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

FORM 10-Q

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

For the quarterly period ended September 30, 2022

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: **001-33071**

EHEALTH, INC.

(Exact name of registrant as specified in its charter)

Delaware	**56-2357876**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

2625 AUGUSTINE DRIVE, SUITE 150
SANTA CLARA, CA 95054
(Address of principal executive offices)

(650) 210-3150
(Registrant's telephone number, including area code)

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

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

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 x No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulations 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 x No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a 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 is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The number of shares of the registrant's common stock, par value $0.001 per share, outstanding as of October 31, 2022 was 27,422,321 shares.

EHEALTH, INC.
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Summary of Risk Factors

The following is a summary of the principal risks we face, any of which could adversely affect our business, operating results, financial condition or prospects:

- If our ability to enroll individuals during enrollment periods is impeded or if investments we make in enrollment periods do not result in the returns we expected when making those investments, our business, operating results and financial condition would be harmed.
- We may be unsuccessful in competing effectively against current and future competitors, including government-run health insurance exchanges.
- Our business may be harmed if we lose our relationship with health insurance carriers or our relationship with health insurance carriers is modified.
- Our financial results will be adversely impacted if our membership does not grow or if member retention does not improve and plan terminations do not decline.
- If we are not able to maintain and enhance our brand, our business and operating results will be harmed.
- The ongoing COVID-19 pandemic and other public health crises, illness, epidemics or pandemics could adversely impact our business, operating results and financial condition.
- Changes in our management and key employees could affect our business and financial results.
- Our business may be harmed if we are not successful in executing on our strategic plans, including our growth strategy, cost-saving and enrollment quality initiatives.
- Our failure to effectively manage our operations and maintain our company culture as our business evolves and our work practices change could harm us.
- Seasonality may cause fluctuations in our financial results, and if we are not successful in responding to changes in the seasonality of our business, our business, operating results and financial condition could be harmed.
- The success of our customer care center operations depends upon our ability to timely hire, train, retain and ensure the productivity of our licensed health insurance agents.
- We rely on multiple channels, including the Internet, telephone, mail, email, marketing partners and other channels, to market our services and to communicate with qualified prospects and our existing customers. If we are unable to successfully provide a relevant and reliable experience in a cost-effective manner to attract and convert such prospects into members for whom we receive commissions and retain our existing customers, our business, operating results and financial condition would be harmed.
- We rely significantly on marketing partners and our business and operating results would be harmed if we are unable to maintain effective relationships with our existing marketing partners or if we do not establish successful relationships with new marketing partners.
- Our future operating results are likely to fluctuate and could fall short of expectations, which could negatively affect the value of our common stock.
- If commission reports we receive from carriers are inaccurate or not sent to us in a timely manner, our business and operating results could be harmed and we may not recognize trends in our membership.
- We do not receive information about membership cancellations from our health insurance carriers directly, which makes it difficult for us to determine the impact of current conditions on our membership retention and to accurately estimate membership as of a specific date.
- If our carrier advertising and sponsorship program are not successful, our business, operating results and financial condition could be harmed.
- Our operations in China involve many risks that could increase expenses, expose us to increased liability and adversely affect our business, operating results and financial condition.
- Our success in selling Medicare-related health insurance will depend upon a number of factors some of which are outside of our control.

- The marketing and sale of Medicare plans are subject to numerous, complex and frequently changing laws, regulations and guidelines, and non-compliance with or changes in laws, regulations and guidelines could harm our business, operating results and financial condition.
- Changes and developments in the health insurance industry or system could harm our business, operating results and financial condition.
- From time to time we are subject to various legal proceedings which could adversely affect our business.
- Our success in selling health insurance is dependent in part on the actions of federal and state governments. Changes in the laws and regulations governing the offer, sale and purchase of health insurance could harm our business and operating results.
- If we fail to comply with the numerous laws and regulations that are applicable to the sale of health insurance, our business and operating results could be harmed.
- Our business is subject to emerging privacy laws being passed at the state level that create unique compliance challenges. Increasing regulatory focus on privacy and security issues and expanding laws could impact our business and expose us to increased liability.
- Any legal liability, regulatory penalties, complaints or negative publicity related to the information on our website or that we otherwise provide could harm our business and operating results.
- Our operating results will be impacted by factors that impact our estimate of the constrained LTV of commissions per approved member.
- Our debt and preferred stock obligations contain restrictions that impact our business and expose us to risks that could materially adversely affect our liquidity and financial condition.
- Operating and growing our business is likely to require additional capital, and if capital is not available to us, our business, operating results and financial condition may suffer.
- Our ability to sell Medicare-related health insurance plans as a health insurance agent depends upon maintenance of functioning information technology systems.
- System failures or capacity constraints could harm our business and operating results.
- Our business is subject to security risks and, if we experience a successful cyberattack, a security breach or are otherwise unable to safeguard the confidentiality and integrity of the data we hold, including sensitive personal information, our business will be harmed.
- We may not be able to adequately protect our intellectual property, which could harm our business and operating results.
- Consumers and our employees depend upon third-party service providers to access our website, services and systems, and our business and operating results could be harmed as a result of technical difficulties experienced by these service providers.
- Our actual operating results may differ significantly from our guidance.
- The price of our common stock has been and may continue to be volatile, and the value of your investment could decline.
- Our Series A preferred stock has rights, preferences and privileges that are not held by, and are preferential to, the rights of our common stockholders, which could adversely affect our liquidity and financial condition, result in the interests of holders of our Series A preferred stock differing from those of our common stockholders and make an acquisition of us more difficult.

Our Risk Factors are not guarantees that no such conditions exist as of the date of this report and should not be interpreted as an affirmative statement that such risks or conditions have not materialized, in whole or in part.

PART I. FINANCIAL INFORMATION

ITEM 1. FINANCIAL STATEMENTS

EHEALTH, INC.
CONDENSED CONSOLIDATED BALANCE SHEETS
(in thousands, unaudited)

	September 30, 2022	December 31, 2021
Assets		
Current assets:		
Cash and cash equivalents	$ 160,258	$ 81,926
Short-term marketable securities	4,491	41,306
Accounts receivable	1,804	5,750
Contract assets – commissions receivable – current	207,505	254,821
Prepaid expenses and other current assets	21,039	23,784
Total current assets	395,097	407,587
Contract assets – commissions receivable – non-current	578,339	653,441
Property and equipment, net	7,927	12,105
Operating lease right-of-use assets	30,845	37,373
Restricted cash	3,239	3,239
Other assets	36,446	35,547
Total assets	$ 1,051,893	$ 1,149,292
Liabilities, convertible preferred stock and stockholders' equity		
Current liabilities:		
Accounts payable	$ 6,626	$ 13,750
Accrued compensation and benefits	14,278	16,458
Accrued marketing expenses	8,209	36,384
Lease liabilities – current	5,988	5,543
Other current liabilities	3,016	3,330
Total current liabilities	38,117	75,465
Long-term debt	65,725	—
Deferred income taxes – non-current	23,589	50,796
Lease liabilities – non-current	31,234	35,826
Other non-current liabilities	4,545	5,094
Total liabilities	163,210	167,181
Commitments and contingencies		
Convertible preferred stock	255,185	232,592
Stockholders' equity:		
Common stock	40	39
Additional paid-in capital	772,328	755,875
Treasury stock, at cost	(199,998)	(199,998)
Retained earnings	61,227	193,213
Accumulated other comprehensive income (loss)	(99)	390
Total stockholders' equity	633,498	749,519
Total liabilities, convertible preferred stock, and stockholders' equity	$ 1,051,893	$ 1,149,292

The accompanying notes are an integral part of these condensed consolidated financial statements.

EHEALTH, INC.
CONDENSED CONSOLIDATED STATEMENTS OF COMPREHENSIVE LOSS
(in thousands, except per share amounts, unaudited)

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2022	2021	2022	2021
Revenue:				
Commission	$ 48,977	$ 59,191	$ 190,662	$ 276,066
Other	4,399	4,723	18,373	18,619
Total revenue	53,376	63,914	209,035	294,685
Operating costs and expenses:				
Cost of revenue	494	(25)	790	1,217
Marketing and advertising	30,556	43,317	118,973	138,772
Customer care and enrollment	29,398	48,956	100,711	121,480
Technology and content	19,399	20,369	56,842	63,996
General and administrative	17,300	16,640	54,485	57,812
Amortization of intangible assets	—	121	—	416
Impairment, restructuring and other charges	4,498	573	10,690	3,004
Total operating costs and expenses	101,645	129,951	342,491	386,697
Loss from operations	(48,269)	(66,037)	(133,456)	(92,012)
Other income (expense), net	(647)	189	(2,835)	511
Loss before income taxes	(48,916)	(65,848)	(136,291)	(91,501)
Benefit from income taxes	(9,767)	(12,834)	(26,898)	(19,278)
Net loss	(39,149)	(53,014)	(109,393)	(72,223)
Paid-in-kind dividends for preferred stock	(4,933)	(4,561)	(14,420)	(7,643)
Change in preferred stock redemption value	(2,916)	(2,373)	(8,173)	(3,770)
Net loss attributable to common stockholders	$ (46,998)	$ (59,948)	$ (131,986)	$ (83,636)
Net loss per share attributable to common stockholders:				
Basic and diluted	$ (1.72)	$ (2.24)	$ (4.83)	$ (3.13)
Weighted-average number of shares used in per share amounts:				
Basic and diluted	27,346	26,786	27,329	26,688
Comprehensive loss:				
Net loss	$ (39,149)	$ (53,014)	$ (109,393)	$ (72,223)
Unrealized holding gain (loss) for available for sales debt securities, net of tax	(4)	3	(6)	(48)
Foreign currency translation adjustments	(245)	(26)	(483)	16
Comprehensive loss	$ (39,398)	$ (53,037)	$ (109,882)	$ (72,255)

The accompanying notes are an integral part of these condensed consolidated financial statements.

EHEALTH, INC.
CONDENSED CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(in thousands, unaudited)

Three Months Ended September 30, 2022

	Common Stock		Additional Paid-in Capital	Treasury Stock		Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total Stockholders' Equity
	Shares	Amount		Shares	Amount			
Balance as of June 30, 2022	39,493	$ 40	$ 767,164	12,287	$ (199,998)	$ 108,225	$ 150	$ 675,581
Issuance of common stock in connection with equity incentive plans	214	—	—	—	—	—	—	—
Repurchase of shares to satisfy employee tax withholding obligations	—	—	(467)	71	—	—	—	(467)
Paid-in-kind dividend and accretion related to convertible preferred stock	—	—	—	—	—	(7,849)	—	(7,849)
Stock-based compensation	—	—	5,631	—	—	—	—	5,631
Other comprehensive loss, net of tax	—	—	—	—	—	—	(249)	(249)
Net loss	—	—	—	—	—	(39,149)	—	(39,149)
Balance as of September 30, 2022	39,707	$ 40	$ 772,328	12,358	$ (199,998)	$ 61,227	$ (99)	$ 633,498

Three Months Ended September 30, 2021

	Common Stock		Additional Paid-in Capital	Treasury Stock		Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total Stockholders' Equity
	Shares	Amount		Shares	Amount			
Balance as of June 30, 2021	38,094	$ 38	$ 738,906	11,925	$ (199,998)	$ 292,467	$ 341	$ 831,754
Issuance of common stock in connection with equity incentive plans	231	—	1,933	—	—	—	—	1,933
Repurchase of shares to satisfy employee tax withholding obligations	—	—	(2,061)	51	—	—	—	(2,061)
Paid-in-kind dividend and accretion related to convertible preferred stock	—	—	—	—	—	(6,934)	—	(6,934)
Stock-based compensation	—	—	6,006	—	—	—	—	6,006
Other comprehensive loss, net of tax	—	—	—	—	—	—	(23)	(23)
Net loss	—	—	—	—	—	(53,014)	—	(53,014)
Balance as of September 30, 2021	38,325	$ 38	$ 744,784	11,976	$ (199,998)	$ 232,519	$ 318	$ 777,661

The accompanying notes are an integral part of these condensed consolidated financial statements.

EHEALTH, INC.
CONDENSED CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(in thousands, unaudited)

Nine Months Ended September 30, 2022

	Common Stock		Additional Paid-in Capital	Treasury Stock		Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total Stockholders' Equity
	Shares	Amount		Shares	Amount			
Balance as of December 31, 2021	38,704	$ 39	$ 755,875	12,016	$ (199,998)	$ 193,213	$ 390	$ 749,519
Issuance of common stock in connection with equity incentive plans	920	1	1,054	—	—	—	—	1,055
Repurchase of shares to satisfy employee tax withholding obligations	—	—	(2,901)	342	—	—	—	(2,901)
Paid-in-kind dividend and accretion related to convertible preferred stock	—	—	—	—	—	(22,593)	—	(22,593)
Issuance of common stock for employee stock purchase program	83	—	873	—	—	—	—	873
Stock-based compensation	—	—	17,427	—	—	—	—	17,427
Other comprehensive loss, net of tax	—	—	—	—	—	—	(489)	(489)
Net loss	—	—	—	—	—	(109,393)	—	(109,393)
Balance as of September 30, 2022	39,707	$ 40	$ 772,328	12,358	$ (199,998)	$ 61,227	$ (99)	$ 633,498

Nine Months Ended September 30, 2021

	Common Stock		Additional Paid-in Capital	Treasury Stock		Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total Stockholders' Equity
	Shares	Amount		Shares	Amount			
Balance as of December 31, 2020	37,755	$ 38	$ 721,013	11,831	$ (199,998)	$ 316,155	$ 350	$ 837,558
Issuance of common stock in connection with equity incentive plans	532	—	2,735	—	—	—	—	2,735
Repurchase of shares to satisfy employee tax withholding obligations	—	—	(7,968)	145	—	—	—	(7,968)
Paid-in-kind dividend and accretion related to convertible preferred stock	—	—	—	—	—	(11,413)	—	(11,413)
Issuance of common stock for employee stock purchase program	38	—	2,248	—	—	—	—	2,248
Stock-based compensation	—	—	26,756	—	—	—	—	26,756
Other comprehensive loss, net of tax	—	—	—	—	—	—	(32)	(32)
Net loss	—	—	—	—	—	(72,223)	—	(72,223)
Balance as of September 30, 2021	38,325	$ 38	$ 744,784	11,976	$ (199,998)	$ 232,519	$ 318	$ 777,661

The accompanying notes are an integral part of these condensed consolidated financial statements.

EHEALTH, INC.
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(in thousands, unaudited)

	Nine Months Ended September 30,	
	2022	**2021**
Operating activities:		
Net loss	$ (109,393)	$ (72,223)
Adjustments to reconcile net loss to net cash used in operating activities:		
Depreciation and amortization	2,971	3,700
Amortization of internally developed software	12,714	9,140
Amortization of intangible assets	—	416
Stock-based compensation expense	15,934	24,881
Deferred income taxes	(27,207)	(20,134)
Impairment charges	3,734	—
Other non-cash items	1,333	908
Changes in operating assets and liabilities:		
Accounts receivable	3,946	493
Contract assets – commissions receivable	122,410	35,244
Prepaid expenses and other assets	2,728	(20,790)
Accounts payable	(7,118)	(26,913)
Accrued compensation and benefits	(1,345)	(118)
Accrued marketing expenses	(28,175)	(6,525)
Deferred revenue	(284)	10,240
Accrued expenses and other liabilities	(538)	1,360
Net cash used in operating activities	(8,290)	(60,321)
Investing activities:		
Capitalized internal-use software and website development costs	(12,540)	(12,589)
Purchases of property and equipment and other assets	(192)	(3,554)
Purchases of marketable securities	(8,402)	(88,967)
Proceeds from redemption and maturities of marketable securities	45,269	68,288
Net cash provided by (used in) investing activities	24,135	(36,822)
Financing activities:		
Proceeds from issuance of preferred stock, net of issuance costs	—	214,025
Net proceeds from debt financing	64,862	—
Net proceeds from exercise of common stock options and employee stock purchases	1,054	4,983
Repurchase of shares to satisfy employee tax withholding obligations	(2,901)	(7,968)
Principal payments in connection with leases	(90)	(126)
Net cash provided by financing activities	62,925	210,914
Effect of exchange rate changes on cash, cash equivalents and restricted cash	(438)	—
Net increase in cash, cash equivalents and restricted cash	78,332	113,771
Cash, cash equivalents and restricted cash at beginning of period	85,165	47,113
Cash, cash equivalents and restricted cash at end of period	$ 163,497	$ 160,884

The accompanying notes are an integral part of these condensed consolidated financial statements.

Note 1 – Summary of Business and Significant Accounting Policies

Description of Business – eHealth, Inc. (the "Company," "eHealth," "we" or "us") is a leading health insurance marketplace with a technology and service platform that provides consumer engagement, education and health insurance enrollment solutions. Our mission is to connect every person with the highest quality, most affordable health insurance and Medicare plans for their life circumstances. Our platform integrates proprietary and third-party developed educational content regarding health insurance plans with decision support tools to aid consumers in what has traditionally been a confusing and opaque health insurance purchasing process, and to help them obtain the health insurance products that meet their individual health and economic needs. Our omnichannel consumer engagement platform enables consumers to use our services online, through interactive chat, or by telephone with a licensed insurance agent. We have created a marketplace that offers consumers a broad choice of insurance products that includes thousands of Medicare Advantage, Medicare Supplement, Medicare Part D prescription drug, individual and family, small business and other ancillary health insurance products from approximately 200 health insurance carriers across all fifty states and the District of Columbia.

Basis of Presentation – The accompanying condensed consolidated balance sheet as of September 30, 2022, the condensed consolidated statements of comprehensive loss and stockholders' equity for the three and nine months ended September 30, 2022 and 2021, and the condensed consolidated statements of cash flows for the nine months ended September 30, 2022 and 2021 are unaudited. The condensed consolidated balance sheet data as of December 31, 2021 was derived from the audited consolidated financial statements included in our Annual Report on Form 10-K for the year ended December 31, 2021, which was filed with the Securities and Exchange Commission on March 1, 2022. The accompanying financial statements and related notes should be read in conjunction with the audited consolidated financial statements and related notes included in our Annual Report on Form 10-K.

The accompanying condensed consolidated financial statements have been prepared in accordance with U.S. generally accepted accounting principles ("U.S. GAAP") for interim financial information and reflect all normal recurring adjustments that are necessary to present fairly the results for the interim periods presented. The condensed consolidated financial statements include the accounts of eHealth, Inc. and its direct and indirect wholly-owned subsidiaries. All intercompany accounts and transactions have been eliminated in consolidation. Certain information and disclosures normally included in financial statements prepared in accordance with U.S. GAAP have been condensed or omitted in accordance with those rules and regulations. Certain prior period amounts have been reclassified to conform with our current period presentation.

The unaudited condensed consolidated financial statements have been prepared on the same basis as the audited consolidated financial statements in our Annual Report on Form 10-K for the year ended December 31, 2021 and include all adjustments necessary for the fair presentation of our financial position as of September 30, 2022 and December 31, 2021, and our results of operations for the periods presented. The results for the three and nine months ended September 30, 2022 are not necessarily indicative of the results to be expected for any subsequent period or for the year ending December 31, 2022 and therefore should not be relied upon as an indicator of future results.

Subsequent to the issuance of our consolidated financial statements for the year ended December 31, 2020, we identified certain errors, including a $3.0 million under-recognition of stock-based compensation expense and a $1.5 million over-recognition of licensing costs for the year ended December 31, 2020. We adjusted for these items in the first quarter of 2021 and the adjustments reduced our net loss by approximately $1.5 million, or $0.06 per basic and diluted share in our Condensed Consolidated Statement of Comprehensive Loss for the three months ended March 31, 2021. These items also reduced our net loss by approximately $1.5 million, or $0.06 per basic and diluted share, on our Condensed Consolidated Statement of Comprehensive Loss for the nine months ended September 30, 2021. We evaluated the effects of these out-of-period adjustments, both qualitatively and quantitatively, and concluded that the errors and the correction thereof were immaterial both individually and in the aggregate to the current reporting period and the periods in which they originated, including quarterly reporting.

Significant Accounting Policies, Estimates and Judgments – The preparation of condensed consolidated financial statements and related disclosures in conformity with U.S. GAAP requires management to make estimates, judgments and assumptions that affect the amounts reported and disclosed in the condensed consolidated financial statements and accompanying notes. On an ongoing basis, we evaluate our estimates, including those related to, but not limited to, the useful lives of intangible assets, fair value of investments, recoverability of intangible assets, the commissions we expect to collect for each approved member cohort, valuation allowance for deferred income taxes, provision (benefit) for income taxes and the assumptions used in determining stock-based compensation. We base our estimates of the carrying value of certain assets and liabilities on historical experience and on various other assumptions that we believe to be reasonable. Actual results may differ from these estimates. There have been no material changes to our significant accounting policies discussed in our Annual Report on Form 10-K for the year ended December 31, 2021.

Seasonality – Open enrollment periods drive the seasonality of our business. A greater number of our Medicare-related health insurance plans are sold in our fourth quarter during the Medicare annual enrollment period when Medicare-eligible individuals are permitted to change their Medicare Advantage and Medicare Part D prescription drug coverage for the following year. As a result, our Medicare plan-related commission revenue is highest in our fourth quarter. Our Medicare plan-related commission revenue is also elevated in the first quarter compared to the second and third quarters as a result of the reintroduction of the Medicare Advantage open enrollment period in the first quarter of 2019. Any changes to or additional enrollment periods may change the seasonality of our business.

The majority of our individual and family health insurance plans are sold in the fourth quarter during the annual open enrollment period as defined under the federal Patient Protection and Affordable Care Act and related amendments in the Health Care and Education Reconciliation Act. In the states where the Federally Facilitated marketplace operates as the state health insurance exchange, individuals and families generally are not able to purchase individual and family health insurance outside of the annual enrollment period, unless they qualify for a special enrollment period as a result of certain qualifying events, such as losing employer-sponsored health insurance or moving to another state. Extended open enrollment or special enrollment periods may change the seasonality of our individual and family health insurance business. For example, the COVID-related special enrollment period which ended on August 15, 2021 caused increased commission revenue from the sale of individual and family health insurance plans outside of the open enrollment period.

Recently Adopted Accounting Pronouncements

Reference Rate Reform (Topic 848) – In March 2020, the Financial Accounting Standards Board (the "FASB") issued Accounting Standards Update ("ASU") 2020-04, Reference Rate Reform (Topic 848): Facilitation of the Effects of Reference Rate Reform on Financial Reporting, which provides optional expedients and exceptions for applying U.S. GAAP to contract modifications and other transactions affected by reference rate reform if certain criteria are met in order to ease the financial reporting burden as the market transitions from the London Interbank Offered Rate ("LIBOR") and other interbank offered rates expected to be discontinued to alternative reference rates. The FASB further issued ASU 2021-01 in January 2021 to refine and clarify the scope of Topic 848. The election allows relief from remeasuring the contracts at modification or from reassessing a previous accounting determination. The guidance was effective upon issuance and may be applied through December 31, 2022. We elected the optional expedient under ASU 2020-04 and ASU 2021-01 in the third quarter of 2022 upon the amendment to our term loan credit agreement, which transitions the use of LIBOR to the Secured Overnight Financing Rate ("SOFR"). The adoption of the standard allows entities to account for such modification as if the modification was not substantial and as a result, the implementation of this standard did not have a material impact on our condensed consolidated financial statements. See *Note 12 – Debt* for additional information regarding the amendment to our term loan credit agreement.

Note 2 – Revenue

Disaggregation of Revenue **–** The table below depicts the disaggregation of revenue by product and is consistent with how we evaluate our financial performance (in thousands):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2022	2021	2022	2021
Medicare				
Medicare Advantage	$ 37,454	$ 36,557	$ 152,061	$ 209,224
Medicare Supplement	2,534	3,214	11,291	15,357
Medicare Part D	1,167	1,338	2,165	(2,953)
Total Medicare	41,155	41,109	165,517	221,628
Individual and Family [1]				
Non-Qualified Health Plans	1,991	5,909	5,970	20,352
Qualified Health Plans	714	2,266	2,975	7,204
Total Individual and Family	2,705	8,175	8,945	27,556
Ancillary				
Short-term	967	1,370	3,287	4,639
Dental	715	3,938	2,249	9,326
Vision	245	642	741	1,781
Other	674	845	1,803	1,901
Total Ancillary	2,601	6,795	8,080	17,647
Small Business	2,640	2,190	8,546	7,703
Commission Bonus and Other	(124)	922	(426)	1,532
Total Commission Revenue	48,977	59,191	190,662	276,066
Other Revenue				
Sponsorship and Advertising Revenue	3,805	4,165	16,540	16,002
Other	594	558	1,833	2,617
Total Other Revenue	4,399	4,723	18,373	18,619
Total Revenue	$ 53,376	$ 63,914	$ 209,035	$ 294,685

[1] We define our Individual and Family plan offerings as major medical individual and family health insurance plans, which does not include Medicare-related, small business or ancillary plans. Individual and family health insurance plans include both qualified and non-qualified plans. Qualified health plans are individual and family health insurance plans that meet the requirements of the Affordable Care Act and are offered through the government-run health insurance exchange in the relevant jurisdiction. Non-qualified health plans are Individual and Family plans that meet the requirements of the Affordable Care Act and are not offered through the exchange in the relevant jurisdiction. Individuals that purchase non-qualified health plans cannot receive a subsidy in connection with the purchase of non-qualified plans.

Commission revenue by segment is presented in the table below (in thousands):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2022	2021	2022	2021
Medicare				
Commission Revenue from Members Approved During the Period	$ 39,652	$ 42,698	$ 173,790	$ 235,974
Net Commission Revenue from Members Approved in Prior Periods[1]	1,685	(171)	(9,052)	(11,700)
Total Medicare Segment Commission Revenue	$ 41,337	$ 42,527	$ 164,738	$ 224,274
Individual, Family and Small Business				
Commission Revenue from Members Approved During the Period	$ 3,600	$ 4,892	$ 14,254	$ 16,495
Commission Revenue from Renewals of Small Business Members During the Period	2,200	1,744	7,281	6,154
Net Commission Revenue from Members Approved in Prior Periods[1]	1,840	10,028	4,389	29,143
Total IFP/SMB Segment Commission Revenue	$ 7,640	$ 16,664	$ 25,924	$ 51,792
Total Commission Revenue from Members Approved During the Period	$ 43,252	$ 47,590	$ 188,044	$ 252,469
Commission Revenue from Renewals of Small Business Members During the Period	2,200	1,744	7,281	6,154
Total Net Commission Revenue from Members Approved in Prior Periods [1][2]	3,525	9,857	(4,663)	17,443
Total Commission Revenue	$ 48,977	$ 59,191	$ 190,662	$ 276,066

[1] These amounts reflect our revised estimates of cash collections for certain members approved prior to the relevant reporting period that are recognized as adjustments to revenue within the relevant reporting period. The net adjustment revenue includes both increases in revenue for certain prior period cohorts as well as reductions in revenue for certain prior period cohorts.

[2] The impacts of total net commission revenue from members approved in prior periods were $0.13 and $0.37 per basic and diluted share, for the three months ended September 30, 2022 and 2021, respectively. The impacts of total net commission revenue from members approved in prior periods were $(0.17) and $0.65 per basic and diluted share, for the nine months ended September 30, 2022 and 2021, respectively.

The total reductions to revenue from members approved in prior periods were $2.1 million and $3.2 million for the three months ended September 30, 2022 and 2021, respectively, and $15.8 million and $22.6 million for the nine months ended September 30, 2022 and 2021. These reductions to revenue primarily related to the Medicare segment.

Note 3 – Supplemental Financial Statement Information

Cash, Cash Equivalents and Restricted Cash

We consider all investments with an original maturity of 90 days or less from the date of purchase to be cash equivalents. Cash and cash equivalents are stated at fair value. We also invest in marketable securities that are measured and recorded at fair value. See *Note 4 – Fair Value Measurements* for further discussion about our marketable securities.

Our cash, cash equivalents and restricted cash balances are summarized as follows (in thousands):

	September 30, 2022	December 31, 2021
Cash	$ 23,476	$ 33,253
Cash equivalents	136,782	48,673
Cash and cash equivalents	160,258	81,926
Restricted cash	3,239	3,239
Total cash, cash equivalents and restricted cash	$ 163,497	$ 85,165

As of September 30, 2022 and December 31, 2021, we had $3.2 million of restricted cash which was classified as a non-current asset on our Condensed Consolidated Balance Sheets. This amount collateralizes letters of credit related to certain lease commitments.

Contract Assets and Accounts Receivable

We do not require collateral or other security for our contract assets and accounts receivable. We believe the potential for collection issues with any of our customers was minimal as of September 30, 2022.

We estimate an allowance for credit losses using relevant available information from internal and external sources, related to past events, current conditions, and reasonable and supportable forecasts. Specifically, for the purpose of measuring the probability of default parameters, we utilize Capital IQ's, Standard & Poor's and Moody's analytics. Our estimates of loss given default are determined by using our historical collections data as well as historical information obtained through our research and review of other insurance related companies. Our estimated exposure at default is determined by applying these internal and external data sources to our commission receivable balances. As such, we apply an immediate reversion method and revert to historical loss information when computing our credit loss exposure. Credit loss expenses are assessed quarterly and included in the "General and administrative" line in our Condensed Consolidated Statements of Comprehensive Loss. There were no write-offs during the nine months ended September 30, 2022 and 2021.

We considered the impact of recent events and global economic conditions when evaluating the appropriate adjustments to our allowance for credit losses as of September 30, 2022. We also considered the current and expected future economic and market conditions surrounding the COVID-19 pandemic.

The change in the allowance for credit losses for the nine months ended September 30, 2022 is summarized as follows (in thousands):

Beginning balance	$ 2,198
Change in allowance	9
Ending balance	$ 2,207

Our contract assets – commission receivable activities, net of credit loss allowances are summarized as follows (in thousands):

	Nine Months Ended September 30, 2022		
	Medicare Segment	IFP/SMB Segment	Total
Beginning balance	$ 837,474	$ 70,788	$ 908,262
Commission revenue from members approved during the period	173,790	14,254	188,044
Commission revenue from renewals of small business members during the period	—	7,281	7,281
Net commission revenue from members approved in prior periods	(9,052)	4,389	(4,663)
Cash receipts	(279,048)	(34,023)	(313,071)
Net change in credit loss allowance	(8)	(1)	(9)
Ending balance	$ 723,156	$ 62,688	$ 785,844

	Nine Months Ended September 30, 2021		
	Medicare Segment	IFP/SMB Segment	Total
Beginning balance	$ 739,637	$ 52,768	$ 792,405
Commission revenue from members approved during the period	235,974	16,495	252,469
Commission revenue from renewals of small business members during the period	—	6,154	6,154
Net commission revenue from members approved in prior periods	(11,700)	29,143	17,443
Cash receipts	(276,825)	(34,485)	(311,310)
Net change in credit loss allowance	188	19	207
Ending balance	$ 687,274	$ 70,094	$ 757,368

Credit Risk

Our financial instruments that are exposed to concentrations of credit risk principally consist of cash, cash equivalents, marketable securities, contract assets – commissions receivable, and accounts receivable. We invest our cash and cash equivalents with major banks and financial institutions and such investments are in excess of federally insured limits. We also have deposits with major banks in China that are denominated in both U.S. dollars and Chinese Yuan Renminbi and are not insured by the U.S. federal government. The deposits in China were $4.8 million as of September 30, 2022. See *Note 4 – Fair Value Measurements* for more information regarding our marketable securities.

We do not require collateral or other security for either our contract assets or accounts receivable. Carriers that represented 10% or more of our total contract assets – commission receivable and accounts receivable balances are summarized as of the dates presented below:

	September 30, 2022	December 31, 2021
Humana	26 %	25 %
UnitedHealthCare [(1)]	24 %	23 %
Aetna [(1)]	16 %	17 %
Centene [(1)]	9 %	10 %

[(1)] Percentages include the carriers' subsidiaries.

Prepaid Expenses and Other Current Assets **–** Our prepaid expenses and other current assets are summarized as of the periods presented as follows (in thousands):

	September 30, 2022	December 31, 2021
Prepaid expenses	$ 12,174	$ 11,379
Prepaid maintenance contracts	6,480	6,246
Prepaid licenses	1,243	3,076
Prepaid insurance	880	2,161
Other current assets	262	922
Prepaid expenses and other current assets	$ 21,039	$ 23,784

Note 4 – Fair Value Measurements

We define fair value as the price that would be received for an asset or paid to transfer a liability (an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. Valuation techniques we use to measure fair value maximize the use of observable inputs and minimize the use of unobservable inputs. We classify the inputs used to measure fair value into the following hierarchy:

Level 1	Unadjusted quoted prices in active markets for identical assets or liabilities.
Level 2	Unadjusted quoted prices in active markets for similar assets or liabilities; unadjusted quoted prices for identical or similar assets or liabilities in markets that are not active; inputs other than quoted prices that are observable for the asset or liability.
Level 3	Unobservable inputs for the asset or liability.

Our financial assets measured at fair value on a recurring basis are summarized below by their classification within the fair value hierarchy as of the dates presented (in thousands):

	September 30, 2022				
	Carrying Value	Level 1	Level 2	Level 3	Total
Assets					
Cash equivalents					
Money market funds	$ 14,424	$ 14,424	$ —	$ —	$ 14,424
Commercial paper	115,756	—	115,756	—	115,756
Agency bonds	6,602	—	6,602	—	6,602
Short-term marketable securities					
Commercial paper	4,491	—	4,491	—	4,491
Total assets measured at fair value	$ 141,273	$ 14,424	$ 126,849	$ —	$ 141,273

	December 31, 2021				
	Carrying Value	Level 1	Level 2	Level 3	Total
Assets					
Cash equivalents					
Money market funds	$ 9,217	$ 9,217	$ —	$ —	$ 9,217
Commercial paper	39,456	—	39,456	—	39,456
Short-term marketable securities					
Commercial paper	38,801	—	38,801	—	38,801
Corporate bond	2,505	—	2,505	—	2,505
Total assets measured at fair value	$ 89,979	$ 9,217	$ 80,762	$ —	$ 89,979

We endeavor to utilize the best available information in measuring fair value. Our money market funds are measured at fair value based on quoted prices in active markets and are classified as Level 1 within the fair value hierarchy. Our available for sale marketable securities, which include commercial paper, agency bonds and a corporate bond with maturities of less than one year, are measured at fair value using quoted market prices to the extent available or alternative pricing sources and models utilizing market observable inputs and are classified as Level 2 within the fair value hierarchy. Our portfolio primarily consisted of financial instruments with a credit rating of AA or equivalent by S&P Rating and Moody's Investor Services. There were no transfers between the hierarchy levels during either the nine months ended September 30, 2022 or the year ended December 31, 2021.

The following table summarizes our cash equivalents and available-for-sale debt securities by contractual maturity (in thousands):

	As of September 30, 2022	
	Amortized Cost	Fair Value
Due in 1 year	$ 141,288	$ 141,273

Unrealized gains and losses on available-for-sale debt securities that are not credit related are included in accumulated other comprehensive income and summarized as follows as of September 30, 2022 (in thousands):

	Amortized Cost	Unrealized Gains	Unrealized Losses	Fair Value
Cash equivalents				
Money market funds	$ 14,424	$ —	$ —	$ 14,424
Commercial paper	115,772	1	(17)	115,756
Agency bonds	6,599	3	—	6,602
Short-term marketable securities				
Commercial paper	4,493	—	(2)	4,491
Total	$ 141,288	$ 4	$ (19)	$ 141,273

As of September 30, 2022, we had 33 securities in net loss positions and their unrealized losses were immaterial individually and in aggregate. We did not record any credit losses regarding our available-for-sale debt securities during the nine months ended September 30, 2022. We do not intend to sell these securities and it is more likely than not that we will not be required to sell these securities before the recovery of their amortized cost basis.

