2022	
	Amount	Percentage	Amount	Percentage	Amount	Percentage
Loss before tax at statutory federal rate	$ (26,891)	21.0 %	$ (31,121)	21.0 %	$ (31,353)	21.0 %
Valuation allowance	25,677	(20.1)	29,426	(19.9)	82,922	(55.5)
State income tax - net of federal tax benefit	(5,771)	4.5	(5,173)	3.4	(58,286)	39.0
Nondeductible expenses	180	(0.1)	169	(0.1)	334	(0.2)
Equity-based compensation	—	—	—	—	—	—
Cumulative deferred adjustment and other	844	(0.7)	(947)	0.6	(1,510)	1.1
Provision to return adjustment	(2,721)	2.1	908	(0.6)	231	(0.2)
Nondeductible executive compensation	8,703	(6.8)	6,716	(4.5)	8,001	(5.4)
Net income tax expense (benefit)	$ 21	(0.1)%	$ (22)	0.1 %	$ 339	(0.2)%

The components of deferred income taxes as of December 31, 2024 and 2023, were as follows:

	December 31, 2024	December 31, 2023
Deferred tax assets:		
Federal and state net operating loss carryforwards	$ 169,044	$ 151,052
Employee benefits	56,693	49,650
Interest deduction limitation	11,661	12,019
Other	5,777	3,560
Gross deferred tax assets	243,175	216,281
Deferred tax liabilities:		
Intangibles	(1,404)	(476)
Depreciation	(214)	(1,052)
Lease liabilities	(2,105)	(2,755)
Other	(31)	(56)
Gross deferred tax liabilities	(3,754)	(4,339)
Net deferred tax assets	239,421	211,942
Valuation allowance	(239,421)	(211,942)
Net deferred taxes	$ —	$ —

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain federal and state net operating loss ("NOL") carryforwards. For the years ended December 31, 2024 and 2023, federal NOL carryforwards were $565,838 and $504,097, respectively. For the years ended December 31, 2024 and 2023, state NOL carryforwards were $543,513 and $498,933, respectively, and $374,188 of the total federal net operating loss carryforwards have an indefinite life while the remaining federal and state net operating loss carryforwards begin to expire in 2033 if not utilized.

Of the total NOL carryforwards, approximately $19,031 of federal and $13,221 of California NOL carryforwards relate to Alignment Health Plan, Inc. for which the utilization of the federal NOL carryforward is subject to a federal Section 382 limitation of $870 per year, and the utilization of the California NOL carryforwards is subject to a similar California annual limitation. In June 2020, California's Governor signed into law Assembly Bill ("AB") 85 suspending California NOL utilization for taxpayers with more than $1 million of taxable income, effective for tax years 2021, 2022, and 2023. AB 85 includes an extended carryover period for the suspended NOLs with an additional year carryforward for each year of suspension. Subsequently, on February 9, 2022, the California governor signed Senate Bill 113 (S.B. 113), which restores the NOL deduction and eliminates the $5 million annual cap on business incentive tax credits, effective for tax years beginning on or after January 1, 2022. In June 2024, California's Governor signed into law AB 167 suspending California NOL utilization for taxpayers with more than $1 million of taxable income, effective for tax years 2024, 2025, and 2026. AB 167 includes an extended carryover period for suspended NOLs that would have been utilized if not for AB 167.

We have cumulative NOLs as of December 31, 2024 and 2023. Given the history of losses, and after consideration for the risk associated with estimates of future taxable income, we established a full valuation allowance against net deferred tax assets at December 31, 2024 and 2023. Under the Tax Cuts and Jobs Act ("TCJA"), federal NOLs generated after 2017 will be carried forward indefinitely but are limited to an 80% deduction of taxable income. NOLs generated prior to 2018 have a 20-year carryforward period and can be used to offset 100% of taxable income. An exception to the TCJA federal NOL rule applies to certain of our subsidiaries and requires all NOLs generated from those entities to have a 20-year carryforward period and offset 100% of taxable income.

Additionally, an "ownership change" as defined under Section 382 of the Internal Revenue Code, could potentially limit the ability to utilize certain tax attributes including the Company's substantial NOLs. Ownership change is generally defined as any significant change in ownership of more than 50% of its stock over a three-year testing period. If, as a result of current or future transactions involving our common stock, we undergo cumulative ownership changes which exceed 50% over the testing period, our ability to utilize our NOL carryforwards would be subject to additional limitations under IRC Section 382. We continue to monitor changes in ownership with respect to these income tax provisions.

As of December 31, 2024 and 2023, there were no liabilities for unrecognized tax benefits.

10. Equity-Based Compensation

2021 Equity Incentive Plan

On March 25, 2021, our Board of Directors adopted the 2021 Equity Incentive Plan (the "2021 Plan"). Under the 2021 Plan, employees, consultants and directors of our Company and our affiliates that perform services for us are eligible to receive awards. The 2021 Plan provides for the grant of incentive stock options ("ISOs"), non-statutory stock options ("NSOs"), stock appreciation rights, restricted shares, performance awards, other share based awards (including restricted stock units) and other cash-based awards. ISOs may be granted only to employees, including officers. All other awards may be granted to employees, including officers, non-employee directors and consultants. The maximum number of shares available for issuance under the 2021 Plan may not exceed 20,744,444 shares (subject to a discretionary annual increase of up to 4% effective as of January 1 of each year for 10 years).

Equity Awards

Stock options

Our outstanding stock options generally vest 25% annually over four years and generally expire 10 years from the date of the grant. The 2021 Equity Incentive Plan provides that stock option grants will be made with an exercise price at no less than the estimated fair value of common stock at the date of the grant.

