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

FORM 10-Q

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

For the quarterly period ended March 31, 2025

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.)

13620 RANCH ROAD 620 N, SUITE A250
AUSTIN, TX 78717
(Address of principal executive offices)

(737) 248-2340
(Registrant's telephone number, including area code)

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

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

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

The number of shares of the registrant's common stock, par value $0.001 per share, outstanding as of May 2, 2025 was 30,326,646 shares.

CAUTIONARY NOTE REGARDING FORWARD-LOOKING STATEMENTS

In addition to historical information, this Quarterly Report on Form 10-Q contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended (the "Securities Act") and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). The words "expect," "anticipate," "believe," "estimate," "target," "goal," "project," "hope," "intend," "plan," "seek," "continue," "may," "could," "should," "might," "forecast," "depends," "predict," "are positioned" and variations or the negative of such words and similar expressions are intended to identify such forward-looking statements. These statements include, among other things, statements regarding the following:

- our expectations relating to estimated membership and approved members;
- our estimates regarding the constrained lifetime value of commissions per approved member 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 business, industry and market trends, including market opportunity, consumer demand and our competitive advantage;
- our expectations regarding our Medicare, individual and family, small business and other ancillary products, including anticipated trends and our ability to enroll members;
- our expectations regarding our operational initiatives;
- our expectations regarding our growth strategies and cost-saving initiatives;
- the impact of future and existing laws and regulations on our business;
- the impact of public health crises, pandemics, natural disasters and other extreme events;
- the impact of macroeconomic conditions, including adverse events or perceptions affecting the U.S. or international financial systems, tariffs and trade tensions, inflationary pressures and the political climate on our business;
- our expectations regarding commission rates, conversion rates, plan termination rates and duration, membership retention rates and membership acquisition costs;
- our expectations regarding insurance agent licensing and productivity;
- our expectations regarding beneficiary complaints, customer experience and enrollment quality;
- our expectations relating to the seasonality of our business;
- expected competition, including from government-run health insurance exchanges and other sources;
- our expectations relating to marketing and advertising investments and expected contributions from our marketing and strategic partnership channels;
- the timing of our receipt of commission and other payments;
- our critical accounting policies and related estimates;
- liquidity and capital needs;
- political, legislative, regulatory and legal challenges;
- the merits or potential impact of any lawsuits filed against us or any government enforcement actions, including the legal proceedings disclosed in Part II, Item 1 - "Legal Proceedings," and elsewhere in this report; and
- 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, the Medicare Advantage open enrollment period and other special enrollment periods; changes in laws, regulations and guidelines, including in connection with healthcare reform or with respect to the marketing and sale of Medicare plans; competition, including competition from government-run health insurance exchanges and other sources; the seasonality of our business and the fluctuation of our operating results; our ability to accurately estimate membership, lifetime value of commissions and commissions receivable; changes in product offerings among carriers on our ecommerce platform and changes in our estimated conversion rate of an approved member to a paying member and the resulting impact of each on our commission revenue; the concentration of our revenue with a small number of health insurance carriers; our ability to execute on our growth strategy and other business initiatives; changes in our senior

management or other key employees; our ability to recruit, train, retain and ensure the productivity of licensed insurance agents, or benefit advisors, and other personnel; exposure to security risks and our ability to safeguard the security and privacy of confidential data; our relationships with health insurance carriers; the success of our carrier advertising and sponsorship program; our success in marketing and selling health insurance plans and our unit cost of acquisition; our ability to effectively manage our operations as our business evolves and execute on our business plan and other strategic initiatives; the need for health insurance carrier and regulatory approvals in connection with the marketing of Medicare-related insurance products; changes in the market for private health insurance; consumer satisfaction of our service and actions we take to improve the quality of enrollments; changes in member conversion rates; changes in commission rates; our ability to sell qualified health insurance plans to subsidy-eligible individuals and to enroll subsidy-eligible individuals through government-run health insurance exchanges; our ability to derive desired benefits from investments in our business, including membership growth and retention initiatives; our reliance on marketing partners; the success and cost of our marketing efforts, including branding, online advertising, direct-to-consumer mail, email, social media, telephone, SMS text, television, radio and other 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 our convertible preferred stock investor; our ability to raise additional capital; compliance with insurance, privacy, cybersecurity and other laws and regulations; the outcome of litigation, government enforcement actions or regulatory inquiries in which we are or may from time to time be involved, including the complaint filed against us and certain defendants by the U.S. Attorney's Office for the District of Massachusetts on May 1, 2025 alleging the violation of the Federal False Claims Act; the performance, reliability and availability of our information technology systems, ecommerce platform and underlying network infrastructure, including any new systems we may implement; our ability to deploy new and evolving technologies, such as artificial intelligence; public health crises, pandemics, natural disasters and other extreme events; general economic and macroeconomic conditions, including inflation, recession, political events, instability or geopolitical tensions, tariffs and trade tensions or other international disputes, financial, banking and credit market disruptions; our ability to effectively administer our self-insurance program; 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.

Because these forward-looking statements involve risks and uncertainties, there are important factors that could cause our actual results to differ materially from those in the forward-looking statements.

SUMMARY OF RISK FACTORS

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

- The markets in which we participate are intensely competitive. If we cannot compete effectively against current and future competitors, including government-run health insurance exchanges, our business, operating results and financial condition could suffer.
- Our business may be harmed if we lose our relationship with health insurance carriers or our relationships with health insurance carriers are modified.
- We derive a significant portion of our revenue from a small number of health insurance carriers. Any impairment of our relationships with them or impairment of their businesses could adversely affect our business, operating results and financial condition.
- If we are unable to successfully attract and convert qualified prospects into members for whom we receive commissions, our business, operating results and financial condition would be harmed.
- Our business, operating results and financial condition will be adversely impacted if we are unable to retain our existing members.
- Our marketing efforts may not be successful or may become more expensive, either of which could adversely affect our business, operating results and financial condition.
- If our carrier advertising and sponsorship program is not successful, our business, operating results and financial condition could be harmed.
- Our operations in China involve many risks that could increase expenses, expose us to increased liability and adversely affect our business, operating results and financial condition.
- Our business is seasonal in nature, and if we are not successful in responding to changes in the seasonality of our business, our business, operating results and financial condition could be harmed.
- Changes in our senior management or other key employees could affect our business, operating results and financial condition.
- Our business success depends on our ability to timely recruit, train and retain qualified licensed insurance agents, or benefit advisors, and other personnel to provide superior customer service and support our strategic initiatives while also controlling our labor costs.
- Our business could be harmed if we are not successful in executing on our operational and strategic plans.
- Changes and developments in the health insurance industry or system, including changes in laws and regulations, could harm our business, operating results and financial condition.
- The marketing and sale of health insurance plans, including Medicare plans are subject to numerous, complex and frequently changing laws, regulations and guidelines. Non-compliance with or changes in laws, regulations and guidelines, or changes in their interpretation or the manner in which they are enforced could harm our business, operating results and financial condition.
- We have been and may in the future be subject to various legal proceedings, including litigation, government enforcement actions or regulatory inquiries, which could adversely affect our business, operating results and financial condition.
- We may be unable to operate our business if we fail to maintain our health insurance licenses and otherwise comply with the numerous laws and regulations applicable to the sale of health insurance.
- Increasing regulatory focus on privacy and data security issues and expanding laws could impact our business and expose us to increased liability.
- Our business could be harmed if we are unable to contact our consumers or market the availability of our products through specific channels.
- If we fail to properly maintain existing or implement new information systems, our business may be materially adversely affected.
- Issues relating to the use of new and evolving technologies, such as artificial intelligence, in our business operations could result in liability, reputational harm and an adverse impact on our operating results and financial condition.
- Our business is subject to security risks. If we experience a successful cyberattack or a security breach or are otherwise unable to safeguard the confidentiality and integrity of the data we hold, including sensitive personal information, our business will be harmed.

- Our commission revenue could be negatively impacted by changes in our estimated conversion rate of an approved member to a paying member, our forecast of average plan duration or our forecast of likely commission amounts.
- Our operating results will be impacted by factors that impact our estimate of the constrained lifetime value of commissions per approved member.
- If commission reports we receive from carriers are inaccurate or not sent to us in a timely manner, our business and operating results could be harmed, and we may not recognize trends in our membership.
- We do not receive information about membership cancellations from our health insurance carriers directly, which makes it difficult for us to determine the impact of current conditions on our membership retention and to accurately estimate membership as of a specific date.
- Our agreements with our lender and our convertible preferred stock investor contain restrictions that impact our business and expose us to risks that could materially adversely affect our liquidity and financial condition.
- Operating and growing our business is likely to require additional capital. If capital is not available to us, our business, operating results and financial condition may suffer.
- Our future operating results are likely to fluctuate and could fall short of our guidance and other expectations, which could negatively affect the value of our common stock.
- The price of our common stock has been and may continue to be volatile, and the value of your investment could decline.
- Our convertible preferred stock investor has rights, preferences and privileges that are not held by, and are preferential to, the rights of our common stockholders and may exercise influence over us. This could adversely affect our liquidity and financial condition, result in the interests of our convertible preferred stock investor differing from those of our common stockholders and make an acquisition of us more difficult.
- We may not be able to adequately protect our intellectual property, which could harm our business, operating results and financial condition.
- Our self-insurance programs may expose us to significant and unexpected costs and losses.
- Our business, operating results and financial condition can be impacted by political events, political instability, trade and other international disputes, geopolitical tensions or natural disasters.
- Adverse economic conditions including slow growth, recession, high unemployment, inflation, financial and credit market disruptions, could materially adversely affect our business, operating results and financial condition.

