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 March 31, 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, SECOND FLOOR
SANTA CLARA, CA 95054
(Address of principal executive offices)

(650) 584-2700
(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 April 22, 2022 was 26,836,405 shares.

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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.
- 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.
- 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 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 investments, including our growth strategy and enrollment quality initiatives.
- 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.
- If we are not successful in cost-effectively converting visitors to our website and customers who call into our call centers into members for whom we receive commissions, our business and operating results would be harmed.
- 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 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.
- Our carrier advertising and sponsorship program may not be successful.
- 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 as a result of health care reform could harm our business, operating results and 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.
- 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. Our business is also subject to emerging privacy laws being passed at the state level that create unique compliance challenges.
- Our operating results will be impacted by factors that impact our estimate of the constrained lifetime value, or LTV, of commissions per approved member.
- Our debt obligations contain restrictions that impact our business and expose us to risks that could materially adversely affect our liquidity and financial condition.

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)

	March 31, 2022	December 31, 2021
Assets		
Current assets:		
Cash and cash equivalents	$ 220,563	$ 81,926
Short-term marketable securities	10,938	41,306
Accounts receivable	1,978	5,750
Contract assets – commissions receivable – current	204,237	254,821
Prepaid expenses and other current assets	11,825	23,784
Total current assets	449,541	407,587
Contract assets – commissions receivable – non-current	626,941	653,441
Property and equipment, net	11,106	12,105
Operating lease right-of-use assets	36,099	37,373
Restricted cash	3,239	3,239
Other assets	35,936	35,547
Total assets	$ 1,162,862	$ 1,149,292
Liabilities, convertible preferred stock, and stockholders' equity		
Current liabilities:		
Accounts payable	$ 8,196	$ 13,750
Accrued compensation and benefits	18,501	16,458
Accrued marketing expenses	19,537	36,384
Lease liabilities – current	5,655	5,543
Other current liabilities	8,500	3,330
Total current liabilities	60,389	75,465
Long-term debt	64,989	—
Deferred income taxes – non-current	42,763	50,796
Lease liabilities – non-current	34,410	35,826
Other non-current liabilities	4,574	5,094
Total liabilities	207,125	167,181
Commitments and contingencies		
Convertible preferred stock	239,810	232,592
Stockholders' equity:		
Common stock	39	39
Additional paid-in capital	762,212	755,875
Treasury stock, at cost	(199,998)	(199,998)
Retained earnings	153,253	193,213
Accumulated other comprehensive income	421	390
Total stockholders' equity	715,927	749,519
Total liabilities, convertible preferred stock, and stockholders' equity	$ 1,162,862	$ 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 March 31,	
	2022	**2021**
Revenue:		
Commission	$ 93,850	$ 127,052
Other	11,400	7,162
Total revenue	105,250	134,214
Operating costs and expenses:		
Cost of revenue	(127)	996
Marketing and advertising	58,454	50,874
Customer care and enrollment	42,164	34,162
Technology and content	19,663	23,163
General and administrative	19,987	23,054
Amortization of intangible assets	—	176
Restructuring and reorganization charges	4,823	2,431
Total operating costs and expenses	144,964	134,856
Loss from operations	(39,714)	(642)
Other income (expense), net	(1,021)	150
Loss before income taxes	(40,735)	(492)
Provision for (benefit from) income taxes	(7,993)	308
Net loss	(32,742)	(800)
Paid-in-kind dividends for preferred stock	(4,717)	—
Change in preferred stock redemption value	(2,501)	—
Net loss attributable to common stockholders:	$ (39,960)	$ (800)
Net loss per share attributable to common stockholders:		
Basic and diluted	$ (1.46)	$ (0.03)
Weighted-average number of shares used in per share amounts:		
Basic and diluted	27,278	26,620
Comprehensive income (loss):		
Net loss	$ (32,742)	$ (800)
Unrealized holding gain (loss) for available for sales debt securities, net of tax	8	(16)
Foreign currency translation adjustment	23	(17)
Comprehensive loss	$ (32,711)	$ (833)

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 March 31, 2022

	Common Stock		Additional Paid-in Capital	Treasury Stock		Retained Earnings	Accumulated Other Comprehensive Income	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	176	—	1,054	—	—	—	—	1,054
Repurchase of shares to satisfy employee tax withholding obligations	—	—	(508)	37	—	—	—	(508)
Paid-in-kind dividend and accretion related to convertible preferred stock	—	—	—	—	—	(7,218)	—	(7,218)
Stock-based compensation	—	—	5,791	—	—	—	—	5,791
Other comprehensive income, net of tax	—	—	—	—	—	—	31	31
Net loss	—	—	—	—	—	(32,742)	—	(32,742)
Balance as of March 31, 2022	38,880	$ 39	$ 762,212	12,053	$ (199,998)	$ 153,253	$ 421	$ 715,927

Three Months Ended March 31, 2021

	Common Stock		Additional Paid-in Capital	Treasury Stock		Retained Earnings	Accumulated Other Comprehensive Income	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	238	—	285	—	—	—	—	285
Repurchase of shares to satisfy employee tax withholding obligations	—	—	(5,037)	81	—	—	—	(5,037)
Stock-based compensation	—	—	11,952	—	—	—	—	11,952
Other comprehensive income, net of tax	—	—	—	—	—	—	(33)	(33)
Net loss	—	—	—	—	—	(800)	—	(800)
Balance as of March 31, 2021	37,993	$ 38	$ 728,213	11,912	$ (199,998)	$ 315,355	$ 317	$ 843,925

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

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

	Three Months Ended March 31,	
	2022	**2021**
Operating activities:		
Net loss	$ (32,742)	$ (800)
Adjustments to reconcile net loss to net cash provided by operating activities:		
Depreciation and amortization	946	1,138
Amortization of internally developed software	3,832	2,806
Amortization of intangible assets	—	176
Stock-based compensation expense	5,285	11,402
Deferred income taxes	(8,032)	(570)
Other non-cash items	215	420
Changes in operating assets and liabilities:		
Accounts receivable	3,773	(48)
Contract assets – commissions receivable	77,142	50,635
Prepaid expenses and other assets	12,418	4,225
Accounts payable	(5,525)	(25,826)
Accrued compensation and benefits	2,042	4,088
Accrued marketing expenses	(16,848)	(6,712)
Deferred revenue	(223)	570
Accrued expenses and other liabilities	4,829	1,305
Net cash provided by operating activities	47,112	42,809
Investing activities:		
Capitalized internal-use software and website development costs	(4,205)	(3,242)
Purchases of property and equipment and other assets	(55)	(1,899)
Purchases of marketable securities	(3,938)	(7,771)
Proceeds from redemption and maturities of marketable securities	34,319	23,409
Net cash provided by investing activities	26,121	10,497
Financing activities:		
Net proceeds from debt financing	64,862	—
Net proceeds from exercise of common stock options and employee stock purchases	1,054	285
Repurchase of shares to satisfy employee tax withholding obligations	(508)	(5,037)
Principal payments in connection with leases	(35)	(38)
Net cash provided by (used in) financing activities	65,373	(4,790)
Effect of exchange rate changes on cash, cash equivalents and restricted cash	31	(25)
Net increase in cash, cash equivalents and restricted cash	138,637	48,491
Cash, cash equivalents and restricted cash at beginning of period	85,165	47,113
Cash, cash equivalents and restricted cash at end of period	$ 223,802	$ 95,604

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 March 31, 2022, the condensed consolidated statements of comprehensive loss and stockholders’ equity for the three months ended March 31, 2022 and 2021, and the condensed consolidated statements of cash flows for the three months ended March 31, 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 March 31, 2022 and December 31, 2021, and our results of operations for the periods presented. The results for the three months ended March 31, 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 three months ended March 31, 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

We did not adopt any new accounting pronouncements during the three months ended March 31, 2022.

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 March 31,	
	2022	**2021**
Medicare		
Medicare Advantage	$ 78,130	$ 103,525
Medicare Supplement	6,120	8,222
Medicare Part D	1,460	1,736
Total Medicare	85,710	113,483
Individual and Family [(1)]		
Non-Qualified Health Plans	1,610	3,367
Qualified Health Plans	1,516	2,100
Total Individual and Family	3,126	5,467
Ancillary		
Short-term	1,343	1,756
Dental	831	1,728
Vision	243	205
Other	414	35
Total Ancillary	2,831	3,724
Small Business	3,483	3,223
Commission Bonus and Other	(1,300)	1,155
Total Commission Revenue	93,850	127,052
Other Revenue		
Sponsorship and Advertising Revenue	10,645	5,814
Other	755	1,348
Total Other Revenue	11,400	7,162
Total Revenue	$ 105,250	$ 134,214

(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 March 31,	
	2022	2021
Medicare		
Commission Revenue from Members Approved During the Period	$ 84,283	$ 114,678
Net Commission Revenue from Members Approved in Prior Periods[1]	51	14
Total Medicare Segment Commission Revenue	$ 84,334	$ 114,692
Individual, Family and Small Business		
Commission Revenue from Members Approved During the Period	$ 6,042	$ 6,395
Commission Revenue from Renewals of Small Business Members During the Period [2]	3,037	2,687
Net Commission Revenue from Members Approved in Prior Periods[1]	437	3,278
Total IFP/SMB Segment Commission Revenue	$ 9,516	$ 12,360
Total Commission Revenue from Members Approved During the Period [1]	$ 90,325	$ 121,073
Commission Revenue from Renewals of Small Business Members During the Period	3,037	2,687
Total Net Commission Revenue from Members Approved in Prior Periods [1][2]	488	3,292
Total Commission Revenue	$ 93,850	$ 127,052

[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 $0.02 and $0.12 per basic and diluted share, for the three months ended March 31, 2022 and 2021, respectively.

There were no reductions to revenue from members approved in prior periods for the three months ended March 31, 2022 and $0.9 million for the three months ended March 31, 2021. These reductions to revenue primarily related to the Individual, Family and Small Business 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 equivalent and restricted cash balances are summarized as follows (in thousands):

	March 31, 2022	December 31, 2021
Cash	$ 91,414	$ 33,253
Cash equivalents	129,149	48,673
Cash and cash equivalents	220,563	81,926
Restricted cash	3,239	3,239
Total cash, cash equivalents and restricted cash	$ 223,802	$ 85,165

As of March 31, 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 March 31, 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 general and administrative expense on our Condensed Consolidated Statement of Comprehensive Loss. There were no write-offs during the three month periods ended March 31, 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 March 31, 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 three months ended March 31, 2022 is summarized as follows (in thousands):

Beginning balance	$	2,198
Change in allowance		(59)
Ending balance	$	2,139

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

	Three Months Ended March 31, 2022		
	Medicare Segment	IFP/SMB Segment	Total
Beginning balance	$ 837,474	$ 70,788	$ 908,262
Commission revenue from members approved during the period	84,283	6,042	90,325
Commission revenue from renewals of small business members during the period	—	3,037	3,037
Net commission revenue from members approved in prior periods	51	437	488
Cash receipts	(159,443)	(11,550)	(170,993)
Net change in credit loss allowance	54	5	59
Ending balance	$ 762,419	$ 68,759	$ 831,178

	Three Months Ended March 31, 2021		
	Medicare Segment	IFP/SMB Segment	Total
Beginning balance	$ 739,637	$ 52,768	$ 792,405
Commission revenue from members approved during the period	114,678	6,395	121,073
Commission revenue from renewals of small business members during the period	—	2,687	2,687
Net commission revenue from members approved in prior periods	14	3,278	3,292
Cash receipts	(165,520)	(12,012)	(177,532)
Net change in credit loss allowance	(72)	(6)	(78)
Ending balance	$ 688,737	$ 53,110	$ 741,847