The following is a summary of the stock option transactions as of and for the years ended December 31, 2024, 2023 and 2022:

	Stock Options Outstanding			
	Shares Subject to Options Outstanding	Weighted- Average Exercise Price per Option	Weighted- Average Remaining Contractual Terms (in years)	Aggregate Intrinsic Value
Balances as of December 31, 2021	10,938,521	$ 18.02		
Options granted	1,370,211	9.10		
Options exercised	—	—		
Options forfeited / expired	(1,705,239)	17.80		
Balances as of December 31, 2022	10,603,493	16.90	8.30	3,519
Options granted	—	—		
Options exercised	—	—		
Options forfeited / expired	(1,467,614)	16.60		
Balances as of December 31, 2023	9,135,879	16.95	7.29	79
Options granted	—	—		
Options exercised	(17,662)	9.06		
Options forfeited / expired	(355,736)	16.82		
Balances as of December 31, 2024	8,762,481	16.97	6.29	2,250
Vested and Exercisable as of December 31, 2024	6,157,005	$ 17.29	6.25	1,099

Aggregate intrinsic value represents the difference between the exercise price of the option and the closing price of our common stock. The aggregate intrinsic value of options exercised for the years ended December 31, 2024 was $39. There were no options exercised during the years ended December 31, 2023 and 2022.

There were no options granted during the years ended December 31, 2024 and 2023. The fair value of options granted during the year ended December 31, 2022 was $5,685.

Restricted Stock Awards

Our outstanding RSAs generally vest 25% annually over four years. RSAs generally vest on the later of the fourth anniversary of the original vesting commencement date or 50% annually on the first and second anniversary of the initial public offering, which was effective March 25, 2021.

The following is a summary of RSA transactions as of and for the years ended December 31, 2024, 2023 and 2022:

	Restricted Shares	Weighted-Average Grant Date Fair Value
Unvested and outstanding as of December 31, 2021	8,613,780	$ 10.32
Vested	(3,553,232)	10.07
Forfeited	(370,107)	6.18
Unvested and outstanding as of December 31, 2022	4,690,441	$ 10.85
Vested	(3,916,030)	11.82
Forfeited	(90,458)	6.58
Unvested and outstanding as of December 31, 2023	683,953	$ 5.86
Vested	(627,491)	4.91
Forfeited	(6,270)	12.22
Unvested and outstanding as of December 31, 2024	50,192	$ 16.86

Restricted Stock Units

Our outstanding restricted stock units ("RSU") generally vest 25% annually over four years.

The following is a summary of RSU transactions as of and for the years ended December 31, 2024, 2023 and 2022:

	Restricted Stock Units	Weighted-Average Grant Date Fair Value
Unvested and outstanding as of December 31, 2021	1,662,282	$ 18.54
Granted	7,916,647	13.24
Vested	(479,177)	18.47
Forfeited	(370,816)	14.10
Unvested and outstanding as of December 31, 2022	8,728,936	$ 13.93
Granted	4,425,771	6.76
Vested	(1,875,329)	12.59
Forfeited	(737,753)	12.57
Unvested and outstanding as of December 31, 2023	10,541,625	$ 11.25
Granted	6,994,001	5.30
Vested [(1)]	(2,993,372)	8.37
Forfeited	(1,197,569)	8.17
Unvested and outstanding as of December 31, 2024	13,344,685	$ 9.05

(1) Includes 107,948 shares that vested, but the issuance and delivery of the shares was deferred.

Performance-based Restricted Stock Units ("PSUs")

On September 14, 2023, the Board of Directors of the Company approved the grant of performance-based restricted stock units under the Company's 2021 Equity Incentive Plan to its executive management team and other key employees. Each grantee is eligible to vest in a number of PSUs ranging from 0% to 150% of the target number of PSUs granted, based on the aggregated achievement by the Company of certain performance metrics during the performance period beginning on January 1, 2024 and ending on December 31, 2024. The achievement of PSUs relative to the approved target is based on the following performance metrics and relative weighting: Health Plan Revenue Growth Percentage (60%), At-Risk Returning Member Medical Benefit Ratio (20%) and Adjusted EBITDA, less Capital Expenditures (20%).

50% of the total number of earned PSUs will become vested upon certification of achievement of the performance metrics by the Compensation Committee on or about March 1, 2025 and the remaining 50% of earned PSUs will be become vested as of December 31, 2025, subject to continued service to the Company through such dates.

On March 13, 2024, the Compensation Committee of the Board of Directors of the Company approved additional grants of PSUs under the Company's 2021 Equity Incentive Plan. Each grantee is eligible to vest in a number of PSUs ranging from 0% to 200% of the target number of PSUs granted, based on the aggregated achievement by the Company of certain performance metrics during the performance period beginning on January 1, 2024 and ending on December 31, 2026. The achievement of PSUs relative to the approved target is based on the following performance metrics and relative weighting: Revenue 50% and Adjusted EBITDA 50%. 100% of the total number of earned PSUs will become vested upon certification of achievement of the performance metrics by the Compensation Committee on or about March 1, 2027, subject to continued service to the Company through such date.