Note 5 – Equity

2021 Inducement Plan – On September 22, 2021, the Company adopted an inducement plan (the “2021 Inducement Plan”), pursuant to which the Company reserved 410,000 shares of its common stock (subject to customary adjustments in the event of a change in capital structure of the Company) to be used exclusively for grants of awards to individuals who were not previously employees or directors of the Company, other than following a bona fide period of non-employment, as an inducement material to the individual's entry into employment with the Company within the meaning of Rule 5635(c)(4) of the Nasdaq Listing Rules (“Nasdaq Rules”). In March 2022, the Company amended and restated its 2021 Inducement Plan to reserve an additional 500,000 shares of its common stock, and in September 2022, the Company further amended and restated the 2021 Inducement Plan to reserve an additional 1,500,000 shares of its common stock (as amended and restated, the "A&R 2021 Inducement Plan"). The 2021 Inducement Plan and its amendments were approved by the Company's board of directors (the “Board”) without stockholder approval pursuant to Rule 5635(c)(4) of the Nasdaq Rules, and the terms and conditions of the A&R 2021 Inducement Plan and awards to be granted thereunder are substantially similar to the Company's stockholder-approved Amended and Restated 2014 Equity Incentive Plan. As of September 30, 2022, 756,485 shares were issued under the A&R 2021 Inducement Plan.

Stock Repurchase Programs – We had no stock repurchase activity during the three and nine months ended September 30, 2022. In addition to 10.7 million shares repurchased under our previous repurchase programs, we have in treasury 1.7 million shares as of September 30, 2022 that were previously surrendered by employees to satisfy tax withholding due in connection with the vesting of certain restricted stock units. As of September 30, 2022 and December 31, 2021, we had a total of 12.4 million shares and 12.0 million shares, respectively, held in treasury.

For accounting purposes, common stock repurchased under our stock repurchase programs is recorded based upon the settlement date of the applicable trade. Such repurchased shares are held in treasury and are presented using the cost method.

Stock-Based Compensation Expense – Our stock-based compensation expense is summarized as follows by award types (in thousands):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2022	2021	2022	2021
Restricted stock units*	$ 4,687	$ 4,666	$ 14,625	$ 23,031
Common stock options	313	82	864	402
Employee stock purchase plan	144	486	445	1,448
Total stock-based compensation expense	$ 5,144	$ 5,234	$ 15,934	$ 24,881

* Amounts include market-based and performance-based restricted stock units.

The following table summarizes stock-based compensation expense by operating function for the periods presented below (in thousands):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2022	2021	2022	2021
Marketing and advertising	$ 570	$ 2,297	$ 1,311	$ 6,922
Customer care and enrollment	610	740	1,576	1,901
Technology and content	1,341	2,380	5,012	7,483
General and administrative *	2,623	(183)	8,035	8,575
Total stock-based compensation expense	$ 5,144	$ 5,234	$ 15,934	$ 24,881
Amount capitalized for internal-use software	487	772	1,493	1,875
Total stock-based compensation	$ 5,631	$ 6,006	$ 17,427	$ 26,756

* Stock-based compensation expense for the three and nine months ended September 30, 2021 was impacted by a $4.1 million credit related to forfeited equity awards due to our chief executive officer's separation.

Note 6 — Convertible Preferred Stock

On April 30, 2021 (the “Closing Date”), we issued and sold to Echelon Health SPV, LP (“H.I.G.”), an investment vehicle of H.I.G. Capital, in a private placement, 2,250,000 shares of our newly designated Series A convertible preferred stock (the “Series A preferred stock”), par value $0.001 per share, at an aggregate purchase price of $225.0 million. We received $214.0 million in net proceeds from the private placement with H.I.G., net of sales commissions and certain transaction fees totaling $11.0 million. The Series A preferred stock ranks senior to all other equity securities of the Company with respect to dividend rights and rights on the distribution of assets on any voluntary or involuntary liquidation, dissolution or winding up of the affairs of the Company.

Dividends – Dividends initially accrue on the Series A preferred stock daily at 8% per annum on the stated value of $100 per share (“Stated Value”) and compound semiannually, payable in kind (“PIK”) until the second anniversary of the Closing Date on June 30 and December 31 of each year (each, a “Dividend Payment Date”), beginning on June 30, 2021, and thereafter 6% PIK and 2% payable in cash in arrears on June 30 and December 31 of each year, beginning on June 30, 2023. PIK dividends are cumulative and are added to the Accrued Value (as defined below). “Accrued Value” means, as of any date, with respect to any share of Series A preferred stock, the sum of the Stated Value per share plus, on each Dividend Payment Date, on a cumulative basis, all accrued PIK dividends on such share that have not previously compounded and been added to the Accrued Value. The Series A preferred stock participates, on an as-converted basis in all dividends paid to the holders of our common stock.

Conversion Rights – The Series A preferred stock is convertible at any time into common stock at a conversion rate equal to (i) the Accrued Value plus accrued PIK dividends that have not yet been added to the Accrued Value, (ii) divided by the conversion price as of the applicable conversion date (the "Conversion Price"). As of the date of this report, the Conversion Price is equal to $79.5861 per share. This Conversion Price is subject to further adjustment and the number of shares of common stock issuable upon conversion of the Series A preferred stock is subject to certain limitations, each as set forth in the Certificate of Designations of Series A preferred stock, as filed with the Secretary of State of the State of Delaware on April 30, 2021 (the "Certificate of Designations").

Redemption Put Right – At any time on or after the sixth anniversary of the Closing Date, holders of the Series A preferred stock will have the right to cause the Company to redeem all or any portion of the Series A preferred stock in cash at an amount equal to the greater of (i) 135% of the Accrued Value per share as of the redemption date, plus accrued PIK dividends that have not yet been added to the Accrued Value and (ii) the amount per share that would be payable on an as-converted basis on such Series A preferred stock at the then-current Accrued Value, plus accrued PIK dividends that have not yet been added to the Accrued Value, and in either case of (i) or (ii) plus any unpaid cash dividends that would have otherwise been settled in cash in connection with such conversion (the greater of (i) and (ii), the "Redemption Price").

Redemption Call Right – At any time on or after the sixth anniversary of the Closing Date, the Company will have the right (but not the obligation) to redeem out of legally available funds and for cash consideration all (but not less than all) of the Series A preferred stock upon at least 30 days prior written notice at an amount equal to the Redemption Price.

Board Nomination Rights – H.I.G. is entitled to nominate one individual for election to the Board so long as it continues to own at least 30% of the common stock issuable or issued upon conversion of the Series A preferred stock originally issued to it in the private placement. H.I.G. also has the right to nominate an additional individual to the Board if the Company fails to maintain certain levels of commissions receivable and liquidity.

Voting Rights – The Series A preferred stock will vote together with the common stock as a single class on all matters submitted to a vote of the holders of the common stock (subject to certain voting limitations set forth in, and the terms and conditions of, the Certificate of Designations). Each holder of Series A preferred stock shall be entitled to the number of votes, rounded down to the nearest whole number, equal to the product of (i) the aggregate Accrued Value of the issued and outstanding shares of Series A preferred stock divided by the Minimum Price (as defined below), multiplied by (ii) a fraction, the numerator of which is the number of shares of Series A preferred stock held by such holder and the denominator of which is the aggregate number of issued and outstanding shares of Series A preferred stock. "Minimum Price" means the lower of: (i) the Nasdaq Official Closing Price per share of common stock on the Closing Date; or (ii) the average Nasdaq Official Closing Price per share of common stock for the five trading days immediately prior to the Closing Date. Holders of Series A preferred stock will have one vote per share on any matter on which the holders of the Series A preferred stock are entitled to vote separately as a class (subject to certain voting limitations set forth in, and the terms and conditions of, the Certificate of Designations).

Mandatory Conversion of the Series A Preferred Stock – At any time on or after the third anniversary of the Closing Date, if the volume-weighted average price per share of our common stock is greater than 167.5% of the then-current Conversion Price for 20 consecutive trading days in a 30-day trading day period, the Company will have the right to convert all, but not less than all, of the Series A preferred stock into common stock at a conversion rate with respect to each share of Series A preferred stock of (i) the Accrued Value plus accrued PIK dividends that have not yet been added to the Accrued Value, (ii) divided by the then applicable Conversion Price.

Covenants and Liquidity Requirements – As long as H.I.G. continues to own at least 30% of the Series A preferred stock originally issued to it in the private placement, the consent of H.I.G. will be required for the Company to incur certain indebtedness and to take certain other corporate actions as set forth in the Company's investment agreement with H.I.G. entered into on February 17, 2021 (the "Investment Agreement"). In addition, the Company is required to maintain an asset coverage ratio (as defined in the Investment Agreement) of at least 2x, which increases to 2.5x 30 months after the date of the Investment Agreement. Additionally, the Investment Agreement

requires the Company to maintain a minimum liquidity amount (as defined in the Investment Agreement) for certain periods that ranges from $65.0 million to $125.0 million. If the Company fails to maintain the minimum asset coverage ratio or minimum liquidity amount as of a certain date or for a certain time period required by the Investment Agreement and H.I.G continues to own at least 30% of the Series A preferred stock originally issued to it in the private placement, H.I.G will have the right to nominate an additional director to the Board, and the consent of H.I.G. will be required to approve the Company's annual budget, hire or terminate certain key executives, and incur certain indebtedness as outlined in the Investment Agreement. H.I.G. will no longer have these additional board nomination and consent rights if the Company is able to satisfy the minimum liquidity amount requirements in the Investment Agreement for any subsequent 12 consecutive months. As of September 30, 2022, we were in compliance with the asset coverage ratio and minimum liquidity amounts as required in the Investment Agreement.

Our Series A preferred stock is considered temporary equity in our condensed consolidated financial statements. We have determined there are no material embedded features that require recognition as a derivative asset or liability. We recognized the Series A preferred stock at its stated amount less issuance costs of $11.0 million, or $214.0 million.

As of September 30, 2022, the estimated Series A preferred stock redemption value equals 135% of the Accrued Value per share as of the redemption date, plus any accrued and unpaid dividends, which is significantly in excess of the fair value of the common stock into which the Series A preferred stock is convertible as of September 30, 2022. We have elected to apply the accretion method to adjust the carrying value of the Series A preferred stock to its redemption value at the earliest date of redemption, April 30, 2027. Amounts recognized to accrete the Series A preferred stock to its estimated redemption value are treated as a deemed dividend and are recorded as a reduction to retained earnings. The estimated redemption value will vary in subsequent periods due to the redemption put right described above and we have elected to recognize such changes prospectively. No shares of Series A preferred stock have been converted and the Series A preferred stock was convertible into approximately 3.2 million shares of common stock as of September 30, 2022.

The following table summarizes the proceeds and changes to our Series A preferred stock (in thousands):

Gross proceeds	$	225,000
Less: issuance costs		(10,975)
Net proceeds	$	214,025
Balance as of Closing Date	$	214,025
Accrued paid-in-kind dividends		12,206
Change in preferred stock redemption value		6,361
Balance as of December 31, 2021	$	232,592
Accrued paid-in-kind dividends		14,420
Change in preferred stock redemption value		8,173
Balance as of September 30, 2022	$	255,185

Note 7 – **Net Loss Per Share Attributable to Common Stockholders**

Our Series A preferred stock is considered a participating security which requires the use of two-class method for the computation of basic and diluted per share amounts. Under the two-class method, earnings available to common stockholders for the period are allocated between common stockholders and participating securities according to dividends accumulated and participation rights in undistributed earnings. Net loss attributable to common stockholders is not allocated to the convertible preferred stock as the holder of the Series A preferred stock does not have a contractual obligation to share in losses. Basic net loss attributable to common stockholders per share is computed by dividing net loss available to common stockholders by the weighted-average number of shares of common stock outstanding for the period. Diluted net loss attributable to common stockholders per share is computed by dividing the net loss available to common stockholders for the period by the weighted average number of common and common equivalent shares outstanding during the period. Diluted net loss attributable to common stockholders per share reflects all potential dilutive common stock equivalent shares, including conversion of preferred stock, stock options, restricted stock units and shares to be issued under our employee stock purchase program.

The following table sets forth the computation of basic and diluted net loss attributable to common stockholders per share (in thousands, except per share amounts):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2022	2021	2022	2021
Numerator:				
Net loss attributable to common stockholders	$ (46,998)	$ (59,948)	$ (131,986)	$ (83,636)
Denominator:				
Shares used in per share calculation – basic	27,346	26,786	27,329	26,688
Dilutive effect of common stock	—	—	—	—
Shares used in diluted share calculation	27,346	26,786	27,329	26,688
Net loss attributable to common stockholders per share – basic and diluted	$ (1.72)	$ (2.24)	$ (4.83)	$ (3.13)

For each of the three and nine months ended September 30, 2022 and 2021, we had securities outstanding that could potentially dilute per share amounts, but the shares from the assumed conversion or exercise of these securities were excluded in the computation of diluted net loss per share as their effect would have been anti-dilutive. The number of outstanding anti-dilutive shares that were excluded from the computation of diluted net loss per share consisted of the following (in thousands):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2022	2021	2022	2021
Convertible preferred stock	3,130	2,866	3,083	1,595
Restricted stock units*	1,999	1,134	1,299	1,055
Common stock options	239	278	282	330
Employee stock purchase program	—	7	—	12
Total	5,368	4,285	4,664	2,992

* Amounts include market-based and performance-based restricted stock units.

Note 8 – Commitments and Contingencies

Service and Licensing Obligations

We have entered into service and licensing agreements with third party vendors to provide various services, including network access, equipment maintenance, and software licensing. As the benefits of these agreements are experienced uniformly over the applicable contractual periods, we record the related service and licensing expenses on a straight-line basis, although actual cash payment obligations under certain of these agreements fluctuate over the terms of the agreements.

Our future minimum payments under non-cancellable contractual service and licensing obligations as of September 30, 2022 (in thousands):

For the Years Ending December 31,		
2022 (remainder)	$	2,895
2023		7,782
2024		2,519
2025		229
2026		—
Thereafter		—
Total	$	13,425

Operating Leases

Refer to *Note 10 – Leases* for commitments related to our operating leases.

Contingencies

From time to time, we receive inquiries from governmental bodies and also may be subject to various legal proceedings and claims arising in the ordinary course of business. We assess contingencies to determine the degree of probability and range of possible loss for potential accrual in our condensed consolidated financial statements. An estimated loss contingency is accrued in the condensed consolidated financial statements if it is probable that a liability has been incurred and the amount of the loss can be reasonably estimated. There was no material litigation-related accrual during the three and nine months ended September 30, 2022. Legal proceedings or other contingencies could result in material costs, even if we ultimately prevail.

Legal Proceedings

Securities Class Action – On April 8, 2020 and April 30, 2020, two purported class action lawsuits were filed against the Company, its then-chief executive officer, Scott N. Flanders, its then-chief financial officer, Derek N. Yung, and its then-chief operating officer, David K. Francis in the United States District Court for the Northern District of California. The cases are captioned *Patel v. eHealth, Inc., et al*., Case No. 5:20-cv-02395 (N.D. Cal.) and *Bertrand v. eHealth, Inc. et al.*, Case No. 4:20-cv-02967 (N.D. Cal.). The complaints allege, among other things, that the Company and Messrs. Flanders, Yung and Francis made materially false and misleading statements and/or failed to disclose material information regarding the Company's accounting and modeling assumptions, rate of member churn and the Company's profitability during the alleged class period of March 19, 2018 to April 7, 2020. The complaints allege that we and Messrs. Flanders, Yung and Francis violated Sections 10(b) and 20(a) of the Securities Exchange Act of 1934 (as amended, the "Exchange Act") and Rule 10b-5 promulgated thereunder. The complaints seek compensatory and (in the *Patel* lawsuit) punitive damages, attorneys' fees and costs, and such other relief as the court deems proper. On June 24, 2020, the Court consolidated the above-referenced matters under the caption *In re eHealth Securities Litig.*, Master File No. 4:20-cv-02395-JST (N.D. Cal.). The Court also appointed a lead plaintiff and lead counsel for the consolidated matter. An Amended Complaint was filed on August

25, 2020, which Defendants moved to dismiss on October 23, 2020. Defendants' motion, which Plaintiff opposed, was granted in part and denied in part on August 12, 2021. The Court dismissed Plaintiff's claims to the extent premised upon alleged misrepresentations or omissions relating to churn, but denied Defendants' motion with respect to alleged misstatements regarding purported operating costs. On October 1, 2021, the Company filed an Answer denying in part and admitting in part the remaining allegations, and denying any wrongdoing. On November 11, 2021, Plaintiff's counsel filed a suggestion of death with respect to the lead plaintiff Billy White. The parties stipulated to a schedule for the lead plaintiff process to be re-opened, which was so-ordered by the Court on January 10, 2022. Plaintiff's counsel published notice regarding the appointment of a new lead plaintiff on January 17, 2022. On March 18, 2022, several motions were filed by class members seeking appointment as lead plaintiff. The lead plaintiff motions are pending with the court.

Derivative Actions – On July 7, 2020 and October 13, 2020, two derivative lawsuits were filed against the Company's then-chief executive officer, Mr. Flanders, its then-chief financial officer, Mr. Yung, its then-chief operating officer, Mr. Francis, and the then-current members of the Board (collectively, the "Individual Defendants"), in the United States District Court for the Northern District of California and the Superior Court of California, County of Santa Clara. The cases are captioned *Chernet v. Flanders et al*., Case No. 3:20-cv-04477-SK (N.D. Cal.), and *Lincolnshire Police Pension Fund v. Flanders et al.*, Case No. 20CV371555 (Cal. Super. Ct.), and also name the Company as a nominal defendant. A third derivative lawsuit was filed against the same defendants on October 5, 2021 in the United States District Court for the Northern District of California, captioned *Badwal v. Flanders et al*., Case No. 4:21-cv-07795 (N.D. Cal.). The complaints allege, among other things, that the Individual Defendants made or caused the Company to make materially false and misleading statements and/or failed to disclose material information regarding our accounting and modeling assumptions, rate of member churn, profitability and internal controls for the period of March 2018 through the present. The *Chernet* and *Lincolnshire* complaints purport to assert claims for breach of fiduciary duty, unjust enrichment and waste of corporate assets. The *Chernet* lawsuit also alleges that the Individual Defendants violated Sections 14(a), 10(b), and 20(a) of the Exchange Act and asserts claims for abuse of control and gross mismanagement. The *Badwal* complaint purports to assert a claim for breach of fiduciary duty, an insider trading claim and violations of Section 14(a), 10(b) and 21D of the Exchange Act. The *Chernet* and *Lincolnshire* complaints seek damages, restitution, attorneys' fees and costs, and certain measures with respect to the Company's corporate governance and internal procedures, and (in the *Lincolnshire* lawsuit) equitable and/or injunctive relief. The *Badwal* complaint seeks damages, declaratory relief, corporate governance measures, equitable and injunctive relief, restitution and disgorgement, and attorneys' fees and costs. On August 10, 2020, the parties filed a Stipulation and Proposed Order in the *Chernet* matter to stay the action until and through the resolution of the Defendants' anticipated motion to dismiss the consolidated securities class action, and filed a similar stipulation in the *Lincolnshire* matter on December 11, 2020. The *Chernet* stipulation was granted by the Court on August 12, 2020 and the *Lincolnshire* stipulation on December 11, 2020. In December 2021, the parties entered into a stipulation to further stay the *Badwal* and *Chernet* actions pending the appointment of a lead plaintiff in the consolidated action, which was so ordered by the Court on December 14, 2021.

Note 9 – Segment and Geographic Information

Operating Segments

We report segment information based on how our chief executive officer, who is our chief operating decision maker ("CODM"), regularly reviews our operating results, allocates resources and makes decisions regarding our business operations. The performance measures of our segments include total revenue and profit. Our business structure is comprised of two operating segments: Medicare and Individual, Family and Small Business. Please refer to *Note 1 – Summary of Business and Significant Accounting Policies* of the *Notes to Consolidated Financial Statements* in Part II, Item 8 of the Annual Report on Form 10-K for the year ended December 31, 2021 for our accounting policies relating to operating segments.

The results of our operating segments are summarized for the periods presented below (in thousands):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2022	2021	2022	2021
Revenue:				
Medicare	$ 45,137	$ 46,381	$ 181,266	$ 240,633
Individual, Family and Small Business	8,239	17,533	27,769	54,052
Total revenue	$ 53,376	$ 63,914	$ 209,035	$ 294,685
Segment profit (loss)				
Medicare	$ (22,962)	$ (52,882)	$ (63,050)	$ (46,141)
Individual, Family and Small Business	2,688	12,499	12,285	38,476
Segment loss	(20,274)	(40,383)	(50,765)	(7,665)
Corporate	(12,795)	(14,827)	(40,382)	(43,206)
Stock-based compensation expense	(5,144)	(5,234)	(15,934)	(24,881)
Depreciation and amortization	(5,558)	(4,899)	(15,685)	(12,840)
Amortization of intangible assets	—	(121)	—	(416)
Impairment, restructuring and other charges	(4,498)	(573)	(10,690)	(3,004)
Other income (expense), net	(647)	189	(2,835)	511
Loss before income taxes	$ (48,916)	$ (65,848)	$ (136,291)	$ (91,501)

There were no inter-segment revenue transactions for the periods presented. With the exception of contract assets – commissions receivable, which is presented by segment in *Note 3 – Supplemental Financial Statement Information*, our CODM does not separately evaluate assets by segment, and therefore, assets by segment are not presented.

Geographic Information

Our long-lived assets primarily consist of property and equipment and internally-developed software. Our long-lived assets are attributed to the geographic location in which they are located. Long-lived assets by geographical area are summarized as follows (in thousands):

	September 30, 2022	December 31, 2021
United States	$ 42,051	$ 45,134
China	399	595
Total	$ 42,450	$ 45,729

Significant Customers

Substantially all revenue for the three and nine months ended September 30, 2022 and 2021 was generated from customers located in the United States. Carriers representing 10% or more of our total revenue are summarized as follows:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2022	2021	2022	2021
UnitedHealthCare [(1)]	27 %	21 %	22 %	21 %
Humana	17 %	20 %	18 %	18 %
Centene [(1)]	10 %	11 %	13 %	12 %
Aetna [(1)]	12 %	15 %	12 %	20 %

(1) Percentages include the carriers' subsidiaries.

Note 10 – Leases

Our lease portfolio primarily consists of operating leases for office space and our leases have remaining lease terms of 1 to 7 years. Certain of these leases have free or escalating rent payment provisions. We recognize lease expense on a straight-line basis over the terms of the leases, although actual cash payment obligations under certain of these agreements fluctuate over the terms of the agreements. Most leases include options to renew, and the exercise of these options is at our discretion.

In August 2022, we executed and commenced the sublease of our office space located in Santa Clara, California, which will run through the remaining term of the primary lease, March 31, 2029. This sublease is expected to generate approximately $13.5 million in sublease income over the sublease term. Sublease income is recorded on a straight-line basis as a reduction of lease expense in our Condensed Consolidated Statements of Comprehensive Loss.

We test right-of-use assets when impairment indicators are present in accordance with the asset impairment provisions of Accounting Standards Codification 360, *Property, Plant and Equipment.* The sublease of our Santa Clara, California office space triggered impairment testing for the underlying right-of-use asset as the expected sublease income is less than the remaining head lease obligation. We utilized an income approach to value the asset group by performing a discounted cash flow analysis and determined that the net carrying value exceeded the estimated discounted future cash flows. As a result, we recorded a $3.4 million impairment charge related to operating lease right-of-use assets and property, plant and equipment, which was reflected in the "Impairment, restructuring and other charges" line in our Condensed Consolidated Statements of Comprehensive Loss for the three and nine months ended September 30, 2022. See *Note 11 – Impairment, Restructuring and Other Charges* for further discussion about our asset impairment charges.

Total operating lease expenses were $1.9 million for the three months ended September 30, 2022 and 2021 and $5.7 million for the nine months ended September 30, 2022 and 2021. Sublease income was immaterial for the three and nine months ended September 30, 2022 and 2021.

Supplemental information related to leases are as follows (dollars in thousands):

	September 30, 2022	December 31, 2021
Weighted-average remaining lease term of operating leases	5.7 years	6.3 years
Weighted-average discount rate used to recognize operating lease right-of-use-assets	5.4 %	5.4 %

	Nine Months Ended September 30,	
	2022	2021
Cash paid for amounts included in the measurement of operating lease liabilities	$ 5,878	$ 5,722

As of September 30, 2022, maturities of operating lease liabilities are as follows (in thousands):

Year ending December 31,	
2022 (remainder)	$ 1,819
2023	8,029
2024	7,828
2025	8,005
2026	6,734
Thereafter	12,827
Total lease payments [(1)]	$ 45,242
Less imputed interest	(8,020)
Total	$ 37,222

(1) Noncancellable sublease income for the remainder of 2022 and the years ending December 31, 2023, 2024, 2025, 2026 and thereafter of $0.6 million, $1.6 million, $2.1 million, $2.2 million, $2.2 million, and $5.1 million, respectively, are not included in the table above.

As of September 30, 2022, we had an additional operating lease for office space which had not yet commenced with total future lease payments of $4.6 million.

Note 11 — Impairment, Restructuring and Other Charges

The following table details impairment, restructuring and other charges for each of the periods presented:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2022	2021	2022	2021
Restructuring and reorganization charges	$ 764	$ 573	$ 6,956	$ 3,004
Asset impairment charges	3,734	—	3,734	—
Impairment, restructuring and other charges	$ 4,498	$ 573	$ 10,690	$ 3,004

Our restructuring and reorganization costs and liabilities consist primarily of severance, transition and other related costs. The following table summarizes the cash-based restructuring and reorganization related liabilities (in thousands):

	Nine Months Ended September 30, 2022
Beginning balance	$ 146
Restructuring and reorganization charges	6,956
Payments	(6,588)
Ending balance	$ 514

During the three and nine months ended September 30, 2022, we incurred pre-tax restructuring charges of $0.8 million and $7.0 million, respectively, primarily related to employee termination benefits.

In the first half of 2022, we eliminated 339 full-time positions, which represented approximately 14% of our workforce, primarily within our customer care and enrollment group, and to a lesser extent, in our marketing and advertising, technology and content, and general and administrative groups, and, as a result, recorded pre-tax restructuring charges of $6.2 million in the "Impairment, restructuring and other charges" line in our Condensed Consolidated Statements of Comprehensive Loss. In the three months ended September 30, 2022, we incurred pre-tax restructuring charges of $0.8 million for additional eliminated positions. Substantially all of the restructuring charges will be settled in cash and no equity awards were modified. As of September 30, 2022, the restructuring accrual of $0.5 million is recorded in other current liabilities on our Condensed Consolidated Balance Sheets.

In September 2021, we announced the transition of our chief executive officer. Mr. Scott Flanders resigned as a member of our Board and chief executive officer, effective October 31, 2021. We recognized $2.4 million in severance costs related to his separation for the year ended December 31, 2021. Stock-based compensation expense for the year ended December 31, 2021 was impacted by a $4.1 million credit related to forfeited equity awards due to Mr. Flanders' separation, which was included in the "General and administrative" line in our Condensed Consolidated Statements of Comprehensive Loss.

In February 2021, we eliminated approximately 89 full-time positions, primarily in the United States, representing approximately 5% of our workforce, primarily within our customer care and enrollment group, and to a lesser extent, in our marketing and advertising, technology and content, and general and administrative groups. Total pre-tax restructuring charges were $2.4 million for the year ended December 31, 2021, which primarily related to employee termination benefits. Substantially all of the restructuring charges resulted in cash expenditures. The restructuring activities were completed by March 31, 2021.

For the three and nine months ended September 30, 2022, we recognized a non-cash, pre-tax asset impairment charge of $3.4 million related to the sublease of our office space in Santa Clara, California in the "Impairment, restructuring and other charges" line in our Condensed Consolidated Statements of Comprehensive Loss. This charge was comprised of $2.5 million of operating lease right-of-use assets impairment and $0.9 million of property, plant and equipment impairment. We also incurred $0.3 million of impairment charges related to abandoned in-process internally developed software during the quarter, which was also recognized in the "Impairment, restructuring and other charges" line in our Condensed Consolidated Statements of Comprehensive Loss.

Note 12 – Debt

We entered into a term loan credit agreement with Blue Torch Finance LLC, as administrative agent and collateral agent, and other lenders party thereto on February 28, 2022 (the "Original Credit Agreement"). On August 16, 2022, we entered into an Amendment (the "Amendment") to the Original Credit Agreement (as amended by the Amendment, the "Credit Agreement"). The Amendment replaced the LIBOR-based Adjusted Euro currency Rate (as

defined in the Original Credit Agreement) with Adjusted Term SOFR (as defined in the Amendment) as a reference rate for loans under the Credit Agreement.

The Credit Agreement provides for a $70.0 million secured term loan credit facility. We terminated our credit agreement with Royal Bank of Canada ("RBC"), pursuant to which we had an up to $75 million revolving credit facility, in connection with entering into the Credit Agreement. As of December 31, 2021, there were $0.4 million of unamortized issuance costs related to the RBC credit agreement recorded in other assets in our Condensed Consolidated Balance Sheet. As a result of the termination of our credit agreement with RBC, we wrote-off our remaining related debt issuance cost of $0.4 million in the first quarter of 2022. We had no outstanding borrowings under our agreement with RBC at the time of termination.

The proceeds of the loans under the Credit Agreement may be used for working capital and general corporate purposes, to refinance our credit agreement with RBC and to pay fees and expenses in connection with the entry into the Credit Agreement. The Original Credit Agreement bore interest, at our option, at either a rate based on the LIBOR for the applicable interest period or a base rate, in each case plus a margin. The base rate was the highest of the prime rate, the federal funds rates plus 0.50% and one month adjusted LIBOR plus 1.0%. The margin was 7.50% for LIBOR loans and 6.50% for base rate loans. After the Amendment, the loans under the Credit Agreement bear interest, at our option, at either a rate based on the Adjusted Term SOFR or a base rate, in each case plus a margin. The base rate is the highest of the prime rate, the federal funds rate plus 0.50% and three-month Adjusted Term SOFR plus 1.00%. The margin is 7.50% for Adjusted Term SOFR loans and 6.50% for base rate loans. As of September 30, 2022, the interest rate was 10.66%.

Furthermore, as part of the agreement, we will incur a $0.3 million fee per annum, payable annually. The outstanding obligations under the Credit Agreement are payable in full on the maturity date. The Credit Agreement matures in February 2025. We have the right to prepay the loans under the Credit Agreement in whole or in part at any time, subject, in the case of certain mandatory prepayments or any voluntary prepayment of the loans under the Credit Agreement after February 28, 2023, to an exit fee. Our obligations under the Credit Agreement are guaranteed by certain of our material domestic subsidiaries and substantially all of our assets and the assets of such guarantors, in each case, subject to customary exclusion. We are obligated to pay administration fees under the Credit Agreement.

Financial covenants in the Credit Agreement require that we maintain Liquidity (as defined in the Credit Agreement) at or above $25.0 million as of the last calendar day of any month. The Credit Agreement also requires that the outstanding amount as of the last calendar day of any month be less than 50% of our total contract assets - commissions receivables (i.e., both current and non-current commissions receivables). As of September 30, 2022, we were in compliance with our loan covenants.

In the first quarter of 2022, we obtained a $70.0 million secured term loan under our Credit Agreement. We incurred closing costs totaling $5.1 million, which were recorded as a direct deduction from the face of the loan on our Condensed Consolidated Balance Sheet. There was $4.3 million of unamortized issuance costs as of September 30, 2022. The carrying value of the loan was $65.7 million as of September 30, 2022.

Note 13 – Income Taxes

The following table summarizes our benefit from income taxes and our effective tax rates for the periods presented below (in thousands, except effective tax rate):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2022	2021	2022	2021
Loss before income taxes	$ (48,916)	$ (65,848)	$ (136,291)	$ (91,501)
Benefit from income taxes	(9,767)	(12,834)	(26,898)	(19,278)
Effective tax rate	20.0 %	19.5 %	19.7 %	21.1 %

For the three and nine months ended September 30, 2022, we recognized a benefit from income taxes of $9.8 million and $26.9 million, respectively, representing an effective tax rate of 20.0% and 19.7%, respectively, which was lower than the statutory federal tax rate primarily due to stock-based compensation adjustments and non-deductible lobbying expenses, partially offset by research and development credits and state taxes. For the three and nine months ended September 30, 2021, we recognized a benefit from income taxes of $12.8 million and $19.3 million, respectively, representing an effective tax rate of 19.5% and 21.1%, respectively, which was lower than the statutory federal tax rate primarily due to stock-based compensation adjustments, non-deductible lobbying expenses and state taxes, partially offset by research and development credits.

Assessing the realizability of our deferred tax assets is dependent upon several factors, including the likelihood and amount, if any, of future taxable income in relevant jurisdictions during the periods in which those temporary differences become deductible. We forecast taxable income by considering all available positive and negative evidence, including our history of operating income and losses and our financial plans and estimates that we use to manage the business. These assumptions require significant judgment about future taxable income. As a result, the amount of deferred tax assets considered realizable is subject to adjustment in future periods if estimates of future taxable income change. We continue to recognize our deferred tax assets as of September 30, 2022, as we believe it is more likely than not that the net deferred tax assets will be realized, with the exception of certain net operating losses and credits that are expected to expire unutilized which have a valuation allowance.

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

In addition to historical information, this Quarterly Report on Form 10-Q contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended (the "Securities Act") and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). The words "expect," "anticipate," "believe," "estimate," "target," "goal," "project," "hope," "intend," "plan," "seek," "continue," "may," "could," "should," "might," "forecast," and variations of such words and similar expressions are intended to identify such forward-looking statements. These statements include, among other things, statements regarding our expectations relating to approved members, new paying members and estimated membership; our estimates regarding the constrained lifetime value of commissions; our expectations relating to revenue, operating costs, cash flows and profitability; our expectations regarding our strategy and investments, including investments in our ecommerce and call center capabilities, technology, agent training and quality assurance efforts; our expectations regarding our Medicare business, including market opportunity, consumer demand and our competitive advantage; our expectations regarding our individual and family business, including anticipated trends and our ability to enroll individuals and families into qualified health plans; our expectations regarding our strategic plans, including our growth strategy, cost savings and enrollment quality initiatives; the impact of future and existing laws and regulations on our business; the expected impact of the COVID-19 pandemic and continued remote operations on our business; the expected impact of inflation and general economic conditions on our business; our expectations regarding commission rates, payment rates, conversion rates, plan termination rates and duration, membership retention rates and membership acquisition costs; our expectations regarding health insurance agents licensing and productivity; our expectations regarding beneficiary complaints, customer experience and enrollment quality; our expectations relating to the seasonality of our business; expected competition from government-run health insurance exchanges and other sources; our expectations relating to marketing and advertising expense and expected contributions from our marketing and strategic partnership channels; the timing of our receipt of commission and other payments; our critical accounting policies and related estimates; liquidity and capital needs; political, legislative, regulatory and legal challenges; the merits or potential impact of any lawsuits filed against us; as well as other statements regarding our future operations, financial condition, prospects and business strategies.