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 $4.2 million as of March 31, 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:

	March 31, 2022	December 31, 2021
Humana	26 %	25 %
UnitedHealthCare [(1)]	24 %	23 %
Aetna [(1)]	17 %	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):

	March 31, 2022	December 31, 2021
Prepaid maintenance contracts	$ 6,052	$ 6,246
Prepaid licenses	2,149	3,076
Prepaid expenses	1,837	11,379
Prepaid insurance	1,431	2,161
Others	356	922
Prepaid expenses and other current assets	$ 11,825	$ 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 below (in thousands):

	March 31, 2022				
	Carrying Value	Level 1	Level 2	Level 3	Total
Assets					
Cash equivalents					
Money market funds	$ 17,186	$ 17,186	$ —	$ —	$ 17,186
Commercial paper	111,964	—	111,964	—	111,964
Short-term marketable securities					
Commercial paper	10,938	—	10,938	—	10,938
Total assets measured at fair value	$ 140,088	$ 17,186	$ 122,902	$ —	$ 140,088

	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

As of March 31, 2022, our cash equivalents consisted of money market funds and commercial paper with original maturity of 90 days or less were classified as Level 1 and 2, respectively. We endeavor to utilize the best available information in measuring fair value. We used observable prices in active markets in determining the classification of our money market funds as Level 1. Our Level 2 assets consisted of available for sale marketable securities, which included commercial paper, agency bonds, and a corporate bond with maturities of less than one year. We classify our marketable debt securities within Level 2 in the fair value hierarchy, because we use quoted market prices to the extent available or alternative pricing sources and models utilizing market observable inputs to determine fair value. 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 three months ended March 31, 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 March 31, 2022	
	Amortized Cost	Fair Value
Due in 1 year	$ 140,089	$ 140,088

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 March 31, 2022 (in thousands):

	Amortized Cost	Unrealized Gain	Unrealized Loss	Fair Value
Cash equivalents				
Money market funds	$ 17,186	$ —	$ —	$ 17,186
Commercial paper	111,964	5	(5)	111,964
Short-term marketable securities				
Commercial paper	10,939	1	(2)	10,938
Total	$ 140,089	$ 6	$ (7)	$ 140,088

As of March 31, 2022, we had 31 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 three months ended March 31, 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 the 2021 Inducement Plan to reserve an additional 500,000 shares of its common stock. The 2021 Inducement Plan and its amendment 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 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 March 31, 2022, 390,584 shares were issued under the 2021 Inducement Plan.

Stock Repurchase Programs – We had no stock repurchase activity during the three months ended March 31, 2022. In addition to 10.7 million shares repurchased under our previous repurchase programs, we have in treasury 1.4 million shares as of March 31, 2022 that were previously surrendered by employees to satisfy tax withholding due in connection with the vesting of certain restricted stock units. As of March 31, 2022 and December 31, 2021, we had a total of 12.1 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 March 31,	
	2022	2021
Restricted stock units*	$ 4,706	$ 10,719
Common stock options	257	180
Employee stock purchase plan	322	503
Total stock-based compensation expense	$ 5,285	$ 11,402

* 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 March 31,	
	2022	2021
Marketing and advertising	$ 313	$ 2,485
Customer care and enrollment	454	469
Technology and content	1,850	2,743
General and administrative	2,668	5,705
Total stock-based compensation expense	$ 5,285	$ 11,402
Amount capitalized for internal-use software	506	550
Total stock-based compensation	$ 5,791	$ 11,952

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 million to $125 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.

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 March 31, 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 March 31, 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 3.0 million shares of common stock as of March 31, 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		4,717
Change in preferred stock redemption value		2,501
Balance as of March 31, 2022	$	239,810

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 (“ESPP”).

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 March 31,	
	2022	2021
Numerator:		
Net loss attributable to common stockholders:	$ (39,960)	$ (800)
Denominator:		
Shares used in per share calculation – basic	27,278	26,620
Dilutive effect of common stock	—	—
Shares used in diluted share calculation	27,278	26,620
Net loss attributable to common stockholders per share – basic and diluted	$ (1.46)	$ (0.03)

For each of the three months ended March 31, 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 March 31,	
	2022	2021
Convertible preferred stock	2,981	—
Restricted stock units	1,548	1,090
Common stock options	279	363
ESPP	53	7
Total	4,861	1,460

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 March 31, 2022 (in thousands):

For the Years Ending December 31,		
Remainder of 2022	$	8,258
2023		8,370
2024		2,470
2025		229
2026		—
Thereafter		—
Total	$	19,327

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 months ended March 31, 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 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 presently set to be heard on May 12, 2022.

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 Securities Exchange Act of 1934, 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 Securities Exchange Act of 1934. 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 March 31,	
	2022	2021
Revenue:		
Medicare	$ 95,067	$ 121,021
Individual, Family and Small Business	10,183	13,193
Total revenue	$ 105,250	$ 134,214
Segment profit (loss)		
Medicare segment profit (loss)	$ (14,817)	$ 24,545
Individual, Family and Small Business segment profit	5,254	8,052
Segment profit (loss)	(9,563)	32,597
Corporate	(15,265)	(15,286)
Stock-based compensation expense	(5,285)	(11,402)
Depreciation and amortization	(4,778)	(3,944)
Amortization of intangible assets	—	(176)
Restructuring and reorganization charges	(4,823)	(2,431)
Other income (expense), net	(1,021)	150
Loss before income taxes	$ (40,735)	$ (492)

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):

	March 31, 2022	December 31, 2021
United States	$ 44,573	$ 45,134
China	547	595
Total	$ 45,120	$ 45,729

Significant Customers

Substantially all revenue for the three months ended March 31, 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 March 31,	
	2022	2021
Humana	27 %	17 %
UnitedHealthCare [1]	15 %	22 %
Centene [1]	14 %	12 %
Aetna [1]	11 %	21 %

[1] Percentages include the carriers' subsidiaries.

Note 10 – Leases

Our leases have remaining lease terms of 1 to 8 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.

Total operating lease expenses were $1.9 million and $2.0 million for the three months ended March 31, 2022 and 2021, respectively and sublease income was immaterial for both periods.

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

	March 31, 2022	December 31, 2021
Weighted-average remaining lease term of operating leases	6.1 years	6.3 years
Weighted-average discount rate used to recognize operating lease right-of-use-assets	5.4 %	5.4 %

	Three Months Ended March 31,	
	2022	2021
Operating lease expense	$ 1,912	$ 1,986
Cash outflows related to operating leases	1,953	1,900

As of March 31, 2022, maturities of operating lease liabilities are as follows (in thousands):

Year ending December 31,	
Remainder of 2022	$ 5,744
2023	8,029
2024	7,828
2025	8,004
2026	6,734
Thereafter	12,827
Total lease payments [1]	49,166
Less imputed interest	(9,101)
Total	$ 40,065

(1) Noncancellable sublease income for the remainder of 2022 and year ending December 31, 2023 of $0.3 million and $0.4 million, respectively, is not included in the table above.

Note 11 — Restructuring and Reorganization

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):

	Three Months Ended March 31, 2022
Beginning balance	$ 146
Restructuring and reorganization charges	4,823
Payments	(1,565)
Ending balance	$ 3,404

In the first quarter of 2022, we recorded pre-tax restructuring charges of $4.8 million related to the elimination of 339 full-time positions that was completed in April 2022. The reduction 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. The expense was primarily related to employee termination benefits. Substantially all of the restructuring charges will be settled in cash. No equity awards were modified. As of March 31, 2022, we recorded a restructuring accrual of $3.4 million in other current liabilities on our Condensed Consolidated Balance Sheet.

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 general and administrative expenses on our Condensed Consolidated Statement 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.

Note 12 – Debt

We entered into a term loan credit agreement (the "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 Term Loan 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 Term Loan Credit Agreement. As of December 31, 2021, there was $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 Term Loan 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 Term Loan Credit Agreement. The term loan bears interest, upon our option, at either a rate based on the London Interbank Offered Rate ("LIBOR") for the applicable interest period or a base rate, in each case plus a margin. The base rate is the highest of the prime rate, the federal funds rates plus 0.50% and one month adjusted LIBOR plus 1.0%. The margin is 7.50% for LIBOR loans and 6.50% for base rate loans and the Term Loan Credit Agreement includes customary "fallback" provisions with respect to potential transition from the LIBOR. Furthermore, as part of the agreement, we will incur a $0.3 million fee per annum, payable annually. The outstanding obligations under the Term Loan Credit Agreement are payable in full on the maturity date. The Term Loan Credit Agreement matures in February 2025. We have the right to prepay the loans under the Term Loan 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 Term Loan Credit Agreement after February 28, 2023, to an exit fee. Our obligations under the Term Loan 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 with the Term Loan Credit Agreement.

Financial covenants in the Term Loan Credit Agreement require that we maintain Liquidity (as defined in the Term Loan Credit Agreement) at or above $25.0 million as of the last calendar day of any month. The Term Loan Credit Agreement also requires that the outstanding amount as of any day be less than 50% of our total contract assets - commissions receivables (i.e., both current and non-current commissions receivables). As of March 31, 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 Term Loan 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 $5.0 million of unamortized issuance costs as of March 31, 2022. The carrying value of the loan was $65.0 million as of March 31, 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 March 31,	
	2022	2021
Loss before income taxes	$ (40,735)	$ (492)
Provision for (benefit from) income taxes	(7,993)	308
Effective tax rate	19.6 %	(62.6)%

For the three months ended March 31, 2022, we recognized a benefit from income taxes of $8.0 million, representing an effective tax rate of 19.6% which was lower than the statutory federal tax rate due primarily to stock-based compensation adjustments and non-deductible lobbying expenses, partially offset by research and development credits and state taxes. For the three months ended March 31, 2021, we recognized provision for income taxes of $0.3 million, representing an effective tax rate of (62.6)%, respectively, which was lower than the statutory federal tax rate due primarily to one-time state tax adjustments.

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 March 31, 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 and Section 21E of the Securities Exchange Act of 1934. 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 e-commerce 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; the impact of future and existing laws and regulations on our business; the expected impact of the COVID-19 pandemic 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 healthcare open enrollment period, the Medicare annual enrollment period and other special enrollment periods; changes in laws, regulations and guidelines, including in connection with healthcare 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 continued impact of the COVID-19 pandemic 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; 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 email, 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 and other laws and regulations; the outcome of litigation in which we are 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 in the fourth quarter. We continue to build on these initiatives in 2022. The investments in our telesales operations, technology and enrollment quality assurance have resulted in lower conversion rates and longer average talk times for telephonic enrollments and negatively impacted our first quarter financial results. However, we are seeing position traction in CTM scores and retention characteristics for the new enrollments that we added during the 2022 annual enrollment period ("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 and increased plan longevity.

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 to our quality assurance efforts initiated in 2021, we continue to introduce further initiatives in our customer care centers. This includes increased agent specialization by product and geography, improvement of agent scripts to make them more consumer friendly, an outbound call program that allows and incentivizes agents to proactively work their pipeline during down times, and emphasis on extending agents' tenure with us. Furthermore, our agent mix will be more mature in 2022 compared to a year ago. We expect these initiatives will build on positive momentum in our conversion rates as we prepare for AEP.

We are making effort in creating greater collaboration between our digital and conventional marketing teams to create synergies between our diversified demand generation channels. We are launching a series of omni-channel tools aimed at supporting seamless transition of customers between channels, including an online chat staffed by licensed Medicare agents. These initiatives enhance our technology differentiation and create a stronger connection between agent driven and digital organizations.