The following is a summary of PSU transactions for the year ended December 31, 2024:

	Performance-based restricted stock units	Weighted-Average Grant Date Fair Value
Unvested and outstanding as of December 31, 2023	7,233,205	$ 5.74
Granted	1,160,000	5.00
Vested	—	—
Cancelled/forfeited	(318,334)	5.69
Unvested and outstanding as of December 31, 2024	8,074,871	$ 5.64

Equity-Based Compensation Expense

Total equity-based compensation expense was presented on the statement of operations as follows:

	Year Ended December 31,		
	2024	2023	2022
Selling, general and administrative expenses	$ 66,202	$ 59,294	$ 72,590
Medical expenses	4,930	7,541	9,128
Total equity-based compensation expense [1]	$ 71,132	$ 66,835	$ 81,718

As of December 31, 2024, there was $61,809 in unrecognized compensation expense related to all non-vested awards (RSAs, options and RSUs) that will be recognized over the weighted-average period of 1.55 years. As of December 31, 2023 and December 31, 2022, there was $98,004 and $120,241, respectively, in unrecognized compensation expense related to all non-vested awards (RSAs, options and RSUs) that will be recognized over the weighted-average period of 1.88 and 2.42 years, respectively.

11. Regulatory Requirements and Restricted Funds

Our health plans or risk-bearing entities are required to maintain minimum capital requirements prescribed by various regulatory authorities in each of the states in which it operates.

Risk-Based Capital Regulatory

The National Association of Insurance Commissioners has adopted rules, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital ("RBC") rules, which may vary from state to state. Certain states in which our health plans or risk bearing entities operate in have adopted the RBC rules. Our health plans or risk-bearing entities were in compliance with the minimum capital requirements for all periods presented.

Tangible Net Equity

Our health plan in California is required to comply with the tangible net equity ("TNE") requirements. The required amount is the larger of: (1) $1,000; (2) 2% of the first $150,000 of annualized premium revenue, plus 1% of annualized premium revenue in excess of $150,000; or (3) 8% of the first $150,000 of annualized health care expenditures, except for those paid on a capitated or managed hospital payment basis, plus 4% of the annualized health care expenditures in excess of $150,000, except those paid on a capitated or managed hospital payment basis, plus 4% of annualized hospital expenditures paid on a managed hospital payment basis. We were in compliance with the TNE requirement for all periods presented.

We have the ability to provide additional capital to each of our health plans or risk-bearing entities when necessary to ensure that the RBC and TNE requirements are met.

Certain states regulate the payment of dividends, loans, or other cash transfers from our regulated subsidiaries to our non-regulated subsidiaries and parent company. Such payments may require approval by state regulatory authorities and are limited based on certain

financial criteria, such as the entity's level of statutory income and statutory capital and surplus, or the entity's level of tangible net equity or net worth, among other measures. These regulations vary by state. Our state regulated subsidiaries had aggregate regulatory capital of approximately $156,167 and $111,967 as of December 31, 2024 and 2023, respectively, which exceeded aggregate minimum regulatory requirements of $75,212 and $48,326, respectively. The amount of undistributed dividends from our regulated subsidiaries that may be paid out to our parent without regulatory approval was $46,785 and $24,349 as of December 31, 2024 and 2023, respectively. We were in compliance with the RBC and TNE requirements as of December 31, 2024.

Restricted Assets

Pursuant to the regulations governing our subsidiaries, we maintain certain deposits required by the government authorities in the form of cash, certificates of deposit and Treasury bills as protection in the event of insolvency. The use of funds from these investments is limited as required by regulation in the various states in which we operate, or as needed in the event of insolvency. Therefore, these deposits are reported within other assets on the consolidated balance sheets.

We hold these assets until maturity, at which time these assets will renew or are invested in a similar type of investment instrument. Given the regulatory requirements, we expect to hold these investments for long-term. As a result, we do not expect the value of these investments to decline significantly due to a sudden change in market interest rates. These investments are carried at amortized cost, which approximates fair value. See note 3, Fair Value, for further discussion.

12. Leases

Our leases are primarily for our corporate office, including parking spaces, and healthcare services operating facilities and expire at various intervals up through 2030. The majority of our leases contain renewal options, some of which include options to extend the lease for up to five years per option.

The majority of our leases are comprised of fixed payments. When certain portions of the lease payments are not fixed, we consider those payments to be variable in nature. These variable lease payments include, but are not limited to, common area maintenance, parking, taxes and insurance. These variable payments are not included in the ROU asset or lease liability and are recorded within selling, general and administrative expenses in the consolidated statement of operations and are recorded based upon actual costs in the period incurred.

Certain leases also contain rent escalation clauses that require additional rental amounts in the later years of the term. Rent expense for leases with rent escalation is recognized on a straight-line basis over the minimum lease term. The lease agreements do not contain any material residual value guarantees or material restrictive covenants.

At December 31, 2024, $7,818 of operating ROU assets were recorded as right of use assets on the consolidated balance sheets. Lease liabilities of $1,212 and $7,835 were included in accounts payable and accrued expenses and long-term lease liabilities, respectively. At December 31, 2023, $9,959 of operating ROU assets were recorded as right of use assets on the consolidated balance sheets. Lease liabilities of $1,717 and $8,974 were included in accounts payable and accrued expenses and long-term lease liabilities, respectively.

The following table summarizes total fixed operating lease costs and variable operating lease cost, excluding short-term lease and finance lease costs, for the years ended December 31, 2024, 2023, and 2022:

	Year Ended December 31,		
	2024	2023	2022
Fixed operating lease costs	$ 2,592	$ 2,817	$ 3,415
Variable operating lease costs	404	431	352
Total operating leases costs	$ 2,996	$ 3,248	$ 3,767

Fixed and variable operating leases costs are included within selling, general and administrative expenses in the consolidated statement of operations. Short term and finance lease costs were immaterial. For the year-ended December 31, 2024, 2023 and 2022, cash paid for amounts included in the measurement of lease liabilities included within our operating cash flows was $1,525, $3,510 and $4,214, respectively.