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

EHEALTH, INC.
FORM 10-Q

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PART I. FINANCIAL INFORMATION

ITEM 1. FINANCIAL STATEMENTS

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

	March 31, 2025	December 31, 2024
Assets		
Current assets:		
Cash and cash equivalents	$ 121,092	$ 39,197
Short-term marketable securities	34,495	43,043
Accounts receivable	3,387	16,807
Contract assets – commissions receivable – current	197,493	242,467
Prepaid expenses and other current assets	12,974	12,961
Total current assets	369,441	354,475
Contract assets – commissions receivable – non-current	725,764	757,523
Property and equipment, net	4,123	4,437
Operating lease right-of-use assets	11,265	12,081
Restricted cash	3,090	3,090
Other assets	23,479	23,819
Total assets	$ 1,137,162	$ 1,155,425
Liabilities, convertible preferred stock and stockholders' equity		
Current liabilities:		
Accounts payable	$ 7,349	$ 23,448
Accrued compensation and benefits	44,974	43,888
Accrued marketing expenses	9,071	16,612
Short term debt	68,765	—
Lease liabilities – current	7,841	7,732
Other current liabilities	5,354	4,331
Total current liabilities	143,354	96,011
Long-term debt	—	68,458
Deferred income taxes – non-current	40,400	38,870
Lease liabilities – non-current	18,739	20,731
Other non-current liabilities	5,061	5,418
Total liabilities	207,554	229,488
Commitments and contingencies (Note 8)		
Convertible preferred stock	347,985	337,509
Stockholders' equity:		
Common stock	43	43
Additional paid-in capital	776,569	773,371
Treasury stock, at cost	(199,998)	(199,998)
Retained earnings	5,274	15,246
Accumulated other comprehensive loss	(265)	(234)
Total stockholders' equity	581,623	588,428
Total liabilities, convertible preferred stock and stockholders' equity	$ 1,137,162	$ 1,155,425

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

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

	Three Months Ended March 31,	
	2025	**2024**
Revenue:		
Commission	$ 98,946	$ 80,927
Other	14,173	12,037
Total revenue	113,119	92,964
Operating costs and expenses:		
Marketing and advertising	41,189	38,737
Customer care and enrollment	37,221	32,901
Technology and content	12,601	13,305
General and administrative	17,310	19,619
Impairment, restructuring and other charges	—	6,313
Total operating costs and expenses	108,321	110,875
Income (loss) from operations	4,798	(17,911)
Interest expense	(2,648)	(2,809)
Other income, net	1,576	2,391
Income (loss) before income taxes	3,726	(18,329)
Provision for (benefit from) income taxes	1,776	(1,345)
Net income (loss)	1,950	(16,984)
Preferred stock dividends	(5,781)	(5,480)
Change in preferred stock redemption value	(6,141)	(5,247)
Net loss attributable to common stockholders	$ (9,972)	$ (27,711)
Net loss per share attributable to common stockholders:		
Basic and diluted	$ (0.33)	$ (0.96)
Weighted-average number of shares used in per share amounts:		
Basic and diluted	29,997	28,912
Comprehensive income (loss):		
Net income (loss)	$ 1,950	$ (16,984)
Unrealized loss on available for sale debt securities, net of tax	(37)	(23)
Foreign currency translation adjustments	6	45
Comprehensive income (loss)	$ 1,919	$ (16,962)

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

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

Three Months Ended March 31, 2025

	Common Stock		Additional Paid-in Capital	Treasury Stock		Retained Earnings	Accumulated Other Comprehensive Loss	Total Stockholders' Equity
	Shares	Amount		Shares	Amount			
Balance as of December 31, 2024	43,225	$ 43	$ 773,371	13,379	$ (199,998)	$ 15,246	$ (234)	$ 588,428
Issuance of common stock in connection with equity incentive plans	252	—		—	—	—	—	—
Repurchase of shares to satisfy employee tax withholding obligations	—	—	(699)	75	—	—	—	(699)
Dividends and accretion related to convertible preferred stock	—	—	—	—	—	(11,922)	—	(11,922)
Stock-based compensation	—	—	3,897		—	—	—	3,897
Other comprehensive loss, net of tax	—	—	—	—	—	—	(31)	(31)
Net income	—	—	—	—	—	1,950	—	1,950
Balance as of March 31, 2025	43,477	$ 43	$ 776,569	13,454	$ (199,998)	$ 5,274	$ (265)	$ 581,623

Three Months Ended March 31, 2024

	Common Stock		Additional Paid-in Capital	Treasury Stock		Retained Earnings (Accumulated Deficit)	Accumulated Other Comprehensive Loss	Total Stockholders' Equity
	Shares	Amount		Shares	Amount			
Balance as of December 31, 2023	41,457	$ 41	$ 798,786	12,828	$ (199,998)	$ 7,284	$ (82)	$ 606,031
Issuance of common stock in connection with equity incentive plans	545	1	—	—	—	—	—	1
Repurchase of shares to satisfy employee tax withholding obligations	—	—	(1,256)	172	—	—	—	(1,256)
Dividends and accretion related to convertible preferred stock	—	—	—	—	—	(10,727)	—	(10,727)
Stock-based compensation	—	—	5,718	—	—	—	—	5,718
Other comprehensive income, net of tax	—	—	—	—	—	—	22	22
Net loss	—	—	—	—	—	(16,984)	—	(16,984)
Balance as of March 31, 2024	42,002	$ 42	$ 803,248	13,000	$ (199,998)	$ (20,427)	$ (60)	$ 582,805

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

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

	Three Months Ended March 31,	
	2025	**2024**
Operating activities:		
Net income (loss)	$ 1,950	$ (16,984)
Adjustments to reconcile net income (loss) to net cash provided by operating activities:		
Depreciation and amortization	471	533
Amortization of internally developed software	3,463	3,873
Stock-based compensation expense	3,789	5,540
Deferred income taxes	1,529	(1,382)
Impairment charges	—	5,492
Other non-cash items	(306)	(75)
Changes in operating assets and liabilities:		
Accounts receivable	13,421	2,586
Contract assets – commissions receivable	77,048	73,095
Prepaid expenses and other assets	(978)	460
Accounts payable	(16,034)	(937)
Accrued compensation and benefits	1,087	132
Accrued marketing expenses	(7,541)	(10,936)
Deferred revenue	(332)	8,080
Accrued expenses and other liabilities	(446)	1,284
Net cash provided by operating activities	77,121	70,761
Investing activities:		
Capitalized internal-use software and website development costs	(3,118)	(2,286)
Purchases of property and equipment and other assets	(308)	(204)
Purchases of marketable securities	(27,362)	(13,797)
Proceeds from redemption and maturities of marketable securities	36,260	6,000
Net cash provided by (used in) investing activities	5,472	(10,287)
Financing activities:		
Repurchase of shares to satisfy employee tax withholding obligations	(699)	(1,255)
Principal payments in connection with leases	—	(4)
Net cash used in financing activities	(699)	(1,259)
Effect of exchange rate changes on cash, cash equivalents and restricted cash	1	49
Net increase in cash, cash equivalents and restricted cash	81,895	59,264
Cash, cash equivalents and restricted cash at beginning of period	42,287	118,812
Cash, cash equivalents and restricted cash at end of period	$ 124,182	$ 178,076

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

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

Note 1 – Summary of Business and Significant Accounting Policies

Description of Business – eHealth, Inc., a Delaware corporation, and its consolidated subsidiaries (collectively, "eHealth") is 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 expertly guide consumers through their health insurance enrollment and related options, when, where and how they prefer. Our platform leverages technology to solve a critical problem in a large and growing market by aiding consumers in what has traditionally been a complex, confusing and opaque health insurance purchasing process. Our omnichannel consumer engagement platform differentiates our offering from competitors and enables consumers to use our services online, by telephone with a licensed insurance agent, or benefit advisor, or through a hybrid online assisted interaction that includes live agent chat and co-browsing capabilities. We have created a consumer-centric marketplace that offers consumers a broad choice of insurance products that includes thousands of Medicare Advantage, Medicare Supplement, Medicare Part D prescription drug, individual, family, small business and other ancillary health insurance products from over 180 health insurance carriers nationwide. Our plan recommendation tool curates this broad plan selection by analyzing consumer health-related information against plan data for insurance coverage fit. This tool is supported by a unified data platform and is available to our ecommerce consumers and our benefit advisors. We strive to be the most trusted, unbiased, transparent partner to consumers in their journeys through the health insurance market.

Unless otherwise specified or required by the context, references in this Quarterly Report on Form 10-Q to "eHealth," "the Company," "we," "us" or "our" mean eHealth, Inc. and its consolidated direct and indirect wholly owned subsidiaries.

