UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549
FORM 10-K

☒ ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2020

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**

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of 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 ☒ 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 has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☒

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

Based on the closing price of the registrant's common stock on the last business day of the registrant's most recently completed second fiscal quarter, which was June 30, 2020, the aggregate market value of its shares (based on a closing price of $98.24 per share) held by non-affiliates was $1.5 billion. Shares of the registrant's common stock held by each executive officer and director and by each entity or person that owned five percent or more of the registrant's outstanding common stock were excluded as such persons may be deemed to be affiliates. This determination of affiliate status is not necessarily a conclusive determination for other purposes.

The number of shares of the registrant's common stock, par value $0.001 per share, outstanding as of February 16, 2021 was 25,932,593 shares.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Definitive Proxy Statement for the 2021 Annual Meeting of Stockholders, which is expected to be filed within 120 days after the Company's fiscal year ended December 31, 2020, are incorporated by reference into Part III of this Annual Report on Form 10-K to the extent stated herein.

EHEALTH, INC.

FORM 10-K

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Summary of Risk Factors

Our business is subject to numerous risks and uncertainties, including those risks discussed at length below. 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 we are not able to successfully retain our existing members and limit health insurance plan termination.
- 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.
- Our business may be harmed if we are not successful in executing on our strategic investments and initiatives, including our growth strategy and retention 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.
- 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 cyberattacks, security breaches or are otherwise unable to safeguard the security and privacy of confidential data, including personal health information, our business will be harmed.
- Our operating results will be impacted by factors that impact our estimate of the constrained lifetime value, or LTV, of commissions per approved member.
- The closing of the financing transaction with the purchaser of our Series A preferred stock is subject to terms and conditions, many of which are outside our control. We may experience delays and difficulties with the closing of the transaction and no assurance can be given that it will close. The failure to close the financing transaction would adversely impact our liquidity and our financial condition.

Forward-Looking Statements

In addition to historical information, this Annual Report on Form 10-K 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, online enrollments and estimated membership; our estimates regarding the constrained lifetime value of commissions and commissions receivable; our expectations relating to revenue, operating costs, cash flows and profitability; our expectations regarding our strategy and investments; 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 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 ability to improve customer engagement and retention; our expectations regarding our ability to hire, retain, train and ensure the productivity of our health insurance agents; 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 online 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 a COVID-19-related or other special enrollment period; changes in laws, regulations and guidelines, including in connection with healthcare reform or with respect to the marketing and sale of Medicare plans; 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; customer concentration; 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; changes in the market for private health insurance; consumer satisfaction of our service; 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, compliance with insurance and other laws and regulations; the outcome of litigation in which we are involved; and 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.

PART I

ITEM 1. BUSINESS

Overview

We are 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 circumstance. 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 purchasing process and to help them obtain the health insurance product that meets 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 over 200 health insurance carriers across all fifty states and the District of Columbia. We strive to be the most trusted partner to the consumer in their life's journey through the health insurance market. We were incorporated in Delaware in November 1997.

Our shift toward the health insurance market for Medicare eligible individuals has enabled us to mitigate the impact of the Patient Protection and Affordable Care Act, or Affordable Care Act, on our business, which among other things, established competing government exchanges that offer non-Medicare, Affordable Care Act-compliant individual and family health insurance plans.

We operate our business in two segments: (1) Medicare, and (2) Individual, Family and Small Business. Our Medicare segment represents the majority of our business and constituted approximately 89% of our revenue in 2020. We derive the majority of our revenues from commission payments paid to us by health insurance carriers related to insurance plans that have been purchased by members who used our services. Our platform and services are free to the consumer, and we are not responsible for the payment of consumer health insurance claims.

Our focus on marketing of Medicare-related health insurance products has enabled our business to benefit from (1) strong demographic trends, with 10,000 people on average turning 65 every day over the next ten years, (2) the increasing proportion of the Medicare eligible population that is choosing commercial insurance solutions rather than obtaining healthcare through the original Medicare program, and (3) the growing consumer demand for online tools to compare and enroll in Medicare related health insurance plans.

In January 2018, we completed our acquisition of Wealth, Health and Life Advisors, LLC, more commonly known as GoMedigap, a technology-enabled provider of Medicare Supplement enrollment services. GoMedigap has built a leading consumer acquisition and engagement platform focused on meeting the Medicare Supplement insurance needs of its individual consumer with a technology-enabled, consumer-centric approach that aligns with our mission and operations. This strategic acquisition enhanced our presence in the Medicare Supplement market, put us in a stronger position with health insurance carriers and strategic partners and helped us to accelerate our Medicare plan enrollment growth.

In January 2019, we entered into an underwriting agreement with RBC Capital Markets, LLC and Credit Suisse Securities (USA) LLC as representatives of the several underwriters to issue and sell a total of 2,760,000 shares of our common stock in a public offering, which total included the exercise in full of the underwriters' option to purchase 360,000 additional shares of common stock, at a price to the public of $48.50 per share, for total net proceeds of $126.2 million, after deducting underwriting discounts, commissions and offering expenses.

In March 2020, we entered into an underwriting agreement to issue and sell a total of 2,070,000 shares of our common stock, which total included the exercise in full of the underwriters' option to purchase 270,000 additional shares of common stock, at a price to the public of $115.00 per share. Net proceeds from the offering

were approximately $228.0 million after deducting underwriting discounts, commissions and expenses of the offering.

On February 17, 2021, we entered into an investment agreement with Echelon Health SPV, LP, an investment vehicle of H.I.G. Capital ("H.I.G."), pursuant to which we have agreed to sell to H.I.G. at closing, 2,250,000 shares of our newly designated Series A preferred stock, par value $0.001 per share, at an aggregate purchase price of $225.0 million (the "Private Placement"). The Private Placement is subject to closing conditions, including, among others: (i) the expiration or early termination of the waiting period (and any extension thereof) applicable to the consummation of the Private Placement under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended; (ii) the confirmation by Nasdaq that it has no objection to the terms and conditions of the Private Placement; and (iii) the determination that consummation of the Private Placement would not cause our outside auditor to no longer be deemed independent under the rules and regulations of the Securities and Exchange Commission or the Public Company Accounting Oversight Board. The parties have agreed to cooperate with each other and use reasonable best efforts to promptly take such actions to cause the closing conditions to be satisfied as promptly as reasonably practicable.

Available Information

We make available free of charge on the Investor Relations page of our web site (*ir.ehealthinsurance.com*) our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, proxy statements, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as soon as reasonably practicable after we file such material with, or furnish it to, the Securities and Exchange Commission, or the SEC. The SEC also maintains an Internet website (*www.sec.gov*) that contains reports, proxy and information statements, and other information regarding issuers that file electronically with the SEC. The information that can be accessed on or through our websites is not part of this Annual Report on Form 10-K.

Our Business Model

Our management evaluates our business performance and manages our operations in the following two segments:

Medicare Segment

Through a combination of demand generation strategies, we actively market, a large selection of Medicare-related health insurance plans, and to a lesser extent, ancillary products such as dental and vision insurance, to our Medicare-eligible consumers. Our Medicare ecommerce platform, which can be accessed through our websites (*www.eHealthMedicare.com*, *www.Medicare.com*, *www.PlanPrescriber.com* and *www.GoMedigap.com*), and telephonic enrollment capabilities enable consumers to research, compare and purchase Medicare-related health insurance plans, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans. To the extent that we assist in the sale of Medicare-related insurance plans as a health insurance agent, either online or telephonically, we generate revenue as a result of commissions we receive from health insurance carriers. In the first effective plan year of a Medicare Advantage and Medicare Part D prescription drug plan, after the health insurance carrier approves the application, we are paid a fixed commission that is prorated for the number of months remaining in the calendar year. Additionally, if the plan is the first Medicare Advantage or Medicare Part D prescription drug plan issued to the member, we may receive a higher commission amount that covers a full twelve-month period, regardless of the month the plan was effective. Beginning with and subsequent to the second plan year, we typically receive fixed, monthly commissions for Medicare Advantage plans and fixed, annual commissions for Medicare Part D prescription drug plans. We are paid commissions for Medicare Advantage and Medicare Part D prescription drug plans for which we are the broker of record, typically until either the plan is cancelled or we otherwise do not remain the agent on the plan. Commission payments we receive for Medicare Supplement plans sold by us typically are a percentage of the premium on the plan and are paid to us monthly until

either the plan is cancelled or we otherwise do not remain the agent on the plan. Medicare Advantage and Medicare Part D prescription drug plan pricing is approved by the Centers for Medicare and Medicaid Services, or CMS, an agency of the United States Department of Health and Human Services, and is not subject to negotiation or discounting by health insurance carriers or our competitors. Similarly, Medicare Supplement plan pricing is set by the health insurance carrier and approved by state regulators and is not subject to negotiation or discounting by health insurance carriers or our competitors.

Individual, Family and Small Business Segment

We actively market individual and family health insurance and small business health insurance plans through our ecommerce platform, which can be accessed through our websites (*www.eHealth.com* and *www.eHealthInsurance.com*), and generate revenue as a result of commissions we receive from health insurance carriers whose health insurance plans are purchased through us, as well as commission override payments we receive for achieving sales volume thresholds or other objectives. In addition, we market a variety of ancillary products, including but not limited to, short-term limited duration, dental and vision plans. These ancillary products are offered to individual and family and small business consumers and are also sold on a standalone basis. The commission payments we receive for individual and family, small business and ancillary health insurance plans are either a percentage of the premium consumers pay for those plans or a flat amount per member per month, and vary depending on the carrier that is offering the plan, the state where the plan was sold and the size of the small business. Commission payments are typically made to us on a monthly basis until either the plan is cancelled or we otherwise do not remain the agent on the plan. Health insurance pricing, which is set by the health insurance carrier and approved by state regulators, is not subject to negotiation or discounting by health insurance carriers or our competitors.

Non-Commission Revenue Sources

Within our two operating segments, we earn commission revenue, as well as non-commission revenue, or other revenue, which includes online sponsorship and advertising, lead referral, and technology licensing revenue.

Online Sponsorship and Advertising. We generate revenue from our sponsorship and advertising program that allows carriers to purchase advertising space for non-Medicare products on our website and Medicare plan related advertising on separate websites that we develop, host and maintain. In addition, in connection with our Medicare plan advertising program, we may engage in other marketing activities. In return for our services, we typically are paid either a flat amount, a monthly amount, or, in our individual and family health insurance sponsorship advertising program, a performance-based fee based on metrics such as submitted health insurance applications.

Lead Referrals. We generate revenue from the sale of Medicare-related and individual and family health insurance leads generated by our ecommerce platforms and our marketing activities.

Technology Licensing. We generate revenue from licensing the use of our health insurance ecommerce technology. Our technology platform enables health insurance carriers to market and distribute health insurance plans online. Health insurance carriers that license our technology typically pay us implementation fees and performance-based fees that are based on metrics such as submitted health insurance applications.

Additional financial information about our company is included in Part II, Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations* and Item 8, *Financial Statements and Supplementary Data*, of this Annual Report on Form 10-K.

Industry Background

The purchase and sale of health insurance have historically been complex, time-consuming and paper-intensive processes. The complexity can make it difficult to make informed health insurance decisions. In addition, the human errors that arise from traditional paper-intensive distribution have historically resulted in a high number of incomplete and inaccurate applications being submitted to health insurance carriers. These incomplete and inaccurate paper applications often result in back-and-forth communications, delay and additional costs. The Internet's convenient, information-rich and interactive nature offers the opportunity to provide consumers with more organized up-to-date information, a broader choice of plans and a more efficient and accurate process than have typically been available from traditional health insurance distribution channels. We believe that over time the Internet will become an increasingly important channel for researching and enrolling into health insurance plans, similar to other consumer-focused industries such as travel, financial services and shopping.

Medicare is a federal program that provides persons sixty-five years of age and over, and some persons under the age of sixty-five who meet certain conditions, with hospital and medical insurance benefits. Medicare beneficiaries choose between Medicare Fee-For-Service and Medicare Advantage plans. Medicare Fee-For-Service is a government plan where the consumer is responsible for select health care related payments with no limit on out-of-pocket expenses. To increase coverage, Medicare Fee-For-Service beneficiaries can purchase commercially offered Medicare Supplement plans. Medicare Advantage is an alternative to Medicare Fee-For-Service. CMS contracts with private health insurance carriers under the Medicare Advantage and Medicare Part D prescription drug programs. Under these programs, the government pays health insurance carriers per enrollee to cover health care expenses rather than the government making payments directly to providers under Medicare Fee-For-Service. Medicare Advantage plans are required to cover the same services as Medicare Fee-For-Service and usually cover a variety of other health care services and include a cap on out-of-pocket spending for the consumer.

Individual and family products are typically purchased by consumers under 65 years of age that do not have coverage through their employer. Small business group health insurance addresses the health insurance needs of businesses with 100 or fewer employees, although we have chosen to focus on employer groups of 20 or fewer employees. Individual, family and small business health insurance has historically been sold by independent insurance agents and, to a lesser degree, directly by insurance companies. Many of these agents are self-employed or part of small agencies, and they typically service only their local communities. In addition, many of these agents sell health insurance from a limited number of insurance carriers (in some cases only one), resulting in a reduced selection of plans for the consumer.

Our Growth Strategy

We believe our consumer engagement platform and approach to bringing value to consumers is unique in the health insurance market and creates significant opportunities for growth in our core Medicare business and in other areas of the health insurance market. We intend to pursue the following strategies to further advance our business.

Increase Medicare Membership and Commission Revenue

We intend to enroll additional Medicare Advantage, Medicare Supplement, and Medicare Part D prescription drug plan members for our commercial carrier partners. In addition to the expansion of the Medicare-eligible population, a significantly large number of Medicare-eligible individuals have insufficient coverage or a suboptimal plan for their circumstances. We believe that our platform of proprietary content, decision support tools and enrollment solutions and go-to-market strategies in direct-to-consumer and partner channels, can allow us to reach a large portion of this underserved market and grow our membership and revenue more rapidly than the overall Medicare market.

Enhance Post-Enrollment Consumer Engagement and Increase Customer Retention

In 2020, we implemented a comprehensive customer retention program in our Medicare business. At the core of the program is a proactive post-enrollment engagement as customers start utilizing their Medicare policies. This engagement is achieved through a combination of agent and technology-driven initiatives. We are also enhancing our consumer experience, both online and telephonically, to simplify and encourage the use of our platform for future enrollments and further increase the accuracy of plan recommendations. Our goal is to not only drive higher retention rates for our existing Medicare customers but also increase the contribution from repeat customers to our new enrollments. We believe that increased consumer engagement and customer retention will have a positive impact on our revenue as well as lower our marketing, customer care and enrollment costs.

Increase Online Enrollment to Improve Margins and Enhance Operating Leverage

We view our consumer engagement platform as unique in the Medicare market and attractive to the growing number of Medicare beneficiaries who prefer to research, compare and purchase health insurance online through a hybrid process with partial agent assistance. We believe that over time the Internet will become an increasingly important channel for researching and enrolling into health insurance plans allowing us to capture a growing share of the Medicare distribution market. The percentage of members who submit applications for Medicare Advantage and Medicare Supplement products online, including fully unassisted and partially agent assisted online enrollments, has substantially increased from 16% in 2018 to 27% in 2019 to 37% in 2020. We are able to scale growth more rapidly and at an incrementally lower cost basis though our online platform, which we expect will significantly reduce our investments in call center operations over time.

Expand Our Strategic Relationships

The value of our consumer engagement and enrollment solution platform allows us to work closely with strategic partners in the health care market to leverage their relationships with consumers. We expect to increase the contribution to total Medicare enrollments from this effective demand generation channel which has shown a positive impact on consumer engagement and increased member retention. In 2020, we had strategic relationships with each of the top four retail pharmacies in the United States, a growing network of leading hospital systems in the United States and with select financial and affinity marketing organizations to expand the availability of our platform to more consumers. Through greater data integration, co-branding and further investments to improve the consumer experience with our platform, we believe that we can create significant value for each of our partners and further expand our partner relationships.

Acquire Capabilities that Leverage our Consumer Engagement Platform

We intend to pursue strategic relationships or acquisitions that expand our platform, provide additional capabilities or enable us to access adjacent markets within the broader health insurance and related consumer facing segments of the healthcare industry. We acquired GoMedigap in January 2018 to help us expand our presence and engagement capabilities in the Medicare Supplement market.

Our Platforms and Technology

Our ecommerce platforms and consumer engagement solutions are built to provide market leading information, decision support and transactional services to a broad group of health insurance consumers across the country while prioritizing accessibility to health insurance. Our ecommerce platforms organize and present voluminous and complex health insurance information in an objective format that empowers individuals, families and small businesses to research, analyze, compare and purchase a wide variety of health insurance plans.

Elements of our platforms include:

New Customer Center. We launched our Customer Center in September 2020. The Customer Center enables members to create a secure personal profile that stores their prescription drug regimen, preferred doctors and pharmacies, current coverage, and other relevant data and make this data available to the member and our licensed agents that they contact. Our members who enroll by phone can also access this new online experience. After members create a Customer Center account, our technology will import details provided to an agent over telephone to the account. The following are important benefits of our Customer Center:

- ***Empowers Medicare beneficiaries to take control of their personal information*** – Our Customer Center will put our members in the driver's seat by helping them track and update the information they will need when it is time to reconsider their coverage options.
- ***Identification of Medicare plan options*** – With their personal information easily accessible online and to our agents, it is easier for shoppers to find the best plan options for their personal needs and budget and also incentivizes them to return to us when their needs change.
- ***Drives retention through communication*** – Our Customer Center allows beneficiaries to track the status of their applications over time and connects them with us if they have questions.

Plan Comparisons and Recommendations. We offer online comparison and recommendation tools that process and simplify voluminous health insurance information according to each consumer's specific insurance need. Our ecommerce platform enables consumers to compare and personalize health insurance options based on plan characteristics such as price, plan type, coverage limits, deductible amount, co-payment amount, and in-network and out-of-network benefits. After entering relevant information on our website, our platforms allow consumers to instantly receive a list of applicable health insurance plans and rate and benefit information in an easy-to-understand format.

Online Application and Enrollment Forms. Health insurance applications vary widely by carrier and state. Our proprietary application tool allows us to capture each insurance application's unique business rules and build a corresponding online application. Our online application process offers our consumers significant improvements over the traditional, paper-intensive application process. It employs dynamic business logic to help individuals and families complete the application and enrollment forms correctly in real-time. This reduces delay resulting from application rework, a significant problem with traditional health insurance distribution, where incomplete applications are mailed back and forth between the consumer, the traditional agent and the carrier. We further simplify the enrollment process by accepting electronic signature.

Customer and Carrier Data Interchange. Our digital data interface technology integrates our online application process with health insurance carriers' technology systems, enabling us to electronically deliver our consumers' applications to health insurance carriers. Our digital interface technology also expedites the loading of insurance product inventory in to our various shopping experiences and accelerates the application process by eliminating manual delivery. We also receive alerts and data from carriers, such as notification of approval or a request from a carrier for a consumer's medical records for underwriting purposes, which we then relay electronically to the consumer. These features of our service help prevent applications from becoming delayed or rejected through inactivity of the consumer or the carrier.

Call Center Technology Systems. Our proprietary agent-assist management systems enable us to provide a full range of customer service tasks in an efficient and personalized manner while complying with Medicare and health insurance regulatory requirements. Call center agents have script-on-screen tools that align to health insurance needs and leverage a common back office platform that powers our direct-to-consumer shopping experience. Data science driven algorithms are used to route and match call center agents with the right training and experience to certain consumers. These systems also have customer relationship management tools that can track each consumer throughout the application process, obtain real-time updates from the carrier, generate automated emails specific to each consumer and access a cross-sell engine and dashboard to identify and track cross-sell opportunities. Our auto-

email system is feature-rich with HTML capability, customizable merge tags, granular segmentation and tracking capability.

Customer Data Platform. We have developed proprietary recommendation algorithms that are carrier agnostic and are designed based on the several million customer assistance encounters we have facilitated.

Carrier Relationships

We have developed strategic relationships with leading health insurance carriers in the United States, enabling us to offer thousands of health insurance plans online. We have relationships with a large number of Medicare-related, individual and family, small business and ancillary health insurance plan carriers, including large national carriers and well-established regional carriers. Many of these major carriers have been selling their products through us for over ten years. In many cases, we have back-office integration with major carriers allowing us to submit applications efficiently and cost-effectively, which is an area of competitive differentiation for our business. We typically enter into contractual agency relationships with health insurance carriers that are non-exclusive and terminable on short notice by either party for any reason. Health insurance carriers often have the ability to terminate or amend our agreements unilaterally on short notice, including provisions in our agreements relating to our commission rates.

Marketing

We focus on building brand awareness, increasing Medicare, individual, family and small business customer visits to our websites and telephonic sales centers and converting these visitors into members. Our marketing initiatives are varied and numerous. They include:

Direct Marketing. Our direct member acquisition channel consists of consumers who call our call centers directly or access our website addresses (*www.eHealth.com*, *www.eHealthInsurance.com*, *www.Medicare.com*, *www.eHealthMedicare.com*, *www.PlanPrescriber.com* and *www.GoMedigap.com*) either directly or through algorithmic search listings on Internet search engines and directories. Our direct marketing programs include direct mail, email marketing, search engine optimization, and television, radio and print advertising.

Online Advertising. Our online advertising member acquisition channel consists of consumers who access our website or call centers through paid keyword search advertising from search engines such as Google, Bing and Yahoo!, paid social platforms like Facebook, as well as various Internet marketing programs such as display advertising and retargeting campaigns. Our online advertising programs are delivered across all Internet-enabled devices, including desktop computers, tablet computers and smart phones.

Marketing Partners. Our marketing partner member acquisition channel consists of consumers who access our website and call centers through a network comprised of hundreds of partners that drive consumers to our ecommerce platform and call centers. These partners include health care industry participants, such as insurance carriers; affiliate organizations; online advertisers and content providers that are specialists in paid and unpaid (algorithmic) search, as well as specialists in other types of Internet marketing; pharmacies and hospital networks; financial and online services partners in industries such as banking, insurance and mortgage; and off-line lead generators who specialize in traditional direct marketing channels, such as direct mail and television advertising.

Technology and Content

We have a technology and content team that is responsible for ongoing enhancements to the features and functionality of our ecommerce platform, which we believe are critical to maintaining our technology leadership position in the industry. A large number of our technology and content employees are located in our subsidiary in Xiamen, China. There are many risks associated with having an operation and doing business in China. Information

regarding risks involving our operations in China is included in Part I, Item 1A, *Risk Factors*, of this Annual Report on Form 10-K.

Government Regulation and Compliance

We distribute health insurance plans in all 50 states and in the District of Columbia. The health insurance industry is heavily regulated. Each of these jurisdictions has its own rules and regulations relating to the offer and sale of health insurance plans, typically administered by a department of insurance. State insurance departments have administrative powers relating to, among other things: regulating premium prices; granting and revoking licenses to transact insurance business; approving individuals and entities to which, and circumstances under which, commissions can be paid; regulating advertising, marketing and trade practices; monitoring broker and agent conduct; and imposing continuing education requirements. We are required to maintain valid life and/or health agency and/or agent licenses in each jurisdiction in which we transact health insurance business.

In addition to state regulations, we also are subject to federal laws, regulations and guidelines issued by CMS that place a number of requirements on health insurance carriers and agents and brokers in connection with the marketing and sale of Medicare Advantage and Medicare Part D prescription drug plans. We are subject to similar requirements of state insurance departments with respect to our marketing and sale of Medicare Supplement plans. Medicare plans are not generally able to be purchased outside of an annual enrollment period that occurs in the fourth quarter of the year, subject to exception for individuals aging into Medicare eligibility and for individuals who qualify for a special enrollment period as a result of certain qualifying events. In addition, Medicare Advantage plan enrollees may enroll in another Medicare Advantage plan or disenroll from their Medicare Advantage plan and return to original Medicare during the Medicare Advantage open enrollment period that occurs in the first quarter of the year. CMS and state insurance department regulations and guidelines include a number of prohibitions regarding the ability to contact Medicare-eligible individuals and place many restrictions on the marketing of Medicare-related plans. For example, our health insurance carrier partners are required to file with CMS and state departments of insurance certain of our websites, our call center scripts and other marketing materials we use to market Medicare-related plans. In some instances, CMS or state departments of insurance must approve the material before we use it. In addition, the laws and regulations applicable to the marketing and sale of Medicare-related plans are ambiguous, complex and, particularly with respect to regulations and guidance issued by CMS for Medicare Advantage and Medicare Part D prescription drug plans, change frequently.

In March 2010, the Affordable Care Act and related amendments in the Health Care and Education Reconciliation Act were signed into law. The Affordable Care Act has primarily impacted our business of selling individual, family, and small business insurance plans. Among several other provisions, these laws and the regulations implementing them included a mandate requiring individuals to maintain health insurance or face tax penalties, which was repealed effective in 2019; a mandate that certain employers offer and contribute to their employees' group health insurance coverage or face tax penalties if they do not do so; prohibitions against insurance companies using pre-existing health conditions as a reason to deny an application for health insurance; requirements for minimum individual and small business health insurance benefit levels, including prohibitions on lifetime coverage limits and limitations on annual coverage limits; medical loss ratio requirements that require each health insurance carrier to spend a certain percentage of their premium revenue on reimbursement for clinical services and activities that improve health care quality; establishment of state and/or federal health insurance exchanges to facilitate access to, and the purchase of, health insurance; Medicaid expansion so that a greater number of individuals will be insured under Medicaid programs; and subsidies and cost-sharing credits to make health insurance more affordable for those below certain income levels.

The Affordable Care Act also established annual open enrollment periods for the purchase of individual and family health insurance. Individuals and families generally are not able to purchase individual and family health insurance outside of the annual enrollment periods, 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. Moreover, in order to be eligible for a subsidy, qualified individuals must purchase subsidy-qualifying health plans, known as qualified health plans, through a government-run health insurance exchange during the open enrollment period or a

special enrollment period. While they are not required to do so, government-run exchanges are permitted to allow agents and brokers to enroll individuals and families into qualified health plans through them. The Federally Facilitated Marketplace, or FFM, run by CMS operated some part of the health insurance exchange in 38 states during the last health care open enrollment period. Our enrollment of individuals and families into qualified health plans to date has generally occurred through the FFM.

We are subject to various federal and state privacy and security laws, regulations and requirements. These laws govern our collection, use, disclosure, protection and maintenance of the individually-identifiable information that we collect from consumers. For example, we are subject to the Health Insurance Portability and Accountability Act, or HIPAA. HIPAA and regulations adopted pursuant to HIPPA require us to maintain the privacy of individually-identifiable health information that we collect on behalf of health insurance carriers, implement measures to safeguard such information and provide notification in the event of a breach in the privacy or confidentiality of such information. In addition, we have entered into contracts with health insurance carriers and others regarding the collection, maintenance, protection, use, transmission, disclosure or disposal of sensitive personal information. The use and disclosure of certain data that we collect from consumers is also regulated in some instances by other federal laws, including the Gramm-Leach-Bliley Act, or GLBA, and state statutes implementing GLBA, which generally require brokers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before sharing such information with a third party, and which generally require safeguards for the protection of personal information. We regularly assess our compliance with privacy and security requirements. These requirements are evolving, and states are beginning to adopt additional requirements, such as the California Consumer Privacy Act, which went into effect January 1, 2020, which establishes, among other things, new privacy rights for California residents such as the right to know what personal information has been collected about them, how we use and disclose this information and the right to request deletion of that information. In addition to government action, health insurance carrier expectations relating to privacy and security protections are increasing and evolving. We have incurred significant costs to develop new processes and procedures and to adopt new technology in an effort to comply with privacy and security laws and regulations and carrier expectations and to protect against cyber security risks and security breaches. We expect to continue to do so in the future. Violations of federal and state privacy and security laws and other contractual requirements may result in significant liability and expense, damage to our reputation or termination of relationship with government-run health insurance exchanges and our members, marketing partners and health insurance carriers**.**

Intellectual Property

We rely on a combination of trademark, copyright and trade secret laws in the United States and other jurisdictions, as well as confidentiality procedures and contractual provisions, to protect our proprietary technology and our brand. We also have filed patent applications that relate to certain of our technology and business processes.

Competition

The market for selling health insurance plans is highly competitive. Our competitors include government entities, including government-run health insurance exchanges; health insurance carriers; other health insurance agents and brokers; and companies that use the Internet and other means to attract individuals interested in purchasing health insurance and generate revenue by referring these individuals to us or one of our competitors.

Other agents and brokers. We compete with agents and brokers who offer and sell health insurance plans utilizing traditional offline distribution channels as well as the Internet. Our current competitors include the tens of thousands of local insurance agents across the United States who sell health insurance plans in their communities. A number of these agents operate websites and provide an online shopping experience for consumers interested in purchasing health insurance. In addition, there are a number of direct-to-consumer Medicare platforms that generate demand through a combination of online and traditional marketing channels and fulfill it through their call center operations.

Government. In connection with our marketing of Medicare related health insurance plans, we compete with the federal government's original Medicare program. CMS also offers Medicare plan online enrollment, information and comparison tools and has established call centers for the sale of Medicare Advantage and Medicare Part D prescription drug plans. CMS has regulatory authority over the Medicare Advantage and Medicare Part D prescription drug program and can influence the competitiveness of Medicare Advantage and Medicare Part D prescription drug plans compared to the original Medicare program, as well as the compensation that health insurance carriers are allowed to pay us.

Insurance carriers. Many health insurance carriers directly market and sell their plans to consumers through call centers 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 and, to a much lesser extent, to small businesses. Health insurance carriers have become more experienced in marketing their products directly to consumers, both over the Internet and through more traditional channels, which has resulted in increased competition.

Internet marketers and other advertisers. There are many internet marketing companies and other advertisers that use the Internet and other means to find consumers interested in purchasing health insurance and are compensated for referring those consumers to agents and health insurance carriers. We compete with these companies for individuals who are looking to purchase health insurance.

Seasonality

The majority of our commission revenue is recognized in the fourth quarter of each calendar year under Accounting Standards Codification, *Revenue from Contracts with Customers (ASC 606)*, which we adopted using the full retrospective transition method on January 1, 2018. We have historically sold a significant portion of Medicare plans for the year in the 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. During 2020, 2019, and 2018, 57%, 63%, and 61%, respectively, of our Medicare plan-related applications were submitted during the fourth quarter. As a result, we generate a significant portion of our commission revenues related to new Medicare plan-related enrollments in the fourth quarter.

Beginning January 1, 2019, CMS revived the Medicare Advantage open enrollment period during which Medicare Advantage plan enrollees may enroll in another Medicare Advantage plan or disenroll from their Medicare Advantage plan and return to original Medicare. The Medicare Advantage open enrollment period is scheduled to occur between January 1 and March 31 of each year. As a result, we expect to generate higher commission revenue in the first quarter compared to the second and third quarters.

The annual open enrollment period for individual and family health insurance also takes place in the fourth quarter of the calendar year, resulting in seasonality of individual and family plan submitted applications volume. During 2020, 2019, and 2018, 56%, 57%, and 64%, respectively, of our individual and family plan-related applications were submitted during the fourth quarter. As a result, we generate a significant portion of our commission revenues related to individual and family plan-related enrollments in the fourth quarter.

Our marketing and advertising expenses are typically lower in each of our first through third quarters compared to the fourth quarter. We incur a significant portion of our marketing and advertising expenses in the fourth quarter as a result of the Medicare annual enrollment period and the open enrollment period under the Affordable Care Act. We expect this seasonal trend in marketing and advertising expenses to continue in 2021.