Lease liabilities are based on the net present value of the remaining lease payments over the remaining lease term. In determining the present value of lease payments, the Company used its incremental borrowing rate based on the information available at the lease commencement date.

The weighted average remaining lease term for operating leases is 4.4 years with a weighted average discount rate 12.0% at December 31, 2024.

In the year ended December 31, 2024, $26 and $0 of operating lease and finance lease assets, respectively, were exchanged for lease liabilities related to newly commenced leases.

The following table summarizes our lease assets and liabilities as of December 31, 2024 and 2023:

	December 31, 2024	December 31, 2023
Lease assets		
Operating lease assets	$ 7,818	$ 9,819
Finance lease assets	—	140
Total lease assets	$ 7,818	$ 9,959
Lease liabilities		
Current		
Operating lease liabilities	1,212	1,597
Finance lease liabilities	—	120
Non-current		
Operating lease liabilities	7,835	8,974
Finance lease liabilities	—	—
Total lease liabilities	$ 9,047	$ 10,691

Maturities of lease liabilities under operating leases by fiscal year are as follows:

	As of December 31, 2024
2025	$ 2,122
2026	2,578
2027	2,335
2028	2,184
2029 and thereafter	2,681
Total lease payments	$ 11,900
Less: Interest	2,853
Present value of lease liabilities	$ 9,047

We sublease space not used in our operations. For the years ended December 31, 2024, 2023 and 2022, sublease income was $206, $565, and $393, respectively. For the year ended December 31, 2024, we recorded ROU asset impairment of $143. We recorded no ROU asset impairment for the year ended December 31, 2023, and there was $510 of ROU asset impairment recorded for the year ended December 31, 2022.

13. Employee Benefit Plans

All full-time employees are eligible to participate in a 401(k) plan that we sponsor upon completing 90 days of services. Eligible employees are permitted to contribute up to the maximum amount allowed by law. We match 100% of contributions not exceeding 4% of the employee's compensation. We made matching contributions of $3,798, $3,471, and $2,599 during 2024, 2023, and 2022, respectively, and were included within medical expenses and selling, general, and administrative expenses in the consolidated statement of operations.

14. Commitments and Contingencies

Legal Proceedings

We record a liability and accrue the costs for a loss when an unfavorable outcome is probable and the amount of the loss can be reasonably estimated. In some cases, no estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made because of the inherently unpredictable nature of legal and regulatory proceedings. While the liability and accrued costs reflect our best estimate, the actual amounts may materially be different.

On April 27, 2022, a former employee of the Company filed a purported class action lawsuit (Dabney v. Alignment Healthcare USA, LLC, Orange County Superior Court) alleging that the Company failed to provide hourly employees with required meal and rest breaks or pay such workers a premium equal to an hour of pay for missed meal or rest breaks. Discovery in the matter commenced on June 8, 2022. On September 2, 2022, the court granted a stay of proceedings and discovery in anticipation of mediation scheduled for August 2023. On August 15, 2023, the Company entered into a tentative settlement of the action in consideration of an aggregate payment of

$913. The settlement of this matter is subject to approval by the court which is expected in the first quarter of 2025. As a result of the tentative settlement, the Company has accrued for a potential liability of $913 as of December 31, 2024 for this matter, which was recorded within accounts payable and accrued expenses on the consolidated balance sheet and selling, general and administrative expenses on the consolidated statement of operations.

On July 7, 2023, a stockholder of Alignment filed a purported class action lawsuit (Maglione v. Alignment Healthcare, Inc., et al, Delaware Chancery Court). The plaintiff alleged that certain provisions of Alignment's stockholder agreement with General Atlantic ("GA") and Warburg Pincus violate Delaware law. On April 30, 2024, the Company agreed to amend the stockholder agreement to eliminate the provisions challenged by the Maglione plaintiff. On May 24, 2024, the parties filed a stipulation and proposed order voluntarily dismissing the action as moot, which the court granted. Pursuant to the order, the court retained jurisdiction regarding attorneys' fees.

The Company has entered into discussions with plaintiffs' counsel to negotiate with respect to attorney's fees. Plaintiff's counsel made a settlement demand and the Company presented a counteroffer that was rejected by plaintiff's counsel. Negotiations remain ongoing. The Company expects losses related to this case to be immaterial.

We may be involved in various litigation matters in the ordinary course of business. In the opinion of management, the ultimate resolution of legal proceedings is not expected to have a material adverse effect on the consolidated financial statements. Amounts accrued for legal proceedings were not material as of December 31, 2024 and 2023.

Purchase Obligations

We have agreements for goods and services which include fixed, minimum and estimated payments under existing contractual obligations that are legally enforceable and binding. These obligations include agreements that are cancellable with the payment of an early termination penalty and other funding commitments that require fixed or minimum levels of service to be purchased with a specific timing established. Purchase obligations exclude agreements that are cancellable without penalty.

Professional Liability Insurance

We maintain coverage for professional liability, errors and omissions, directors and officers, employment practices liability insurance, and worker's compensation. The professional liability insurance policy is claims based while the other insurance policies are occurrence based. Such policies provide coverage for our employees, certain covered physicians, loss of income due to potential business interruption, and possible destruction or theft of assets. There have not been any reductions in coverage nor have there been any claims, which have exceeded such coverage(s) for the year ended December 31, 2024 and 2023.