Basis of Presentation – The accompanying Condensed Consolidated Balance Sheet as of March 31, 2025 and other condensed consolidated financial statements for the three months ended March 31, 2025 and 2024 are unaudited. The Condensed Consolidated Balance Sheet as of December 31, 2024 was derived from the audited consolidated financial statements included in our Annual Report on Form 10-K for the year ended December 31, 2024, which was filed with the Securities and Exchange Commission on February 27, 2025. The accompanying financial statements and related notes should be read in conjunction with the audited consolidated financial statements and related notes included in our Annual Report on Form 10-K.

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

The unaudited condensed consolidated financial statements have been prepared on the same basis as the audited consolidated financial statements in our Annual Report on Form 10-K for the year ended December 31, 2024 and include all adjustments necessary for the fair presentation of our financial position as of March 31, 2025 and December 31, 2024 and our results of operations for the periods presented. The results for the three months ended March 31, 2025 are not necessarily indicative of the results to be expected for any subsequent period or for the year ended December 31, 2025 and therefore, should not be relied upon as an indicator of future results.

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

Significant Accounting Policies, Estimates and Judgments – The preparation of condensed consolidated financial statements and related disclosures in conformity with U.S. GAAP requires management to make estimates, judgments and assumptions that affect the amounts reported and disclosed in the condensed consolidated financial statements and accompanying notes. On an ongoing basis, we evaluate our estimates, including those related to, but not limited to, the fair value of investments, the commissions we expect to collect for each approved member cohort, valuation allowance for deferred income taxes, uncertain tax positions and the assumptions used in determining stock-based compensation. We base our estimates of the carrying value of certain assets and liabilities on historical experience and on various other assumptions that we believe to be reasonable. Actual results may differ from these estimates. There have been no material changes to our significant accounting policies discussed in our Annual Report on Form 10-K for the year ended December 31, 2024.

Recently Adopted Accounting Pronouncements

We did not adopt any new accounting pronouncements during the three months ended March 31, 2025.

Recently Issued Accounting Pronouncements Not Yet Adopted

Income Taxes (Topic 740) — In December 2023, the FASB issued Accounting Standards Update ("ASU") 2023-09, *Income Taxes (Topic 740): Improvements to Income Tax Disclosures*, which will require public entities, on an annual basis, to provide disclosure of specific categories in the rate reconciliation, as well as additional disclosure on income taxes paid. The ASU is effective on a prospective basis for fiscal years beginning after December 15, 2024 for public entities and early adoption is permitted. We are currently evaluating the impact of adopting this ASU on our consolidated financial statements and related disclosures.

Income Statement – Reporting Comprehensive Income – Expense Disaggregation Disclosures (Subtopic 220-40) — In November 2024, the FASB issued ASU 2024-03, *Income Statement – Reporting Comprehensive Income – Expense Disaggregation Disclosures (Subtopic 220-40): Disaggregation of Income Statement Expenses*. This ASU will require more detailed information about specified categories of expenses (purchases of inventory, employee compensation, depreciation, intangible asset amortization and depletion) included in certain expense captions presented on the face of the income statement. The ASU is effective for fiscal years beginning after December 15, 2026 and for interim periods beginning after December 15, 2027. The ASU may be applied either prospectively to financial statements issued for reporting periods after the effective date of this ASU or retrospectively to all prior periods presented in the financial statements and early adoption is permitted. We are currently evaluating the impact of adopting this ASU on our consolidated financial statements and related disclosures.

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

Note 2 – Revenue

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

	Three Months Ended March 31,	
	2025	**2024**
Medicare		
Medicare Advantage	$ 74,986	$ 61,996
Medicare Supplement	8,604	5,478
Medicare Part D	2,443	2,685
Total Medicare	86,033	70,159
Individual and Family [1]		
Non-Qualified Health Plans	918	1,645
Qualified Health Plans	1,765	2,046
Total Individual and Family	2,683	3,691
Ancillary		
Short-term	370	388
Dental	2,234	877
Vision	769	689
Other	2,459	734
Total Ancillary	5,832	2,688
Small Business	3,434	3,616
Commission Bonus and Other	964	773
Total Commission Revenue	98,946	80,927
Other Revenue		
Sponsorship and Advertising Revenue	8,139	10,189
Fee-based and Other Revenue	6,034	1,848
Total Other Revenue	14,173	12,037
Total Revenue	$ 113,119	$ 92,964

[1] We define our individual and family plan offerings as major medical individual and family health insurance plans, which do 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 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 do not meet the requirements of the Affordable Care Act and are not offered through the government-run health insurance 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.

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

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

	Three Months Ended March 31,	
	2025	2024
Medicare		
Commission revenue from members approved during the period	$ 81,754	$ 69,752
Net commission revenue from members approved in prior periods [1]	7,965	1,002
Total Medicare segment commission revenue	$ 89,719	$ 70,754
Employer and Individual		
Commission revenue from members approved during the period	$ 3,858	$ 5,677
Commission revenue from renewals of small business members during the period	2,850	3,028
Net commission revenue from members approved in prior periods [1]	2,519	1,468
Total Employer and Individual segment commission revenue	$ 9,227	$ 10,173
Total commission revenue from members approved during the period	$ 85,612	$ 75,429
Commission revenue from renewals of small business members during the period	2,850	3,028
Total net commission revenue from members approved in prior periods [1][2]	10,484	2,470
Total commission revenue	$ 98,946	$ 80,927

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

[2] The after-tax impact of total net commission revenue from members approved in prior periods for the three months ended March 31, 2025 and 2024 was $0.26 and $0.06 per basic and diluted share, respectively.

Note 3 – Supplemental Financial Statement Information

Cash, Cash Equivalents and Restricted Cash

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

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

	March 31, 2025	December 31, 2024
Cash	$ 27,982	$ 10,927
Cash equivalents	93,110	28,270
Cash and cash equivalents	121,092	39,197
Restricted cash	3,090	3,090
Total cash, cash equivalents and restricted cash	$ 124,182	$ 42,287

As of March 31, 2025 and December 31, 2024, we had $3.1 million of restricted cash which was classified as a non-current asset on our Condensed Consolidated Balance Sheets. This amount collateralizes letters of credit related to certain lease commitments.

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Contract Assets and Accounts Receivable

We estimate an allowance for credit losses using relevant available information from internal and external sources, related to past events, current conditions and reasonable and supportable forecasts. Specifically, for the purpose of measuring the probability of default parameters, we utilize Capital IQ's, Standard & Poor's and Moody's analytics. Our estimates of loss given default are determined by using our historical collections data as well as historical information obtained through our research and review of other insurance related companies. Our estimated exposure at default is determined by applying these internal and external data sources to our commissions receivable balances. As such, we apply an immediate reversion method and revert to historical loss information when computing our credit loss exposure. Credit loss expenses are assessed quarterly and included in the "General and administrative" line in our Condensed Consolidated Statements of Comprehensive Income (Loss). There were no write-offs during the three months ended March 31, 2025 or for the year ended December 31, 2024.

The change in the allowance for credit losses is summarized as follows (in thousands):

	March 31, 2025	December 31, 2024
Beginning balance	$ 2,222	$ 2,118
Change in allowance	(315)	104
Ending balance	$ 1,907	$ 2,222

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

	Medicare Segment	E&I Segment	Total
Beginning balance at December 31, 2024	$ 936,940	$ 63,050	$ 999,990
Commission revenue from members approved during the period	81,754	3,858	85,612
Commission revenue from renewals of small business members during the period	—	2,850	2,850
Net commission revenue from members approved in prior periods	7,965	2,519	10,484
Cash receipts	(168,715)	(7,279)	(175,994)
Net change in credit loss allowance	293	22	315
Ending balance at March 31, 2025	$ 858,237	$ 65,020	$ 923,257

Credit Risk

Our financial instruments that are exposed to concentrations of credit risk principally consist of cash, cash equivalents, marketable securities, contract assets – commissions receivable and accounts receivable. We invest our cash and cash equivalents with major banks and financial institutions and, 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 $2.4 million as of March 31, 2025. See *Note 4 – Fair Value Measurements* for additional information regarding our marketable securities.

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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 – commissions receivable and accounts receivable balances are summarized as follows:

	March 31, 2025	December 31, 2024
Humana	29 %	28 %
UnitedHealthcare [1]	29 %	27 %
Aetna [1]	17 %	17 %

[1] Percentages include the carriers' subsidiaries.

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

	March 31, 2025	December 31, 2024
Prepaid software and maintenance contracts	$ 5,996	$ 5,582
Prepaid marketing and other expenses	2,742	2,405
Prepaid licenses	1,924	2,358
Prepaid insurance	957	1,296
Other current assets	1,355	1,320
Prepaid expenses and other current assets	$ 12,974	$ 12,961

Note 4 – Fair Value Measurements

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

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

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

	March 31, 2025				
	Carrying Value	Level 1	Level 2	Level 3	Total
Assets					
Cash equivalents					
Money market funds	$ 13,055	$ 13,055	$ —	$ —	$ 13,055
Commercial paper	76,661	—	76,661	—	76,661
Government securities	3,394	—	3,394	—	3,394
Short-term marketable securities					
Commercial paper	27,613	—	27,613	—	27,613
Government securities	6,882	—	6,882	—	6,882
Total assets measured at fair value	$ 127,605	$ 13,055	$ 114,550	$ —	$ 127,605

	December 31, 2024				
	Carrying Value	Level 1	Level 2	Level 3	Total
Assets					
Cash equivalents					
Money market funds	$ 15,090	$ 15,090	$ —	$ —	$ 15,090
Commercial paper	10,562	—	10,562	—	10,562
Government securities	2,618	—	2,618	—	2,618
Short-term marketable securities					
Commercial paper	17,799	—	17,799	—	17,799
Government securities	25,244	—	25,244	—	25,244
Total assets measured at fair value	$ 71,313	$ 15,090	$ 56,223	$ —	$ 71,313

We endeavor to utilize the best available information in measuring fair value. Our money market funds are measured at fair value based on quoted prices in active markets and are classified as Level 1 within the fair value hierarchy. Our available for sale marketable securities, which include commercial paper and government securities with maturities of less than one year, are measured at fair value using quoted market prices to the extent available or alternative pricing sources and models utilizing market observable inputs and are classified as Level 2 within the fair value hierarchy. There were no transfers between the hierarchy levels during the three months ended March 31, 2025 or the year ended December 31, 2024.