We have based these forward-looking statements on our current expectations about future events. These statements are not guarantees of future performance and involve risks, uncertainties and assumptions that are difficult to predict. Our actual results may differ materially from those suggested by these forward-looking statements for various reasons, including our ability to retain existing members and enroll new members during the annual health care open enrollment period, the Medicare annual enrollment period and other special enrollment periods; changes in laws, regulations and guidelines, including in connection with health care reform or with respect to the marketing and sale of Medicare plans; competition, including competition from government-run health insurance exchanges and other sources; the seasonality of our business and the fluctuation of our operating results; our ability to accurately estimate membership, lifetime value of commissions and commissions receivable; changes in product offerings among carriers on our ecommerce platform and the resulting impact on our commission revenue; our ability to execute on our growth strategy in the Medicare market; the impact of the COVID-19 pandemic and other public health crises, illness, epidemics or pandemics on our operations, business, financial condition and growth prospects, as well as on the general economy; changes in our management and key employees; exposure to security risks and our ability to safeguard the security and privacy of confidential data; our relationships with health insurance carriers; the success of our carrier advertising and sponsorship program; customer concentration and consolidation of the health insurance industry; our success in marketing and selling health insurance plans and our unit cost of acquisition; our ability to hire, train, retain and ensure the productivity of licensed health insurance agents and other employees; our ability to effectively manage our operations as our business evolves and execute on our transformational plan and other strategic initiatives; the need for health insurance carrier and regulatory approvals in connection with the marketing of Medicare-related insurance products; changes in the market for private health insurance; consumer satisfaction of our service and actions we take to improve the quality of enrollments; changes in member conversion rates; changes in commission rates; our ability to sell qualified health insurance plans to subsidy-eligible individuals and to enroll subsidy-eligible individuals through government-run health insurance exchanges; our ability to maintain and enhance our brand identity; our ability to derive desired benefits from investments in our business, including membership growth and retention initiatives; reliance on marketing partners; the impact of our direct-to-consumer mail, email, social media, telephone and television marketing efforts; timing of receipt and accuracy of commission reports; payment practices of health insurance carriers; dependence on our operations in China; the restrictions in our debt obligations; the restrictions in

our investment agreement with H.I.G.; our ability to raise additional capital; compliance with insurance, privacy and other laws and regulations; the outcome of litigation in which we are and may from time to time become involved; the performance, reliability and availability of our information technology systems, ecommerce platform and underlying network infrastructure; and those identified under the heading "Risk Factors" in Part II, Item 1A. of this report and those discussed in our other Securities and Exchange Commission filings. Given these risks and uncertainties, you are cautioned not to place undue reliance on such forward-looking statements. The forward-looking statements included in this report are made only as of the date hereof. Except as required by applicable law, we do not undertake, and specifically decline, any obligation to update any of these statements or to publicly announce the results of any revisions to any forward-looking statements, whether as a result of new information, future events, changes in assumptions or otherwise. The following discussion should be read in conjunction with our Annual Report on Form 10-K as filed with the Securities and Exchange Commission in March 2022, and the audited consolidated financial statements and related notes contained therein.

Overview

We are a leading private health insurance marketplace with a technology and service platform that provides consumer engagement, education and health insurance enrollment solutions. Our mission is to connect every person with the highest quality, most affordable health insurance and Medicare plans for their life circumstances. Our platform leverages technology to solve a critical problem in a large and growing market by aiding consumers in what has traditionally been a complex, confusing, and opaque health insurance purchasing process. Our omnichannel consumer engagement platform enables consumers to use our services online, by telephone with a licensed insurance agent, or through a hybrid online assisted interaction. We have created a consumer-centric marketplace that offers consumers a broad choice of insurance products that includes thousands of Medicare Advantage, Medicare Supplement, Medicare Part D prescription drug, individual and family, small business and other ancillary health insurance products from approximately 200 health insurance carriers across all fifty states and the District of Columbia. Our plan recommendation tool curates this broad plan selection by analyzing customer health-related information against plan data for insurance coverage fit. This tool is supported by a unified data platform and is available to our ecommerce customers and our licensed agents.

Updates on Business Initiatives

During 2021, we made a number of changes to our telesales and online capabilities with a focus on driving performance and improving enrollment quality in preparation for the annual enrollment period ("AEP") in the fourth quarter. We continue to build on these initiatives in 2022. The introduction of enrollment quality assurance in the third quarter of 2021, in particular, resulted in an initial decline in conversion rates and longer talk times through the second quarter 2022. However, we are seeing improvement in enrollment quality metrics including Complaint Tracking Module scores and retention characteristics for the new enrollments that we added during the 2022 AEP, relative to comparable enrollment cohorts from the 2021 and 2020 AEPs. This suggests that the enrollments are of higher quality, resulting in higher customer satisfaction, increased plan longevity and potentially higher lifetime values.

Enrollment quality has been our focus since the launch of our retention program in 2020, which helps ensure that we present Medicare beneficiaries with choices that best align with their eligibility status, lifestyle, health conditions and economic means with the goal of minimal disruption in existing provider relationships. We have been seeking additional ways to improve our customer experience, enhance accuracy of plan recommendations and reduce disenrollment. In addition, over the past twelve months, we introduced a number of significant enhancements to our sales and marketing processes. This includes increased agent specialization by product and geography, improvement of agent training to further enhance their sales skills, and continued improvements in our omnichannel enrollment platform. For example, we launched an online chat tool powered by licensed agents and a co-browsing feature that allows agents and customers to share screens for more effective navigation of the enrollment experience. These initiatives enhance our technology differentiation and allow beneficiaries to progress through shopping and enrollment more easily. As a result, we saw a significant year-over-year increase in conversion rates in the third quarter of 2022 on our Medicare calls and increased productivity from our tenured and newly hired agents. We expect to continue to build on the positive momentum in our conversion rates as we move through the 2023 AEP season.

Transformational Plan — We are implementing a multi-year transformational plan to right-size our cost structure and drive future profitability. This plan incorporates different operational and cost savings initiatives, including a reduction in vendor-related spend outside of mission critical areas, plans to reduce our real-estate footprint as we become a virtual-first workplace, and a targeted workforce reduction implemented during the second quarter of 2022. In April 2022, we eliminated over 300 full-time positions, representing approximately 14% of our workforce, primarily within our customer care and enrollment group, and to a lesser extent, in our marketing and advertising, technology and content, and general and administrative groups.

We are also making changes to variable cost management. These initiatives are intended to improve our operations through re-engineering, reorganizing, and better deployment of marketing expenses. For example, we have de-emphasized underperforming demand generation channels in favor of channels that bring higher quality leads. Through this transformational plan, we expect to achieve ongoing significant cost savings while preserving our competitive edge and focusing on initiatives with highest in-period returns on investment. In 2022, we expect to achieve over $90 million in annualized cost savings compared to 2021. The variable cost reduction is expected to lead to a temporary decline in our Medicare enrollments and revenue in 2022 before a return to enrollment growth in 2023 on a significantly improved operational and cost foundation.

Changes in Senior Management

In January 2022, we announced the termination of employment of chief revenue officer, Timothy C. Hannan, effective January 31, 2022, and the appointment of Robert S. Hurley as interim chief revenue officer effective February 1, 2022. Mr. Hurley served as an interim chief revenue officer until Michelle Barbeau was appointed as chief marketing officer effective September 6, 2022. Mr. Hurley continues to serve as an executive advisor to senior management.

In February 2022, we announced the appointment of Roman Rariy as our chief operating officer and chief transformation officer, effective March 1, 2022.

In May 2022, we announced the appointment of John Dolan as our chief accounting officer and principal accounting officer of the Company, effective May 31, 2022.

COVID-19 Impact Updates

We experienced a number of changes in our business related to the impacts from the COVID-19 pandemic from 2020 onwards. During the first quarter of 2020, we closed our offices in the United States and China and shifted our employees to a work-from-home model in response to the virus outbreak. Our office in China has reopened since the second quarter of 2020 given the improvements in the situation in the region where our office is located. As a result of the pandemic, we have had to adjust our business operations, including onboarding and training new health insurance agents remotely. Since the pandemic, we have offered several programs to provide additional support to our employees and contractors, including our comfort equipment reimbursement program and internet and mobile phone reimbursement programs, to assist all employees with purchasing equipment to better enable remote work; access to digital health and mental wellness services for employees; and rigorous remote training programs.

Remote Work

We currently operate with a combination of remote and in-office work in the United States. All of our offices are open for employees who would prefer to work from one of our offices. Except for those whose job responsibilities require in-office work, none of our employees are required to return to the office full time. Most of our employees work remotely at this time, and we are taking steps to become a virtual-first workplace. For example, in August 2022, we signed a sublease agreement for our office space located in Santa Clara, California, and we may consider entering into additional sublease arrangements in the future. As we continue to assess challenges associated with enabling remote work, including the reconfiguration of work space and our facility footprint and fostering a cohesive workplace culture, we believe flexible workforce positions will make us a more attractive employer, increase productivity and enable us to recruit from a more diverse pool of applicants.

Summary of Selected Metrics

We rely upon certain metrics to estimate and recognize commission revenue, evaluate our business performance and facilitate strategic planning. Our commission revenue is influenced by a number of factors including but not limited to:

- the number of individuals on applications for Medicare-related, individual and family, small business and ancillary health insurance plans that are approved by the relevant health insurance carriers;
- the number of approved members for Medicare-related, individual and family, small business and ancillary health insurance plans from whom we have received an initial commission payment; and
- the constrained lifetime value ("LTV"), of approved members for Medicare-related, individual and family and ancillary health insurance plans we sell, as well as the estimated annual value of approved members for small business plans we sell.

Approved Members

Approved members represent the number of individuals on submitted applications that were approved by the relevant insurance carrier for the identified product during the period presented. The applications may be submitted in either the current period or prior periods. Not all approved members ultimately become paying members.

The following table shows approved members by product for the periods presented:

	Three Months Ended September 30,			Nine Months Ended September 30,		
	2022	2021	% Change	2022	2021	% Change
Medicare						
Medicare Advantage	37,777	36,836	3 %	171,714	222,289	(23)%
Medicare Supplement	2,581	4,258	(39)%	12,229	18,170	(33)%
Medicare Part D	4,532	5,690	(20)%	16,200	20,677	(22)%
Total Medicare	44,890	46,784	(4)%	200,143	261,136	(23)%
Individual and Family	4,859	8,232	(41)%	19,261	29,019	(34)%
Ancillary	17,019	23,084	(26)%	54,255	73,643	(26)%
Small Business	2,436	2,320	5 %	6,775	7,856	(14)%
Total Approved Members	69,204	80,420	(14)%	280,434	371,654	(25)%

Three Months Ended September 30, 2022 and 2021 – Total Medicare approved members decreased 4% in the three months ended September 30, 2022 compared to the same period in 2021. The decrease was attributable to a 39% and 20% decline in Medicare Supplement and Medicare Part D approved members, respectively, partially offset by an increase of 3% in Medicare Advantage approved members. The decrease in Medicare Supplement and Medicare Part D plan approved members was driven primarily by a shift in consumer demand which now favors Medicare Advantage as well as our targeted deployment of marketing and advertising costs toward Medicare Advantage. The increase in Medicare Advantage approved members was due to an increase in telephonic conversion rates and growth in online unassisted applications.

Individual and family plan approved members decreased 41% in the three months ended September 30, 2022 compared to the same period in 2021 due to an extension of the enrollment period in 2021 that did not occur in 2022.

Ancillary product approved members declined 26% in the three months ended September 30, 2022 compared to the same period in 2021 primarily due to declines in approved members across all ancillary insurance products that are typically cross sold with new individual and family plan enrollments. Small business group health insurance approved members increased 5% in the three months ended September 30, 2022 compared to the same period in 2021.

Nine Months Ended September 30, 2022 and 2021 – Total Medicare approved members decreased 23% in the nine months ended September 30, 2022 compared to the same period in 2021. This decrease was attributable to a decrease in approved members across all Medicare products that we market including Medicare Advantage, Medicare Supplement, and Medicare Part D prescription drug plans, driven primarily by a decrease in member acquisition spend including marketing and customer care and enrollment, as well as a decline in conversion rates in the first half of 2022 compared to the same period 2021.

Individual and family plan approved members declined 34% in the nine months ended September 30, 2022 compared to the same period in 2021 primarily due to an extension of the enrollment period in 2021 that did not occur in 2022.

Ancillary product approved members declined 26% in the nine months ended September 30, 2022 compared to the same period in 2021 primarily due to declines in approved members across all ancillary insurance products. Small business group health insurance approved members declined 14% in the nine months ended September 30, 2022 compared to the same period in 2021.

New Paying Members

New Paying Members consist of approved members from the period presented and any periods prior to the period presented from whom we have received an initial commission payment during the period presented. The following table shows our new paying members by product for the periods presented below:

	Three Months Ended September 30,			Nine Months Ended September 30,		
	2022	2021	% Change	2022	2021	% Change
Medicare						
Medicare Advantage	35,934	38,193	(6)%	203,053	256,900	(21)%
Medicare Supplement	1,972	3,832	(49)%	11,796	19,145	(38)%
Medicare Part D	4,146	5,601	(26)%	35,979	41,620	(14)%
Total Medicare	42,052	47,626	(12)%	250,828	317,665	(21)%
Individual and Family	5,034	8,143	(38)%	26,214	34,961	(25)%
Ancillary	17,751	24,662	(28)%	58,669	79,356	(26)%
Small Business	1,916	2,230	(14)%	6,921	8,746	(21)%
Total New Paying Members	66,753	82,661	(19)%	342,632	440,728	(22)%

Three Months Ended September 30, 2022 and 2021 – Total new paying members declined 19% in the three months ended September 30, 2022 compared to the same period in 2021 primarily due to a decline in Medicare Supplement and Medicare Part D plan approved members, as well the timing of the receipt of payments with respect to Medicare Advantage plan approved members.

Nine Months Ended September 30, 2022 and 2021 – Total new paying members declined 22% in the nine months ended September 30, 2022 compared to the same period in 2021, primarily due to an overall decline in approved members for all products.

Estimated Constrained Lifetime Value of Commissions Per Approved Member

The following table shows our estimated constrained LTV of commissions per approved member by product for the periods presented below:

	Three Months Ended September 30,		
	2022	2021	% Change
Medicare			
Medicare Advantage [1]	$ 953	$ 975	(2)%
Medicare Supplement [1]	956	955	— %
Medicare Part D [1]	219	227	(4)%
Individual and Family			
Non-Qualified Health Plans [1]	306	254	20 %
Qualified Health Plans [1]	289	296	(2)%
Ancillary			
Short-term [1]	149	157	(5)%
Dental [1]	100	98	2 %
Vision [1]	61	60	2 %
Small Business [2]	217	186	17 %

[1] Constrained LTV of commissions per approved member represents commissions estimated to be collected over the estimated life of an approved member's plan after applying constraints in accordance with our revenue recognition policy. The estimate is driven by multiple factors, including but not limited to, contracted commission rates, carrier mix, estimated average plan duration, the regulatory environment, and cancellations of insurance plans offered by health insurance carriers with which we have a relationship. These factors may result in varying values from period to period. For additional information on constrained LTV, see Critical Accounting Policies and Estimates in our Annual Report on Form 10-K for the year ended December 31, 2021.

[2] For small business, the amount represents the estimated commissions we expect to collect from the plan over the following twelve months. The estimate is driven by multiple factors, including but not limited to, contracted commission rates, carrier mix, estimated average plan duration, the regulatory environment, and cancellations of insurance plans offered by health insurance carriers with which we have a relationship and applied constraints. These factors may result in varying values from period to period.

Medicare

The constrained LTV of commissions per approved member declined by 2% and 4% for Medicare Advantage and Medicare Part D prescription drug plans, respectively, during the three months ended September 30, 2022 compared to the same period in 2021. The decrease in Medicare Advantage LTVs was primarily driven by less stable churn observations and a decrease in estimated average plan duration.

Individual and Family, Ancillary and Small Business

The constrained LTV of commissions per non-qualified health plan approved member increased 20% and qualified health plan approved member decreased 2% during the three months ended September 30, 2022 compared to the same period in 2021. The increase for non-qualified health plans was primarily due to more stable churn observations and an increase in estimated average plan duration. The decrease for qualified health plans was due to pressures on churn performance.

The constrained LTV of commissions per approved member for dental, vision, and small business insurance plans increased by 2%, 2% and 17%, respectively, during the three months ended September 30, 2022 compared with the same period in 2021. The increase for small business was due to higher commissions per group. The constrained LTV of commissions per approved member for short-term health insurance decreased 5% during the three months ended September 30, 2022 compared with the same period in 2021 primarily due to lower expected commissions.

The constraints applied to the total estimated lifetime commissions we expect to receive for selling the plan after the carrier approves an application in order to derive the constrained LTV of commissions for approved members recognized for the periods presented below are summarized as follows:

	Three Months Ended September 30,	
	2022	2021
Medicare		
Medicare Advantage	7 %	7 %
Medicare Supplement	9 %	9 %
Medicare Part D	7 %	7 %
Individual and Family		
Non-Qualified Health Plans	4 %	7 %
Qualified Health Plans	4 %	4 %
Ancillary		
Short-term	20 %	20 %
Dental	5 %	5 %
Vision	5 %	5 %
Other	10 %	10 %
Small Business	5 %	5 %

The constraints for all Medicare products remained the same during the three months ended September 30, 2022, as compared to the same period in the prior year. The constraints for non-qualified health plans decreased during the three months ended September 30, 2022, as compared to the same period in the prior year, due to stabilization of market conditions and historical increases in LTV values. The constraints for ancillary and small business insurance plans remained the same during the three months ended September 30, 2022, as compared to the same period in the prior year.

Estimated Membership

Estimated membership represents the estimated number of members active as of the date indicated based on the estimation methodology below. The following table shows estimated membership by product for the periods presented below:

	As of September 30,		
	2022	2021	% Change
Medicare [1]			
Medicare Advantage	582,203	559,235	4 %
Medicare Supplement	97,829	99,622	(2)%
Medicare Part D	224,542	216,582	4 %
Total Medicare	904,574	875,439	3 %
Individual and Family [1]	103,262	108,126	(4)%
Ancillary [1]	215,616	241,366	(11)%
Small Business [2]	49,543	45,697	8 %
Total Estimated Membership	1,272,995	1,270,628	— %

(1) To estimate the number of members on Medicare-related, Individual and Family ("IFP"), and ancillary health insurance plans, we take the respective sum of (i) the number of members for whom we have received or applied a commission payment for a month that may be up to three months prior to the date of estimation (after reducing that number using historical experience for assumed member cancellations over the period being estimated); and (ii) the number of approved members over that period (after reducing that number using historical experience for an assumed number of members who do not accept their approved policy and for estimated member cancellations through the date of the estimate). To the extent we determine through confirmations from a health insurance carrier that a commission payment is delayed or is inaccurate as of the date of estimation, we adjust the estimated membership to also reflect the number of members for whom we expect to receive or to refund a commission payment. Further the extent we have received substantially all of the commission payments related to a given month during the period being estimated, we will take the number of members for whom we have received or applied a commission payment during the month of estimation. For ancillary health insurance plans, the one to three-month period varies by insurance product and is largely dependent upon the timeliness of commission payment and related reporting from the related carriers.

(2) To estimate the number of members on small business health insurance plans, we use the number of initial members at the time the group was approved, and we update this number for changes in membership if such changes are reported to us by the group or carrier. However, groups generally notify the carrier directly of policy cancellations and increases or decreases in group size without informing us. Health insurance carriers often do not communicate policy cancellation information or group size changes to us. We often are made aware of policy cancellations and group size changes at the time of annual renewal and update our membership statistics accordingly in the period they are reported.

A member who purchases and is active on multiple standalone insurance plans will be counted as a member more than once. For example, a member who is active on both an individual and family health insurance plan and a standalone dental plan will be counted as two continuing members.

Health insurance carriers bill and collect insurance premiums paid by our members. The carriers do not report to us the number of members that we have as of a given date. The majority of our members who terminate their plans do so by discontinuing their premium payments to the carrier or notifying the carrier directly and do not inform us of the cancellation. Also, some of our members pay their premiums less frequently than monthly. Given the number of months required to observe non-payment of commissions in order to confirm cancellations, we estimate the number of members who are active on insurance policies as of a specified date.

After we have estimated membership for a period, we may receive information from health insurance carriers that would have impacted the estimate if we had received the information prior to the date of estimation. We may receive commission payments or other information that indicates that a member who was not included in our estimates for a prior period was in fact an active member at that time, or that a member who was included in our estimates was in fact not an active member of ours. For instance, we reconcile information carriers provide to us and may determine that we were not historically paid commissions owed to us, which would cause us to have underestimated membership. Conversely, carriers may require us to return commission payments paid in a prior

period due to policy cancellations for members we previously estimated as being active. We do not update our estimated membership numbers reported in previous periods. Instead, we reflect updated information regarding our historical membership in the membership estimate for the current period. If we experience a significant variance in historical membership as compared to our initial estimates, we keep the prior period data consistent with previously reported amounts, while we may provide the updated information in other communications or disclosures. As a result of the delay in our receipt of information from insurance carriers, actual trends in our membership are most discernible over periods longer than from one quarter to the next. As a result of the delay we experience in receiving information about our membership, it is difficult for us to determine with any certainty the impact of current conditions on our membership retention. Various circumstances could cause the assumptions and estimates that we make in connection with estimating our membership to be inaccurate, which would cause our membership estimates to be inaccurate.

Medicare-related plan estimated membership as of September 30, 2022 increased 3% compared to estimated membership as of September 30, 2021 due to a 4% growth in both Medicare Advantage and Medicare Part D plan estimated memberships and a 2% decline in Medicare Supplement plan estimated membership. The overall growth in Medicare estimated membership was due to new paying members we added over the last twelve months, net of churn.

Individual and family plan estimated membership as of September 30, 2022 declined 4% compared to estimated membership as of September 30, 2021 due to a decrease in applications. Ancillary plan estimated membership as of September 30, 2022 declined 11% compared to estimated membership as of September 30, 2021 primarily as a result of the decline across all ancillary plans estimated membership.

Member Acquisition

Marketing initiatives are an important component of our strategy to increase revenue and are primarily designed to encourage consumers to complete an application for health insurance. Variable marketing cost represents direct costs incurred in member acquisition from our direct, marketing partners and online advertising channels. In addition, we incur customer care and enrollment (“CC&E”) expenses in assisting applicants during the enrollment process. Variable marketing costs exclude fixed overhead costs, such as personnel related costs, consulting expenses, facilities and other operating costs allocated to the marketing and advertising department.

The following table shows the estimated variable marketing cost per approved member and the estimated customer care and enrollment expense per approved member metrics for the periods presented below. The numerator used to calculate each metric is the portion of the respective operating expenses for marketing and advertising and customer care and enrollment that is directly related to member acquisition for our sale of Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans (collectively, “Medicare Plans”) and for all individual and family major medical plans and short-term health insurance (collectively, “IFP Plans”), respectively. The denominator used to calculate each metric is based on a derived metric that represents the relative value of the new members acquired. For Medicare Plans, we call this derived metric Medicare Advantage (“MA”)-equivalent members, and for IFP Plans, we call this derived metric IFP-equivalent members. The calculations for MA-equivalent members and for IFP-equivalent members are based on the weighted number of approved members for Medicare Plans and IFP Plans during the period, with the number of approved members adjusted based on the relative LTV of the product they are purchasing. Since the LTV for any product fluctuates from period to period, the weight given to each product was determined based on their relative LTVs at the time of our adoption of *Accounting Standards Codification 606 – Revenue from Contracts with Customers* ("ASC 606").

	Three Months Ended September 30,		
	2022	2021	% Change
Medicare			
Estimated CC&E cost per MA-equivalent approved member [1]	$ 659	$ 1,099	(40)%
Estimated variable marketing cost per MA-equivalent approved member [1]	554	775	(29)%
Total Medicare estimated cost per approved member	$ 1,213	$ 1,874	(35)%
Individual and Family Plan			
Estimated CC&E cost per IFP-equivalent approved member [2]	$ 173	$ 119	45 %
Estimated variable marketing cost per IFP-equivalent approved member [2]	91	65	40 %
Total IFP estimated cost per approved member	$ 264	$ 184	43 %

[1] MA-equivalent approved members is a derived metric with a Medicare Part D approved member being weighted at 25% of a Medicare Advantage member and a Medicare Supplement member based on their relative LTVs at the time of our adoption of ASC 606. We calculate the number of approved MA-equivalent members by adding the total number of approved Medicare Advantage and Medicare Supplement members and 25% of the total number of approved Medicare Part D members during the period presented.

[2] IFP-equivalent approved members is a derived metric with a short-term approved member being weighted at 33% of a major medical individual and family health insurance plan member based on their relative LTVs at the time of our adoption of ASC 606. We calculate the number of approved IFP-equivalent members by adding the total number of approved qualified and non-qualified health plan members and 33% of the total number of short-term approved members during the period presented.

Estimated CC&E cost per MA-equivalent approved member decreased 40% in the three months ended September 30, 2022 compared to the same period in 2021 due to better channel mix and higher telephonic conversion rates. Estimated variable marketing cost per MA-equivalent approved member decreased 29% compared to the same period in 2021 primarily as a result of the improvements to our sales and marketing operations.

Estimated CC&E cost per IFP-equivalent approved member increased 45% in the three months ended September 30, 2022 compared to the same period in 2021 primarily due to an increase in the number of agents as we invest in individual coverage health reimbursement arrangement and state exchange opportunities. Estimated variable marketing cost per IFP-equivalent approved member increased 40% in the three months ended September 30, 2022 compared to the same period in 2021 primarily due to the decline in approved members compared to the same period in 2021.

Critical Accounting Policies and Estimates

The preparation of financial statements and related disclosures in conformity with U.S. generally accepted accounting principles requires us to make judgments, assumptions, and estimates that affect the amounts reported in the consolidated financial statements and the accompanying notes. These estimates and assumptions are based on current facts, historical experience, and various other factors that we believe are reasonable under the circumstances to determine reported amounts of assets, liabilities, revenue and expenses that are not readily apparent from other sources. To the extent there are material differences between our estimates and the actual results, our future consolidated results of comprehensive income (loss) may be affected.

An accounting policy is considered to be critical if the nature of the estimates or assumptions is material due to the levels of subjectivity and judgment necessary to account for highly uncertain matters or the susceptibility of such matters to change, and the effect of the estimates and assumptions on financial condition or operating performance. The accounting policies we believe to reflect our more significant estimates, judgments and assumptions and are most critical to understanding and evaluating our reported financial results are as follows:

- Revenue Recognition and contract assets - commission receivable;
- Stock-Based Compensation; and
- Accounting for Income Taxes.

There have been no changes to our critical accounting policies and estimates described in our Annual Report on Form 10-K for the year ended December 31, 2021, filed with the SEC on March 1, 2022, that have had a significant impact on our condensed consolidated financial statements and related notes. Please refer to *Management's Discussion and Analysis of Financial Condition and Results of Operations* contained in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2021, for a complete discussion of our other critical accounting policies and estimates.

Results of Operations

Our operating results and related percentage of total revenue are summarized below for the periods presented (dollars in thousands):

	Three Months Ended September 30,				Nine Months Ended September 30,			
	2022		2021		2022		2021	
Revenue								
Commission	$ 48,977	92 %	$ 59,191	93 %	$ 190,662	91 %	$ 276,066	94 %
Other	4,399	8 %	4,723	7 %	18,373	9 %	18,619	6 %
Total revenue	53,376	100 %	63,914	100 %	209,035	100 %	294,685	100 %
Operating costs and expenses [(1)]								
Cost of revenue	494	1 %	(25)	— %	790	— %	1,217	— %
Marketing and advertising	30,556	57 %	43,317	68 %	118,973	57 %	138,772	47 %
Customer care and enrollment	29,398	55 %	48,956	77 %	100,711	48 %	121,480	41 %
Technology and content	19,399	36 %	20,369	31 %	56,842	27 %	63,996	22 %
General and administrative	17,300	32 %	16,640	26 %	54,485	26 %	57,812	20 %
Amortization of intangible assets	—	— %	121	— %	—	— %	416	— %
Impairment, restructuring and other charges	4,498	8 %	573	1 %	10,690	5 %	3,004	1 %
Total operating costs and expenses	101,645	190 %	129,951	203 %	342,491	164 %	386,697	131 %
Loss from operations	(48,269)	(90)%	(66,037)	(103)%	(133,456)	(64)%	(92,012)	(31)%
Other income (expense), net	(647)	(1)%	189	— %	(2,835)	(1)%	511	— %
Loss before income taxes	(48,916)	(92)%	(65,848)	(103)%	(136,291)	(65)%	(91,501)	(31)%
Benefit from income taxes	(9,767)	(18)%	(12,834)	(20)%	(26,898)	(13)%	(19,278)	(7)%
Net loss	$ (39,149)	(73)%	$ (53,014)	(83)%	$ (109,393)	(52)%	$ (72,223)	(24)%

(1) Operating costs and expenses include the following amounts of stock-based compensation expense (in thousands):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2022	2021	2022	2021
Marketing and advertising	$ 570	$ 2,297	$ 1,311	$ 6,922
Customer care and enrollment	610	740	1,576	1,901
Technology and content	1,341	2,380	5,012	7,483
General and administrative	2,623	(183)	8,035	8,575
Total stock-based compensation expense	$ 5,144	$ 5,234	$ 15,934	$ 24,881

Revenue

Our commission revenue, other revenue and total revenue are summarized as follows (dollars in thousands):

	Three Months Ended September 30,		Change		Nine Months Ended September 30,		Change	
	2022	2021	$	%	2022	2021	$	%
Commission	$ 48,977	$ 59,191	$ (10,214)	(17)%	$ 190,662	$ 276,066	$ (85,404)	(31)%
% of total revenue	92 %	93 %			91 %	94 %		
Other	4,399	4,723	(324)	(7)%	18,373	18,619	(246)	(1)%
% of total revenue	8 %	7 %			9 %	6 %		
Total revenue	$ 53,376	$ 63,914	$ (10,538)	(16)%	$ 209,035	$ 294,685	$ (85,650)	(29)%

Three Months Ended September 30, 2022 and 2021 – Commission revenue decreased $10.2 million, or 17% during the three months ended September 30, 2022 compared to the same period in 2021 due to a $1.2 million decrease in commission revenue from the Medicare segment and a $9.0 million decrease in commission revenue from the Individual, Family and Small Business segment.

The decrease in commission revenue from the Medicare segment was driven by a 4% decline in Medicare plan approved members. This was primarily due to a 39% and 20% decline in Medicare Supplement and Medicare Part D plan approved members, respectively, partially offset by a 3% increase in Medicare Advantage plan approved members compared to the same period in 2021. The decrease in commission revenue from the Individual, Family and Small Business segment was primarily due to $1.8 million in net adjustment revenue from prior period enrollments for the three months ended September 30, 2022 compared to $10.0 million for the same period in 2021, a 41% decrease in individual and family plan approved members and a 26% decline in ancillary product approved members, partially offset by an increase in constrained lifetime value of commissions per approved IFP member compared to the same period in 2021. See *Approved Members* above and *Segment Information* below for further discussion.

Other revenue decreased $0.3 million, or 7%, during the three months ended September 30, 2022 compared to the same period in 2021 due to a decrease in advertising revenue.

Nine Months Ended September 30, 2022 and 2021 – Commission revenue decreased $85.4 million, or 31%, during the nine months ended September 30, 2022 compared to the same period in 2021 due to a $59.5 million decrease in commission revenue from the Medicare segment and a $25.9 million decrease in Individual, Family and Small Business segment commission revenue.

The decrease in commission revenue from the Medicare segment was driven by a 23% decline in overall Medicare plan approved members, specifically a 23% decline in Medicare Advantage plan approved members compared to the same period in 2021. The decrease in commission revenue from the Individual, Family and Small Business segment was primarily due to a 34% decline in individual and family plan approved members, a 26% decline in ancillary product approved members, and $4.4 million in net adjustment revenue from prior period enrollments for the nine months ended September 30, 2022 compared to $29.1 million for the same period in 2021. See *Approved Members* above and *Segment Information* below for further discussion.

Other revenue decreased $0.2 million, or 1%, during the nine months ended September 30, 2022 compared to the same period in 2021 due to a decrease in advertising revenue.

Cost of Revenue

Cost of revenue consists of payments related to health insurance plans sold to members who were referred to our website by marketing partners with whom we have revenue-sharing arrangements. In order to enter into a revenue-sharing arrangement, marketing partners must be licensed to sell health insurance in the state where the policy is sold. Costs related to revenue-sharing arrangements are expensed as the related revenue is recognized.

Additionally, cost of revenue includes the amortization of consideration we paid to certain broker partners in connection with the transfer of their health insurance members to us as the new broker of record on the underlying plans. These transfers include primarily Medicare plan members. Consideration for all book-of-business transfers is being amortized to cost of revenue as we recognize commission revenue related to the transferred members.

Our cost of revenue is summarized as follows (dollars in thousands):

	Three Months Ended September 30,		Change		Nine Months Ended September 30,		Change	
	2022	2021	$	%	2022	2021	$	%
Cost of revenue	$ 494	$ (25)	$ 519	2,076 %	$ 790	$ 1,217	$ (427)	(35)%
% of total revenue	1 %	— %			— %	— %		

Three Months Ended September 30, 2022 and 2021 – Cost of revenue increased by $0.5 million during the three months ended September 30, 2022, compared to the same period in 2021, primarily due to increased activity from our revenue sharing arrangements.

Nine Months Ended September 30, 2022 and 2021 – Cost of revenue decreased by $0.4 million during the nine months ended September 30, 2022, compared to the same period in 2021, primarily due to decreased activity from our revenue sharing arrangements.

Marketing and Advertising

Marketing and advertising expenses consist primarily of member acquisition expenses associated with our direct, marketing partner and online advertising member acquisition channels, in addition to compensation and other expenses related to marketing, business development, partner management, public relations and carrier relations personnel who support our offerings.

Our marketing and advertising expenses are summarized as follows (dollars in thousands):

	Three Months Ended September 30,		Change		Nine Months Ended September 30,		Change	
	2022	2021	$	%	2022	2021	$	%
Marketing and advertising	$ 30,556	$ 43,317	$ (12,761)	(29)%	$ 118,973	$ 138,772	$ (19,799)	(14)%
% of total revenue	57 %	68 %			57 %	47 %		

Three Months Ended September 30, 2022 and 2021 – Marketing and advertising expenses decreased $12.8 million, or 29%, during the three months ended September 30, 2022 compared to the same period in 2021, primarily driven by decreases of $10.0 million in Medicare plan related variable advertising, $1.7 million in stock-based compensation expense, and $1.4 million in personnel and compensation costs, partially offset by an increase of $0.4 million in consulting expenses. The decrease in variable advertising expenses was due to a decrease in our advertising expense through select lead generation partners and direct TV channels as we shift to a more targeted deployment of our marketing budget to emphasize highest performing channels.

Nine Months Ended September 30, 2022 and 2021 – Marketing and advertising expenses decreased $19.8 million, or 14%, during the nine months ended September 30, 2022 compared to the same period in 2021, primarily driven by decreases of $14.6 million in Medicare plan related variable advertising, $5.6 million in stock-based compensation expense, and $1.7 million in personnel and compensation costs, partially offset by an increase of $1.7 million in consulting expenses. The decrease in variable advertising expenses was due to a decrease in our advertising expense through select lead generation partners and direct TV channels.

Customer Care and Enrollment

Customer care and enrollment expenses primarily consist of compensation, benefits and licensing costs for personnel engaged in assistance to applicants who call our customer care center and for enrollment personnel who assist applicants during the enrollment process.

Our customer care and enrollment expenses are summarized as follows (dollars in thousands):

	Three Months Ended September 30,		Change		Nine Months Ended September 30,		Change	
	2022	2021	$	%	2022	2021	$	%
Customer care and enrollment	$ 29,398	$ 48,956	$ (19,558)	(40)%	$ 100,711	$ 121,480	$ (20,769)	(17)%
% of total revenue	55 %	77 %			48 %	41 %		

Three Months Ended September 30, 2022 and 2021 – Customer care and enrollment expenses decreased $19.6 million, or 40%, during the three months ended September 30, 2022 compared to the same period in 2021, primarily due to decreases of $17.2 million in personnel cost from decreased headcount, $1.2 million in facilities and other expenses, and $0.7 million in consulting expenses.