In preparation for the Medicare annual enrollment period during 2020, 2019, and 2018, and to a lesser extent the open enrollment period for individual and family health insurance plans during the same periods, we began increasing our customer care center staff during the third and fourth quarters to handle the anticipated increased volume of health insurance transactions, which resulted in higher customer care and enrollment expenses in the third and fourth quarters. Historically, a significant portion of the seasonal increase in customer care center

staffing was through the utilization of vendors that employ their own health insurance agents. Going forward, we plan to shift to a predominantly internal agent model and will employ and maintain the majority of our health insurance agent force year-round. We expect to increase our internal agents' utilization outside of the enrollment periods by expanding our offerings of ancillary products and increasing our outbound calling efforts. In addition, we are planning to enhance our new agent onboarding and training program and commence these processes earlier in the second quarter of the year. As a result, we expect to incur increased employee costs beginning earlier in 2021 and reduced outsourced vendor agent costs during the fourth quarter AEP season. We believe the earlier investments in expanding our internal team will enable stronger execution during the fourth quarter AEP season of 2021.

Human Capital Resources

As of December 31, 2020, we had approximately 1,960 full-time employees, of which 1,190 were in customer care and enrollment, 410 were in technology and content, 260 were in general and administrative, and 100 were in marketing and advertising. Of the 1,960 full-time employees, 275 were non-US employees based in our China office. None of our U.S. employees are represented by a labor union. As required under Chinese law, the employees in our Xiamen, China office established a labor union in January 2014. We have not experienced any work stoppages and consider our employee relations to be strong.

We value our employees for their critical role in the success of our business. We focus on our culture and maintain a generous benefits package for our employees to attract, motivate, and retain them. Health benefits we offer are extended to all full-time employees. Our employee wellness benefits include mental health and financial well-being benefits, including fertility assistance, a tuition reimbursement program, a student loan repayment program, and financial counseling resources. During 2020, we implemented an employee stock purchase plan for our U.S. employees which enables them to purchase shares of our common stock at a discount from market prices and participate in equity ownership of us. We focus on diversity, equality, and inclusion and they form a part of our culture and values. We recently formed a diversity and inclusion committee to identify ways in which we can further support a culture of acceptance and inclusivity. We have also introduced expanded offerings for virtual employee training to ensure our employees continue to develop their skills while working remotely.

Information Security

We are committed to maintaining information security through responsible management, appropriate use, and protection in accordance with legal and regulatory requirements and our contractual relationships. Information security is an integral part of our business, and we emphasize to every employee that information security is “everyone’s responsibility.” We maintain an office of the chief information security officer, or CISO, focused on information and systems technology and corporate governance to drive a common security framework practice. The office of the CISO concentrates on technology, behaviors and safeguarding information from unauthorized or inappropriate access, use, or disclosure. We utilize various industry recognized information security frameworks, including Health Information Trust Alliance, National Institute of Standards and Technology, Payment Card Industry Data Security Standard, CIS Controls, and CIS Benchmarks.

Climate Change

Though our direct environmental impact is limited, we believe that we all have a role to play in effectively planning for, and mitigating the effects of, climate change. Therefore, we consider climate-related risks when assessing our larger enterprise-level risks. We also consider how we can build upon our business model to reduce environmental impacts, such as those associated with the use of paper for processing insurance applications. Through the use of our online platforms, we have transformed a paper intensive health insurance application process into an easy to use digital experience. As we continue to grow, we plan to select and design our offices in a manner that promotes the health, well-being, and productivity of our workforce and consider the environmental impacts of our facilities. For example, our Santa Clara office is located in a high performance building and adheres to a number of sustainability requirements under local and California state guidance. We have extended our data tracking

mechanisms to better understand our organizational footprint and to identify ways to further mitigate our impact on the environment, including increasing the automation of our procurement activities.

ITEM 1A. RISK FACTORS

In addition to other information in this Annual Report on Form 10-K 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.

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. If it does not, or is not, our business, operating results and financial condition would be harmed. 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 and our outsourced call centers and their health insurance agents 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.

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, decreased demand and loss of market share, increased health insurance plan termination, 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. Carriers may be unwilling to allow us to sell their existing or new health insurance plans, or desire to 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 could 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 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 can unilaterally amend the commission rates that they pay to us. For example, given the significant losses that carriers sustained in connection with their sale of individual and family health insurance as a result of health care reform, many health insurance carriers with which we have a relationship, including large national health insurance carriers, reduced or eliminated our commissions for selling individual and family health insurance, and in a limited number of cases, our renewal commissions. As a result, we experienced a meaningful reduction in our average commission rates for our aggregate individual and family health insurance plan membership. In addition, the reduction in contractual commission rates and these carriers' desire to not sell individual and family health insurance reduced the number of plans that we are able to offer on our websites, which resulted in less consumer demand for the individual and family health insurance that we sell and a reduction in our membership. In the future, 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. In addition to reducing commission rates, health insurance carriers may 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 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 CMS, state laws or regulations, a health insurance carrier may terminate our relationship or CMS may penalize a health insurance carrier by suspending or terminating the carrier's ability to market and sell Medicare plans. 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 we are not able to successfully retain our existing members and limit health insurance plan termination.

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 attrition rate in our Medicare Advantage and Medicare prescription drug plan membership in 2020 above historical levels prior to that time. While we have implemented measures to improve the attrition rate, 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 Advantage plan and Medicare Part D prescription drug plan 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. If we are not able to successfully retain our existing members and limit health insurance plan termination, our business, operating results and financial condition would be 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 twelve months of a policy. After the first twelve 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 generally have directed employees to work from home and implemented new business protocols for employees who have resumed work in our offices. 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 and asking employees to work from home, which 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 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 some of 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 extended office closures. 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 is especially uncertain because of increases in unemployment rate, potential delays in customer premium payments and/or health insurance carrier commission payments, potential changes to the open enrollment period, and potential 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 to which the COVID-19 pandemic impacts our business will depend on future developments, which are highly uncertain and cannot be predicted.

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

Our success is dependent upon 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. The transition and the departure of members of our senior management could result in 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 and initiatives, including our growth strategy and retention initiatives.

As part of our strategy, we have determined to invest in initiatives to accelerate growth in our Medicare product sales, to enhance post-enrollment consumer engagement and increase customer retention, 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 will 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, 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, 2021 and was negative in each of the years ended December 31, 2020, 2019 and 2018. 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 typically runs from November 1 through December 15 each year. 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 1st through March 31st of each year. We experience 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 enrollment periods such as the COVID-related special enrollment period that was adopted in the second quarter of 2020, 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 and, during the Medicare annual enrollment period, outsourced call centers to sell Medicare plans. The success of our customer care center operations is largely dependent on licensed health insurance agents and other employees. In order to sell Medicare-related health insurance plans, our health insurance agent employees and employees of outsourced call centers 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. Because a significant number of Medicare plans are sold in the fourth quarter each year during the Medicare annual enrollment period, we contract with outsourced call centers and hire additional employees on a temporary or seasonal basis in a limited period of time to address the expected increase in the volume of health insurance transactions during this period. 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. The COVID-19 pandemic and resulting containment measures have negatively impacted the capacity of health insurance license testing facilities and have caused delays in the completion of background checks and fingerprinting requirements. As a result, these health insurance agents may experience delays in obtaining health insurance licenses and certifications and health insurance carrier appointments. We and our outsourced call centers may experience difficulties hiring a sufficient number of additional licensed agents and retaining existing licensed agents for the Medicare annual enrollment period. If we and our outsourced call centers 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 or our outsourced call centers 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. We have observed that our health insurance agent employees are more productive than the employees of our outsourced call centers and that experienced health insurance agents are more productive than less-tenured health insurance agents. As a result, the success of our business depends upon our ability to retain existing health insurance agents and hiring and training a sufficient number of internal health insurance agent employees who can perform to the standard we expect of them. Failure to retain, train and ensure the productivity of our health insurance agent employees and employees of outsourced call centers would harm our business, operating results and financial condition.

During the 2020 annual enrollment period, we experienced reduced conversion rates from health insurance agents that work at an outsourced call center, which impacted our revenue and cost of acquisition during the fourth quarter of 2020. As a result, we have determined to increase the number of our health insurance agent employees to a much more significant degree than we have in the past. Our ability to do so successfully will depend on the success of our recruiting efforts and our ability to train, license and appoint with carriers the newly employed agents so that they are effective in selling plans in time for the Medicare annual enrollment period occurring in 2021. If we are not successful in these efforts, we may need to rely more than we have planned on outsourced health insurance agents or rely on a fewer number of employed agents, which could harm our business, operating results and financial condition.

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 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;
- health insurance carriers offering the health insurance plans for which consumers have expressed interest, and the degree to which our technology is integrated with those carriers;
- health insurance carrier guidelines applicable to applications submitted by consumers, 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 whether the health insurance agent is an employee or works with an outsourced call center with which we have a relationship; 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 or a health insurance agent that works with an outsourced call center. We may make changes to our ecommerce platforms in response to regulatory requirements or undertake other initiatives in an attempt to improve consumer experience 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, which 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 results 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.

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, and 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 be in non-compliance with those laws, regulations and guidelines. 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 CMS or state departments of insurance 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 and initiatives we determined 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 reports would adversely impact our 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, 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, our estimated membership reported as of March 31, 2020 was higher than our actual membership, because we experienced increased membership cancellation compared to the historical cancellation rates we used to estimate our membership as of March 31, 2020. 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 business may not be successful.

We develop, host and maintain carrier dedicated Medicare plan websites and may undertake other marketing and advertising initiatives 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, we may in the future not be permitted to sell Medicare plan-related advertising. If we are not successful in generating Medicare plan-related advertising revenue, 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, 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 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.

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 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 are required to meet certain additional requirements. To the extent we enroll individuals and families into qualified health plans, we do so through the FFM, which runs all or part of the health insurance exchange in 36 states. 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 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 to enroll individuals in qualified health plans or change the requirements for doing so. If it does so or if the FFM platform does not function properly, 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. On June 1, 2017, a national cybersecurity law came into effect in China. The law, along with its implementation 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. There remains considerable uncertainty as to how the cybersecurity law will be applied, and the regulatory environment continues to evolve with new draft regulations and standards published frequently. Such laws, regulations and standards are complex, ambiguous and subject to change or interpretation, which create uncertainty regarding compliance. 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. 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

initiated by the current administration 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 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 timely implement Medicare sales expertise into 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 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 the 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. Health insurance carriers may terminate our relationship with them or 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 would reduce the products we are able to offer, could result in the loss of commissions for past and future sales and would 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.

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.

The United States health insurance system 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. These and other impacts of health care reform caused a significant decline in our individual and family plan and revenue 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.

The Affordable Care Act contains a mandate requiring individuals to maintain health insurance plans that comply with the Affordable Care Act or face a tax penalty. As a part of the tax reform law that came into effect in December 2017, the tax penalty for violating the mandate was set at zero effective in 2019, essentially repealing it. The essential repeal of the individual mandate could cause individuals to determine not to purchase or maintain individual and family health insurance and could cause carriers to increase premiums, reduce commissions or exit the business of selling individual and family health insurance, any of which would adversely impact our business, operating results and financial condition.

Since the enactment of the Affordable Care Act, there have been judicial and Congressional challenges to certain aspects of the law. In December 2018, a federal district court in Texas determined that the individual mandate in the Affordable Care Act is unconstitutional, because it was not within Congress's tax power or interstate commerce power. It also determined that the remaining provisions of the Affordable Care Act were inseverable and therefore invalid. The court, however, did not rule that the operation of the Affordable Care Act be enjoined, so the law continues to operate until determined otherwise by the court or an appellate court. The Fifth Circuit Court of Appeals agreed with the district court that the mandate is unconstitutional, but remanded the case back to the district court to address whether the unconstitutionality of the mandate should impact the rest of the law. In March 2020, the Supreme Court agreed to review the case, including whether the individual mandate is unconstitutional, and if the mandate is unconstitutional whether the rest of the Affordable Care Act can survive. Oral argument of the case before the Supreme Court occurred and we are awaiting the court's decision. If the Affordable Care Act were finally determined to be unconstitutional and no longer operated, it is unclear what impact it or its replacement would have on our business. However, it or its replacement could adversely impact our business, operating results and financial condition.

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 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 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 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 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. Any claims asserted against us, with or without merit, could be time-consuming, expensive to settle or litigate 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 was recently passed that requires disclosure of commissions paid to us to the purchaser of small business, major medical individual and family and short-term health insurance plans. The provisions of the law have not gone into effect. It is unclear what impact the law will have when it goes into effect, but it could 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 given that the Biden administration recently took office. 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 state insurance 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 state insurance laws and regulations, we may not have always been, and we may not always be, in compliance with them. New state insurance 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 in a particular jurisdiction, termination of our relationship with health insurance carriers or 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 cyberattacks, security breaches or are otherwise unable to safeguard the security and privacy of confidential data, including personal health information, our business will be harmed.

Our services involve the collection and storage of confidential and personally identifiable information of consumers and the transmission of this information to their chosen health insurance carriers and to government. For example, we collect names, addresses, credit card and social security numbers and protected health information such as information regarding the medical history of consumers. As a result, we are subject to various laws and regulations and contractual requirements regarding the collection, maintenance, protection, use, transmission, disclosure and disposal of sensitive personal information. We also hold a significant amount of information relating to our current and former employees. 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 privacy and security laws, requirements and regulations, particularly new state legislation such as the California Consumer Privacy Act, may result in cost increases due to new constraints on our business, the development of new processes, the effects of potential non-compliance by us or third party service providers, and enforcement actions. We may be required to expend significant amounts and other resources to protect against security breaches or to alleviate problems caused by security breaches. Despite our implementation of security measures, 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. 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 addition, in the event that additional data security laws are implemented, or our health insurance carrier or other partners determine to impose requirements on us relating to

data 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 or conduct health insurance business, 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, or negative publicity for 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, 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 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 CMS or state departments of insurance regarding our marketing and business practices and compliance with laws and regulations. Although in the past we have resolved these complaints and governmental inquiries without significant financial cost or impact to our brand or reputation, we cannot guarantee that we will be able to do so in the future. 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, despite our legal compliance, 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.

Effective January 1, 2018, we adopted Accounting Standards Update 2014-09, *Revenue from Contracts with Customers (ASC 606)*. As a result of the adoption of ASC 606, 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 commission rates 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. 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 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.

The closing of the financing transaction with the purchaser of our Series A preferred stock is subject to terms and conditions, many of which are outside our control. We may experience delays and difficulties with the closing of the transaction and no assurance can be given that it will close. The failure to close the transaction could adversely impact our future liquidity and our financial condition.

On February 17, 2021, we entered into an investment agreement pursuant to which we have agreed to issue to a purchaser at closing, 2,250,000 shares of our newly designated Series A preferred stock at an aggregate purchase price of $225 million (the "Private Placement"). The Private Placement is subject to closing conditions, including, among others: (i) the expiration or early termination of the waiting period (and any extension thereof) applicable to the consummation of the Private Placement under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended; (ii) the confirmation by Nasdaq that it has no objection to the terms and conditions of the Private Placement; and (iii) the determination that consummation of the Private Placement would not cause our outside auditor to no longer be deemed independent under the rules and regulations of the Securities and Exchange Commission or the Public Company Accounting Oversight Board. While we intend to actively pursue the steps necessary to fulfill our closing conditions, some of the conditions are outside of our control and it is possible that not all of the closing conditions to the Private Placement will be satisfied. The failure to close the Private Placement could adversely impact our future liquidity and financial condition.

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

As of February 17, 2021, the common stock to be issued to the purchaser of our Series A preferred stock upon closing of the transaction in the Private Placement represent approximately 8.8% of our outstanding common stock on an as-converted basis. The Series A preferred stock is convertible at the option of the holders at any time after May 31, 2021 into shares of common stock based on the conversion rate set forth 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, 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 will receive 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 on or after the sixth anniversary of the closing of the Private Placement and (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, each subject to the terms, conditions and exceptions contained in the certificate of designations.

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. Our obligations to the purchaser of our Series A Preferred Stock, as the initial holder 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. The preferential rights could also result in divergent interests between the Series A preferred stockholder 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.

The purchaser of our Series A preferred stock may exercise influence over us, including through its ability to designate a director on our board of directors.

The investment agreement contains certain negative operating covenants which we have agreed to comply with following closing of the Private Placement and for so long as the purchaser continues to own at least 30% of the shares of Series A preferred stock issued to it in the Private Placement.

Further, the terms of the investment agreement will entitle the initial purchaser of our Series A preferred stock to nominate one individual for election to our board of directors so long as the purchaser 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. In addition, if we fail to maintain certain levels of commissions receivable and liquidity, the purchaser will be entitled to nominate one additional director. The director designated by the purchaser 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 the purchaser of our Series A preferred stock may differ from the interests of our security holders as a whole or of our other directors.

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

We are party to a credit agreement with Royal Bank of Canada and other lenders that enables us to borrow up to $75 million pursuant to a revolving credit facility. This credit agreement imposes certain covenants and restrictions on our business and our ability to obtain additional financing. As of December 31, 2020, we had no outstanding debt under our revolving credit facility.

The credit agreement contains customary affirmative covenants, including covenants regarding the payment of taxes and other obligations, maintenance of insurance, reporting requirements and compliance with applicable laws and regulations. The credit agreement also contains restrictions that, subject to certain exceptions, limit our ability to merge or consolidate, sell or transfer assets outside the ordinary course of business, make certain types of investments and restricted payments, pay dividends, incur additional indebtedness, grant liens, or enter into transactions with affiliates without the lender's consent. Further, the credit agreement contains a financial covenant requiring the Company to maintain a minimum level of excess availability at any time. The facility contains events of default, including, among others, non-payment defaults, inaccuracy of representations and warranties, covenant defaults, cross-defaults to other indebtedness, judgment defaults, collateral defaults, bankruptcy and insolvency defaults and a change of control default.

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 loan facility. If we are unable to generate sufficient cash flow or otherwise obtain the funds necessary to make required payments under the credit facility, or if we fail to comply with the requirements of our indebtedness, we could default under our credit facility. Any default that is not cured or waived could result in the acceleration of the obligations under the credit facility, an increase in the applicable interest rate under the credit facility, and would permit our lender to exercise rights and remedies with respect to all of the collateral that is securing the credit facility, 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 credit facility 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.

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, or GAAP, relating to accounting for income taxes. In addition, we are subject to examinations of our income tax returns by the Internal Revenue Service, or IRS, 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 2021, 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 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 Internal Revenue Code of 1986, as amended, or 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.

The success of our Medicare plan customer care center operations is dependent upon information technology systems. Many of our Medicare plan members utilize our customer care center in connection with their purchase of 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 and telephony platforms and underlying network infrastructures are critical to our financial results, our brand and our 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 data center, cloud infrastructure, and bandwidth providers, to operate our ecommerce and telephony platforms. 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. Our facilities and our database and systems are vulnerable to damage or interruption from human error, fire, floods, power loss, telecommunications failures, physical or electronic break-ins, computer viruses, acts of terrorism, other attempts to harm our systems and similar events. In addition, our operations are vulnerable to earthquakes, fire, severe weather conditions, including those brought about by climate change, and other natural disasters in the San Francisco Bay Area and elsewhere in Northern California, China, and as well as in other parts of the U.S. where we or our outsourced health insurance agents maintain offices.

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 depend upon third-party service providers to access our website and services, 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. Many of these service providers have experienced significant outages, delays and other difficulties in the past and could experience them in the future. 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 year ended December 31, 2020, the closing price of our common stock fluctuated from $61.81 to $146.09 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;

- 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 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 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.

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.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

The following table sets forth the location, approximate square footage and primary use of each of the principal properties we occupied as of December 31, 2020:

Location	Approximate Square Footage	Primary Use
Santa Clara, California	45,657	Corporate headquarters, marketing and advertising, technology and content and general and administrative
Gold River, California	63,206	Customer care and enrollment, technology and content and general and administrative
South Jordan, Utah	41,813	Customer care and enrollment
Xiamen, China	53,758	Technology and content, customer care and enrollment, marketing and advertising and general and administrative
Austin, Texas	26,878	Technology and content, customer care and enrollment, marketing and advertising and general and administrative
Indianapolis, Indiana	56,276	Customer care and enrollment

ITEM 3. 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 II, Item 8 of this Form 10-K in the *Notes to Consolidated Financial Statements* in *Note 8 – Commitments and Contingencies*,

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Our common stock is traded on The Nasdaq Global Market under the symbol EHTH. As of February 16, 2021, there were 26 stockholders of record of our common stock (which does not include the number of stockholders holding shares of our common stock in "street name") and the closing price of our common stock was $53.74 per share on February 16, 2021 as reported by The Nasdaq Global Market.

Dividend Policy

We have never declared or paid any cash dividend on our common stock. We currently do not expect to pay any dividends on our common stock in the foreseeable future.

Unregistered Sales of Equity Securities

In February 2019, we issued 294,608 shares of our common stock and in January 2020 we issued another 294,608 shares of our common stock, each as a part of earnout payments in connection with our acquisition of GoMedigap, as described in *Item 8 – Financial Statements and Supplementary Data – Note 3 – Acquisition* of our *Notes to Consolidated Financial Statements* of this Annual Report on Form 10-K. These shares were issued in reliance on Section 4(a)(2) of the Securities Act of 1933, as amended, as transactions not involving any public offering.

On February 17, 2021, we entered into an investment agreement with H.I.G. pursuant to which we have agreed to sell to H.I.G. at closing, 2,250,000 shares of our newly designated Series A preferred stock at an aggregate purchase price of $225.0 million. These shares will be issued in reliance on Section 4(a)(2) of the Securities Act of 1933, as amended, as a transaction not involving any public offering.

Securities Authorized for Issuance under Equity Compensation Plans

See Item 12, "Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters" for information regarding securities authorized for issuance.

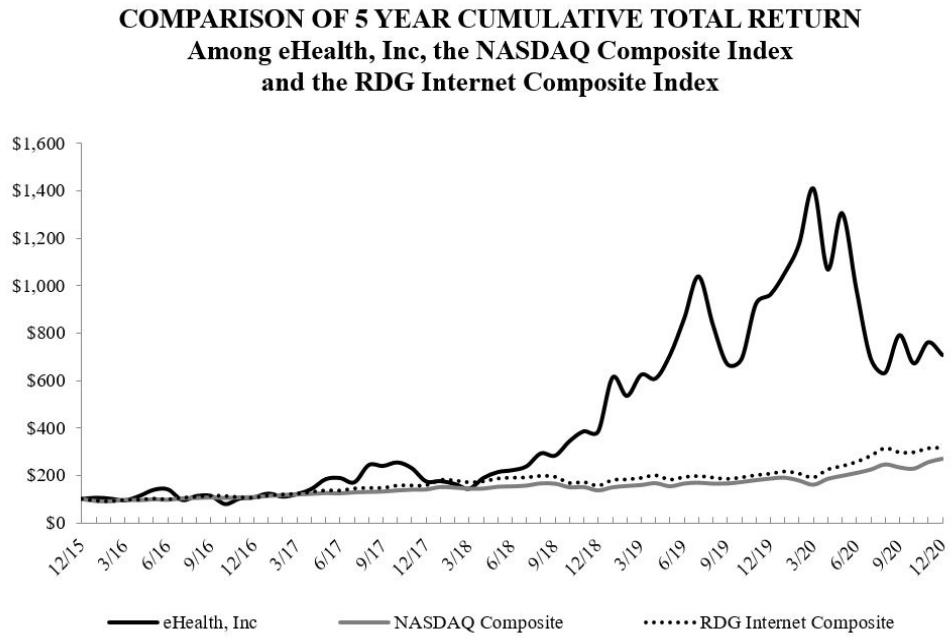
Issuer Purchases of Equity Securities

We did not repurchase any of our common stock in the open market or in privately negotiated transactions during the year ended December 31, 2020.

STOCK PERFORMANCE GRAPH

The following information relating to the price performance of our common stock shall not be deemed "filed" with the Securities and Exchange Commission or "soliciting material" under the Securities Exchange Act of 1934, as amended, or subject to Regulation 14A or 14C, or to liabilities under Section 18 of the Exchange Act, except to the extent that we specifically request that such information be treated as soliciting material or to the extent that we specifically incorporate this information by reference.

The graph below matches our cumulative total stockholder return on our common stock with the cumulative 5-year total returns on the Nasdaq Composite index and the Research Data Group, or RDG Internet Composite index. The graph tracks the performance of a $100 investment in our common stock and in each index (with the reinvestment of dividends) from December 31, 2015 to December 31, 2020.



	12/31/2015	12/31/2016	12/31/2017	12/31/2018	12/31/2019	12/31/2020
eHealth, Inc.	$ 100.00	$ 106.71	$ 174.05	$ 384.97	$ 962.73	$ 707.52
Nasdaq Composite	$ 100.00	$ 108.87	$ 141.13	$ 137.12	$ 187.44	$ 271.64
RDG Internet Composite	$ 100.00	$ 104.75	$ 157.67	$ 156.03	$ 207.10	$ 318.18

ITEM 6. SELECTED CONSOLIDATED FINANCIAL DATA

No disclosure is required by Item 301 of Regulation S-K as in effect on the date of this Annual Report on Form 10-K.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

Please read the following discussion and analysis of our financial condition and results of operations together with our consolidated financial statements and related notes included under Part II, Item 8 of this Annual Report on Form 10-K.

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 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 is designed to meet the consumer wherever they prefer to engage with us, and 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 include thousands of Medicare Advantage, Medicare Supplement, Medicare Part D prescription drug, individual and family, small business and other ancillary health insurance products from over 200 health insurance carriers across all fifty states and the District of Columbia.

Impact from COVID-19

We experienced a number of changes in our business related to the impacts from the COVID-19 pandemic. 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. While some of our offices in the United States remain closed, we reopened our office in China in the second quarter of 2020 given the improvements in the situation in the region where our office is located. During the third quarter of 2020, we also reopened some of our U.S. office locations at a reduced capacity with additional safety and social distancing measures. Based on our success in shifting existing agents to work from home, we launched a remote agent model in 2020, tapping into nationwide agent talent to hire full-time customer care agents. We expect this model to provide us with geographic hiring flexibility as we grow our telesales capacity.

In addition, we believe the COVID-19 pandemic had an impact on consumer behavior when it comes to selecting and utilizing health insurance. We believe that more seniors are now likely to shop for Medicare products online or over the phone versus a face-to-face meeting with a traditional broker. This should have a positive impact on comparison Medicare platforms such as ours. At the same time, we believe that reduced utilization of healthcare by seniors in 2020 also had a dampening effect on Medicare plan switching during the fourth quarter annual enrollment period, or AEP, of 2020. See *Risk Factors* in Part I, Item 1A of this Annual Report on Form 10-K for a discussion of risks related to the COVID-19 pandemic.

H.I.G. Investment

On February 17, 2021, we entered into an investment agreement pursuant to which we have agreed to sell to the purchaser at closing, 2,250,000 shares of our newly designated Series A preferred stock at an aggregate purchase price of $225.0 million. The Private Placement is subject to closing conditions, including, among others: (i) the expiration or early termination of the waiting period (and any extension thereof) applicable to the consummation of the Private Placement under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended; (ii) the confirmation by Nasdaq that it has no objection to the terms and conditions of the Private Placement; and (iii) the determination that consummation of the Private Placement would not cause our outside auditor to no longer be

deemed independent under the rules and regulations of the Securities and Exchange Commission or the Public Company Accounting Oversight Board. The parties have agreed to cooperate with each other and use reasonable best efforts to promptly take such actions to cause the closing conditions to be satisfied as promptly as reasonably practicable.

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, or 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.

We have included the number of new paying members in our selected metrics to provide more detail and visibility into new paying member contribution to the changes in membership. We count an approved member as a new paying member when we have received a commission payment from the carrier relating to the plan purchased by the member. Not all approved members become paying members for various reasons. In addition, for any given period, the rate at which approved members become new paying members is impacted by the time lag between carrier approval and our receipt of the commission payment from the carrier. The difference in our metrics between the number of approved members and new paying members tends to vary, especially in the first and fourth quarters given this time lag and given that plans we sell in the fourth quarter do not begin generating commissions until the first quarter when they become effective.

We have removed submitted applications from our selected metrics given that we do not recognize revenue based on this metric, and it is not as indicative of our commission receivable collection as other metrics we do provide.

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 period presented:

	Year Ended December 31,		
	2020	2019	2018
Medicare:			
Medicare Advantage	387,652	279,561	148,478
Medicare Supplement	40,551	42,688	29,837
Medicare Part D	74,357	112,677	61,373
Total Medicare	502,560	434,926	239,688
Individual and Family:			
Non-Qualified Health Plans	19,578	20,187	23,075
Qualified Health Plans	13,750	11,999	19,575
Total Individual and Family	33,328	32,186	42,650
Ancillaries:			
Short-term	41,640	58,687	107,846
Dental	40,455	43,640	47,343
Vision	18,581	21,391	24,638
Other	14,270	22,980	33,500
Total Ancillaries	114,946	146,698	213,327
Small Business	14,809	16,685	19,550
Total Approved Members	665,643	630,495	515,215

2020 compared to 2019 – Medicare approved members increased 16% in 2020 compared to 2019. The increase in total Medicare approved members was primarily attributable to a 39% growth in Medicare Advantage plan members, partially offset by a 34% decline in Medicare Part D plan members. The increase in approved Medicare Advantage members was primarily driven by strong online enrollment growth, increased marketing efforts, an increase in our internal agent productivity and the COVID-19 related special enrollment period in the second quarter of 2020. During this special enrollment period, certain individuals were permitted to enroll, disenroll or switch their Medicare Advantage and Medicare Part D prescription drug plans. However, our approved application growth was less than expected primarily due to the underperformance of our outsourced external agent force and, to a lesser extent, increased competition in our direct television marketing channel during the fourth quarter 2020 AEP. We also believe that external factors, including the pandemic and the prolonged election cycle, impacted consumer demand on our platform during the 2020 AEP. To address the underperformance of our external agents, we have determined to shift our agent salesforce to a predominantly internal full-time agent model as our internal agents have experienced stronger performance and productivity than our outsourced agents. We began this shift towards the increased utilization of internal agents near the end of the 2020 AEP.

Individual and Family Plan approved members grew 4% in 2020 compared to 2019 primarily due to a 15% increase in approved members for qualified health plans. Ancillary plan approved members declined 22% in 2020 compared to 2019 primarily due to a decrease in short-term health insurance approved members. Small business group health insurance approved members declined 11% in 2020 compared to 2019 mainly due to the shift of our focus on our Medicare business.

2019 compared to 2018 – Medicare approved members grew 81% in 2019 compared to 2018. The growth was primarily due to an 88% growth in Medicare Advantage submitted applications and an 84% growth in Medicare

Part D submitted applications. Individual and Family Plan approved members declined 25% in 2019 compared to 2018, due primarily to market conditions in the individual and family plan market and our decision to shift our marketing investments towards our Medicare business. Approved members for all ancillary products combined declined 31% in 2019 compared to 2018, due primarily to a 46% decline in short term plan submitted applications. Small business approved members decreased 15% in 2019 compared to 2018, due primarily to a decrease in the number of members per application and in the percentage of approved applications.