Transformation Initiatives — We are implementing a multi-year transformation initiative to right-size our cost structure and drive future profitability. These initiatives include targeted reductions in fixed expenses and vendor-related spend outside of mission critical areas, as well as changes to variable cost management. Through this program, we expect to achieve ongoing significant cost savings while preserving our competitive edge and focusing on initiatives with highest in-period returns on investment. We expect to achieve over $60 million in annualized cost savings, excluding restructuring costs in 2022 of approximately $10 million to $20 million. We expect the variable cost reduction to lead to a temporary decline in our Medicare enrollments and revenue in 2022 before a return to growth in 2023 on a significantly improved operational and cost foundation. 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. 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.

Changes in Senior Management

In January 2022, we announced the termination 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 previously served as an executive officer of the Company for over 20 years until his retirement in March 2020.

In February 2022, we announced the appointment of Roman Rariy as our chief operating officer and chief transformation officer, effective March 1, 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 of March 31, 2022, all of our U.S. offices are open at reduced capacity and with additional safety and social distancing measures. We currently plan to operate with a combination of remote and in-office work in the United States at least through part of 2022. We plan to adjust the number of in-office employees during the year depending upon the COVID-19 situation. The emergence of COVID-19 variants could cause us to alter our operations and plans for in-office and remote work.

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. See *Risk Factors* in Part II, Item 1A of this Quarterly Report on Form 10-Q for a discussion of risks related to the COVID-19 pandemic.

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 current period. 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 March 31,		
	2022	2021	% Change
Medicare			
Medicare Advantage	82,431	106,884	(23)%
Medicare Supplement	6,556	7,782	(16)%
Medicare Part D	6,823	8,011	(15)%
Total Medicare	95,810	122,677	(22)%
Individual and Family	9,801	11,314	(13)%
Ancillary	18,970	26,511	(28)%
Small Business	2,514	2,948	(15)%
Total Approved Members	127,095	163,450	(22)%

Three Months Ended March 31, 2022 and 2021 – Total Medicare approved members decreased 22% in the three months ended March 31, 2022 compared to the same period in 2021. The decrease in total Medicare approved members 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, during the three months ended March 31, 2022 compared to the same period in 2021. The decrease in Medicare Advantage approved members, in particular, was driven by a decrease in submitted applications primarily due to lower telephonic conversion rates and our decision to reduce our investment in telephonic enrollment growth in 2022.

Individual and family plan approved members declined 13% in the three months ended March 31, 2022 compared to the same period in 2021 partially due to an extension of the enrollment period in 2021 that did not occur in 2022.

Ancillary plan approved members declined 28% in the three months ended March 31, 2022 compared to the same period in 2021 primarily due to declines in approved members for short-term health insurance plans and dental insurance plans. Small business group health insurance approved members declined 15% in the three months ended March 31, 2022 compared to the same period in 2021 mainly due to a decrease in approved groups.

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 March 31,		
	2022	2021	% Change
Medicare			
Medicare Advantage	117,643	140,997	(17)%
Medicare Supplement	7,062	9,996	(29)%
Medicare Part D	27,384	29,139	(6)%
Total Medicare	152,089	180,132	(16)%
Individual and Family	16,230	17,607	(8)%
Ancillary	22,917	31,591	(27)%
Small Business	3,084	4,125	(25)%
Total New Paying Members	194,320	233,455	(17)%

Three Months Ended March 31, 2022 and 2021 – Total Medicare new paying members declined 16% in the three months ended March 31, 2022 compared to the same period in 2021, due primarily to a decrease in approved members for all Medicare products. Individual and family plan new paying members declined 8% in the three months ended March 31, 2022 compared to the same period in 2021 due primarily to decreases in approved members for non-qualified and qualified plans. Ancillary new paying members declined 27% in the three months ended March 31, 2022 compared to the same period in 2021 primarily due to a decrease in approved members for short-term and dental insurance plans. Small business new paying members declined 25% in the three months ended March 31, 2022 compared to the same period in 2021 primarily due to a decrease in approved members for small business plans.

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 March 31,		
	2022	2021	% Change
Medicare			
Medicare Advantage [1]	$ 948	$ 968	(2)%
Medicare Supplement [1]	927	1,057	(12)%
Medicare Part D [1]	213	217	(2)%
Individual and Family			
Non-Qualified Health Plans [1]	330	200	65 %
Qualified Health Plans [1]	302	298	1 %
Ancillary			
Short-term [1]	182	180	1 %
Dental [1]	104	91	14 %
Vision [1]	62	59	5 %
Small Business [2]	198	182	9 %

[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%, 12%, and 2%, respectively, for Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans during the three months ended March 31, 2022 compared to the same period in 2021. The decrease in constrained LTV was due to decreased estimates of average plan durations for these products.

Individual and Family and Ancillary

The constrained LTV of commissions per non-qualified health plan approved member and qualified health plan approved member increased 65% and 1%, respectively, during the three months ended March 31, 2022 compared with the same period in 2021 mostly due to increased estimates of average plan duration and a lower constraint for non-qualified health insurance plans.

The constrained LTV of commissions per approved member for short-term health insurance, dental, vision, and small business insurance plans increased by 1%, 14%, 5%, and 9%, respectively, during the three months ended March 31, 2022 compared with the same period in 2021 primarily due to an increase in estimated average plan duration.

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 March 31,	
	2022	2021
Medicare		
Medicare Advantage	7 %	7 %
Medicare Supplement	9 %	5 %
Medicare Part D	7 %	5 %
Individual and Family		
Non-Qualified Health Plans	7 %	15 %
Qualified Health Plans	4 %	4 %
Ancillary		
Short-term	20 %	20 %
Dental	5 %	7 %
Vision	5 %	5 %
Other	10 %	10 %
Small Business	5 %	5 %

The constraints for Medicare Supplement and Medicare Part D prescription drug plans increased during the three months ended March 31, 2022, as compared to the same period in the prior year, due to declining LTV trends for these products. The constraints for non-qualified health plans decreased during the three months ended March 31, 2022, as compared to the same period in the prior year, due to stabilization of market conditions and increases in LTV values. The constraints for dental plans decreased during the three months ended March 31, 2022, as compared to the same period in the prior year, due to improved LTV trends.

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 March 31,		
	2022	2021	% Change
Medicare [1]			
Medicare Advantage	585,824	538,716	9 %
Medicare Supplement	100,006	104,727	(5)%
Medicare Part D	219,801	229,598	(4)%
Total Medicare	905,631	873,041	4 %
Individual and Family [2]	104,849	103,844	1 %
Ancillary [3]	229,284	241,415	(5)%
Small Business [4]	47,876	45,207	6 %
Total Estimated Membership	1,287,640	1,263,507	2 %

(1) To estimate the number of members on Medicare-related health insurance plans, we take the 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 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.

(2) To estimate the number of members on Individual and Family health insurance plans ("IFP"), we take the sum of (i) the number of IFP 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 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.

(3) To estimate the number of members on ancillary health insurance plans (such as short-term, dental and vision insurance), we take the 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 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. 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.

(4) 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 March 31, 2022 grew 4% compared to estimated membership as of March 31, 2021 due to a 9% growth in Medicare Advantage estimated membership, offset by a 5% and 4% decline in Medicare Supplement plan and Medicare Part D plan estimated membership, respectively. 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 March 31, 2022 grew 1% compared to estimated membership as of March 31, 2021 due to overall market conditions in the individual and family plan market, including recent stabilization and improvement. Ancillary plan estimated membership as of March 31, 2022 declined 5% compared to estimated membership as of March 31, 2021 primarily as a result of the decline in short-term health 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 March 31,		
	2022	2021	% Change
Medicare			
Estimated CC&E cost per approved MA-equivalent approved member [1]	$ 441	$ 278	59 %
Estimated variable marketing cost per MA-equivalent approved member [1]	545	353	54 %
Total Medicare estimated cost per approved member	$ 986	$ 631	56 %
Individual and Family Plan			
Estimated CC&E cost per IFP-equivalent approved member [2]	$ 88	$ 63	40 %
Estimated variable marketing cost per IFP-equivalent approved member [2]	49	44	11 %
Total IFP estimated cost per approved member	$ 137	$ 107	28 %

(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 approved MA-equivalent member increased 59% in the three months ended March 31, 2022 compared to the same period in 2021 due to lower enrollment volume while having more agents than the prior year and a decline in our telesales conversion rate resulting from enrollment quality initiatives. We believe that this investment in our telesales organization will improve our competitive positioning and drive higher quality enrollments characterized by improved persistency. Estimated variable marketing cost per MA-equivalent member increased 54% primarily due to lower enrollment volume as a result of lower conversion rates from our telephonic leads. In addition, a greater focus on our online advertising channel also contributed to the increase as it carries higher per enrollment marketing costs but lower customer care and enrollment costs.

Estimated CC&E cost per approved IFP-equivalent member increased 40% in the three months ended March 31, 2022 compared to the same period in 2021 due primarily to an increase in the number of agents in anticipation of volume increases for the rest of 2022. Estimated variable marketing cost per IFP-equivalent member increased 11% in the three months ended March 31, 2022 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 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 March 31,			
	2022		2021	
Revenue				
Commission	$ 93,850	89 %	$ 127,052	95 %
Other	11,400	11 %	7,162	5 %
Total revenue	105,250	100 %	134,214	100 %
Operating costs and expenses [(1)]				
Cost of revenue	(127)	— %	996	1 %
Marketing and advertising	58,454	56 %	50,874	38 %
Customer care and enrollment	42,164	40 %	34,162	25 %
Technology and content	19,663	19 %	23,163	17 %
General and administrative	19,987	19 %	23,054	17 %
Amortization of intangible assets	—	— %	176	— %
Restructuring and reorganization charges	4,823	5 %	2,431	2 %
Total operating costs and expenses	144,964	139 %	134,856	100 %
Loss from operations	(39,714)	(38)%	(642)	— %
Other income (expense), net	(1,021)	(1)%	150	— %
Loss before income taxes	(40,735)	(39)%	(492)	— %
Provision for (benefit from) income taxes	(7,993)	(8)%	308	— %
Net loss	$ (32,742)	(31)%	$ (800)	(1)%

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

	Three Months Ended March 31,	
	2022	2021
Marketing and advertising	$ 313	$ 2,485
Customer care and enrollment	454	469
Technology and content	1,850	2,743
General and administrative	2,668	5,705
Total stock-based compensation expense	$ 5,285	$ 11,402

Revenue

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

	Three Months Ended March 31,		Change	
	2022	2021	$	%
Commission	$ 93,850	$ 127,052	$ (33,202)	(26)%
% of total revenue	89 %	95 %		
Other	11,400	7,162	4,238	59 %
% of total revenue	11 %	5 %		
Total revenue	$ 105,250	$ 134,214	$ (28,964)	(22)%

Three Months Ended March 31, 2022 and 2021 – Commission revenue decreased $33.2 million, or 26%, during the three months ended March 31, 2022 compared to the same period in 2021 due to a $27.8 million decrease in commission revenue from the Medicare segment and a $3.0 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 22% decrease in Medicare plan approved members, driven primarily by a 23% decline in Medicare Advantage plan approved members compared to 2021. The decrease in commission revenue from the Individual, Family and Small Business segment was primarily due to a 28% decrease in ancillary plan approved members, a 13% decrease in individual and family major medical plan approved members, and a $2.8 million decrease in net adjustment revenue. See *Segment Information* below for further discussion.