Nine Months Ended September 30, 2022 and 2021 – Customer care and enrollment expenses decreased $20.8 million, or 17%, during the nine months ended September 30, 2022 compared to the same period in 2021, primarily due to decreases of $15.4 million in personnel costs and $6.5 million in consulting expenses, partly offset by an increase of $0.8 million in facilities and other expenses.

Technology and Content

Technology and content expenses consist primarily of compensation and benefits costs for personnel associated with developing and enhancing our website technology as well as maintaining our website. A portion of our technology and content group is located at our wholly-owned subsidiary in China, where technology development costs are generally lower than in the United States.

Our technology and content expenses are summarized as follows (dollars in thousands):

	Three Months Ended September 30,		Change		Nine Months Ended September 30,		Change	
	2022	2021	$	%	2022	2021	$	%
Technology and content	$ 19,399	$ 20,369	$ (970)	(5)%	$ 56,842	$ 63,996	$ (7,154)	(11)%
% of total revenue	36 %	31 %			27 %	22 %		

Three Months Ended September 30, 2022 and 2021 – Technology and content expenses decreased $1.0 million, or 5%, during the three months ended September 30, 2022 compared to the same period in 2021 primarily driven by decreases of $1.0 million in stock-based compensation expense, $0.7 million in consulting costs, and $0.6 million in personnel and compensation costs due to lower headcount, partially offset by increases of $1.2 million in amortization of internally developed software and $0.7 million in facilities and other operating costs.

Nine Months Ended September 30, 2022 and 2021 – Technology and content expenses decreased $7.2 million, or 11%, during the nine months ended September 30, 2022 compared to the same period in 2021 primarily driven by decreases of $3.3 million in personnel and compensation costs due to lower headcount, $2.5 million in stock-based compensation expense, $2.1 million in consulting costs, and $2.0 million in facilities and other operating costs, partially offset by an increase of $3.6 million in amortization of internally developed software.

General and Administrative

General and administrative expenses include compensation and benefits costs for personnel working in our executive, finance, investor relations, government affairs, legal, human resources, internal audit, facilities and

internal information technology departments. These expenses also include fees paid for outside professional services, including audit, tax, legal, government affairs and information technology fees.

Our general and administrative expenses are summarized as follows (dollars in thousands):

	Three Months Ended September 30,		Change		Nine Months Ended September 30,		Change	
	2022	2021	$	%	2022	2021	$	%
General and administrative	$ 17,300	$ 16,640	$ 660	4 %	$ 54,485	$ 57,812	$ (3,327)	(6)%
% of total revenue	32 %	26 %			26 %	20 %		

Three Months Ended September 30, 2022 and 2021 – General and administrative expenses increased $0.7 million, or 4%, during the three months ended September 30, 2022 compared to the same period in 2021, primarily driven by increases of $2.8 million in stock-based compensation expense, $0.4 million in other professional fees, and $0.4 million in personnel costs, partially offset by a decrease of $3.1 million in facilities and other operating costs. The increase in stock-based compensation expense during the third quarter of 2022 was primarily due to a $4.1 million credit related to equity awards forfeited in the third quarter of 2021 in connection with the termination of employment of our former chief executive officer.

Nine Months Ended September 30, 2022 and 2021 – General and administrative expenses decreased $3.3 million, or 6%, during the nine months ended September 30, 2022 compared to the same period in 2021, primarily driven by a decrease of $4.3 million in in facilities and other operating cost, partially offset by an increase of $1.0 million in consulting expenses.

Amortization of Intangible Assets

Our intangible asset amortization expense is summarized as follows (dollars in thousands):

	Three Months Ended September 30,		Change		Nine Months Ended September 30,		Change	
	2022	2021	$	%	2022	2021	$	%
Amortization of intangible assets	$ —	$ 121	$ (121)	(100)%	$ —	$ 416	$ (416)	(100)%
% of total revenue	— %	— %			— %	— %		

Amortization expense decreased during the three and nine months ended September 30, 2022 compared to the same periods in 2021 due to the impairment of our finite-lived intangible assets at December 31, 2021.

Impairment, Restructuring and Other Charges

Our impairment, restructuring and other charges consist primarily of severance, transition and other related costs and impairment charges. Our impairment, restructuring and other charges are summarized as follows (dollars in thousands):

	Three Months Ended September 30,		Change		Nine Months Ended September 30,		Change	
	2022	2021	$	%	2022	2021	$	%
Impairment, restructuring and other charges	$ 4,498	$ 573	$ 3,925	685 %	$ 10,690	$ 3,004	$ 7,686	256 %
% of total revenue	8 %	1 %			5 %	1 %		

Three Months Ended September 30, 2022 and 2021 – Impairment, restructuring and other charges for the three months ended September 30, 2022 primarily consisted of $3.7 million of impairment charges, which were related to $2.5 million of operating lease right-of-use assets impairment and $0.9 million of property, plant and equipment impairment related to our Santa Clara, California office sublease and $0.3 million of impairment charges related to abandoned in-process internally developed software during the quarter. Additionally, we incurred

$0.8 million of restructuring charges primarily related to employee termination benefits during the three months ended September 30, 2022.

Nine Months Ended September 30, 2022 and 2021 – Impairment, restructuring and other charges for the nine months ended September 30, 2022 primarily consisted of $7.0 million of severance and other personnel related cost related to the restructuring that took place throughout 2022 as well as $3.7 million of impairment charges, which were related to $2.5 million of operating lease right-of-use assets impairment and $0.9 million of property, plant and equipment impairment related to our Santa Clara, California office sublease and $0.3 million of impairment charges related to abandoned in-process internally developed software during the quarter. In the first half of 2022, we completed a reduction in force in April 2022 in which we eliminated 339 full-time positions, representing approximately 14% of our workforce, primarily within the customer care and enrollment groups, and to a lesser extent, in our marketing and advertising and general and administrative groups, and, as a result, incurred $6.2 million of restructuring charges. In the three months ended September 30, 2022, we incurred restructuring charges of $0.8 million for additional eliminated positions.

Other Income (Expense), Net

Other income (expense), net, primarily consisted of interest income, sublease income and margin earned on commissions received from Medicare plan members transferred to us in 2010 through 2012 by a broker partner, partially offset by interest expense on finance leases and debt and other bank fees.

Our other income (expense), net is summarized as follows (dollars in thousands):

	Three Months Ended September 30,		Change		Nine Months Ended September 30,		Change	
	2022	2021	$	%	2022	2021	$	%
Other income (expense), net	$ (647)	$ 189	$ (836)	(442)%	$ (2,835)	$ 511	$ (3,346)	(655)%
% of total revenue	(1)%	— %			(1)%	— %		

Three Months Ended September 30, 2022 and 2021 – Other income (expense), net was $(0.6) million and $0.2 million during the three months ended September 30, 2022 and September 30, 2021, respectively. The change for the three months ended September 30, 2022 was primarily due to $2.1 million of interest expense for the Credit Agreement entered into during the first quarter of 2022, partially offset by an increase of approximately $0.8 million in interest income.

Nine Months Ended September 30, 2022 and 2021 – Other income (expense), net was $(2.8) million and $0.5 million during the nine months ended September 30, 2022 and September 30, 2021, respectively. The change for the nine months ended September 30, 2022 was primarily due to $4.7 million of interest expense for the Credit Agreement entered into during the first quarter of 2022 and $0.4 million of expenses related to the termination of the RBC revolving credit facility at the same time, partially offset by an increase of $1.2 million in interest income.

Benefit from Income Taxes

Our benefit from income taxes are summarized as follows (dollars in thousands):

	Three Months Ended September 30,		Change		Nine Months Ended September 30,		Change	
	2022	2021	$	%	2022	2021	$	%
Benefit from income taxes	$ (9,767)	$ (12,834)	$ 3,067	(24)%	$ (26,898)	$ (19,278)	$ (7,620)	40 %
Effective tax rate	20.0 %	19.5 %			19.7 %	21.1 %		

Three Months Ended September 30, 2022 and 2021 – Our effective tax rate of 20.0% for the three months ended September 30, 2022 was higher than our 19.5% effective tax rate for the three months ended September 30, 2021 primarily due to fluctuations in stock-based compensation adjustments. Our effective tax rate for the three months ended September 30, 2022 was lower than the statutory federal tax rate primarily due to stock-based compensation adjustments, non-deductible lobbying expenses, partially offset by research and development credits and state taxes.

Nine Months Ended September 30, 2022 and 2021 – Our effective tax rate of 19.7% for the nine months ended September 30, 2022 was lower than our 21.1% effective tax rate for the nine months ended September 30, 2021 primarily due to fluctuations in stock-based compensation adjustments. Our effective tax rate for the nine months ended September 30, 2022 was lower than the statutory federal tax rate due primarily to stock-based compensation adjustments, non-deductible lobbying expenses, partially offset by research and development credits and state taxes.

Segment Information

We report segment information based on how our chief executive officer, who is our chief operating decision maker, or CODM, regularly reviews our operating results, allocates resources and makes decisions regarding our business operations. The performance measures of our segments include total revenue and profit (loss). Our business structure is comprised of two operating segments:

- Medicare; and
- Individual, Family and Small Business.

Our CODM does not separately evaluate assets by segment, with the exception of commissions receivable, and therefore assets by segment are not presented.

The Medicare segment consists primarily of commissions earned from our sale of Medicare-related health insurance plans, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans, and to a lesser extent, ancillary products sold to our Medicare-eligible applicants, including but not limited to, dental and vision plans, as well as our advertising program that allows Medicare-related carriers to purchase advertising on a separate website developed, hosted and maintained by us and to purchase other marketing and advertising services, as well as our delivery and sale to third parties of Medicare-related health insurance leads generated by our ecommerce platforms and our marketing activities.

The Individual, Family and Small Business segment consists primarily of commissions earned from our sale of individual, family and small business health insurance plans and ancillary products sold to our non-Medicare-eligible applicants, including but not limited to, dental, vision, and short-term health insurance. To a lesser extent, the Individual, Family and Small Business segment consists of amounts earned from our online sponsorship program that allows carriers to purchase advertising space in specific markets in a sponsorship area on our website, our licensing to third parties for the use of our health insurance ecommerce technology, and our delivery and sale to third parties of individual and family health insurance leads generated by our ecommerce platforms and our marketing activities.

Marketing and advertising, customer care and enrollment, technology and content, and general and administrative operating expenses that are directly attributable to a segment are reported within the applicable segment. Indirect marketing and advertising, customer care and enrollment, and technology and content operating expenses are allocated to each segment based on usage. Other indirect general and administrative operating expenses are managed in a corporate shared services environment and, since they are not the responsibility of segment operating management, are not allocated to the operating segments and instead reported within Corporate.

Segment profit (loss) is calculated as total revenue for the applicable segment less direct and indirect allocated marketing and advertising, customer care and enrollment, technology and content, and general and administrative operating expenses, excluding stock-based compensation expense, depreciation and amortization expense, amortization of intangible assets, and impairment, restructuring and other charges.

Our operating segment revenue and profit (loss) are summarized as follows (in thousands):

	Three Months Ended September 30,		Change		Nine Months Ended September 30,		Change	
	2022	2021	$	%	2022	2021	$	%
Revenue:								
Medicare	$ 45,137	$ 46,381	$ (1,244)	(3)%	$ 181,266	$ 240,633	$ (59,367)	(25)%
Individual, Family and Small Business	8,239	17,533	(9,294)	(53)%	27,769	54,052	(26,283)	(49)%
Total revenue	$ 53,376	$ 63,914	$ (10,538)	(16)%	$ 209,035	$ 294,685	$ (85,650)	(29)%
Segment profit (loss)								
Medicare	$ (22,962)	$ (52,882)	$ 29,920	57 %	$ (63,050)	$ (46,141)	$ (16,909)	(37)%
Individual, Family and Small Business	2,688	12,499	(9,811)	(78)%	12,285	38,476	(26,191)	(68)%
Segment loss	(20,274)	(40,383)	20,109	50 %	(50,765)	(7,665)	(43,100)	(562)%
Corporate	(12,795)	(14,827)	2,032	14 %	(40,382)	(43,206)	2,824	7 %
Stock-based compensation expense	(5,144)	(5,234)	90	2 %	(15,934)	(24,881)	8,947	36 %
Depreciation and amortization [1]	(5,558)	(4,899)	(659)	(13)%	(15,685)	(12,840)	(2,845)	(22)%
Amortization of intangible assets	—	(121)	121	100 %	—	(416)	416	100 %
Impairment, restructuring and other charges	(4,498)	(573)	(3,925)	(685)%	(10,690)	(3,004)	(7,686)	(256)%
Other income (expense), net	(647)	189	(836)	(442)%	(2,835)	511	(3,346)	(655)%
Loss before income taxes	$ (48,916)	$ (65,848)	$ 16,932	26 %	$ (136,291)	$ (91,501)	$ (44,790)	(49)%

[1] Depreciation and amortization has been adjusted to include amortization of software development costs.

Revenue

Three Months Ended September 30, 2022 and 2021 – Revenue from our Medicare segment declined $1.2 million, or 3%, during the three months ended September 30, 2022 compared to the same period in 2021, primarily attributable to a $1.2 million decrease in commission revenue, driven by an overall decline of 4% in Medicare plan approved members and a 2% decline in Medicare Advantage LTVs.

Revenue from our Individual, Family and Small Business segment declined $9.3 million, or 53%, during the three months ended September 30, 2022 compared to the same period in 2021, primarily attributable to a $9.0 million decrease in commission revenue driven by a 41% decrease in individual and family plan approved members and a 26% decline in ancillary product approved members. Based on our evaluation of the updated LTV models and retention trends, we recognized $1.8 million in net adjustment revenue from prior period enrollments during the three months ended September 30, 2022 compared to $10.0 million for the same period in 2021.

Nine Months Ended September 30, 2022 and 2021 – Revenue from our Medicare segment declined $59.4 million, or 25%, during the nine months ended September 30, 2022 compared to the same period in 2021, primarily attributable to a $59.5 million decrease in commission revenue. The decrease in Medicare segment commission revenue is primarily due to a $57.2 million decrease in Medicare Advantage plan related commission revenue, driven by a 23% decline in Medicare Advantage plan approved members.

Revenue from our Individual, Family and Small Business segment declined $26.3 million, or 49%, during the nine months ended September 30, 2022 compared to the same period in 2021, primarily attributable to a $25.9 million decrease in commission revenue driven by a 34% decline in individual and family plan approved members and a decline of 26% in ancillary product approved members. Based on our evaluation of the updated LTV models and retention trends, we recognized $4.4 million in net adjustment revenue from prior period enrollments during the nine months ended September 30, 2022 compared to $29.1 million for the same period in 2021.

Segment Profit (Loss)

Three Months Ended September 30, 2022 and 2021 – Our Medicare segment loss was $23.0 million during the three months ended September 30, 2022, a decrease of $29.9 million, or 57%, compared to segment loss of $52.9 million for the same period in 2021. The improvement in net segment loss was primarily due to a decrease of $31.2 million in operating expenses, excluding stock-based compensation expense, depreciation and amortization expense, impairment, restructuring and other charges, and other income (expense), partially offset by a $1.2 million decrease in revenue. The decrease in operating expenses was due to impacts from our transformation initiatives.

Our Individual, Family and Small Business segment profit was $2.7 million during the three months ended September 30, 2022, a decrease of $9.8 million, or 78%, compared to segment profit of $12.5 million for the same period in 2021. The decrease was primarily driven by a $9.3 million decrease in revenue.

Nine Months Ended September 30, 2022 and 2021 – Our Medicare segment loss was $63.1 million during the nine months ended September 30, 2022, an increase of $16.9 million, or 37%, compared to segment loss of $46.1 million for the same period in 2021. This was primarily due to a $59.4 million decrease in revenue, partially offset by a $42.5 million decrease in operating expenses, excluding stock-based compensation expense, depreciation and amortization expense, impairment, restructuring and other charges, and other income (expense). The decrease in operating expenses was mostly attributable to impacts from our transformation initiatives.

Our Individual, Family and Small Business segment profit was $12.3 million during the nine months ended September 30, 2022, a decrease of $26.2 million, or 68% compared to segment profit of $38.5 million for the same period in 2021. The decrease was primarily driven by a $26.3 million decrease in revenue.

Liquidity and Capital Resources

Material Cash Requirements

Our material cash requirements include our operating leases and service and licensing obligations. See *Note 10 – Leases* in our *Notes to Condensed Consolidated Financial Statements* for the details of our operating lease obligations. We have entered into service and licensing agreements with third party vendors to provide various services, including network access, equipment maintenance and software licensing. The terms of these services and licensing agreements are generally up to three years. We record the related service and licensing expenses on a straight-line basis, although actual cash payment obligations under certain of these agreements fluctuate over the terms of the agreements. See Note 8 – *Commitments and Contingencies* in our *Notes to Condensed Consolidated Financial Statements.*

Short-term obligations were $8.3 million for leases and $9.1 million for service and licensing as of September 30, 2022. Long-term obligations were $36.9 million for leases and $4.3 million for service and licensing as of September 30, 2022. We expect to fund these obligations through our existing cash and cash equivalents and cash generated from operations.

Our future capital requirements will depend on many factors, including our enrollment volume, membership, retention rates, telesales conversion rates, and our level of investment in technology and content, marketing and advertising, customer care and enrollment, and other initiatives. In addition, our cash position could be impacted by the level of investments we make to pursue our strategy. To the extent that available funds are insufficient to fund our future activities or to execute our financial strategy, we may raise additional capital through bank debt, or public or private equity or debt financing to the extent such funding sources are available. We are implementing a multi-

year transformational plan to right-size our cost structure and drive future profitability. This plan incorporates different operational and cost savings initiatives, including a reduction in vendor-related spend outside of mission critical areas, plans to reduce our real-estate footprint as we become a virtual-first workplace, and a targeted workforce reduction implemented during 2022. In April 2022, we eliminated 339 full-time positions, representing approximately 14% of our workforce, primarily within our customer care and enrollment group, and to a lesser extent, in our marketing and advertising, technology and content, and general and administrative groups. These reductions could adversely impact the growth of membership and revenue.

We believe our current cash and cash equivalents, including the proceeds from the term loan we obtained on February 28, 2022 under our Credit Agreement and expected cash collections will be sufficient to fund our operations for at least 12 months after the filing date of this Quarterly Report on Form 10-Q.

Our cash, cash equivalents, and short-term marketable securities are summarized as follows (in thousands):

	September 30, 2022	December 31, 2021
Cash and cash equivalents	$ 160,258	$ 81,926
Short-term marketable securities	4,491	41,306
Total cash, cash equivalents, and short-term marketable securities	$ 164,749	$ 123,232

While we recognize constrained LTV as revenue at the time applications are approved, our collection of the cash commissions resulting from approved applications generally occurs over a number of years. The expense associated with approved applications, however, is generally incurred at the time of enrollment. As a result, the net cash flow resulting from approved applications is generally negative in the period of revenue recognition and generally becomes positive over the lifetime of the member. In periods of membership growth, cash receipts associated with new and continuing members may be less than the cash outlays to acquire new members. We expect a reduction in cash and cash equivalents in the future resulting from our continued investments to grow our business. To the extent that available funds are insufficient to fund our future activities or to execute our financial strategy, we may raise additional capital through bank debt, or public or private equity or debt financing to the extent such funding sources are available. Alternatively, we may decide to reduce marketing and advertising, customer care and enrollment, technology and content, or other expenses in order to manage liquidity. These reductions could adversely impact our rate of membership and revenue growth.

As of September 30, 2022, our cash and cash equivalents totaled $160.3 million. Cash equivalents, which are comprised of financial instruments with an original maturity of 90 days or less from the date of purchase, primarily consist of money market funds and commercial paper. The increase in cash and cash equivalents reflects $8.3 million of net cash used in operating activities, $24.1 million of net cash provided by investing activities, and $62.9 million of net cash provided by financing activities. We also maintained $3.2 million in restricted cash as of September 30, 2022 and December 31, 2021.

The following table presents a summary of our cash flows for the nine months ended September 30, 2022 (in thousands):

	Nine Months Ended September 30,	
	2022	2021
Net cash used in operating activities	$ (8,290)	$ (60,321)
Net cash provided by (used in) investing activities	24,135	(36,822)
Net cash provided by financing activities	62,925	210,914

Operating Activities

Net cash used in operating activities primarily consists of net loss, adjusted for certain non-cash items, including, deferred income taxes, stock-based compensation expense, depreciation and amortization, amortization of intangible assets and internally developed software, other non-cash items, and the effect of changes in working capital and other activities.

Collection of commissions receivable depends upon the timing of our receipt of commission payments and associated commission reports from health insurance carriers. If we were to experience a delay in receiving a commission payment from a health insurance carrier within a quarter, our operating cash flows for that quarter could be adversely impacted.

A significant portion of our marketing and advertising expense is directly correlated with the number of health insurance applications submitted on our ecommerce platforms. Since our marketing and advertising costs are expensed and generally paid as incurred, and since commission revenue is recognized upon approval of a member but commission payments are paid to us over time, our operating cash flows could be adversely impacted by a substantial increase in the volume of applications submitted during a quarter or positively impacted by a substantial decline in the volume of applications submitted during a quarter. During the Medicare annual enrollment period that takes place during the last quarter of each year and the reintroduced Medicare Advantage open enrollment period in the first quarter of the year, we experience an increase in the number of submitted Medicare-related health insurance applications and marketing and advertising expenses compared to outside of these enrollment periods. Similarly, during the open enrollment period for individual and family health insurance plans which typically takes place during the fourth quarter of each year, we experience an increase in the number of submitted individual and family plan health insurance applications and marketing and advertising expenses compared to outside of open enrollment periods. The timing of enrollment periods for individual and family health insurance plans, the Medicare annual enrollment period and the open enrollment period for Medicare-related health insurance can positively or negatively affect our cash flows during each quarter.

Nine Months Ended September 30, 2022 – Net cash used in operating activities was $8.3 million during the nine months ended September 30, 2022, primarily driven by a net loss of $109.4 million, offset by changes in net operating assets and liabilities of $91.6 million and adjustments for non-cash items of $9.5 million. Adjustments for non-cash items primarily consisted of $15.9 million of stock-based compensation expense and $12.7 million of amortization of internally-developed software, partially offset by a $27.2 million decrease due to the change in deferred income taxes. Cash provided by changes in net operating assets and liabilities during the nine months ended September 30, 2022 primarily consisted of decreases of $122.4 million in contract assets – commissions receivable, $2.7 million in prepaid expenses and other assets, and $3.9 million in accounts receivable, partly offset by decreases of $28.2 million in accrued marketing expenses and $7.1 million in accounts payable.

Nine Months Ended September 30, 2021 – Net cash used in operating activities was $60.3 million during the nine months ended September 30, 2021, primarily driven by net loss of $72.2 million and changes in net operating assets and liabilities of $7.0 million, partially offset by adjustments for non-cash items of $18.9 million. Adjustments for non-cash items primarily consisted of $24.9 million of stock-based compensation expense, $9.6 million of amortization of intangible assets and internally-developed software, and $3.7 million of depreciation and amortization, partially offset by a $20.1 million decrease due to the change in deferred income taxes. Cash used from changes in net operating assets and liabilities during the nine months ended September 30, 2021 primarily consisted of decreases of $26.9 million in accounts payable, $6.5 million in accrued marketing expense, increases of $20.8 million in prepaid expenses and other current asset, and decreases in $0.1 million in accrued compensation and benefits, partially offset by decreases of $35.2 million in contract assets – commissions receivable, increases of $10.2 million in deferred revenue and $1.4 million in accrued expenses and other liabilities.

Investing Activities

Our investing activities primarily consist of purchases, maturities, and redemptions of marketable securities as well as purchases of computer hardware and software to enhance our website and customer care operations, leasehold improvements related to facilities expansion, capitalized internal-use software and website development costs and security deposit payments.

Nine Months Ended September 30, 2022 – Net cash provided by investing activities of $24.1 million for the nine months ended September 30, 2022 mainly consisted of $45.3 million of proceeds from the maturities and redemptions of marketable securities, partially offset by $12.5 million in capitalized internal-use software and website development costs and $8.4 million used to purchase marketable securities.

Nine Months Ended September 30, 2021 – Net cash used in investing activities of $36.8 million for the nine months ended September 30, 2021 mainly consisted of $89.0 million used to purchase marketable securities, $12.6 million in capitalized internal-use software and website development costs and $3.6 million used to purchase property and equipment and other assets, partially offset by $68.3 million of proceeds from the maturities and redemptions of marketable securities.

Financing Activities

Nine Months Ended September 30, 2022 – Net cash provided by financing activities of $62.9 million for the nine months ended September 30, 2022 was primarily due to $64.9 million of net proceeds from debt financing and $1.1 million of net proceeds from the exercise of common stock options, partially offset by $2.9 million in repurchases of shares to satisfy employee tax withholding obligations.

Nine Months Ended September 30, 2021 – Net cash provided by financing activities of $210.9 million for the nine months ended September 30, 2021 was primarily due to $214.0 million of net proceeds from the issuance of convertible preferred stock and $5.0 million of net proceeds from exercise of common stock options, partially offset by $8.0 million in repurchases of shares to satisfy employee tax withholding obligations.

Convertible Preferred Stock

On April 30, 2021 (the “Closing Date”), we issued and sold 2,250,000 shares of our newly designated Series A convertible preferred stock (“Series A preferred stock”) at an aggregate purchase price of $225.0 million, at a price of $100 (the “Stated Value” per share of Series A preferred stock) per share. We received $214.0 million net proceeds from the private placement with Echelon Health SPV, LP ("H.I.G."), which are net of sales commissions and certain transaction fees.

Dividends on our outstanding shares of Series A preferred stock accrue daily at 8% per annum on the Stated Value per share and compound semiannually, payable in kind until April 30, 2023, which is the second anniversary of the Closing Date, on June 30 and December 31 of each year, beginning on June 30, 2021, and will thereafter become 6% payable in kind and 2% payable in cash in arrears on June 30 and December 31 of each year, beginning on June 30, 2023 (each, a “Cash Dividend Payment Date”). Dividends payable in kind will be cumulative. The Series A preferred stock also participates, on an as-converted basis (without regard to conversion limitations) in all dividends paid to the holders of our common stock. If we fail to declare and pay full cash dividend payments as required by the certificate of designations for the Series A preferred stock for two consecutive Cash Dividend Payment Dates, the cash dividend rate then in effect shall increase one time by 2%, retroactive to the first day of the semiannual period immediately preceding the first Cash Dividend Payment Date at which we failed to pay such accrued cash dividends, until such failure to pay full cash dividends is cured (at which time the dividend rate shall return to the rate prior to such increase). The dividend rights of the Series A preferred stock are senior to all of our other equity securities.

Beginning on April 30, 2027, which is the sixth anniversary of the Closing Date, each holder of Series A preferred stock will have the right to require us to redeem all or any portion of the Series A preferred stock for cash at a price calculated as set forth in the certificate of designations. In addition, upon certain change of control events,

holders of Series A preferred stock can require us, subject to certain exceptions, to repurchase any or all of their Series A preferred stock.

As of September 30, 2022, no shares of the Series A preferred stock have been converted and the balance of our Series A preferred stock was $255.2 million, including a change in the redemption value of $8.2 million and the accrued paid-in-kind dividends of $14.4 million, which was equivalent to 3.2 million shares of common stock on an as-converted basis. See *Note 6 – Convertible Preferred Stock* in our *Notes to Condensed Consolidated Financial Statements* included in this Quarterly Report on Form 10-Q for additional information.

Term Loan Credit Agreement

We entered into a Credit Agreement with Blue Torch Finance LLC, as administrative agent and collateral agent, and the other lenders party thereto in February 2022 (the "Original Credit Agreement") and entered into an amendment (the "Amendment") to the Original Credit Agreement in August 2022 (as amended by the Amendment, the "Credit Agreement"). The Credit Agreement provides for a $70.0 million secured term loan credit facility, which term loans were made available to us on February 28, 2022. We terminated our credit agreement with Royal Bank of Canada ("RBC"), pursuant to which we had an up to $75 million revolving credit facility in connection with our receiving the loan under the Term Loan Credit Agreement. The Amendment replaced the LIBOR-based Adjusted Eurocurrency Rate (as defined in the original Term Loan Credit Agreement) with Adjusted Term SOFR (as defined in the Amendment) as a reference rate for loans under the Credit Agreement

The proceeds of the loans under the Credit Agreement may be used for working capital and general corporate purposes, to refinance our credit agreement with RBC and to pay fees and expenses in connection with the entry into the Credit Agreement. The Original Credit Agreement bore interest, at our option, at either a rate based on the LIBOR for the applicable interest period or a base rate, in each case plus a margin. The base rate was the highest of the prime rate, the federal funds rates plus 0.50% and one month adjusted LIBOR plus 1.0%. The margin was 7.50% for LIBOR loans and 6.50% for base rate loans. After the Amendment, the loans under the Credit Agreement bear interest, at our option, at either a rate based on the Adjusted Term SOFR or a base rate, in each case plus a margin. The base rate is the highest of the prime rate, the federal funds rate plus 0.50% and three-month Adjusted Term SOFR plus 1.00%. The margin is 7.50% for Adjusted Term SOFR loans and 6.50% for base rate loans.

Furthermore, as part of the Credit Agreement, we will incur a $0.3 million fee per annum, payable annually. The outstanding obligations under the Credit Agreement are payable in full on the maturity date. The Credit Agreement matures in February of 2025. We have the right to prepay the loans under the Credit Agreement in whole or in part at any time, subject, in the case of certain mandatory prepayments or any voluntary prepayment of the loans under the Credit Agreement after February 28, 2023, to an exit fee. Our obligations under the Credit Agreement are guaranteed by certain of our material domestic subsidiaries and substantially all of our assets and the assets of such guarantors, in each case, subject to customary exclusion. We are obligated to pay administration fees under the Credit Agreement.

As of September 30, 2022, we had $65.7 million outstanding principal amount under our Credit Agreement, net of closing costs. See *Note 12 – Debt* of *Notes to Condensed Consolidated Financial Statements* included in this Quarterly Report on Form 10-Q for additional information regarding the Credit Agreement.

Recent Accounting Pronouncements

See *Note 1 – Summary of Business and Significant Accounting Policies* in the *Notes to Condensed Consolidated Financial Statements* of this Quarterly Report on Form 10-Q for recently issued accounting standards that could have an effect on us.

ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Credit and Interest Rate Risk

Our financial instruments that are exposed to concentrations of credit risk principally consist of cash and cash equivalents, marketable securities, accounts receivable, and contract assets – commission receivable.

Our cash, cash equivalents, short-term marketable securities, and restricted cash are summarized as follows (in thousands):

	September 30, 2022	December 31, 2021
Cash and cash equivalents [1] [2]	$ 160,258	$ 81,926
Short-term marketable securities [2]	4,491	41,306
Restricted cash	3,239	3,239
Total cash, cash equivalents, short-term marketable securities, and restricted cash	$ 167,988	$ 126,471

[1] We deposit our cash and cash equivalents in accounts with major banks and financial institutions and such deposits are in excess of federally insured limits. We also have deposits with major banks in China that are denominated in both U.S. dollars and Chinese Yuan Renminbi and are not insured by the U.S. federal government.

[2] See *Note 4 – Fair Value Measurements* in our *Notes to Condensed Consolidated Financial Statements* for more information on our cash and cash equivalents and marketable securities.

Our portfolio of available-for-sale debt securities is exposed to credit and interest rate risk. As of September 30, 2022, we invested $4.5 million in marketable securities primarily consisting of commercial paper with credit rating of AA or equivalent by S&P Rating and Moody's Investor Services. The maturity of these securities were less than one year. See *Note 4 – Fair Value Measurements* in our *Notes to Condensed Consolidated Financial Statements* for further discussion on our available-for-sale debt securities.

As of September 30, 2022, our net contract assets – commissions receivable balance was $785.8 million. Our contracts with carriers expose us to credit risk that a financial loss could be incurred if the counterparty does not fulfill its financial obligation. While we are exposed to credit losses due to the non-performance of our counterparties, we consider the risk of this remote. We estimate our maximum credit risk in determining the contract assets – commissions receivable balance recognized on the balance sheet. We had a $2.2 million allowance for credit losses for our commissions receivable balance as of September 30, 2022.

Our total contract assets and accounts receivable are summarized as follows (in thousands):

	September 30, 2022	December 31, 2021
Contract assets – commissions receivable – current	$ 207,505	$ 254,821
Contract assets – commissions receivable – non-current	578,339	653,441
Accounts receivable	1,804	5,750
Total contract assets and accounts receivable	$ 787,648	$ 914,012

Foreign Currency Exchange Risk

To date, substantially all of our revenue has been derived from transactions denominated in United States Dollars. We have exposure to adverse changes in exchange rates associated with operating expenses of our foreign operations, which are denominated in Chinese Yuan Renminbi. Foreign currency fluctuations have not had a material impact historically on our results of operations; however, they may in the future. We have not engaged in any foreign currency hedging or other derivative transactions to date.

ITEM 4. CONTROLS AND PROCEDURES

Evaluation of Our Disclosure Controls and Procedures

Our management, with the participation of our chief executive officer and chief financial officer, evaluated the effectiveness of our disclosure controls and procedures as defined in Rule 13a-15(e) under the Exchange Act, as of the end of the period covered by this Quarterly Report on Form 10-Q.

Based on management's evaluation, our chief executive officer and chief financial officer concluded that our disclosure controls and procedures are effective to provide reasonable assurance that information we are required to disclose in reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in Securities and Exchange Commission rules and forms, and that such information is accumulated and communicated to our management, including our chief executive officer and chief accounting officer, as appropriate, to allow timely decisions regarding required disclosure.

Changes in Internal Control over Financial Reporting

There were no changes in our internal control over financial reporting that occurred during the nine months ended September 30, 2022 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Inherent Limitations on Effectiveness of Controls

Our management, including our chief executive officer and chief financial officer, believes that our disclosure controls and our internal control over financial reporting are designed to provide reasonable assurance of achieving their objectives and are effective at the reasonable assurance level. However, our management does not expect that our disclosure controls or our internal control over financial reporting will prevent all errors and all fraud. A control system, no matter how well conceived and operated, can provide only reasonable, not absolute, assurance that the objectives of the control system are met. Further, the design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that all control issues and instances of fraud, if any, have been detected. These inherent limitations include the realities that judgments in decision-making can be faulty, and that breakdowns can occur because of a simple error or mistake. Additionally, controls can be circumvented by the individual acts of some persons, by collusion of two or more people or by management override of the controls. The design of any system of controls also is based in part upon certain assumptions about the likelihood of future events, and there can be no assurance that any design will succeed in achieving its stated goals under all potential future conditions; over time, controls may become inadequate because of changes in conditions, or the degree of compliance with policies or procedures may deteriorate. Because of the inherent limitations in a cost-effective control system, misstatements due to error or fraud may occur and not be detected.

PART II. OTHER INFORMATION

ITEM 1. LEGAL PROCEEDINGS

In the ordinary course of our business, we have received and may continue to receive inquiries from state and federal regulators relating to various matters. We have become, and may in the future become, involved in litigation in the ordinary course of our business. If we are found to have violated laws or regulations in any jurisdiction, we could be subject to various fines and penalties, including revocation of our license to sell insurance in those states, and our business, operating results and financial condition would be harmed. Revocation of any of our licenses or penalties in one jurisdiction could cause our license to be revoked or for us to face penalties in other jurisdictions. In addition, without a health insurance license in a jurisdiction, carriers would not pay us commissions for the products we sold in that jurisdiction, and we would not be able to sell new health insurance products in that jurisdiction. We could also be harmed to the extent that related publicity damages our reputation as a trusted source of objective information relating to health insurance and its affordability. It could also be costly to defend ourselves regardless of the outcome. Our material legal proceedings are described in Part I, Item I of this Quarterly Report on Form 10-Q in the *Notes to Condensed Consolidated Financial Statements* in *Note 8 – Commitments and Contingencies.*

ITEM 1A. RISK FACTORS

In addition to other information in this Quarterly Report on Form 10-Q and in other filings we make with the Securities and Exchange Commission, the following risk factors should be carefully considered in evaluating our business as they may have a significant impact on our business, operating results and financial condition. If any of the following risks actually occurs, our business, financial condition, results of operations and future prospects could be materially and adversely affected. Because of the following factors, as well as other variables affecting our operating results, past financial performance should not be considered as a reliable indicator of future performance and investors should not use historical trends to anticipate results or trends in future periods. Our Risk Factors are not guarantees that no such conditions exist as of the date of this report and should not be interpreted as an affirmative statement that such risks or conditions have not materialized, in whole or in part.