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 member by product for the periods presented below:

	Year Ended December 31,		
	2020	**2019**	**2018**
Medicare:			
Medicare Advantage	324,916	235,978	134,565
Medicare Supplement	35,649	37,069	48,403
Medicare Part D	104,833	84,369	30,990
Total Medicare	465,398	357,416	213,958
Individual and Family:			
Non-Qualified Health Plans	18,279	20,687	27,105
Qualified Health Plans	12,378	10,310	23,199
Total Individual and Family	30,657	30,997	50,304
Ancillaries:			
Short-term	41,953	62,124	94,778
Dental	38,253	42,439	45,876
Vision	17,128	21,332	22,604
Other	13,918	21,601	34,029
Total Ancillaries	111,252	147,496	197,287
Small Business	14,362	17,606	18,874
Total New Paying Members	621,669	553,515	480,423

2020 compared to 2019 – Medicare total new paying members grew 30% in 2020 compared to 2019, primarily driven by a 38% increase in Medicare Advantage plan new paying members and a 24% increase in Medicare Part D prescription drug plan new paying members. Individual and family plan new paying members declined 1% in 2020 compared to 2019 due to a decrease in new paying members for non-qualified plans, partially offset by an increase in new paying members for qualified plans. Ancillary new paying members declined 25% in 2020 compared 2019 due primarily to a decline in approved members across all ancillary plans. Small business new paying members declined 18% in 2020 compared to 2019 primarily due to a decrease in approved members.

2019 compared to 2018 – Medicare total new paying members grew 67% in 2019 compared to 2018, primarily driven by a 75% increase in Medicare Advantage plan new paying members and a 172% increase in Medicare Part D prescription drug plan new paying members. The increases were primarily driven by an increase in enrollment volume. Individual and family plan new paying members declined 38% in 2019 compared 2018 due to a decrease in new paying members for both non-qualified and qualified plans. Ancillary new paying members declined 25% in 2019 compared to 2018 primarily due to a decline in approved members across all ancillary plans. Small business new paying members declined by 7% in 2019 compared to 2018 primarily due to a decrease in approved members.

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 years presented below:

	Year Ended December 31,		
	2020	2019	2018
Medicare:			
Medicare Advantage [1]	$ 952	$ 1,013	$ 964
Medicare Supplement [1]	1,125	979	1,047
Medicare Part D [1]	215	238	243
Individual and Family:			
Non-Qualified Health Plans [1]	203	213	151
Qualified Health Plans [1]	265	217	141
Ancillaries:			
Short-term [1]	162	101	56
Dental [1]	79	70	77
Vision [1]	55	56	55
Small Business [2]	157	159	168

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[1] Constrained LTV of commissions per approved member represents commissions estimated to be collected over the estimated life of an approved member's policy 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.

[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

2020 compared to 2019 – The constrained LTV of commissions per Medicare Supplement approved member increased by 15% in 2020 compared to 2019, primarily as a result of an increase in estimated average plan duration.

The constrained LTV of commissions per approved member for Medicare Advantage and Medicare Part D prescription drug plans declined by 6% and 10%, respectively, in 2020 compared to 2019, primarily due to a decrease in estimated average plan duration. The decline in estimated average plan duration was driven by various factors, including our historical emphasis on optimizing member experience during the initial enrollment process and driving new enrollment growth with less emphasis and resources allocated to post-transaction communications and existing member retention. In addition, the decline in estimated plan duration was also impacted by certain market related factors including the introduction of the open enrollment period in 2019 which provided an additional opportunity for Medicare Advantage and Medicare Part D prescription drugs plan members to change plans. We also believe that a larger number of Medicare Advantage plan members terminated their plans due to an increased selection of plans with new features and benefits available to consumers for the 2020 plan year and the additional opportunities for consumers to shop and switch Medicare Advantage and Medicare Part D prescription drug plans

during the recent open enrollment periods. The decline had a more pronounced impact on our newer member cohorts and on our telephonic enrollments, while our online enrollments continue to have higher average duration.

During the third quarter of 2020, we initiated a number of programs to improve our member retention. For example, we have launched a customer retention team, adjusted the compensation structure of our agents to better align with our retention goals, and deployed new technologies aimed at improving member retention, including the launch of our Customer Center. We believe these efforts will lead to improved plan duration trends during 2021.

2019 compared to 2018 – The constrained LTV of commissions per approved member for Medicare Advantage plans increased by 5% in 2019 compared to 2018, primarily due to improved member attrition and higher commission rates. The constrained LTV for Medicare Supplement approved members declined by 6% primarily as a result of a decrease in the average plan duration, and the constrained LTV of commissions per Medicare Part D approved member declined by 2% primarily as a result of carrier mix.

Individual and Family and Ancillaries

2020 compared to 2019 – The constrained LTV of commissions per approved qualified health plan member increased by 22% in 2020 compared to 2019 primarily due to increased estimates of average plan duration. The constrained LTV of commissions per short-term health insurance approved member increased 60% in 2020 compared to 2019 primarily as a result of selling plans with higher premium and an increase in estimated average plan duration. The constrained LTV of commission per approved member for dental plans increased by 13% in 2020 compared to 2019 primarily due to an increase in estimated average plan duration and lower constraints as a result of reduced volatility based on historical trends.

2019 compared to 2018 – The constrained LTV of commissions per qualified and non-qualified health plan for approved members increased by 54% and 41%, in 2019 compared to 2018, respectively, mostly due to improved plan duration. The constrained LTV of commissions per short-term approved member increased 80% in 2019 compared to 2018, primarily driven by an increase in average plan duration.

Estimated Membership

Estimated membership represents the estimated number of members active as of the date indicated based on the number of members for whom we have received or applied a commission payment during the period of estimation. The following table shows estimated membership by product as of the periods presented below:

	As of December 31,		
	2020	2019	2018
Medicare [1]			
Medicare Advantage	533,282	404,694	276,357
Medicare Supplement	104,188	93,477	70,426
Medicare Part D	238,503	212,478	139,907
Total Medicare	875,973	710,649	486,690
Individual and Family [2]	116,247	128,487	151,904
Ancillaries [3]			
Short-term	23,088	27,862	24,192
Dental	118,647	127,083	138,916
Vision	68,587	71,277	73,987
Other	37,033	38,119	38,136
Total Ancillaries	247,355	264,341	275,231
Small Business [4]	45,771	42,638	39,101
Total Estimated Membership	1,285,346	1,146,115	952,926

(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 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.

(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.

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 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. 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. 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.

2020 compared to 2019 – Medicare estimated membership grew 23% as of December 31, 2020 compared to December 31, 2019 driven by a 32% increase in Medicare Advantage, as well as 12% and 11% increases in Medicare Part D prescription drug plan and Medicare Supplement plan estimated membership, respectively. The overall growth in Medicare estimated membership was due to our investment in our Medicare business. Individual and family plan estimated membership declined by 10% as of December 31, 2020 compared to December 31, 2019 due to market conditions in the individual and family plan market and our decision to shift our investment to our Medicare business. Ancillary plan estimated membership as of December 31, 2020 declined 6% compared to estimated membership as of December 31, 2019 primarily as a result of the decline of estimated membership of dental, short-term health plans, and vision plans.

2019 compared to 2018 – Medicare estimated membership grew 46% as of December 31, 2019 compared to December 31, 2018 primarily driven by a 46% and 52% increase in Medicare Advantage and Medicare Part D prescription drug plan estimated membership, respectively. Individual and family plan estimated membership declined by 15% as of December 31, 2019 compared to December 31, 2018 primarily due to market conditions in the individual and family plan market and our decision to shift our marketing investments towards our Medicare business. Ancillary plan estimated membership declined 4% as of December 31, 2019 compared to December 31, 2018, primarily due to a 9% decline in dental plan estimated membership. Small business estimated membership grew 9% as of December 31, 2019 compared to December 31, 2018, primarily driven by our focus on key partnerships and technology enhancements.

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 expenses ("CC&E") 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 years 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 year, 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 year to year, the weight given to each product was determined based on their relative LTVs at the time of our adoption of ASC 606.

	Year Ended December 31,		
	2020	2019	2018
Medicare:			
Estimated CC&E cost per approved MA-equivalent approved member [1]	$ 368	$ 355	$ 315
Estimated variable marketing cost per MA-equivalent approved member [1]	384	330	297
Total Medicare estimated cost per approved member	$ 752	$ 685	$ 612
Individual and Family Plan:			
Estimated CC&E cost per IFP-equivalent approved member [2]	$ 92	$ 102	$ 61
Estimated variable marketing cost per IFP-equivalent approved member [2]	83	67	59
Total IFP estimated cost per approved member	$ 175	$ 169	$ 120

(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 years 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 years presented.

2020 compared to 2019 – Estimated CC&E costs per approved MA-equivalent member increased 4% in 2020 compared to 2019, due to underperformance of vendor agents which led to lower than expected approved members. Estimated variable marketing costs per approved MA-equivalent member increased by 16% in 2020 compared to 2019, due to a larger portion of applications originating from our online marketing channels which tend to have higher average marketing costs, and it was also impacted by underperformance of vendor agents which resulted in lower than expected approved members. Going forward, we expect a reduction in member acquisition costs per approved MA-equivalent member as a result of improved productivity of our agent force by

shifting to a predominantly internal employed agent model and, to a lesser extent, an increase in the percentage of unassisted online enrollment.

Estimated variable CC&E cost per approved IFP-equivalent member decreased 10% in 2020 compared to 2019 due primarily to a decrease in personnel-related costs and an increase in the number of approved members. Estimated variable marketing cost per approved IFP-equivalent member increased by 24% in 2020 compared to 2019 primarily driven by an increase in variable marketing costs.

2019 compared to 2018 – Estimated CC&E costs per approved MA-equivalent member increased 13% in 2019 compared to 2018, due to our decision to have more customer care agents during the lower volume quarters, and a significant increase in overtime costs and average call length during the peak volume period in the fourth quarter. Estimated variable marketing costs per approved MA-equivalent member increased by 11% in 2019 compared to 2018, due to an increase in online advertising costs and higher variable marketing costs for select initiatives within the direct and partner channels. As we increased our spending on digital advertising channel for accelerated enrollment growth and market share expansion, the average costs were higher per member.

Estimated variable CC&E cost per approved IFP-equivalent member increased 67% in 2019 compared to 2018, also primarily driven by decline in the number of approved members for non-qualified health plans, qualified health plans, and short-term products as well as increase in investments of IFP-dedicated customer care agents. Estimated variable marketing cost per approved IFP-equivalent member increased by 14% in 2019 compared to 2018 primarily driven by a decline in the number of approved members for non-qualified health plans, qualified health plans, and short-term products.

Results of Operations

The following table sets forth our operating results and related percentage of total revenues for the years presented below (dollars in thousands):

	Year Ended December 31,					
	2020		2019		2018	
Revenue:						
Commission	$ 508,189	87 %	$ 466,676	92 %	$ 227,211	90 %
Other	74,585	13 %	39,525	8 %	24,184	10 %
Total revenue	582,774	100 %	506,201	100 %	251,395	100 %
Operating costs and expenses [(1)]						
Cost of revenue	4,083	1 %	2,738	1 %	1,228	— %
Marketing and advertising	209,340	36 %	150,249	30 %	82,939	33 %
Customer care and enrollment	172,895	30 %	134,304	27 %	70,547	28 %
Technology and content	65,188	11 %	47,085	9 %	31,970	13 %
General and administrative	76,452	13 %	64,150	13 %	45,828	18 %
Change in fair value of earnout liability	—	— %	24,079	4 %	12,300	5 %
Amortization of intangible assets	1,493	— %	2,187	— %	2,091	1 %
Restructuring charges	—	— %	—	— %	1,865	1 %
Acquisition costs	—	— %	—	— %	76	— %
Total operating costs and expenses	529,451	91 %	424,792	84 %	248,844	99 %
Income from operations	53,323	9 %	81,409	16 %	2,551	1 %
Other income, net	666	— %	2,090	— %	755	— %
Income before income taxes	53,989	9 %	83,499	16 %	3,306	1 %
Provision for income taxes	8,539	1 %	16,612	3 %	3,065	1 %
Net income	$ 45,450	8 %	$ 66,887	13 %	$ 241	— %

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

	Year Ended December 31,		
	2020	2019	2018
Marketing and advertising	$ 5,102	$ 4,230	$ 1,974
Customer care and enrollment	2,723	1,451	816
Technology and content	5,460	3,611	1,675
General and administrative	11,887	13,278	7,824
Restructuring charges	—	—	251
Total stock-based compensation expense	$ 25,172	$ 22,570	$ 12,540

Revenue

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

	2020	Change $	Change %	2019	Change $	Change %	2018
Commission	$ 508,189	$ 41,513	9%	$ 466,676	$ 239,465	105%	$ 227,211
% of total revenue	87 %			92 %			90 %
Other	74,585	35,060	89%	39,525	15,341	63%	24,184
% of total revenue	13 %			8 %			10 %
Total revenue	$ 582,774	$ 76,573	15%	$ 506,201	254,806	101%	$ 251,395

2020 compared to 2019 – Commission revenue increased $41.5 million, or 9% in 2020 compared to 2019 due to a $35.2 million increase in commission revenue from the Medicare segment and a $6.3 million increase in commission revenue from Individual, Family and Small Business segment. The increase in commission revenue from the Medicare segment was driven by a 16% increase in Medicare plan approved members, primarily attributable to a 39% growth in Medicare Advantage plan approved members, partially offset by a decrease in net adjustment revenue for the year ended December 31, 2020 compared to 2019 and a decline in the estimated constrained LTV for Medicare Advantage plans. Excluding $42.3 million revenue recorded in the fourth quarter of 2019 related to a change in estimate of expected cash commission collections for Medicare Advantage plans since we began selling such products through the third quarter of 2019, commission revenue increased 20% in 2020 as compared to 2019. The increase in commission revenue from Individual, Family and Small Business segment was primarily driven by a 21% increase in adjustment revenue and a 4% increase in individual and family plan approved members. See *Segment Information* below for further discussion.

Net adjustment revenue consists of increases in revenue for certain prior period cohorts as well as reductions in revenue for certain prior period cohorts. We recognize positive adjustments to revenue to the extent that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur. Net adjustment revenue for our Medicare segment in 2020 and 2019 was $5.7 million and $55.3 million, respectively. For our Individual, Family and Small Business segment net adjustment revenue in 2020 and 2019 was $39.8 million and $32.9 million, respectively. See *Note 2 – Revenue* in our *Notes to Consolidated Financial Statements* for more information.

Other revenue increased $35.1 million, or 89% in 2020 compared to the same period in 2019 due to an increase in Medicare advertising revenue as a result of an increase in the size and number of advertising programs with certain carriers.

2019 compared to 2018 – Commission revenue increased $239.5 million, or 105% in 2019 compared to 2018 due to a $219.0 million increase in commission revenue from the Medicare segment and a $20.5 million increase in commission revenue from Individual, Family and Small Business segment. The increase in commission revenue from the Medicare segment was attributable to an 81% increase in Medicare plan approved members, higher LTVs for Medicare Advantage plans, and an increase in adjustment revenue from Medicare Advantage plans approved in prior periods. Of the adjustment revenue of $55.3 million for the year ended December 31, 2019, $42.3 million was related to a change in estimate of expected cash commission collections for Medicare Advantage plans since we began selling such products through the third quarter of 2019. The increase in individual and family commission revenue was primarily driven by an increase in LTVs for IFP plans and an increase in adjustment revenue from IFP plans approved in prior periods as we continued to observe longer member duration than initially anticipated at the time of enrollment for these plans

Other revenue increased $15.3 million, or 63%, in 2019 compared to 2018, primarily driven by a $17.4 million growth in Medicare advertising revenue, partially offset by a $2.1 million decline in revenue from our individual and family health insurance sponsorship advertising program.

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):

		Change			Change		
	2020	$	%	2019	$	%	2018
Cost of revenue	$ 4,083	$ 1,345	49 %	$ 2,738	$ 1,510	123 %	1,228
% of total revenue	1 %			1 %			— %

2020 compared to 2019 – Cost of revenue increased $1.3 million in 2020, compared to $2.7 million in 2019, primarily due to increased activity from our revenue sharing arrangements.

2019 compared to 2018 – Cost of revenue increased $1.5 million in 2019, compared to $1.2 million in 2018, primarily due to an increased amount of payments to marketing partners with whom we have 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. We recognize expenses in our direct member acquisition channel in the period in which they are incurred. We generally compensate our marketing partners for referrals based on the consumer submitting a health insurance application on our platform, regardless of whether the consumer's application is approved by the health insurance carrier, or for the referral of a Medicare-related lead to us by the marketing partner. Some of our partners such as pharmacies and hospital networks are not compensated for referrals to us as a result of legal requirements. These organizations have relationships with us to provide their customers and patients with our consumer experience and to help them find the plan that best meets their needs. Some of our marketing partners have tiered arrangements where the amount we pay the marketing partner per submitted application increases as the volume of submitted applications we receive from the marketing partner increases. We recognize these expenditures in the period when a marketing partner’s referral results in the submission of a health insurance application. In our Medicare business, our current emphasis is on reducing the contribution from the lead aggregator marketing channel that is characterized by high acquisition costs and emphasizing strategic partnerships including relationships with health care industry participants, such as pharmacies and hospital networks, and with affiliate organizations where our acquisition costs may be significantly lower.

Since the total volume of submitted applications that we receive from our marketing partners is largely outside of our control, particularly during any short-term period, and because of our tiered marketing partner

arrangements, we could incur expenses in excess of, or below, the amounts we had planned in periods of rapid change in the volume of submitted applications from marketing partner referrals. Similar to our marketing partner channel, expenses in our online advertising channel will increase or decrease in relation to any increase or decrease in consumers referred to our website as a result of search engine advertising or retargeting campaigns. We recognize expenses in our online advertising member acquisition channels in the period in which the consumer clicks on the advertisement. Increases in submitted applications resulting from marketing partner referrals or visitors to our website from our online advertising channel has in the past, and could in the future, result in marketing and advertising expenses significantly higher than our expectations.

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

		Change			Change		
	2020	$	%	2019	$	%	2018
Marketing and advertising	$ 209,340	$ 59,091	39 %	$ 150,249	$ 67,310	81 %	$ 82,939
% of total revenue	36 %			30 %			33 %

2020 compared to 2019 – Marketing and advertising expenses increased by $59.1 million or 39% in 2020, compared to 2019, primarily driven by a $56.3 million increase in Medicare plan related variable advertising costs, and $2.4 million increase in consulting. The increase in variable advertising expenses was due to an increase in our investment for Medicare enrollment growth and the increase in expense as a percentage of revenue reflects lower than expected volumes driven by underperformance of certain marketing channels.

2019 compared 2018 – Marketing and advertising expenses increased by $67.3 million or 81% in 2019, compared to 2018, primarily driven by a $59.3 million increase in Medicare plan related variable advertising costs and a $4.4 million increase in personnel costs due to higher headcount as we continued to invest in our marketing initiatives in Medicare-related products.

Customer Care and Enrollment

Customer care and enrollment expenses primarily consist of compensation and benefits 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):

		Change			Change		
	2020	$	%	2019	$	%	2018
Customer care and enrollment	$ 172,895	$ 38,591	29 %	$ 134,304	$ 63,757	90 %	$ 70,547
% of total revenue	30 %			27 %			28 %

2020 compared to 2019 – Customer care and enrollment expenses increased by $38.6 million, or 29%, in 2020 compared to 2019. This increase was primarily driven by $27.5 million increase in personnel costs associated with an increase in customer care and enrollment headcount, $5.1 million increase in consulting expenses, $2.8 million increase in facilities and other operating expenses, $1.3 million increase in stock-based compensation and $1.0 million increase in licensing costs.

2019 compared to 2018 – Customer care and enrollment expenses increased by $63.8 million, or 90%, in 2019 compared to 2018. This increase was primarily due to a $28.4 million increase in personnel costs and a $24.3 million increase for the external agents hired for the AEP in the fourth quarter. The increase in personnel costs resulted from higher headcount in the lower application volume quarters compared to the prior year as we started to hire and train agents earlier in 2019 in preparation for the AEP in the fourth quarter, a significant increase in

overtime costs and average call length during the peak volume period in the fourth quarter, as well as the expenses incurred related to the opening of the new customer care center in Indianapolis.

Historically, we experienced a seasonal increase in customer care and enrollment costs during the third and fourth quarters primarily due to increased customer care center staffing to handle the anticipated increased volume of health insurance transactions during the AEP in the fourth quarter. A significant portion of these costs were due to increased outsourced vendor agent costs. Going forward, we plan to shift to a predominantly internal agent model and will employ and maintain the majority of our health insurance agent force year-round. We expect to increase our internal agents' utilization outside of the enrollment periods by expanding our offerings of ancillary products and increasing our outbound calling efforts. As a result, we expect to incur increased customer care and enrollment costs beginning earlier in 2021 and a reduced level of outsourced vendor agent costs during the fourth quarter AEP season.

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):

		Change			Change		
	2020	$	%	2019	$	%	2018
Technology and content	$ 65,188	$ 18,103	38 %	$ 47,085	$ 15,115	47 %	$ 31,970
% of total revenue	11 %			9 %			13 %

2020 compared to 2019 – Technology and content expenses increased $18.1 million, or 38%, in 2020 compared to 2019, primarily driven by increases of $8.4 million in personnel and compensation costs, $5.8 million in facilities and other operating costs, $3.9 million in amortization of internally developed software and $1.8 in stock-based compensation expense, partially offset by $2.1 million decrease in consulting expense.

2019 compared 2018 – Technology and content expenses increased $15.1 million, or 47%, in 2019 compared to 2018, primarily driven by increases of $5.3 million in personnel and compensation costs, $3.3 million in consulting expenses, and $2.6 million in facilities and other operating costs.

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):

		Change			Change		
	2020	$	%	2019	$	%	2018
General and administrative	$ 76,452	$ 12,302	19 %	$ 64,150	$ 18,322	40 %	$ 45,828
% of total revenue	13 %			13 %			18 %

2020 compared to 2019 – General and administrative expenses increased by $12.3 million, or 19%, in 2020 compared to 2019, primarily driven by increases of $5.2 million in compensation and personnel costs, $3.0 million in consulting expense, and $2.8 million in facilities and other operating costs.

2019 compared to 2018 – General and administrative expenses increased by $18.3 million, or 40%, in 2019 compared to 2018, primarily driven by increases of $7.5 million in compensation and personnel costs, $5.4 million in stock-based compensation expense, and $2.5 million in legal and professional fees.

Change in Fair Value of Earnout Liability

During the year ended December 31, 2020, there were no changes in fair value of earnout liability as the earnout consideration was settled in January 2020. During the year ended December 31, 2019, we recorded a $24.1 million increase in the fair value of earnout liability. The adjustment to fair value of earnout liability in 2019 was due to an increase in the value of our common stock since our acquisition of GoMedigap in January 2018.

Amortization of Intangible Assets

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

		Change			Change		
	2020	$	%	2019	$	%	2018
Amortization of intangible assets	$ 1,493	$ (694)	(32)%	$ 2,187	$ 96	5 %	$ 2,091
% of total revenue	— %			— %			1 %

2020 compared to 2019 – Amortization expense was primarily related to intangible assets purchased through our acquisitions. Amortization expense decreased in 2020 compared to 2019 due to certain intangible assets being fully amortized in 2020.

2019 compared to 2018 – Amortization expense was primarily related to intangible assets purchased through our acquisitions of PlanPrescriber and GoMedigap. Amortization expense in 2019 remained flat compared to 2018.

Other Income, Net

Other income, 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, net is summarized as follows (dollars in thousands):

		Change			Change		
	2020	$	%	2019	$	%	2018
Other income, net	$ 666	$ (1,424)	(68)%	$ 2,090	$ 1,335	177 %	$ 755
% of total revenue	— %			— %			— %

2020 compared to 2019 – Other income, net, decreased by $1.4 million or 68% in 2020 compared to 2019 due primarily to a decrease in interest income.

2019 compared to 2018 – Other income, net, increased by $1.3 million or 177% in 2019 compared to 2018 primarily driven by an increase in interest income and an increase in margin earned on from members previously

transferred from a broker partner, partially offset by the accretion of debt related costs incurred from the debt facility that we entered into in 2018 and amended in 2019.

Provision for Income Taxes

The following table presents our provision for income taxes for the years presented below (dollars in thousands):

	2020	Change $	Change %	2019	Change $	Change %	2018
Provision for income taxes	$ 8,539	$ (8,073)	(49)%	$ 16,612	$ 13,547	442 %	$ 3,065
Effective tax rate	15.8 %			19.9 %			92.7 %

2020 compared to 2019 – For the year ended December 31, 2020, we recorded a provision for income taxes of $8.5 million representing an effective tax rate of 15.8%, which is lower than the effective tax rate of 19.9% in 2019 primarily due to increased impact from stock-based compensation tax benefits and higher research and development tax credits as compared to 2019.

2019 compared to 2018 – For the year ended December 31, 2019, we recorded a provision for income taxes of $16.6 million representing an effective tax rate of 19.9%, which is lower than the effective federal tax rate of 92.7% for 2018 primarily due to a $2.4 million valuation allowance which was recorded in 2018 against certain state net operating losses.

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. 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, by segment, 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 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 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, change in fair value of earnout liability, depreciation and amortization expense, and amortization of intangible assets.

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

		Change			Change		
	2020	$	%	2019	$	%	2018
Revenue							
Medicare	$ 516,762	$ 69,801	16 %	$ 446,961	$ 236,391	112 %	$ 210,570
Individual, Family and Small Business	66,012	6,772	11 %	59,240	18,415	45 %	40,825
Total revenue	$ 582,774	76,573	15 %	$ 506,201	254,806	101 %	$ 251,395
Segment profit							
Medicare segment profit	$ 101,963	(53,271)	(34)%	$ 155,234	94,390	155 %	$ 60,844
Individual, Family and Small Business segment profit	39,383	16,015	69 %	23,368	17,565	303 %	5,803
Total segment profit	141,346	(37,256)	(21)%	178,602	111,955	168 %	66,647
Corporate	(57,664)	(12,290)	27 %	(45,374)	(12,378)	38 %	(32,996)
Stock-based compensation expense	(25,172)	(2,602)	12 %	(22,570)	(10,281)	84 %	(12,289)
Depreciation and amortization	(3,694)	(711)	24 %	(2,983)	(504)	20 %	(2,479)
Change in fair value of earnout liability	—	24,079	(100)%	(24,079)	(11,779)	96 %	(12,300)
Restructuring charges	—	—	*	—	1,865	(100)%	(1,865)
Acquisition costs	—	—	*	—	76	(100)%	(76)
Amortization of intangible assets	(1,493)	694	(32)%	(2,187)	(96)	5 %	(2,091)
Other income, net	666	(1,424)	(68)%	2,090	1,335	177 %	755
Income before income taxes	$ 53,989	$ (29,510)	(35)%	$ 83,499	$ 80,193	2,426 %	$ 3,306

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* Percentage calculated is not meaningful.

2020 compared to 2019

Revenue **–** Revenue from Medicare segment revenue grew $69.8 million or 16% in 2020 compared to 2019, primarily attributable to an increase in Medicare Advantage plan related commission revenue of $35.2 million and an increase in other revenue of $34.6 million. Excluding $42.3 million revenue resulting from a change in estimate recorded in the fourth quarter of 2019 regarding expected cash commission collections for Medicare Advantage plans since we began selling such products through the third quarter of 2019, Medicare segment revenue increased 28% in 2020 compared to 2019.The increase in Medicare Advantage commission revenue was driven by 39% growth in Medicare Advantage approved members. The overall growth of our Medicare business was a result of our investment and marketing efforts in this segment and the increases in approved application volume due to the

open enrollment period in the first quarter and the COVID-19 related special enrollment period introduced in the second quarter. The increase in other revenue was driven by an increase in advertising revenue due to increases in size and number of advertising arrangements.

Revenue from Individual, Family and Small Business segment grew $6.8 million, or 11% in 2020 compared to 2019, primarily attributable to $6.3 million increase in commission revenue. The increase in commission revenue from Individual, Family and Small Business segment was primarily due to an increase in adjustment revenue of $7.0 million in 2020 compared to 2019, partially offset by $0.6 million decrease in commission revenue from members approved during the period. We recognized $39.8 million adjustment revenue in 2020 due to stronger retention rates for earlier period cohorts of certain products based on our latest LTV assessment.

Segment Profit – Our Medicare segment profit was $102.0 million in 2020, a decrease of $53.3 million or 34%, compared to 2019. This was primarily due to a $123.1 million increase in operating expenses, excluding stock-based compensation expense, change in earnout liability, depreciation and amortization expenses, and amortization of intangible assets, partially offset by a $69.8 million increase in revenue. The increase in operating expenses was mostly attributable to increases in marketing costs and customer care and enrollment costs as we continued to invest in telesales capacity, internal agent counts, agent productivity tools and incentives, customer engagement and retention initiatives, and enhancements to our technology platform. Our Medicare segment profit was negatively impacted by the underperformance of our outsourced external agent force and certain of our marketing channels during the fourth quarter 2020 AEP. We also believe that some external factors, including the COVID-19 pandemic and, to a lesser extent, the prolonged election cycle, might have influenced consumer demand.

Our Individual, Family and Small Business segment profit was $39.4 million in 2020, an increase of $16.0 million or 69% compared to 2019. The increase was primarily driven by a $6.8 million increase in revenue and a $9.2 million decrease in operating expenses, excluding stock-based compensation expense, change in earnout liability, depreciation and amortization expenses, and amortization of intangible assets.

2019 compared to 2018

Revenue – Medicare segment revenue grew $236.4 million or 112% in 2019 compared to 2018, primarily attributable to an increase in Medicare Advantage plan related commission revenue of $196.4 million. This was driven by 88% increase in approved Medicare Advantage applications in 2019 compared to 2018 and an increase in adjustment revenue for Medicare Advantage plans approved in prior periods.

Revenue from Individual, Family and Small Business segment grew $18.4 million or 45% in 2019 compared to 2018, primarily attributable to $11.1 million increase in non-qualified health plans commission revenue and $7.0 million increase in ancillary commission revenue. The increases were primarily attributable to an increase in net adjustment revenue.

Segment Profit – Our Medicare segment profit was $155.2 million in 2019, an increase of $94.4 million or 155%, compared to 2018. This was primarily driven by a $236.4 million increase in revenue, partially offset by a $142.0 million increase in operating expenses, excluding stock-based compensation expense, change in earnout liability, depreciation and amortization expenses, and amortization of intangible assets. The increase in operating expenses was mostly attributable to increased variable marketing costs and customer care and enrollment costs.

Our Individual, Family and Small Business segment profit was $23.4 million in 2019, an increase of $17.6 million or 303% compared to 2018. The increase was primarily driven by an $18.4 million increase in revenue and a $0.9 million increase in operating expenses, excluding stock-based compensation expense, change in earnout liability, depreciation and amortization expenses, and amortization of intangible assets.

Liquidity and Capital Resources

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

	December 31, 2020	December 31, 2019
Cash and cash equivalents	$ 43,759	$ 23,466
Short-term marketable securities	49,620	—
Total cash, cash equivalents, and short-term marketable securities	$ 93,379	$ 23,466

We believe our current cash and cash equivalents, credit facility, and expected cash collections will be sufficient to fund our operations for at least twelve months after the filing date of this Annual Report on Form 10-K. Our future capital requirements will depend on many factors, including our expected membership, retention rates, and our level of investment in technology, marketing and advertising and our customer care initiatives. In addition, our cash position could be impacted by further acquisitions and investments we make to pursue our growth strategy.

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.