Other revenue increased $4.2 million, or 59%, during the three months ended March 31, 2022 compared to the same period in 2021 due to an increase in Medicare 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 March 31,		Change	
	2022	2021	$	%
Cost of revenue	$ (127)	$ 996	$ (1,123)	(113)%
% of total revenue	— %	1 %		

Three Months Ended March 31, 2022 and 2021 – Cost of revenue decreased by $1.1 million during the three months ended March 31, 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 March 31,		Change	
	2022	2021	$	%
Marketing and advertising	$ 58,454	$ 50,874	$ 7,580	15 %
% of total revenue	56 %	38 %		

Three Months Ended March 31, 2022 and 2021 – Marketing and advertising expenses increased $7.6 million, or 15%, during the three months ended March 31, 2022 compared to the same period in 2021, primarily driven by a $8.1 million increase in Medicare plan related variable advertising, $0.6 million in personnel and compensation costs, and $0.6 million in consulting expenses, partially offset by decreases of $2.2 million in stock-based compensation expenses. The increase in variable advertising expenses was due to an increase in our advertising expense through our partner and online 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 March 31,		Change	
	2022	2021	$	%
Customer care and enrollment	$ 42,164	$ 34,162	$ 8,002	23 %
% of total revenue	40 %	25 %		

Three Months Ended March 31, 2022 and 2021 – Customer care and enrollment expenses increased $8.0 million, or 23%, during the three months ended March 31, 2022 compared to the same period in 2021, primarily due to increases of $7.9 million in personnel cost from increased headcount, $1.4 million in facilities and other costs, and $1.3 million in licensing costs, partially offset by decreases of $2.6 million in consulting 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 March 31,		Change	
	2022	2021	$	%
Technology and content	$ 19,663	$ 23,163	$ (3,500)	(15)%
% of total revenue	19 %	17 %		

Three Months Ended March 31, 2022 and 2021 – Technology and content expenses decreased $3.5 million, or 15%, during the three months ended March 31, 2022 compared to the same period in 2021 primarily driven by decreases of $1.4 million in personnel and compensation costs due to lower capitalized project costs, $1.4 million in facilities and other operating costs, $0.9 million in stock-based compensation expense, and $0.8 million in consulting costs, partially offset by an increase of $1.0 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 March 31,		Change	
	2022	2021	$	%
General and administrative	$ 19,987	$ 23,054	$ (3,067)	(13)%
% of total revenue	19 %	17 %		

Three Months Ended March 31, 2022 and 2021 – General and administrative expenses decreased $3.1 million, or 13%, during the three months ended March 31, 2022 compared to the same period in 2021, primarily driven by decreases of $3.0 million in stock-based compensation expenses, $0.6 million in facilities and other operating costs, and $0.6 million in consulting expenses, partially offset by an increase of $1.3 million in other professional fees.

Amortization of Intangible Assets

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

	Three Months Ended March 31,		Change	
	2022	2021	$	%
Amortization of intangible assets	$ —	$ 176	$ (176)	(100)%
% of total revenue	— %	— %		

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

Restructuring and Reorganization Charges

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

	Three Months Ended March 31,		Change	
	2022	2021	$	%
Restructuring and reorganization charges	$ 4,823	$ 2,431	$ 2,392	98%
% of total revenue	5 %	2 %		

Three Months Ended March 31, 2022 and 2021 – Restructuring and reorganization costs for the three months ended March 31, 2022 primarily consisted of the severance and other personnel related cost related to the restructuring that took place in early second quarter of 2022. We completed a reduction in force in April 2022 in which we eliminated approximately 339 full-time positions, representing approximately 14% of our workforce, primarily in within the customer care and enrollment groups, and to a lesser extent, in our marketing and advertising and general and administrative groups.

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 March 31,		Change	
	2022	2021	$	%
Other income (expense), net	$ (1,021)	$ 150	$ (1,171)	(781)%
% of total revenue	(1)%	— %		

Three Months Ended March 31, 2022 and 2021 – Other income (expense), net decreased $1.2 million during the three months ended March 31, 2022 compared to the same period in 2021 due primarily to interest expense for the Term Loan Credit Agreement entered in the first quarter of 2022 and expenses related to the termination of the RBC revolving credit facility at the same time.

Benefit from Income Taxes

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

	Three Months Ended March 31,		Change	
	2022	2021	$	%
Provision for (benefit from) income taxes	$ (7,993)	$ 308	$ (8,301)	(2,695)%
Effective tax rate	19.6 %	(62.6)%		

Three Months Ended March 31, 2022 and 2021 – Our effective tax rate of 19.6% for the three months ended March 31, 2022 was lower compared to (62.6)% for the three months ended March 31, 2021 primarily due to a one-time state tax adjustment in 2021 that did not occur in 2022. Our effective tax rate for the three months ended March 31, 2022 was lower than the statutory federal tax rate due primarily to stock-based compensation adjustments and 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 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 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 restructuring and reorganization charges.

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

	Three Months Ended March 31,		Change	
	2022	2021	$	%
Revenue:				
Medicare	$ 95,067	$ 121,021	$ (25,954)	(21) %
Individual, Family and Small Business	10,183	13,193	(3,010)	(23) %
Total revenue	$ 105,250	$ 134,214	$ (28,964)	(22) %
Segment profit (loss)				
Medicare segment profit (loss)	$ (14,817)	$ 24,545	$ (39,362)	(160) %
Individual, Family and Small Business segment profit	5,254	8,052	(2,798)	(35) %
Segment profit (loss)	(9,563)	32,597	(42,160)	(129) %
Corporate	(15,265)	(15,286)	21	*
Stock-based compensation expense	(5,285)	(11,402)	6,117	(54) %
Depreciation and amortization [1]	(4,778)	(3,944)	(834)	21 %
Amortization of intangible assets	—	(176)	176	(100) %
Restructuring and reorganization charges	(4,823)	(2,431)	(2,392)	98 %
Other income (expense), net	(1,021)	150	(1,171)	(781) %
Loss before income taxes	$ (40,735)	$ (492)	$ (40,243)	8179 %

* Percentage calculated is not meaningful.

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

Revenue

Three Months Ended March 31, 2022 and 2021 – Revenue from our Medicare segment declined $26.0 million, or 21%, during the three months ended March 31, 2022 compared to the same period in 2021, attributable to a $27.8 million decrease in commission revenue, partially offset by a $4.4 million increase in sponsorship and advertising revenue. The decrease in Medicare segment commission revenue is primarily due to a decrease in Medicare Advantage plan related commission revenue of $25.4 million. The decrease in Medicare Advantage commission revenue was driven by 23% decline in Medicare Advantage plan approved members.

Revenue from our Individual, Family and Small Business segment declined $3.0 million, or 23%, during the three months ended March 31, 2022 compared to the same period in 2021, primarily attributable to a $3.0 million decrease in commission revenue. Based on our evaluation of the updated LTV models and retention trends, we recognized $0.4 million in net adjustment revenue, a decrease of $2.8 million during the three months ended March 31, 2022 compared to the same period in 2021. The decrease in commission revenue is attributable to a decline of 28% in ancillary approved members and a decline of 13% in individual and family approved members.

Segment Profit (Loss)

Three Months Ended March 31, 2022 and 2021 – Our Medicare segment loss was $14.8 million during the three months ended March 31, 2022, a decrease of $39.4 million, or 160%, compared to segment profit of $24.5 million for the same period in 2021. This was primarily due to a $13.4 million increase in operating expenses, excluding stock-based compensation expense, depreciation and amortization expense, restructuring and reorganization charges, and other income (expense), as well as a $26.0 million decrease in revenue. The increase in operating expenses was mostly attributable to a higher agent work force in 2022 compared to the prior year as well as higher spending on certain marketing channels, especially online marketing.

Our Individual, Family and Small Business segment profit was $5.3 million during the three months ended March 31, 2022, a decrease of $2.8 million, or 35% compared to the same period in 2021. The decrease was primarily driven by a $3.0 million decrease in revenue and a $0.2 million decrease in operating expenses, excluding

stock-based compensation expense, depreciation and amortization expense, restructuring and reorganization charges, and other income (expense).

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 $7.7 million for leases and $10.4 million for service and licensing as of March 31, 2022. Long-term obligations were $41.4 million for leases and $8.9 million for service and licensing as of March 31, 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. Alternatively, we may decide to reduce expenses in order to manage liquidity. These reductions could adversely impact the growth of membership and revenue.

We believe our current cash and cash equivalents, along with the proceeds from the term loan we obtained on February 28, 2022, 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):

	March 31, 2022	December 31, 2021
Cash and cash equivalents	$ 220,563	$ 81,926
Short-term marketable securities	10,938	41,306
Total cash, cash equivalents, and short-term marketable securities	$ 231,501	$ 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 March 31, 2022, our cash and cash equivalents totaled $220.6 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 $65.4 million of net cash provided by financing activities, partially offset by $47.1 million of net cash provided by operating activities and $26.1 million of net cash provided by investing activities. We also maintained $3.2 million in restricted cash as of March 31, 2022 and December 31, 2021.

The following table presents a summary of our cash flows for the three months ended March 31, 2022 (in thousands):

	Three Months Ended March 31,	
	2022	2021
Net cash provided by operating activities	$ 47,112	$ 42,809
Net cash provided by investing activities	26,121	10,497
Net cash provided by (used in) financing activities	65,373	(4,790)

Operating Activities

Net cash provided by 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 driven by 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.

Three Months Ended March 31, 2022 – Net cash provided by operating activities was $47.1 million during the three months ended March 31, 2022, primarily driven by changes in net operating assets and liabilities of $77.6 million and adjustments for non-cash items of $2.2 million, partially offset by a net loss of $32.7 million. Adjustments for non-cash items primarily consisted of $5.3 million of stock-based compensation expense and $3.8 million of amortization of intangible assets and internally-developed software, partially offset by an $8.0 million decrease due to the change in deferred income taxes. Cash provided by changes in net operating assets and liabilities during the three months ended March 31, 2022 primarily consisted of decreases of $77.1 million in contract assets – commissions receivable, $12.4 million in prepaid expenses and other current asset, and increases of $4.8 million in accrued expenses and other liabilities, partly offset by decreases of $16.8 million in accrued marketing expense and $5.5 million in accounts payable.

Three Months Ended March 31, 2021 – Net cash provided by operating activities was $42.8 million during the three months ended March 31, 2021, primarily driven by changes in net operating assets and liabilities of $28.2 million and a net loss of $0.8 million, partially offset by adjustments for non-cash items of $15.4 million. Adjustments for non-cash items primarily consisted of $11.4 million of stock-based compensation expense, $3.0 million of amortization of intangible assets and internally-developed software, and $1.1 million of depreciation and amortization. Cash used from changes in net operating assets and liabilities during the three months ended March 31, 2021 primarily consisted of decreases of $50.6 million in contract assets – commissions receivable and $4.2 million in prepaid expenses and other current asset, increases of $4.1 million in accrued compensation and benefits and $1.3 million in accrued expenses and other liabilities, partially offset by decreases of $25.8 million in accounts payable and $6.7 million in accrued marketing expense. Cash collection during the three months ended March 31, 2021 increased primarily driven by enrollment growth and increases in commission rates for new enrollments, as compared to the three months ended March 31, 2020.

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.

Three Months Ended March 31, 2022 – Net cash provided by investing activities of $26.1 million for the three months ended March 31, 2022 mainly consisted of $34.3 million proceeds from the maturities and redemptions of marketable securities, partially offset by $4.2 million in capitalized internal-use software and website development costs and $3.9 million used to purchase marketable securities.