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

	As of March 31, 2025		As of December 31, 2024	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value
Due in 1 year	$ 127,626	$ 127,605	$ 71,297	$ 71,313

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Unrealized gains and losses on available for sale debt securities that are not credit related are included in accumulated other comprehensive loss and summarized as follows (in thousands):

	March 31, 2025			
	Amortized Cost	Unrealized Gains	Unrealized Losses	Fair Value
Cash equivalents				
Money market funds	$ 13,055	$ —	$ —	$ 13,055
Commercial paper	76,675	—	(14)	76,661
Government securities	3,394	—	—	3,394
Short-term marketable securities				
Commercial paper	27,620	—	(7)	27,613
Government securities	6,882	—	—	6,882
Total	$ 127,626	$ —	$ (21)	$ 127,605

	December 31, 2024			
	Amortized Cost	Unrealized Gains	Unrealized Losses	Fair Value
Cash equivalents				
Money market funds	$ 15,090	$ —	$ —	$ 15,090
Commercial paper	10,565	—	(3)	10,562
Government securities	2,618	—	—	2,618
Short-term marketable securities				
Commercial paper	17,792	7	—	17,799
Government securities	25,232	12	—	25,244
Total	$ 71,297	$ 19	$ (3)	$ 71,313

As of March 31, 2025 and December 31, 2024, we had 43 and 11 securities, respectively, in a net unrealized loss position that were immaterial individually and in aggregate. We did not record any credit losses regarding our available for sale debt securities during the three months ended March 31, 2025 or the year ended December 31, 2024. 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. We recognized interest income of $1.4 million and $2.2 million for the three months ended March 31, 2025 and 2024, respectively.

Note 5 – Equity

Stock Repurchase Programs – We had no stock repurchase activity during the three months ended March 31, 2025 or 2024 except for the repurchase of shares to satisfy employee tax withholding obligations. As of March 31, 2025 and 2024, we had a total of 13.5 million and 13.0 million shares, respectively, held in treasury. As of March 31, 2025 and 2024, we had 2.8 million and 2.3 million shares, respectively, in treasury that were previously surrendered by employees to satisfy tax withholding due in connection with the vesting of certain restricted stock units as well as 10.7 million shares previously repurchased under our past repurchase programs.

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.

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Stock-Based Compensation Expense – Our stock-based compensation expense is summarized by award types for the periods presented below (in thousands):

	Three Months Ended March 31,	
	2025	**2024**
Restricted stock units	$ 3,137	$ 4,636
Performance-based stock units	446	407
Common stock options	166	400
Employee stock purchase program	40	97
Total stock-based compensation expense	$ 3,789	$ 5,540
Related tax benefit recognized	$ 910	$ 1,312

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

	Three Months Ended March 31,	
	2025	**2024**
Marketing and advertising	$ 497	$ 644
Customer care and enrollment	264	524
Technology and content	688	974
General and administrative	2,340	3,398
Total stock-based compensation expense	$ 3,789	$ 5,540
Amount capitalized for internal-use software	108	178
Total stock-based compensation	$ 3,897	$ 5,718

Note 6 — Convertible Preferred Stock

Pursuant to an investment agreement dated February 17, 2021 with Echelon Health SPV, LP (“H.I.G.”), an investment vehicle of H.I.G. Capital (the “H.I.G. Investment Agreement”), we issued and sold to H.I.G., in a private placement, 2,250,000 shares of Series A convertible preferred stock (the “Series A Preferred Stock”), par value $0.001 per share, at an aggregate purchase price of $225.0 million on April 30, 2021 (the “Closing Date”). We received $214.0 million in net proceeds from the private placement with H.I.G., net of sales commissions and certain transaction fees totaling $11.0 million. Our Series A Preferred Stock is considered temporary equity in our Condensed Consolidated Balance Sheets and we have determined there are no material embedded features that require recognition as a derivative asset or liability. The Series A Preferred Stock ranks senior to all other equity securities of the Company with respect to dividend rights and rights on the distribution of assets on any voluntary or involuntary liquidation, dissolution or winding up of the affairs of the Company.

Voting Rights – The Series A Preferred Stock votes together with the common stock as a single class on all matters submitted to a vote of the holders of the common stock in accordance with the Certificate of Designations of Series A Preferred Stock, as filed with the Secretary of State of the State of Delaware on April 30, 2021 (the “Certificate of Designations”).

Dividends – The Series A Preferred Stock participates, on an as-converted basis, in all dividends paid to the holders of our common stock. From April 30, 2021 through June 30, 2023, dividends accrued at 8% per annum on the stated value of $100 per share, payable in kind (“PIK”). Subsequent to June 30, 2023, dividends accrue at 8% per annum, with 6% PIK and 2% payable in cash in arrears. Dividends compound semiannually and are PIK

and payable in cash in arrears, as applicable, on June 30 and December 31 of each year. PIK dividends are cumulative and are added to the Accrued Value, as defined in the H.I.G. Investment Agreement. As of March 31, 2025 we have accrued $1.4 million for cash dividends.

Board Nomination Rights – As of March 31, 2025, H.I.G. has designated one member and one board observer to the Company's Board of Directors.

Conversion Rights – The Series A Preferred Stock is convertible at any time into common stock at a conversion rate (the "Conversion Price") and is subject to further adjustment and the number of shares of common stock issuable upon conversion is subject to certain limitations, each as set forth in the H.I.G Investment Agreement. As of March 31, 2025, the Conversion Price was equal to $79.5861 per share.

Mandatory Conversion of the Series A Preferred Stock by the Company – At any time on or after the third anniversary of the Closing Date, if the volume-weighted average price per share of our common stock is greater than 167.5% of the then-current Conversion Price for 20 consecutive trading days in a 30-day trading day period, the Company will have the right to convert all, but not less than all, of the Series A Preferred Stock into common stock at a conversion rate in accordance with the Certificate of Designations.

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

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

Covenants and Liquidity Requirements – As long as H.I.G. continues to own at least 30% of the Series A Preferred Stock originally issued to it in the private placement, the consent of H.I.G. is required for the Company to incur certain indebtedness and to take certain other corporate actions as set forth in the H.I.G. Investment Agreement. The Company is required to maintain an Asset Coverage Ratio (as defined in the H.I.G. Investment Agreement), which was 2.5x from August 2023 onwards. Additionally, the H.I.G. Investment Agreement requires the Company to maintain a Minimum Liquidity Amount (as defined in the H.I.G. Investment Agreement) for certain periods that ranges from $65.0 million to $125.0 million. Failure to maintain the Minimum Asset Coverage Ratio or the Minimum Liquidity Amount as of the date or for the time period required by the H.I.G. Investment Agreement, for as long as H.I.G. continues to own at least 30% of the Series A Preferred Stock originally issued to it in the private placement, entitles H.I.G., subject to conditions and restrictions specified therein, to additional rights, including the right to nominate one additional member to the Company's Board of Directors, the right to approve the Company's annual budget, the right to approve hiring or termination of certain key executives, and the right to approve the incurrence of certain indebtedness. As of September 30, 2023, we failed to maintain the Minimum Asset Coverage Ratio, which entitles H.I.G. to the additional rights set forth above. On March 13, 2024, the Nominating and Corporate Governance Committee of our Board of Directors approved the appointment of a board observer designated by H.I.G. As of November 30, 2024, we were no longer in compliance with the Minimum Liquidity Amount. The non-compliance with the Minimum Asset Coverage Ratio or the Minimum Liquidity Amount does not entitle H.I.G. to accelerate the redemption of the Series A Preferred Stock.

As of March 31, 2025, the estimated Series A Preferred Stock redemption value equals 135% of the Accrued Value per share as of the redemption date, plus accrued PIK dividends that have not yet been added to the

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Accrued Value, which is significantly in excess of the fair value of the common stock into which the Series A Preferred Stock is convertible as of March 31, 2025. We have elected to apply the accretion method to adjust the carrying value of the Series A Preferred Stock to its redemption value at the earliest date of redemption, April 30, 2027. Amounts recognized to accrete the Series A Preferred Stock to its estimated redemption value are treated as a deemed dividend and are recorded as a reduction to retained earnings, to the extent available, and if not, are recorded as a reduction to additional-paid-in-capital. The estimated redemption value will vary in subsequent periods due to the redemption put right described above and we have elected to recognize such changes prospectively. No shares of Series A Preferred Stock have been converted, and the Series A Preferred Stock was convertible into 3.7 million shares of common stock as of March 31, 2025.