Risks Related to Our Business

If our ability to enroll individuals during enrollment periods is impeded or if investments we make in enrollment periods do not result in the returns we expected when making those investments, our business, operating results and financial condition would be harmed.

In an attempt to attract and enroll a large number of individuals during the Medicare annual enrollment period and to a lesser extent, the Medicare Advantage open enrollment period and the health care reform open enrollment period under the Affordable Care Act, we may invest in areas of our business, including technology and content, customer care and enrollment, and marketing and advertising. We have in the past made investments in areas of our business in advance of enrollment periods that have not yielded the results we expected when making those investments. Any investment we make in any enrollment period may not result in a significant number of approved and paying members or may not be as cost-effective as we anticipated. During the 2021 annual enrollment period ("AEP") for 2022 enrollments, we invested in marketing and advertising programs and in customer care and enrollments that did not yield the returns we expected, which adversely impacted our business, operating results and financial condition. If our ability to market and sell Medicare-related health insurance and individual and family health insurance is constrained during an enrollment period for any reason, such as technology failures, interruptions in the operation of our ecommerce or telephony platforms, reduced allocation of resources, any inability to timely employ, license, train, certify and retain our employees to sell health insurance, we could acquire fewer members, suffer a reduction in our membership, and our business, operating results and financial condition could be harmed.

We may be unsuccessful in competing effectively against current and future competitors, including government-run health insurance exchanges.

The market for selling health insurance plans is highly competitive. We compete with government-run health insurance exchanges, among others, with respect to our sale of Medicare-related and individual and family health insurance. The federal government operates a website where Medicare beneficiaries can purchase Medicare Advantage and Medicare Part D prescription drug plans or be referred to carriers to purchase Medicare Supplement plans. We also compete with the original Medicare program. The Affordable Care Act exchanges have websites where individuals and small businesses can purchase health insurance, and they also have offline customer support and enrollment capabilities. Our competitors also include local insurance agents across the United States who sell health insurance plans in their communities, companies that advertise primarily through television, and companies that operate call centers or websites that provide quote information or the opportunity to purchase health insurance telephonically or online, including lead aggregator services. Many health insurance carriers also directly market and sell their plans to consumers through call centers, Internet advertising and their own websites. Although we offer health insurance plans for many of these carriers, they also compete with us by offering their plans directly to consumers. In recent years, we also have seen increased competition from national telesales insurance brokers.

To remain competitive against our current and future competitors, we will need to market our services effectively and continue to improve the online health insurance shopping experience and functionalities of our website and other platforms that our current and future customers may access to purchase health insurance products from us. If we cannot predict, develop and deliver the right shopping experience and functionality in a timely and cost-effective manner, or if we are not effective in cost-effectively driving a substantial number of consumers interested in purchasing health insurance to our website and customer care centers, we may not be able to compete successfully against our current or future competitors and our business, operating results and financial condition may be adversely affected.

Some of our current and potential competitors have longer operating histories, larger customer bases, greater brand recognition and significantly greater financial, technical, marketing and other resources than we do. As compared to us, our current and future competitors may be able to undertake more extensive marketing campaigns for their brands and services, devote more resources to website and systems development, negotiate more favorable commission rates and commission override payments, and make more attractive offers to potential employees, marketing partners and third-party service providers.

Competitive pressures from government-run health insurance exchanges and other competitors may result in our experiencing increased marketing costs, especially during the Medicare annual enrollment period, decreased demand and loss of market share, increased health insurance plan termination and member turnover, reduction in our membership or revenue and may otherwise harm our business, operating results and financial condition.

Our business may be harmed if we lose our relationship with health insurance carriers or our relationship with health insurance carriers is modified.

We typically enter into contractual relationships with health insurance carriers that are non-exclusive and terminable on short notice by either party for any reason. In many cases, health insurance carriers also may amend the terms of our agreements unilaterally, including commission rates, on short notice. Health insurance carriers may decide to reduce our commissions, rely on their own internal distribution channels to sell their own plans, determine not to sell their plans or otherwise limit or prohibit us from selling their plans. Carriers may also amend our agreements with them for a variety of reasons, including for competitive or regulatory reasons, dissatisfaction with the economics of the members that we place with them or because they do not want to be associated with our brand. The termination of our relationship with a health insurance carrier, the reduction of commission rates or the amendment of or change in our relationship with a carrier has in the past, and may in the future, reduce the variety, quality and affordability of health insurance plans we offer, cause a loss of commission payments, including commissions for past and/or future sales, cause a reduction in the estimated constrained lifetime values ("LTVs") we use for revenue recognition purposes, result in a loss of existing and potential members, adversely impact our profitability or have other adverse impacts, which could harm our business, operating results and financial condition. Health insurance carriers may also determine to exit certain states or increase premiums to a significant degree, which could cause our members' health insurance to be terminated or our members to purchase new health

insurance or determine not to pay for health insurance at all. If we lose these members, our business, operating results and financial condition could be harmed.

Our Medicare plan-related revenue is concentrated in a small number of health insurance carriers. The success of our Medicare-related health insurance business depends upon our ability to enter into new and maintain existing relationships with health insurance carriers on favorable economic terms. We expect that a small number of health insurance carriers will account for a significant portion of our revenue for the foreseeable future and any impairment of our relationship with, or the material financial impairment of, these health insurance carriers could adversely affect our business, operating results and financial condition.

We may also temporarily or permanently lose the ability to market and sell Medicare plans for one or more of our Medicare plan carriers. The laws and regulations applicable to the business of selling Medicare-related health insurance are complex and frequently change. If we or our health insurance agents violate any of the requirements imposed by the Centers for Medicare and Medicaid Services ("CMS"), or applicable federal or state laws or regulations, a health insurance carrier may terminate our relationship or other adverse consequences could result. Health insurance carriers may also terminate their relationship with us or require us to take corrective action if our Medicare product sales or marketing give rise to too many complaints. Given the concentration of our Medicare plan sales in a small number of carriers, if we lose a relationship with a health insurance carrier to market their Medicare plans, even temporarily, or if the health insurance carrier loses its Medicare product membership, our business, operating results and financial condition would be harmed.

Our financial results will be adversely impacted if our membership does not grow or if member retention does not improve and plan terminations do not decline.

We receive commissions from health insurance carriers for health insurance plans sold through us. When one of these plans is canceled, or if we otherwise do not remain the agent on the plan, we no longer receive the related commission payment. Our members and/or health insurance carriers may choose to discontinue their health insurance plans for a variety of reasons. Consumers may also purchase individual and family and Medicare-related health insurance plans directly from other sources, such as our competitors, and we would not remain the agent on the policy and receive the related commission. Medicare Advantage plan and Medicare Part D prescription drug plan enrollees may select another plan during the Medicare annual enrollment period that occurs in the fourth quarter every year. Medicare Advantage plan enrollees may also select another plan during the Medicare Advantage open enrollment period that occurs in the first quarter of the year. In addition, certain individuals are permitted to enroll, disenroll or change their Medicare Advantage or Medicare Part D prescription drug plans during special enrollment periods. Our ability to grow and retain our membership depends on various factors, including the ability of enrollees to change their health plan outside of the Medicare annual enrollment period, the source of referrals and their enrollment experience. For example, we experienced an increased plan termination rate in our Medicare membership in 2020 and 2021 above historical levels. As a result, the LTVs of our Medicare plan-related products have been negatively impacted. If our Medicare Advantage and other health insurance plan termination rates do not decline in subsequent quarters, our business, operating results and financial condition would be harmed. In addition, enrollment periods could cause us to further experience increased termination rates in the future, which could adversely impact our business, operating results and financial condition.

Any decrease in the amount of time we retain our members on the health insurance plans that they purchased through us could adversely impact the estimated constrained LTVs we use for purposes of recognizing revenue, which would harm our business, operating results and financial condition. We have taken and may take additional actions to improve the customer experience, enhance accuracy of plan recommendations, reduce rapid disenrollment and beneficiary complaints, and improve the quality of our enrollments. While we have recently placed a stronger operational focus on enrollment quality and member retention, there are no assurances that investments we make to pursue retention initiatives will result in a decline in health insurance plan termination rate and/or improvement in our constrained LTVs in the future. For example, in response to the increased plan termination rate in our Medicare Membership in 2020 and 2021, which negatively impacted the LTVs of our Medicare plan-related products, in the third quarter of 2021, we introduced mandatory additional training for our agents and added a new customer care role to verify certain Medicare enrollments prior to submission. While our focus on enrollment quality could improve retention rates and increase LTVs of our Medicare products, it has led to lower call conversion rates and longer average talk times for telephonic enrollments, resulting in a reduction in enrollments and increased cost of acquisition that has negatively impacted our business, operating results and financial condition. If agent

productivity and member retention do not improve, our business, operating results and financial condition would be further harmed. If we experience higher health insurance plan termination rates than we estimated when we recognized commission revenue, we may not collect all of the related commissions receivable, which could result in a reduction in LTV and a write-off of contract assets-commissions receivable, which would harm our business, operating results and financial condition.

In addition, the growth of our membership is highly dependent upon our success in attracting new members during the Medicare annual enrollment period and to a lesser extent, the Medicare Advantage open enrollment period and the health care reform open enrollment period. The Medicare-related commission rates that we receive may be higher in the first calendar year of a plan if the plan is the first Medicare-related plan issued to the member. Similarly, the individual and family plan commission rates that we receive are typically higher in the first 12 months of a policy. After the first 12 months, the commission rates generally decline significantly. As a result, if we do not add a sufficient number of members to new plans, our business, operating results and financial condition would be harmed. In addition, adverse market events or economic conditions, such as inflation and rising unemployment levels, could impact consumer behavior and demand for health insurance. If more consumers decide to delay enrollment or decrease or discontinue coverage under plans sold through us, our business, operating results and financial condition would be adversely affected.

If we are not able to maintain and enhance our brand, our business and operating results will be harmed.

We believe that maintaining and enhancing our brand identity is critical to our relationships with existing members, marketing partners and health insurance carriers and to our ability to attract new members, marketing partners and health insurance carriers. The promotion of our brand in these and other ways may require us to make substantial investments and we anticipate that, as our market becomes increasingly competitive, these branding initiatives may become increasingly difficult and expensive. Our brand promotion 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 operating results could be harmed. If we do not successfully maintain and enhance our brand, our business may not grow and we could lose our relationships with health insurance carriers, marketing partners and/or members, which would harm our business, operating results and financial condition.

The ongoing COVID-19 pandemic and other public health crises, illness, epidemics or pandemics could adversely impact our business, operating results and financial condition.

COVID-19 and public health crises, illness, epidemics or pandemics, in general, and any associated disruption to our call center and service operations, in particular, could materially impact our business, operations and financial condition. In an effort to mitigate the spread of COVID-19, and to comply with applicable government directives, nearly all of our employees have been working remotely since the first quarter of 2020, and we transitioned to a virtual-first workplace in the United States in the third quarter of 2022. Our business operations may be disrupted if key personnel or significant portions of our employees are unable to work effectively in a remote setting, especially if such disruption occurs during or in our preparation for the Medicare AEP. Our business operations and recruitment efforts could also be impacted if government offices, including CMS and state departments of insurance, are adversely impacted by COVID-19 given that our marketing materials require CMS approval and health insurance agent licensing and licensing renewals are dependent on state department of insurance processing.

Furthermore, if any of our health insurance carriers, business partners or vendors increase the prices of or become unable to continue to provide their products or services as a result of COVID-19, or if health insurance carriers reduce our commission rates or the amount they pay us, our business, operating results and financial condition would be harmed. Our Individual, Family and Small Business segment could be impacted by potential increases in unemployment rates, inflation, potential delays in customer premium payments and/or health insurance carrier commission payments, the extension of the open enrollment period, and changes to qualified health plans subsidies, among others. COVID-19 presents uncertainties and risks with respect to the demand for and pricing of health insurance plans, which could negatively impact our business, operating results and financial condition.

The extent of the impact of the COVID-19 pandemic on our operational and financial performance will depend on future developments, including the duration, spread and severity of the pandemic, the availability, effectiveness and uptake of vaccines for COVID-19, the emergence of new variants of COVID-19 and whether

existing vaccines are effective with respect to such variants, the actions to contain the disease or mitigate its impact, and the duration, timing and severity of the impact on consumer behavior, including any recession resulting from the pandemic, all of which are unpredictable.

Changes in our management and key employees could affect our business and financial results.

Our success is dependent upon the performance of our senior management and our ability to attract and retain qualified personnel for all areas of our organization. We may not be successful in attracting and retaining personnel on a timely basis, on competitive terms or at all. If we are unable to attract and retain the necessary personnel, our business would be harmed. Our executive officers and employees can terminate their employment at any time. In recent years, we have appointed several new executive officers across multiple functions, and we may have additional changes in the future. For example, in 2021 we appointed a new chief executive officer and a new chief financial officer after the departure of their predecessors. In 2022, we have appointed a new chief operating officer and chief transformation officer, a new chief accounting officer, a new general counsel, a new chief marketing officer and a new chief people officer. This transition in senior management could adversely impact our business, operating results and financial condition as it will take time for our officers to integrate into our business. The transition and the departure of members of our senior management could result in additional attrition in our senior management and key personnel and any significant change in leadership over a short period of time could harm our business, operating results and financial condition.

The loss of the services of any of our executive officers or key employees could harm our business. For example, we are required to appoint a single designated writing agent with each insurance carrier. A small number of our employees act as writing agent and each employee that acts as writing agent does so for a number of carriers. When an employee that acts as writing agent terminates their employment with us, we need to replace such writing agent with another employee who has health insurance licenses. Due to our national reach and the large number of carriers whose plans are purchased by our members, the process of changing writing agents has in the past taken and could take a significant period of time to complete. If the transition is not successful, our ability to sell health insurance plans may be interrupted, our agency relationship with particular insurance carriers may be terminated, our commission payments could be discontinued or delayed and, as a result, our business, operating results and financial condition would be harmed.

Our business may be harmed if we are not successful in executing on our strategic plans, including our growth strategy, cost-saving and enrollment quality initiatives.

As part of our strategy, we have invested in initiatives to grow our Medicare membership and revenue, to improve our consumer experience, enhance accuracy of plan recommendations and reduce disenrollment, to increase online enrollment and enhance operating leverage, to expand our strategic partner relationships, improve our technology platform to optimize the consumer experience and relationship, and to utilize data analytics to increase the productivity of our customer care employees. Pursuing and investing in these and other initiatives we develop has required and will in the future require significant investments in marketing and advertising, technology and product offerings, and customer care and enrollment, among others, and involves risks and uncertainties described elsewhere in this Risk Factors section, including the initiatives not achieving our retention, cost-savings, growth or profitability targets, inadequate return of capital on our investments, legal and regulatory compliance risks, potential changes in laws and regulations and other issues that could cause us to fail to realize the anticipated benefits of our investments and incur unanticipated liabilities. Our pursuit of these strategic initiatives may not be successful.

In addition, from time to time, we may initiate restructuring plans to implement cost savings initiatives or programs including, among other things, reductions in workforce and other fixed and variable expenses. For example, as part of our transformational plan, we are currently implementing a cost savings initiative designed to right-size our cost structure and drive future profitability, which includes targeted reductions in fixed expenses and vendor-related spend outside of mission critical areas, as well as changes to variable cost management. In connection with this initiative, among other things, we completed a reduction in force in April 2022 in which we eliminated over 300 full-time positions, representing approximately 14% of our workforce. In addition, we are making changes to variable cost management. While such initiatives are intended to improve our operations through re-engineering, reorganizing, and better deployment of marketing expenses, we may not successfully realize the expected benefits of the actions that we have or may in the future take in connection therewith. A variety of risks could cause us not to realize some or all of the expected benefits of these or any other restructuring plans that we may undertake, including, among others, higher than anticipated costs in implementing such restructuring plans,

management distraction from ongoing business activities, damage to our reputation and brand image, including negative publicity, workforce attrition beyond planned reductions and risks and uncertainties described elsewhere in this Risk Factors section. Even if we do implement and administer these plans in the manner contemplated, our estimated cost savings resulting therefrom are based on several assumptions that may prove to be inaccurate and, as a result, we cannot assure you that we will realize these cost savings. Our cash flow from operations is expected to be negative in the year ending December 31, 2022 and was negative in each of the years ended December 31, 2021, 2020 and 2019. If we are not successful in executing on our strategic plans, our business, operating results and financial condition would be harmed.

Our failure to effectively manage our operations and maintain our company culture as our business evolves and our work practices change could harm us.

Our future operating results will depend on our ability to manage our operations. It is also important to our success that we hire qualified personnel and properly train and manage them, all while maintaining our corporate culture and spirit of innovation. If we are not successful in these efforts, our growth and operations could be adversely affected.

As a result of the pandemic, we had to adjust our business operations, including onboarding and training new health insurance agents remotely, and currently most of our employees work remotely. In addition, as part of our transformational plan, we decided to become a virtual-first workplace and may continue to make operational adjustments as needed. While we believe allowing employees to work remotely will help us attract and retain talent, transitioning to and operating as a virtual-first company could cause operational difficulties, reduce the relative effectiveness of our sales agents and impair our ability to manage our business. An increased number of employees in a remote work environment may also exacerbate certain risks to our business, including an increased demand for information technology resources, increased risk of phishing and other cybersecurity attacks, and increased risk of unauthorized dissemination of sensitive personal information or proprietary or confidential information about us or our customers or other third-parties. Our product development initiatives could also be negatively impacted by the prevalence of remote work. Technologies in our employees' homes may also be more limited or less reliable than those provided in our offices. We may also be exposed to risks associated with the various locations of our remote employees, including compliance with local laws and regulations, and if employees fail to inform us of changes in their work location, we may be exposed to additional risks without our knowledge. If our key personnel or a significant portion of our employees are unable to work effectively in a remote setting or our business operations are otherwise disrupted during the Medicare or individual and family health insurance enrollment periods, the adverse impact on our business would be particularly pronounced. It may also be difficult for us to preserve our corporate culture, and our employees may have less opportunities to collaborate in meaningful ways, which could harm our ability to retain and recruit employees, innovate and operate our business effectively.

Seasonality may cause fluctuations in our financial results, and if we are not successful in responding to changes in the seasonality of our business, our business, operating results and financial condition could be harmed.

Open enrollment periods drive the seasonality of our business. The Medicare annual enrollment period occurs from October 15 to December 7 each year and the individual and family health insurance open enrollment period has historically occurred from November 1 through December 15 each year. However, for the 2022 plan year, the individual and family health insurance open enrollment period ran from November 1, 2021 through January 15, 2022 for most states. In addition, the Medicare Advantage open enrollment period, during which Medicare-eligible individuals who enrolled in a Medicare Advantage plan can switch to the original Medicare program or switch to a different Medicare Advantage plan, runs from January 1 through March 31 of each year. We have traditionally experienced an increase in the number of submitted Medicare-related applications and approved members during the fourth quarter and, to a lesser extent, in the first quarter, and an increase in Medicare plan related expense during the third and fourth quarters in connection with the open enrollment periods. In addition, we typically experience the highest plan termination rates from our Medicare Advantage plan members in the first year following the effective date of plan enrollment. If we experience significant growth in Medicare Advantage approved members resulting in an increased number of first year members as a percentage of our total estimated membership, we may also experience increased health insurance plan terminations in the year following such periods of growth.

The seasonality of our business could change in the future due to other factors, including as a result of changes in timing of the Medicare or individual and family health plan enrollment periods, adoption of new or special

enrollment periods, changes in eligibility and subsidies applicable to the purchase of health insurance, and changes in the laws and regulations that govern the sale of health insurance. We may not be able to timely adjust to changes in customer demand and the seasonality of our business. If we are not successful in responding to changes in the seasonality of our business, our business, operating results and financial condition could be harmed.

The success of our customer care center operations depends upon our ability to timely hire, train, retain and ensure the productivity of our licensed health insurance agents.

In addition to our websites, we rely upon our customer care centers to sell Medicare plans. The success of our customer care center operations is dependent on licensed health insurance agents and other employees. In order to sell Medicare-related health insurance plans, our health insurance agent employees must be licensed by the states in which they are selling plans and certified and appointed with the health insurance carrier that offers the plans in each applicable state. We depend upon our employees, state departments of insurance, government exchanges and health insurance carriers for the licensing, certification and appointment of our health insurance agents. We may experience difficulties hiring a sufficient number of additional licensed agents and retaining existing licensed agents for the Medicare annual enrollment period. If we are not successful in these regards, our ability to sell Medicare-related health insurance plans will be impaired during the Medicare annual enrollment period, which would harm our business, operating results and financial condition.

Even if we are successful in hiring licensed health insurance agents, our success depends on the productivity of these health insurance agents. Health insurance agents may not perform to the standard we expect of them, which could result in lower than expected conversion rates and revenue, higher costs of acquisition per member and higher plan termination rates. Historically, our health insurance agent employees have generally been more productive than the employees of our outsourced call centers and experienced health insurance agents have generally been more productive than less-tenured health insurance agents. During the Medicare annual enrollment period that occurred in the fourth quarter of 2020, we experienced reduced conversion rates from health insurance agents that work for outsourced call centers, which impacted our revenue and cost of acquisition. As a result, in preparation for the 2021 Medicare annual enrollment period, we increased the number of our health insurance agent employees significantly, and we also began hiring, onboarding and training our health insurance agent employees earlier than we have in the past. We incurred increased expenses in agent onboarding and training in preparation for the 2021 Medicare annual enrollment period. Despite our investments in hiring and training a significantly larger number of our health insurance agent employees in 2021, the conversion rates of our health insurance agents were lower than our expectations starting in the third quarter of 2021 through the first half of 2022. Our increased focus on enrollment quality that began in the third quarter of 2021 negatively impacted the conversion rates of our health insurance agents. Although we observed significant improvements in conversion rates in the third quarter of 2022, we cannot guarantee the trends will continue. If our health insurance agents do not perform to the standards we expect of them or if we do not generate sufficient call volumes for our health insurance agents to remain productive, our conversion and retention rates could be negatively impacted, and our business, operating results and financial condition would be harmed. Failure to retain, train and ensure the productivity of our health insurance agents would harm our business, operating results and financial condition. If investments we make in our call center operations do not result in the returns we expected when making those investments, we could acquire fewer members, suffer a reduction in our membership, and our business, operating results and financial condition would be harmed.

We rely on multiple channels, including the Internet, telephone, mail, email, marketing partners and other channels, to market our services and to communicate with qualified prospects and our existing customers. If we are unable to successfully provide a relevant and reliable experience in a cost-effective manner to attract and convert such prospects into members for whom we receive commissions and retain our existing customers, our business, operating results and financial condition would be harmed.

We employ different marketing channels and may from time to time adjust our member acquisition strategy to attract visitors to our website and communicate with customers who call into our call centers. Our growth depends in large part upon growth in approved members in a given period. The rate at which consumers visiting our ecommerce platforms and customer care centers seeking to purchase health insurance are converted into approved members directly impacts our revenue. In addition, the rate at which consumers who are approved become paying members impacts the constrained LTV of our approved members, which impacts the revenue that we are able to recognize.

A number of factors have influenced, and could in the future influence, these conversion rates for any given period, some of which are outside of our control. These factors include, but are not limited to:

- changes in consumer shopping behavior due to circumstances outside of our control, such as economic conditions, inflation, the COVID-19 pandemic or other public health crises or illnesses, consumers' ability or willingness to pay for health insurance, adverse weather conditions or natural disasters, unemployment rates, availability of unemployment benefits or proposed or enacted legislative or regulatory changes impacting our business, including health care reform;
- the quality of and changes to the consumer experience on our ecommerce platforms and/or with our customer care centers;
- regulatory requirements, including those that make the experience on our ecommerce platforms cumbersome or difficult to navigate or reduce the ability of consumers to purchase plans outside of enrollment periods;
- the variety, competitiveness, quality and affordability of the health insurance plans that we offer;
- system failures or interruptions in the operation of our ecommerce platform or call center operations;
- changes in the mix of consumers who are referred to us through our direct, marketing partner and online advertising member acquisition channels, including the quality of sales leads;
- health insurance carrier guidelines applicable to applications submitted by consumers, the degree to which our technology is integrated with health insurance carriers, the amount of time a carrier takes to make a decision on that application and the percentage of submitted applications approved by health insurance carriers;
- the effectiveness of health insurance agents in assisting consumers, including the tenure of the health insurance agent; and
- our ability to enroll subsidy-eligible individuals in qualified health plans through government-run health insurance exchanges and the efficacy of the process we are required to use to do so.

Our conversion rates can be impacted by changes in the mix of consumers referred to us through our member acquisition channels and whether they interact with a more seasoned health insurance agent. We have made and may in the future, make changes to our ecommerce platforms, telephonic operations, marketing material or enrollment process in response to regulatory or health insurance carrier requirements or undertake other initiatives in an attempt to improve consumer experience, increase retention or for other reasons. These changes have in the past, and may have in the future, the unintended consequence of adversely impacting our conversion rates. A decline in the percentage of consumers who submit health insurance applications on our ecommerce platforms or telephonically via our customer care centers and are converted into approved and paying members could cause an increase in our cost of acquiring members on a per member basis and impact our revenue in any given period. To the extent the rate at which we convert consumers visiting our ecommerce platforms or telephonically via our customer care centers into members suffers, our membership may decline, which would harm our business, operating results and financial condition.

We depend upon Internet search engines and social media platforms to attract a significant portion of the consumers who visit our website, and if we are unable to effectively advertise on search engines or social media platforms on a cost-effective basis, our business and operating results would be harmed.

We derive a significant portion of our website traffic from consumers who search for health insurance through Internet search engines, such as Google and Bing, and through social media platforms, such as Facebook. A critical factor in attracting consumers to our website is whether we are prominently displayed in response to an Internet search relating to health insurance or on a social media platform. Search engines typically provide two types of search results, algorithmic listings and paid advertisements. We rely on both to attract consumers to our websites and otherwise generate demand for our services.

Algorithmic search result listings are determined and displayed in accordance with a set of formulas or algorithms developed by the particular Internet search engine. The algorithms determine the order of the listing of

results in response to the consumer's Internet search. From time to time, search engines revise these algorithms. In some instances, these modifications have caused our website to be listed less prominently in algorithmic search results, which has resulted in decreased traffic to our website. We may also be listed less prominently as a result of other factors, such as new websites, changes we make to our website or technical issues with the search engine itself. For example, government health insurance exchange websites appear prominently in algorithmic search results and may reduce the prominence of our website. In addition, search engines have deemed the practices of some companies to be inconsistent with search engine guidelines and decided not to list their website in search result listings at all. If we are listed less prominently in, or removed altogether from, search result listings for any reason, the traffic to our websites would decline and we may not be able to replace this traffic, which would harm our business, operating results and financial condition. If we decide to attempt to replace this traffic, we may be required to increase our marketing expenditures, which would also increase our cost of member acquisition and harm our business, operating results and financial condition.

We purchase paid advertisements on search engines and social media platforms in order to attract consumers to our platforms. We typically pay a search engine for prominent placement of our website when particular health insurance-related terms are searched for on the search engine, regardless of the algorithmic search result listings. The prominence of the placement of our advertisement is determined by a combination of factors, including the amount we are willing to pay and algorithms designed to determine the relevance of our paid advertisement to a particular search term. As with algorithmic search result listings, search engines may revise the algorithms relevant to paid advertisements, and websites other than our ecommerce platform may become more optimized for the algorithms. These changes may result in our having to pay increased amounts to maintain our paid advertisement placement in response to a particular search term. We could also have to pay increased amounts should the market share of major search engines continue to become more concentrated with a single search engine. Additionally, we bid against our competitors, insurance carriers, government health insurance exchanges and others for the display of these paid search engine or social media platform advertisements. We have experienced increased competition for both algorithmic search result listings and for paid advertisements, and that competition increases substantially during the enrollment periods for Medicare-related health insurance and for individual and family health insurance. The competition has increased the cost of paid Internet search advertising and has increased our marketing and advertising expenses. If paid search advertising costs increase or become cost prohibitive, whether as a result of competition, algorithm changes or otherwise, our advertising expenses could rise significantly or we could reduce or discontinue our paid search advertisements, either of which would harm our business, operating results and financial condition.

We rely significantly on marketing partners and our business and operating results would be harmed if we are unable to maintain effective relationships with our existing marketing partners or if we do not establish successful relationships with new marketing partners.

We frequently enter into contractual marketing relationships with partners that drive consumers to our ecommerce platform and call centers. These marketing partners include financial and online services companies, affiliate organizations, online advertisers and content providers, and other marketing vendors. We also have relationships with strategic marketing partners, including provider groups, hospitals and pharmacy chains that promote our Medicare platforms to their customers as well as pharmacy service providers and other affinity groups. We compensate many of our marketing partners for their referrals on either a submitted health insurance application basis or a per-referral basis or, if they are licensed to sell health insurance, we may share a percentage of the commission we earn from the health insurance carrier for each member referred by the marketing partner. The success of our relationship is dependent on a number of factors, including but not limited to the continued positive market presence, reputation and growth of the marketing partner, the effectiveness of the marketing partner in marketing our website and services, the compliance of each marketing partner with applicable laws, regulations and guidelines, the contractual terms we negotiate with our marketing partners, including the marketing fees we agree to pay and our ability to accurately and timely track, pay and manage marketing partners. We depend on our marketing partners for a large number of quality referrals to keep our health insurance agents productive. If our marketing partners fail to deliver effective and/or timely marketing campaigns, especially during the Medicare annual enrollment period, our business and financial condition could be harmed.

While we have relationships with a large number of marketing partners, we depend upon referrals from a limited number of marketing partners for a significant portion of the submitted applications we receive from our marketing partner customer acquisition channel. Given our reliance on our marketing partners, our business

operating results and financial condition would be harmed if we are unable to maintain successful relationships with these companies, if we fail to establish successful relationships with new marketing partners, if we experience competition in our receipt of referrals from high volume marketing partners, or if we are required to pay increased amounts to our marketing partners.

Competition for referrals from our marketing partners has increased particularly during the enrollment periods for Medicare-related health insurance and individual and family health insurance. We may lose marketing partner referrals if our competitors pay marketing partners more than we do or be forced to pay increased fees to our marketing partners, which could harm our business, operating results and financial condition. If we lose marketing partner referrals during the Medicare or individual and family health insurance enrollment periods, the adverse impact on our business would be particularly pronounced. In addition, the promulgation of laws, regulations or guidelines, or the interpretation of existing laws, regulations and guidelines, by state departments of insurance or by CMS, could cause our relationships with our marketing partners to change or be in non-compliance with those laws, regulations and guidelines. For example, CMS proposed rules in January 2022 which were deemed final, with minimal modification, in May 2022. The final rules, which went into effect on June 28, 2022, require us and our marketing partners to implement additional verbal and written disclaimers and require us to implement further oversight measures over our marketing partners, beginning with the 2023 annual enrollment period. Given the adoption of these rules, we may incur additional costs to generate and convert leads from our marketing partners, as well as additional administrative costs, which could adversely affect our business, operating results and financial condition. In addition, we are required to file marketing partner marketing materials relating to Medicare Advantage and Medicare Part D prescription drug plans with CMS, and health insurance carriers must review and approve the marketing materials. Recent changes to the CMS marketing guidelines have resulted in a more complicated and time-consuming process for marketing material filing and the need to file a significantly greater number of our and our marketing partners' marketing materials with CMS. If our marketing partners' marketing materials do not comply with the CMS marketing guidelines or other Medicare program related laws, rules and regulations, such non-compliance could result in our losing the ability to receive referrals of individuals interested in purchasing Medicare-related plans from that marketing material or being delayed in doing so. In the event that CMS or a health insurance carrier requires changes to, disapproves or delays approval of these materials, we could lose a significant source of Medicare plan demand and the operations of our Medicare business could be adversely affected. We also have relationships with hospital systems and pharmacy chains that utilize aspects of our platform and tools. Our relationships with these hospital systems and pharmacy chains result in the referral of a significant number of individuals to us who are interested in purchasing Medicare-related health insurance plans. If federal or state authorities were to change existing laws, regulations or guidelines, or interpret existing laws, regulations or guidelines, to prohibit these arrangements, or if hospital systems or pharmacy partners otherwise decided to no longer utilize aspects of our platform and tools, we could experience a significant decline in the number of Medicare-eligible individuals who are referred to our platforms and customer care centers, which would harm our business, operating results and financial condition.

Our future operating results are likely to fluctuate and could fall short of expectations, which could negatively affect the value of our common stock.

Our operating results are likely to fluctuate as a result of a variety of factors, including the factors described elsewhere in this Risk Factors section, many of which are outside of our control. For example and among these factors, the assumptions underlying our estimates of commission revenue as required by ASC 606 may vary significantly over time. As a result, comparing our operating results on a period-to-period basis may not be meaningful and you should not rely on our past results as an indication of our future performance, particularly in light of the fact that our business and industry are undergoing substantial change as a result of health care reform, competition, shifts in carrier and regulator priorities and initiatives we determine to pursue. If our revenue or operating results differ from our guidance or fall below the expectations of investors or securities analysts, the price of our common stock could decline substantially. In the past, when our revenue and operating results differed from our guidance and the expectations of investors or securities analysts, the price of our common stock was impacted.

If commission reports we receive from carriers are inaccurate or not sent to us in a timely manner, our business and operating results could be harmed and we may not recognize trends in our membership.

We rely on health insurance carriers to timely and accurately report the amount of commissions earned by us, and we calculate our commission revenue, prepare our financial reports, projections and budgets and direct our

marketing and other operating efforts based on the reports we receive from health insurance carriers. There have been instances where we have determined that plan cancellation data reported to us by a health insurance carrier has not been accurate. The extent to which health insurance carriers are inaccurate in their reporting of plan cancellations could cause us to change our cancellation estimates, which could adversely impact our revenue. We have designed controls to assess the completeness and accuracy of the data received, whereby we apply judgment and make estimates based on historical data and current trends to independently determine whether or not carriers are accurately reporting commissions due to us. We also operate procedures with carriers on an ongoing basis whereby potential under or over reporting is reconciled and discrepancies are resolved. For instance, we reconcile information health insurance carriers provide to us and may determine that we were not historically paid commissions owed to us, which would cause us to have underestimated our membership. Conversely, health insurance carriers may require us to return commission payments paid in a prior period due to plan cancellations for members we previously estimated as being active. To the extent that health insurance carriers understate or fail to accurately report the amount of commissions due to us in a timely manner or at all, our estimates of constrained LTV may be adversely impacted, which would harm our business, operating results and financial condition. In addition, any inaccuracies in the reporting from and reconciliations with insurance carriers may also impact our estimates of constrained LTV or our estimates of commission revenue for future periods which is based on historical trends, including trends relating to contracted commission rates and expected health insurance plan cancellation.

We do not receive information about membership cancellations from our health insurance carriers directly, which makes it difficult for us to determine the impact of current conditions on our membership retention and to accurately estimate membership as of a specific date.