Three Months Ended March 31, 2021 – Net cash provided by investing activities of $10.5 million for the three months ended March 31, 2021 mainly consisted $23.4 million proceeds from the maturities and redemptions of marketable securities, partially offset by $7.8 million used to purchase marketable securities, $3.2 million in capitalized internal-use software and website development costs and $1.9 million used to purchase property and equipment and other assets.

Financing Activities

Three Months Ended March 31, 2022 – Net cash provided by financing activities of $65.4 million for the three months ended March 31, 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 $0.5 million in repurchases of shares to satisfy employee tax withholding obligations.

Three Months Ended March 31, 2021 – Net cash used in financing activities of $4.8 million for the three months ended March 31, 2021 was primarily due to repurchase 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."), 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 March 31, 2022, no shares of the Series A preferred stock have been converted and the balance of our Series A preferred stock was $239.8 million, including a change in the redemption value of $2.5 million and the accrued paid-in-kind dividends of $4.7 million, which was equivalent to 3.0 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 term loan credit agreement (the "Term Loan Credit Agreement") with Blue Torch Finance LLC, as administrative agent and collateral agent, and the other lenders party thereto in February 2022. The Term Loan 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 proceeds of the loans under the Term Loan Credit Agreement may be used for working capital and general corporate purposes, to refinance our credit agreement with Royal Bank of Canada and to pay fees and expenses in connection with the entry into the Term Loan Credit Agreement. The term loan bears interest, at our option, at either a rate based on the London Interbank Offered Rate ("LIBOR") for the applicable interest period 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 one month adjusted LIBOR plus 1.0%. The margin is 7.50% for LIBOR loans and 6.50% for base rate loans and the Term Loan Credit Agreement includes customary "fallback" provisions with respect to potential

transition from the LIBOR. The outstanding obligations under the Term Loan Credit Agreement are payable in full on the maturity date. The Term Loan Credit Agreement matures in February of 2025. We have the right to prepay the loans under the Term Loan 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 Term Loan Credit Agreement after February 28, 2023, to an exit fee. Our obligations under the Term Loan 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 exclusions. We are obligated to pay administration fees in connection with the Term Loan Credit Agreement.

As of March 31, 2022, we had $65.0 million outstanding principal amount under our Term Loan 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 this credit agreement and subsequent amendment.

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):

	March 31, 2022	December 31, 2021
Cash and cash equivalents [1] [2]	$ 220,563	$ 81,926
Short-term marketable securities [2]	10,938	41,306
Restricted cash	3,239	3,239
Total cash, cash equivalents, short-term marketable securities, and restricted cash	$ 234,740	$ 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 March 31, 2022, we invested $10.9 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 March 31, 2022, our net contract assets – commissions receivable balance was $831.2 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 $2.1 million allowance for credit losses for our commissions receivable balance as of March 31, 2022.

Our total contract assets and accounts receivable as of March 31, 2022 and December 31, 2021 are summarized as follows (in thousands):

	March 31, 2022	December 31, 2021
Contract assets – commissions receivable – current	$ 204,237	$ 254,821
Contract assets – commissions receivable – non-current	626,941	653,441
Accounts receivable	1,978	5,750
Total contract assets and accounts receivable	$ 833,156	$ 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 accounting officer, evaluated the effectiveness of our disclosure controls and procedures as defined in Rule 13a-15(e) under the Securities Exchange Act of 1934, as amended, 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 accounting 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 three months ended March 31, 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 accounting 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 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 e-commerce 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 websites that provide quote information or the opportunity to purchase health insurance 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 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, or 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, or CMS, 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. We experienced an increased plan termination rate in our Medicare membership in 2020 and 2021 above historical levels prior to 2020. While we have implemented measures to improve enrollment quality and member retention, 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. For example, our Medicare plan related products' LTVs have been negatively impacted by increased plan termination rates. While we have recently placed a stronger operational focus on 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. 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. For example, 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.

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 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, we currently operate with a combination of remote and in-office work in the United States, although our employees predominantly work remotely, and have implemented new business protocols for employees who have resumed work in our offices. Any safety measures required by local or state governments or otherwise imposed by us, such as vaccination or mask mandates, could increase our turnover and make recruiting more difficult. When we have more employees who have returned to in-office work, we may implement additional safety measures for our employees. A potential COVID-19 infection of any of our employees could adversely impact our operations, including resulting in the sudden closure of any of our offices. Our business operations may be disrupted if key personnel or significant portions of our employees are unable to work effectively, especially if such disruption occurs during or in our preparation for the Medicare annual enrollment period. We have had to adjust our business operations, including onboarding and training new health insurance agents remotely. The prevalence of remote work could cause operational difficulties, reduce the effectiveness of our agents in selling health insurance 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 business operations and recruitment efforts could 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. Our product development initiatives could also be negatively impacted by our current combination of remote and in-office work and could be further impacted by potential extended office closures in the future.

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. The impact of COVID-19 to our Individual, Family and Small Business segment could be impacted by potential increases in unemployment rates, 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. For example, we appointed a new chief executive officer and new chief financial officer in November and September 2021, respectively, after the departure of their predecessors. Further, our former chief revenue officer's employment terminated in January 2022 and we recently appointed an interim chief revenue officer. We also appointed a new chief operating officer and chief transformation officer in March 2022. 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 investments, including our growth strategy 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. 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 business strategy, our business, operating results and financial condition would be harmed.

Seasonality may cause fluctuations in our financial results.

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, where 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 to a much more significant degree, 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 have been lower than our expectations since the third quarter of 2021. Our increased focus on enrollment quality that began in the third quarter of 2021 has negatively impacted the conversion rates of our health insurance agents. 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 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.

If we are not successful in cost-effectively converting visitors to our website and customers who call into our call centers into members for whom we receive commissions, our business and operating results would be harmed.

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, the COVID-19 pandemic, consumers' ability or willingness to pay for health insurance, adverse weather conditions or natural disasters, 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 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 in the future have 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, Bing and Yahoo!, 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. 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 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 a submitted health insurance application basis and, if they are licensed to sell health insurance, 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, and the contractual terms we negotiate with our marketing partners, including the marketing fees we agree to pay. 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. CMS proposed rules in January 2022 which, if adopted, would require us and our marketing partners to implement additional verbal and written disclaimers. These proposed rules would also require us to implement additional oversight measures over our marketing partners, beginning with the 2022 annual enrollment period for enrollments effective as of January 1, 2023 and later. If these proposed rules are adopted, 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 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.

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. For example, in the past, our estimated membership has been higher than our actual membership, because we experienced increased membership cancellation compared to the historical cancellation rates we used to estimate our membership. We were not able to observe the increased membership cancellations that occurred during the first quarter of 2020 until after we reported our estimated membership for the period. Various circumstances, including market-related factors such as changes in timing of enrollment periods 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.

Our carrier advertising and sponsorship program may not be successful.

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 unclear, 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, or FFM, which runs all or part of the health insurance exchange in 33 states, using a third-party partnership. 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. 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.

There are many risks associated with our operations in China.

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 the Internet to communicate with our subsidiary in China. Our business would be harmed if our ability to communicate over the Internet 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. The cybersecurity law adopted on June 1, 2017, along with its implementing regulations, applies to the establishment, operation, maintenance and usage of networks within China and the supervision and management of cybersecurity. Under the law, network operators are required to comply with certain tiered security obligations based on the networks' relative impact on national security, social order, public interest and individuals' privacy rights. Pursuant to the draft regulations, we

may be required to perform self-assessments, obtain third party certifications, report cybersecurity incidents and make filings with public security authorities. We could also be subject to security inspections and evaluations by public security authorities and be restricted to use only network products and services that meet certain standards based on the level of risk applicable to us. In addition, a new data security law became effective on September 1, 2021. The new data security law 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 both the cybersecurity law and 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 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 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 sudden 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 from China to our offices in the United States 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 additional 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 government, 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 some of our marketing material. We must receive these approvals in order for us 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 determine 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 and our agents take, including our marketing material 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.

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 healthcare 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 healthcare reform efforts and measures may expand the role of government-sponsored coverage, including single payer or so called “Medicare-for-All” proposals, 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 healthcare 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 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 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. The Biden administration has also indicated that it is in support of changes to the Affordable Care Act. It is difficult to predict what changes the Biden administration 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 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. Our business is also subject to emerging privacy laws being passed at the state level that create unique compliance challenges.

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. As a result, we are subject to various state and federal laws and contractual requirements regarding the access, use and disclosure of personal information. We also hold a significant amount of personal information relating to our current and former employees. 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. 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.

We may be required to expend significant amounts and other resources to protect against privacy and security breaches or to mitigate and remediate problems caused by privacy or 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, 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. In the event that additional data privacy or 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. For instance, health insurance carriers may require us to be compliant with additional security standards in order to accept credit card information from consumers or require us to comply with additional privacy and security standards to do business with us at all. Compliance with privacy and 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 credit card 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. We have experienced an increased rate of complaints filed directly with CMS from Medicare beneficiaries enrolled by us and have taken actions to address the quality of our enrollments and to improve our customer experience. If the actions we take do not effectively 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, e-mail service providers and others attempt to block the transmission of unsolicited email, commonly known as "spam." Many Internet and e-mail service providers have relationships with organizations whose purpose it is to detect and notify the Internet and e-mail service providers of entities that the organization believes is sending unsolicited e-mail. If an Internet or e-mail 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, or 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 to make certain telephone calls to consumers without prior express consent. We have policies in place to comply with the TCPA and other telemarketing laws. However, we have 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. If we are unable to communicate effectively by email or telephone with our members and potential members as a result of legislation, 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 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 and other lenders, or the Term Loan Credit Agreement, which provided us with $70 million in term loans. In connection with entering into the Term Loan 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 Term Loan Credit Agreement contains certain mandatory prepayment triggers and imposes certain covenants and restrictions on our business and our ability to obtain additional financing.

The Term Loan 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 Term Loan 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 Term Loan 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 Term Loan 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 Term Loan Credit Agreement. If we are unable to generate sufficient cash flow or otherwise obtain the funds necessary to make required payments under the Term Loan Credit Agreement, or if we fail to comply with the requirements of our indebtedness, we could default under our Term Loan Credit Agreement. Any default that is not waived could result in the acceleration of the obligations under the Term Loan 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 Term Loan Credit Agreement, which includes substantially all of our assets. Any such default could materially adversely affect our liquidity and financial condition.

Even if we comply with all of the applicable covenants, the restrictions on the conduct of our business 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 Term Loan 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.

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 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 - Transformation Initiatives. 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 Term Loan Credit Agreement and our investment agreement with Echelon Health SPV, LP, or 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, 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, or 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.

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 March 31, 2022, the closing price of our common stock fluctuated from $9.79 to $27.44 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;
- 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 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 provides that the federal district courts will be the exclusive forum for resolving any complaint asserting a cause of action arising under 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 DGCL, 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 Exchange Act 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		Credit Agreement, dated February 28, 2022, by and among eHealth, Inc., Blue Torch Finance LLC and the other lenders identified therein.	Current Report on Form 8-K (File No. 001-33071)	February 28, 2022
10.2		Amended and Restated 2021 Inducement Plan	Current Report on Form 8-K (File No. 001-33071)	March 18, 2022
10.3	†*	Severance Agreement, dated February 22, 2022, between Roman Rariy and eHealth, Inc.		
10.4	†*	Sign-on and Retention Bonus Repayment Agreement, dated February 22, 2022, between Roman Rariy and eHealth, Inc.		
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 March 31, 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: May 6, 2022

/s/ Francis Soistman

Francis Soistman
Chief Executive Officer
(Principal Executive Officer)

Date: May 6, 2022

/s/ Christine Janofsky

Christine Janofsky
Chief Financial Officer
(Principal Financial and Accounting Officer)

EHEALTH, INC.
SEVERANCE AGREEMENT

This Severance Agreement (the "***Agreement***") is by and between **eHealth, Inc**. (together with its subsidiary, eHealthInsurance Services, Inc., the "***Company***") and Roman Rariy ("***Executive***").