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

Gross proceeds	$	225,000
Less: issuance costs		(10,975)
Net proceeds	$	214,025
Balance as of December 31, 2024	$	337,509
Accrued paid-in-kind dividends		4,335
Change in preferred stock redemption value		6,141
Balance as of March 31, 2025	$	347,985

Note 7 – Net Loss Per Share Attributable to Common Stockholders

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

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

	Three Months Ended March 31,	
	2025	2024
Numerator:		
Net loss attributable to common stockholders	$ (9,972)	$ (27,711)
Denominator:		
Shares used in per share calculation – basic	29,997	28,912
Dilutive effect of common stock	—	—
Shares used in per share calculation – diluted	29,997	28,912
Net loss attributable to common stockholders per share – basic and diluted	$ (0.33)	$ (0.96)

For each of the three months ended March 31, 2025 and 2024, we had securities outstanding that could potentially dilute net loss per share, but the shares from the assumed conversion or exercise of these securities were excluded in the computation of diluted net loss per share as their effect would have been anti-dilutive. The number of weighted-average outstanding anti-dilutive shares that were excluded from the computation of diluted net loss per share consisted of the following (in thousands):

	Three Months Ended March 31,	
	2025	2024
Convertible preferred stock	3,680	3,469
Restricted stock units	1,303	2,204
Performance-based stock units	440	97
Common stock options	213	218
Employee stock purchase program	20	8
Total	5,656	5,996

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.

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Our future minimum payments under non-cancellable contractual service and licensing obligations as of March 31, 2025 were as follows (in thousands):

Year ending December 31,		
2025 (remainder)	$	5,456
2026		4,453
2027		606
2028		—
2029		—
Thereafter		—
Total	$	10,515

Operating Leases

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

Self-Insurance

We provide comprehensive major medical benefits to our employees. We maintain a substantial portion of our U.S. employee health insurance benefits on a self-insured basis with up to $0.3 million per individual per year with the maximum claim liability as of March 31, 2025 of $26.0 million. As a result, we record a self-insurance liability based on claims filed and an estimate of claims incurred but not yet reported. As of March 31, 2025 and December 31, 2024, we had a self-insurance liability balance of $2.1 million in the “Accrued compensation and benefits” line on our Condensed Consolidated Balance Sheets.

Contingencies

From time to time, we receive inquiries from governmental bodies and also may be subject to various legal proceedings and claims arising in the ordinary course of business. We assess contingencies to determine the degree of probability and range of possible loss for potential accrual in our condensed consolidated financial statements. An estimated loss contingency is accrued in the condensed consolidated financial statements if it is probable that a liability has been incurred and the amount of the loss can be reasonably estimated.

As of March 31, 2025, we have not recorded any material litigation-related accruals for loss contingencies associated with legal proceedings or matters or have determined that an unfavorable outcome is reasonably possible or estimable. Legal proceedings or other contingencies may be material to our results of operations, financial condition or cash flows, even if we ultimately prevail, and we may from time to time enter into settlements to resolve such litigation. Legal costs incurred in connection with the resolution of claims, lawsuits and other contingencies generally are expensed as incurred.

Legal Proceedings

On May 1, 2025, we became aware that a *qui tam* action filed against eHealth, Inc. and its subsidiary, eHealthInsurance Services, Inc. was unsealed by order of the United States District Court for the District of Massachusetts entered on or about May 1, 2025. The *qui tam* action, *United States ex rel. Andrew Shea v. eHealth, Inc. et al*, which was originally filed under seal on November 2, 2021, was brought by a former eHealth marketing representative on behalf of the United States under the Federal False Claims Act. The complaint alleges that we and eHealthInsurance Services, Inc., CVS Health Corporation, Aetna Life Insurance Company, Aetna, Inc., Humana Inc., Elevance Health, Inc., GoHealth, Inc., and SelectQuote, Inc. violated the Federal False Claims Act in connection with the defendants’ enrollment and marketing activities. The complaint seeks, among other things, treble damages, civil penalties and costs. On January 13, 2025, the United States filed notice of its election to intervene in part in the *qui tam* action. In this notice, which was also unsealed pursuant to the Court’s order entered

on or about May 1, 2025, the United States indicated that it determined to intervene in the action with respect to certain defendants named in the original complaint, including us. We dispute the allegations and plan to vigorously defend ourselves.

Note 9 – Segment and Geographic Information

Reportable Segments

Our operating and reportable segments have been determined in accordance with Accounting Standards Codification ("ASC") 280, *Segment Reporting*. Our business structure is comprised of two reportable operating segments: (i) Medicare, and (ii) Employer and Individual ("E&I"). Our Medicare segment includes operating segments that have been aggregated based on the nature of products and services, types or class of customers, methods used to distribute the products and services, the nature of the regulatory environment and similarity of economic characteristics.

The Medicare segment consists primarily of commissions earned as the broker of record 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 beneficiaries, including but not limited to, dental and vision insurance and hospital indemnity plans. Our commissions may include certain bonus payments, which are generally based on attaining predetermined target sales levels or other objectives, as determined by the health insurance carriers. The Medicare segment also consists of amounts earned in connection with our advertising program that allows Medicare-related carriers to purchase advertising on a separate website developed, hosted and maintained by us or pursuant to which we perform other services as marketing and our delivery and sale to third parties of Medicare-related health insurance leads generated by our ecommerce platforms and our marketing activities. The Medicare segment also generates revenue from our fee-based business process outsourcing services ("BPO") where we are not the broker of record and cash is collected in advance or in close proximity to when revenue is recognized.

The E&I segment consists primarily of commissions earned from our sale of individual and family plans, including qualified and non-qualified plans, small business health insurance plans, and ancillary products sold to our non-Medicare-eligible consumers, including but not limited to, dental, vision and short-term insurance. To a lesser extent, the E&I segment includes amounts earned from our online sponsorship program that allows carriers to purchase advertising space in specific markets on our website as well as our technology licensing activities.

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 in the annual budget and forecasting process along with evaluation of actual performance. Our CODM considers budget-to-actual variances on a monthly basis for our segment performance measures when making decisions about allocating capital and personnel to our segments. These performance measures include total segment revenue and segment gross profit (loss). Prior to the fourth quarter of 2024, we reported our measure of segment profitability as segment profit (loss). Accordingly, prior period amounts have been reclassified to conform to the current period presentation, in all material respects.

Segment gross profit (loss) is calculated as total revenue for the applicable segment less variable marketing and advertising expenses, segment CC&E expenses and cost of revenue for the applicable segment. Variable marketing and advertising expenses represent costs incurred in member acquisition from our direct marketing and marketing partner channels and exclude fixed overhead costs, such as personnel related costs, consulting expenses and other operating costs allocated to the marketing and advertising department. Segment CC&E expenses include expenses we incur in assisting applicants during the enrollment process and exclude operating costs allocated to the CC&E department.

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

	Three Months Ended March 31,	
	2025	2024
Medicare:		
Total revenue	$ 103,669	$ 82,388
Variable marketing and advertising	(33,753)	(30,248)
Medicare CC&E	(34,469)	(29,949)
Cost of revenue	300	(143)
Medicare segment gross profit	$ 35,747	$ 22,048

	Three Months Ended March 31,	
	2025	2024
Employer and Individual:		
Total revenue	$ 9,450	$ 10,576
Variable marketing and advertising	(1,190)	(776)
E&I CC&E	(2,180)	(2,277)
Cost of revenue	(92)	(118)
E&I segment gross profit	$ 5,988	$ 7,405

	Three Months Ended March 31,	
	2025	2024
Consolidated:		
Total revenue	$ 113,119	$ 92,964
Variable marketing and advertising	(34,943)	(31,024)
Segment CC&E	(36,649)	(32,226)
Cost of revenue	208	(261)
Total segment gross profit	$ 41,735	$ 29,453

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A reconciliation of our segment gross profit to the Condensed Consolidated Statements of Comprehensive Income (Loss) for the periods presented is as follows (in thousands):

	Three Months Ended March 31,	
	2025	2024
Total segment gross profit	$ 41,735	$ 29,453
Other marketing and advertising [1]	(6,454)	(7,452)
Other CC&E [2]	(572)	(675)
Technology and content	(12,601)	(13,305)
General and administrative	(17,310)	(19,619)
Impairment, restructuring and other charges	—	(6,313)
Interest expense	(2,648)	(2,809)
Other income, net	1,576	2,391
Income (loss) before income taxes	$ 3,726	$ (18,329)

(1) Other marketing and advertising costs consist of fixed marketing and advertising, previously capitalized labor, depreciation and share-based compensation costs.

(2) Other CC&E costs consist of previously capitalized labor, depreciation and share-based compensation costs.

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

Geographic Information

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

	March 31, 2025	December 31, 2024
United States	$ 25,425	$ 26,033
China	255	299
Total	$ 25,680	$ 26,332

EHEALTH, INC.
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Significant Customers

Substantially all revenue for the three months ended March 31, 2025 and 2024 was generated from customers located in the United States. Carriers representing 10% or more of our total revenue are summarized as follows. The majority of the revenue was from the Medicare segment.

	Three Months Ended March 31,	
	2025	2024
Humana	24 %	26 %
UnitedHealthcare [1]	24 %	15 %
Aetna [1]	14 %	23 %

[1] Percentages include the carriers' subsidiaries.