As of December 31, 2020 and 2019, our cash and cash equivalents totaled $43.8 and $23.5 million, respectively. 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. The increase in cash and cash equivalents reflects $201.2 million of net cash provided by financing activities, partially offset by $73.3 million of net cash used in investing activities and $107.9 million of net cash used in operating activities. See *Note 6 — Equity* in our *Notes to Consolidated Financial Statements* for information regarding our equity offering in March 2020. We also had $3.4 million in restricted cash as of December 31, 2020 and December 31, 2019.

As of December 31, 2020 and 2019, we had 1.1 million and 1.0 million shares held in treasury stock, respectively, that were shares repurchased to satisfy tax withholding obligations. As of December 31, 2020 and 2019, we had a total of 11.8 million and 11.6 million shares held in treasury stock, respectively, including 10.7 million shares previously repurchased.

Our cash flows are summarized as follows (in thousands):

	Year Ended December 31,		
	2020	2019	2018
Net cash used in operating activities	$ (107,860)	$ (71,492)	$ (3,230)
Net cash used in investing activities	(73,283)	(16,944)	(25,757)
Net cash provided by financing activities	201,249	102,141	1,860

Operating Activities

Net cash used in operating activities primarily consists of net loss, adjusted for certain non-cash items, including change in fair value of earnout liability, 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 expenses 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 AEP which takes place during the last quarter of each year, we experience an increase in the number of submitted Medicare-related health insurance applications and marketing and advertising expenses compared to outside of Medicare annual enrollment periods. Similarly, during open enrollment periods for individual and family health insurance plans which takes place during the first 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 open enrollment periods for individual and family health insurance and the Medicare AEP and open enrollment period for Medicare-related health insurance can positively or negatively affect our cash flows during each quarter.

Year Ended December 31, 2020 – Net cash used in operating activities was $107.9 million during the year ended December 31, 2020, primarily driven by cash used from changes in net operating assets and liabilities of $201.3 million, partially offset by net income of $45.5 million and adjustments for non-cash items of $48.0 million. Cash used from changes in net operating assets and liabilities during the year ended December 31, 2020 primarily consisted of an increase of $205.2 million in contract assets – commissions receivable, a decrease of $9.0 million in accrued compensation and benefits, an increase of $6.2 million in prepaid expenses and other assets and a decrease of $2.3 million in deferred revenue, partially offset by increases of $12.3 million in accounts payable, $5.7 million in accrued marketing expenses, and $2.8 million in accrued expenses and other liabilities. Adjustments for non-cash items primarily consisted of $25.2 million of stock-based compensation expense, $8.8 million change in deferred income taxes, $7.8 million of amortization of internally-developed software, and $1.5 million of amortization of intangible assets.

Year Ended December 31, 2019 – Net cash used in operating activities was $71.5 million in 2019, consisted of cash used for working capital needs and other activities of $209.5 million, partially offset by net income of $66.9 million and adjustments for non-cash items totaling $71.1 million. Adjustments for non-cash items primarily consisted of $24.1 million change in fair value of earnout liabilities, $22.6 million of stock-based compensation expense, $16.2 million increase in deferred income taxes, $3.8 million of amortization of internally-developed software, $3.0 million of depreciation and amortization, and $2.2 million of amortization of intangible assets. The cash decrease resulting from changes in working capital in 2019 primarily consisted of $243.4 million increase in commissions receivable, partially offset by increases of $19.7 million in accounts payable, $8.8 million in accrued compensation and benefits, $1.9 million in accrued expenses and other liabilities, $1.7 million in deferred revenue, and $1.0 million in accrued marketing expenses.

Year Ended December 31, 2018 – Net cash used in operating activities was $3.2 million during the year ended December 31, 2018, primarily driven by changes in net operating assets and liabilities of $38.6 million and, partially offset by adjustments for non-cash items of $35.1 million. Adjustments for non-cash items primarily consisted of $12.5 million of stock-based compensation expense, $12.3 million change in fair value of earnout liability, $2.8 million change in deferred income taxes, $2.5 million of depreciation and amortization, $2.2 million of

amortization of internally-developed software, and $2.1 million of amortization of intangible assets. Cash used from changes in net operating assets and liabilities during the year ended December 31, 2018 primarily consisted of increases of $51.0 million in contract assets – commissions receivable and $2.1 million in accounts receivable, partially offset by increases of $6.3 million in accrued marketing expenses, $5.1 million in accrued compensation and benefits, and $1.4 million in accounts payable.

Investing Activities

Our investing activities primarily consist of purchases and redemption of marketable securities, purchases of computer hardware and software to enhance our website and customer care operations, leasehold improvements related to facilities expansion, internal-use software and the purchase of certain intangible assets.

Year Ended December 31, 2020 – Net cash used in investing activities of $73.3 million during 2020 mainly consisted of $180.5 million used to purchase marketable securities, $16.0 million of capitalized internal-use software and website development costs, and $7.8 million used to purchase property and equipment and other assets, partially offset by $131.0 million of proceeds from redemption and maturities of marketable securities.

Year Ended December 31, 2019 – Net cash used in investing activities of $16.9 million during 2019 mainly consisted of $10.2 million of capitalized internal-use software and website development costs and $6.6 million used to purchase property and equipment and other assets.

Year Ended December 31, 2018 – Net cash used in investing activities of $25.8 million during 2018 was due to $14.9 million of net cash used to acquire GoMedigap, $6.3 million of capitalized internal-use software and website development costs, and $4.5 million used to purchase property and equipment and other assets.

Financing Activities

Year Ended December 31, 2020 – Net cash provided by financing activities of $201.2 million during 2020 was primarily attributable to $228.0 million proceeds from issuance of common stock, net of issuance costs and $1.9 million of net proceeds from exercise of common stock options, partially offset by $19.8 million cash used for share repurchases to satisfy employee tax withholding obligations and $8.8 million of acquisition-related contingent consideration payments.

Year Ended December 31, 2019 – Net cash provided by financing activities of $102.1 million during 2019 was primarily attributable to $126.1 million proceeds from issuance of common stock, net of issuance costs and $5.5 million of net proceeds from exercise of common stock options, partially offset by $14.3 million cash used for share repurchases to satisfy employee tax withholding obligations, $9.5 million of acquisition-related contingent payments, and $5.0 million repayment of debt.

Year Ended December 31, 2018 – Net cash provided by financing activities of $1.9 million during 2018 was primarily due to $5.0 million of proceeds from drawing on our line of credit, $2.7 million of net proceeds from exercises of common stock options, partially offset by $4.5 million used for share repurchases to satisfy employee tax withholding obligations, and $1.2 million of debt issuance costs.

Common Stock Issuance

In January 2019, we entered into an underwriting agreement with RBC Capital Markets, LLC and Credit Suisse Securities (USA) LLC as representatives of the several underwriters to issue and sell a total of 2,760,000 shares of our common stock in a public offering, which total included the exercise in full of the underwriters' option to purchase 360,000 additional shares of common stock, at a price to the public of $48.50 per share, for total net proceeds of $126.2 million, after deducting underwriting discounts, commissions and offering expenses.

In March 2020, we entered into an underwriting agreement to issue and sell a total of 2,070,000 shares of common stock, which total included the exercise in full of the underwriters' option to purchase 270,000 additional shares of common stock, at a price to the public of $115.00 per share. Net proceeds from the offering were approximately $228.0 million after deducting underwriting discounts, commissions and expenses of the offering. We intend to use the net proceeds of the offering for general corporate purposes, including working capital.

Preferred Stock

On February 17, 2021, we entered into an investment agreement with H.I.G. pursuant to which we have agreed to sell to H.I.G. at closing, 2,250,000 shares of our newly designated 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. The Private Placement is subject to closing conditions, including, among others: (i) the expiration or early termination of the waiting period (and any extension thereof) applicable to the consummation of the Private Placement under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended; (ii) the confirmation by Nasdaq that it has no objection to the terms and conditions of the Private Placement; and (iii) the determination that consummation of the Private Placement would not cause our outside auditor to no longer be deemed independent under the rules and regulations of the Securities and Exchange Commission or the Public Company Accounting Oversight Board. The parties have agreed to cooperate with each other and use reasonable best efforts to promptly take such actions to cause the closing conditions to be satisfied as promptly as reasonably practicable.

Dividends will initially accrue on the Series A preferred stock daily at 8% per annum on the Stated Value per share and compound semiannually, payable in kind until the second anniversary of the closing date of the Private Placement on June 30 and December 31 of each year, beginning on June 30, 2021, and thereafter 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 will also participate, 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.

At any time on or after the sixth anniversary of the closing date of the Private Placement, 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.

Credit Agreement

We entered into a credit agreement with Royal Bank of Canada, or RBC, as administrative agent and collateral agent, (the "Credit Agreement") in September 2018. The Credit Agreement provides for a $40.0 million secured asset-backed revolving credit facility with a $5 million letter of credit sub-facility. On December 20, 2019, we amended our revolving credit facility agreement with RBC (the "Amendment") and increased the maximum borrowing amount to $75.0 million and extended the expiration to December 20, 2022.

The borrowing base under the Credit Agreement is comprised of an amount equal to (a) the lesser of (i) eighty percent (80%) of Eligible Commissions Receivables (as defined in the Credit Agreement) we actually collected during the immediately preceding period of three months or (ii) eighty percent (80%) of our Eligible Commission Receivables for the immediately succeeding period of three months, plus (b) fifty percent (50%) of our

Eligible Commission Receivables for the immediately succeeding period of six months (excluding the immediately succeeding period of three months), in each case subject to reserves established by RBC, or the Borrowing Base. The proceeds of the loans under the Credit Agreement may be used for working capital and general corporate purposes. We have the right to prepay the loans under the Credit Agreement in whole or in part at any time without penalty. Subject to availability under the Borrowing Base, amounts repaid may be reborrowed. Amounts not borrowed under the Credit Agreement are subject to a commitment fee of 0.5% per annum on the daily unused portion of the credit facility, to be paid in arrears on the first business day of each calendar quarter. At closing of the Credit Agreement, we paid a one-time facility fee of 1.75% of the total commitments of $40 million. We also paid a one-time closing fee of 0.5% of the new commitment of $75.0 million in connection with the Amendment. We are also obligated to pay other customary administration fees for a credit facility of this size and type.

As of December 31, 2020 and 2019, we had no outstanding principal amount under our revolving credit facility. See *Note 11 – Debt* of *Notes to Consolidated Financial Statements* included in this Annual Report on Form 10-K for additional information regarding this credit agreement and subsequent amendment.

Acquisition

On January 22, 2018, we completed our acquisition of Wealth, Health and Life Advisors, LLC, more commonly known as GoMedigap, a technology-enabled provider of Medicare Supplement enrollment services. The acquisition price paid at closing of the transaction consisted of cash of $15.0 million, less $0.1 million cash acquired, and approximately 294,637 shares of our common stock. In addition, we were obligated to pay an additional $20.0 million in cash and 589,275 shares of our common stock, subject to the terms of the acquisition agreement and upon final determination of the achievement of certain milestones in 2018 and 2019. The first and second earnout liability payments were made in February 2019 and January 2020, respectively. See *Note 5 – Fair Value Measurements* of our *Notes to Consolidated Financial Statements* for the discussion on the milestone payments.

Critical Accounting Policies and Estimates

The preparation of financial statements and related disclosures in conformity with U.S. generally accepted accounting principles, or U.S. GAAP, 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.

Among our significant accounting policies, which are described in *Note 1 – Summary of Business and Significant Accounting Policies* in our *Notes to Consolidated Financial Statements*, the following accounting policies and specific estimates involve a greater degree of judgments and complexity:

- Revenue recognition and contract assets - commission receivable;
- Stock-based compensation; and
- Accounting for income taxes.

During the year ended December 31, 2020, there were no significant changes to our critical accounting policies and estimates.

Revenue Recognition and Contract Assets - Commission Receivable

Commission Revenue – Our commission revenue results from approval of an application from health insurance carriers, which we define as our customers under ASC 606. Our commission revenue is primarily

comprised of commissions from health insurance carriers which is computed using the estimated constrained lifetime values as the "constrained LTVs" of commission payments that we expect to receive.

We estimate commission revenue for each insurance product by using a portfolio approach to a group of approved members by plan type and the effective month of the relevant plan, which we refer to as "cohorts". We estimate the commissions we expect to collect for each approved member cohort by evaluating various factors, including but not limited to, 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. Contract assets - commissions receivable represent the variable consideration for policies that have not renewed yet and therefore are subject to the same assumptions, judgements and estimates used when recognizing revenue as noted above.

For Medicare-related, individual and family and ancillary health insurance plans, our services are complete once a submitted application is approved by the relevant health insurance carrier. Accordingly, we recognize commission revenue based upon the total estimated lifetime commissions we expect to receive for selling the plan after the carrier approves an application, net of an estimated constraint. We refer to these as estimated and constrained LTVs for the plan. We provide annual services in selling and renewing small business health insurance plans; therefore, we recognize small business health insurance plan commission revenue at the time the plan is approved by the carrier, and when it renews each year thereafter, equal to the estimated commissions we expect to collect from the plan over the following twelve months. Our estimate of commission revenue for each product line is based on a number of assumptions, which include, but are not limited to, estimating conversion of an approved member to a paying member, forecasting average plan duration and forecasting the commission amounts likely to be received per member. These assumptions are based on our analysis of historical trends for the different cohorts and incorporate management's judgment in interpreting those trends to apply the constraints discussed below. The estimated average plan duration used to calculate Medicare health insurance plan LTVs historically has been approximately 3-5 years, while the estimated average plan duration used to calculate the LTV for major medical individual and family health insurance plans historically has been approximately six months to 3 years. To the extent we make changes to the assumptions we use to calculate constrained LTVs, we recognize any material impact of the changes to commission revenue in the reporting period in which the change is made, including revisions of estimated lifetime commissions either below or in excess of previously estimated constrained LTV recognized as revenue.

We recognize revenue for members approved during the period by applying the latest estimated constrained LTV for that product. We recognize adjustment revenue for members approved in prior periods when our cash collections are different from the estimated constrained LTVs. Adjustment revenue is a result of a change in estimate of expected cash collections when actual cash collections have indicated a trend that is different from the estimated constrained LTV for the revenue recognized at the time of approval. Adjustment revenue can be positive or negative and we recognize adjustment revenue when we do not believe there is a probable reversal. We assess the risk of reversal based on statistical analysis given historical information and consideration of the constraints used at the time of approval.

Adjustment revenue can have a significant favorable or unfavorable impact on our revenue and we seek to enhance our LTV estimation models to improve the accuracy and to reduce the fluctuations of our LTV estimates.

Other Revenue – Sponsorship and Advertising – Our sponsorship and advertising program allows carriers to purchase advertising space in specific markets in a sponsorship area on our website. In return, we are typically paid a fee, which is recognized over the period that advertising is displayed, and often a performance fee based on metrics such as submitted health insurance applications, which is recognized when control has been transferred. We also offer Medicare advertising services, which include website development, hosting and maintenance. In these instances, we are typically paid a fixed, up-front fee, which we recognize as revenue as control is transferred ratably over the service period.

Stock-Based Compensation

We recognize stock-based compensation expense in the accompanying Consolidated Statements of Comprehensive Income based on the fair value of our stock-based awards over their respective vesting periods, which is generally four years. The estimated attainment of performance-based awards and related expense is based on the expectations of revenue and earnings target achievement. The estimated fair value of performance awards with market conditions is determined using the Monte-Carlo simulation model. The assumptions used in calculating the fair value of stock-based payment awards and expected attainment of performance-based awards represent our best estimates, but these estimates involve inherent uncertainties and the application of management judgment. We will continue to use judgment in evaluating the expected term and volatility related to our own stock-based awards on a prospective basis, and incorporating these factors into the model. Changes in key assumptions could significantly impact the valuation of such instruments. The estimated grant date fair value of our stock options is determined using the Black-Scholes-Merton pricing model and a single option award approach. The weighted-average expected term for stock options granted is calculated using historical option exercise behavior. The dividend yield is determined by dividing the expected per share dividend during the coming year by the grant date stock price. Through December 31, 2020, we had not declared or paid any cash dividends to common stock holders, and we do not expect to pay any in the foreseeable future. We base the risk-free interest rate on the implied yield currently available on U.S. Treasury zero-coupon issues with a remaining term equal to the expected term of our stock options. Expected volatility is determined using a combination of the implied volatility of publicly traded options in our stock and historical volatility of our stock price.

Accounting for Income Taxes

We account for income taxes using the liability method. Deferred income taxes are determined based on the differences between the financial reporting and tax bases of assets and liabilities, using enacted statutory tax rates in effect for the year in which the differences are expected to reverse.

Since tax laws and financial accounting standards differ in their recognition and measurement of assets, liabilities, equity, revenues, expenses, gains and losses, differences arise between the amount of taxable income and pretax financial income for a year and between the tax bases of assets or liabilities and their reported amounts in our financial statements. Because we assume that the reported amounts of assets and liabilities will be recovered and settled, respectively, a difference between the tax basis of an asset or a liability and its reported amount in the balance sheet will result in a taxable or a deductible amount in some future years when the related liabilities are settled or the reported amounts of the assets are recovered, which gives rise to a deferred tax asset or liability. We must then assess the likelihood that our deferred tax assets will be recovered from future taxable income and to the extent we believe that recovery does not meet the more likely than not criteria, we must establish a valuation allowance. Management judgment is required in determining any valuation allowance recorded against our net deferred tax assets.

As part of the process of preparing our consolidated financial statements, we are required to estimate our income taxes. This process involves estimating our actual current tax expense together with assessing temporary differences that may result in deferred tax assets.

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.

Future changes in various factors, such as the amount of stock-based compensation we record during the period and the related tax benefit we realize upon the exercise of employee stock options, potential limitations on the

use of our federal and state net operating loss credit carry forwards, pending or future tax law changes including rate changes and the tax benefit from or limitations on our ability to utilize research and development credits, the amount of non-deductible lobbying and acquisition-related costs, changes in our valuation allowance and state and foreign taxes, would impact our estimates, and as a result, could affect our effective tax rate and the amount of income tax expense we record, and pay, in future periods.

Contractual Obligations and Commitments

The following table presents a summary of our future minimum payments under non-cancellable operating lease agreements and contractual service and licensing obligations as of December 31, 2020 (in thousands):

Years Ending December 31,	Operating Lease Obligations*	Service and Licensing Obligations	Total Obligations
2021	$ 7,644	$ 5,775	$ 13,419
2022	7,701	3,408	11,109
2023	8,033	2,745	10,778
2024	7,832	2,056	9,888
2025	8,009	1,353	9,362
Thereafter	19,408	1,353	20,761
Total	$ 58,627	$ 16,690	$ 75,317

* See *Note 10 – Leases* of our *Notes to Consolidated Financial Statements* for details of our operating lease obligations.

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. 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.

Off-Balance Sheet Arrangements

As of December 31, 2020, we did not have any off-balance sheet arrangements, as defined in Item 303(a)(4)(ii) of Regulation S-K, that have or are reasonably likely to have a current or future effect on our financial condition, changes in our financial condition, revenue, or expenses, results of operations, liquidity, capital expenditures, or capital resources that is material to investors.

Recent Accounting Pronouncements

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

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET 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):

	December 31, 2020	December 31, 2019
Cash and cash equivalents [1] [2]	$ 43,759	$ 23,466
Short-term marketable securities[2]	49,620	—
Restricted cash	3,354	3,354
Total cash, cash equivalents, short-term marketable securities, and restricted cash	$ 96,733	$ 26,820

[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 a major bank 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 5 – Fair Value Measurements* in our *Notes to 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 December 31, 2020, we invested $49.6 million in marketable securities primarily consisting of commercial paper and agency bonds with credit rating of AA+ or equivalent by S&P Rating and Moody's Investor Services. The maturity of these securities were below two years. See *Note 5 – Fair Value Measurements* in our *Notes to Consolidated Financial Statements* for further discussion on our available-for-sale debt securities.

As of December 31, 2020, our net contract assets consisted of commissions receivable balance of $792.4 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 commissions receivable amount recorded on the balance sheet. Upon the adoption of ASC 326, we recorded $1.5 million of allowance for credit losses for our commissions receivable balance as of December 31, 2019. During the year ended December 31, 2020, we recorded an additional $0.5 million for the allowance for credit losses. See *Note 1 – Summary of Business and Significant Accounting Policies* in our *Notes to Consolidated Financial Statements* for additional information regarding the accounting standard adoption.

Our total contract assets and accounts receivable as of December 31, 2020 and December 31, 2019 are summarized as follows (in thousands):

	December 31, 2020	December 31, 2019
Contract assets – commissions receivable – current	$ 219,153	$ 174,526
Contract assets – commissions receivable – non-current	573,252	414,696
Accounts receivable	1,799	2,332
Total contract assets and accounts receivable	$ 794,204	$ 591,554

Foreign Currency Exchange Risk

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 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Index to the Consolidated Financial Statements

Report of Independent Registered Public Accounting Firm

To the Stockholders and the Board of Directors of eHealth, Inc.

Opinion on the Financial Statements
We have audited the accompanying consolidated balance sheets of eHealth, Inc. (the Company) as of December 31, 2020 and 2019, the related consolidated statements of comprehensive income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2020, and the related notes (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2020 and 2019, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2020, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2020, based on criteria established in Internal Control - Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) and our report dated February 26, 2021 expressed an unqualified opinion thereon.

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

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

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

Revenue recognition: Estimated constrained lifetime value of commission revenue

Description of the Matter

The Company recognized commission revenue of approximately $508.2 million in 2020 and related commissions receivable were approximately $792.4 million at December 31, 2020. As described in Notes 1 and 2 to its consolidated financial statements, the Company's commission revenue is recognized as the amount of the total estimated lifetime value of the commissions expected to be received when a member obtains a plan through the Company and is approved by the carrier ("LTV").

Auditing management's determination of the LTV of commission revenue was especially complex and highly judgmental due to the complexity of the models used and the subjectivity required by the Company to estimate the amount and timing of future cash flows, calculate the amount of commission revenue that is probable of not being reversed, and determine the timing and amount of any adjustment revenue that results from changes in the estimates of previously recorded LTV. The Company utilizes statistical tools and methodologies to estimate member attrition, which is a key driver when estimating the amount and timing of future cash flows and can be particularly volatile during the first several years. To determine the initial constraint to be applied to LTV, the Company evaluates the difference between prior estimates of LTV and actual cash received and applies judgment to determine the constraint to apply. For the ongoing evaluation of the constraint, the Company also analyzes whether circumstances have changed and considers any known or potential modifications to the inputs into LTV and the factors that can impact the amount of cash expected to be collected in future periods such as commission rates, carrier mix, estimated average plan duration, changes in laws and regulations, and cancellations of insurance plans offered by health insurance carriers with which the Company has a relationship. The Company also compares actual versus expected cash collections of previously recorded LTV and assesses qualitative and quantitative factors to determine whether adjustment revenue should be recognized and, if so, the amount and timing of such.

How We Addressed the Matter in Our Audit

We obtained an understanding, evaluated the design, and tested the operating effectiveness of controls over the Company's process to estimate the amount and timing of future cash flows and LTV. These processes and controls include those covering the models and methods used to calculate LTV, the use of management judgment to determine the constraint applied to LTV, management's evaluation of any required adjustments to previously recorded LTV estimates, and the completeness and accuracy of the data used in such estimates and calculations.

Our audit procedures also included, among others, evaluating the methodology used and significant assumptions discussed above, and testing the completeness and accuracy of the underlying data used by the Company. We involved our valuation specialists to assist in our testing of the estimated average plan duration, which includes member attrition assumptions, including performing certain corroborative calculations. We inspected and compared the results of the Company's retrospective review analysis of historical estimates for certain plan effective years to historical cash collection experience, including reperforming the calculations and validating the completeness and accuracy of the underlying data used. In addition, we performed inquiries of key personnel regarding their evaluation of changes to LTV, the adjustments made to the constraint for current and expected future economic conditions, and any decisions on the timing and amount of adjustment revenue recognized. We also reviewed analyst reports, press releases, and other relevant third-party and/or industry trends data for contrary evidence including competitor data.

/s/ Ernst & Young LLP

We have served as the Company's auditor since 2000.
Redwood City, California
February 26, 2021

EHEALTH, INC.
CONSOLIDATED BALANCE SHEETS
(In thousands, except per share amounts)

	December 31, 2020*	December 31, 2019
Assets		
Current assets:		
Cash and cash equivalents	$ 43,759	$ 23,466
Short-term marketable securities	49,620	—
Accounts receivable	1,799	2,332
Contract assets – commissions receivable – current	219,153	174,526
Prepaid expenses and other current assets	16,661	7,822
Total current assets	330,992	208,146
Contract assets – commissions receivable – non-current	573,252	414,696
Property and equipment, net	14,609	10,518
Operating lease right-of-use assets	42,558	36,621
Restricted cash	3,354	3,354
Other assets	26,455	18,004
Intangible assets, net	8,569	10,062
Goodwill	40,233	40,233
Total assets	$ 1,040,022	$ 741,634
Liabilities and stockholders' equity		
Current liabilities:		
Accounts payable	$ 36,921	$ 24,554
Accrued compensation and benefits	20,542	29,578
Accrued marketing expenses	17,788	12,041
Earnout liability – current	—	37,273
Lease liabilities – current	5,192	4,759
Deferred revenue	308	2,570
Other current liabilities	3,657	2,210
Total current liabilities	84,408	112,985
Commitments and contingencies		
Deferred income taxes – non-current	72,317	64,130
Lease liabilities – non-current	41,369	34,305
Other non-current liabilities	4,370	3,050
Stockholders' equity:		
Preferred stock, par value $0.001 per share; 10,000 authorized; none issued and outstanding	—	—
Common stock, par value $0.001 per share; 100,000 authorized; 37,755 and 34,752 issued as of December 31, 2020 and 2019, respectively; 25,924 and 23,136 outstanding as of December 31, 2020 and 2019, respectively	38	35
Additional paid-in capital	721,013	455,159
Treasury stock, at cost: 11,831 and 11,616 shares as of December 31, 2020 and 2019, respectively	(199,998)	(199,998)
Retained earnings	316,155	271,852
Accumulated other comprehensive income	350	116
Total stockholders' equity	837,558	527,164
Total liabilities and stockholders' equity	$ 1,040,022	$ 741,634

* Reflects the impact from the adoption of ASC 326 on January 1, 2020. See *Note 1 – Summary of Business and Significant Accounting Policies* for details.

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

EHEALTH, INC.
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME
(In thousands, except per share amounts)

	Year Ended December 31,		
	2020	**2019**	**2018**
Revenue			
Commission	$ 508,189	$ 466,676	$ 227,211
Other	74,585	39,525	24,184
Total revenue	582,774	506,201	251,395
Operating costs and expenses			
Cost of revenue	4,083	2,738	1,228
Marketing and advertising	209,340	150,249	82,939
Customer care and enrollment	172,895	134,304	70,547
Technology and content	65,188	47,085	31,970
General and administrative	76,452	64,150	45,828
Amortization of intangible assets	1,493	2,187	2,091
Change in fair value of earnout liability	—	24,079	12,300
Restructuring charges	—	—	1,865
Acquisition costs	—	—	76
Total operating costs and expenses	529,451	424,792	248,844
Income from operations	53,323	81,409	2,551
Other income, net	666	2,090	755
Income before income taxes	53,989	83,499	3,306
Provision for income taxes	8,539	16,612	3,065
Net income	$ 45,450	$ 66,887	$ 241
Net income per share:			
Basic	$ 1.75	$ 2.90	$ 0.01
Diluted	$ 1.68	$ 2.73	$ 0.01
Weighted-average number of shares used in per share amounts:			
Basic	26,025	23,075	19,294
Diluted	27,014	24,539	20,409
Comprehensive income:			
Net income	$ 45,450	$ 66,887	$ 241
Unrealized holding gain for available for sale debt securities, net of tax	28	—	—
Foreign currency translation adjustment	206	(11)	(75)
Comprehensive income	$ 45,684	$ 66,876	$ 166

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

EHEALTH, INC.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(In thousands)

	Common Stock		Additional Paid-in Capital	Treasury Stock		Retained Earnings	Accumulated Other Comprehensive Income	Total Stockholders' Equity
	Shares	Amount		Shares	Amount			
Balance at December 31, 2017	**29,880**	**$ 30**	**$ 281,706**	**11,238**	**$ (199,998)**	**$ 204,724**	**$ 202**	**$ 286,664**
Issuance of common stock in connection with equity incentive plans	688	1	2,687	—	—	—	—	2,688
Repurchase of shares to satisfy employee tax withholding obligations	—	—	(4,504)	188	—	—	—	(4,504)
Shares issued for GMG acquisition	295	—	5,595	—	—	—	—	5,595
Stock-based compensation expense	—	—	12,540	—	—	—	—	12,540
Other comprehensive income, net of tax	—	—	—	—	—	—	(75)	(75)
Net income	—	—	—	—	—	241	—	241
Balance as of December 31, 2018	**30,863**	**31**	**298,024**	**11,426**	**(199,998)**	**204,965**	**127**	**303,149**
Issuance of common stock in connection with equity incentive plans	834	1	5,534	—	—	—	—	5,535
Repurchase of shares to satisfy employee tax withholding obligations	—	—	(14,281)	190	—	—	—	(14,281)
Shares issued in equity offering	2,760	3	126,048	—	—	—	—	126,051
Settlement of earnout liability	295	—	17,264	—	—	—	—	17,264
Stock-based compensation expense	—	—	22,570	—	—	—	—	22,570
Other comprehensive income, net of tax	—	—	—	—	—	—	(11)	(11)
Net income	—	—	—	—	—	66,887	—	66,887
Balance as of December 31, 2019	**34,752**	**35**	**455,159**	**11,616**	**(199,998)**	**271,852**	**116**	**527,164**
Cumulative effect from the adoption of ASU 2016-13	—	—	—	—	—	(1,147)	—	(1,147)
Issuance of common stock in connection with equity incentive plans	638	1	1,940	—	—	—	—	1,941
Repurchase of shares to satisfy employee tax withholding obligations	—	—	(19,808)	215	—	—	—	(19,808)
Shares issued in equity offering	2,070	2	228,022	—	—	—	—	228,024
Settlement of earnout liability	295	—	28,521	—	—	—	—	28,521
Stock-based compensation	—	—	27,179	—	—	—	—	27,179
Other comprehensive income, net of tax	—	—	—	—	—	—	234	234
Net income	—	—	—	—	—	45,450	—	45,450
Balance as of December 31, 2020	**37,755**	**$ 38**	**$ 721,013**	**11,831**	**$ (199,998)**	**$ 316,155**	**$ 350**	**$ 837,558**

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

EHEALTH, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(In thousands)

	Year Ended December 31,		
	2020	**2019**	**2018**
Operating activities:			
Net income	$ 45,450	$ 66,887	$ 241
Adjustments to reconcile net income to net cash used in operating activities:			
Depreciation and amortization	3,694	2,983	2,479
Amortization of internally developed software	7,756	3,821	2,201
Amortization of intangible assets	1,493	2,187	2,091
Stock-based compensation expense	25,172	22,570	12,540
Deferred income taxes	8,817	16,197	2,812
Change in fair value of earnout liability	—	24,079	12,300
Other non-cash items	1,091	(755)	675
Changes in operating assets and liabilities:			
Accounts receivable	533	1,270	(2,127)
Contract assets – commissions receivable	(205,209)	(243,364)	(50,967)
Prepaid expenses and other assets	(6,180)	(466)	232
Accounts payable	12,294	19,694	1,414
Accrued compensation and benefits	(9,036)	8,814	5,133
Accrued marketing expenses	5,747	1,028	6,320
Deferred revenue	(2,262)	1,694	491
Accrued expenses and other liabilities	2,780	1,869	935
Net cash used in operating activities	(107,860)	(71,492)	(3,230)
Investing activities:			
Capitalized internal-use software and website development costs	(16,005)	(10,231)	(6,294)
Purchases of property and equipment and other assets	(7,751)	(6,641)	(4,534)
Purchases of marketable securities	(180,505)	—	—
Proceeds from redemption and maturities of marketable securities	130,978	—	—
Payments for security deposits	—	(72)	—
Acquisition of business, net of cash acquired	—	—	(14,929)
Net cash used in investing activities	(73,283)	(16,944)	(25,757)
Financing activities:			
Proceeds from issuance of common stock, net of issuance costs	228,024	126,051	—
Net proceeds from exercise of common stock options	1,941	5,535	2,688
Repurchase of shares to satisfy employee tax withholding obligations	(19,808)	(14,281)	(4,504)
Proceeds from line of credit	—	—	5,000
Debt issuance costs	—	(517)	(1,221)
Repayment of debt	—	(5,000)	—
Acquisition-related contingent payments	(8,751)	(9,542)	—
Principal payments in connection with leases	(157)	(105)	(103)
Net cash provided by financing activities	201,249	102,141	1,860
Effect of exchange rate changes on cash, cash equivalents and restricted cash	187	26	(77)
Net increase (decrease) in cash, cash equivalents and restricted cash	20,293	13,731	(27,204)
Cash, cash equivalents and restricted cash at beginning of period	26,820	13,089	40,293
Cash, cash equivalents and restricted cash at end of period	$ 47,113	$ 26,820	$ 13,089
Supplemental disclosure of cash flows			
Cash paid for interest	$ —	$ 42	$ 44
Cash refunds from (paid for) income taxes, net	$ 882	$ 741	$ (139)

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

EHEALTH, INC.
NOTES TO 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 private health insurance exchange for individuals, families and small businesses in the United States. Through our website addresses (*www.eHealth.com*, *www.eHealthInsurance.com*, *www.eHealthMedicare.com*, *www.Medicare.com*, *www.PlanPrescriber.com and www.GoMedigap.com)*, consumers can get quotes from leading health insurance carriers, compare plans side-by-side, and apply for and purchase Medicare-related, individual and family, small business and ancillary health insurance plans. We actively market the availability of Medicare-related insurance plans and offer Medicare plan comparison tools and educational materials for Medicare-related insurance plans, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans. Our ecommerce technology also enables us to deliver consumers' health insurance applications electronically to health insurance carriers. We are licensed to market and sell health insurance in all fifty states and the District of Columbia.