1. At-Will Employment. Executive and the Company agree that Executive's employment with Company constitutes "at-will" employment. Executive and the Company acknowledge that this employment relationship may be terminated at any time, upon written notice to the other party, with or without Cause or Good Reason (as each such term is defined in Section 4 below), at the option either of the Company or Executive. However, as described in this Agreement, Executive may be entitled to severance benefits depending upon the circumstances of Executive's termination of employment.

2. Severance Benefits.

(a) Involuntary Termination Other than for Cause or Voluntary Termination for Good Reason. If (i) Executive terminates his employment with the Company (or any parent or subsidiary of the Company) for "Good Reason" (as defined herein), or (ii) the Company (or any parent or subsidiary of the Company) terminates Executive's employment for other than "Cause" (as defined herein), and Executive signs and does not revoke a standard release of claims with the Company in a form substantially similar to that attached hereto as **Exhibit A** (the "***Release***"), then Executive shall receive the following severance benefits from the Company:

(i) ***Severance Payment***. Executive shall receive a single lump-sum cash severance payment (less applicable withholding taxes) in an amount equal to twelve (12) months of Executive's then current annual base salary.

(ii) ***COBRA***. Subject to Executive timely electing continuation coverage under Title X of the Consolidated Budget Reconciliation Act of 1985 ("COBRA"), Executive shall receive one-hundred percent (100%) Company-paid group health, dental and vision coverage (the "***Company-Paid Coverage***"). If such coverage included Executive's dependents immediately prior to the termination, such dependents shall also be covered at Company expense. Company-Paid Coverage shall continue until the earlier of (i) twelve (12) months following the date of termination, or (ii) the date upon which Executive and his dependents become covered under another employer's group health, dental and vision plans that provide Executive and his dependents with comparable benefits and levels of coverage (such earlier date, the "***COBRA Termination Date***"). Notwithstanding the foregoing, if the Company determines, in its sole discretion, that it cannot provide the Company-Paid Coverage without a substantial risk of violating applicable law (including, without limitation, Section 2716 of the Public Health Service Act), the Company shall in lieu thereof provide to Executive a taxable monthly payment in an amount equal to the monthly COBRA premium that Executive would be required to pay to continue Executive's (and Executive's dependents', as applicable) group health, dental and vision coverage in effect on

the date of Executive's employment termination (which amount shall be based on the premium for the first month of COBRA coverage), which payments shall be made to Executive regardless of whether Executive elects COBRA continuation coverage and shall end on the COBRA Termination Date.

(b) Involuntary Termination Other than for Cause or Voluntary Termination for Good Reason During the One-Year Period Following a Change in Control. If (i) Executive terminates his employment with the Company (or any parent or subsidiary of the Company) for "Good Reason" (as defined herein), or (ii) the Company (or any parent or subsidiary of the Company) terminates Executive's employment for other than "Cause" (as defined herein) during the one-year period following a Change in Control, and Executive signs and does not revoke the Release, then in addition to the severance benefits provided in Section 2(a) above, Executive shall receive the following severance benefits from the Company:

(i) ***Bonus Payment***. Executive shall receive a single lump-sum cash payment (less applicable withholding taxes) in an amount equal to one hundred percent (100%) of Executive's then current target annual bonus.

(ii) ***Equity Award Vesting.*** One hundred percent (100%) of Executive's then outstanding and unvested time-based equity awards (whether stock options, stock appreciation rights, shares of restricted stock, restricted stock units or otherwise) shall become vested and shall otherwise remain subject to the terms and conditions of the applicable equity incentive plan and the award agreements pursuant to which the time-based equity awards were granted. Executive's then outstanding and unvested performance-based equity awards, shall vest in accordance with the terms of the applicable equity incentive plan and the award agreements pursuant to which the performance-based equity awards were granted and not pursuant to the terms of this Agreement. For the avoidance of doubt, all performance-based equity awards, including those where performance goals have been achieved but which remain subject to time-based vesting, shall not be considered time-based awards under the terms of this Agreement and shall be governed by the applicable incentive plan and the award agreements pursuant to which the performance-based equity awards were granted.

(c) Voluntary Resignation; Termination for Cause; Death or Disability. If Executive's employment with the Company terminates (i) voluntarily by Executive other than for Good Reason (ii) for Cause by the Company, or (iii) due to Executive's death or Disability (as defined hereunder), then Executive shall not be entitled to receive severance or other benefits except for those (if any) as may then be established under the Company's then existing severance and benefits plans and practices or pursuant to other written agreements with the Company.

(d) Exclusive Remedy. The provisions of this Section 2 are intended to be and are Executive's exclusive rights to severance payments and benefits in the event of termination of service. The parties hereto agree that nothing herein is intended to result in duplication of severance or any other benefits.

(e) Code Section 409A.

(i) Any amount paid under this Agreement that satisfies the requirements of the "short-term deferral" rule set forth in Section 1.409A-l(b)(4) of the regulations issued under Section 409A of the Code (the "***Treasury Regulations***") shall not constitute Deferred Compensation Separation Benefits for purposes of Section 2(e)(ii) below, and consequently shall be paid to Executive promptly following termination as otherwise required by this Agreement.

(ii) Notwithstanding anything to the contrary in this Agreement, if Executive is a "specified employee" within the meaning of Section 409A of the Code, and the final regulations and any guidance promulgated thereunder ("***Section 409A***") at the time of Executive's separation from service (as such term is defined in Section 409A), then the cash severance benefits payable to Executive under this Agreement along with any other severance payments or separation benefits that may be considered deferred compensation under Section 409A (together, the "***Deferred Compensation Separation Benefits***") that are otherwise due to Executive on or within the six (6) month period following Executive's separation from service shall accrue during such six (6) month period and shall become payable in a lump sum payment on the date six (6) months and one (1) day following the date of Executive's separation from service. All subsequent payments, if any, shall be payable in accordance with the payment schedule applicable to each payment or benefit. Notwithstanding anything herein to the contrary, if Executive dies following his separation from service but prior to the six (6) month anniversary of his date of separation from service, then any payments delayed in accordance with this Section shall be payable in a lump sum as soon as administratively practicable after the date of Executive's death and all other Deferred Compensation Separation Benefits shall be payable in accordance with the payment schedule applicable to each payment or benefit.

(iii) Any amount paid under this Agreement that qualifies as a payment made as a result of an involuntary separation from service pursuant to Section 1.409A-l(b)(9)(iii) of the Treasury Regulations that does not exceed the Section 409A Limit (as defined below) shall not constitute Deferred Compensation Separation Benefits for purposes of Section 2(e)(ii) above. For purposes of this Section 2(e), "***Section 409A Limit***" will mean the lesser of two (2) times: (i) Executive's annualized compensation based upon the annual rate of pay paid to Executive during the Company's taxable year preceding the Company's taxable year of Executive's termination of employment as determined under Treasury Regulation 1.409A-l(b)(9)(iii)(A)(l); or (ii) the maximum amount that may be taken into account under a qualified plan pursuant to Section 401(a)(17) of the Code for the year in which Executive's employment is terminated.

(iv) It is the intent of this Agreement to comply with the requirements of Section 409A so that none of the severance payments and benefits to be provided hereunder shall be subject to the additional tax imposed under Section 409A, and any ambiguities herein shall be interpreted to so comply. The Company and Executive agree to work together in good faith to consider amendments to this Agreement and to take such reasonable actions which are necessary, appropriate or desirable to avoid imposition of any additional tax or income recognition under Section 409A prior to actual payment to Executive.

3.

(v) Notwithstanding any other provisions of this Agreement, Executive's receipt of severance payments and benefits under this Agreement is conditioned upon Executive signing and not revoking the Release and subject to the Release becoming effective within sixty (60) days following Executive's termination of employment (the "***Release Period***"). No severance will be paid or provided unless the Release becomes effective during the Release Period. Any severance payments to which Executive is entitled under this Agreement shall be paid by the Company to Executive in cash and in full arrears on the date on which the Release becomes effective or such later date as is required to comply with Section 409A; provided however, that if the Release Period straddles two calendar years, the severance payments to which Executive is entitled under this Agreement shall be paid on the latest of (A) the date on which the Release becomes effective, (B) the first business day of the calendar year following the year in which Executive terminates employment with the Company or (C) such later date as is required to comply with Section 409A.

(vi) With respect to reimbursements or in-kind benefits provided to Executive hereunder (or otherwise) that are not exempt from Section 409A, the following rules shall apply: (A) the amount of expenses eligible for reimbursement, or in-kind benefits provided, during any one of Executive's taxable years shall not affect the expenses eligible for reimbursement, or in-kind benefit to be provided in any other taxable year, (B) in the case of any reimbursements of eligible expenses, reimbursement shall be made on or before the last day of Executive's taxable year following the taxable year in which the expense was incurred and (C) the right to reimbursement or in-kind benefits shall not be subject to liquidation or exchange for another benefit.

3. Golden Parachute Excise Tax Best Results. If any payment or benefit Executive would receive pursuant to this Agreement or otherwise ("***Payment***") would (i) constitute a "parachute payment" within the meaning of Section 280G of the Internal Revenue Code of 1986, as amended (the "***Code***"), and (ii) but for this sentence, be subject to the excise tax imposed by Section 4999 of the Code (the "***Excise Tax***"), then such Payment shall be reduced to the Reduced Amount. The "***Reduced Amount***" shall be either (x) the largest portion of the Payment that would result in no portion of the Payment being subject to the Excise Tax or (y) the largest portion, up to and including the total, of the Payment, whichever amount, after taking into account all applicable federal, state and local employment taxes, income taxes, and the Excise Tax (all computed at the highest applicable marginal rate), results in Executive's receipt, on an after-tax basis, of the greater amount of the Payment notwithstanding that all or some portion of the Payment may be subject to the Excise Tax. If a reduction in payments or benefits constituting "parachute payments" is necessary so that the Payment equals the Reduced Amount, reduction shall occur in the following order: (A) cash payments shall be reduced first and in reverse chronological order such that the cash payment owed on the latest date following the occurrence of the event triggering such excise tax will be the first cash payment to be reduced; (B) accelerated vesting of stock awards shall be cancelled/reduced next and in the reverse order of the date of grant for such stock awards (i.e., the vesting of the most recently granted stock awards will be reduced first); and (C) employee benefits shall be reduced last and in reverse chronological order such that the benefit owed on the latest date following the occurrence of the event triggering such excise tax will be the first benefit to be reduced.

The Company shall appoint a nationally recognized accounting firm or consulting firm to make the determinations required hereunder and perform the foregoing calculations. The Company shall bear all expenses with respect to the determinations by such accounting or consulting firm required to be made hereunder.

The accounting or consulting firm engaged to make the determinations hereunder shall provide its calculations, together with detailed supporting documentation, to the Company and Executive within fifteen (15) calendar days after the date on which right to a Payment is triggered (if requested at that time by the Company or Executive) or such other time as requested by the Company or Executive. If the accounting or consulting firm determines that no Excise Tax is payable with respect to a Payment, either before or after the application of the Reduced Amount, it shall furnish the Company and Executive with an opinion reasonably acceptable to Executive that no Excise Tax will be imposed with respect to such Payment. Any good faith determinations of the accounting or consulting firm made hereunder shall be final, binding and conclusive upon the Company and Executive.