Note 10 – Leases

Our lease portfolio primarily consists of operating leases for office space and our leases have remaining lease terms of 1 year to 5 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.

Subsequent to becoming a remote first workplace in the third quarter of 2022, we executed several subleases of our office space in the United States. The subleases run through the remaining term of the primary leases. As of March 31, 2025, we expect to generate a total of $11.5 million in future sublease income through January 31, 2030. Sublease income is recorded on a straight-line basis as a reduction of lease expense in our Condensed Consolidated Statements of Comprehensive Income (Loss).

We test right-of-use assets when impairment indicators are present in accordance with the asset impairment provisions of ASC 360, *Property, Plant and Equipment*. In 2024, as part of our continued cost savings initiatives, we reassessed our occupied leased office space to identify excess space to vacate and potentially sublease. We also reassessed current market conditions in our previously vacated leased office spaces that had not yet been subleased. As a result, we determined impairment indicators were present at that time and we performed impairment testing of our right-of-use assets, including leasehold improvements. We utilized an income approach to value the asset groups by performing a discounted cash flow analysis and determined that for certain leases the net carrying values exceeded the estimated discounted future cash flows expected to be derived from the properties based on Level 3 inputs, including current sublease market rent, future sublease market conditions and the discount rate. We recorded $5.5 million of impairment charges related to our operating lease right-of-use assets and property, plant and equipment, which was reflected in the "Impairment, restructuring and other charges" line in our Condensed Consolidated Statements of Comprehensive Income (Loss) for the three months ended March 31, 2024. We recorded no impairment charges related to our operating lease right-of-use assets and the corresponding property, plant and equipment for the three months ended March 31, 2025. See *Note 11 – Impairment, Restructuring and Other Charges* for further discussion about our asset impairment charges.

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(unaudited)

The components of operating lease costs for the three months ended March 31, 2025 and 2024 were as follows (in thousands):

	Three Months Ended March 31,	
	2025	2024
Operating lease expense	$ 1,218	$ 1,737
Operating sublease income	(689)	(576)
Total operating lease cost	$ 529	$ 1,161

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

	Three Months Ended March 31,	
	2025	2024
Cash paid for amounts included in the measurement of operating lease liabilities	$ 2,285	$ 2,231

	March 31, 2025	December 31, 2024
Weighted-average remaining lease term (in years) of operating leases	3.7	4.6
Weighted-average discount rate used to recognize operating lease right-of-use-assets	5.7 %	5.7 %

As of March 31, 2025, maturities of our operating lease liabilities are as follows (in thousands):

Year ending December 31,	
2025 (remainder)	$ 6,879
2026	7,693
2027	6,950
2028	4,998
2029	3,008
Thereafter	196
Total lease payments [(1)]	$ 29,724
Less imputed interest	(3,144)
Total	$ 26,580

(1) Non-cancellable sublease proceeds for the remainder of 2025 and the years ending December 31, 2026, 2027, 2028, 2029 and thereafter of $2.0 million, $2.9 million, $3.0 million, $3.1 million, $1.1 million, and $0.1 million, respectively, are not included in the table above.

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Note 11 — Impairment, Restructuring and Other Charges

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

	Three Months Ended March 31,	
	2025	2024
Asset impairment charges	$ —	$ 5,492
Restructuring and reorganization charges	—	821
Impairment, restructuring and other charges	$ —	$ 6,313

Asset Impairments

We did not incur any asset impairment charges for the three months ended March 31, 2025. For the three months ended March 31, 2024, we recognized non-cash, pre-tax asset impairment charges of $5.5 million, related to several of our leased office spaces in the "Impairment, restructuring and other charges" line in our Condensed Consolidated Statements of Comprehensive Income (Loss). These charges were comprised of $5.1 million of operating lease right-of-use asset impairments and $0.4 million of property and equipment impairment for the three months ended March 31, 2024. Refer to *Note 10 – Leases* for additional information related to our lease impairment charges.

Restructuring

We did not incur any restructuring or reorganization charges for the three months ended March 31, 2025 and as of March 31, 2025, we had no restructuring accrual on our Condensed Consolidated Balance Sheet. For the three months ended March 31, 2024, we recognized $0.8 million of pre-tax restructuring charges in the "Impairment, restructuring and other charges" line in our Condensed Consolidated Statements of Comprehensive Income (Loss), primarily related to employee termination benefits as a result of our cost-reduction efforts. All of the restructuring charges were settled in cash and no equity awards were modified.

Note 12 – Debt

On February 28, 2022, we entered into a term loan credit agreement, which provides for a $70.0 million secured term loan credit facility, with Blue Torch Finance LLC, as administrative agent and collateral agent, and other lenders party thereto (the "Original Credit Agreement"). On August 16, 2022, we entered into a first amendment (the "First Amendment") to the Original Credit Agreement (as amended by the First Amendment, the "First Amended Credit Agreement"). The First Amendment replaced the LIBOR-based Adjusted Euro currency Rate (as defined in the Original Credit Agreement) with Adjusted Term SOFR (as defined in the First Amendment) as a reference rate for loans under the Original Credit Agreement. On November 1, 2024, we entered into a second amendment (the "Second Amendment") to the First Amended Credit Agreement (as amended by the First Amendment and the Second Amendment, the "Credit Agreement"), which, among other things, (i) extends the maturity date of the Credit Agreement from February 2025 to February 2026, (ii) removes the "exit fee" contemplated by the Credit Agreement and replaces it with an "applicable premium" that is payable in the event of any voluntary or mandatory prepayment of the loan and (iii) reduces the margin applicable to SOFR loans and the margin applicable to base rate loans. The proceeds of the loans under the Credit Agreement may be used for working capital and general corporate purposes and to pay fees and expenses in connection with the entry into the Credit Agreement.

In accordance with ASC 470-50, Debt Modification and Extinguishments, the Second Amendment was accounted for as a debt modification. The $1.1 million extension fee paid to the lenders of the Credit Agreement during the quarter ended December 31, 2024 has been recorded as a direct deduction from the face amount of the

loan. Similar to the $5.1 million of closing costs incurred for the Original Credit Agreement, the extension fee is amortized on a straight-line basis over the remaining term of the Credit Agreement in the “Interest expense” line in our Condensed Consolidated Statements of Comprehensive Income (Loss). Additionally, we paid $1.3 million during the quarter ended December 31, 2024 in third-party costs as part of the Second Amendment. Total amortization of closing costs, or debt issuance costs, was $0.3 million for the three months ended March 31, 2025, and $0.4 million for the three months ended March 31, 2024, and is recorded in the “Interest expense” line in our Condensed Consolidated Statements of Comprehensive Income (Loss). There were $1.2 million of unamortized issuance costs as of March 31, 2025. The carrying value of the term loan approximates the fair value, based on Level 2 inputs (observable market prices in less than active markets), as the interest rate is variable over the selected interest period and is similar to current rates at which we can borrow funds. The carrying value of the loan was $68.8 million as of March 31, 2025.

The loans under the Credit Agreement bear interest, at our option, at either a rate based on the Adjusted Term SOFR or a base rate, in each case plus a margin. The base rate is the highest of the prime rate, the federal funds rate plus 0.50% and three-month Adjusted Term SOFR plus 1.00%. The Second Amendment reduced the margin from 7.50% to 7.00% for Adjusted Term SOFR loans and from 6.50% to 6.00% for base rate loans. As of March 31, 2025, the interest rate was 11.57%. For the three months ended March 31, 2025 and 2024 we incurred interest expense of $2.0 million and $2.3 million, respectively.

Furthermore, as part of the Credit Agreement, we incur a $0.3 million fee per annum, payable annually. The outstanding obligations under the Credit Agreement are payable in full on the maturity date. The Credit Agreement matures in February 2026. We have the right to prepay the loans under the Credit Agreement in whole or in part at any time, subject, to an “applicable premium” that is payable in the event of any voluntary prepayment or certain mandatory prepayments of the loans under the Credit Agreement in an amount equal to 1.00% of the loans being prepaid, plus, solely in the case of loans prepaid on or prior to March 1, 2025, an additional “make-whole” amount. Our obligations under the Credit Agreement are guaranteed by certain of our material domestic subsidiaries and substantially all of our assets and the assets of such guarantors, in each case, subject to customary exclusion.

Financial covenants in the Credit Agreement require that we maintain Liquidity (as defined in the Credit Agreement) at or above $25.0 million as of the last calendar day of any month. The Credit Agreement also requires that the outstanding amount as of the last calendar day of any month be less than 50% of our total contract assets - commissions receivable (i.e., both current and non-current commissions receivable). As of March 31, 2025, we were in compliance with our loan covenants.

Note 13 – Income Taxes

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

	Three Months Ended March 31,	
	2025	2024
Income (loss) before income taxes	$ 3,726	$ (18,329)
Provision for (benefit from) income taxes	1,776	(1,345)
Effective tax rate	47.7 %	7.3 %

For the three months ended March 31, 2025 and 2024 we calculated our provision for (benefit from) income taxes by applying an estimate of the annual effective tax rate to income (loss) before income taxes for the reporting period.