Basis of Presentation – Our consolidated financial statements include the accounts of eHealth, Inc. and its wholly-owned subsidiaries. All intercompany accounts and transactions have been eliminated in consolidation. The consolidated financial statements have been prepared in accordance with U.S. generally accepted accounting principles ("U.S. GAAP.") Certain prior period amounts have been reclassified to conform with our current period presentation.

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 (loss). Our business structure is comprised of two operating segments:

- Medicare; and
- Individual, Family and Small Business

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 customers, including but not limited to, dental and vision insurance, 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 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 and family and small business health insurance plans and ancillary products sold to our non-Medicare-eligible customers, including but not limited to, dental, vision, short term disability and long term disability insurance. To a lesser extent, the Individual, Family and Small Business segment includes 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 two operating segments and are presented as a reconciling item to our consolidated financial results.

Segment profit 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, depreciation and amortization expense and amortization of intangible assets.

Use of Estimates – The preparation of 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 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 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.

Cash Equivalents – 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.

Property and Equipment – Property and equipment are stated at cost, less accumulated depreciation and amortization. Finance lease amortization expenses are included in depreciation expense in our Consolidated Statements of Comprehensive Income. Maintenance and minor replacements are expensed as incurred. Depreciation and amortization expenses are computed using the straight-line method based on estimated useful lives as follows:

Computer equipment and software	3 to 5 years
Office equipment and furniture	5 years
Leasehold improvements*	5 to 10 years

_____

* Lesser of useful life or related lease term

See *Note 4 – Supplemental Financial Statement Information* of the *Notes to Consolidated Financial Statements* for additional information regarding our property and equipment.

Business Combinations – We allocate the fair value of the acquisition consideration transferred in exchange for our acquired businesses to the tangible assets, liabilities and intangible assets acquired based on their estimated fair values at the acquisition date. The excess of the fair value of acquisition consideration over the fair values of these identifiable assets and liabilities is recorded as goodwill. Acquisition-related costs are recognized separately from the business combination and are expensed as incurred.

Goodwill and Intangible Assets – Goodwill represents the excess of the consideration paid over the estimated fair value of assets acquired and liabilities assumed in a business combination. In the event that we realign our reporting units, we allocate our goodwill to the new reporting units using the relative fair value approach. We test our goodwill for impairment on an annual basis in the fourth quarter of each year or whenever events or changes in circumstances indicate that the asset may be impaired. Factors that we consider in deciding when to perform an impairment test include significant negative industry or economic trends or significant changes or planned changes in our use of the intangible assets.

Our goodwill is allocated among our two segments, (1) Medicare and (2) Individual, Family and Small Business. No goodwill impairment has been identified in any of the years presented in the accompanying Consolidated Statements of Comprehensive Income.

Intangible assets are reviewed for impairment whenever events or changes in circumstances indicate a potential reduction in their fair values below their respective carrying amounts. Intangible assets with finite useful lives, which include purchased technology, pharmacy and customer relationships, trade names, and certain trademarks, are amortized over their estimated useful lives.

Goodwill and intangible assets are considered non-financial assets and therefore, subsequent to their initial recognition are not revalued at fair value each reporting period unless an impairment charge is recognized.

We must make subjective judgments in determining the independent cash flows that can be related to specific asset groupings. In addition, we must make subjective judgments regarding the remaining useful lives of assets with finite useful lives. When we determine that the useful life of an asset is shorter than we had originally estimated, we accelerate the rate of amortization over the assets' new, remaining useful life. We evaluated the remaining useful lives of our intangible assets with finite lives and determined no material adjustments to the remaining lives were required. See *Note 4 – Supplemental Financial Statement Information* of the *Notes to Consolidated Financial Statements* for additional information regarding our intangible assets.

Other Long-Lived Assets – We evaluate other long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. If such assets are considered to be impaired, the impairment to be recognized is measured by the amount by which the carrying amount of the asset exceeds its fair value.

Revenue Recognition – Our commission revenue consists of commission payments from health insurance carriers whose health insurance policies are purchased through our ecommerce platforms or telephonically via our customer care center, and bonus payments which are generally based on our attaining predetermined target sales levels or other objectives, as determined by the health insurance carriers. In addition, we also generate revenue from non-commission sources, which include online sponsorship, advertising, lead referrals, and technology licensing.

We account for revenue under ASC 606 – Revenue from Contracts with Customers. The core principle of ASC 606 is to recognize revenue upon the transfer of promised goods or services to customers in an amount that reflects the consideration the entity expects to be entitled in exchange for those goods or services. Accordingly, we recognize revenue for our services through the application of the following steps:

- *Identification of the contract, or contracts, with a customer.*
- *Identification of the performance obligations in the contract.*
- *Determination of the transaction price.*
- *Allocation of the transaction price to the performance obligations in the contract.*
- *Recognition of revenue when, or as, we satisfy a performance obligation.*

Commission Revenue — Our commission revenue results from approval of an application from health insurance carriers, which we define as our customers under ASC 606. Our commission revenue is primarily comprised of commissions from health insurance carriers which is computed using the estimated constrained lifetime value of commission payments that we expect to receive. We estimate commission revenue for each insurance product by using a portfolio approach to a group of approved members by plan type and the effective month of the relevant plan, which we refer to as "cohorts". We recognize revenue for plans approved during the period by applying the latest estimated constrained lifetime value ("LTV") for that product. We recognize

adjustment revenue for plans approved in prior periods when changes in assumptions for constrained LTV calculations are made and when there is sufficient evidence demonstrating a trend that is different from the estimated constrained LTV at the time of approval resulting in a change in estimate to expected cash collections. Net adjustment revenue consists of increases in revenue for certain prior period cohorts as well as reductions in revenue for certain prior period cohorts. We recognize positive adjustments to revenue to the extent that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur. We assess the risk of significant revenue reversal based on statistical and qualitative analysis given historical information and current market conditions.

Our commission revenue for each product line is based on a number of assumptions, which include, but are not limited to, estimating conversion of an approved member to a paying member, forecasting average plan duration and forecasting the commission amounts likely to be received per member. These assumptions are based on our analysis of historical trends for the different cohorts and incorporate management's judgment in interpreting those trends and applying the constraints discussed below. For our Medicare commission revenue, which represented 86%, 87% and 83% of our total commission revenue for the years ended December 31, 2020, 2019 and 2018, respectively, the estimated average plan duration, which is the average length of time paying members are active on their plans, used to calculate Medicare health insurance plan LTVs historically has been approximately 3 years for Medicare Advantage plans, approximately 5 years for Medicare Part D prescription drug plans, and approximately 5 years for Medicare Supplement plans. While the average plan duration has been approximately 3 years for Medicare Advantage plans, certain members may have a duration of up to approximately 13 years. The estimated average plan duration used to calculate the LTV for major medical individual and family health insurance plans historically has been approximately 1.5 to 2 years. For short term health insurance plan LTVs, the estimated average plan duration historically has been less than six months. For all other ancillary health insurance plan LTVs, the estimated average plan duration has historically varied from 1 to 3 years.

Constraints are applied to LTV for revenue recognition purposes to help ensure that the total estimated lifetime commissions expected to be collected for an approved member's plan are recognized as revenue only to the extent that it 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. Significant judgment can be involved in determining the constraint. To determine the constraints to be applied to LTV, we compare 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, cancellations of insurance plans offered by health insurance carriers with which we have a relationship, changes in laws and regulations, and changes in the economic environment. 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.

We re-compute LTVs for all outstanding cohorts on a quarterly basis. We continually review and monitor changes in the data used to estimate LTV and compare the cash received for each cohort to our original estimates at the time of approval. The fluctuations of cash received for each cohort as compared to our estimates and the fluctuations in LTV can be significant and may or may not be indicative of the need to adjust revenue for prior period cohorts. Changes in LTV may result in an increase or a decrease to revenue and a corresponding increase or decrease to contract assets – commissions receivable. We analyze these fluctuations and, to the extent we see changes in our estimates of the cash commission collections that we believe are indicative of an increase or decrease to prior period LTVs, we adjust revenue for the affected cohorts at the time such determination is made and when it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur. As we accumulate more historical data, we continue to enhance our LTV estimation models using statistical tools to increase the accuracy of LTV estimates with an emphasis on improving member attrition forecasting. The

enhancements to the LTV estimation model provide greater statistical certainty on expected cash collections, particularly for earlier period cohorts where there is more historical data available.

For both Medicare Advantage and Medicare Part D prescription drug plans, we receive a fixed, annual commission payment from insurance carriers once the plan is approved by the carrier and either a fixed, monthly, or annual commission payment beginning with and subsequent to the second plan year. In the first plan year of a Medicare Advantage and Medicare Part D prescription drug plan, after the health insurance carrier approves the application but during the effective year of the plan, we are paid a fixed commission that is prorated for the number of months remaining in the calendar year. Additionally, if the plan is the first Medicare Advantage or Medicare Part D prescription drug plan issued to the member, we may receive a higher commission rate that covers a full twelve-month period, regardless of the month the plan was effective. We earn commission revenue for Medicare Advantage and Medicare Part D prescription drug plans for which we are the broker of record, typically until either the policy is cancelled or we otherwise do not remain the agent on the policy.

For individual and family, Medicare Supplement, small business and ancillary plans, our commissions generally represent a flat amount per member per month or a percentage of the premium amount collected by the carrier during the period that a member maintains coverage under a plan. Premium-based commissions are reported to us after the premiums are collected by the carrier, generally on a monthly basis. We generally continue to receive the commission payment from the relevant insurance carrier until the health insurance plan is cancelled or we otherwise do not remain the agent on the policy.

For Medicare-related, individual and family and ancillary health insurance plans, our services are complete once a submitted application is approved by the relevant health insurance carrier. Accordingly, we recognize commission revenue based upon the total estimated lifetime commissions we expect to receive for selling the plan after the carrier approves an application, net of an estimated constraint. We refer to these as estimated and constrained LTVs for the plan. We provide annual services in selling and renewing small business health insurance plans; therefore, we recognize small business health insurance plan commission revenue at the time the plan is approved by the carrier, and when it renews each year thereafter, equal to the estimated commissions we expect to collect from the plan over the following twelve months.

See *Note 2 – Revenue* of the *Notes to Consolidated Financial Statements* for additional information regarding our commission revenue.

Other Revenue – Our sponsorship and advertising program allows carriers to purchase advertising space in specific markets in a sponsorship area on our website. In return, we are typically paid a fee, which is recognized over the period that advertising is displayed, and often a performance fee based on metrics such as submitted health insurance applications, which is recognized when control has been transferred. We also offer Medicare advertising services, which include website development, hosting and maintenance. In these instances, we are typically paid a fixed, up-front fee, which we recognize as revenue as control is transferred ratably over the service period.

Our commercial technology licensing business allows carriers the use of our ecommerce platform to offer their own health insurance policies on their websites and agents to utilize our technology to power their online quoting, content and application submission processes. Typically, we are paid a one-time implementation fee, which we recognize on a straight-line basis over the estimated term of the customer relationship, and a performance fee based on metrics such as submitted health insurance applications. The performance fees are based on performance criteria. In instances where the performance criteria data is tracked by us, we recognize revenue in the period of performance and when all other revenue recognition criteria has been met. In instances where the performance criteria data is tracked by the third party, we recognize revenue when reversal of such amounts is not likely to occur.

Deferred Revenue – Deferred revenue includes deferred fees and amounts billed to or collected from advertising, sponsorship or technology licensing customers in advance of our performing our service for such

customers. It also includes the amount by which both unbilled and billed services provided under our technology licensing arrangements exceed the revenue recognized to date.

Incremental Costs to Obtain a Contract — Our sales compensation plans, which are directed at converting leads into approved members, represent fulfillment costs and not costs to obtain a contract with a customer. Additionally, we reviewed compensation plans related to personnel responsible for identifying new health insurance carriers and entering into contracts with new health insurance carriers and concluded that no incremental costs are incurred to obtain such contracts. Therefore, costs related these compensation plans are expensed as incurred.

Cost of Revenue – Included in cost of revenue are payments related to health insurance policies 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.

Marketing and Advertising Expenses – 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. We recognize direct marketing expenses in our direct member acquisition channel in the period in which they are incurred. We recognize online marketing expenses associated with search advertising in the period in which the consumer clicks on the advertisement. Advertising costs incurred in the years ended December 31, 2020, 2019 and 2018 totaled $178.9 million, $122.6 million, and $64.4 million, respectively.

Our direct channel expenses primarily consist of costs for direct mail, email marketing and television and radio advertising. Advertising costs for our direct channel are expensed the first time the related advertising takes place. Our marketing partner channel expenses primarily consist of fees paid to marketing partners with which we have a relationship. Our online advertising channel expenses primarily consist of paid keyword search advertising on search engines and retargeting campaigns. Advertising costs for our marketing partner channel and our online advertising channel are expensed as incurred.

Research and Development Expenses – Research and development expenses consist primarily of compensation and related expenses incurred for employees on our engineering and technical teams, which are expensed as incurred. Research and development costs, which totaled $9.1 million, $8.1 million and $6.9 million for the years ended December 31, 2020, 2019 and 2018, respectively, are included in technology and content expense in the accompanying Consolidated Statements of Comprehensive Income.

Internal-Use Software and Website Development Costs – We capitalize costs of materials, consultants and compensation and benefits costs of employees who devote time to the development of internal-use software during the application development stage. The amortization of these assets are recorded in technology and content. Our judgment is required in determining the point at which various projects enter the phases at which costs may be capitalized, in assessing the ongoing value of the capitalized costs and in determining the estimated useful lives over which the costs are amortized, which is generally 3 years. For the years ended December 31, 2020, 2019 and 2018, we capitalized internal-use software and website development costs of $18.0 million, $10.2 million and $6.3 million respectively, and recorded amortization expense of $7.8 million, $3.8 million, and $2.2 million respectively. Capitalized internal-use software and website development costs are included in Other Assets on our Consolidated Balance Sheets and were $24.6 million and $14.7 million as of December 31, 2020 and 2019, respectively.

Stock-Based Compensation – We recognize stock-based compensation expense in the accompanying Consolidated Statements of Comprehensive Income based on the fair value of our stock-based awards over their respective vesting periods, which is generally 4 years. The estimated attainment of performance-based awards and

related expense is based on the expectations of revenue and earnings target achievement. The estimated fair value of performance awards with market conditions is determined using the Monte-Carlo simulation model. The assumptions used in calculating the fair value of stock-based payment awards and expected attainment of performance-based awards represent our best estimates, but these estimates involve inherent uncertainties and the application of management judgment. We will continue to use judgment in evaluating the expected term and volatility related to our own stock-based awards on a prospective basis, and incorporating these factors into the model. Changes in key assumptions could significantly impact the valuation of such instruments. The estimated grant date fair value of our stock options is determined using the Black-Scholes pricing model and a single option award approach. The weighted-average expected term for stock options granted is calculated using historical option exercise behavior. The dividend yield is determined by dividing the expected per share dividend during the coming year by the grant date stock price. Through December 31, 2020, we had not declared or paid any cash dividends to common stockholders, and we do not expect to pay any in the foreseeable future. We base the risk-free interest rate on the implied yield currently available on U.S. Treasury zero-coupon issues with a remaining term equal to the expected term of our stock options. Expected volatility is determined using a combination of the implied volatility of publicly traded options in our stock and historical volatility of our stock price.

401(k) Plan – Our board of directors adopted a defined contribution retirement plan ("401(k) Plan") in 1998, which qualifies under Section 401(k) of the Internal Revenue Code of 1986. Participation in the 401(k) Plan is available to substantially all employees in the United States. Employees can contribute up to 25% of their salary, up to the federal maximum allowable limit, on a before-tax basis to the 401(k) Plan. Employee contributions are fully vested when contributed. Our contributions to the 401(k) Plan are discretionary and are expensed when incurred. We also match employee contributions to our 401(k) Plan at 100% of an employee's contribution each pay period, up to a maximum of 3% of the employee's salary during such pay period for the year ended December 31, 2020, compared to 25% contribution match, with maximum of 3% and 2% for the years ended December 31, 2019 and 2018, respectively. Our matching contributions are expensed as incurred and vest one-third for each of the first three years of the recipient's service. The recipient is fully vested in all 401(k) Plan matching contributions after three years of service. We recognized expense of $3.5 million, $2.3 million and $1.0 million for the years ended December 31, 2020, 2019 and 2018, respectively, related to 401(k) matching contributions.

Income Taxes – We account for income taxes using the liability method. Deferred income taxes are determined based on the differences between the financial reporting and tax bases of assets and liabilities, using enacted statutory tax rates in effect for the year in which the differences are expected to reverse.

We utilize a two-step approach for evaluating uncertain tax positions. Step one, *Recognition*, requires a company to determine if the weight of available evidence indicates that a tax position is more likely than not to be sustained upon audit, including resolution of related appeals or litigation processes, if any. Step two, *Measurement*, is based on the largest amount of benefit, which is more likely than not to be realized on ultimate settlement. We record interest and penalties related to uncertain tax positions as income tax expense in the consolidated financial statements.

Seasonality – 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. Any changes or additional enrollment periods may change the seasonality of our business. For instance, due to the recent reintroduction of the Medicare Advantage open enrollment period that takes place in the first quarter of the year, our first quarter is generally the second-highest revenue generating quarter.

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. Individuals and families generally are not able to

purchase individual and family health insurance outside of these open enrollment periods, 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 due to the recent COVID-19 pandemic.

Recently Adopted Accounting Pronouncements

Financial Instruments – Credit Losses (Topic 326) – In June 2016, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") No. 2016-13, *Financial Instruments – Credit Losses (Topic 326)*, that requires companies to present certain financial assets net of the amount expected to be collected. The guidance requires the measurement of expected credit losses to be based on relevant information from past events, including historical experiences, current conditions and reasonable and supportable forecasts that affect collectability. Contract assets – commissions receivable were our only financial assets that were materially impacted by this guidance.

We adopted ASU 2016-13, including applicable amendments in other ASUs issued subsequent to ASU 2016-13, using a modified retrospective transition method on January 1, 2020 for all financial assets measured at amortized cost. Results for periods after January 1, 2020 are presented under ASU 2016-13 while prior period amounts continue to be reported under the previous accounting standards. We recorded a $1.1 million decrease, net of income taxes, to retained earnings as of January 1, 2020 for the cumulative effect of adopting ASU 2016-13. See *Note 4 – Supplemental Financial Statement Information* for further discussion on credit losses.

The impact from the adoption of ASU 2016-13 is summarized as follows (in thousands):

Balance Sheet Impact:	**December 31, 2019**	**Transition Adjustments**	**January 1, 2020**
Contract assets – commissions receivable – current	$ 174,526	$ (71)	$ 174,455
Contract assets – commissions receivable – non-current	414,696	(1,442)	413,254
Other assets*	18,004	366	18,370
Total assets	741,634	(1,147)	740,487
Retained earnings	271,852	(1,147)	270,705

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* Adjustment to Other assets is due to the increase in deferred tax assets resulting from the adoption of ASU 2016-13.

Cloud Computing Arrangements (Topic 350) – In 2018, the FASB issued ASU No. 2018-15, which amends ASC 350-40 to address a customer's accounting for implementation costs incurred in a cloud computing arrangement (CCA) that is a service contract. The update conforms the requirements of capitalizing costs incurred in a CCA that is a service contract with the accounting guidance on capitalizing costs associated with developing or obtaining internal-use software. This update amends ASC 350 to include in its scope implementation costs of a CCA that is a service contract and clarifies that a customer should apply ASC 350-40 to determine which implementation costs should be capitalized. The new guidance is effective for annual and interim reporting periods beginning after December 15, 2019. We adopted this guidance prospectively in the first quarter of 2020. Cloud computing implementation costs incurred in hosting arrangements are capitalized and recorded in Other assets on our Consolidated Balance Sheet, and were immaterial for the year ended December 31, 2020.

Financial Instruments (Topic 820) – In 2018, the FASB issued ASU No. 2018-13, to change the disclosure requirements for fair value measurement with the objective of improving the effectiveness of the notes to financial statements. This new guidance removed and modified certain disclosure requirements under Topic 820. We adopted this guidance in the first quarter of 2020 with no material impact on our consolidated financial statements.

Intangible – Goodwill and Other (Topic 350) – In 2017, the FASB issued ASU 2017-04 to simplify the subsequent measurement of goodwill by removing the requirement to perform a hypothetical purchase price allocation to compute the implied fair value of goodwill to measure impairment. Instead, any goodwill impairment will equal the amount by which a reporting unit's carrying value exceeds its fair value, not to exceed the carrying amount of goodwill. In addition, the guidance eliminates the requirements for any reporting unit with a zero or negative carrying amount to perform a qualitative assessment and, if it fails that qualitative test, to perform Step 2 of the goodwill impairment test. This standard is effective for annual or any interim goodwill impairment test in fiscal years beginning after December 15, 2019. We adopted this guidance in the first quarter of 2020 with no material impact on our consolidated financial statements.

Recent Accounting Pronouncement Not Yet Adopted

Income Taxes (Topic 740) – In December 2019, the FASB issued ASU No. 2019-12, Income Tax, *Simplifying the Accounting for Income Taxes*, which aims to simplify the accounting by removing certain exceptions to the general principles in Topic 740 and improve consistent application of and simplify GAAP for other areas under this Topic by clarifying existing guidance. ASU 2019-12 is effective for us beginning January 1, 2021. The amendments in this standard update have individually different adoption approaches. We do not anticipate a material impact on our consolidated financial statements and disclosures from the adoption of this standard update.

Codification Improvements – In October 2020, the FASB issued ASU No. 2020-10, *Codification Improvements*. ASU 2020-10 is intended to facilitate codification updates for technical corrections, such as conforming amendments, clarifications to guidance, simplifications to wording or structure of guidance, and other minor improvements. It contains amendments that improve the consistency of the codification by including all disclosure guidance in the appropriate disclosure section and other updates that varies in nature. ASU 2020-10 is effective for us beginning January 1, 2021. We do not anticipate a material impact on our consolidated financial statements and disclosures from adoption of this standard update.

Debt with Conversion and Other Options (Topic 470) and Contracts in Entity's Own Equity (Topic 815) – In June 2020, the FASB issued No. 2020-06 to simplify the accounting for convertible instruments and improve the usefulness and relevance of information regarding convertible instruments. This ASU reduce the number of accounting models for converting debt instruments and convertible preferred stock. ASU 2020-06 is effective for us beginning January 1, 2022, with early adoption permitted. We are currently evaluating the potential effect on our consolidated financial statements and related disclosures.

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):

	Year Ended December 31,		
	2020	2019	2018
Medicare			
Medicare Advantage	$ 374,981	$ 339,810	$ 143,445
Medicare Supplement	48,526	40,345	31,166
Medicare Part D	12,909	26,824	14,609
Total Medicare	436,416	406,979	189,220
Individual and Family [1]			
Non-Qualified Health Plans	20,813	17,559	6,470
Qualified Health Plans	5,856	6,866	5,789
Total Individual and Family	26,669	24,425	12,259
Ancillary			
Short-term	9,494	10,524	5,583
Dental	9,354	5,238	2,717
Vision	3,896	2,002	1,467
Other	4,392	3,985	4,941
Total Ancillary	27,136	21,749	14,708
Small Business	9,568	9,922	8,595
Commission Bonus	8,400	3,601	2,429
Total Commission Revenue	508,189	466,676	227,211
Other Revenue			
Sponsorship and Advertising Revenue	68,383	35,375	15,796
Other	6,202	4,150	8,388
Total Other Revenue	74,585	39,525	24,184
Total Revenue	$ 582,774	$ 506,201	$ 251,395

[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 health insurance 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

Since the adoption of ASC 606, we have evaluated changes in estimated cash collections and compare these to the initial estimates of LTV at the time of approval. We record adjustment revenue in the period when the risk of significant reversal in not probable and continue to enhance our LTV estimation models to improve the accuracy and to reduce the fluctuations of our LTV estimates.

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

	Years Ended December 31,		
	2020	2019	2018
Medicare			
Commission Revenue from Members Approved During the Period [1]	$ 440,722	$ 355,916	$ 192,382
Net Commission Revenue from Members Approved in Prior Periods [2]	5,665	55,292	(124)
Total Medicare Segment Commission Revenue	$ 446,387	$ 411,208	$ 192,258
Individual, Family and Small Business			
Commission Revenue from Members Approved During the Period [1]	$ 21,971	$ 22,614	$ 24,079
Net Commission Revenue from Members Approved in Prior Periods [2]	39,831	32,854	10,874
Total Individual, Family and Small Business Segment Commission Revenue	$ 61,802	$ 55,468	$ 34,953
Total Commission Revenue from Members Approved During the Period [1]	$ 462,693	$ 378,530	$ 216,461
Total Net Commission Revenue from Members Approved in Prior Periods [2][3]	45,496	88,146	10,750
Total Commission Revenue	$ 508,189	$ 466,676	$ 227,211

[1] These amounts include commission bonus revenue.

[2] 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.

[3] The impact of total net commission revenue from members approved in prior periods was $1.75, $3.82 and $0.56 per basic share, respectively, or $1.68, $3.59 and $0.53 per diluted share, respectively, for the years ended December 31, 2020, 2019 and 2018, respectively. The total reductions to revenue from members approved in prior periods were $17.3 million, $3.1 million and $3.2 million for the years ended December 31, 2020, 2019 and 2018, respectively. These reductions to revenue primarily related to the Medicare segment.

Enhancement to LTV Estimation Model and Impacts Related to COVID-19

During the fourth quarter of 2019, we enhanced our Medicare Advantage LTV estimation model to increase the accuracy of LTV estimates with an emphasis on improving member attrition forecasting by utilizing statistical tools. For the Medicare segment, we recognized adjustment revenue of $55.3 million for the year ended December 31, 2019, of which $50.8 million was recognized for Medicare Advantage plans during the fourth quarter of 2019 due to enhancements made to the Medicare Advantage LTV estimation model. For the Individual, Family and Small Business segment, we recognized adjustment revenue of $32.9 million for the year ended December 31, 2019, in response to observing longer plan duration than initially anticipated at the time of enrollment for these plans.

During 2020, we expanded the enhanced statistical models to our remaining insurance products. Despite the impact of COVID-19 in 2020 and uncertainties regarding the Presidential election and the U.S. economy, we continued to observe stronger member retention rates in our LTV assessments for the majority of the earlier period cohorts of certain products in our Individual, Family and Small Business segment. Based on our evaluation of the updated LTV models and retention trends, we recognized $39.8 million of net adjustment revenue for the Individual, Family and Small Business segment for the year ended December 31, 2020. In addition, we evaluated various

market factors related to our Medicare segment and recorded net adjustment revenue of $5.7 million for the year ended December 31, 2020.

We will continue to monitor our member retention rates as compared to our forecasts and other market factors and evaluate whether any addition or reduction of adjustment revenue shall be recorded as we continue to assess our LTV models in future periods.

Note 3 – Acquisition

On January 22, 2018, we completed our acquisition of all outstanding membership interests of Wealth, Health and Life Advisors, LLC, more commonly known as GoMedigap, a technology-enabled provider of Medicare Supplement enrollment services. The acquisition consideration consisted of cash of $15.0 million, less $0.1 million of cash acquired, and 294,637 shares of our common stock. In addition, the members of GoMedigap were entitled to receive earnout payments ("Earnout Consideration") consisting of up to $20.0 million in cash and 589,275 shares of our common stock. The Earnout Consideration became payable, subject to the terms and conditions of the purchase agreement relating to the acquisition, upon the final determination of the achievement of certain milestones in 2018 and 2019.

The GoMedigap acquisition was accounted for using the acquisition method of accounting under ASC 805, *Business Combinations.* The acquisition method of accounting requires, among other things, that assets acquired and liabilities assumed be recognized at their fair values as of the acquisition date. The major classes of assets and liabilities to which we have allocated the acquisition consideration were as follows (in thousands):

Acquisition Consideration		
Cash paid	$	15,000
Fair value of equity awards issued to GoMedigap members [(1)]		5,595
Estimated fair value of earnout liability		27,700
	$	48,295
Allocation		
Cash and cash equivalents	$	71
Contract assets – commissions receivable – current		4,371
Prepaid expenses and other current assets		11
Contract assets – commissions receivable – non-current		11,103
Property and equipment, net		174
Accounts payable		(110)
Accrued compensation and benefits		(132)
Other current liabilities		(130)
Net tangible assets acquired		15,358
Intangible assets		6,800
Goodwill		26,137
Total intangible assets acquired		32,937
Total net assets acquired	$	48,295

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(1) The fair value of equity awards issued was determined based on the January 22, 2018 closing price of our common stock of $18.99 per share.

Goodwill and Intangible Assets – Goodwill represents the excess of the purchase price of the acquired business over the acquisition date fair value of the net assets acquired. Goodwill was primarily attributable to the assembled workforce, new product development capabilities and anticipated synergies and economies of scale expected from the operations of the combined company. The goodwill was assigned to our Medicare segment. Goodwill is tested for impairment on an annual basis in the fourth quarter of each year or whenever events or changes in circumstances indicate that the asset may be impaired. Factors that we consider in deciding when to perform an impairment test include significant negative industry or economic trends or significant changes or planned changes in our use of the intangible assets. Goodwill is deductible for tax purposes over 15 years.