Medical Reinsurance (Stop-Loss insurance)

We utilize medical insurance (or stop-loss agreements) to limit excess losses on individual members. Under the terms of the stop-loss agreements, we are reimbursed for certain proportions of the cost of each member's hospital expenses in excess of a specified deductible in a coverage period, limited to $2,000 in aggregate per member per coverage period. In 2024, all of our markets were covered by stop-loss agreements which included dates of service prior to October 1, 2024, and we have until April 30, 2025, to submit claims to the reinsurance carrier for reimbursement.

We began a new policy on October 1, 2024, which will cover dates of service through September 30, 2025, and will allow us to submit claims for reimbursement through November 31, 2026. The new policy includes both professional and hospital expenses in the calculation against the specified deductibles and removes the recovery limit of $2,000 in aggregate per member per policy period.

Reinsurance premiums are included in medical costs in the consolidated statement of operations.

In the event that the third-party with whom we have contracted is unable to meet its obligations under the stop-loss agreement, we remain 100% liable for paying such claim amounts submitted.

Related Parties

Joseph Konowiecki currently serves as Chairman of the Board and previously served in an executive role with the Company. Mr. Konowiecki's son is a partner in the law firm of McDermott Will & Emery LLP ("MWE"), which provided legal services to the Company and our subsidiaries during the fiscal years ended December 31, 2024, 2023 and 2022 and continues to do so. For providing these services, MWE received fees related to the fiscal years ended December 31, 2024, 2023 and 2022 of approximately $272, $518 and $1,326, respectively. Mr. Konowiecki's son does not receive any direct compensation from the fees paid to MWE by us, and the fees paid by us to MWE in fiscal 2024 were considered immaterial to the service provider.

15. Condensed Financial Information (Parent Company Only)

Certain subsidiaries are subject to state regulatory restrictions which set minimum capitalization requirements and require us to maintain certain deposits in the form of cash, certificates of deposit and Treasury bills as protection in the event of insolvency. Refer to Note 11 Regulatory Requirements and Restricted Funds for more information. Since the restricted net assets of our subsidiaries exceed 25% of

our consolidated net assets, the accompanying condensed parent company financial statements have been prepared in accordance with Rule 12-04, Schedule 1 of Regulation S-X. This information should be read in conjunction with our consolidated financial statements.

Alignment Healthcare, Inc.
(Parent Company Only)
Condensed Balance Sheets

	December 31, 2024	December 31, 2023
Assets		
Investment in subsidiary	$ 425,033	$ 158,265
Total assets	$ 425,033	$ 158,265
Liabilities and Stockholders' Equity		
Due to subsidiary	1,762	1,319
Accrued expenses	1,992	—
Long-term debt, net of debt issuance costs	321,428	—
Total liabilities	$ 325,182	$ 1,319
Commitments and Contingencies (Note 14)		
Stockholders' Equity:		
Preferred stock, $.001 par value; 100,000,000 shares authorized as of December 31, 2024 and 2023, respectively; no shares issued and outstanding as of December 31, 2024 and 2023	—	—
Common stock, $.001 par value; 1,000,000,000 shares authorized as of December 31, 2024 and December 31, 2023; 191,778,639 and 188,951,643 shares issued and outstanding as of December 31, 2024 and December 31, 2023, respectively	192	189
Additional paid-in-capital	1,107,952	1,037,015
Accumulated deficit	(1,008,293)	(880,258)
Total Alignment Healthcare, Inc. stockholders' equity	99,851	156,946
Total liabilities and stockholders' equity	$ 425,033	$ 158,265

Alignment Healthcare, Inc.
(Parent Company Only)
Condensed Statements of Operations

	Year Ended December 31,		
	2024	2023	2022
Revenues:			
Total revenues	$ —	$ —	$ —
Expenses:			
Selling, general, and administrative expenses	443	488	438
Total expenses	443	488	438
Loss from operations	(443)	(488)	(438)
Other expenses:			
Interest expense	1,700	—	—
Total other expenses	1,700	—	—
Loss before income taxes	(2,143)	(488)	(438)
Provision for income taxes	—	—	—
Net loss of Parent Company	(2,143)	(488)	(438)
Subsidiary's net loss	(125,928)	(147,685)	(149,201)
Net loss	(128,071)	(148,173)	(149,639)
Less: Net loss attributable to noncontrolling interest	36	156	92
Net loss attributable to Alignment Healthcare, Inc.	$ (128,035)	$ (148,017)	$ (149,547)

Alignment Healthcare, Inc.
(Parent Company Only)
Condensed Statements of Cash Flows

	Year Ended December 31,		
	2024	2023	2022
Operating Activities:			
Net loss attributable to Alignment Healthcare, Inc.	$ (128,035)	$ (148,017)	$ (149,547)
Adjustments to reconcile net loss to net cash used in operating activities:			
Equity in loss of subsidiary	125,892	147,529	149,109
Amortization of debt issuance costs	220	—	—
Changes in operating assets and liabilities:			
Due to subsidiary	1,923	488	438
Net cash provided by operating activities	—	—	—
Investing Activities:			
Investment in Subsidiary	(321,525)	—	—
Net cash used in investing activities	(321,525)	—	—
Financing Activities:			
Shares withheld net of restricted stock	(350)	—	—
Stock options exercised	155	—	—
Proceeds from long-term debt	330,000	—	—
Debt issuance costs	(8,280)	—	—
Net cash provided by financing activities	321,525	—	—
Net (decrease) increase in cash	—	—	—
Cash, cash equivalents and restricted cash at beginning of period	—	—	—
Cash, cash equivalents and restricted cash at end of period	$ —	$ —	$ —
Supplemental non-cash financing and investing activities:			
Contribution of equity to subsidiary related to equity-based compensation	$ 71,132	$ 66,835	$ 81,718
Distribution from subsidiary	$ —	$ —	$ 85
Debt issuance costs in accounts payable	$ 512	$ —	$ —

Basis of Presentation

Alignment Healthcare, Inc's. (the "Parent") parent company financial information has been derived from our consolidated financial statements and have been presented on a "parent-only" basis. Under a parent-only presentation, the investment in subsidiaries is presented under the equity method of accounting. The accounting policies for the parent company are the same as those described in Note 2 Summary of Significant Accounting Policies. The Parent is a holding company with no material operations of its own that conducts substantially all of its activities through its subsidiaries. The Parent has no cash and, as a result, expenses and obligations of the Parent are allocated to and paid by its subsidiaries. The accompanying condensed financial information of the Parent should be read in conjunction with the consolidated financial statements and accompanying notes.