We depend on health insurance carriers and others for data related to our membership. For instance, with respect to health insurance plans other than small business health insurance, health insurance carriers do not directly report member cancellations to us, resulting in the need for us to determine cancellations using payment data that carriers provide. We infer cancellations from this payment data by analyzing whether payments from members have ceased for a period of time, and we may not learn of a cancellation for several months. The majority of our members who terminate their plans do so by discontinuing their insurance premium payments to the health insurance carrier and do not inform us of the cancellation. With respect to our small business membership, many groups notify the carrier directly with respect to increases or decreases in group size and policy cancellations. Our insurance carrier partners often do not communicate this information to us, and it often takes a significant amount of time for us to learn about small business group cancellations and changes in our membership within the group itself. We often are not made aware of policy cancellations until the time of the group's annual renewal.

Given the number of months required to observe non-payment of commissions in order to confirm cancellations, we estimate the number of members who are active on health insurance plans as of a specified date. After we have estimated membership for a period, we may receive information from health insurance carriers that would have impacted the estimate if we had received the information prior to the date of estimation. We may receive commission payments or other information that indicates that a member who was not included in our estimates for a prior period was in fact an active member at that time, or that a member who was included in our estimates was in fact not an active member of ours. As a result of the Medicare annual enrollment and other open enrollment periods, we may not receive information from our carriers on as timely a basis due to the significant increase in health insurance transaction volume and for other reasons, which could impair the accuracy of our membership estimates. For these and other reasons, including if current trends in membership cancellation are inconsistent with past cancellation trends that we use to estimate our membership or if carriers subsequently report changes to the commission payments that they previously reported to us, our actual membership could be different from our estimates, perhaps materially. If our actual membership is different from our estimates, the constrained LTV component of our revenue recognition could also be inaccurate, including as a result of an inaccurate estimate of the average amount of time our members maintain their health insurance plans. As a result of the delay we experience in receiving information about our membership, it is difficult for us to determine with any certainty the impact of current conditions on our membership retention. Various circumstances, including market-related factors such as changes in timing of enrollment periods, the ability of enrollees to change their health plan outside of the Medicare annual enrollment period, the source of referrals, their enrollment experience and other factors specific to our business, could cause the assumptions and estimates that we make in connection with estimating our membership and constrained LTV to be inaccurate, which would harm our business, operating results and financial condition.

If our carrier advertising and sponsorship program are not successful, our business, operating results and financial condition could be harmed.

We develop, host and maintain carrier dedicated Medicare plan websites and may undertake other marketing and advertising initiatives or perform other services through our Medicare plan advertising program. We also allow health insurance carriers to purchase advertising space for non-Medicare products on our website through our sponsorship program. To the extent that economic conditions, health care reform or other factors impact the amount health insurance carriers are willing to pay for advertising, our advertising and sponsorship program will be adversely impacted. In addition, since we maintain relationships with a limited number of health insurance carriers to sell their Medicare plans, our Medicare plan-related advertising revenue is concentrated in a small number of health insurance carriers, and our ability to generate Medicare plan-related advertising revenue would be harmed by the termination or non-renewal of any of these relationships as well as by a reduction in the amount a health insurance carrier is willing to pay for these services. Moreover, in light of the regulations applicable to the marketing and sale of Medicare plans, and given that these regulations are often complex, change frequently and are subject to changing interpretations or enforcement actions, we may in the future not be permitted to sell Medicare plan-related advertising services. If we are not successful in these areas or these factors are unfavorable to us, our business, operating results and financial condition could be harmed.

The success of our sponsorship and advertising program depends on a number of factors, including the amount health insurance carriers are willing to pay for advertising services, the effectiveness of the sponsorship and advertising program as a cost-effective method for carriers to obtain additional members, consumer demand for the health insurance carrier’s product, our ability to attract consumers to our ecommerce platform, our call centers or the dedicated Medicare plan websites and convert those consumers into members, and the cost, benefit and brand recognition of the health insurance plan that is the subject of the advertising, among others. In addition, increased carrier focus on the quality of enrollments and reduction in member complaints could adversely impact our ability to successfully negotiate and operate our sponsorship and advertising programs. If we are not successful in these areas or these factors are unfavorable to us, our business, operating results and financial condition could be harmed.

Our business may be harmed if we do not enroll subsidy-eligible individuals through government-run health insurance exchanges efficiently.

In order to offer the qualified health plans that individuals and families must purchase to receive Affordable Care Act subsidies, agents and brokers must meet certain conditions, such as receiving permission to do so from the applicable government health insurance exchange, entering into or maintaining an agreement with the health insurance exchange or a partner of the exchange, ensuring that the enrollment and subsidy application is completed through the health insurance exchange and complying with privacy, security and other standards. In the event Internet-based agents and brokers such as us use the Internet for completion of qualified health plan selection purposes, their websites may be required to meet certain additional requirements. To the extent we enroll individuals and families into qualified health plans, we do so predominantly through the Federally Facilitated Marketplace ("FFM"), which runs all or part of the health insurance exchange in 33 states, using a third-party partnership. The number of states using the FFM may decrease in the future, reducing our ability to enroll members through the FFM. We may experience difficulty in satisfying the conditions and requirements to offer qualified health plans to our existing members and new potential members and in getting them enrolled through the FFM or any similar state-based exchange. If we are not able to satisfy these conditions and requirements, or if we are not able to successfully adopt and maintain solutions that allow us to enroll large numbers of individuals and families in qualified plans over the Internet both during and outside of open enrollment periods, we will lose existing members and new members and may incur additional expense, which would harm our business, operating results and financial condition.

Beginning in the open enrollment period that occurred in the fourth quarter of 2018, CMS adopted a new enhanced direct enrollment pathway for CMS-approved partners to enroll individuals into qualified health plans through the FFM and complete all steps in the eligibility and enrollment process on a single website. Before enhanced direct enrollment partners are approved, extensive security and privacy reviews are conducted by an independent third-party auditor and CMS reviews the audit results to ensure the entity satisfies numerous additional

privacy and security standards. We entered into an agreement to outsource certain aspects of the enrollment process for qualified health plans to a third party in light of the expense and burden associated with the additional requirements. However, if we do not develop the ability to satisfy the requirements to use the improved qualified health plan enrollment process in the future, or if we are unsuccessful in entering into or maintaining a relationship with a third party who is approved to use the process, we may not be able to enroll individuals into qualified health plans through the FFM or could be required to use an inferior process to do so, which could cause a reduction in our individual and family health insurance plan membership and commission revenue. In addition, if we are not able to adopt or contract with and maintain solutions to integrate with government-run health insurance exchanges or if the health insurance exchange websites and other processes are unstable or not consumer friendly, efficient and compatible with the process we have adopted for enrolling individuals and families into qualified health plans through the exchanges, we would not be successful in retaining and acquiring members, and our business, operating results and financial condition would be harmed. The FFM may at any time cease allowing us or our third-party partner to enroll individuals in qualified health plans or change the requirements for doing so, or relevant government regulations or agencies may prevent us from efficiently working with our third-party partner, including timely receiving and using data from our third-party partner. If the FFM ceases allowing us or our third-party partner to enroll individuals, if the FFM platform does not function properly or if we are prevented from efficiently working with our third-party partner, our ability to retain existing members and add new members could be negatively impacted, which would harm our business, operating results and financial condition. Similarly for states that use state-based exchanges instead of the FFM, we may not be able to establish or maintain stable, consumer friendly, efficient or compatible legal arrangements or technical processes to enroll members in qualified health plans through such state-based exchanges, either directly with the governmental entities running such state-based exchanges or through appropriate third parties that allow us to access such state-based exchanges. If we are unable to adapt our operations in a timely, efficient and cost-effective manner to respond to changing circumstances to allow us to continue to effectively enroll members through the FFM and state-based exchanges, our business may be adversely affected.

Our operations in China involve many risks that could increase expenses, expose us to increased liability and adversely affect our business, operating results and financial condition.

A portion of our operations is conducted by our subsidiary in China. Among other things, we use employees in China to maintain and update our ecommerce platform and perform certain tasks within our finance and customer care and enrollment functions. We rely on third party partners to communicate with our subsidiary in China. Our business would be harmed if our ability to communicate via these partners with these employees failed, and we were prevented from promptly updating our software or implementing other changes to our database and systems, among other things. From time to time we receive inquiries from health insurance carriers relating to our operations in China and the security measures we have implemented to protect data that our employees in China may be able to access. As a part of these inquiries, we have implemented additional security measures relating to our operations in China. We may be required to implement further security measures to continue aspects of our operations in China or health insurance carriers may require us to bring aspects of our operations in China back to the United States, which could be time-consuming and expensive and harm our operating results and financial condition. Health insurance carriers may also terminate our relationship due to concerns surrounding protection of data that our employees in China are able to access, which would harm our business, operating results and financial condition.

Our operations in China also expose us to different and unfamiliar laws, rules and regulations, including different intellectual property laws, which are not as protective of our intellectual property as the laws in the United States. United States and Chinese trade laws may also impose restrictions on the importation of programming or technology to or from the United States. We are also subject to anti-bribery and anti-corruption laws, privacy and data security laws, labor laws, tax laws, foreign exchange controls and cash repatriation restrictions in China. In recent years, China has adopted laws regulating cybersecurity and data protection. For example, a new data security law in China that became effective on September 1, 2021 applies to the usage, collection and protection of data within China and imposes data security obligations and restrictions on transfers of certain data outside of China, including prohibition on providing any data stored in China to law enforcement authorities or judicial bodies outside of China without prior Chinese government approval. There remains considerable uncertainty as to how the data security law will be applied, and the regulatory environment continues to evolve. Such laws, regulations and

standards are complex, ambiguous and subject to change or interpretation, which create uncertainty regarding compliance. Compliance with these laws and regulations could cause us to incur substantial costs or require us to change our business operations in China. Violation of applicable laws and regulations could adversely affect our brand, affect our relationship with our health insurance carriers, and could result in regulatory enforcement actions and the imposition of civil or criminal penalties and fines, which would harm our business, operating results and financial condition.

Our business may be adversely impacted by changes in China's economic or political condition. We have experienced greater competition for qualified personnel in China, which has raised market salaries and increased our compensation costs related to employees in China. If competition for personnel increases further, our compensation expenses could rise considerably or, if we determine to not increase compensation levels, our ability to attract and retain qualified personnel in China may be impaired, which could harm our business, operating results and financial condition. These risks could cause us to incur increased expenses and could harm our ability to effectively and successfully manage our operations in China. Moreover, any significant or prolonged deterioration in the relationship between the United States and China could adversely affect our operations in China. Certain risks and uncertainties of doing business in China are solely within the control of the Chinese government, and Chinese law regulates the scope of our foreign investments and business conducted within China. The escalation of trade tensions has increased the risk associated with our operations in China. Either the United States or the Chinese government may limit or sever our ability to communicate with our China operations or may take actions that force us to close our operations in China. We employ a large number of our technology and content employees in China, and we have other employees in China that support our business. Any disruption of our operations in China, including any disruption as a result of the Chinese government's COVID-19 related policies, would adversely impact our business. If we are required to move aspects of our operations out of China as a result of political instability, changes in laws, inquiries from health insurance carriers or for other reasons, we could incur increased expenses, and our business, operating results and financial condition could be harmed.

We cannot predict the impact that changing climate conditions, including legal, regulatory and social responses thereto, may have on our business.

Global climate change has added, and will continue to add, to the unpredictability, frequency and severity of natural disasters, including but not limited to hurricanes, tornadoes, freezes, droughts, other storms and fires in certain parts of the world. In response, a number of legal and regulatory measures and social initiatives have been introduced in an effort to reduce greenhouse gas and other carbon emissions that are chief contributors to global climate change. We cannot predict the impact that changing climate conditions will have on our business, though extreme weather events could impact our facilities, technological assets, business continuity and reputation. The legal, regulatory and social responses to climate change could also adversely affect our results of business, operating results and financial conditions.

Our success in selling Medicare-related health insurance will depend upon a number of factors, some of which are outside of our control.

Our success in selling Medicare-related health insurance is dependent upon a number of factors, including:

- our ability to continue to adapt our ecommerce platforms to market Medicare plans, including our development or acquisition of marketing tools and features important in the sale of Medicare plans online and the effective modification of our user experience;
- our success in marketing to Medicare-eligible individuals, including television advertising, online marketing and direct mail marketing, and in entering into and maintaining marketing partner relationships to drive Medicare-eligible individuals to our ecommerce platforms or customer care centers on a cost-effective basis;
- our ability to hire and retain a sufficient number of qualified employees with experience in Medicare, including our ability to develop Medicare sales expertise in our customer care centers;

- our ability to implement and maintain an effective information technology infrastructure for the sale of Medicare plans, including the infrastructure and systems that support our websites, call centers and call recording;
- our ability to leverage technology in order to sell, and otherwise become more efficient at selling, Medicare-related plans over the telephone;
- our ability to comply with the numerous, complex and changing laws, regulations, guidelines and policies of the federal and state governments, including CMS guidelines and policies relating to the marketing and sale of Medicare plans and health care reform; and
- the effectiveness with which our competitors market the availability of Medicare plans from sources other than our ecommerce platforms.

As a result of these and other factors, we may prove unsuccessful in marketing Medicare plans and acting as a health insurance agent in connection with their sale, which would harm our business, operating results and financial condition. In addition, if our efforts to market Medicare plans during enrollment periods were impeded due to lack of timely health insurance carrier or CMS approval, or for other reasons, the impact on our business, operating results and financial condition would be significantly greater given the seasonality of our Medicare-related revenue, membership acquisition and expenses and the fact that much of the sales of Medicare plans occur during this period.

Risks Related to Laws and Regulations

The marketing and sale of Medicare plans are subject to numerous, complex and frequently changing laws, regulations and guidelines, and non-compliance with or changes in laws, regulations and guidelines could harm our business, operating results and financial condition.

The marketing and sale of Medicare plans are subject to numerous laws, regulations and guidelines at the federal and state level. The marketing and sale of Medicare Advantage and Medicare Part D prescription drug plans are principally regulated by CMS but are also subject to state laws. The marketing and sale of Medicare Supplement plans are principally regulated on a state-by-state basis by state departments of insurance. The laws and regulations applicable to the marketing and sale of Medicare plans are numerous, ambiguous and complex, and, particularly with respect to regulations and guidance issued by CMS for Medicare Advantage and Medicare Part D prescription drug plans, change frequently. We have altered, and likely will have to continue to alter, our marketing and sales process to comply with these laws, regulations and guidelines.

Health insurance carriers whose Medicare plans we sell approve our websites, our call center scripts and a large portion of our marketing material. We must receive these approvals in order for us to market and sell Medicare plans to Medicare-eligible individuals as a health insurance agent. We are also required to file many of these materials on a regular basis with CMS. In addition, certain aspects of our Medicare plan marketing partner relationships have been in the past, and will be in the future, subjected to CMS and health insurance carrier review. CMS, state departments of insurance or health insurance carriers may decide to object to or not to approve aspects of our online platforms, sales function or marketing material and processes and may determine that certain existing aspects of our Medicare-related business are not in compliance with legal requirements. CMS scrutinizes health insurance carriers whose Medicare plans we sell and those health insurance carriers may be held responsible for actions that we, our agents and our partners take, including our marketing materials and actions that lead to complaints or disenrollment. We expect that health insurance carriers will be increasingly evaluating broker performance based on quality of their enrollments, including complaints, retention rates, customer satisfaction and volumes. As a result, health insurance carriers may terminate their relationship with us or require us to take other corrective action if our Medicare product sales, marketing and operations are not in compliance or give rise to too many complaints. The termination of or change in our relationship with health insurance carriers for this reason could reduce the products we are able to offer, could result in the loss of commissions for past and future sales and could otherwise harm our business, operating results and financial condition. Changes to the laws, regulations and guidelines relating to the sale of Medicare plans, their interpretation or the manner in which they are enforced could impact the manner in which we conduct our Medicare business, our ecommerce platforms or our sale of Medicare plans, or we could be prevented from operating aspects of our Medicare revenue-generating activities altogether,

which would harm our business, operating results and financial condition. We have received, and may in the future receive, inquiries from CMS or state departments of insurance regarding our marketing and business practices and compliance with laws and regulations. Inquiries and proceedings initiated by the government could adversely impact our health insurance licenses, require us to pay fines, require us to modify marketing and business practices, result in litigation and otherwise harm our business, operating results or financial condition.

In May 2021, CMS changed its process for the submission and approval of marketing materials related to Medicare Advantage and Medicare Part D prescription drug plans. The practical application of the previous process allowed for a lead carrier to handle most of the review and filing of Medicare plan marketing materials with CMS. The new process requires each carrier to approve of each filed marketing material and has resulted in a more complicated and time-consuming process to get our marketing material filed with CMS and through the process with carriers. In October 2021, CMS issued new guidance that significantly broadens the types of marketing materials that we are required to file with CMS, including the requirement to file certain generic marketing materials that refer to the benefits or costs of Medicare Advantage or Medicare Part D prescription drug plans but that do not specifically mention a health insurance carrier's name or a specific plan. As a result, we now submit to each Medicare Advantage and Medicare Part D prescription drug plan carrier with which we have a relationship a significantly larger number of marketing materials than we have in the past. We may not be able to use certain marketing materials and implement our marketing programs effectively if CMS or a health insurance carrier has comments or disapproves of our marketing materials. If we do not timely file the additional marketing materials with CMS or if health insurance carriers do not adapt to the new CMS requirements or increase the efficiency with which they review our marketing material, it could harm our sales and also harm our ability to efficiently change and implement new or existing marketing material, including call center scripts and our websites, which could harm our business, operating results and financial condition. If we or our marketing partners are not successful in timely receiving health insurance carrier or CMS approval of our marketing materials, or if a health insurance carrier refuses to accept enrollments relating to specific materials or marketing endeavors, we could be prevented from implementing our Medicare marketing and sales initiatives, which could harm our business, operating results and financial condition, particularly if such delay or non-compliance occurs during the Medicare annual enrollment period or the Medicare Advantage open enrollment period.

In June 2022, CMS released final versions of the rules initially proposed in January 2022, which included several new provisions aimed at Third Party Marketing Organizations ("TPMO"). CMS first sought to define TPMOs as organizations that are compensated to perform lead generation, marketing, sales, and enrollment related functions as a part of the chain of enrollment, that is the steps taken by a beneficiary from becoming aware of a Medicare plan or plans to making an enrollment decision. In addition, the proposed definition of TPMOs specifies that TPMOs may be first tier, downstream or related entities ("FDRs"), but TPMOs may also be other businesses which provide services to customers including a Medicare Advantage or Medicare Part D prescription drug plan or a Medicare Advantage or Medicare Part D prescription plan’s FDRs. This new definition now encompasses lead generation partners, previously considered not covered by CMS requirements. In addition, this rule imposes additional requirements including marketing disclaimers and more stringent oversight requirements for carriers for our business activities. The potential for corresponding increased administrative operating costs as well as the further potential increase in costs passed down from lead generation partners to implement such initiatives is anticipated.

In October 2022, CMS announced that in response to concerns about certain marketing practices in the Medicare marketplace, it would, among other things, be increasing review of certain marketing materials and practices and, beginning January 1, 2023, television advertisements will no longer be eligible for the CMS file and use process and instead will be subject to a more time-consuming review process. Compliance with these evolving laws and regulations may involve significant costs or require changes in our business practices that could have adverse impact on our business, operating results, financial condition and prospects. Non-compliance could also result in fines, damages, prohibitions on the conduct of our business, and damage to our reputation

Changes and developments in the health insurance industry or system could harm our business, operating results and financial condition.

The United States health insurance system, including the Medicare program, is subject to a changing regulatory environment. The future financial performance of our business will depend in part on our ability to adapt to regulatory developments. For example, the federal Patient Protection and Affordable Care Act of 2010 and related regulatory reforms have and will continue to change the industry in which we operate in substantial ways. The implementation of health care reform has increased, and could further increase, our competition in the

individual and family health insurance market, reduce demand for the health insurance for individuals and families that we sell, decrease the number of health insurance plans that we sell as well as the number of health insurance carriers offering them, cause carriers to increase premiums or reduce commissions and other amounts they pay for our services, any of which could materially harm our business, operating results and financial condition. Legislative or regulatory changes to the Medicare program could have similar impacts on our Medicare business. The impacts of health care reform on our business included a significant decline in our individual and family plan revenue and membership and other changes in the future could have a similar impact on our Medicare related health insurance business. Our business, operating results, financial condition and prospects may be materially and adversely affected if we are unable to adapt to developments in health care reform in the United States.

Our business depends upon the private sector of the United States health insurance system, which is subject to a changing environment. Changes and developments in the health insurance system and Medicare program in the United States could reduce demand for our services and harm our business. Ongoing health care reform efforts and measures may expand the role of government-sponsored coverage, including proposals for single payer or so called “Medicare-for-All” or other proposals that may have the effect of reducing or eliminating the market for our current range of health insurance products, which could have far-reaching implications for the health insurance industry if enacted. Some proposals would seek to eliminate the private marketplace while others would expand a government-sponsored option to a larger population. We are unable to predict the full impact of health care reform initiatives or other regulatory changes on our operations in light of the uncertainty of whether initiatives will be successful and the uncertainty regarding the terms and timing of any provisions enacted and the impact of any of those provisions on various healthcare and insurance industry participants. Changes to the Medicare program or the broader health insurance system as a result of the change in the balance of power in Congress or as a result of the Biden administration's health care reform initiatives could harm our business, operating results and financial condition. In the event that laws, regulations or rules that eliminate or reduce private sources of health insurance or Medicare are adopted, the demand for our products could be adversely impacted, and our business, operating results and financial condition would be harmed.

From time to time we are subject to various legal proceedings which could adversely affect our business.

We are, and may in the future become, involved in various legal proceedings and governmental inquiries, including labor and employment-related claims, claims relating to our marketing or sale of health insurance, intellectual property claims and claims relating to our compliance with securities laws. For example, in January 2022, we received a subpoena from the United States Attorney's Office for the District of Massachusetts, seeking, among other things, information regarding our arrangements with insurance carriers. This inquiry, and any other claims asserted against us, with or without merit, could be time-consuming, expensive to address and divert management’s attention and other resources. These claims also could subject us to significant liability for damages, jeopardize our licenses to operate and harm our reputation. Our insurance and indemnities may not cover all claims that may be asserted against us. If we are unsuccessful in our defense in these legal proceedings, we may be forced to pay damages or fines, enter into consent decrees, stop offering our services or change our business practices, any of which would harm our business, operating results or financial condition.

Our success in selling health insurance is dependent in part on the actions of federal and state governments. Changes in the laws and regulations governing the offer, sale and purchase of health insurance could harm our business and operating results.

The laws and regulations governing the offer, sale and purchase of health insurance are complex and subject to change, and future changes may be adverse to our business. For example, a long-standing provision in most applicable state laws that we believe is advantageous to our business is that once health insurance premiums are set by the carrier and approved by state regulators, they are fixed and not generally subject to negotiation or discounting by insurance companies or agents. Additionally, state regulations generally prohibit carriers, agents and brokers from providing financial incentives, such as rebates, to their members in connection with the sale of health insurance. As a result, we do not currently compete with carriers or other agents and brokers on the price of the health insurance plans offered on our website. If these regulations change, we could be forced to reduce prices or provide rebates or other incentives for the health insurance plans sold through our ecommerce platform, which

would harm our business, operating results and financial condition. In addition, a federal law that went into effect in December 2021 requires disclosure of commissions paid to us to the purchaser of small business, major medical individual and family and short-term health insurance plans. It is unclear what impact the law will have, but it could impact consumers' demand for our services or cause health insurance carriers to lower our commission rates, which could reduce our revenue.

States and federal governments may adopt laws and regulations that are adverse to our business, including laws and regulations that impact the types of health insurance coverage available to consumers, the product features and benefits, our marketing and selling of plans and the role and compensation of agents and brokers in the sale of health insurance.

Changes to the rules and regulations that apply to our sale of Medicare-related health insurance are more likely under the Biden administration compared to the previous administration. CMS may change the rules and regulations applicable to us in connection with our Medicare plan business, and those changes could harm our business, operating results and financial condition. For example, the recent CMS final rules released in June 2022 regarding TPMOs will likely impose additional administrative oversight responsibilities and restrict our business activities. The Biden administration has also indicated that it is in support of changes to the Affordable Care Act. In addition, Republican politicians have indicated they would make changes to or repeal the Affordable Care Act or make other regulatory changes if they regain control of Congress. It is difficult to predict what changes the Biden administration or a Republican Congressional majority may make in the rules and regulations relating to our sale of the products that we sell, but the changes could harm our business, operating results and financial condition.

If we fail to comply with the numerous laws and regulations that are applicable to the sale of health insurance, our business and operating results could be harmed.

We are required to maintain a valid license in each state in which we transact health insurance business and to adhere to sales, documentation and administration practices specific to that state. We must maintain our health insurance licenses to continue selling plans and to continue to receive commissions from health insurance carriers. In addition, each employee who transacts health insurance business on our behalf must maintain a valid license in one or more states. Because we do business in all 50 states and the District of Columbia, compliance with health insurance-related laws, rules and regulations is difficult and imposes significant costs on our business. Each jurisdiction’s insurance department typically has the power, among other things, to:

- grant, limit, suspend and revoke licenses to transact insurance business;
- conduct inquiries into the insurance-related activities and conduct of agents and agencies;
- require and regulate disclosure in connection with the sale and solicitation of health insurance;
- authorize how, by which personnel and under what circumstances insurance premiums can be quoted and published and an insurance policy sold;
- approve which entities can be paid commissions from carriers and the circumstances under which they may be paid;
- regulate the content of insurance-related advertisements, including web pages, and other marketing practices;
- approve policy forms, require specific benefits and benefit levels and regulate premium rates;
- impose fines and other penalties; and
- impose continuing education requirements.

Due to the complexity, periodic modification and differing interpretations of insurance laws and regulations, we may not have always been, and we may not always be, in compliance with them. New laws, regulations and guidelines also may not be compatible with the sale of health insurance over the Internet or with various aspects of our platform or manner of marketing or selling health insurance plans. Failure to comply with insurance laws, regulations and guidelines or other laws and regulations applicable to our business could result in significant liability,

additional department of insurance licensing requirements, required modification of our advertising and business practices, changes to our existing technology or platforms, the limitation, suspension and/or revocation of our licenses to sell health insurance, termination of our relationship with health insurance carriers and loss of commissions and/or our inability to sell health insurance plans, which would harm our business, operating results and financial condition. Moreover, an adverse regulatory action in one jurisdiction could result in penalties and adversely affect our license status, business or reputation in other jurisdictions due to the requirement that adverse regulatory actions in one jurisdiction be reported to other jurisdictions. Even if the allegations in any regulatory or other action against us are proven false, any surrounding negative publicity could harm consumer, marketing partner or health insurance carrier confidence in us, which could significantly damage our brand.

Our business is subject to emerging privacy laws being passed at the state level that create unique compliance challenges. Increasing regulatory focus on privacy and security issues and expanding laws could impact our business and expose us to increased liability.

Our services involve the collection and storage of confidential and personally identifiable information of consumers and the transmission of certain personal information to their chosen health insurance carriers and to the government. For example, we collect names, addresses, credit card and social security numbers and health information such as information regarding consumers' prescription drugs and providers. We also hold a significant amount of personal information relating to our current and former employees. As a result, we are subject to various state and federal laws and contractual requirements regarding the access, use and disclosure of personal information. Compliance with state and federal privacy-related laws, particularly new state legislation such as the California Consumer Privacy Act, and increasingly robust industry standard security frameworks will result in cost increases due to an increased need for privacy compliance, oversight and monitoring, and the development of new processes to effectuate and demonstrate compliance. The effects of potential non-compliance by us or third party service providers, and enforcement actions, may result in increased costs to our business and reputational harm. The privacy legislation landscape is rapidly evolving on a state-by-state basis that creates challenges for businesses to comply with the new legal obligations in a systematic fashion. For example, Virginia, Colorado and California have new privacy legislation that will come into effect in 2023; however, these laws have differing consumer rights and business obligations, differing obligations on data controllers and differing enforcement mechanisms. These new legal operations may change the way we conduct our business and may harm our results of operations and financial condition.

Any perception that our practices, products or services violate individual privacy or data protection rights may subject us to public criticism, class action lawsuits, reputational harm, or investigations or claims by regulators, industry groups or other third parties, all of which could disrupt or adversely impact our business and expose us to increased liability. In the event that additional data privacy or data security laws are implemented, or our health insurance carrier or other partners determine to impose requirements on us relating to data privacy security, we may not be able to timely comply with such requirements or such requirements may not be compatible with our current processes. Changing our processes could be time-consuming and expensive, and failure to timely implement required changes could result in our inability to sell health insurance plans in a particular jurisdiction or for a particular health insurance carrier or subject us to liability for non-compliance, any of which would damage our business, operating results and financial condition. Health insurance carriers that we work with may also require us to comply with additional privacy and data security standards to do business with us at all. Compliance with privacy and data security standards is regularly assessed, and we may not always be compliant with the standards. If we are not in compliance, we may not be able to accept information from consumers, and our relationship with health insurance carriers could be adversely impacted or terminated, which would harm our business, operating results and financial condition.

Any legal liability, regulatory penalties, complaints or negative publicity related to the information on our website or that we otherwise provide could harm our business and operating results.

We provide information on our website, through our customer care centers, in our marketing materials and in other ways regarding health insurance in general and the health insurance plans we market and sell, including information relating to insurance premiums, coverage, benefits, provider networks, exclusions, limitations, availability, plan comparisons and insurance company ratings. A significant amount of both automated and manual effort is required to maintain the considerable amount of insurance plan information on our website. We also use the information provided on our website and otherwise collected by us to publish reports designed to educate

consumers, facilitate public debate, and facilitate reform at the state and federal level. If the information we provide on our website, through our customer care centers, in our marketing materials or otherwise is not accurate or is construed as misleading, or if we do not properly assist individuals and businesses in purchasing health insurance, members, health insurance carriers and others could attempt to hold us liable for damages or require us to take corrective actions, our relationships with health insurance carriers could be terminated or impaired and regulators could attempt to subject us to penalties, force us to stop using our websites, marketing material or certain aspects of them, revoke our licenses to transact health insurance business in a particular jurisdiction, and/or compromise the status of our licenses to transact health insurance business in other jurisdictions, which could result in our loss of our commission revenue and harm our business, operating results and financial condition.

In the ordinary course of operating our business, we and our health insurance carrier partners have received complaints that the information we provided was not accurate or was misleading. We have received, and may in the future receive, inquiries from health insurance carriers, CMS or state departments of insurance regarding our marketing and business practices and compliance with laws and regulations. In 2021, we experienced an increased rate of complaints filed directly with CMS from Medicare beneficiaries enrolled by us as well as an increase in beneficiary complaints filed with insurance carriers. Although we have taken actions to address the quality of our enrollments and to improve our customer experience, if the actions we have taken do not effectively and sustainably reduce the rate of complaints and improve our retention rates, our relationship with health insurance carriers could be modified or terminated, our Medicare commission and advertising revenue could decline, and we may incur significant expenses without realizing the value of our investment. Even if we are successful in reducing the rate of complaints, any initiatives we take to address retention could reduce our number of enrollments and conversion rates, which could harm our business, operating results and financial condition. Also, our sales of short-term health insurance plans that lack the same benefits as major medical health insurance plans may increase the risk that we receive complaints regarding our marketing and business practices due to the potential for consumer confusion between short-term health insurance and major medical health insurance. In addition, these types of claims could be time-consuming and expensive to defend, could divert our management's attention and other resources, and could cause a loss of confidence in our services. As a result, whether or not we are able to successfully resolve these claims, they could harm our business, operating results and financial condition.

Our business could be harmed if we are unable to contact our consumers or market the availability of our products through specific channels.

We use email and telephone, among other channels, to market our services to potential members and as the primary means of communicating with our existing members. The laws and regulations governing the use of email and telephone calls for marketing purposes continue to evolve, and changes in technology, the marketplace or consumer preferences may lead to the adoption of additional laws or regulations or changes in interpretation of existing laws or regulations. If new laws or regulations are adopted, or existing laws and regulations are interpreted or enforced, to impose additional restrictions on our ability to send email or telephone messages to our members or potential members, we may not be able to communicate with them in a cost-effective manner. In addition to legal restrictions on the use of email, Internet service providers, email service providers and others attempt to block the transmission of unsolicited email, commonly known as "spam." Many Internet and email service providers have relationships with organizations whose purpose it is to detect and notify the Internet and email service providers of entities that the organization believes is sending unsolicited email. If an Internet or email service provider identifies email from us as "spam" as a result of reports from these organizations or otherwise, we can be placed on a restricted list that will block our email to members or potential members.

We use telephones to communicate with customers and prospective customers and some of these communications may be subject to the Telephone Consumer Protection Act ("TCPA") and other telemarketing laws. The TCPA and other laws, including state laws, relating to telemarketing restrict our ability to market using the telephone in certain respects. For instance, the TCPA prohibits us from using an automatic telephone dialing system or prerecorded or artificial voices to make certain telephone calls to consumers without prior express written consent. We have policies in place to comply with the TCPA and other telemarketing laws. However, we have been in the past, and may in the future become, subject to claims that we have violated the TCPA. The TCPA provides for statutory damages of $500 for each violation and $1,500 for each willful violation. In the event that we were found to have violated the TCPA, our business, operating results and financial condition could be harmed. In addition, telephone carriers may block or put consumer warnings on calls originating from call centers. Consumers

increasingly screen their incoming emails and telephone calls, including by using screening tools and warnings, and therefore our members or potential members may not reliably receive our emails or telephone messages, whether or not such messages constitute marketing. If we are unable to communicate effectively by email or telephone with our members and potential members as a result of legislation, legal or regulatory actions, blockage, screening technologies or otherwise, our business, operating results and financial condition would be harmed.

Risks Related to Finance, Accounting and Tax Matters

Our operating results will be impacted by factors that impact our estimate of the constrained LTV of commissions per approved member.

We recognize revenue for plans approved during the period by applying the latest estimated constrained LTVs for that product. Constrained LTVs are estimates and are based on a number of assumptions, which include, but are not limited to, estimates of the conversion rates of approved members into paying members, forecasted average plan duration and forecasted commissions we expect to receive per approved member's plan. These assumptions are based on historical trends and require significant judgment by our management in interpreting those trends and in applying the constraints. Changes in our historical trends will result in changes to our constrained LTV estimates in future periods and therefore could adversely affect our revenue and financial results in those future periods. As a result, negative changes in the factors upon which we estimate constrained LTVs, such as reduced conversion of approved members to paying members, increased health insurance plan terminations or a reduction in the lifetime commission amounts we expect to receive for selling the plan to a member or other changes could harm our business, operating results and financial condition. Changes in LTV may result in an increase or a decrease to revenue and a corresponding increase or decrease to commission receivables. In addition, if we ultimately receive commission payments that are less than the amount we estimated when we recognized commission revenue, we would need to write off the remaining commission receivable balance, which would adversely impact our business, operating results and financial condition.

The rate at which approved members become paying members is a significant factor in our estimation of constrained LTVs. To the extent we experience a decline in the rate at which approved members turn into our paying members, our business, operating results, and financial condition would be harmed.

The forecasted average plan duration is another important factor in our estimation of constrained LTV. When a plan is canceled, or if we otherwise do not remain the agent on the policy, we no longer receive the related commission payment. Our forecasted average plan duration and health insurance plan termination rate are calculated based on our historical data by plan type. As a result, a reduction in our forecasted average plan duration or an inability to produce accurate forecasted average plan duration may adversely impact our business, operating results and financial condition.