Earnout liability – The earnout liability represents the fair value of the Earnout Consideration payable and was adjusted to fair value at each reporting date until settled. Changes in fair value were recognized in income (loss) from operations. The first and second earnout liability payments were made in February 2019 and January 2020, respectively. See *Note 5 – Fair Value Measurements* for further discussion regarding the earnout liability.

Fair Value Measurements – The assets acquired and liabilities assumed of GoMedigap were recognized at fair value in accordance with ASC 820, *Fair Value Measurement.* See *Note 5 – Fair Value Measurements* for the hierarchy level assigned to each asset and liability based on the assessment of the transparency and reliability of inputs used in the valuation of such items based on the lowest level of input that is significant to fair value measurement.

The fair value of prepaid expenses and other current assets, property and equipment, net, accounts payable, accrued compensation and benefits and other current liabilities approximated their carrying value at the date of acquisition. The fair value of commissions receivable was determined using a discounted rate of interest, which is a Level 2 input. Intangible assets and the earnout liability were valued using Level 3 inputs.

The fair values of the acquired technology were determined by using income and cost methods. Fair value of trade names were determined using the profit allocation method, which is based on the estimated royalties we are relieved from paying because we own the assets.

The fair value of the Earnout Consideration payable was measured using probability-weighted analysis and was discounted using a rate that appropriately captured the risk associated with the obligation. Key assumptions included new enrollments and volatility for the years ended December 31, 2020 and 2019, as well as eHealth's simulated stock price at the time of payment. The Earnout Consideration payable was part of the acquisition consideration and was adjusted to fair value at each reporting date until settled. The fair value adjustment to the earnout liability was $24.1 million during the year ended December 31, 2019. We had no fair value adjustments to the earnout liability in 2020.

Following are the details of the acquisition consideration allocated to the intangible assets acquired (in thousands):

Technology	$	2,000
Trade names, trademarks and website addresses		4,800
Total intangible assets	$	6,800

We are amortizing the existing technology, trade names, trademarks, and website addresses using the straight-line method over an estimated life of 3 and 10 years, respectively. The estimated useful lives are based on the time periods during which the intangibles are expected to result in incremental cash flows. Acquisition-related costs incurred were immaterial during the year ended December 31, 2018.

Prior to the acquisition date, GoMedigap recognized revenue and expenses on the cash basis of accounting. GoMedigap's historical books and records did not contain the information required to recognize revenue or prepare financial statements on a basis that would be comparable to us. Thus, the required pro-forma financial disclosures are not presented herein.

GoMedigap generated revenue of $15.2 million for the period from the acquisition date of January 22, 2018 through December 31, 2018.

Note 4 – Supplemental Financial Statement Information

Cash, Cash Equivalents, and Restricted Cash

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

	December 31, 2020	December 31, 2019
Cash	$ 39,552	$ 16,205
Cash equivalents	4,207	7,261
Cash and cash equivalents	$ 43,759	$ 23,466
Restricted cash	3,354	3,354
Total cash, cash equivalents and restricted cash	$ 47,113	$ 26,820

As of December 31, 2020 and 2019, we had $3.4 million of restricted cash which was classified as a non-current asset on our 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 December 31, 2020.

Our contract assets and accounts receivable consisted of the following for the periods presented below (in thousands):

	December 31, 2020	December 31, 2019
Contract assets – commissions receivable – current	$ 219,153	$ 174,526
Contract assets – commissions receivable – non-current	573,252	414,696
Accounts receivable	1,799	2,332
Total contract assets and accounts receivable	$ 794,204	$ 591,554

We estimate the allowance for credit loss balance 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 Consolidated Statement of Comprehensive Loss.

Subsequent to the adoption of ASC 326, we considered the impact of recent events and global economic conditions when evaluating the appropriate adjustments to our allowance for credit losses as of December 31, 2020. Determining the extent of these adjustments in the twelve months ended December 31, 2020 was especially challenging because we do not have any historical loss information for a period of similar economic decline. We considered the current and expected future economic and market conditions surrounding the COVID-19 pandemic. There were no allowance for doubtful accounts or credit losses for the years ended December 31, 2019 and 2018.

The changes in the allowance for credit losses for the year ended December 31, 2020 are summarized as follows (in thousands):

	December 31, 2020
Beginning balance	$ —
Impact from the adoption of ASU 2016-13	1,513
Current period provision for expected credit losses	513
Ending balance	$ 2,026

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

	Year Ended December 31, 2020		
	Medicare Segment	IFP/SMB Segment	Total
Beginning balance	$ 550,922	$ 38,300	$ 589,222
Commission revenue from members approved during the period	440,722	21,971	462,693
Net commission revenue adjustments from members approved in prior period	5,665	39,831	45,496
Cash receipts	(255,781)	(47,199)	(302,980)
Net change in credit loss allowance*	(1,891)	(135)	(2,026)
Ending balance	$ 739,637	$ 52,768	$ 792,405

	Year Ended December 31, 2019		
	Medicare Segment	IFP Segment	Total
Beginning balance	$ 311,977	$ 33,881	$ 345,858
Commission revenue from members approved during the period	355,916	22,614	378,530
Net commission revenue adjustments from members approved in prior period	55,292	32,854	88,146
Cash receipts	(172,263)	(51,049)	(223,312)
Ending balance	$ 550,922	$ 38,300	$ 589,222

* Amount consists of transition adjustment of $1.5 million related to the adoption of ASC 326 as of January 1, 2020 and the subsequent credit loss adjustment of $0.5 million during the year ended December 31, 2020 . See *Note 1 – Summary of Business and Significant Accounting Policies* for details regarding the adoption impact.

Credit Risk

Our financial instruments that are exposed to concentrations of credit risk principally consist of cash, cash equivalents, contract assets – commissions receivable, and accounts receivable. We invest our cash and cash

equivalents with major banks and financial institutions and, at times, 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 $3.5 million as of December 31, 2020.

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 and accounts receivable balance are summarized as of the dates presented below:

	December 31, 2020	December 31, 2019
Humana	21 %	22 %
UnitedHealthCare [1]	21 %	20 %
Aetna [2]	20 %	20 %

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[1] UnitedHealthcare also includes other carriers owned by UnitedHealthcare.
[2] Aetna also includes other carriers owned by Aetna.

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

	December 31, 2020	December 31, 2019
Prepaid maintenance contracts	$ 7,715	$ 3,853
Prepaid expenses	6,628	2,207
Prepaid insurance	1,672	918
Income tax receivable	51	584
Other	595	260
Prepaid expenses and other current assets	$ 16,661	$ 7,822

Property and Equipment – Our property and equipment are summarized as of the periods presented below (in thousands):

	December 31, 2020	December 31, 2019
Computer equipment and software	$ 20,121	$ 17,893
Office equipment and furniture	6,292	4,995
Leasehold improvements	7,458	6,051
Property and equipment, gross	33,871	28,939
Less accumulated depreciation and amortization	(19,262)	(18,421)
Property and equipment, net	$ 14,609	$ 10,518

Depreciation and amortization expense related to property and equipment totaled $3.7 million, $3.0 million, and $2.5 million in the years ended December 31, 2020, 2019 and 2018, respectively.

Intangible Assets – The carrying amounts, accumulated amortization, net carrying value and weighted average remaining life of our definite-lived amortizable intangible assets, as well as our indefinite-lived intangible trademarks, are presented in the tables below (dollars in thousands, useful life in years):

	December 31, 2020				December 31, 2019			
	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Weighted-average remaining useful life	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Weighted-average remaining useful life
Technology	$ 2,000	$ (1,945)	$ 55	0.1	$ 2,000	$ (1,278)	$ 722	1.1
Pharmacy and customer relationships	9,500	(9,500)	—	0.0	9,500	(9,183)	317	0.3
Trade names, trademarks and website addresses	5,700	(2,300)	3,400	7.1	5,700	(1,791)	3,909	8.0
Total intangible assets subject to amortization	$ 17,200	$ (13,745)	3,455		$ 17,200	$ (12,252)	$ 4,948	
Indefinite-lived trademarks and domain names			5,114	Indefinite			5,114	Indefinite
Intangible assets			$ 8,569				$ 10,062	

During the years ended December 31, 2020, 2019, and 2018, amortization expense related to intangible assets totaled $1.5 million, $2.2 million, and $2.1 million, respectively.

As of December 31, 2020, our expected amortization expense in future periods were as follows (in thousands):

Years Ending December 31,	Technology	Trade Names, Trademarks and Website Addresses	Total
2021	$ 55	$ 480	$ 535
2022	—	480	480
2023	—	480	480
2024	—	480	480
2025	—	480	480
Thereafter	—	1,000	1,000
Total	$ 55	$ 3,400	$ 3,455

Note 5 – 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.

The following table is a summary of financial assets measured at fair value on a recurring basis and their classification within the fair value hierarchy (in thousands):

	December 31, 2020				
	Carrying Value	Level 1	Level 2	Level 3	Total
Assets					
Cash equivalents					
Money market funds	$ 4,207	$ 4,207	$ —	$ —	$ 4,207
Short-term marketable securities					
Commercial paper	14,197	—	14,197	—	14,197
Agency bonds	35,423	—	35,423	—	35,423
Total assets measured at fair value	$ 53,827	$ 4,207	$ 49,620	$ —	$ 53,827

	As of December 31, 2019				
	Carrying Value	Level 1	Level 2	Level 3	Total
Assets					
Cash equivalents					
Money market funds	$ 7,261	$ 7,261	$ —	$ —	$ 7,261
Liabilities					
Earnout liability - current	$ 37,273	$ —	$ —	$ 37,273	$ 37,273

Our cash equivalents were invested in money market funds and commercial paper with original maturity of 90 days or less were classified as Level 1. 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. There were no transfers between the hierarchy levels during the years ended December 31, 2020 and 2019.

As of December 31, 2020, our Level 2 assets included our available for sale marketable securities, which consisted of commercial paper and agency bonds with maturity 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 credit rating of AA+ or equivalent by S&P Rating and Moody's Investor Services. There were no transfers between the hierarchy levels during the years ended December 31, 2020 and 2019.

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

	As of December 31, 2020		As of December 31, 2019	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value
Due in 1 year	$ 53,788	$ 53,827	$ 7,261	$ 7,261

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 December 31, 2020:

	Amortized Cost	Unrealized Gain	Unrealized Loss	Fair Value
Cash equivalents				
Money market funds	$ 4,207	$ —	$ —	$ 4,207
Short-term marketable securities				
Commercial paper	14,197	—	—	14,197
Agency bonds	35,384	40	(1)	35,423
Total	$ 53,788	$ 40	$ (1)	$ 53,827

As of December 31, 2020, there were six securities in net loss positions and their unrealized losses were immaterial. We did not record any credit losses regarding our available-for-sales debt securities during the year ended December 31, 2020. 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.

Earnout Liabilities

Earnout liabilities in connection with our GoMedigap acquisition in 2018 were recognized at fair value. We measure the earnout liability using internally developed assumptions; therefore, it is classified as Level 3. The fair value of the earnout liability was measured using probability-weighted analysis and is discounted using a rate that appropriately captures the risk associated with the obligation. The fair value of the earnout liability as of December 31, 2019 was adjusted to the amount that we settled in January 2020. Key assumptions included new enrollments and volatility for the years ended December 31, 2019 and 2018 and our stock price at the time of payment.

Our earnout liability activities are summarized as follows (in thousands):

Balance as of December 31, 2018	$ 40,000
Change in fair value	24,079
Settlements	(26,806)
Balance as of December 31, 2019	37,273
Settlements	(37,273)
Balance as of December 31, 2020	$ —

In February 2019, we made the first earnout payment to GoMedigap consisting of $9.5 million in cash and 294,608 shares of our common stock with a value of $17.3 million. In January 2020, we made the second payment, which consisted of $8.8 million in cash and 294,608 shares of our common stock with a value of $28.5 million. The $28.5 million and $17.3 million of the earnout payments in 2020 and 2019, respectively, were non-cash financing activities since common stock was used to settle these liabilities.

Note 6 – Equity

Public Offering of Common Stock – Pursuant to an effective registration statement which was filed on December 17, 2018, and amended on January 22, 2019 and March 2, 2020, we entered into an underwriting agreement in March 2020 to issue a total of 2.1 million shares of common stock, which included the exercise in full of the underwriters' option to purchase 0.3 million additional shares of common stock, at a price to the public of $115.00 per share in March 2020. Net proceeds from the offering were approximately $228.0 million after deducting underwriting discounts, commissions and expenses of the offering. We intend to use the net proceeds of the offering for general corporate purposes, including working capital.

Pursuant to the effective registration statement which was filed on December 17, 2018, and amended on January 22, 2019, we entered into an underwriting agreement to issue 2.4 million shares of common stock, which included the exercise in full of the underwriters' option to purchase 0.4 million additional shares of common stock, at a price to the public of $48.50 per share in January 2019, for a total of 2.8 million shares issued in connection with the offering. Net proceeds from the offering were approximately $126.1 million after deducting underwriting discounts, commissions and estimated expenses of the offering. We used the net proceeds of the offering for general corporate purposes, including working capital.

Common Stock – On all matters submitted to our stockholders for vote, our common stockholders are entitled to one vote per share, voting together as a single class, and do not have cumulative voting rights. Accordingly, the holders of a majority of the shares of common stock entitled to vote in any election of directors can elect all of the directors standing for election, if they so choose. Subject to preferences that may apply to any shares of preferred stock outstanding, the holders of common stock are entitled to share equally in any dividends, when and if declared by our board of directors. Upon the occurrence of a liquidation, dissolution or winding-up, the holders of common stock are entitled to share equally in all assets remaining after the payment of any liabilities and the liquidation preferences on any outstanding preferred stock. Holders of common stock have no preemptive or conversion rights or other subscription rights and there are no redemption or sinking funds provisions applicable to the common stock.

Shares Reserved – We generally issue previously unissued common stock upon the exercise of stock options, the vesting of restricted stock units and upon granting of restricted common stock awards; however we may reissue previously acquired treasury shares to satisfy these future issuances. Shares of authorized but unissued common stock reserved for future issuance were as follows (in thousands):

	December 31, 2020	December 31, 2019
Stock options issued and outstanding	527	649
Restricted stock units issued and outstanding	2,370	2,201
Shares available for grant	1,509	2,197
Total shares reserved	4,406	5,047

Stock Plans – On June 12, 2014, upon approval at the Annual Meeting of Stockholders, we adopted the 2014 Equity Incentive Plan (the "2014 Plan") with 4.5 million shares authorized for issuance. The 2014 Plan does not include an evergreen provision to automatically increase the number of shares available under it and increases in the number of shares authorized for issuance under the 2014 Plan require stockholder approval. Also, under the 2014 Plan the following shares are not recycled for future grant under the 2014 Plan: (i) shares used in connection with the exercise of an option and/or stock appreciation right to pay the exercise price or purchase price of such award or satisfy applicable tax withholding obligations; and (ii) the gross number of shares subject to stock appreciation rights that are exercised. Furthermore, the 2014 Plan included a provision that prohibits repricing of outstanding stock options or stock appreciation rights and formalized and updated procedures to qualify awards as "performance-based" compensation under Section 162(m) of the Internal Revenue Code in order to preserve full tax deductibility

of such awards. In 2019, our stockholders approved an amendment to the 2014 Equity Incentive Plan to increase the maximum number of shares that may be issued by 2.5 million shares.

Our stock options granted under the 2014 Plan generally vest over four years at a rate of 25% after one year and 1/48th per month thereafter. Stock options granted under the 2014 Plan generally expire after seven years from the date of grant.

We have granted market-based and performance-based restricted stock units to our executive officers and certain members of our senior management team. For market-based restricted stock units, each represents a contingent right to receive a share of our common stock upon the attainment of certain stock prices generally over a four-year performance period. These awards generally vest on the one-year anniversary of the date of achievement, subject to the employee's continued service through the vesting date. Compensation expense related to these awards is recognized over the requisite service period. For performance-based restricted stock units, each represents a contingent right to receive a share of our common stock upon the attainment of certain financial targets over a trailing twelve month performance period. These awards would vest in the middle of 2022, subject to achievement of performance targets and continued service through the vesting date. Compensation expense related to these awards is recognized over the requisite service period if the performance criteria is probable of being achieved.

The following table summarizes activity under our 2014 Plan for the year ended December 31, 2020 (in thousands):

Beginning balance [(1)]	2,197
Restricted stock units granted [(2)]	(1,038)
Restricted stock units cancelled [(3)]	322
Options cancelled	28
Ending balance	1,509

(1) Shares available for grant do not include treasury stock shares that could be granted if we determined to do so.
(2) Includes grants of restricted stock units with service, performance-based or market-based vesting criteria.
(3) Includes cancelled restricted stock units with service, performance-based or market-based vesting criteria.

The following table summarizes stock option activity (in thousands, except weighted-average exercise price and weighted-average remaining contractual life data):

	Number of Stock Options [1]	Weighted Average Exercise Price	Weighted-Average Remaining Contractual Life (years)	Aggregate Intrinsic Value [2]
Outstanding as of December 31, 2019	649	$ 19.57	4.4	$ 49,661
Granted	—	$ —		
Exercised	(92)	$ 21.20		
Cancelled	(30)	$ 26.67		
Outstanding balance as of December 31, 2020	527	$ 18.88	3.3	$ 29,582
Vested and expected to vest as of December 31, 2020	520	$ 18.71	3.3	$ 29,281
Exercisable as of December 31, 2020	450	$ 17.18	3.1	$ 26,026

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(1) Includes certain stock options with service, performance-based or market-based vesting criteria.
(2) The aggregate intrinsic value is calculated as the product between eHealth's closing stock price as of December 31, 2020 and 2019 and the exercise price of in-the-money options as of those dates.

The following table provides information pertaining to our stock options for the years presented below (in thousands, except weighted-average fair values):

	Year Ended December 31,		
	2020	2019	2018
Weighted average fair value of options granted	n/a	$ 33.19	$ 12.78
Total fair value of options vested	$ 1,367	$ 2,924	$ 2,263
Intrinsic value of options exercised	$ 8,127	$ 19,890	$ 1,461

The following table summarizes restricted stock unit activity (in thousands, except weighted-average grant date fair value and weighted-average remaining contractual life data):

	Number of Restricted Stock Units [1]	Weighted-Average Grant Date Fair Value	Weighted-Average Remaining Service Period	Aggregate Intrinsic Value [2]
Outstanding as of December 31, 2019	2,201	$ 39.08	1.6	$ 211,443
Granted	1,038	$ 94.10		
Vested	(547)	$ 42.28		
Cancelled	(322)	$ 54.81		
Outstanding as of December 31, 2020	2,370	$ 60.44	1.8	$ 177,746

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(1) Includes certain restricted stock units with service, performance-based or market-based vesting criteria.
(2) The aggregate intrinsic value is calculated as the difference of our closing stock price as of December 31, 2020 and 2019 multiplied by the number of restricted stock units outstanding as of December 31, 2020 and 2019, respectively.

Stock Repurchase Programs – We had no stock repurchase activity during the year ended December 31, 2020. In addition to 10.7 million shares repurchased under our previous repurchase programs, we have in treasury 1.1 million shares as of December 31, 2020 that were previously surrendered by employees to satisfy tax withholding due in connection with the vesting of certain restricted stock units. As of December 31, 2020 and 2019, we had a total of 11.8 million shares and 11.6 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 – The fair value of stock options granted to employees was estimated using the Black-Scholes option-pricing model and with the following weighted average assumptions for the years presented below, except for 2020 in which we did not have any options granted:

	Year Ended December 31,		
	2020	**2019**	**2018**
Expected term (years)	n/a	4.3	4.3
Expected volatility	n/a	65.3%	68.3%
Expected dividend yield	n/a	—%	—%
Risk-free interest rate	n/a	2.1%	2.7%

The weighted-average fair value of the market-based restricted stock units was determined using the Monte Carlo simulation model using the following weighted average assumptions:

	Year Ended December 31,		
	2020	**2019**	**2018**
Expected term (years)	3.5	1.4	1.6
Expected volatility	64.4%	57.8%	69.8%
Expected dividend yield	—%	—%	—%
Risk-free interest rate	0.3%	2.4%	2.5%
Weighted-average grant date fair value	$93.85	$58.16	$13.48

We estimate a forfeiture rate to calculate the stock-based compensation for our awards. We evaluate the appropriateness of the forfeiture rate based on historical forfeiture, analysis of employee turnover, and other factors. Forfeitures are estimated at the time of grant and revised, if necessary, in subsequent periods if actual forfeitures differ from those estimates.

2020 Employee Share Purchase Plan – Our board of directors adopted in March 2020 and our stockholders approved in June 2020 the 2020 Employee Stock Purchase Plan ("ESPP"). A total of 500,000 shares of our common stock are available for sale under the ESPP. Eligible employees can purchase shares of our common stock based on a percentage of their compensation subject to certain limits. The purchase price per share is equal to the lower of 85% of the fair market value of our common stock on the offering date or the purchase date.

As of December 31, 2020, no shares of common stock have been purchased under our ESPP.

During the year ended December 31, 2020, we recognized $0.3 million in compensation cost related to our ESPP in our consolidated statement of operations. As of December 31, 2020, the unrecognized compensation cost related to our ESPP is $0.9 million, which is expected to be recognized over a weighted average period of 0.4 years.

We estimated the fair value of ESPP purchase rights for our first offering period using a Black-Scholes option-pricing model with the following assumptions:

	Year Ended December 31, 2020
Expected term (years)	0.5
Expected volatility	77.4 %
Expected dividend yield	— %
Risk-free interest rate	0.1 %

The following table summarizes stock-based compensation expense recognized for the years presented below (in thousands):

	Year Ended December 31,		
	2020	2019	2018
Common stock options	$ 1,097	$ 2,215	$ 1,991
Restricted stock units*	23,729	20,355	10,549
ESPP	346	—	—
Total stock-based compensation expense	**$ 25,172**	**$ 22,570**	**$ 12,540**

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* Amounts include market-based and performance-based RSUs.

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

	Year Ended December 31,		
	2020	2019	2018
Marketing and advertising	$ 5,102	$ 4,230	$ 1,974
Customer care and enrollment	2,723	1,451	816
Technology and content	5,460	3,611	1,675
General and administrative	11,887	13,278	7,824
Restructuring charges	—	—	251
Total stock-based compensation expense	25,172	22,570	12,540
Amount capitalized for internal-use software	2,007	—	—
Total stock-based compensation	**$ 27,179**	**$ 22,570**	**$ 12,540**

During the three months ended December 31, 2020, we made an adjustment to reduce stock-based compensation expense by $5.9 million related to our performance-based restricted stock awards due to attainment of certain performance goals deemed not probable based on our latest estimates. The impact of this adjustment was $0.23 and $0.22 per basic and diluted share, respectively, for the year ended December 31, 2020.

For the year ended December 31, 2020, there was a total of $2.0 million stock-based compensation expense capitalized in the internal-use software and website development costs classified under Other assets, which represents a noncash investing activity.

As of December 31, 2020, there was $1.0 million of total unamortized compensation cost, net of estimated forfeitures, related to stock options, expected to be recognized over a weighted average period of 1.4 years. As of

December 31, 2020, there was $83.2 million of total unamortized compensation cost, net of estimated forfeitures, related to restricted stock units, expected to be recognized over a weighted average period of 2.7 years.

Accelerated Vesting – During the year ended December 31, 2018, due to changes in our senior management, we accelerated the vesting dates of certain stock options and restricted stock units granted to two former employees. We recognized a $0.5 million incremental stock-based compensation expense in connection with this modification.

Note 7 – Net Income Per Share

Basic net income per share is computed by dividing net income by the weighted-average number of common shares outstanding for the period. Diluted net income per share is computed by dividing the net income for the period by the weighted average number of common and common equivalent shares outstanding during the period. Diluted net income per share is computed giving effect to all potential dilutive common stock equivalent shares, including options and restricted stock units. The dilutive effect of outstanding awards is reflected in diluted net income per share by application of the treasury stock method.

The following table sets forth the computation of basic and diluted net income per share (in thousands, except per share amounts):

	Year Ended December 31,		
	2020	2019	2018
Basic			
Net income	$ 45,450	$ 66,887	$ 241
Shares used in per share calculation – basic	26,025	23,075	19,294
Net income per share – basic	**$ 1.75**	**$ 2.90**	**$ 0.01**
Diluted:			
Net income	$ 45,450	$ 66,887	$ 241
Shares used in per share calculation – basic	26,025	23,075	19,294
Dilutive effect of common stock	989	1,464	1,115
Total common stock shares used in diluted share calculation	27,014	24,539	20,409
Net income per share – diluted	**$ 1.68**	**$ 2.73**	**$ 0.01**

For each of the years ended December 31, 2020, 2019 and 2018, we had securities outstanding that could potentially dilute net income per share, but the shares from the assumed conversion or exercise of these securities were excluded in the computation of diluted net income 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 income per share consisted of the following (in thousands):

	Year Ended December 31,		
	2020	2019	2018
Common stock options	—	11	291
Restricted stock units	151	41	13
Total	151	52	304

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 December 31, 2020 (in thousands):

For the Years Ending December 31,		
2021	$	5,775
2022		3,408
2023		2,745
2024		2,056
2025		1,353
Thereafter		1,353
Total	$	16,690

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 consolidated financial statements. An estimated loss contingency is accrued in the consolidated financial statements if it is probable that a liability has been incurred and the amount of the loss can be reasonably estimated. We accrued approximately $1.2 million as of December 31, 2019 for amounts we believed to be payable for certain legal proceedings. The accrued amount was settled and paid in January 2021. There was no material additional litigation-related accrual during the year ended December 31, 2020. 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 us, our chief executive officer, Scott N. Flanders, our chief financial officer, Derek N. Yung, and our 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 we and Messrs. Flanders, Yung and Francis made materially false and misleading statements and/or failed to disclose material information regarding our accounting and modeling assumptions, rate of member churn and our 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. The lead plaintiff filed an amended complaint on August 25, 2020, which Defendants moved to dismiss. The motion to dismiss has been fully briefed and is currently set to be heard by the court on April 1, 2021.

Derivative Actions **–** On July 7, 2020 and October 13, 2020, two derivative lawsuits were filed against our chief executive officer, Mr. Flanders, our chief financial officer, Mr. Yung, our then-chief operating officer, Mr. Francis, and the members of our Board of Directors (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. The complaints allege, among other things, that beginning on March 19, 2018, 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. Both 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 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 *Chernet* and *Lincolnshire* lawsuits have both been stayed pending the resolution of the motion to dismiss in the Securities Class Action, *In re eHealth Securities Litig*., Master File No. 4:20-cv-02395-JST (N.D. Cal.).

The Gonzalez and Le'Vias Complaints – On April 6, 2018, a former employee, Lupita Gonzalez, filed a complaint against us in the Superior Court of the State of California for the County of Sacramento (the "Gonzalez Complaint"). The Gonzalez Complaint is brought under the California Private Attorney General Act ("PAGA") on behalf of all current and former hourly-paid or non-exempt employees who work or have worked for us in California. The claim alleges that we violated wage and hour laws with respect to these non-exempt employees, including, among other things, the failure to comply with California law as to (i) the payment of overtime wages; (ii) the payment of minimum wages; (iii) providing compliant meal and rest periods, (iv) the payment of wages earned during employment and owed upon the termination of employment; (v) providing complete and accurate wage statements, (vi) keeping of accurate payroll records; and (vii) the proper reimbursement for necessary business-related expenses and costs. The Gonzalez Complaint seeks penalties and costs, expenses and attorneys' fees.

On July 1, 2019, two other current or former employees, Michael Le'Vias and Ramona Meadows, filed a related complaint against us and eHealth Ins. Serv. Co., in the Superior Court of the State of California for the County of Santa Clara (the "Le'Vias Complaint"). A substantial overlap exists between the facts and circumstances alleged in the Gonzalez Complaint and the Le'Vias Complaint. Specifically, the Le'Vias Complaint is also brought under PAGA on behalf of all current and former hourly-paid or non-exempt employees who work or have worked for us in California. The claim alleges that we violated wage and hour laws with respect to these non-exempt employees, including, among other things, the failure to comply with California law as to (i) the payment of overtime wages; (ii) the payment of minimum wages; (iii) providing compliant meal and rest periods, (iv) the payment of wages earned during employment and owed upon the termination of employment; (v) providing complete and accurate wage statements, (vi) keeping of accurate payroll records; and (vii) the proper reimbursement for necessary business-related expenses and costs. The Le'Vias Complaint seeks unpaid wages, penalties and costs, expenses and attorneys' fees.

The parties have entered into a court-approved settlement agreement that resolves both matters related to the Gonzalez and Le'Vias Complaints, which settlement agreement, as required by law, has been approved by the Superior Court of the State of California. Plaintiffs Michael Le'Vias and Ramona Meadows have sought dismissal with prejudice of the Le'Vias Complaint and, upon the completion of the distribution of the settlement funds in

accordance with the settlement agreement and the court order approving the settlement agreement, the parties will seek a dismissal with prejudice of the Gonzalez Complaint.

Note 9 – Segment and Geographic Information

Operating Segments

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

	Year Ended December 31,		
	2020	2019	2018
Revenue:			
Medicare	$ 516,762	$ 446,961	$ 210,570
Individual, Family and Small Business	66,012	59,240	40,825
Total revenue	$ 582,774	$ 506,201	$ 251,395
Segment profit:			
Medicare segment profit	$ 101,963	$ 155,234	$ 60,844
Individual, Family and Small Business segment profit	39,383	23,368	5,803
Total segment profit	141,346	178,602	66,647
Corporate	(57,664)	(45,374)	(32,996)
Stock-based compensation expense	(25,172)	(22,570)	(12,289)
Depreciation and amortization	(3,694)	(2,983)	(2,479)
Change in fair value of earnout liability	—	(24,079)	(12,300)
Restructuring charges	—	—	(1,865)
Acquisition costs	—	—	(76)
Amortization of intangible assets	(1,493)	(2,187)	(2,091)
Other income, net	666	2,090	$ 755
Income before income taxes	$ 53,989	$ 83,499	$ 3,306

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 4 – 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 consist primarily 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):

	December 31, 2020	December 31, 2019
United States	$ 40,500	$ 64,408
China	565	471
Total	$ 41,065	$ 64,879

Significant Customers

Substantially all revenue for the years ended December 31, 2020, 2019 and 2018 was generated from customers located in the United States. Carriers representing 10% or more of our total revenue are summarized as follows:

	Year Ended December 31,		
	2020	2019	2018
Humana	22 %	26 %	22 %
UnitedHealthcare [1]	21 %	19 %	19 %
Aetna [2]	15 %	17 %	14 %

(1) UnitedHealthcare also includes other carriers owned by UnitedHealthcare.
(2) Aetna includes other carriers owned by Aetna.