Investment in Subsidiary

For purposes of these condensed financial statements, our wholly owned subsidiaries are recorded using the equity method of accounting. Investment in subsidiary represents capital contributions to subsidiaries and return of capital from our subsidiaries to us.

The Parent and its subsidiaries are included in the consolidated federal and state income tax returns filed by the Parent. Income taxes are allocated to each subsidiary in an amount equivalent to the amount which would be recognized by the subsidiary if it filed a separate tax return.

Commitments and Contingencies

Alignment Healthcare, Inc., along with certain other subsidiaries, is a guarantor of the Term Loans discussed in Note 8 Long-Term Debt. The Terms Loans were repaid in full in November 2024.

For a summary of additional commitments and contingencies, see Note 14 Commitments and Contingencies.

Long-Term Debt

On November 22, 2024, Alignment Healthcare Inc. completed the sale of $330,000 of its 4.25% Convertible Senior Notes. See Note 8 Long-Term Debt for further discussion.

Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure.

None.

Item 9A. Controls and Procedures.

Evaluation of Disclosure Controls and Procedures:

Under the supervision and with the participation of our management, including the Chief Executive Officer and Chief Financial Officer, we have evaluated the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act"), as of the end of the period covered by this report. Based on that evaluation, the Chief Executive Officer and Chief Financial Officer have concluded that these disclosure controls and procedures were effective at the reasonable assurance level as of December 31, 2024.

In designing and evaluating our disclosure controls and procedures, management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving the desired control objectives and management necessarily applies its judgment in evaluating the cost-benefit relationship of possible controls and procedures.

Management's Annual Report on Internal Control Over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as defined in Rules 13a-15(f) and 15d-15(f) of the Exchange Act. 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 reporting purposes in accordance with generally accepted accounting principles. Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate or that the degree of compliance with the policies or procedures may deteriorate.

Our management, including our Chief Executive Officer and Chief Financial Officer, conducted an evaluation of the effectiveness of our internal control over financial reporting as of December 31, 2024 based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission in 2013. Based on the results of this evaluation, our management concluded that our internal control over financial reporting was effective as of December 31, 2024.

The effectiveness of our internal control over financial reporting as of December 31, 2024 has been audited by our independent registered public accounting firm, as stated in their attestation report, which is included herein.

Changes to our Internal Controls over Financial Reporting:

There were no material changes in our internal control over financial reporting during the year ended December 31, 2024 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting. The majority of our work force works in a hybrid-remote fashion. We have not identified any impact in our internal control over financial reporting as a result of this working environment, in part because our internal control over financial reporting was designed to operate in a remote working environment. We are continually monitoring and assessing our remote working arrangements to determine any potential impact on the design and operating effectiveness of our internal controls over financial reporting

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the stockholders and the Board of Directors of Alignment Healthcare, Inc.:

Opinion on Internal Control over Financial Reporting

We have audited the internal control over financial reporting of Alignment Healthcare, Inc. and subsidiaries (the "Company") as of December 31, 2024, based on criteria established in *Internal Control — Integrated Framework (2013)* issued by the Committee of

Sponsoring Organizations of the Treadway Commission (COSO). In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2024, based on criteria established in *Internal Control — Integrated Framework (2013)* issued by COSO.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated financial statements as of and for the year ended December 31, 2024, of the Company and our report dated February 27, 2025 expressed an unqualified opinion on those financial statements.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Annual Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of the financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of the financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ Deloitte & Touche LLP

Costa Mesa, California
February 27, 2025

Item 9B. Other Information.

Rule 10b5-1 Plans

During the fiscal quarter ended December 31, 2024, our executive officers and directors adopted the following trading arrangements that are intended to satisfy the affirmative defense of Rule 10b5-1(c):

Name and Title	Date of Adoption	Date of Termination	Duration of Trading Arrangement	Number of Securities to be Sold[1]
Dawn Maroney, President	11/25/2024	N/A	4/14/2025 - 8/22/2025	350,000
Thomas Freeman, Chief Financial Officer[2]	11/25/2024	N/A	2/28/2025 - 11/28/2025	352,793
Thomas Freeman, Chief Financial Officer[2]	N/A	11/20/2024	3/14/2024 - 6/13/2025	518,000
Christopher Joyce, Chief Legal & Administrative Officer	11/27/2024	N/A	2/26/2025 - 11/14/2025	50,678

(1) Securities reported in this column include securities subject to limit orders and such orders may not fill if limit order conditions are not met. The actual number of shares sold under the plan will depend on the vesting of certain performance-based equity awards and the

number of shares withheld or sold satisfy our income tax withholding obligations and may vary from the number provided herein. Number of performance share units included in plans assumes earned at target.

(2) Represents securities held by FCO Holdings LLC, a limited liability company owned by FCO Holdings Trust One, an irrevocable trust of which Mr. Freeman is an indirect beneficiary.