Commission rates are also a significant factor in our estimation of constrained LTVs. The commission rates we receive are impacted by a variety of factors, including the particular health insurance plans chosen by our members, the carriers offering those plans, our members’ states of residence, the laws and regulations in those jurisdictions, the average premiums of plans purchased through us and health care reform. Our commission revenue per member has in the past decreased, and could in the future decrease, as a result of reductions in contractual commission rates, a change in the mix of carriers whose products we sell during a given period, and increased health insurance plan termination rates, all of which are beyond our control and may occur on short notice. To the extent these and other factors cause our commission revenue per member to decline, our revenue may decline and our business, operating results and financial condition would be harmed. Given that Medicare-related and individual and family health insurance purchasing is concentrated during enrollment periods, we may experience a shift in the mix of Medicare-related and individual and family health insurance products selected by our members over a short period of time. Any reduction in our average commission revenue per member caused by such a shift or otherwise would harm our business, operating results and financial condition.

The determination of constraints is also a factor that requires significant management judgment. Constraints are applied to LTVs for revenue recognition purposes and help ensure that the total estimated lifetime commissions expected to be collected from an approved member's plan are recognized as revenue only to the extent that is

probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with future commissions receivable from the plan is subsequently resolved. We determine the constraint for each product by comparing prior calculations of LTV to actual cash received and review the reasons for any variations. We then apply judgment in assessing whether the difference between historical cash collections and LTV is representative of differences that can be expected in future periods. We also analyze whether circumstances have changed and consider any known or potential modifications to the inputs into LTV in light of the factors that can impact the amount of cash expected to be collected in future periods including but not limited to commission rates, carrier mix, plan duration, changes in laws and regulations and cancellations of insurance plans offered by health insurance carriers with which we have a relationship. We evaluate the appropriateness of our constraints on an ongoing basis, and we update our assumptions when we observe a sufficient amount of evidence that would suggest that the long-term expectation underlying the assumptions has changed. If we underestimate the initial constraint applied to LTVs, we might be required to increase the constraint or record an impairment in a future period which would harm our business, operating results and financial condition.

Our debt and preferred stock obligations contain restrictions that impact our business and expose us to risks that could materially adversely affect our liquidity and financial condition.

On February 28, 2022, we entered into a term loan credit agreement with Blue Torch Finance LLC, as administrative agent and collateral agent, and other lenders party thereto, which was amended on August 16, 2022 (as amended, the "Credit Agreement"). The Credit Agreement provides us with $70 million in term loans. In connection with entering into the Credit Agreement, we terminated our credit agreement with Royal Bank of Canada and other lenders that provided us with an up to $75 million revolving credit facility. The Credit Agreement contains certain mandatory prepayment triggers and imposes certain covenants and restrictions on our business and our ability to obtain additional financing.

The Credit Agreement contains customary affirmative covenants, including covenants regarding the payment of taxes and other obligations, maintenance of insurance, reporting requirements and compliance with applicable laws and regulations. The Credit Agreement also contains restrictions that limit our ability to, among other things, incur debt, grant liens, make certain restricted payments, make fundamental changes, sell assets, transact with affiliates, enter into burdensome agreements, prepay certain indebtedness or modify our organizational documents, in each case, subject to certain exceptions. Further, the Credit Agreement contains financial covenants requiring us to (x) maintain a minimum level of liquidity as of the end of each month and (y) maintain a ratio such that the outstanding amount of obligations under the Term Loan Credit Agreement at the end of any month does not exceed 50% of the value of certain commissions receivable as of the end of such month. The events of default under the Credit Agreement include, among other things and subject to grace periods in certain instances, payment defaults, cross defaults with certain other material indebtedness, breaches of covenants or representations and warranties, changes in control of our company, certain bankruptcy and insolvency events with respect to us and our subsidiaries, a restriction on all or a material portion of our business and the indictment of us or any subsidiary (or any senior officer thereof), or criminal proceedings against the same, which could result in a forfeiture of a material portion of our and our subsidiaries properties.

If we experience a decline in cash flow due to any of the factors described in this “Risk Factors” section or otherwise, we could have difficulty paying interest and principal amounts due on our indebtedness and meeting the financial covenants set forth in our Credit Agreement. If we are unable to generate sufficient cash flow or otherwise obtain the funds necessary to make required payments under the Credit Agreement, or if we fail to comply with the requirements of our indebtedness, we could default under our Credit Agreement. Any default that is not waived could result in the acceleration of the obligations under the Credit Agreement, an increase in the applicable interest rate under the credit facility, and would permit our lender to exercise rights and remedies with respect to all of the collateral that is securing the Credit Agreement, which includes substantially all of our assets. Any such default could materially adversely affect our liquidity and financial condition.

The terms of our investment agreement with Echelon Health SPV, LP ("H.I.G."), the initial purchaser of our Series A Preferred Stock, could also limit our ability to obtain additional financing or increase our borrowing costs, which could have an adverse effect on our financial condition. As of the date of this report, pursuant to the terms of our investment agreement with H.I.G., we must obtain the consent of H.I.G. in order to incur any indebtedness, which could limit our ability to obtain additional financing until our adjusted EBITDA for the trailing four quarters increases.

Even if we comply with all of the applicable covenants, the restrictions on the conduct of our business imposed by our lenders or investors could materially adversely affect our business by, among other things, limiting our ability to take advantage of financings, mergers, acquisitions and other corporate opportunities that may be beneficial to the business. Even if the Credit Agreement were terminated, additional debt we could incur in the future may subject us to similar or additional covenants, which could place restrictions on the operation of our business. Similarly, our investment or financing arrangement with any future investors may subject us to similar or additional covenants.

Operating and growing our business is likely to require additional capital, and if capital is not available to us, our business, operating results and financial condition may suffer.

Operating and growing our business is expected to require further investments in our business. We have generated negative cash from operating activities and may continue to generate negative cash from operating activities in the future. We are likely to raise additional capital through debt and/or equity financing and plan to implement our transformation initiatives, which are discussed in the section of this report titled Management's Discussion and Analysis of Financial Condition and Results of Operations - Updates on Business Initiatives - Transformational Plan. These transformation initiatives may not be successful in reducing expenses and may result in other negative effects on our business, which could result in us requiring additional capital. Further, we may be presented with opportunities that we want to pursue, and business or other challenges may present themselves, any of which could cause us to require additional capital. If we seek to raise funds through debt or equity financing, those funds may prove to be unavailable, may only be available on terms that are not acceptable to us or may result in significant dilution to our stockholders or higher levels of leverage. Our Credit Agreement and our investment agreement with H.I.G, contain restrictions that limit our ability to incur additional indebtedness, issue certain types of equity securities with rights and preferences senior to or pari passu with our Series A Preferred Stock, make certain types of investments or obtain additional financing. As of the date of this report, pursuant to the terms of our investment agreement with H.I.G., we must obtain the consent of H.I.G. in order to incur any indebtedness, which could limit our ability to obtain additional financing until our adjusted EBITDA for the trailing four quarters increases. If we are unable to obtain adequate financing or financing on terms satisfactory to us, when we require it, our ability to continue to pursue our business objectives and to respond to business opportunities or challenges could be harmed, and our business, operating results and financial condition could be materially and adversely affected.

If we fail to maintain proper and effective internal controls, our ability to produce accurate financial statements could be impaired, which could adversely affect our operating results, our ability to operate our business and our stock price.

We have a complex business organization. Ensuring that we have adequate internal financial and accounting controls and procedures in place to help ensure that we can produce accurate financial statements on a timely basis is a costly and time-consuming effort that needs to be re-evaluated frequently and is complicated by the expansion of our business operations and changing accounting requirements. Our management, including our chief executive officer and chief financial officer, does not expect that our internal control over financial reporting will prevent all errors or all fraud. A control system, no matter how well designed and operated, can provide only reasonable, not absolute, assurance that the control system’s objectives will be met. Further, the design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Controls can be circumvented by the individual acts of some persons, by collusion of two or more people, or by management override of the controls. Over time, controls may become inadequate because changes in conditions or deterioration in the degree of compliance with policies or procedures may occur. Because of the inherent limitations in a cost-effective control system, misstatements due to error or fraud may occur and not be detected. We cannot assure that significant deficiencies or material weaknesses in our internal control over financial reporting will not be identified in the future. Any failure to maintain or implement required new or improved controls, or any difficulties we encounter in their implementation, could result in significant deficiencies or material weaknesses, cause us to fail to timely meet our periodic reporting obligations or result in material misstatements in our financial statements. Any such failure could also adversely affect the results of periodic management evaluations and annual auditor attestation reports regarding disclosure controls and the effectiveness of our internal control over financial reporting required under Section 404 of the Sarbanes-Oxley Act of 2002 and the rules promulgated thereunder. The existence of a material weakness could result in errors in our financial statements that

could result in a restatement of financial statements, cause us to fail to timely meet our reporting obligations and cause investors to lose confidence in our reported financial information, leading to a decline in our stock price and potential lawsuits against us.

Changes in our provision for income taxes or adverse outcomes resulting from examination of our income or other tax returns or changes in tax legislation could adversely affect our results.

Our provision for income taxes is subject to volatility and could be adversely affected by earnings differing materially from our projections, changes in the valuation of our deferred tax assets and liabilities, tax effects of stock-based compensation, or adverse outcomes as a result of tax examinations or by changes in tax laws, regulations, accounting principles, including accounting for uncertain tax positions, or interpretations thereof. To the extent that our provision for income taxes is subject to volatility or adverse outcomes as a result of tax examinations, our operating results could be harmed. Significant judgment is required to determine the recognition and measurement attribute prescribed in U.S. generally accepted accounting principles relating to accounting for income taxes. In addition, we are subject to examinations of our income tax returns by the Internal Revenue Service and other tax authorities. We assess the likelihood of adverse outcomes resulting from these examinations to determine the adequacy of our provision for income taxes. There may be exposure that the outcomes from these examinations will have an adverse effect on our operating results and financial condition.

Our ability to use net operating losses to offset future taxable income may be subject to certain limitations.

We have net operating loss carryforwards for federal and state income tax purposes to offset future taxable income. Our federal and state net operating loss carryforwards begin expiring in 2034 and 2033, respectively. A lack of future taxable income would adversely affect our ability to utilize these net operating loss carryforwards. In addition, utilization of the net operating loss carryforwards may be subject to a substantial annual limitation due to ownership changes that may have occurred or that could occur in the future, as required by Section 382 of the Internal Revenue Code of 1986, as amended (the "Code"), and similar state provisions. These ownership change limitations may limit the amount of net operating loss carryforwards and other tax attributes that can be utilized annually to offset future taxable income and tax, respectively. In general, an “ownership change” as defined by Section 382 of the Code results from a transaction or series of transactions over a three-year period resulting in an ownership change of more than 50 percentage points (by value) of the outstanding stock of a company by certain stockholders. Our ability to use the remaining net operating loss carryforwards may be further limited if we experience a Section 382 ownership change as a result of future changes in our stock ownership.

Risks Related to our Technology

Our ability to sell Medicare-related health insurance plans as a health insurance agent depends upon maintenance of functioning information technology systems.

Our Medicare plan customer care center operations' success depends on information technology systems. Many of our Medicare plan members utilize our customer care center to purchase a Medicare plan. CMS rules require that our health insurance agent employees utilize CMS-approved scripts in connection with the sale of Medicare plans and that we record and maintain the recording of telephonic interactions relating to the sale of Medicare plans. We rely on telephone, call recording, customer relationship management and other systems and technology in our Medicare customer care center operations, and we are dependent upon third parties for some of them, including our telephone and call recording systems. These systems have failed temporarily in the past and may experience additional disruption due to systems upgrades, power outages, an increase in remote work or other impacts as a result of the COVID-19 pandemic. The effectiveness and stability of our Medicare customer care center systems and technology are critical to our ability to sell Medicare plans, particularly during the Medicare enrollment periods, and the failure or interruption of any of these systems and technology or any inability to handle increased volume would harm our business, operating results and financial condition.

System failures or capacity constraints could harm our business and operating results.

The performance, reliability and availability of our ecommerce platform, cloud contact center and underlying network infrastructures are critical to our financial results, brand and relationship with members, marketing partners and health insurance carriers. Although we regularly attempt to enhance our platforms and system infrastructure, system failures and interruptions may occur if we are unable to accurately project the rate or timing of increases in our website or call center traffic or for other reasons, some of which are completely outside our control. We could experience significant failures and interruptions, which would harm our business, operating results and financial condition. If these failures or interruptions occurred during the Medicare annual enrollment period, the Medicare Advantage open enrollment period or during the open enrollment period under health care reform, the negative impact on us would be particularly pronounced.

We rely in part upon third-party vendors, including cloud infrastructure and bandwidth providers, to operate our ecommerce platform and contact center. We cannot predict whether additional network capacity will be available from these vendors as we need it, and our network or our suppliers' networks might be unable to achieve or maintain a sufficiently high capacity of data transmission. Any system failure that causes an interruption in or decreases the responsiveness of our services would impair our revenue-generating capabilities and harm our business and operating results and damage our reputation. In addition, any loss of data could result in loss of customers and subject us to potential liability. If these third parties experience difficulty providing the services we require or meeting our standards for those services, it could make it difficult for us to operate some aspects of our business. Our and our vendors' facilities, database and systems are vulnerable to damage or interruption from human error, fire, floods, earthquakes and other natural disasters, power loss, telecommunications failures, physical or electronic break-ins, computer viruses, cyberattacks, acts of terrorism, other attempts to harm our systems and similar events.

Our business is subject to security risks and, if we experience a successful cyberattack, a security breach or are otherwise unable to safeguard the confidentiality and integrity of the data we hold, including sensitive personal information, our business will be harmed.

Maintaining the security of our products and services is a critical issue for us, our consumers and health insurance carriers that we work with. Despite our taking precautions, we cannot guarantee that our facilities and systems and those of our third-party service providers, will be free of security breaches, cyberattacks, acts of vandalism, computer viruses, malware, misplaced or lost data, programming and/or human errors or other similar events. We may be required to expend significant amounts and other resources to protect against security breaches or to mitigate and remediate problems caused by security breaches. Techniques used to obtain unauthorized access or to sabotage systems change frequently. As a result, we may be unable to anticipate these techniques or to implement adequate preventative measures preemptively. Additionally, our third party service providers may cause security breaches for which we are responsible.

Any compromise or perceived compromise of our security or the security of one of our vendors could damage our reputation, cause the termination of relationships with government-run health insurance exchanges and our members, marketing partners and health insurance carriers, reduce demand for our services and subject us to significant liability and expense as well as regulatory action and lawsuits, any of which would harm our business, operating results and financial condition. The COVID-19 pandemic generally is increasing the attack surface available to criminals, as more companies and individuals work remotely and otherwise work online. Consequently, the risk of a cybersecurity incident has increased. We cannot provide assurances that our preventative efforts, or those of our vendors or service providers, will be successful. These actual and potential breaches of our security measures and the accidental loss, inadvertent disclosure or unauthorized dissemination of proprietary information or sensitive, personal or confidential data about us, our employees, our customers or their end users, including the potential loss or disclosure of such information or data as a result of hacking, fraud, trickery or other forms of deception, could expose us, our employees, our customers or the individuals affected to a risk of loss or misuse of this information. This may result in litigation and liability or fines, our compliance with costly and time-intensive notice requirements, governmental inquiry or oversight or a loss of customer confidence, any of which could harm our business or damage our brand and reputation, thereby requiring time and resources to mitigate these impacts.

We may not be able to adequately protect our intellectual property, which could harm our business and operating results.

We believe that our intellectual property is an essential asset of our business and that our technology currently gives us a competitive advantage in the distribution of Medicare-related, individual and family and small business health insurance. We rely on a combination of copyright, trademark and trade secret laws as well as confidentiality procedures and contractual provisions to establish and protect our intellectual property rights in the United States. The efforts we have taken to protect our intellectual property may not be sufficient or effective, and our trademarks may be held invalid or unenforceable. Moreover, the law relating to intellectual property is not as developed in China, and our intellectual property rights may not be as respected in China as they are in the United States. We may not be effective in policing unauthorized use of our intellectual property, trade secrets and other confidential information, and even if we do detect violations, litigation may be necessary to enforce our intellectual property rights. Any enforcement efforts we undertake, including litigation, could be time-consuming and expensive, could divert our management's attention and may result in a court determining that our intellectual property or other rights are unenforceable. If we are not successful in cost-effectively protecting our intellectual property rights, trade secrets and confidential information, our business, operating results and financial condition could be harmed.

Consumers and our employees depend upon third-party service providers to access our website, services and systems, and our business and operating results could be harmed as a result of technical difficulties experienced by these service providers.

Consumers using our website and accessing our services depend upon Internet, online and other service providers for access to our website and services. Our remote employees rely on third-party service providers to access our systems and other agent productivity tools. Many of these service providers have experienced significant outages, delays and other difficulties in the past and could experience them in the future. Our business operations may be disrupted if our employees are unable to work from home effectively as a result of technical difficulties experienced by these service providers. Any significant interruption in access to our call centers or our website or increase in our website's response time as a result of these difficulties could damage our relationship with insurance carriers, marketing partners and existing and potential members and could harm our business, operating results and financial condition.

Risks Related to Ownership of Our Common Stock

Our actual operating results may differ significantly from our guidance.

From time to time, we have released, and may continue to release guidance in earnings conference calls, earnings releases, or otherwise, regarding our future performance that represents our management's estimates as of the date of release. This guidance, which includes forward-looking statements, has been, and will be, based on projections prepared by our management. Guidance is necessarily speculative in nature, and it can be expected that some or all of the assumptions underlying the guidance furnished by us will not materialize or will vary significantly from actual results. Accordingly, our guidance is only an estimate of what management believes is realizable as of the date of release. Our actual results have, and may in the future, vary from our guidance and the variations may be material. In light of the foregoing, investors are urged not to rely upon our guidance in making an investment decision regarding our common stock.

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 and are based upon specific assumptions with respect to future business decisions, some of which will change. Among these factors, the assumptions underlying our estimates of commission revenue as required by ASC 606*,* may vary significantly over time. We may state possible outcomes as high and low ranges. Any range we provide is not intended to imply that actual results could not fall outside of the suggested ranges. Any failure to successfully implement our operating strategy or the occurrence of any of the events or circumstances set forth in this "Risk Factors" section could result in the actual operating results being different from our guidance, and the differences may be adverse and material. The principal reason that we release guidance is to provide a basis for our management to discuss our business outlook with analysts and investors and

we may decide to suspend guidance at any time. We do not accept any responsibility for any projections or reports published by any such third parties.

The price of our common stock has been and may continue to be volatile, and the value of your investment could decline.

The trading price of our common stock has been volatile and is likely to continue to fluctuate substantially. For the quarter ended September 30, 2022, the closing price of our common stock fluctuated from $3.91 to $9.63 per share. The trading price of our common stock depends on a number of factors, including those described in this “Risk Factors” section, many of which are beyond our control and may not be related to our operating performance. These fluctuations could cause you to lose all or part of your investment in our common stock since you might be unable to sell your shares at or above the price you paid. Factors that could cause fluctuations in the trading price of our common stock include the following:

- price and volume fluctuations in the overall stock market from time to time, including as a result of the COVID-19 pandemic, inflation or political instability;
- volatility in the market prices and trading volumes of our competitors' shares, including high technology stocks, which have historically experienced high levels of volatility;
- any new debt and/or equity financing that we undertake to raise additional capital;
- new laws or regulations or new interpretations of existing laws or regulations applicable to our business, including developments relating to the health care industry and the marketing and sale of Medicare plans;
- actual or anticipated changes in our operating results or the growth rate of our business;
- changes in operating performance and stock market valuations of other technology or insurance brokerage companies generally and of our competitors;
- failure of securities analysts to maintain coverage of us, changes in financial estimates by any securities analysts who follow our company or our failure to meet these estimates or the expectations of investors;
- sales of shares of our common stock by us or our stockholders;
- announcements by us or our competitors of new products or services;
- the public reaction to our press releases, other public announcements and filings with the SEC;
- rumors and market speculation involving us or other companies in our industry;
- negative publicity about us, including accurate and inaccurate third-party commentary or reports regarding us;
- actual or anticipated developments in our business, our competitors' businesses or the competitive landscape generally;
- our ability to control costs, including our operating expenses;
- litigation involving us, our industry or both, or investigations by regulators into our operations or those of our competitors;
- developments or disputes concerning our intellectual property or other proprietary rights;
- announced or completed acquisitions of businesses or technologies by us or our competitors;
- changes in accounting standards, policies, guidelines, interpretations, or principles;
- any significant change in our management; and
- general economic conditions, political instability and slow or negative growth of our markets.

The effect of such factors on the trading market for our stock may be enhanced by the lack of a large and established trading market for our stock. In addition, the stock market in general, and the market for technology

companies in particular, have experienced extreme price and volume fluctuations that have often been unrelated or disproportionate to the operating performance of those companies. Broad market and industry factors may seriously affect the market price of our common stock, regardless of our actual operating performance. Additionally, as a public company, we face the risk of shareholder lawsuits, particularly if we experience declines in the price of our common stock. In the past, following periods of volatility in the overall market and the market prices of a particular company's securities, securities class action lawsuits have often been instituted against affected companies. We have been, and may in the future be, subject to such legal actions.

The issuance of shares of common stock underlying our Series A preferred stock would dilute the ownership and relative voting power of holders of our common stock and may adversely affect the market price of our common stock.

The Series A preferred stock is convertible at the option of the holders at any time into shares of common stock based on the then applicable conversion rate as determined in the certificate of designations for the Series A preferred stock, which conversion would dilute the ownership interest of existing holders of our common stock. In addition, because holders of our Series A preferred stock are entitled to vote, on an as-converted basis (subject to certain voting limitations and conversion calculations set forth in the certificate of designations for the Series A preferred stock), together with holders of our common stock on all matters submitted to a vote of the holders of our common stock, the issuance of the Series A preferred stock effectively reduces the relative voting power of the holders of our common stock.

Any sales in the public market of the common stock issuable upon conversion of the Series A preferred stock could adversely affect prevailing market prices of our common stock. Pursuant to the investment agreement, holders of our Series A preferred stock have customary resale registration rights for common stock issued upon conversion of the Series A preferred stock upon closing. Any resale of our common stock would increase the number of shares of our common stock available for public trading. Sales by our Series A preferred stockholder of a substantial number of shares of our common stock in the public market, or the perception that such sales might occur, could have a material adverse effect on the price of our common stock.

Our Series A preferred stock has rights, preferences and privileges that are not held by, and are preferential to, the rights of our common stockholders, which could adversely affect our liquidity and financial condition, result in the interests of holders of our Series A preferred stock differing from those of our common stockholders and make an acquisition of us more difficult.

Holders of our Series A preferred stock have (i) a liquidation preference (ii) rights to dividends, which are senior to all of our other equity securities, (iii) redemption rights beginning on April 30, 2027, (iv) the right to require us to repurchase any or all of their Series A preferred stock in connection with certain change of control events, and (v) conversion price adjustments in connection with certain corporate transactions, each subject to the terms, conditions and exceptions contained in the certificate of designations for the Series A preferred stock.

These dividend and share repurchase and redemption obligations could impact our liquidity and reduce the amount of cash flows available for working capital, capital expenditures, growth opportunities, acquisitions, and other general corporate purposes.

The terms of our investment agreement with H.I.G., the initial purchaser of our Series A Preferred Stock, could also limit our ability to obtain additional financing or increase our borrowing costs, which could have an adverse effect on our financial condition. As of the date of this report, pursuant to the terms of our investment agreement with H.I.G., we must obtain the consent of H.I.G. in order to incur any indebtedness, which could limit our ability to obtain additional financing until our adjusted EBITDA for the trailing four quarters increases. The preferential rights could also result in divergent interests between H.I.G. and holders of our common stock. Furthermore, a sale of our company, as a change of control event, may require us to repurchase Series A preferred stock, which could have the effect of making an acquisition of our company more expensive and potentially deterring proposed transactions that may otherwise be beneficial to our stockholders.

H.I.G. may exercise influence over us, including through its ability to designate up to two directors on our board of directors.

Our investment agreement with H.I.G. contains certain negative operating covenants that will remain in effect for so long as H.I.G. continues to own at least 30% of the shares of Series A preferred stock originally issued to it. Further, the investment agreement entitles H.I.G. to nominate one individual for election to our board of directors for so long as it continues to own at least 30% of the common stock issuable or issued upon conversion of the Series A preferred stock originally issued to it. The director designated by H.I.G. will also be entitled to serve on committees of our board of directors, subject to applicable law and stock exchange rules. Notwithstanding the fact that all directors will be subject to fiduciary duties to us and to applicable law, the interests of the director designated by H.I.G. of our Series A preferred stock may differ from the interests of our security holders as a whole or of our other directors. H.I.G. nominated Aaron C. Tolson to our board of directors. Mr. Tolson was appointed to our board of directors as a Class I director on August 30, 2021, and as of the date of this report serves as the chairperson of the compensation committee and as a member of the equity incentive committee, nominating and corporate governance committee and government and regulatory affairs committee of the board of directors. In addition, if we fail to maintain certain levels of commissions receivable and liquidity, H.I.G. will be entitled to nominate one additional director, and the consent of H.I.G. will be required to approve our annual budget, hire or terminate certain key executives and incur certain indebtedness as outlined in the investment agreement.

Anti-takeover provisions contained in our certificate of incorporation and bylaws, as well as provisions of Delaware law, could impair a takeover attempt.

Our certificate of incorporation, bylaws, and Delaware law contain provisions which could have the effect of rendering more difficult, delaying, or preventing an acquisition deemed undesirable by our board of directors. Our corporate governance documents include provisions:

- creating a classified board of directors whose members serve staggered three-year terms;
- authorizing undesignated preferred stock, which could be issued by our board of directors without stockholder approval and may contain voting, liquidation, dividend, and other rights superior to our common stock;
- limiting the liability of, and providing indemnification to, our directors and officers;
- limiting the ability of our stockholders to call and bring business before special meetings;
- requiring advance notice of stockholder proposals for business to be conducted at meetings of our stockholders and for nominations of candidates for election to our board of directors;
- controlling the procedures for the conduct and scheduling of board of directors and stockholder meetings; and
- providing our board of directors with the express power to postpone previously scheduled annual meetings and to cancel previously scheduled special meetings.

These provisions, alone or together, could delay or prevent hostile takeovers and changes in control or changes in our management.

As a Delaware corporation, we are also subject to provisions of Delaware law, including Section 203 of the Delaware General Corporation law, which prevents some stockholders holding more than 15% of our outstanding common stock from engaging in certain business combinations without approval of the holders of substantially all of our outstanding common stock.

Any provision of our certificate of incorporation, bylaws or Delaware law that has the effect of delaying or deterring a change in control could limit the opportunity for our stockholders to receive a premium for their shares of our common stock, and could also affect the price that some investors are willing to pay for our common stock.

Our bylaws designate a state or federal court located within the State of Delaware as the exclusive forum for substantially all disputes between us and our stockholders and also provide that the federal district courts will be the exclusive forum for resolving any complaint asserting a cause of action arising under the Securities Act of 1933, as amended (the "Securities Act"), each of which could limit our stockholders' ability to choose the judicial forum for disputes with us or our directors, officers, stockholders or employees.

Our bylaws provide that, unless we consent in writing to the selection of an alternative forum, 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, stockholders, officers or other employees to us or our stockholders, (3) any action arising pursuant to any provision of the Delaware General Corporation Law, our certificate of incorporation or our bylaws or (4) any other action asserting a claim that is governed by the internal affairs doctrine shall be the Court of Chancery of the State of Delaware (or, if the Court of Chancery does not have jurisdiction, another State court in Delaware or the federal district court for the District of Delaware), except for any claim as to which such court determines that there is an indispensable party not subject to the jurisdiction of such court (and the indispensable party does not consent to the personal jurisdiction of such court within ten days following such determination), which is vested in the exclusive jurisdiction of a court or forum other than such court or for which such court does not have subject matter jurisdiction. This provision would not apply to any action brought to enforce a duty or liability created by the Securities Exchange Act of 1934, as amended, and the rules and regulations thereunder.

Section 22 of the Securities Act establishes concurrent jurisdiction for federal and state courts over Securities Act claims. Accordingly, both state and federal courts have jurisdiction to hear such claims. To prevent having to litigate claims in multiple jurisdictions and the threat of inconsistent or contrary rulings by different courts, among other considerations, our bylaws also provide that, unless we consent in writing to the selection of an alternative forum, the federal district courts of the United States will be the sole and exclusive forum for resolving any complaint asserting a cause of action arising under the Securities Act and against any person in connection with an offering of our securities.

Any person or entity purchasing or otherwise acquiring or holding or owning (or continuing to hold or own) any interest in any of our securities shall be deemed to have notice of and consented to the foregoing bylaw provisions. 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 of its choosing for disputes with us or our current or former directors, officers, stockholders or other employees, which may discourage such lawsuits against us and our current and former directors, officers, stockholders and other employees. 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, the enforceability of similar exclusive forum provisions in other companies' organizational documents have been challenged in legal proceedings, and it is possible that a court of law could rule that these types of provisions are inapplicable or unenforceable if they are challenged in a proceeding or otherwise. If a court were to find either exclusive forum provision contained in our bylaws to be inapplicable or unenforceable in an action, we may incur significant additional costs associated with resolving such action in other jurisdictions, all of which could harm our results of operations.

ITEM 6. EXHIBITS

(a) Exhibits

Except as so indicated in Exhibits 32.1 and 32.2, the following exhibits are filed as part of, or incorporated by reference into, this Quarterly Report on Form 10-Q.

Exhibit Number		Description of Exhibit	Incorporation by Reference Herein	
			Form	Date
10.1		Sublease, dated July 11, 2022, between SiFive, Inc. and eHealthInsurance Services, Inc.	Quarterly Report on Form 10-Q (File No. 001-33071)	August 9, 2022
10.2		Consent to Subletting, dated August 8, 2022, by and among Augustine Bowers LLC, eHealthInsurance Services, Inc. and SiFive, Inc.	Quarterly Report on Form 10-Q (File No. 001-33071)	August 9, 2022
10.3		First Amendment to Credit Agreement, dated August 16, 2022, by and among eHealth, Inc., Blue Torch Finance LLC and the lenders identified therein.	Current Report on Form 8-K (File No. 001-33071)	August 22, 2022
10.4		Amended and Restated 2021 Inducement Plan	Current Report on Form 8-K (File No. 001-33071)	October 5, 2022
10.5	†	Amended and Restated 2014 Equity Inducement Plan		
31.1	†	Certification of Francis Soistman, Chief Executive Officer of eHealth, Inc., pursuant to Exchange Act Rule 13a-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.		
31.2	†	Certification of Christine Janofsky, Chief Financial Officer of eHealth, Inc., pursuant to Exchange Act Rule 13a-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.		
32.1	‡	Certification of Francis Soistman, Chief Executive Officer of eHealth, Inc., 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 Christine Janofsky, Chief Financial Officer of eHealth, Inc., pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.		
101.INS	†	XBRL Instance Document - The instance document does not appear in the Interactive Data File because its 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		The cover page from the Company's Quarterly Report on Form 10-Q for the three months ended September 30, 2022, formatted in Inline XBRL and contained in Exhibit 101		

† Filed herewith.

‡ Furnished herewith.

* Indicates a management contract or compensatory plan or arrangement.

SIGNATURES

Pursuant to the requirements 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.

EHEALTH, INC.

Date: November 8, 2022

/s/ Francis Soistman

Francis Soistman
Chief Executive Officer
(Principal Executive Officer)

Date: November 8, 2022

/s/ Christine Janofsky

Christine Janofsky
Chief Financial Officer
(Principal Financial Officer)

EHEALTH, INC.

AMENDED AND RESTATED 2014 EQUITY INCENTIVE PLAN

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EHEALTH, INC.

AMENDED AND RESTATED 2014 EQUITY INCENTIVE PLAN

ARTICLE 1. INTRODUCTION.

The Plan was established effective as of June 12, 2014, the date of its original approval by stockholders of the Company (the "**Effective Date**"), and was amended and restated as of June 11, 2019, as of June 15, 2022 and as of September 29, 2022. The purpose of the Plan is to promote the long-term success of the Company and the creation of stockholder value by (a) encouraging Employees, Outside Directors and Consultants to focus on the Company's performance, (b) encouraging the attraction and retention of Employees, Outside Directors and Consultants with exceptional qualifications and (c) linking Employees, Outside Directors and Consultants directly to stockholder interests through increased stock ownership. The Plan seeks to achieve this purpose by providing for Awards in the form of Restricted Shares, Stock Units, Options (which may constitute ISOs or NSOs) or SARs.

The Plan shall be governed by, and construed in accordance with, the laws of the State of Delaware (except its choice-of-law provisions).

ARTICLE 2. ADMINISTRATION.

2.1 Administrator. The Committee shall serve as Administrator of the Plan. The Committee shall consist of no less than two (2) Outside Directors who shall be appointed by the Board. The Committee shall be comprised solely of Outside Directors who are (a) "outside directors" under Section 162(m) of the Code, (b) "non-employee directors" under Rule 16b-3 of the Exchange Act, and (c) who meet any listing standards prescribed by the principal securities market on which the Company's equity securities are traded.

2.2 Administrator Responsibilities. The Administrator shall (a) select the Employees, Outside Directors and Consultants who are to receive Awards under the Plan, (b) determine the type, number, vesting requirements and other features and conditions of such Awards, (c) interpret the Plan and the terms of the Awards, and (d) make all other decisions relating to the operation of the Plan. The Administrator may adopt such rules or guidelines as it deems appropriate to implement the Plan and amend any Award, subject to the consent of the holder of such Award to the extent required by applicable law. The Administrator's determinations under the Plan shall be final and binding on all persons.

2.3 Committee for Non-Officer Grants. The Committee may delegate all or part of its authority and power under the Plan to a secondary committee of the Board or officers of the Company, that may administer the Plan with respect to Employees and Consultants who are not Outside Directors and are not considered executive officers of the Company under section 16 of the Exchange Act, may grant Awards under the Plan to such Employees and Consultants and may determine all features and conditions of such Awards. Notwithstanding the foregoing, with respect to Awards intended to qualify as performance-based compensation under Section 162(m) of the Code, the Committee many not delegate its authority with respect to such Awards if doing so would cause such Awards to fail to so qualify. Within the limitations of this Section 2.3, any reference in the Plan to the Administrator shall include such secondary committee.

2.4 No Repricing. The Administrator may not reduce the Exercise Price for an Option or SAR, other than pursuant to Article 11. This shall include, without limitation, a repricing of the Option or SAR as well as an Option or SAR exchange program whereby the Participant agrees to cancel an existing Option in exchange for an Option, SAR, cash or other Award.

ARTICLE 3. SHARES AVAILABLE FOR GRANTS.

3.1 Basic Limitation. Common Shares issued pursuant to the Plan may be authorized but unissued shares or treasury shares. The aggregate number of Common Shares issued under the Plan shall not exceed 10,000,000. The Company's 2006 Equity Incentive Plan will be terminated on the Effective Date if this Plan is approved by Company stockholders at the Company's 2014 Annual Meeting of Stockholders (but awards outstanding under the

2006 Incentive Plan shall continue in accordance with their respective terms and conditions). The limitations of this Section 3.1 shall be subject to adjustment pursuant to Article 11.

3.2 Shares Returned to Reserve. If Restricted Shares or Common Shares issued upon the exercise of Options under the Plan are forfeited or repurchased, then such shares of Stock shall again become available for Awards under the Plan. If Stock Units, Options or SARs under the Plan are forfeited or terminate for any other reason before being exercised or settled, then the corresponding shares of Stock shall again become available for Awards under the Plan. Notwithstanding the foregoing, the following Common Shares shall not again become available for Awards or increase the number of Common Shares available for grant under the Plan: (i) Stock tendered by the Participant or withheld by the Company in payment of the purchase price of an Option issued under the Plan, (ii) Stock tendered by the Participant or withheld by the Company to satisfy any tax withholding obligation with respect to an Award, (iii) Stock repurchased by the Company with proceeds received from the exercise of an Option issued under the Plan, and (iv) Stock subject to a SAR issued under this Plan that are not issued in connection with the stock settlement of that SAR upon its exercise. To the extent an Award under the Plan is paid out in cash rather than Stock, such cash payment shall not reduce the number of Common Shares available for issuance under the Plan.