Note 10 – Leases

We account our leases in accordance with Accounting Standards Codification Topic 842, *Leases*. We determine if an arrangement is a lease at inception. Our lease portfolio is primarily composed of operating leases for corporate offices and as of January 1, 2019 with the adoption of the new guidance for leasing arrangements, are included in operating lease right-of-use ("ROU") assets and lease liabilities on our consolidated balance sheets. ROU assets represent our right to use an underlying asset for the lease term and lease liabilities represent our obligation to make lease payments arising from the lease. Operating lease ROU assets and lease liabilities are recognized at commencement date based on the present value of lease payments over the lease term. As the Company's leases generally do not provide an implicit rate, we use our incremental borrowing rate based on the information available at commencement date. In determining the present value of lease payments, we utilized the assistance of third-party specialists to assist us in determining our yield curve based upon our credit rating, lease term and adjustment for security. The operating lease ROU asset also includes any lease payments made and excludes lease incentives. Our lease terms may include options to extend or terminate the lease when it is reasonably certain that we will exercise that option. Lease expense for lease payments is recognized on a straight-line basis over the lease term.

Our leases have remaining lease terms of 3 to 9 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 $7.8 million, $6.4 million, and $5.3 million for the years ended December 31, 2020, 2019 and 2018, respectively. We have a sublease agreement for our office space in Mountain View, California to sublease to a third party, which commenced in December 2018 and will expire in July 2023. We recorded $1.2 million and $1.1 million of sublease income during the years ended December 31, 2020 and 2019, respectively.

The following table summarizes the lease-related assets and liabilities recorded on the Consolidated Balance Sheet for the periods presented below (in thousands):

	December 31, 2020	December 31, 2019
Operating lease right-of-use assets	$ 42,558	$ 36,621
Lease liabilities – current	$ 5,192	$ 4,759
Lease liabilities – non-current	41,369	34,305
Total operating lease liabilities	$ 46,561	$ 39,064

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

	December 31, 2020	December 31, 2019
Operating cash outflows from operating leases	$ 7,090	$ 5,464
Non-cash investing activities relating to operating lease right-of-use assets	$ 10,919	$ 40,646
Weighted-average remaining lease term of operating leases	7.2 years	7.6 years
Weighted-average discount rate used to recognize operating lease right-of-use-assets	5.4 %	5.9 %

As of December 31, 2020, maturities of operating lease liabilities are as follows (in thousands):

Year ending December 31,	
2021	$ 7,644
2022	7,701
2023	8,033
2024	7,832
2025	8,009
Thereafter	19,408
Total lease payments [(1)]	58,627
Less imputed interest	(12,066)
Total	$ 46,561

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[(1)] Noncancellable sublease income for the years ending December 31, 2021, 2022 and 2023 of $1.2 million, $0.4 million and $0.4 million, respectively, are not included in the table above.

Note 11 – Debt

On September 17, 2018, we entered into a Credit Agreement with Royal Bank of Canada (“RBC”), as administrative agent and collateral agent (the “Credit Agreement”). The Credit Agreement provides for a $40.0 million secured asset-backed revolving credit facility with a $5.0 million letter of credit sub-facility.

On December 20, 2019, we amended our revolving credit facility agreement with RBC (the “Amendment”) and increased the borrowing amount from $40.0 to $75.0 million. The maturity date has been extended to December 20, 2022.

The borrowing base under the Credit Agreement is comprised of an amount equal to (a) the lesser of (i) eighty percent (80%) of Eligible Commissions Receivables (as defined in the Credit Agreement) we actually collected during the immediately preceding period of three months or (ii) eighty percent 80%) of our Eligible Commission Receivables for the immediately succeeding period of three months, plus (b) fifty percent (50%) of our Eligible Commission Receivables for the immediately succeeding period of six months (excluding the immediately succeeding period of three months), in each case subject to reserves established by RBC (the "Borrowing Base"). The proceeds of the loans under the Credit Agreement may be used for working capital and general corporate purposes. The Borrowers have the right to prepay the loans under the Credit Agreement in whole or in part at any time without penalty. Subject to availability under the Borrowing Base, amounts repaid may be reborrowed.

Amounts not borrowed under the Credit Agreement will be subject to a commitment fee of 0.5% per annum on the daily unused portion of the credit facility, to be paid in arrears on the first business day of each calendar quarter. At the closing of the Credit Agreement, we paid a one-time facility fee of 1.75% of the total commitments of $40.0 million. We also paid a one-time closing fee of 0.5% of the new commitment of $75.0 million in connection with the Amendment. The Company is also obligated to pay other customary administration fees for a credit facility of this size and type.

The availability under the credit facility was up to the lesser of $40.0 million or the Borrowing Base in the original credit agreement. The Amendment increased the availability up to the lesser of $75.0 million or the Borrowing Base, which may be reduced from time to time pursuant to the Credit Agreement.

Financial covenants in the original Credit Agreement required that we maintain Excess Availability (as defined in the Credit Agreement) at or above $6.0 million at any time. The Amendment also changed the financial covenants to require us to maintain at least $6.0 million of Excess Availability at all times or, if greater, up to $11.3 million depending on our borrowing base as determined by eligible past and future commission receivables. In addition, the Amendment also included changes in the payment conditions to, among other things, require us to have at least $10.0 million of liquidity or, if greater, up to $18.8 million depending on our borrowing base as determined by eligible past and future commission receivables, in order for us to make certain permitted acquisitions, investments, distributions and payments of indebtedness. The Amendment also stated the seasonal amount thresholds used in connection with the cash dominion and field examination covenants in the Credit Agreement.

We incurred $1.2 million of issuance costs in connection with the Credit Agreement, which were capitalized as part of Other assets on our Consolidated Balance Sheet in the period we entered into the Credit Agreement. The Amendment did not change the interest rate. In connection with this Amendment, we incurred closing costs totaling $0.5 million, which were capitalized and recorded as Other assets on our Consolidated Balance Sheet as of December 31, 2020. The remaining balance of unamortized issuance costs was $0.7 million and $1.1 million as of December 31, 2020 and 2019, respectively.

As of December 31, 2020, we had no outstanding borrowings under our revolving credit facility.

Note 12 – Income Taxes

The components of our income before provision for income taxes were as follows (in thousands):

	Year Ended December 31,		
	2020	2019	2018
United States	$ 53,078	$ 82,391	$ 2,458
Foreign	911	1,108	848
Income before provision for income taxes	$ 53,989	$ 83,499	$ 3,306

The federal and state income tax provision is summarized as follows (in thousands):

	Year Ended December 31,		
	2020	2019	2018
Current:			
Federal	$ —	$ —	$ 5
State	88	75	48
Foreign	(361)	326	213
Total current	(273)	401	266
Deferred:			
Federal	7,303	13,594	165
State	1,245	2,635	2,648
Foreign	264	(18)	(14)
Total deferred	8,812	16,211	2,799
Provision for income taxes	$ 8,539	$ 16,612	$ 3,065

In 2020, we had worldwide consolidated income before tax of $54.0 million, and tax expense of $8.5 million, with an annual effective tax rate of 15.8%.

The effective tax rate of our provision for income taxes differs from the federal statutory rate as follows:

	Year Ended December 31,		
	2020	2019	2018
Statutory rate	21.0 %	21.0 %	21.0 %
State income taxes, net of federal benefit	2.2	2.6	(7.2)
Stock-based compensation shortfalls (windfalls), net	(7.9)	(7.0)	(29.4)
Non-deductible stock-based compensation	2.2	2.5	21.6
Non-deductible lobbying expenses	0.8	1.0	15.2
Research and development credits	(2.2)	(0.9)	(17.1)
Changes in valuation allowance	0.1	—	72.8
Foreign income tax and income inclusion	(0.7)	0.1	6.8
Non-deductible parking expense	—	0.2	3.1
Other permanent differences	0.3	0.4	5.9
Effective tax rate	15.8 %	19.9 %	92.7 %

Deferred income taxes reflect the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes, together with operating losses and tax credit carryforwards.

The tax effects of significant items comprising our deferred taxes as of December 31, 2020 and 2019 were as follows (in thousands):

	December 31, 2020	December 31, 2019
Deferred tax assets:		
Net operating losses	$ 104,860	$ 60,023
Accruals and reserves	2,557	4,143
Operating lease liabilities	11,368	9,471
Intangible assets	2,592	6,306
Tax credits	7,805	5,818
Stock-based compensation	4,500	2,835
Fixed assets	111	203
Other	176	187
Total deferred tax assets	133,969	88,986
Valuation allowance	(2,479)	(2,407)
Total deferred tax assets net of valuation allowance	131,490	86,579
Deferred tax liabilities:		
Commissions receivable	(193,416)	(141,566)
Right-of-use assets	(10,391)	(8,879)
Total deferred tax liabilities	(203,807)	(150,445)
Net deferred tax liabilities	$ (72,317)	$ (63,866)

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.

The valuation allowance was recorded as a result of increased uncertainty regarding our future taxable income and a lack of sources of other taxable income to realize certain net operating losses and credits prior to expiration. The change in our valuation allowance is summarized as follows (in thousands):

Deferred Tax Assets - Valuation Allowance	Balance at beginning of year	Provision for income taxes	Balance at end of year
Year Ended December 31, 2020	$ 2,407	$ 72	$ 2,479
Year Ended December 31, 2019	2,407	—	2,407
Year Ended December 31, 2018	—	2,407	2,407

The net operating loss and tax credit carryforwards as of December 31, 2020 are summarized as follows (in thousands):

	Amount	Expires
Net operating losses, federal (with expiration)	$ 39,194	2034
Net operating losses, federal (without expiration)	381,001	Indefinite
Net operating losses, state	283,700	2021
Tax credits, federal	7,373	2021
Tax credits, state	7,754	n/a

Utilization of the net operating loss carryforwards and credits 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 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.

A reconciliation of the beginning and ending amount of our unrecognized tax benefits is as follows (in thousands):

	Year Ended December 31,		
	2020	2019	2018
Beginning balance	$ 4,709	$ 3,740	$ 3,096
Increase based on tax positions related to the prior year	—	—	70
Lapse of statute of limitations	(8)	—	(5)
Additions based on tax positions related to the current year	1,629	969	579
Ending balance	$ 6,330	$ 4,709	$ 3,740

As of December 31, 2020, the total amount of gross unrecognized tax benefits was $6.3 million, of which $5.7 million, if recognized, would affect our effective tax rate. As of December 31, 2019, the total amount of gross unrecognized tax benefits was $4.7 million, of which $4.2 million, if recognized, would affect our effective tax rate.

We record interest and penalties related to unrecognized tax benefits in income tax expense. As of December 31, 2020, the amount accrued for estimated interest related to uncertain tax positions was immaterial. We did not record an accrual for penalties.

Included in the balance of income tax liabilities and accrued interest as of December 31, 2020 is an immaterial amount related to tax positions for which it is reasonably possible that the statute of limitations will expire in various jurisdictions and income tax exams will close within the next twelve months.

We are subject to taxation in various jurisdictions, including federal, state and foreign. Our federal and state income tax returns are generally not subject to examination by taxing authorities for fiscal years before 2001 due to our net operating losses and credits carryforward.

The Coronavirus Aid, Relief and Economic Security (“CARES”) Act was signed into law on March 27, 2020. The business tax provisions of the CARES Act include temporary changes to income based tax laws, including the ability to utilize net operating losses, interest expense deductions, alternative minimum tax credit refunds, charitable contributions, and depreciation of qualified improvement property. The income tax provisions of

the CARES Act did not have a material impact on our Consolidated Financial Statements for the year ended December 31, 2020.

Note 13 – Subsequent Event

On February 17, 2021,we entered into an investment agreement with an affiliate of H.I.G. Capital (together with its affiliated funds, "H.I.G."), pursuant to which we have agreed to issue and sell to affiliated entities of H.I.G., 2,250,000 shares of the Company's newly designated Series A preferred stock for an aggregate purchase price of $225.0 million.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. CONTROLS AND PROCEDURES

Evaluation of Our Disclosure Controls and Procedures

Our management, with the participation of our chief executive officer and chief financial officer, evaluated the effectiveness of our disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended, as of the end of the period covered by this Annual Report on Form 10-K.

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

Management's Report on Internal Control over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934, as amended. Under the supervision and with the participation of our management, including our chief executive officer and chief financial officer, we conducted an evaluation of the effectiveness of our internal control over financial reporting as of December 31, 2020 based on the guidelines established in *Internal Control—Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework). Our internal control over financial reporting includes policies and procedures that provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external reporting purposes in accordance with U.S. generally accepted accounting principles.

Based on the results of our evaluation, our management concluded that our internal control over financial reporting was effective as of December 31, 2020. We reviewed the results of management's assessment with our Audit Committee.

Ernst & Young LLP, our independent registered public accounting firm, has issued a report on the Company's internal control over financial reporting as of December 31, 2020, which is presented below.

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 December 31, 2020 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Inherent Limitations on Effectiveness of Controls

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

Report of Independent Registered Public Accounting Firm

To the Stockholders and the Board of Directors of eHealth, Inc.

Opinion on Internal Control over Financial Reporting

We have audited eHealth, Inc.'s internal control over financial reporting as of December 31, 2020, based on criteria established in Internal Control - Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, eHealth, Inc. (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2020, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the 2020 consolidated financial statements of the Company and our report dated February 26, 2021 expressed an unqualified opinion thereon.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects.

Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control Over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ Ernst & Young LLP

Redwood City, California
February 26, 2021

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

The information concerning our directors, executive officers, compliance with Section 16(a) of the Securities Exchange Act of 1934, as amended, and corporate governance required by this Item 10 of Form 10-K is incorporated by reference from the information contained in the Definitive Proxy Statement for the Annual Meeting of Stockholders, which is expected to be filed within 120 days after our fiscal year ended December 31, 2020.

We have adopted a code of ethics that applies to all employees, including our principal executive officer, Scott Flanders, principal financial officer, Derek Yung, principal accounting officer, John Pierantoni. and all other executive officers. The code of ethics is available on the governance page of our website at *ir.ehealthinsurance.com*. A copy may also be obtained without charge by contacting investor relations, attention Vice President of Investor Relations, 2625 Augustine Drive, Second Floor, Santa Clara, CA, 95054 or by calling (650) 584-2700.

We plan to post on our website at the address described above any future amendments or waivers of our Code of Conduct.

ITEM 11. EXECUTIVE COMPENSATION

The information required by Item 11 of Form 10-K is incorporated herein by reference from the information contained in the Definitive Proxy Statement for the Annual Meeting of Stockholders, which is expected to be filed within 120 days after our fiscal year ended December 31, 2020.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

The information required by Item 12 of Form 10-K is incorporated herein by reference from the information contained in the Definitive Proxy Statement for the Annual Meeting of Stockholders, which is expected to be filed within 120 days after our fiscal year ended December 31, 2020.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by Item 13 of Form 10-K is incorporated herein by reference from the information contained in the Definitive Proxy Statement for the Annual Meeting of Stockholders, which is expected to be filed within 120 days after our fiscal year ended December 31, 2020.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES

The information required by Item 14 of Form 10-K is incorporated herein by reference from the information contained in the Definitive Proxy Statement for the Annual Meeting of Stockholders, which is expected to be filed within 120 days after our fiscal year ended December 31, 2020.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) We have filed the following documents as part of this Annual Report on Form 10-K:

1. Consolidated Financial Statements

Information in response to this Item is included in Item 8 of Part II of this Annual Report on Form 10-K.

2. Financial Statement Schedules

All schedules are omitted because they are not applicable, not required or because the required information is included in the consolidated financial statements or notes thereto.

3. Exhibits

See Item 15(b) below.

(b) ***Exhibits*** – We have filed, or incorporated into this Annual Report on Form 10-K by reference, the exhibits listed on the accompanying Index to Exhibits of this Annual Report on Form 10-K.

(c) ***Financial Statement Schedule*** – See Item 15(a) above.

ITEM 16. FORM 10-K SUMMARY

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, as amended, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

February 26, 2021

eHealth, Inc.

/s/ SCOTT N. FLANDERS	/s/ DEREK N. YUNG
Scott N. Flanders *Chief Executive Officer*	Derek N. Yung *Chief Financial Officer*

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities indicated on February 26, 2021.

Signature	Title
/s/ SCOTT N. FLANDERS Scott N. Flanders	Chief Executive Officer (Principal Executive Officer) and Director
/s/ DEREK N. YUNG Derek N. Yung	Chief Financial Officer (Principal Financial Officer)
/s/ JOHN PIERANTONI John Pierantoni	Chief Accounting Officer (Principal Accounting Officer)
/s/ ANDREA BRIMMER Andrea Brimmer	Director
/s/ BETH A. BROOKE Beth A. Brooke	Director
/s/ MICHAEL D. GOLDBERG Michael D. Goldberg	Director
/s/ RANDALL S. LIVINGSTON Randall S. Livingston	Director
/s/ JACK L. OLIVER III Jack L. Oliver III	Director
/s/ DALE B. WOLF Dale B. Wolf	Director

EXHIBIT INDEX

Exhibit Number		Description of Exhibit	Incorporation by Reference Herein	
			Form	Date
2.1		Purchase Agreement dated January 16, 2018 by and among eHealth, Inc., Wealth, Health and Life Advisors, LLC (d/b/a GoMedigap), WHL Advisors, Inc., Qavah Ventures, LLC, Richard Cantu, Kevin Walbrick, and Kevin Walbrick as the exclusive member representative thereunder	Current Report on Form 8-K (File No. 001-33071)	January 16, 2018
3.1		Amended and Restated Certificate of Incorporation of the Registrant	Registration Statement on Form S-l, as amended (File No. 333-133526)	April 25, 2006
3.2		Amended and Restated Bylaws of the Registrant	Current Report on Form 8-K (File No. 001-33071)	November 17, 2008
4.1		Form of the Registrant's Common Stock Certificate	Registration Statement on Form S-l, as amended (File No. 333-133526)	June 28, 2006
4.2		Description of Capital Stock	Annual Report on Form 10-K (File No. 001-33071)	March 2, 2020
10.1*		Form of Indemnification Agreement entered into between the Registrant and its directors and officers	Registration Statement on Form S-l, as amended (File No. 333-133526)	April 25, 2006
10.2*	†	Form of Indemnification Agreement adopted in 2021		
10.3*		Employment Agreement, dated May 31, 2016, between Scott N. Flanders and eHealth, Inc.	Quarterly Report on Form 10-Q (File No. 001-33071)	August 8, 2016
10.4*		Employment Agreement, dated July 11, 2016, between David Francis and eHealth, Inc.	Quarterly Report on Form 10-Q (File No. 001-33071)	August 8, 2016
10.5*		Letter Agreement, dated November 17, 2005, between Jack L. Oliver III and eHealth, Inc.	Registration Statement on Form S-l, as amended (File No. 333-133526)	April 25, 2006
10.6*		Employment Agreement, dated June 4, 2018, between Derek Yung and eHealth, Inc.	Quarterly Report on Form 10-Q (File No. 001-33071)	August 7, 2018
10.7*		Employment Agreement, dated as of February 20, 2020, between eHealthInsurance Services, Inc. and Robert Hurley.	Current Report on Form 8-K (File No. 001-33071)	February 21, 2020
10.8*	†	Severance Agreement, dated as of February 10, 2021, between Timothy Hannan and eHealth, Inc.		
10.9		Investment Agreement, dated as of February 17, 2021, by and between eHealth, Inc. and Echelon Health SPV, LP	Current Report on Form 8-K (File No. 001-33071)	February 18, 2021
10.10		Credit Agreement, dated September 17, 2018, by and among eHealth, Inc., eHealthInsurance Services, Inc., Wealth, Health and Life Advisors, LLC, PlanPrescriber, Inc., Royal Bank of Canada and other lenders identified therein	Current Report on Form 8-K (File No. 001-33071)	September 19, 2018
10.10.1		Amendment No. 1 to Credit Agreement, dated October 16, 2018, by and among eHealth, Inc., eHealthInsurance Services, Inc., Wealth, Health and Life Advisors, LLC, PlanPrescriber, Inc., Royal Bank of Canada and other lenders identified therein	Quarterly Report on Form 10-Q (File No. 001-33071)	August 8, 2019
10.10.2		Amendment No. 2 to Credit Agreement, dated July 2, 2019, by and among eHealth, Inc., eHealthInsurance Services, Inc., Wealth, Health and Life Advisors, LLC, PlanPrescriber, Inc., Royal Bank of Canada and other lenders identified therein	Quarterly Report on Form 10-Q (File No. 001-33071)	August 8, 2019
10.10.3		Amendment No. 3 to Credit Agreement, dated December 20, 2019, by and among eHealth, Inc., eHealthInsurance Services, Inc., Wealth, Health and Life Advisors, LLC, PlanPrescriber, Inc., Royal Bank of Canada and other lenders identified therein	Current Report on Form 8-K (File No. 001-33071)	December 26, 2019
10.11		Security Agreement, dated September 17, 2018, by and among eHealth, Inc., eHealthInsurance Services, Inc., PlanPrescriber, Inc., Wealth, Health and Life Advisors, LLC, and Royal Bank of Canada	Current Report on Form 8-K (File No. 001-33071)	September 19, 2018
10.12		Guaranty, dated September 17, 2018, by and between PlanPrescriber, Inc. and Royal Bank of Canada	Current Report on Form 8-K (File No. 001-33071)	September 19, 2018
10.13		Lease Agreement, dated March 29, 2018, between Ascentris-116b, LLC and eHealth, Inc.	Current Report on Form 8-K (File No. 001-33071)	April 2, 2018
10.14		Lease Agreement, dated April 25, 2018, between Augustine Bowers LLC and eHealthInsurance Services, Inc.	Current Report on Form 8-K (File No. 001-33071)	April 30, 2018
10.14.1		First Amendment to Lease, dated August 19, 2019, between Augustine Bowers LLC and eHealthInsurance Services, Inc.	Current Report on Form 8-K (File No. 001-33071)	August 21, 2019

10.15	Lease Agreement, dated May 2004, between eHealthInsurance Services, Inc. and Brian Avery, Trustee of the 1983 Avery Investments Trust, as amended	Registration Statement on Form S-l, as amended (File No. 333-133526)	April 25, 2006
10.15.1	First Amendment to Lease Agreement, effective as of May 15, 2009, between eHealthInsurance Services, Inc. and Brian Avery, Trustee of the 1983 Avery Investments Trust	Current Report on Form 8-K (File No. 001-33071)	May 21, 2009
10.15.2	Second Amendment to Lease Agreement, effective as of August 5, 2010 between eHealth Insurance Services, Inc. and Brian Avery, Trustee of the 1983 Avery Investments Trust	Current Report on Form 8-K (File No. 001-33071)	August 18, 2010
10.15.3	Third Amendment to Lease Agreement, effective as of July 8, 2011, between eHealthInsurance Services, Inc. and Brian Avery, Trustee of the 1983 Avery Generations Trust	Current Report on Form 8-K (File No. 001-33071)	July 12, 2011
10.15.4	Fourth Amendment to Lease Agreement, effective as of July 13, 2018, between eHealthInsurance Services, Inc. and Brian Avery, Trustee of the 1983 Avery Investments Trust	Quarterly Report on Form 10-Q (File No. 001-33071)	November 6, 2018
10.16	Standard Lease Agreement, dated June 10, 2004, between eHealthInsurance Services, Inc. and Gold Pointe E LLC, as amended	Registration Statement on Form S-l, as amended (File No. 333-133526)	April 25, 2006
10.16.1	Fourth Amendment to Standard Lease Agreement (Office), effective as of November 6, 2007, between eHealthInsurance Services, Inc. and Carlsen Investments, LLC	Current Report on Form 8-K (File No. 001-33071)	November 7, 2007
10.16.2	Sixth Amendment to Lease and Acknowledgment to Standard Lease Agreement, dated August 29, 2012, between Carlsen Investments, LLC and eHealthInsurance Services, Inc.	Current Report on Form 8-K (File No. 001-33071)	August 31, 2012
10.16.3	Seventh Amendment to Lease and Acknowledgment to Standard Lease Agreement, dated August 6, 2014, between Carlsen Investments, LLC and eHealthInsurance Services, Inc.	Quarterly Report on Form 10-Q (File No. 001-33071)	August 8, 2014
10.16.4	Eighth Amendment to Standard Lease Agreement (Officer) and Partial Termination of Lease dated June 23, 2016 between Carlsen Investments, LLC and eHealthInsurance Services, Inc.	Current Report on Form 8-K (File No. 001-33071)	June 28, 2016
10.16.5	Ninth Amendment to Lease and Acknowledgment to Standard Lease Agreement (Office) dated August 17, 2016 between Carlsen Investments, LLC and eHealthInsurance Services, Inc.	Current Report on Form 8-K (File No. 001-33071)	August 22, 2016
10.16.6	Tenth Amendment to Lease and Acknowledgment to Standard Lease Agreement (Office) between Carlsen Investments, LLC and eHealthInsurance Services, Inc.	Current Report on Form 8-K (File No. 001-33071)	April 12, 2019
10.16.7	Eleventh Amendment to Lease and Acknowledgment to Standard Lease Agreement (Office) between Carlsen Investments, LLC and eHealthInsurance Services, Inc.	Current Report on Form 8-K (File No. 001-33071)	February 4, 2020
10.16.8	Twelfth Amendment to Lease and Acknowledgment to Standard Lease Agreement (Office), dated August 28, 2020, between Carlsen Investments, LLC and eHealthInsurance Services, Inc.	Quarterly Report on Form 10-Q (File No. 001-33071)	November 5, 2020
10.17	Office Lease Contract, effective as of September 1, 2019, between eHealth China (Xiamen) Technology Co., Ltd and Xiamen Software Industry Investment & Development Co. Ltd.	Current Report on Form 8-K (File No. 001-33071)	September 6, 2019
10.17.1	Property Management Service Contract, effective as of September 1, 2019, between eHealth China (Xiamen) Technology Co., Ltd and Xiamen Software Industry Investment & Development Co. Ltd.	Current Report on Form 8-K (File No. 001-33071)	September 6, 2019
10.17.2	Office Lease Contract, effective as of September 15, 2019, between eHealth China (Xiamen) Technology Co., Ltd and Xiamen Software Industry Investment & Development Co. Ltd.	Current Report on Form 8-K (File No. 001-33071)	September 6, 2019
10.17.3	Property Management Service Contract, effective as of September 15, 2019, between eHealth China (Xiamen) Technology Co., Ltd and Xiamen Software Industry Investment & Development Co. Ltd.	Current Report on Form 8-K (File No. 001-33071)	September 6, 2019
10.18	Lease Agreement, dated March 23, 2012, between 340 Middlefield, LLC and eHealth, Inc.	Current Report on Form 8-K (File No. 001-33071)	March 27, 2012
10.18.1	First Amendment to Lease Agreement, effective as of May 28, 2013, between 340 Middlefield, LLC and eHealth, Inc.	Current Report on Form 8-K (File No. 001-33071)	May 29, 2013
10.18.2	Sublease, dated November 2, 2018, between JJ Lake Corporation and eHealth, Inc.	Current Report on Form 8-K (File No. 001-33071)	November 30, 2018
10.18.3	Consent to Sublease, dated November 27, 2018, by and among 340 Middlefield, LLC, JJ Lake Corporation and eHealth, Inc.	Current Report on Form 8-K (File No. 001-33071)	November 30, 2018
10.19	Office Lease, dated May 7, 2012, between Lake Pointe Three, LC, and eHealthInsurance Services, Inc.	Quarterly Report on Form 10-Q (File No. 001-33071)	August 9, 2012

10.19.1		Subordination, Non-Disturbance and Attornment Agreement dated as September 14, 2016 by and among Deutsche Bank, AG, SLC Lake Pointe Equities LLC and eHealthInsurance Services, Inc.	Quarterly Report on Form 10-Q (File No. 001-33071)	November 8, 2016
10.19.2		Amendment No. 1 to Lease, dated August 17, 2017, between SLC Lake Pointe SPE LLC and eHealthInsurance Services, Inc.	Current Report on Form 8-K (File No. 001-33071)	August 22, 2017
10.19.3		Amendment No. 2 to Lease, dated December 12, 2017, between SLC Lake Pointe SPE LLC and eHealthInsurance Services, Inc.	Annual Report on Form 10-K (File No. 001-33071)	March 19, 2018
10.19.4		Amendment No. 3 to Lease, dated March 20, 2019, between SLC Lake Pointe SPE LLC and eHealthInsurance Services, Inc.	Current Report on Form 8-K (File No. 001-33071)	March 26, 2019
10.19.5		Amendment No. 4 to Lease, dated November 19, 2019, between SLC Lake Pointe SPE LLC and eHealthInsurance Services, Inc.	Current Report on Form 8-K (File No. 001-33071)	November 19, 2019
10.20		Sublease Agreement, dated June 3, 2019, between Home Point Financial Corporation and eHealthInsurance Services, Inc.	Current Report on Form 8-K (File No. 001-33071)	June 7, 2019
10.20.1		Office Lease, dated June 3, 2019, between Precedent Lakeside Acquisitions, LLC and eHealthInsurance Services, Inc.	Current Report on Form 8-K (File No. 001-33071)	June 7, 2019
10.20.2		Consent to Sublease, dated June 3, 2019, between Home Point Financial Corporation, eHealthInsurance Services, Inc. and Precedent Lakeside Acquisitions, LLC.	Current Report on Form 8-K (File No. 001-33071)	June 7, 2019
10.21*		Executive Bonus Plan	Quarterly Report on Form 10-Q (File No. 001-33071)	November 7, 2017
10.22*		Amended and Restated 2014 Equity Incentive Plan	Current Report on Form 8-K (File No. 001-33071)	June 14, 2019
10.22.1*		Form of Notice of Stock Option Grant and Stock Option Agreement under the 2014 Equity Incentive Plan of the Registrant	Registration Statement on Form S-8 (File No. 333-196675)	June 11, 2014
10.22.2*		Form of Notice of Stock Unit Grant and Stock Unit Agreement under the 2014 Equity Incentive Plan of the Registrant	Registration Statement on Form S-8 (File No. 333-196675)	June 11, 2014
10.22.3*		Form of Notice of Stock Unit Grant and Stock Unit Agreement (Initial Director Grant) under the 2014 Equity Incentive Plan of the Registrant	Registration Statement on Form S-8 (File No. 333-196675)	June 11, 2014
10.22.4*		Form of Notice of Stock Unit Grant and Stock Unit Agreement (Annual Director Grant) under the 2014 Equity Incentive Plan of the Registrant	Registration Statement on Form S-8 (File No. 333-196675)	June 11, 2014
10.22.5		Form of Notice of Stock Option Grant and Stock Option Agreement (People's Republic of China) under the 2014 Equity Incentive Plan of the Registrant	Registration Statement on Form S-8 (File No. 333-196675)	June 11, 2014
10.22.6		Form of Notice of Stock Unit Grant and Stock Unit Agreement (People's Republic of China) under the 2014 Equity Incentive Plan of the Registrant	Registration Statement on Form S-8 (File No. 333-196675)	June 11, 2014
10.22.7*		Form of Notice of Stock Unit Grant and Stock Unit Agreement (Performance-Based Vesting) under the 2014 Equity Incentive Plan of the Registration	Current Report on Form 8-K (File No. 001-33071)	March 23, 2015
10.22.8*		Form of Notice of Stock Option Grant and Stock Option Agreement (Performance-Based Vesting) under the 2014 Equity Incentive Plan of eHealth, Inc.	Quarterly Report on Form 10-Q (File No. 001-33071)	August 8, 2016
10.22.9*		Form of Notice of Stock Unit Grant and Stock Unit Agreement (Performance-Based Vesting) under the 2014 Equity Incentive Plan of eHealth, Inc.	Quarterly Report on Form 10-Q (File No. 001-33071)	August 8, 2016
10.23*		Form of Deferral Election Form for Newly Eligible Individual with Existing Awards	Quarterly Report on Form 10-Q (File No. 001-33071)	November 6, 2015
10.23.1*		Form of Deferral Election Form for Eligible Individual for Award to be Granted in the Next Calendar Year	Quarterly Report on Form 10-Q (File No. 001-33071)	November 6, 2015
10.24*		2020 Employee Stock Purchase Plan	Current Report on Form 8-K (File No. 001-33071)	June 15, 2020
21.1		List of Subsidiaries	Annual Report on Form 10-K (File No. 001-33071)	March 19, 2018
23.1	†	Consent of Independent Registered Public Accounting Firm		
31.1	†	Certification of Scott N. Flanders, Chief Executive Officer of eHealth, Inc., pursuant to Exchange Act Rule 13a-14(a) and 15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002		
31.2	†	Certification of Derek N. Yung, Chief Financial Officer of eHealth, Inc., pursuant to Exchange Act Rule 13a-14(a) and 15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002		
32.1	‡	Certification of Scott N. Flanders, 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 Derek N. Yung, 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	†	Inline 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 Annual Report on Form 10-K for the fiscal year ended December 31, 2020, formatted in Inline XBRL and contained in Exhibit 101

† Filed herewith.
‡ Furnished herewith.
* Indicates a management contract or compensatory plan or arrangement.