For the three months ended March 31, 2025, we recorded a provision for income taxes of $1.8 million, representing an effective tax rate of 47.7%, which was higher than the statutory federal tax rate primarily due to

state taxes, nondeductible stock-based compensation, lobbying expenses and prior year discrete adjustments, partially offset by research and development credits. For the three months ended March 31, 2024, we recognized a benefit from income taxes of $1.3 million, representing an effective tax rate of 7.3%, which was lower than the statutory federal tax rate primarily due to stock-based compensation adjustments, non-deductible lobbying expenses and an increase in global intangible low-taxed income, partially offset by research and development credits and state taxes.

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 available positive and negative evidence, including our history of operating income and losses and our financial plans and estimates that we use to manage the business. These assumptions require significant judgment about future taxable income. As a result, the amount of deferred tax assets considered realizable is subject to adjustment in future periods if estimates of future taxable income change. We continue to recognize our deferred tax assets as of March 31, 2025, as we believe it is more likely than not that such deferred tax assets will be realized, with the exception of certain net operating losses and credits for which there is increased uncertainty regarding our future taxable income and a lack of other sources of taxable income, which have a valuation allowance.

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

Please read the following discussion and analysis together with our condensed consolidated financial statements and accompanying notes included elsewhere in this Quarterly Report on Form 10-Q and our audited consolidated financial statements included in our Annual Report on Form 10-K for the year ended December 31, 2024 (the "Annual Report"). This discussion and analysis contains forward-looking statements, which involve risks and uncertainties. As a result of many factors, such as those described under "Cautionary Note Regarding Forward-Looking Statements," "Risk Factors" and elsewhere in this Quarterly Report on Form 10-Q and in our Annual Report, our actual results may differ materially from those anticipated in these forward-looking statements.

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 expertly guide consumers through their health insurance enrollment and related options, when, where, and how they prefer. Our platform leverages technology to solve a critical problem in a large and growing market by aiding consumers in what has traditionally been a complex, confusing and opaque health insurance purchasing process. Our omnichannel consumer engagement platform differentiates our offering from competitors and enables consumers to use our services online, by telephone with a licensed insurance agent, or benefit advisor, or through a hybrid online assisted interaction that includes live agent chat and co-browsing capabilities. We have created a consumer-centric marketplace that offers consumers a broad choice of insurance products that includes thousands of Medicare Advantage, Medicare Supplement, Medicare Part D prescription drug, individual, family, small business and other ancillary health insurance products from over 180 health insurance carriers nationwide. Our plan recommendation tool curates this broad plan selection by analyzing consumer health-related information against plan data for insurance coverage fit. This tool is supported by a unified data platform and is available to our ecommerce consumers and our benefit advisors. We strive to be the most trusted, unbiased, transparent partner to consumers in their journeys through the health insurance market.

Business Update

Our fiscal 2025 growth strategy is focused on pursuing deliberate revenue diversification and scaling of our business, evolving our brand awareness for all products and channels, improving member retention and conversions on our platform while continuing to evolve our telesales organization, advancing our digital technology leadership, and strengthening and expanding health insurance carrier partnerships.

During the first quarter of 2025, we maintained the momentum we built during the most recent Annual Enrollment Period ("AEP"), which observed strong consumer demand driven by recent Medicare Advantage plan benefit and premium changes, plan cancellations and market exits due primarily to carriers facing higher medical costs and regulatory pressures. As a result, we delivered strong Medicare Advantage enrollment growth in Q1 2025, with 25% growth in total Medicare Advantage submissions, inclusive of our broker of record and fee-based business process outsourcing ("BPO") arrangements, compared to the same period in 2024. Submissions describe applications that are submitted by individuals online through our eHealth platform or completed with the assistance of our benefit advisors where the individual provides authorization to the benefit advisor to submit the application to the insurance carrier partner. The individual may have additional actions to take before the application will be reviewed by the insurance carrier and not all submissions ultimately become approved members. Additionally, we observed improvements in our cash flow from operations for the three months ended March 31, 2025, compared to the same period in 2024, reflecting strong cash collections from new enrollments.

During the first quarter of 2025, we invested in our post-enrollment retention strategy and nearly doubled the size of our retention and customer service team. Despite this investment, Medicare unit margins experienced meaningful expansion in Q1 2025, compared to the same period in 2024. Additionally, we began piloting the

integration of artificial intelligence across several components of our telephonic enrollment platform during the second quarter of 2025.

Summary of Selected Metrics

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

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

Approved Members

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

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

	Three Months Ended March 31,		
	2025	2024	% Change
Medicare			
Medicare Advantage	82,671	65,750	26 %
Medicare Supplement	2,565	6,182	(59)%
Medicare Part D	2,642	3,575	(26)%
Total Medicare	87,878	75,507	16 %
Individual and Family	5,817	7,160	(19)%
Ancillary	16,925	13,950	21 %
Small Business	1,190	1,642	(28)%
Total Approved Members	111,810	98,259	14 %

Three Months Ended March 31, 2025 and 2024 – Total approved members grew 14% during the three months ended March 31, 2025 compared to the same period in 2024, driven by:

- 16% growth in Medicare approved members, as a result of:
  - a 26% increase in Medicare Advantage approved members due to a 21% increase in Medicare Advantage broker of record submissions primarily as a result of the continued increase in consumer demand due to recent market disruptions, increased variable marketing spend and an increased number of benefit advisors with improved telesales conversion rates year-over-year,
  - partially offset by a 59% and 26% decline in Medicare Supplement and Medicare Part D approved members, respectively, primarily caused by the shift of some Medicare Supplement

broker of record arrangements to fee-based arrangements within our Amplify platform and a shift away from standalone Medicare Part D plans.

- 21% growth in ancillary approved members primarily due to a targeted increase in hospital indemnity plan members and an increase in vision plan approved members, partially offset by declines in dental and short-term approved members;
- a 19% and 28% decline in individual and family plan and small business health insurance plan approved members, respectively, primarily due to a decrease in volume as we continued to focus on implementing operational enhancements in our E&I segment.

Estimated Constrained Lifetime Value of Commissions Per Approved Member

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

	Three Months Ended March 31,		
	2025	2024	% Change
Medicare [1] [2]			
Medicare Advantage	$ 907	$ 952	(5)%
Medicare Supplement	1,256	957	31 %
Medicare Part D	167	237	(30)%
Individual and Family [1]			
Non-Qualified Health Plans	386	385	— %
Qualified Health Plans	415	402	3 %
Ancillary [1]			
Short-term	118	184	(36)%
Dental	134	124	8 %
Vision	88	84	5 %
Small Business [1]	249	215	16 %

[1] Constrained LTV of commissions per approved member for Medicare, individual and family and ancillary plans represents commissions estimated to be collected over the estimated life of an approved member's plan after applying constraints in accordance with our revenue recognition policy. Constrained LTV of commissions per approved member for small business 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, cancellations of insurance plans offered by health insurance carriers with which we have a relationship and applied constraints. The constraints are applied to help ensure that commissions estimated to be collected over the estimated life of 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. These factors may result in varying values from period to period. For additional information on constrained LTV, see "*Critical Accounting Estimates*" in our Annual Report on Form 10-K for the year ended December 31, 2024.

[2] The constraints applied to the total estimated lifetime value of commissions we expect to receive for selling the plan after the carrier approves an application in order to derive the constrained LTV of commissions for approved members recognized for Medicare Advantage, Medicare Supplement and Medicare Part D were 5.5%, 9% and 7%, respectively, for the three months ended March 31, 2025 and 7%, 9% and 7%, respectively, for the three months ended March 31, 2024.

Three Months Ended March 31, 2025 and 2024 – The changes in constrained LTV of commissions per approved member primarily consisted of:

- a 5% decrease in Medicare Advantage plans, reflecting less favorable retention assumptions for the Q1 2025 cohorts compared to Q1 2024 cohorts, partly offset by lower constraint due to a decline in volatility and observed LTV trends;
- a 31% increase in Medicare Supplement plans, primarily due to favorable carrier and contract mix and favorable retention assumptions for the Q1 2025 cohorts compared to Q1 2024 cohorts;

- a 30% decrease in Medicare Part D plans, primarily driven by unfavorable carrier and contract mix, partially offset by improved retention assumptions for the Q1 2025 cohorts compared to Q1 2024 cohorts;
- a 3% increase in qualified health plans, primarily due to improved enrollment quality;
- a 36% decrease in short-term plans, primarily driven by unfavorable retention assumptions year-over-year as a result of the regulatory change that decreased term limits for short-term health plans; and
- an 8%, 5% and 16% increase in dental, vision and small business plans, respectively, primarily driven by favorable carrier and contract mix.

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 as well as the number of approved members during the period of estimation from whom we expect to receive commission payments. There is generally up to a few months lag between newly approved plans and the receipt of commission payments from the health insurance carrier and is most pronounced in the fourth and first quarters of our fiscal year due to the annual and open enrollment periods. A member who purchases and is active on multiple standalone insurance plans will be counted as a member more than once. For example, a member who is active on both an individual and family health insurance plan and a standalone dental plan will be counted as two continuing members.