3.3 Dividend Equivalents. Any dividend equivalents paid or credited under the Plan shall, if paid in Common Shares, be applied against the number of Common Shares that may be issued under the Plan. Any dividend equivalents paid or credited under the Plan shall, if paid in cash, not be applied against the number of Common Shares that may be issued under the Plan.

ARTICLE 4. ELIGIBILITY.

4.1 Incentive Stock Options. Only Employees who are common-law employees of the Company, a Parent or a Subsidiary shall be eligible for the grant of ISOs. In addition, an Employee who owns more than 10% of the total combined voting power of all classes of outstanding stock of the Company or any of its Parents or Subsidiaries shall not be eligible for the grant of an ISO unless the requirements set forth in section 422(c)(5) of the Code are satisfied.

4.2 Other Grants. Only Employees, Outside Directors and Consultants shall be eligible for the grant of Restricted Shares, Stock Units, NSOs or SARs.

ARTICLE 5. OPTIONS.

5.1 Stock Option Agreement. Each grant of an Option under the Plan shall be evidenced by a Stock Option Agreement between the Optionee and the Company. Such Option shall be subject to all applicable terms of the Plan and may be subject to any other terms that are not inconsistent with the Plan. The Stock Option Agreement shall specify whether the Option is an ISO or an NSO. The provisions of the various Stock Option Agreements entered into under the Plan need not be identical.

5.2 Number of Shares. Each Stock Option Agreement shall specify the number of shares of Stock subject to the Option and shall provide for the adjustment of such number in accordance with Article 11. Options granted to any Optionee in a single fiscal year of the Company shall not cover more than 500,000 shares of Stock, except that Options granted to a new Employee in the fiscal year of the Company in which his or her Service as an Employee first commences shall not cover more than 1,000,000 shares of Stock. The limitations set forth in the preceding sentence shall be subject to adjustment in accordance with Article 11.

5.3 Exercise Price. Each Stock Option Agreement shall specify the Exercise Price; provided that the Exercise Price under an Option shall in no event be less than 100% of the Fair Market Value of a share of Stock on the date of grant.

5.4 Exercisability and Term. Each Stock Option Agreement shall specify the date or event when all or any installment of the Option is to become exercisable and vested. The Stock Option Agreement shall also specify the term of the Option; provided that the term of an Option shall in no event exceed seven (7) years from the date of grant. A Stock Option Agreement may provide for accelerated exercisability in the event of the Optionee's death,

disability or retirement or other events and may provide for expiration prior to the end of its term in the event of the termination of the Optionee's Service.

ARTICLE 6. PAYMENT FOR OPTION SHARES.

6.1 General Rule. The entire Exercise Price of shares of Stock issued upon exercise of Options shall be payable in cash or cash equivalents at the time when such shares of Stock are purchased, except that the Administrator at its sole discretion may accept payment of the Exercise Price in any other form(s) described in this Article 6. However, if the Optionee is an Outside Director or executive officer of the Company, he or she may pay the Exercise Price in a form other than cash or cash equivalents only to the extent permitted by section 13(k) of the Exchange Act.

6.2 Surrender of Stock. With the Administrator's consent, all or any part of the Exercise Price may be paid by surrendering, or attesting to the ownership of, shares of Stock that are already owned by the Optionee. Such shares of Stock shall be valued at their Fair Market Value on the date when the new shares of Stock are purchased under the Plan.

6.3 Exercise/Sale. With the Administrator's consent, all or any part of the Exercise Price and any withholding taxes may be paid by delivering (on a form prescribed by the Company) an irrevocable direction to a securities broker approved by the Company to sell all or part of the shares of Stock being purchased under the Plan and to deliver all or part of the sales proceeds to the Company.

6.4 Promissory Note. With the Administrator's consent, all or any part of the Exercise Price and any withholding taxes may be paid by delivering (on a form prescribed by the Company) a full-recourse promissory note.

6.5 Other Forms of Payment. With the Administrator's consent, all or any part of the Exercise Price and any withholding taxes may be paid in any other form that is consistent with applicable laws, regulations and rules.

ARTICLE 7. AUTOMATIC AWARD GRANTS TO OUTSIDE DIRECTORS.

7.1 Initial Grants. Each Outside Director who first becomes a member of the Board shall receive a one-time grant covering such number and type or types of Awards, and with such terms and conditions, including vesting, as shall be determined from time to time by the Board or its Compensation Committee, in its discretion. Such Awards shall be granted on the date when such Outside Director first joins the Board. An Outside Director who previously was an Employee shall not receive a grant under this Section 7.1.

7.2 Annual Grants. Upon the conclusion of each regular annual meeting of the Company's stockholders (or such other time as determined by the Board or its Committee), each Outside Director who will continue serving as a member of the Board thereafter shall receive an automatic grant covering such number and type or types of Awards, and with such terms and conditions, including vesting, as shall be determined from time to time by the Board or its Compensation Committee, in its discretion, except that such Awards shall not be granted in the calendar year in which the same Outside Director received the Award(s) described in Section 7.1. An Outside Director who previously was an Employee shall be eligible to receive grants under this Section 7.2.

7.3 Accelerated Exercisability. All Awards granted to an Outside Director under this Article 7 shall also become exercisable in full in the event that the Company is subject to a Change in Control before such Outside Director's Service terminates. Acceleration of exercisability may also be required by Section 11.3.

7.4 Exercise Price. The Exercise Price under all NSOs granted to an Outside Director under this Article 7 shall be equal to 100% of the Fair Market Value of a share of Stock on the date of grant, payable in one of the forms described in Sections 6.1, 6.2 and 6.3.

7.5 Term. All NSOs granted to an Outside Director under this Article 7 shall terminate on the earlier of (a) the date seven (7) years after the date of grant or (b) a date following the termination of such Outside Director's Service, as described herein, or such earlier time as is specified by the Board or its Compensation Committee, in its discretion. If an Outside Director's Service terminates for any reason except death or Total and Permanent

Disability, then the Outside Director's NSOs shall expire at the close of business at Company headquarters on the date three months after the Outside Director's Service termination date. If an Outside Director dies before his or her Service terminates, then the Outside Director's NSOs shall expire at the close of business at Company headquarters on the date 12 months after the date of death. If an Outside Director's Service terminates because of the Outside Director's Total and Permanent Disability, then the Outside Director's NSOs shall expire at the close of business at Company headquarters on the date 12 months after the Outside Director's Service termination date.

ARTICLE 8. STOCK APPRECIATION RIGHTS.

8.1 SAR Agreement. Each grant of a SAR under the Plan shall be evidenced by a SAR Agreement between the Optionee and the Company. Such SAR shall be subject to all applicable terms of the Plan and may be subject to any other terms that are not inconsistent with the Plan. The provisions of the various SAR Agreements entered into under the Plan need not be identical.

8.2 Number of Shares. Each SAR Agreement shall specify the number of shares of Stock to which the SAR pertains and shall provide for the adjustment of such number in accordance with Article 11. SARs granted to any Optionee in a single fiscal year shall in no event pertain to more than 500,000 shares of Stock, except that SARs granted to a new Employee in the fiscal year of the Company in which his or her Service as an Employee first commences shall not pertain to more than 1,000,000 shares of Stock. The limitations set forth in the preceding sentence shall be subject to adjustment in accordance with Article 11.

8.3 Exercise Price. Each SAR Agreement shall specify the Exercise Price; provided that the Exercise Price under an SAR shall in no event be less than 100% of the Fair Market Value of a share of Stock on the date of grant.

8.4 Exercisability and Term. Each SAR Agreement shall specify the date when all or any installment of the SAR is to become exercisable. The SAR Agreement shall also specify the term of the SAR; provided that the term of the SAR shall in no event exceed seven (7) years from the date of grant. A SAR Agreement may provide for accelerated exercisability in the event of the Optionee's death, disability or retirement or other events and may provide for expiration prior to the end of its term in the event of the termination of the Optionee's Service. SARs may be awarded in combination with Options, and such an Award may provide that the SARs will not be exercisable unless the related Options are forfeited. A SAR may be included with an ISO only at the time of grant but may be included with an NSO at the time of grant or thereafter. A SAR granted under the Plan may provide that it will be exercisable only in the event of a Change in Control.

8.5 Exercise of SARs. Upon exercise of a SAR, the Optionee (or any person having the right to exercise the SAR after his or her death) shall receive from the Company (a) shares of Stock, (b) cash or (c) a combination of shares of Stock and cash, as the Administrator shall determine. The amount of cash and/or the Fair Market Value of shares of Stock received upon exercise of SARs shall, in the aggregate, not exceed the amount by which the Fair Market Value (on the date of surrender) of the shares of Stock subject to the SARs exceeds the Exercise Price. If, on the date when a SAR expires, the Exercise Price under such SAR is less than the Fair Market Value on such date but any portion of such SAR has not been exercised or surrendered, then such SAR shall automatically be deemed to be exercised as of such date with respect to such portion. A SAR Agreement may also provide for an automatic exercise of the SAR on an earlier date.

ARTICLE 9. RESTRICTED SHARES.

9.1 Restricted Stock Agreement. Each grant of Restricted Shares under the Plan shall be evidenced by a Restricted Stock Agreement between the recipient and the Company. Such Restricted Shares shall be subject to all applicable terms of the Plan and may be subject to any other terms that are not inconsistent with the Plan. The provisions of the various Restricted Stock Agreements entered into under the Plan need not be identical.

9.2 Payment for Awards. Restricted Shares may be sold or awarded under the Plan for such consideration as the Administrator may determine, including (without limitation) cash, cash equivalents, property, full-recourse promissory notes, past services and future services. If the Participant is an Outside Director or executive officer of the Company, he or she may pay for Restricted Shares with a promissory note only to the extent permitted by

section 13(k) of the Exchange Act. Within the limitations of the Plan, the Administrator may accept the cancellation of outstanding options or SARs in return for the grant of Restricted Shares.

9.3 Vesting Conditions. Each Award of Restricted Shares may or may not be subject to vesting. Any vesting shall occur, in full or in installments, upon satisfaction of the conditions specified in the Restricted Stock Agreement. The Administrator may include among such conditions the requirement that the performance of the Company or a business unit of the Company for a specified period of one or more fiscal years equal or exceed a target determined in advance by the Administrator. Such target shall be based on one or more Performance Goals. The Administrator shall identify such target not later than the 90th day of such period. In no event shall more than 500,000 Restricted Shares that are subject to performance-based vesting conditions be granted to any Participant in a single fiscal year of the Company, subject to adjustment in accordance with Article 11. A Restricted Stock Agreement may provide for accelerated vesting in the event of the Participant's death, disability or retirement or other events.

9.4 Voting and Dividend Rights. The holders of Restricted Shares awarded under the Plan shall have the same voting, dividend and other rights as the Company's other stockholders. A Restricted Stock Agreement may require that the holders of Restricted Shares invest any cash dividends received in additional Restricted Shares. Any additional Restricted Shares that represent share dividends shall be subject to the same conditions and restrictions as the Award with respect to which the dividends were paid.

ARTICLE 10. STOCK UNITS.

10.1 Stock Unit Agreement. Each grant of Stock Units under the Plan shall be evidenced by a Stock Unit Agreement between the recipient and the Company. Such Stock Units shall be subject to all applicable terms of the Plan and may be subject to any other terms that are not inconsistent with the Plan. The provisions of the various Stock Unit Agreements entered into under the Plan need not be identical.

10.2 Payment for Awards. To the extent that an Award is granted in the form of Stock Units, no cash consideration shall be required of the Award recipients. Within the limitations of the Plan, the Administrator may accept the cancellation of outstanding options or SARs in return for the grant of Stock Units.

10.3 Vesting Conditions. Each Award of Stock Units may or may not be subject to vesting. Vesting shall occur, in full or in installments, upon satisfaction of the conditions specified in the Stock Unit Agreement. The Administrator may include among such conditions the requirement that the performance of the Company or a business unit of the Company for a specified period of one or more fiscal years equal or exceed a target determined in advance by the Administrator. Such target shall be based on one or more Performance Goals. The Administrator shall identify such target not later than the 90th day of such period. In no event shall more than 500,000 Stock Units that are subject to performance-based vesting conditions be granted to any Participant in a single fiscal year of the Company, subject to adjustment in accordance with Article 11. A Stock Unit Agreement may provide for accelerated vesting in the event of the Participant's death, disability or retirement or other events.

10.4 Voting and Dividend Rights. The holders of Stock Units shall have no voting rights. Prior to settlement or forfeiture, any Stock Unit awarded under the Plan may, at the Administrator's discretion, carry with it a right to dividend equivalents. Such right would entitle the holder to be credited with an amount equal to all cash dividends paid on one share of Stock while the Stock Unit is outstanding, which shall be subject to the terms of the Stock Unit Agreement. Dividend equivalents may be converted into additional Stock Units. Settlement of dividend equivalents may be made in the form of cash, in the form of shares of Stock, or in a combination of both. Prior to distribution, any dividend equivalents that are not paid shall be subject to the same conditions and restrictions as the Stock Units to which they attach.

10.5 Form and Time of Settlement of Stock Units. Settlement of vested Stock Units may be made in the form of (a) cash, (b) shares of Stock or (c) any combination of both, as determined by the Administrator. The actual number of Stock Units eligible for settlement may be larger or smaller than the number included in the original Award, based on predetermined performance factors. Methods of converting Stock Units into cash may include (without limitation) a method based on the average Fair Market Value of shares of Stock over a series of trading days. Vested Stock Units may be settled in a lump sum or in installments. The distribution may occur or commence

when all vesting conditions applicable to the Stock Units have been satisfied or have lapsed, or it may be deferred to any later date. The amount of a deferred distribution may be increased by an interest factor or by dividend equivalents. Until an Award of Stock Units is settled, the number of such Stock Units shall be subject to adjustment pursuant to Article 11.

10.6 Death of Recipient. Any Stock Units Award that becomes payable after the recipient's death shall be distributed to the recipient's beneficiary or beneficiaries. Each recipient of a Stock Units Award under the Plan shall designate one or more beneficiaries for this purpose by filing the prescribed form with the Company. A beneficiary designation may be changed by filing the prescribed form with the Company at any time before the Award recipient's death. If no beneficiary was designated or if no designated beneficiary survives the Award recipient, then any Stock Units Award that becomes payable after the recipient's death shall be distributed to the recipient's estate.

10.7 Creditors' Rights. A holder of Stock Units shall have no rights other than those of a general creditor of the Company. Stock Units represent an unfunded and unsecured obligation of the Company, subject to the terms and conditions of the applicable Stock Unit Agreement.

ARTICLE 11. ADJUSTMENTS, DISSOLUTION OR LIQUIDATION, REORGANIZATIONS.

11.1 Adjustments. In the event of a subdivision of the outstanding shares of Stock, a declaration of a dividend payable in Common Shares (other than regular, ongoing dividends) or other distribution (whether in the form of cash or Common Shares), recapitalization, stock split, reverse stock split, reorganization, merger, consolidation, split-up, spin-off, combination, repurchase, or exchange of Common Shares, or other change in the corporate structure of the Company affecting the Common Shares such that an adjustment is determined by the Administrator (in its discretion) to be appropriate to prevent dilution or enlargement of benefits intended to be made available under the Plan, then the Administrator shall, in such manner as it may deem equitable, adjust each of the following:

(a) The number of Options, SARs, Restricted Shares and Stock Units available for future Awards under Article 3;

(b) The limitations set forth in Sections 5.2, 8.2, 9.3 and 10.3;

(c) The number of shares of Stock covered by each outstanding Option and SAR;

(d) The Exercise Price under each outstanding Option and SAR;

(e) The number of shares of Stock covered by an Option to be granted under Article 7; or

(f) The number of Stock Units included in any prior Award that has not yet been settled.

In the event of a declaration of an extraordinary dividend payable in a form other than shares of Stock in an amount that has a material effect on the price of shares of Stock, the Administrator shall make such adjustments as it, in its sole discretion, deems appropriate in one or more of the foregoing. Except as provided in this Article 11, a Participant shall have no rights by reason of any issuance by the Company of stock of any class or securities convertible into stock of any class, any subdivision or consolidation of shares of stock of any class, the payment of any stock dividend or any other increase or decrease in the number of shares of stock of any class.

11.2 Dissolution or Liquidation. To the extent not previously exercised or settled, Options, SARs and Stock Units shall terminate immediately prior to the dissolution or liquidation of the Company.

11.3 Change in Control. In the event of a Change in Control, all outstanding Awards shall be treated as the Administrator (in its discretion) determines, which need provide for treatment of all outstanding Awards (or a portion thereof) in an identical manner and may be effected without consent of a Participant. Such treatment shall provide for one or more of the following:

(a) The Administrator shall have the discretion, exercisable either at the time an Award is granted or at any time the Award remains outstanding, to provide for automatic acceleration of vesting upon occurrence of a

Change in Control, whether or not the Award is assumed or replaced in the Change in Control, or in connection with a termination of a Participant's Service following a Change in Control.

(b) The assumption of any outstanding Awards by the surviving, continuing, successor or purchasing entity or its parent, provided that the assumption of Options or SARs shall comply with section 424(a) of the Code (whether or not the Options are ISOs).

(c) The substitution by the surviving corporation or its parent of new awards for any outstanding Awards, provided that the substitution of Options or SARs shall comply with section 424(a) of the Code (whether or not the Options are ISOs).

(d) Full exercisability of any outstanding Options and SARs and full vesting of the shares of Stock subject to such Options and SARs, followed by the cancellation of such Options and SARs. The full exercisability of any Options and SARs and full vesting of such shares of Stock may be contingent on the closing of the Change in Control. The Optionees shall be able to exercise such Options and SARs during a period preceding the closing date of the Change in Control. Any exercise of such Options and SARs during such period may be contingent on the closing of the Change in Control.

(e) The cancellation of any outstanding Options and SARs and a payment to the Optionees equal to the excess of (i) the Fair Market Value of the shares of Stock subject to such Options and SARs (whether or not such Options and SARs are then exercisable or such shares of Stock are then vested) as of the closing date of such Change in Control over (ii) their Exercise Price. Such payment shall be made in the form of cash, cash equivalents, or securities of the surviving corporation or its parent with a Fair Market Value equal to the required amount. Such payment may be made in installments and may be deferred until the date or dates when such Options and SARs would have become exercisable or such shares of Stock would have vested. Such payment may be subject to vesting based on the Optionee's continuing Service, provided that the vesting schedule shall not be less favorable to the Optionee than the schedule under which such Options and SARs would have become exercisable or such shares of Stock would have vested. If the Exercise Price of the shares of Stock subject to such Options and SARs exceeds the Fair Market Value of such shares of Stock, then such Options and SARs may be cancelled without making a payment to the Optionees. For purposes of this Subsection (e), the Fair Market Value of any security shall be determined without regard to any vesting conditions that may apply to such security.

(f) The cancellation of any outstanding Stock Units and a payment to the Participants equal to the Fair Market Value of the shares of Stock subject to such Stock Units (whether or not such Stock Units are then vested) as of the closing date of such Change in Control. Such payment shall be made in the form of cash, cash equivalents, or securities of the surviving corporation or its parent with a Fair Market Value equal to the required amount. Such payment may be made in installments and may be deferred until the date or dates when such Stock Units would have vested. Such payment may be subject to vesting based on the Participant's continuing Service, provided that the vesting schedule shall not be less favorable to the Participant than the schedule under which such Stock Units would have vested. For purposes of this Subsection (f), the Fair Market Value of any security shall be determined without regard to any vesting conditions that may apply to such security.

ARTICLE 12. PERFORMANCE-BASED COMPENSATION UNDER CODE SECTION 162(m).

12.1 General. If the Administrator, in its discretion, decides to grant an Award intended to qualify as "performance-based compensation" under Code Section 162(m), the provisions of this Section 12 will control over any contrary provision in the Plan; provided, however, that the Administrator may in its discretion grant Awards that are not intended to qualify as "performance-based compensation" under Section 162(m) of the Code to such Participants that are based on Performance Goals or other specific criteria or goals but that do not satisfy the requirements of this Article 12.

12.2 Performance Goals. The granting and/or vesting of Awards of Restricted Stock or Stock Units or other incentives under the Plan may, in the discretion of the Administrator, be made subject to the achievement of one or more Performance Goals.

12.3 Procedures. To the extent necessary to comply with the performance-based compensation provisions of Code Section 162(m), with respect to any Award granted subject to Performance Goals, within the first twenty-five percent (25%) of the Performance Period, but in no event more than ninety (90) days following the commencement of any Performance Period (or such other time as may be required or permitted by Code Section 162(m)), the Administrator will, in writing, (i) designate one or more Participants to whom an Award will be made, (ii) select the Performance Goals applicable to the Performance Period, (iii) establish the Performance Goals, and amounts of such Awards, as applicable, which may be earned for such Performance Period, and (iv) specify the relationship between Performance Goals and the amounts of such Awards, as applicable, to be earned by each Participant for such Performance Period. Following the completion of each Performance Period, the Administrator will certify in writing whether the applicable Performance Goals have been achieved for such Performance Period. In determining the amounts earned by a Participant, the Administrator will have the right to reduce or eliminate (but not to increase) the amount payable at a given level of performance to take into account additional factors that the Administrator may deem relevant to the assessment of individual or corporate performance for the Performance Period. A Participant will be eligible to receive payment pursuant to an Award for a Performance Period only if the Performance Goals for such period are achieved.

12.4 Additional Limitations. Notwithstanding any other provision of the Plan, any Award which is granted to a Participant and is intended to constitute qualified performance based compensation under Code Section 162(m) will be subject to any additional limitations set forth in the Code (including any amendment to Section 162(m)) or any regulations and ruling issued thereunder that are requirements for qualification as qualified performance-based compensation as described in Section 162(m) of the Code, and the Plan will be deemed amended to the extent necessary to conform to such requirements.

ARTICLE 13. LIMITATION ON RIGHTS.

13.1 Retention Rights. Neither the Plan nor any Award granted under the Plan shall be deemed to give any individual a right to remain an Employee, Outside Director or Consultant. The Company and its Parents, Subsidiaries and Affiliates reserve the right to terminate the Service of any Employee, Outside Director or Consultant at any time, with or without cause, subject to applicable laws, the Company's certificate of incorporation and by-laws and a written employment agreement (if any).

13.2 Stockholders' Rights. A Participant shall have no dividend rights, voting rights or other rights as a stockholder with respect to any shares of Stock covered by his or her Award prior to the time when a stock certificate for such shares of Stock is issued or, if applicable, the time when he or she becomes entitled to receive such shares of Stock by filing any required notice of exercise and paying any required Exercise Price. No adjustment shall be made for cash dividends or other rights for which the record date is prior to such time, except as expressly provided in the Plan.

13.3 Regulatory Requirements. Any other provision of the Plan notwithstanding, the obligation of the Company to issue shares of Stock under the Plan shall be subject to all applicable laws, rules and regulations and such approval by any regulatory body as may be required. The Company reserves the right to restrict, in whole or in part, the delivery of shares of Stock pursuant to any Award prior to the satisfaction of all legal requirements relating to the issuance of such shares of Stock, to their registration, qualification or listing or to an exemption from registration, qualification or listing.

13.4 Transferability of Awards. No Awards granted under this Plan may be sold, transferred, pledged, assigned, or otherwise alienated or hypothecated, other than by will, by the laws of descent and distribution, or beneficiary designations under procedures established by the Administrator. All rights with respect to an Award granted to a Participant shall be available during his or her lifetime only to the Participant. Notwithstanding the foregoing, the Administrator may, in its sole discretion, permit transfers of Awards for estate planning and charitable purposes in accordance with procedures it establishes.

ARTICLE 14. WITHHOLDING TAXES.

14.1 General. To the extent required by applicable federal, state, local or foreign law, a Participant or his or her successor shall make arrangements satisfactory to the Company for the satisfaction of any withholding tax

obligations that arise in connection with the Plan. The Company shall not be required to issue any shares of Stock or make any cash payment under the Plan until such obligations are satisfied.

14.2 Share Withholding. To the extent that applicable law subjects a Participant to tax withholding obligations, the Administrator may permit such Participant to satisfy all or part of such minimum required withholding obligations by having the Company withhold all or a portion of any shares of Stock that otherwise would be issued to him or her or by surrendering all or a portion of any shares of Stock that he or she previously acquired. Such shares of Stock shall be valued at their Fair Market Value on the date when they are withheld or surrendered.

ARTICLE 15. FUTURE OF THE PLAN.

15.1 Term of the Plan. The Plan shall become effective on the Effective Date and shall remain in effect until the earlier of (a) the date when the Plan is terminated under Section 15.2 or (b) the 10th anniversary of the Effective Date.

15.2 Amendment or Termination. The Board may, at any time and for any reason, amend or terminate the Plan. No Awards shall be granted under the Plan after the termination thereof. The termination of the Plan, or any amendment thereof, shall not affect any Award previously granted under the Plan.

15.3 Stockholder Approval. An amendment of the Plan shall be subject to the approval of the Company's stockholders only to the extent required by applicable laws, regulations or rules.

ARTICLE 16. DEFINITIONS.

(a) "**Administrator**" means the Board or any of its Committees that will be administering the Plan, in accordance with Article 2.

(b) "**Affiliate**" means any corporation or other entity (including, but not limited to, partnerships and joint ventures) controlling, controlled by, or under common control with the Company.

(c) "**Award**" means any award of an Option, a SAR, a Restricted Share or a Stock Unit under the Plan.

(d) "**Board**" means the Company's Board of Directors, as constituted from time to time.

(e) "**Change in Control**" means:

(a) The consummation of a merger or consolidation of the Company with or into another entity or any other corporate reorganization, if persons who were not stockholders of the Company immediately prior to such merger, consolidation or other reorganization own immediately after such merger, consolidation or other reorganization 50% or more of the voting power of the outstanding securities of each of (i) the continuing or surviving entity and (ii) any direct or indirect parent corporation of such continuing or surviving entity;

(b) The sale, transfer or other disposition of all or substantially all of the Company's assets;

(c) A change in the effective control of the Company that occurs on the date that a majority of members of the Board is replaced during any twelve (12) month period by directors whose appointment is not endorsed by a majority of the members of the Board prior to the date of the appointment or election; or

(d) Any transaction as a result of which any person is the "beneficial owner" (as defined in Rule 13d-3 under the Exchange Act), directly or indirectly, of securities of the Company representing at least 50% of the total voting power represented by the Company's then outstanding voting securities. For purposes of this Subsection (d), the term "person" shall have the same meaning as when used in sections 13(d) and 14(d) of the Exchange Act but shall exclude (i) a trustee or other fiduciary holding securities under an employee benefit plan of the Company

or of a Parent or Subsidiary and (ii) a corporation owned directly or indirectly by the stockholders of the Company in substantially the same proportions as their

ownership of the common stock of the Company. For purposes of this subsection (d), the acquisition of additional stock by any one person, who is considered to own more than fifty percent (50%) of the total voting power of the stock of the Company will not be considered an additional Change in Control.

A transaction shall not constitute a Change in Control (i) if its sole purpose is to change the state of the Company's incorporation or to create a holding company that will be owned in substantially the same proportions by the persons who held the Company's securities immediately before such transaction, or (ii) it does not qualify as a change of control event within the meaning of Section 409A.

(f) "**Code**" means the Internal Revenue Code of 1986, as amended.

(g) "**Committee**" means a committee appointed by the Board that consists of one or more Board members or other individuals satisfying all applicable laws. As of the Effective Date, and until otherwise determined by the Board, the Compensation Committee of the Board will serve as the Committee.

(h) "**Common Share**" means one share of common stock of the Company.

(i) "**Company**" means eHealth, Inc., a Delaware corporation.

(j) "**Consultant**" means any consultant, advisor or other person who provides significant services to the Company, a Parent, a Subsidiary or an Affiliate, but who is not an Employee or an Outside Director. However, a person shall not be eligible to be granted an Award if inclusion of that person as a Consultant would cause the Awards and/or Shares available under the Plan to be ineligible for registration on a Form S-8 Registration Statement under the 1933 Act.

(k) "**Employee**" means a common-law employee of the Company, a Parent, a Subsidiary or an Affiliate.

(l) "**Exchange Act**" means the Securities Exchange Act of 1934, as amended.

(m) "**Exercise Price**," in the case of an Option, means the amount for which one share of Stock may be purchased upon exercise of such Option, as specified in the applicable Stock Option Agreement. "Exercise Price," in the case of a SAR, means an amount, as specified in the applicable SAR Agreement, which is subtracted from the Fair Market Value of one share of Stock in determining the amount payable upon exercise of such SAR.

(n) "**Fair Market Value**" means the market price of shares of Stock, determined by the Administrator in good faith on such basis as it deems appropriate. Whenever possible, the determination of Fair Market Value by the Administrator shall be based on the prices reported in The Wall Street Journal or as reported directly to the Company by Nasdaq or a stock exchange. Such determination shall be conclusive and binding on all persons.

(o) "**ISO**" means an incentive stock option described in section 422(b) of the Code.

(p) "**NSO**" means a stock option not described in sections 422 or 423 of the Code.

(q) "**Option**" means an ISO or NSO granted under the Plan and entitling the holder to purchase shares of Stock.

(r) "**Optionee**" means a person or estate who holds an Option or SAR.

(s) "**Outside Director**" means a member of the Board who is not an Employee.

(t) "**Parent**" means any corporation (other than the Company) in an unbroken chain of corporations ending with the Company, if each of the corporations other than the Company owns stock possessing 50% or more of the total combined voting power of all classes of stock in one of the other corporations in such chain. A corporation that attains the status of a Parent on a date after the adoption of the Plan shall be considered a Parent commencing as of such date.

(u) “**Participant**” means a person or estate who holds an Award.

(v) "**Performance Goals**" means the goal(s), or combination of goal(s) determined by the Administrator with respect to an Award. The performance goals that may be used by the Administrator may consist of any one or more of the following objective performance criteria, applied to either the Company as a whole or, except with respect to stockholder return metrics, to a region, business unit, affiliate or business segment, and measured either on an absolute basis, a per share basis or relative to a pre-established target, to a previous period's results or to a designated comparison group, and, with respect to financial metrics, which may be determined in accordance with United States Generally Accepted Accounting Principles ("GAAP"), in accordance with accounting principles established by the International Accounting Standards Board ("IASB Principles") or which may be adjusted when established to exclude any items otherwise includable under GAAP or under IASB Principles: (i) cash flow (including operating cash flow or free cash flow), (ii) revenue (on an absolute basis or adjusted for currency effects), (iii) gross margin, (iv) operating expenses or operating expenses as a percentage of revenue, (v) earnings (which may include earnings before interest and taxes, earnings before taxes, net earnings or EBITDA), (vi) earnings per share, (vii) stock price, (viii) return on equity, (ix) total stockholder return, (x) growth in stockholder value relative to the moving average of the S&P 500 Index, or another index, (xi) return on capital, (xii) return on assets or net assets, (xiii) return on investment, (xiv) economic value added, (xv) operating income or net operating income, (xvi) operating margin, (xvii) market share, (xviii) overhead or other expense reduction, (xix) credit rating, (xx) objective customer indicators, (xxi) improvements in productivity, (xxii) attainment of objective operating goals, (xxiii) objective employee metrics, (xxiv) return ratios, (xxv) objective qualitative milestones, (xxvi) other objective financial or other metrics relating to the progress of the Company or to a Subsidiary, division or department thereof, (xxvii) number of customers (or estimated membership, with the formulae for such estimations being objectively determinable), submitted applications or members, or approved applications or members, sold applications or members, (xxviii) conversion yields achieved from website visitors to sold members (including any sub-yield in between), (xxix) increase in membership, (xxx) cost of acquiring members or applicants, or (xxxi) retention of membership.

(w) "**Performance Period**" means a period established by the Administrator during which performance objectives or continued Service must be met pursuant to Section 12.

(x) "**Plan**" means this eHealth, Inc. 2014 Equity Incentive Plan, as amended from time to time.

(y) "**Restricted Share**" means a share of Stock awarded under the Plan.

(z) "**Restricted Stock Agreemen**t" means the agreement between the Company and the recipient of a Restricted Share that contains the terms, conditions and restrictions pertaining to such Restricted Share.

(aa) "**SAR**" means a stock appreciation right granted under the Plan.

(bb) "**SAR Agreemen**t" means the agreement between the Company and an Optionee that contains the terms, conditions and restrictions pertaining to his or her SAR.

(cc) "**Section 409A**" means Section 409A of the Code.

(dd) "**Service**" means service as an Employee, Outside Director or Consultant.

(ee) "**Stock**" means the Common Stock of the Company.

(ff) "**Stock Option Agreement**" means the agreement between the Company and an Optionee that contains the terms, conditions and restrictions pertaining to his or her Option.

(gg) "**Stock Unit**" means a bookkeeping entry representing the equivalent of one share of Stock, as awarded under the Plan.

(hh) "**Stock Unit Agreement**" means the agreement between the Company and the recipient of a Stock Unit that contains the terms, conditions and restrictions pertaining to such Stock Unit.

(ii) "**Subsidiary**" means any corporation (other than the Company) in an unbroken chain of corporations beginning with the Company, if each of the corporations other than the last corporation in the unbroken

chain owns stock possessing 50% or more of the total combined voting power of all classes of stock in one of the other corporations in such chain. A corporation that attains the status of a Subsidiary on a date after the adoption of the Plan shall be considered a Subsidiary commencing as of such date.

(jj) "**Total and Permanent Disability**" means that the Optionee is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted, or can be expected to last, for a continuous period of not less than one year.

Exhibit 31.1

CERTIFICATION

I, Francis Soistman, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of eHealth, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: November 8, 2022

/s/ FRANCIS SOISTMAN

Francis Soistman
Chief Executive Officer

Exhibit 31.2

CERTIFICATION

I, Christine Janofsky, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of eHealth, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: November 8, 2022

/s/ CHRISTINE JANOFSKY

Christine Janofsky
Chief Financial Officer
(Principal Financial Officer)

Exhibit 32.1

Certification of Chief Executive Officer, Pursuant to

18 U.S.C. Section 1350,

As Adopted Pursuant to

Section 906 of the Sarbanes-Oxley Act of 2002

In connection with the Quarterly Report of eHealth, Inc. on Form 10-Q (the "Form 10-Q") for the quarter ended September 30, 2022, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Francis Soistman, Chief Executive Officer of eHealth, Inc., certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that, to my knowledge:

(1) The Form 10-Q, to which this certification is attached as Exhibit 32.1, fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Form 10-Q fairly presents, in all material respects, the financial condition and results of operations of eHealth, Inc.

/s/ FRANCIS SOISTMAN

Francis Soistman
Chief Executive Officer
November 8, 2022

A signed original of this written statement required by Section 906 has been provided to eHealth, Inc. and will be retained by eHealth, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.

Exhibit 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

In connection with the Quarterly Report of eHealth, Inc. on Form 10-Q (the "Form 10-Q") for the quarter ended September 30, 2022, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Christine Janofsky, Chief Financial Officer (Principal Financial Officer) of eHealth, Inc., certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that, to my knowledge:

(1) The Form 10-Q, to which this certification is attached as Exhibit 32.2, fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Form 10-Q fairly presents, in all material respects, the financial condition and results of operations of eHealth, Inc.

/s/ CHRISTINE JANOFSKY

Christine Janofsky
Chief Financial Officer
(Principal Financial Officer)
November 8, 2022

A signed original of this written statement required by Section 906 has been provided to eHealth, Inc. and will be retained by eHealth, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.