INDEMNIFICATION AGREEMENT

THIS AGREEMENT is entered into effective as of _____ by and between eHealth, Inc., a Delaware corporation (the "Company"), and _____ ("Indemnitee").

WHEREAS, it is essential to the Company to retain and attract as directors and officers the most capable persons available;

WHEREAS, Indemnitee is a director and/or officer of the Company;

WHEREAS, both the Company and Indemnitee recognize the increased risk of litigation and other claims currently being asserted against directors and officers of corporations;

WHEREAS, the Certificate of Incorporation and Bylaws of the Company require the Company to indemnify and advance expenses to its directors and officers to the fullest extent permitted under Delaware law, and the Indemnitee has been serving and continues to serve as a director and/or officer of the Company in part in reliance on the Company's Certificate of Incorporation and Bylaws; and

WHEREAS, in recognition of Indemnitee's need for (i) substantial protection against personal liability based on Indemnitee's reliance on the aforesaid Certificate of Incorporation and Bylaws, (ii) specific contractual assurance that the protection promised by the Certificate of Incorporation and Bylaws will be available to Indemnitee (regardless of, among other things, any amendment to or revocation of the Certificate of Incorporation and Bylaws or any change in the composition of the Company's Board of Directors or acquisition transaction relating to the Company) and (iii) an inducement to provide effective services to the Company as a director and/or officer, the Company wishes to provide in this Agreement for the indemnification of and the advancing of expenses to Indemnitee to the fullest extent (whether partial or complete) permitted under Delaware law and as set forth in this Agreement, and, to the extent insurance is maintained, to provide for the continued coverage of Indemnitee under the Company's directors' and officers' liability insurance policies.

NOW, THEREFORE, in consideration of the above premises and of Indemnitee continuing to serve the Company directly or, at its request, with another enterprise, and intending to be legally bound hereby, the parties agree as follows:

1. Certain Definitions:

(a) "Board" shall mean the Board of Directors of the Company.

(b) "Affiliate" shall mean any corporation or other person or entity that directly, or indirectly through one or more intermediaries, controls or is controlled by or is under common control with, the person specified, including, without limitation, with respect to the Company, any direct or indirect subsidiary of the Company.

(c) A "Change in Control" shall be deemed to have occurred if (i) any "person" (as such term is used in Sections 13(d) and 14(d) of the Securities Exchange Act of 1934, as amended (the "Exchange Act")) (other than a trustee or other fiduciary holding securities under an employee benefit plan of the Company or a corporation owned directly or indirectly by the stockholders of the Company in substantially the same proportions as their ownership of stock of the Company, and other than any person holding shares of the Company on the date that the Company first registers under the Act or any transferee of such individual if such transferee is a spouse or lineal descendant of the transferee or a trust for the benefit of the individual, his or her spouse or lineal descendants), is or becomes the "beneficial owner" (as defined in Rule 13d-3 under the Exchange Act), directly or indirectly, of securities of the Company representing 30% or more of the total voting power represented by the Company's then outstanding Voting Securities, (ii) during any period of two consecutive years, individuals who at the beginning of such period constitute the Board and any new director whose election by the Board or nomination for election by the Company's stockholders was approved by a vote of at least two-thirds (2/3) of the directors then still in office who either were directors at the beginning of the period or whose election or nomination for election was previously so approved, cease for any reason to constitute a majority of the Board, (iii) the stockholders of the Company approve a merger or consolidation of the Company with any other entity, other than a merger or consolidation that 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 80% 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 (iv) the stockholders of the Company approve a plan of complete liquidation of the Company or an agreement for the sale or disposition by the Company (in one transaction or a series of transactions) of all or substantially all of the Company's assets.

(d) "Expenses" shall mean any expense, liability or loss, including attorneys' fees, judgments, fines, penalties, costs, ERISA excise taxes and penalties, amounts paid or to be paid in settlement, any interest, assessments or other charges imposed thereon, any federal, state, local or foreign taxes imposed as a result of the actual or deemed receipt of any payments under this Agreement and all other costs and obligations, paid or incurred in connection with investigating, defending, being a witness in, participating in (including on appeal) or preparing for any of the foregoing in, any Proceeding relating to any Indemnifiable Event.

(e) "Indemnifiable Event" shall mean any event or occurrence that takes place either prior to or after the execution of this Agreement, related to the fact that Indemnitee is or was a director or officer of the Company or an Affiliate of the Company, or while a director or officer is or was serving at the request of the Company or an Affiliate of the Company as a director, officer, employee, trustee, agent or fiduciary of another foreign or domestic corporation, partnership, joint venture, employee benefit plan, trust or other enterprise or was a director, officer, employee or agent of a foreign or domestic corporation that was a predecessor corporation of the Company or of another enterprise at the request of such predecessor corporation, or related to anything done or not done by Indemnitee in any such capacity, whether or not the basis of the Proceeding is alleged action in an official capacity as a director, officer, employee or agent or in any other capacity while serving

as a director, officer, employee or agent of the Company or an Affiliate of the Company, as described above.

(f) "Independent Counsel" shall mean the person or body appointed in connection with Section 3.

(g) "Proceeding" shall mean any threatened, pending or completed action, suit or proceeding or any alternative dispute resolution mechanism (including an action by or in the right of the Company or an Affiliate of the Company) or any inquiry, hearing or investigation, whether conducted by the Company or an Affiliate of the Company or any other party, that Indemnitee in good faith believes might lead to the institution of any such action, suit or proceeding, whether civil, criminal, administrative, investigative or other.

(h) "Reviewing Party" shall mean the person or body appointed in accordance with Section 3.

(i) "Voting Securities" shall mean any securities of the Company that vote generally in the election of directors.

2. Agreement to Indemnify.

(a) General Agreement. In the event Indemnitee was, is or becomes a party to or witness or other participant in, or is threatened to be made a party to or witness or other participant in, a Proceeding by reason of (or arising in part out of) an Indemnifiable Event, the Company shall indemnify Indemnitee from and against any and all Expenses to the fullest extent permitted by law, as the same exists or may hereafter be amended or interpreted (but in the case of any such amendment or interpretation, only to the extent that such amendment or interpretation permits the Company to provide broader indemnification rights than were permitted prior thereto). The parties hereto intend that this Agreement shall provide for indemnification in excess of that expressly permitted by statute, including, without limitation, any indemnification provided by the Company's Certificate of Incorporation, its Bylaws, vote of its stockholders or disinterested directors or applicable law.

(b) Initiation of Proceeding. Notwithstanding anything in this Agreement to the contrary, Indemnitee shall not be entitled to indemnification pursuant to this Agreement in connection with any Proceeding initiated by Indemnitee against the Company or any director or officer of the Company unless (i) the Company has joined in or the Board has consented to the initiation of such Proceeding, (ii) the Proceeding is one to enforce indemnification rights under Section 5 or (iii) the Proceeding is instituted after a Change in Control (other than a Change in Control approved by a majority of the directors on the Board who were directors immediately prior to such Change in Control) and Independent Counsel has approved its initiation.

(c) Expense Advances. If so requested by Indemnitee, the Company shall, to the fullest extent permitted by law, advance (within thirty (30) days of such request) any and all Expenses to Indemnitee (an "Expense Advance"). The Indemnitee shall qualify for such Expense Advances upon the execution and delivery to the Company of this Agreement which shall constitute

an undertaking providing that the Indemnitee undertakes to repay such Expense Advances if and to the extent that it is ultimately determined by a court of competent jurisdiction in a final judgment, not subject to appeal, that Indemnitee is not entitled to be indemnified by the Company. Indemnitee's obligation to reimburse the Company for Expense Advances shall be unsecured and no interest shall be charged thereon. This Section 2(c) shall not apply to any claim made by Indemnitee for which indemnity is excluded pursuant to Section 2(b) or 2(f).

(d) Mandatory Indemnification. Notwithstanding any other provision of this Agreement, to the extent that Indemnitee has been successful on the merits or otherwise in defense of any Proceeding relating in whole or in part to an Indemnifiable Event or in defense of any issue or matter therein, Indemnitee shall be indemnified against all Expenses incurred in connection therewith. The termination of any claim, issue or matter in such a Proceeding by dismissal, with or without prejudice, on substantive or procedural grounds, or settlement of any such claim prior to a final judgment, not subject to appeal, by a court of competent jurisdiction with respect to such Proceeding, shall be deemed to be a successful result as to such claim, issue or matter.

(e) Partial Indemnification. If Indemnitee is entitled under any provision of this Agreement to indemnification by the Company for some or a portion of Expenses, but not, however, for the total amount thereof, the Company shall nevertheless indemnify Indemnitee for the portion thereof to which Indemnitee is entitled.

(f) Prohibited Indemnification. No indemnification pursuant to this Agreement shall be paid by the Company on account of any Proceeding in which a final judgment, not subject to appeal, is rendered against Indemnitee or Indemnitee enters into a settlement, in each case for an accounting of profits made from the purchase or sale by Indemnitee of securities of the Company pursuant to the provisions of Section 16(b) of the Exchange Act or similar provisions of any federal, state or local laws. Notwithstanding anything to the contrary stated or implied in this Section 2(f), indemnification pursuant to this Agreement relating to any Proceeding against Indemnitee for an accounting of profits made from the purchase or sale by Indemnitee of securities of the Company pursuant to the provisions of Section 16(b) of the Exchange Act or similar provisions of any federal, state or local laws shall not be prohibited if Indemnitee ultimately establishes in any Proceeding that no recovery of such profits from Indemnitee is permitted under Section 16(b) of the Exchange Act or similar provisions of any federal, state or local laws.

3. Reviewing Party. Prior to any Change in Control, the Reviewing Party shall be any appropriate person or body consisting of a member or members of the Board or any other person or body appointed by the Board who is not a party to the particular Proceeding with respect to which Indemnitee is seeking indemnification, provided that if all members of the Board are parties to the particular Proceeding with respect to which Indemnitee is seeking indemnification, the Independent Counsel referred to below shall become the Reviewing Party; after a Change in Control, the Independent Counsel referred to below shall become the Reviewing Party. With respect to all matters arising before a Change in Control for which Independent Counsel shall be the Reviewing Party and all matters arising after a Change in Control, in each case concerning the rights of Indemnitee to indemnity payments and Expense Advances under this Agreement or any other agreement or under applicable law or the Company's Certificate of Incorporation or Bylaws now or

hereafter in effect relating to indemnification for Indemnifiable Events, the Company shall seek legal advice only from Independent Counsel selected by Indemnitee and approved by the Company (which approval shall not be unreasonably withheld or delayed), and who has not otherwise performed services for the Company or the Indemnitee (other than in connection with indemnification matters) within the last five years. The Independent Counsel shall not include any person who, under the applicable standards of professional conduct then prevailing, would have a conflict of interest in representing either the Company or Indemnitee in an action to determine Indemnitee's rights under this Agreement. Such counsel, among other things, shall render its written opinion to the Company and Indemnitee as to whether and to what extent the Indemnitee should be permitted to be indemnified under applicable law. The Company agrees to pay the reasonable fees of the Independent Counsel and to indemnify fully such counsel against any and all expenses (including attorneys' fees), claims, liabilities, loss and damages arising out of or relating to this Agreement or the engagement of Independent Counsel pursuant hereto.

4. Indemnification Process and Appeal.

(a) Indemnification Payment. Indemnitee shall be entitled to indemnification of Expenses, and shall receive payment thereof, from the Company in accordance with this Agreement as soon as practicable after Indemnitee has made written demand on the Company for indemnification, but in no event later than thirty (30) days after demand, unless the Reviewing Party has given a written opinion to the Company that Indemnitee is not entitled to indemnification under applicable law.

(b) Suit to Enforce Rights. Regardless of any action by the Reviewing Party, if Indemnitee has not received full indemnification within thirty (30) days after making a demand in accordance with Section 4(a), Indemnitee shall have the right to enforce its indemnification rights under this Agreement by commencing litigation in any court in the State of California or the State of Delaware having subject matter jurisdiction thereof seeking an initial determination by the court or challenging any determination by the Reviewing Party or any aspect thereof. The Company hereby consents to service of process and to appear in any such proceeding. Any determination by the Reviewing Party not challenged by the Indemnitee shall be binding on the Company and Indemnitee. The Company shall be precluded from asserting in any such proceeding that the procedures and presumptions of this Agreement are not valid, binding and enforceable and shall stipulate in any such court that the Company is bound by all the provisions of this Agreement. The remedy provided for in this Section 4 shall be in addition to any other remedies available to Indemnitee at law or in equity.

(c) Defense to Indemnification, Burden of Proof, and Presumptions. It shall be a defense to any action brought by Indemnitee against the Company to enforce this Agreement (other than an action brought to enforce a claim for Expenses incurred in defending a Proceeding in advance of its final disposition) that it is not permissible under applicable law for the Company to indemnify Indemnitee for the amount claimed. In connection with any such action or any determination by the Reviewing Party or otherwise as to whether Indemnitee is entitled to be indemnified hereunder, it will be presumed that Indemnitee is entitled to indemnification under this Agreement, and that the Reviewing Party or the Company (including its Board, independent legal

counsel or its stockholders) or any other person or entity challenging such right will have the burden of proving this defense and overcoming Indemnitee's presumption. Neither the failure of the Reviewing Party or the Company (including its Board, independent legal counsel or its stockholders) to have made a determination prior to the commencement of such action by Indemnitee that indemnification of the claimant is proper under the circumstances because Indemnitee has met the standard of conduct set forth in applicable law, nor an actual determination by the Reviewing Party or Company (including its Board, independent legal counsel or its stockholders) that the Indemnitee had not met such applicable standard of conduct, shall be a defense to the action or create a presumption that the Indemnitee has not met the applicable standard of conduct. For purposes of this Agreement, the termination of any claim, action, suit or proceeding, by judgment not subject to appeal, order, settlement (whether with or without court approval), conviction or upon a plea of nolo contendere or its equivalent, shall not create a presumption that Indemnitee did not meet any particular standard of conduct or have any particular belief or that a court has determined that indemnification is not permitted by applicable law. For purposes of any determination of good faith under any applicable standard of conduct, Indemnitee shall be deemed to have acted in good faith if Indemnitee's action is based on the records or books of account of the Company, including financial statements, or on information supplied to Indemnitee by the officers of the Company in the course of their duties, or on the advice of legal counsel for the Company or the Board or counsel selected by any committee of the Board or on information or records given or reports made to the Company by an independent certified public accountant or by an appraiser, investment banker or other expert selected with reasonable care by the Company or the Board or any committee of the Board. The provisions of the preceding sentence shall not be deemed to be exclusive or to limit in any way the other circumstances in which the Indemnitee may be deemed to have met the applicable standard of conduct. The knowledge and/or actions, or failure to act, of any director, officer, agent or employee of the Company shall not be imputed to Indemnitee for purposes of determining the right to indemnification under this Agreement.

5. Indemnification for Expenses Incurred in Enforcing Rights. The Company shall, to the fullest extent permitted by law, indemnify Indemnitee against any and all Expenses and, if requested by Indemnitee, shall advance such Expenses to Indemnitee in accordance with Section 2(c), that are incurred by Indemnitee in connection with any action brought by Indemnitee for

(i) indemnification or advance payment of Expenses by the Company under this Agreement or any other agreement or under applicable law or the Company's Certificate of Incorporation or Bylaws now or hereafter in effect relating to indemnification for Indemnifiable Events, and/or

(ii) recovery under directors' and officers' liability insurance policies maintained by the Company.

6. Notification and Defense of Proceeding.

(a) Notice. Promptly after receipt by Indemnitee of notice of the commencement of any Proceeding, Indemnitee shall, if a claim in respect thereof is to be made against the Company under this Agreement, notify the Company of the commencement thereof; but the omission so to notify the Company will not relieve the Company from any liability that it may have to Indemnitee, except as provided in Section 6(c).

(b) Defense. With respect to any Proceeding as to which Indemnitee notifies the Company of the commencement thereof, the Company will be entitled to participate in the Proceeding at its own expense and except as otherwise provided below, to the extent the Company so wishes, it may assume the defense thereof with counsel reasonably satisfactory to Indemnitee. After notice from the Company to Indemnitee of its election to assume the defense of any Proceeding, the Company shall not be liable to Indemnitee under this Agreement or otherwise for any Expenses subsequently incurred by Indemnitee in connection with the defense of such Proceeding other than reasonable costs of investigation or as otherwise provided below. Indemnitee shall have the right to employ legal counsel in such Proceeding, but all Expenses related thereto incurred after notice from the Company of its assumption of the defense shall be at Indemnitee's expense unless: (i) the employment of legal counsel by Indemnitee has been authorized by the Company, (ii) Indemnitee has reasonably determined that there may be a conflict of interest between Indemnitee and the Company in the defense of the Proceeding, (iii) after a Change in Control, the employment of counsel by Indemnitee has been approved by the Independent Counsel or (iv) the Company shall not in fact have employed counsel to assume the defense of such Proceeding, in each of which cases all Expenses of the Proceeding shall be borne by the Company. The Company shall not be entitled to assume the defense of any Proceeding brought by or on behalf of the Company, or as to which Indemnitee shall have made the determination provided for in (ii) above or under the circumstances provided for in (iii) and (iv) above.

(c) Settlement of Claims. The Company shall not be liable to indemnify Indemnitee under this Agreement or otherwise for any amounts paid in settlement of any Proceeding effected without the Company's written consent, such consent not to be unreasonably withheld; provided, however, that if a Change in Control has occurred, the Company shall be liable for indemnification of Indemnitee for amounts paid in settlement if the Independent Counsel has approved the settlement. The Company shall not settle any Proceeding in any manner that would impose any penalty or limitation on Indemnitee without Indemnitee's written consent. The Company shall not be liable to indemnify the Indemnitee under this Agreement with regard to any judicial award if the Company was not given a reasonable and timely opportunity as a result of Indemnitees' failure to provide notice, at its expense, to participate in the defense of such action, and the lack of such notice materially prejudiced the Company's ability to participate in defense of such action. The Company's liability hereunder shall not be excused if participation in the Proceeding by the Company was barred by this Agreement.

7. Establishment of Trust. In the event of a Change in Control, the Company shall, upon written request by Indemnitee, create a Trust for the benefit of the Indemnitee and from time to time upon written request of Indemnitee shall fund the Trust in an amount sufficient to

satisfy any and all Expenses reasonably anticipated at the time of each such request to be incurred in connection with investigating, preparing for, participating in, and/or defending any Proceeding relating to an Indemnifiable Event. The amount or amounts to be deposited in the Trust pursuant to the foregoing funding obligation shall be determined by the Independent Counsel. The terms of the Trust shall provide that (i) the Trust shall not be revoked or the principal thereof invaded without the written consent of the Indemnitee, (ii) the Trustee shall advance, within thirty (30) days of a request by the Indemnitee, any and all Expenses to the Indemnitee (and the Indemnitee hereby agrees to reimburse the Trust under the same circumstances for which the Indemnitee would be required to reimburse the Company under Section 2(c) of this Agreement), (iii) the Trust shall continue to be funded by the Company in accordance with the funding obligation set forth above, (iv) the Trustee shall promptly pay to the Indemnitee all amounts for which the Indemnitee shall be entitled to indemnification pursuant to this Agreement or otherwise no later than thirty (30) days after notice pursuant to Section 4(a) and (v) all unexpended funds in the Trust shall revert to the Company upon a final determination by the Independent Counsel or a court of competent jurisdiction, as the case may be, that the Indemnitee has been fully indemnified under the terms of this Agreement. The Trustee shall be chosen by the Indemnitee. Nothing in this Section 7 shall relieve the Company of any of its obligations under this Agreement. All income earned on the assets held in the Trust shall be reported as income by the Company for federal, state, local and foreign tax purposes. The Company shall pay all costs of establishing and maintaining the Trust and shall indemnify the Trustee against any and all expenses (including attorneys' fees), claims, liabilities, loss and damages arising out of or relating to this Agreement or the establishment and maintenance of the Trust.

8. Non-Exclusivity. The rights of Indemnitee hereunder shall be in addition to any other rights Indemnitee may have under the Company's Certificate of Incorporation, Bylaws, applicable law or otherwise; provided, however, that this Agreement shall supersede any prior indemnification agreement between the Company and the Indemnitee. To the extent that a change in applicable law (whether by statute or judicial decision) permits greater indemnification than would be afforded currently under the Company's Certificate of Incorporation, Bylaws, applicable law or this Agreement, it is the intent of the parties that Indemnitee enjoy by this Agreement the greater benefits so afforded by such change.

9. Liability Insurance. To the extent the Company maintains an insurance policy or policies providing general and/or directors' and officers' liability insurance, Indemnitee shall be covered by such policy or policies, in accordance with its or their terms, to the maximum extent of the coverage available for any Company director or officer.

10. Period of Limitations. No legal action shall be brought and no cause of action shall be asserted by or on behalf of the Company or any Affiliate of the Company against Indemnitee, Indemnitee's spouse, heirs, executors or personal or legal representatives after the expiration of two (2) years from the date of accrual of such cause of action or such longer period as may be required by state law under the circumstances. Any claim or cause of action of the Company or its Affiliate shall be extinguished and deemed released unless asserted by the timely filing and notice of a legal action within such period; provided, however, that if any shorter period of limitations is otherwise applicable to any such cause of action, the shorter period shall govern.

11. Amendment of this Agreement. No supplement, modification or amendment of this Agreement shall be binding unless executed in writing by both of the parties hereto. No waiver of any of the provisions of this Agreement shall be binding unless in the form of a writing signed by the party against whom enforcement of the waiver is sought, and no such waiver shall operate as a waiver of any other provisions hereof (whether or not similar), nor shall such waiver constitute a continuing waiver. Except as specifically provided herein, no failure to exercise or any delay in exercising any right or remedy hereunder shall constitute a waiver thereof.

12. Subrogation by Company. The Company hereby unconditionally and irrevocably waives, relinquishes and releases, and covenants and agrees not to exercise any rights that the Company may now have or hereafter acquire against Indemnitee or any Affiliate (or former Affiliate) that arise from or relate to the existence, payment, performance or enforcement of the Company's obligations under this Agreement or under any other indemnification agreement (whether pursuant to contract, bylaws or charter) with any person or entity, including, without limitation, any right of subrogation (whether pursuant to contract or common law), reimbursement, exoneration, contribution or indemnification, or to be held harmless, and any right to participate in any claim or remedy of Indemnitee against any Affiliate (or former Affiliate) or Indemnitee, whether or not such claim, remedy or right arises in equity or under contract, statute or common law, including, without limitation, the right to take or receive from any Affiliate (or former Affiliate) or Indemnitee, directly or indirectly, in cash or other property or by set-off or in any other manner, payment or security on account of such claim, remedy or right.

13. Subrogation by Affiliate. The Company shall not be liable to pay or advance to Indemnitee any amounts otherwise indemnifiable under this Agreement or under any other indemnification agreement if and to the extent that Indemnitee has otherwise actually received such payment under any insurance policy, contract, agreement or otherwise; provided, however, that (i) the Company hereby agrees that it is the indemnitor of first resort under this Agreement and under any other indemnification agreement (*i.e.*, its obligations to Indemnitee under this Agreement or any other agreement or undertaking to provide advancement and/or indemnification to Indemnitee are primary and any obligation of any Affiliate or any other entity to provide advancement or indemnification, or any obligation of any insurer of any Affiliate or any other entity to provide insurance coverage, for the same Expenses, liabilities, judgments, penalties, fines and amounts paid in settlement (including all interest, assessments and other charges paid or payable in connection with or in respect of such Expenses, liabilities, judgments, penalties, fines and amounts paid in settlement) incurred by Indemnitee are secondary), and (ii) if any Affiliate or any other entity pays or causes to be paid, for any reason, any amounts otherwise indemnifiable hereunder or under any other indemnification agreement (whether pursuant to contract, bylaws or charter) with Indemnitee in connection with Indemnitee's service to the Company, then (x) such Affiliate or other entity shall be fully subrogated to all rights of Indemnitee with respect to such payment and (y) the Company shall fully indemnify and reimburse such Affiliate or other entity for all such payments actually made by such Affiliate or other entity. Affiliates are express third party beneficiaries of this Agreement, are entitled to rely upon this Agreement, and may specifically enforce the Company's obligations hereunder as though a party hereunder.

14. Binding Effect. This Agreement shall be binding upon and inure to the benefit of and be enforceable by the parties hereto and their respective successors (including any direct or indirect successor by purchase, merger, consolidation or otherwise to all or substantially all of the business and/or assets of the Company), assigns, spouses, heirs and personal and legal representatives. The Company shall require and cause any successor (whether direct or indirect by purchase, merger, consolidation or otherwise) to all, substantially all, or a substantial part, of the business and/or assets of the Company, by written agreement in form and substance satisfactory to Indemnitee, expressly to assume and agree to perform this Agreement in the same manner and to the same extent that the Company would be required to perform if no such succession had taken place. The indemnification provided under this Agreement shall continue as to Indemnitee for any action taken or not taken while serving in an indemnified capacity pertaining to an Indemnifiable Event even though Indemnitee may have ceased to serve in such capacity at the time of any Proceeding.

15. Severability. If any provision (or portion thereof) of this Agreement shall be held by a court of competent jurisdiction to be invalid, void or otherwise unenforceable, (a) the remaining provisions shall remain enforceable to the fullest extent permitted by law; (b) such provision or provisions shall be deemed reformed to the extent necessary to conform to applicable law and to give the maximum effect to the intent of the parties hereto; and (c) to the fullest extent possible, the provisions of this Agreement (including, without limitation, each portion of this Agreement containing any provision held to be invalid, void or otherwise unenforceable, that is not itself invalid, void or unenforceable) shall be construed so as to give effect to the intent manifested by the provision held invalid, void or unenforceable.

16. Contribution. To the fullest extent permissible under applicable law, whether or not the indemnification provided for in this Agreement is available to Indemnitee for any reason whatsoever, the Company shall pay all or a portion of the amount that would otherwise be incurred by Indemnitee for Expenses in connection with any claim relating to an Indemnifiable Event, as is deemed fair and reasonable in light of all of the circumstances of such Proceeding in order to reflect (i) the relative benefits received by the Company and Indemnitee as a result of the event(s) and/or transaction(s) giving cause to such Proceeding; and/or (ii) the relative fault of the Company (and its directors, officers, employees and agents) and Indemnitee in connection with such event(s) and/or transaction(s).

17. Governing Law. This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of Delaware applicable to contracts made and to be performed in such State without giving effect to its principles of conflicts of laws. The Company and Indemnitee hereby irrevocably and unconditionally (i) agree that any action or proceeding arising out of or in connection with this Agreement may be brought in the Delaware Court of Chancery, (ii) consent to submit to the jurisdiction of the Delaware Court of Chancery for purposes of any action or proceeding arising out of or in connection with this Agreement, (iii) waive any objection to the laying of venue of any such action or proceeding in the Delaware Court of Chancery, and (iv) waive, and agree not to plead or to make, any claim that any such action or proceeding brought in the Delaware Court of Chancery has been brought in an improper or inconvenient forum.

18. Notices. All notices, demands and other communications required or permitted hereunder shall be made in writing and shall be deemed to have been duly given if delivered by hand, against receipt or mailed, postage prepaid, certified or registered mail, return receipt requested and addressed to the Company at:

eHealth, Inc.
2625 Augustine Drive, Second Floor
Santa Clara, California 95054
Attention: General Counsel

and to Indemnitee at the address set forth below Indemnitee's signature hereto. Notice of change of address shall be effective only when given in accordance with this Section. All notices complying with this Section shall be deemed to have been received on the date of hand delivery or on the third business day after mailing.

19. Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

* * * * *

IN WITNESS WHEREOF, the parties hereto have duly executed and delivered this Agreement as of the day specified above.

EHEALTH, INC.,
a Delaware corporation

By: _____

Print Name: Scott N. Flanders

Title: Chief Executive Officer

INDEMNITEE,
an individual

_____

Address: _____

_____

_____

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 Tim Hannan ("***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.

(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 equal to 60% of Executive's base salary (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 either the Company's office located at 2625 Augustine Drive, Santa Clara, California or the Company's then current office location in San Francisco, California, or 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/ Scott N. Flanders
Scott Flanders

Title: Chief Executive Officer
Date: Feb 10, 2021

EXECUTIVE

By: /s/ Timothy C. Hannan
Tim Hannan

Date: Feb 10, 2021

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 Vice-President of Human Resources 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]

Exhibit 23.1

Consent of Independent Registered Public Accounting Firm

We consent to the incorporation by reference in the following Registration Statements:
(1) Registration Statement (Form S-3 No. 333-228862) of eHealth, Inc.,
(2) Registration Statement (Form S-8 No. 333-248129) pertaining to the 2020 Employee Stock Purchase Plan of eHealth, Inc., and
(3) Registration Statements (Forms S-8 No. 333-232252 and No. 333-196675) pertaining to the 2014 Equity Incentive Plan of eHealth, Inc.;
of our reports dated February 26, 2021, with respect to the consolidated financial statements of eHealth, Inc. and the effectiveness of internal control over financial reporting of eHealth, Inc. included in this Annual Report (Form 10-K) of eHealth, Inc. for the year ended December 31, 2020.

/s/ Ernst & Young LLP

Redwood City, California
February 26, 2021

Exhibit 31.1

CERTIFICATION

I, Scott N. Flanders, certify that:

1. I have reviewed this Annual Report on Form 10-K 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: February 26, 2021

/s/ SCOTT N. FLANDERS
Scott N. Flanders
Chief Executive Officer

Exhibit 31.2

CERTIFICATION

I, Derek N. Yung, certify that:

1. I have reviewed this Annual Report on Form 10-K 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: February 26, 2021

/s/ DEREK N. YUNG
Derek N. Yung
Chief 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 Annual Report of eHealth, Inc. on Form 10-K (the "Form 10-K") for the year ended December 31, 2020, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Scott N. Flanders, 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-K, 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-K fairly presents, in all material respects, the financial condition and results of operations of eHealth, Inc.

/s/ SCOTT N. FLANDERS

Scott N. Flanders
Chief Executive Officer
February 26, 2021

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 Chief 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 Annual Report of eHealth, Inc. on Form 10-K (the "Form 10-K") for the year ended December 31, 2020, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Derek N. Yung, Chief 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-K, 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-K fairly presents, in all material respects, the financial condition and results of operations of eHealth, Inc.

/s/ DEREK N. YUNG

Derek N. Yung
Chief Financial Officer
February 26, 2021

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.