4. Definition of Terms. The following terms referred to in this Agreement shall have the following meanings:

(a) Cause. "***Cause***" shall mean (i) Executive's commission of any act of fraud, embezzlement or dishonesty, (ii) Executive's conviction of, or plea of *nolo contendere* to, a felony under the laws of the United States or any state thereof, (iii) Executive's continued failure to perform lawfully assigned duties for 30 days after receiving written notification from the Company, (iv) Executive's unauthorized use or disclosure of confidential information or trade secrets of the Company, or (v) any other intentional misconduct by Executive that adversely affects the business of the Company in a material manner.

(b) Change in Control. "***Change in Control***" means the occurrence of any of the following, in one or a series of related transactions:

(i) Any "person" (as such term is used in Sections 13(d) and 14(d) of the Securities Exchange Act of 1934, as amended) becomes the "beneficial owner" (as defined in Rule 13d-3 under said Act), directly or indirectly, of securities of the Company representing fifty percent (50%) or more of the total voting power represented by the Company's then outstanding voting securities; or

(ii) The consummation of a merger or consolidation of the Company with any other corporation, other than a merger or consolidation which would result in the voting securities of the Company outstanding immediately prior thereto continuing to represent (either by remaining outstanding or by being converted into voting securities of the surviving entity) at least fifty percent (50%) of the total voting power represented by the voting securities of the Company or such surviving entity outstanding immediately after such merger or consolidation; or

(iii) The consummation of the sale, lease or other disposition by the Company of all or substantially all the Company's assets.

(c) Disability. "***Disability***" means Executive (i) 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 can be expected to last for a continuous period of not less than twelve (12) months, or (ii) is, by reason of any medically determinable physical or mental impairment which can be expected to last for a continuous period of not less than twelve (12) months, receiving income replacement benefits for a period of not less than three (3) months under an accident and health plan covering Company employees,

(d) Good Reason. "***Good Reason***" means that Executive resigns his employment within 120 days after any of the following is undertaken by the Company (or its acquirer) without Executive's express written consent: (i) a reduction in Executive's title, (ii) a material reduction of Executive's duties, authority or responsibilities; (ii) any material reduction of Executive's base salary or potential target bonus (other than a proportionate reduction in Executive's base salary or potential bonus that affects all senior management of the Company); or (iii) a material change in the geographic location at which Executive must perform services; provided that in no instance will the relocation of Executive to a facility or location of thirty-five (35) miles or less from Executive's then current office location (or one of Executive's then-current office locations, if applicable) be deemed material for purposes of this Agreement; provided, however, that Good Reason shall not exist unless Executive has provided written notice to the Board of Directors of the purported grounds for the Good Reason within 90 days of its initial existence and the Company has been provided at least 30 days to remedy the condition.

5. Successors.

(a) The Company's Successors. Any successor to the Company (whether direct or indirect and whether by purchase, merger, consolidation, liquidation or otherwise) to all or substantially all of the Company's business and/or assets shall assume the obligations under this Agreement and agree expressly to perform the obligations under this Agreement in the same manner and to the same extent as the Company would be required to perform such obligations in the absence of a succession. For all purposes under this Agreement, the term "Company" shall include any successor to the Company's business and/or assets which executes and delivers the assumption agreement described in this Section 5(a) or which becomes bound by the terms of this Agreement by operation of law.

(b) Executive's Successors. The terms of this Agreement and all rights of Executive hereunder shall inure to the benefit of, and be enforceable by, Executive's personal or legal representatives, executors, administrators, successors, heirs, distributees, devisees and legatees.

6. Notice. All notices and other communications required or permitted hereunder shall be in writing, shall be effective when given, and shall in any event be deemed to be given upon receipt or, if earlier, (a) five (5) days after deposit with the U.S. Postal Service or other applicable postal service, if delivered by first class mail, postage prepaid, (b) upon delivery, if delivered by hand, (c) one (1) business day after the business day of deposit with Federal Express or similar overnight courier, freight prepaid, (d) one (1) business day after the business day of facsimile transmission, if delivered by facsimile transmission with copy by first class mail, postage prepaid, (e) upon transmission, if sent by email, and shall be addressed (i) if to Executive, at his or her last known residential

address or email address and (ii) if to the Company, at the address of its principal corporate offices (attention: Secretary), or in any such case at such other address as a party may designate by ten (10) days' advance written notice to the other party pursuant to the provisions above.

7. Notice of Termination. Any termination by the Company for Cause or by Executive for Good Reason or as a result of a voluntary resignation shall be communicated by a notice of termination to the other party hereto given in accordance with Section 6 of this Agreement. Such notice shall indicate the specific termination provision in this Agreement relied upon, shall set forth in reasonable detail the facts and circumstances claimed to provide a basis for termination under the provision so indicated, and shall specify the termination date (which shall be not more than thirty (30) days after the giving of such notice). The failure by Executive to include in the notice any fact or circumstance which contributes to a showing of Good Reason shall not waive any right of Executive hereunder or preclude Executive from asserting such fact or circumstance in enforcing his or her rights hereunder.

8. Miscellaneous Provisions.

(a) No Duty to Mitigate. Executive shall not be required to mitigate the amount of any payment contemplated by this Agreement, nor shall any such payment be reduced by any earnings that Executive may receive from any other source.

(b) Waiver. No provision of this Agreement shall be modified, waived or discharged unless the modification, waiver or discharge is agreed to in writing and signed by Executive and by an authorized officer of the Company (other than Executive). No waiver by either party of any breach of, or of compliance with, any condition or provision of this Agreement by the other party shall be considered a waiver of any other condition or provision or of the same condition or provision at another time.

(c) Headings. All captions and section headings used in this Agreement are for convenient reference only and do not form a part of this Agreement.

(d) Entire Agreement. This Agreement represents the entire agreement between Executive and the Company regarding Executive's severance agreement with the Company, and supersede in their entirety all prior representations, understandings, undertakings or agreements (whether oral or written and whether expressed or implied), of the parties with respect to the subject matter hereof.

(e) Choice of Law. The validity, interpretation, construction and performance of this Agreement shall be governed by the laws of the State of California (with the exception of its conflict of laws provisions).

(f) Severability. The invalidity or unenforceability of any provision or provisions of this Agreement shall not affect the validity or enforceability of any other provision hereof, which shall remain in full force and effect.

(g) Withholding. All payments made pursuant to this Agreement will be subject to withholding of applicable income and employment taxes.

(h) Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed an original, but all of which together will constitute one and the same instrument.

In Witness Whereof, each of the parties has executed this amended and restated Agreement, in the case of the Company by its duly authorized officer, as of the last date signed below.

COMPANY

eHealth, Inc.

By: /s/ Fran Soistman
Fran Soistman

Title: Chief Executive Officer

Date: Feb 22, 2022

EXECUTIVE

By: /s/ Roman Rariy
Roman Rariy
Date: Feb 22, 2022

Exhibit A

eHealth, Inc.
Release of Claims

This Release of Claims ("***Agreement***") is made by and between eHealth, Inc. (the "***Company***"), and _____ ("***Executive***").

Whereas, Executive has agreed to enter into a release of claims in favor of the Company upon certain events specified in the Severance Agreement by and between Company and Executive (the "***Severance Agreement***").

Now Therefore, in consideration of the mutual promises made herein, the Parties hereby agree as follows:

1. Termination. Executive's employment from the Company terminated on _____.

2. Confidential Information. Executive shall continue to maintain the confidentiality of all confidential and proprietary information of the Company and shall continue to comply with the terms and conditions of the Proprietary Information and Inventions Agreement between Executive and the Company. Executive shall return all the Company property and confidential and proprietary information in his possession to the Company on the Effective Date of this Agreement.

3. Payment of Salary. Executive acknowledges and represents that the Company has paid all salary, wages, bonuses, accrued vacation, commissions and any and all other benefits due to Executive.

4. Release of Claims. Except as set forth in the last paragraph of this Section 4, Executive agrees that the foregoing consideration represents settlement in full of all outstanding obligations owed to Executive by the Company. Executive, on behalf of himself, and his respective heirs, family members, executors and assigns, hereby fully and forever releases the Company and its past, present and future officers, agents, directors, employees, investors, shareholders, administrators, affiliates, divisions, subsidiaries, parents, predecessor and successor corporations, and assigns, from, and agrees not to sue or otherwise institute or cause to be instituted any legal or administrative proceedings concerning any claim, duty, obligation or cause of action relating to any matters of any kind, whether presently known or unknown, suspected or unsuspected, that he may possess arising from any omissions, acts or facts that have occurred up until and including the Effective Date of this Agreement including, without limitation,

(a) any and all claims relating to or arising from Executive's employment relationship with the Company and the termination of that relationship;

(b) any and all claims relating to, or arising from, Executive's right to purchase, or actual purchase of shares of stock of the Company, including, without limitation, any claims for fraud, misrepresentation, breach of fiduciary duty, breach of

duty under applicable state corporate law, and securities fraud under any state or federal law;

(c) any and all claims for wrongful discharge of employment; termination in violation of public policy; discrimination; breach of contract, both express and implied; breach of a covenant of good faith and fair dealing, both express and implied; promissory estoppel; negligent or intentional infliction of emotional distress; negligent or intentional misrepresentation; negligent or intentional interference with contract or prospective economic advantage; unfair business practices; defamation; libel; slander; negligence; personal injury; assault; battery; invasion of privacy; false imprisonment; and conversion;

(d) any and all claims for violation of any federal, state or municipal statute, including, but not limited to, Title VII of the Civil Rights Act of 1964, the Civil Rights Act of 1991, the Age Discrimination in Employment Act of 1967, the Americans with Disabilities Act of 1990, the Fair Labor Standards Act, Executive Retirement Income Security Act of 1974, The Worker Adjustment and Retraining Notification Act, the California Fair Employment and Housing Act, and Labor Code section 201, *et seq*. and section 970, *et seq*. and all amendments to each such Act as well as the regulations issued thereunder;

(e) any and all claims for violation of the federal, or any state, constitution;

(f) any and all claims arising out of any other laws and regulations relating to employment or employment discrimination; and

(g) any and all claims for attorneys' fees and costs.

Executive agrees that the release set forth in this section shall be and remain in effect in all respects as a complete general release as to the matters released. This release does not extend to any severance obligations due Executive under the Severance Agreement or to any vested rights to benefits Executive has under any employee benefit plans of the Company. Nothing in this Agreement waives Executive's rights to indemnification or any payments under any fiduciary or directors & officers insurance policy, if any, provided by any act or agreement of the Company, state or federal law or policy of insurance.

5. Acknowledgment of Waiver of Claims under ADEA. Executive acknowledges that he is waiving and releasing any rights he may have under the Age Discrimination in Employment Act of 1967 ("***ADEA***") and that this waiver and release is knowing and voluntary. Executive and the Company agree that this waiver and release does not apply to any rights or claims that may arise under the ADEA after the Effective Date of this Agreement, Executive acknowledges that the consideration given for this waiver and release Agreement is in addition to anything of value to which Executive was already entitled. Executive further acknowledges that he has been advised by this writing that (a) he should consult with an attorney prior to executing this Agreement; (b) he has at least twenty-one (21) days within which to consider this Agreement; (c) he has seven (7) days following the execution of this Agreement by the parties to revoke the Agreement; (d) this Agreement shall not be effective until the revocation period has expired; and (e) nothing in this Agreement prevents or precludes Executive from

challenging or seeking a determination in good faith of the validity of this waiver under the ADEA, nor does it impose any condition precedent, penalties or costs for doing so, unless specifically authorized by federal law. Any revocation should be in writing and delivered to the Chief People Officer at the Company by close of business on the seventh day from the date that Executive signs this Agreement.