Item 9C. Disclosure Regarding Foreign Jurisdictions that Prevent Inspections.

Not applicable.

PART III

Item 10. Directors, Executive Officers and Corporate Governance.

The information required by this Item will be included in our definitive proxy statement for the 2025 Annual Meeting of Stockholders under the headings "Election of Directors," "Executive Officers," "Commonly Asked Questions and Answers About the Annual Meeting," and "Corporate Governance," and is incorporated herein by reference.

We have adopted a code of ethics and business conduct that applies to all employees, including our Chief Executive Officer (our principal executive officer) and Chief Financial Officer (our principal financial officer), and employees, as well as each member of our Board of Directors. The code of ethics and business conduct is available on our website at www.alignmenthealth.com under the Investor Relations section. We intend to satisfy any disclosure requirement under Item 5.05 of Form 8-K regarding an amendment to, or waiver from, a provision of the code of ethics by posting such information on our website, at the address specified above.

We maintain insider trading policies and procedures governing the purchase, sale, and/or other dispositions of our company's securities by directors, officers, employees and other covered persons that we believe are reasonably designed to promote compliance with insider trading laws, rules, and regulations, as well as Nasdaq listing standards. A copy of our insider trading policy is filed as Exhibit 19 to this Annual Report on Form 10-K.

Item 11. Executive Compensation.

The information required by this Item will be included in our definitive proxy statement for the 2025 Annual Meeting of Stockholders under the headings "Compensation Discussion and Analysis" and "Executive and Director Compensation," and is incorporated herein by reference.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.

The information required by this Item will be included in our definitive proxy statement for the 2025 Annual Meeting of Stockholders under the heading "Security Ownership of Certain Beneficial Owners and Management," and is incorporated herein by reference.

Item 13. Certain Relationships and Related Transactions, and Director Independence.

The information required by this Item will be included in our definitive proxy statement for the 2025 Annual Meeting of Stockholders under the headings "Certain Relationships and Related Party Transactions" and "Corporate Governance" and is incorporated herein by reference.

Item 14. Principal Accounting Fees and Services.

The information required by this Item will be included in our definitive proxy statement for the 2025 Annual Meeting of Stockholders under the heading "Ratification of Appointment of Independent Registered Public Accounting Firm," and is incorporated herein by reference.

PART IV

Item 15. Exhibits, Financial Statement Schedules.

The following documents are filed as a part of this report:

(a) (1) *Financial Statements:* The Financial Statements described in Part II. Item 8 and beginning on page 67 are filed as part of this Annual Report on Form 10-K.

(a) (3) *Exhibits:* The following exhibits are filed or furnished with or incorporated by reference this Annual Report on Form 10-K.

Exhibit Number	Description
3.1	Amended and Restated Certificate of Incorporation of Alignment Healthcare, Inc. (incorporated by reference to Exhibit 3.1 to the Company's Form 8-K filed on March 30, 2021).
3.2	Certificate of Amendment to Amended and Restated Certificate of Incorporation dated June 11, 2024 (incorporated by reference to Exhibit 99.1 to the Company's Form 8-K filed on June 13, 2024)
3.3	Amended and Restated Bylaws of Alignment Healthcare, Inc. (incorporated by reference to Exhibit 3.2 to the Company's Form 10-K filed on February 27, 2024).
4.1	Registration Rights Agreement, dated as of March 30, 2021, among Alignment Healthcare, Inc. and the other signatories party thereto (incorporated by reference to Exhibit 4.1 to the Company's Form 8-K filed on March 30, 2021).
4.2	Description of Capital Stock (incorporated by reference to Exhibit 4.2 to the Company's Form 10-K filed on March 3, 2022).
4.3	Indenture dated November 22, 2024, by and among the Company, U.S. Bank Trust Company, National Association, as trustee, governing the 4.25% Convertible Senior Notes due 2029 (incorporated by reference to Exhibit 4.1 to the Company's Form 8-K filed on November 25, 2024).
10.1	Term Loan Agreement, dated as of September 2, 2022, by and among Alignment Healthcare, Inc., Alignment Healthcare USA, LLC, as borrower, certain other subsidiaries of the Company, the lenders from time to time party thereto and Oxford Finance LLC, as administrative agent and collateral agent (incorporated by reference to Exhibit 10.1 to the Company's Form 10-Q filed on November 3, 2022).
10.2	Security Agreement, dated as of September 2, 2022, by and among Alignment Healthcare USA, the other grantors from time to time party thereto and Oxford Finance LLC, as administrative agent and collateral agent (incorporated by reference to Exhibit 10.2 to the Company's Form 10-Q filed on November 3, 2022).
10.3	Amendment No. 1 to Term Loan Agreement and Amendment No. 1 to Security Agreement dated January 30, 2023 (incorporated by reference to Exhibit 10.3 to the Company's Form 10-K filed on February 28, 2023).
10.4	Form of Director and Officer Indemnification Agreement (incorporated by reference to Exhibit 10.6 to the Company's Form S-1 filed on March 23, 2021).
10.5+	Alignment Healthcare Holdings, LLC Stock Appreciation Rights Plan (incorporated by reference to Exhibit 10.7 to the Company's Form S-1 filed on March 3, 2021).
10.6+	Alignment Healthcare, Inc. 2021 Equity Incentive Plan (incorporated by reference to Exhibit 10.2 to the Company's Form 8-K filed on March 30, 2021).
10.7+	Amended & Restated Employment Agreement of John E. Kao dated March 26, 2021 (incorporated by reference to Exhibit 10.9 to the Company's Form 10-Q filed on May 17, 2021).
10.8+	Amended & Restated Employment Agreement of Dawn Maroney dated March 26, 2021 (incorporated by reference to Exhibit 10.10 to the Company's Form 10-Q filed on May 17, 2021).
10.9+	Amended & Restated Employment Agreement of Thomas Freeman dated March 26, 2021 (incorporated by reference to Exhibit 10.11 to the Company's Form 10-Q filed on May 17, 2021).
10.10+	Employment Agreement of Joseph Konowiecki dated October 31, 2022 (incorporated by reference to Exhibit 10.3 to the Company's Form 10-Q filed on November 3, 2022).
10.11+	Amendment to Employment Agreement of Joseph Konowiecki dated December 27, 2023 (incorporated by reference to Exhibit 10.1 to the Company's Form 8-K filed on December 29, 2023).
10.12+	Employment Agreement of Hyong (Ken) Kim, M.D. dated as of September 25, 2023 (incorporated by reference to Exhibit 10.1 to the Company's Form 8-K filed on September 6, 2023).
10.13+*	Employment Agreement of Hakan Kardes dated as of April 11, 2021.
10.14+	Consulting Agreement by and between Alignment Healthcare USA, LLC and Jeffrey Margolis, dated as of August 13, 2024 (incorporated by reference to Exhibit 10.1 to the Company's Form 8-K filed on August 16, 2024)..
10.15+	Form of Option Award Agreement (incorporated by reference to Exhibit 10.16 to the Company's Form S-1 filed on March 23, 2021).

10.16+	Form of Restricted Shares Award Agreement (incorporated by reference to Exhibit 10.17 to the Company's Form S-1 filed on March 23, 2021).
10.17+	Form of RSU Award Agreement (incorporated by reference to Exhibit 10.18 to the Company's Form S-1 filed on March 23, 2021).
10.18+	Form of Option Award Agreement (Senior Executives) (incorporated by reference to Exhibit 10.19 to the Company's Form S-1 filed on March 23, 2021).
10.19+	Form of RSU Award Agreement (Senior Executives) (incorporated by reference to Exhibit 10.20 to the Company's Form S-1 filed on March 23, 2021).
10.20+	Form of Performance Share Unit Award Agreement (incorporated by reference to Exhibit 10.1 to the Company's Form 8-K filed on September 15, 2023).
10.21	Form of CMS Agreement (incorporated by reference to Exhibit 10.14 to the Company's Form S-1 filed on March 3, 2021).
10.22	Amended & Restated Stockholders Agreement, dated as of April 30, 2024, among Alignment Healthcare, Inc. and the other signatories party thereto (incorporated by reference to Exhibit 10.1 to the Company's Form 10-Q filed on May 2, 2024).
19*	Alignment Healthcare, Inc. Insider Trading Policy
21.1*	List of Subsidiaries of Alignment Healthcare, Inc.
23.1*	Consent of Independent Registered Public Accounting Firm
31.1*	Certification of Principal Executive Officer Pursuant to Rules 13a-14(a) and 15d-14(a) under the Securities Exchange Act of 1934, as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2*	Certification of Principal Financial Officer Pursuant to Rules 13a-14(a) and 15d-14(a) under the Securities Exchange Act of 1934, as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1**	Certification of Principal Executive Officer Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2**	Certification of Principal Financial Officer Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
97+	Alignment Healthcare, Inc. Clawback Policy (incorporated by reference to Exhibit 97 to the Company's Form 10-K filed on February 27, 2024).
101.INS*	Inline XBRL Instance Document – the instance document does not appear in the Interactive Data File because XBRL tags are embedded within the Inline XBRL document.
101.SCH*	Inline XBRL Taxonomy Extension Schema Document
101.CAL*	Inline XBRL Taxonomy Extension Calculation Linkbase Document
101.DEF*	Inline XBRL Taxonomy Extension Definition Linkbase Document
101.LAB*	Inline XBRL Taxonomy Extension Label Linkbase Document
101.PRE*	Inline XBRL Taxonomy Extension Presentation Linkbase Document
104*	Cover Page Interactive Data File (embedded within the Inline XBRL document)

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* Filed herewith.

** Furnished herewith

\+ Indicates management contract or compensatory plan.

Item 16. Form 10-K Summary.

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, as amended, the Registrant has duly caused this Report to be signed on its behalf by the undersigned, thereunto duly authorized.

Alignment Healthcare, Inc.

Date: February 27, 2025 By: /s/ John Kao

John Kao
Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, this Report has been signed below by the following persons on behalf of the Registrant in the capacities and on the dates indicated.

Signature	Title	Date
/s/ John Kao **John Kao**	Chief Executive Officer (Principal Executive Officer)	February 27, 2025
/s/ Thomas Freeman **Thomas Freeman**	Chief Financial Officer (Principal Financial Officer)	February 27, 2025
/s/ Joseph Konowiecki **Joseph Konowiecki**	Chairman of the Board	February 27, 2025
/s/ Jody Bilney **Jody Bilney**	Director	February 27, 2025
/s/ David Hodgson **David Hodgson**	Director	February 27, 2025
/s/ Yon Jorden **Yon Jorden**	Director	February 27, 2025
/s/ Jacqueline Kosecoff **Jacqueline Kosecoff**	Director	February 27, 2025
/s/ Margaret McCarthy **Margaret McCarthy**	Director	February 27, 2025
/s/ Mark McClellan **Mark McClellan**	Director	February 27, 2025
/s/ Robbert Vorhoff **Robbert Vorhoff**	Director	February 27, 2025