6. Civil Code Section 1542. Executive represents that he is not aware of any claims against the Company other than the claims that are released by this Agreement. Executive acknowledges that he has been advised by legal counsel and is familiar with the provisions of California Civil Code 1542, below, which provides as follows:

> **A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS WHICH THE CREDITOR DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM OR HER MUST HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR.**

Executive, being aware of said code section, agrees to expressly waive any rights he may have thereunder, as well as under any statute or common law principles of similar effect.

7. No Pending or Future Lawsuits. Executive represents that he has no lawsuits, claims, or actions pending in his name, or on behalf of any other person or entity, against the Company or any other person or entity referred to herein. Executive also represents that he does not intend to bring any claims on his own behalf or on behalf of any other person or entity against the Company or any other person or entity referred to herein.

8. Application for Employment. Executive understands and agrees that, as a condition of this Agreement, he shall not be entitled to any employment with the Company, its subsidiaries, or any successor, and he hereby waives any right, or alleged right, of employment or re-employment with the Company.

9. No Cooperation. Executive agrees that he will not counsel or assist any attorneys or their clients in the presentation or prosecution of any disputes, differences, grievances, claims, charges, or complaints by any third party against the Company and/or any officer, director, employee, agent, representative, shareholder or attorney of the Company, unless under a subpoena or other court order to do so.

10. No Admission of Liability. No action taken by the Company, either previously or in connection with this Agreement shall be deemed or construed to be (a) an admission of the truth or falsity of any claims heretofore made or (b) an acknowledgment or admission by the Company of any fault or liability whatsoever to Executive or to any third party.

11. Costs. The Parties shall each bear their own costs, expert fees, attorneys' fees and other fees incurred in connection with this Agreement.

12. Authority. Executive represents and warrants that he has the capacity to act on his own behalf and on behalf of all who might claim through him to bind them to the terms and conditions of this Agreement.

13. **No Representations**. Executive represents that he has had the opportunity to consult with an attorney, and has carefully read and understands the scope and effect of the provisions of this Agreement. Neither party has relied upon any representations or statements made by the other party hereto which are not specifically set forth in this Agreement.

14. **Severability**. In the event that any provision hereof becomes or is declared by a court of competent jurisdiction to be illegal, unenforceable or void, this Agreement shall continue in full force and effect without said provision.

15. **Arbitration**. THE PARTIES AGREE THAT ANY AND ALL DISPUTES ARISING OUT OF THE TERMS OF THIS AGREEMENT, THEIR INTERPRETATION, AND ANY OF THE MATTERS HEREIN RELEASED, SHALL BE SUBJECT TO ARBITRATION IN SANTA CLARA COUNTY, BEFORE JUDICIAL ARBITRATION & MEDIATION SERVICES, INC. ("***JAMS***"), PURSUANT TO ITS EMPLOYMENT ARBITRATION RULES & PROCEDURES ("***JAMS RULES***"). THE ARBITRATOR MAY GRANT INJUNCTIONS AND OTHER RELIEF IN SUCH DISPUTES. THE ARBITRATOR SHALL ADMINISTER AND CONDUCT ANY ARBITRATION IN ACCORDANCE WITH CALIFORNIA LAW, INCLUDING THE CALIFORNIA CODE OF CIVIL PROCEDURE, AND THE ARBITRATOR SHALL APPLY SUBSTANTIVE AND PROCEDURAL CALIFORNIA LAW TO ANY DISPUTE OR CLAIM, WITHOUT REFERENCE TO ANY CONFLICT-OF-LAW PROVISIONS OF ANY JURISDICTION. TO THE EXTENT THAT THE JAMS RULES CONFLICT WITH CALIFORNIA LAW, CALIFORNIA LAW SHALL TAKE PRECEDENCE. THE DECISION OF THE ARBITRATOR SHALL BE FINAL, CONCLUSIVE, AND BINDING ON THE PARTIES TO THE ARBITRATION. THE PARTIES AGREE THAT THE PREVAILING PARTY IN ANY ARBITRATION SHALL BE ENTITLED TO INJUNCTIVE RELIEF IN ANY COURT OF COMPETENT JURISDICTION TO ENFORCE THE ARBITRATION AWARD. THE PARTIES TO THE ARBITRATION SHALL EACH PAY AN EQUAL SHARE OF THE COSTS AND EXPENSES OF SUCH ARBITRATION, AND EACH PARTY SHALL SEPARATELY PAY FOR ITS RESPECTIVE COUNSEL FEES AND EXPENSES; PROVIDED, HOWEVER, THAT THE ARBITRATOR SHALL AWARD ATTORNEYS' FEES AND COSTS TO THE PREVAILING PARTY, EXCEPT AS PROHIBITED BY LAW. THE PARTIES HEREBY AGREE TO WAIVE THEIR RIGHT TO HAVE ANY DISPUTE BETWEEN THEM RESOLVED IN A COURT OF LAW BY A JUDGE OR JURY. NOTWITHSTANDING THE FOREGOING, THIS SECTION WILL NOT PREVENT EITHER PARTY FROM SEEKING INJUNCTIVE RELIEF (OR ANY OTHER PROVISIONAL REMEDY) FROM ANY COURT HAVING JURISDICTION OVER THE PARTIES AND THE SUBJECT MATTER OF THEIR DISPUTE RELATING TO THIS AGREEMENT AND THE AGREEMENTS INCORPORATED HEREIN BY REFERENCE. SHOULD ANY PART OF THE ARBITRATION AGREEMENT CONTAINED IN THIS PARAGRAPH CONFLICT WITH ANY OTHER ARBITRATION AGREEMENT BETWEEN THE PARTIES, THE PARTIES AGREE THAT THIS ARBITRATION AGREEMENT SHALL GOVERN.

16. **Entire Agreement**. This Agreement, along with the Severance Agreement, the Proprietary Information and Inventions Agreement, and Executive's written equity compensation agreements with the Company, represents the entire

agreement and understanding between the Company and Executive concerning Executive's separation from the Company.

17. No Oral Modification. This Agreement may only be amended in writing signed by Executive and the Chief Executive Officer of the Company.

18. Governing Law. This Agreement shall be governed by the internal substantive laws, but not the choice of law rules, of the State of California.

19. Effective Date. This Agreement is effective eight (8) days after it has been signed by both Parties.

20. Counterparts. This Agreement may be executed in counterparts, and each counterpart shall have the same force and effect as an original and shall constitute an effective, binding agreement on the part of each of the undersigned.

21. Voluntary Execution of Agreement. This Agreement is executed voluntarily and without any duress or undue influence on the part or behalf of the Parties hereto, with the full intent of releasing all claims. The Parties acknowledge that:

(a) They have read this Agreement;

(b) They have had the opportunity of being represented in the preparation, negotiation, and execution of this Agreement by legal counsel of their own choice or that they have voluntarily declined to seek such counsel;

(c) They understand the terms and consequences of this Agreement and of the releases it contains;

(d) They are fully aware of the legal and binding effect of this Agreement.

In Witness Whereof, the Parties have executed this Agreement on the respective dates set forth below.

eHealth, Inc.

Dated: By: __

[name, title]

Dated: ____

[name]

6.

Sign-On & Retention Bonus Repayment Agreement

Dear Roman,

Please review this Sign-On and Retention Bonus (“Bonus”) Repayment Agreement (“Agreement”). This Agreement is made between eHealthInsurance Services, Inc. (the “Company”) and the undersigned individual (“you” or “your”).

If you sign this Agreement, you are eligible to earn a Sign-On & Retention Bonus of $100,000.00, subject to applicable taxes and withholdings. You must remain employed with the Company for one year after the date the Bonus advance is paid to you in order to earn the Bonus in full. If your employment is terminated, either voluntarily by you or for cause by the Company, as determined by the Company in its full and complete discretion, you will not be eligible to earn the full Bonus, as specified below, and must repay the unearned portion of the Bonus advanced to you.

Repayment of Sign-On & Retention Bonus

You agree to repay the Company the portion of the Sign-On & Retention Bonus advanced to you if your employment is terminated either voluntarily by you, or for cause by the Company within one year of the date of the Bonus advance payment. The term "cause" is defined for purposes of this Agreement to mean (a) a commission of any act of fraud, embezzlement or dishonesty, or breach of fiduciary duty, or other willful misconduct in the course of your duties; (b) your being convicted of, or plea of nolo contendere to, a felony, or misdemeanor involving moral turpitude; (c) your failure or refusal to perform Your duties to the Company’s satisfaction after having been warned of any performance deficiencies in writing and having been given an opportunity to correct any such deficiencies; (d) your unauthorized use or disclosure of confidential information, trade secrets, or inside information of the Company; (e) your willful engagement in unfair competition with, or otherwise acting intentionally in a manner materially injurious to the reputation, business, or assets of the Company; or (f) any other serious misconduct or violation of Company policy by you, with any of the above as determined by the Company in its sole discretion. You shall not have any obligation to repay the Bonus advance if your employment with the Company is terminated as the result of a layoff or reduction in force.

The amount of the Bonus you have earned, and the amount of the repayment to the Company by you, shall be determined on the following scale based on the month during which your separation from the Company takes place:

Separation Taking Place During the Months following the Bonus Advance Payment Date Percent of Total Advance Due

- 0 - 6 Months (100%)
- 7 - 9 Months (50%)
- 10-12 Months (25%)
- 12+ Months (0%)

Authorization to Withhold

Should you voluntarily leave the Company or be terminated for cause within one year of the date of the Sign-On & Retention Bonus advance payment, you hereby voluntarily agree to repay to the Company the percentage of the advanced payment as specified in the table above. You understand and agree that you have not earned the full Bonus until you have completed one (1) full year (i.e., twelve (12) complete months) from the date the advance payment was paid to you.

You agree that the law of the state in which you work (“applicable state law”) governs deductions from your final paycheck. By

signing below, you hereby authorize the Company to deduct the repayment amount from any final wages that may be due to you upon termination, to the fullest extent allowed by law. If applicable state law requires other authorization for deduction from a final paycheck, you agree that you will execute such authorization for deduction of the repayment amount from your final wages as otherwise required by law.

If the final wages due you are insufficient to repay the entire repayment amount or if applicable state law does not allow a deduction from final wages under the circumstances present at the time your employment terminates, then you agree to repay the remaining portion of the advanced payment amount to the Company within thirty (30) days of the date your employment terminates.

General: This Agreement constitutes the entire agreement between the parties and supersedes any and all prior written or oral agreements and understandings between the parties regarding the terms of the Bonus. This Agreement may not be extended, changed, or amended unless mutually agreed by both parties in writing.

To agree to the terms of the Agreement, please sign and submit. No Bonus payment will be advanced to you until the signed Agreement is received. If you accept the terms of the Agreement, the advance payment will be paid to you on the first regularly scheduled payday after 30 days of employment, and provided to you in a separate check. You must be employed with the Company on the date the advance payment is made in order to receive the advance payment.

I have read, understood, and agree to the terms above.

/s/ Roman Rariy

Roman Rariy

Feb 22, 2022

Date

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: May 6, 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: May 6, 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 March 31, 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
May 6, 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 March 31, 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)
May 6, 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.