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

After we have estimated membership as of a specified date, we may receive information from health insurance carriers that would have impacted the estimate if we had received the information prior to the date of estimation. We may receive commission payments or other information that indicates that a member who was not included in our estimates for a prior period was in fact an active member at that time, or that a member who was included in our estimates was in fact not an active member of ours. For instance, we reconcile information carriers provide to us and may determine that we were not historically paid commissions owed to us, which would cause us to have underestimated membership. Conversely, carriers may require us to return commission payments paid in a prior period due to policy cancellations for members we previously estimated as being active. We do not update our estimated membership numbers reported in previous periods. Instead, we reflect updated information regarding our historical membership in the membership estimate for the current period. If we experience a significant variance in historical membership as compared to our initial estimates, while we keep the prior period data consistent with previously reported amounts, we may provide the updated information in other communications or disclosures. As a result of the delay in our receipt of information from insurance carriers, actual trends in our membership are most discernible over periods longer than from one quarter to the next, making it 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.

The following table shows estimated membership by product as of the dates presented below:

	As of March 31,		
	2025	2024	% Change
Medicare [1]			
Medicare Advantage	601,431	594,457	1 %
Medicare Supplement	90,917	92,799	(2)%
Medicare Part D	180,076	187,534	(4)%
Total Medicare	872,424	874,790	— %
Individual and Family [1]	69,652	80,928	(14)%
Ancillary [1]	175,270	179,224	(2)%
Small Business [2]	41,317	45,084	(8)%
Total Estimated Membership	1,158,663	1,180,026	(2)%

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

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

March 31, 2025 compared to March 31, 2024 – Total estimated membership declined 2% as of March 31, 2025 compared to March 31, 2024 due to:

- a 14%, 2% and 8% decline year-over-year in individual and family plan, ancillary plan and small business plan estimated membership, respectively, primarily due to a decrease in approved applications as we focus on implementing operational enhancements in our E&I segment;
- Medicare estimated membership remained flat year-over-year primarily due to:
  - a 1% increase in Medicare Advantage estimated membership as a result of increased approved applications,
  - partially offset by a 2% and 4% decrease in Medicare Supplement and Medicare Part D plans, respectively, as a result of decreased approved applications due to the shift of some broker of record arrangements to fee-based arrangements within our Amplify platform, which are not included in estimated membership, as well as a decline in Medicare Part D plan approved applications due to the shift away from standalone Medicare Part D plans.

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. We calculate and evaluate the customer care and enrollment ("CC&E") cost per approved member and the variable marketing cost per approved member. We incur CC&E expenses in assisting applicants during the enrollment process. Variable marketing costs represent costs incurred in member acquisition from our direct marketing and marketing partner channels. Variable marketing costs exclude fixed overhead costs, such as personnel related costs, consulting expenses and other operating costs allocated to the marketing and advertising department.

The numerator used to calculate each member acquisition metric discussed above is the portion of the respective operating expenses for CC&E and marketing and advertising 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 plans (collectively, "IFP Plans"), respectively, for which we are the broker of record. 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 approved members, and for IFP Plans, we call this derived metric IFP-equivalent approved members. The calculations for MA-equivalent approved members and for IFP-equivalent approved members are based on the weighted number of approved members for Medicare Plans and IFP Plans during the period, with the number of approved members adjusted based on the relative LTV of the product they are purchasing. Since the LTV for any product fluctuates from period to period, the weight given to each product was determined based on their relative LTVs at the time of our adoption of Accounting Standards Codification ("ASC") 606, *Revenue from Contracts with Customers*.

The following table shows the CC&E cost per approved member and the variable marketing cost per approved member for the periods presented:

	Three Months Ended March 31,		
	2025	2024	% Change
Medicare			
CC&E cost per MA-equivalent approved member [1]	$ 361	$ 419	(14)%
Variable marketing cost per MA-equivalent approved member [1]	393	415	(5)%
Total acquisition cost per MA-equivalent approved member	$ 754	$ 834	(10)%
Individual and Family Plan			
CC&E cost per IFP-equivalent approved member [2]	$ 189	$ 161	17 %
Variable marketing cost per IFP-equivalent approved member [2]	119	58	105 %
Total acquisition cost per IFP-equivalent approved member	$ 308	$ 219	41 %

[1] We calculate the number of MA-equivalent approved 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 periods presented.

[2] We calculate the number of IFP-equivalent approved 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 periods presented.

Medicare

Three Months Ended March 31, 2025 and 2024 – Total acquisition cost per MA-equivalent approved member decreased $80, or 10%, during the three months ended March 31, 2025 compared to the same period in 2024, driven by:

- a $58, or 14%, decrease in CC&E cost per MA-equivalent approved member due to:
  - efficiencies resulting from a benefit advisor mix that is more tenured when compared to the same period in 2024 as well as the increased use of screeners to answer calls from beneficiaries, and
  - continued optimization of our sales force operations driven by enhanced training protocols and new agent-facing sales tools.
- a $22, or 5%, decrease in variable marketing cost per MA-equivalent approved member, primarily due to continued marketing efficiencies as our brand continues to scale, enabling improvement in our marketing channel mix.

Individual and Family

Three Months Ended March 31, 2025 and 2024 – Total acquisition cost per IFP-equivalent approved member increased $89, or 41%, during the three months ended March 31, 2025 compared to the same period in 2024, driven by:

- a $28, or 17%, increase in CC&E cost per IFP-equivalent approved member due to the overall decline in individual and family plan and short-term plan approved members; and
- a $61, or 105%, increase in variable marketing cost per IFP-equivalent approved member, primarily driven by an increase in marketing spend as we pursue growth in the E&I segment as well as the decline in individual and family plan and short-term plan approved members.

Critical Accounting Policies and Estimates

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

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

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

There have been no changes to our critical accounting policies and estimates described in our Annual Report on Form 10-K for the year ended December 31, 2024, filed with the Securities and Exchange Commission on February 27, 2025, that have had a significant impact on our condensed consolidated financial statements and related notes. Please refer to *Management's Discussion and Analysis of Financial Condition and Results of*

Operations contained in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2024, for a complete discussion of our other critical accounting policies and estimates.

Results of Operations

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

	Three Months Ended March 31,			
	2025		2024	
Revenue				
Commission	$ 98,946	87 %	$ 80,927	87 %
Other	14,173	13 %	12,037	13 %
Total revenue	113,119	100 %	92,964	100 %
Operating costs and expenses [1]				
Marketing and advertising	41,189	36 %	38,737	42 %
Customer care and enrollment	37,221	33 %	32,901	35 %
Technology and content	12,601	11 %	13,305	14 %
General and administrative	17,310	15 %	19,619	21 %
Impairment, restructuring and other charges	—	— %	6,313	7 %
Total operating costs and expenses	108,321	96 %	110,875	119 %
Income (loss) from operations	4,798	4 %	(17,911)	(19)%
Interest expense	(2,648)	(2)%	(2,809)	(3)%
Other income, net	1,576	1 %	2,391	3 %
Income (loss) before income taxes	3,726	3 %	(18,329)	(20)%
Provision for (benefit from) income taxes	1,776	2 %	(1,345)	(1)%
Net income (loss)	$ 1,950	2 %	$ (16,984)	(18)%

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

	Three Months Ended March 31,	
	2025	2024
Marketing and advertising	$ 497	$ 644
Customer care and enrollment	264	524
Technology and content	688	974
General and administrative	2,340	3,398
Total stock-based compensation expense	$ 3,789	$ 5,540

Revenue

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

	Three Months Ended March 31,		Change	
	2025	2024	$	%
Commission	$ 98,946	$ 80,927	$ 18,019	22 %
% of total revenue	87 %	87 %		
Other	14,173	12,037	2,136	18 %
% of total revenue	13 %	13 %		
Total revenue	$ 113,119	$ 92,964	$ 20,155	22 %

Three Months Ended March 31, 2025 and 2024 – Commission revenue increased $18.0 million, or 22%, during the three months ended March 31, 2025 compared to the same period in 2024 due to:

- a $19.0 million, or 27%, increase in commission revenue from our Medicare segment driven by:
  - a 16% increase in overall Medicare plan approved members, specifically driven by 26% growth in Medicare Advantage approved members, and
  - net adjustment revenue from prior periods of $8.0 million during the three months ended March 31, 2025 compared to $1.0 million in the same period in 2024.
- a $0.9 million, or 9%, decrease in commission revenue from our E&I segment driven by:
  - a 19% and 28% decline in individual and family plan and small business plan approved members, respectively,
  - partially offset by higher net adjustment revenue from prior periods enrollments, which was $2.5 million during the three months ended March 31, 2025 compared to $1.5 million in the same period in 2024 along with improved constrained LTV of commissions per approved member for most products in our E&I segment.

Other revenue increased $2.1 million, or 18%, during the three months ended March 31, 2025 compared to the same period in 2024 due to a $4.2 million increase in fee-based revenue driven by the expansion of our fee-based BPO arrangements, partially offset by a $2.0 million decline in sponsorship and advertising revenue.

See *Summary of Selected Metrics* above and *Segment Information* below for further discussion.

Marketing and Advertising

Marketing and advertising expenses consist primarily of member acquisition expenses associated with our direct marketing and marketing partner 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. Marketing and advertising expenses also include cost of revenue, which 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. We recognize direct marketing expenses in our direct marketing acquisition channel in the period in which they are incurred, including in the period in which the consumer clicks on the advertisement for direct online channels. 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 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. Advertising costs for our marketing partner channels are expensed as incurred. Increases in submitted applications resulting from marketing partner referrals or visitors to our website from our direct marketing channel have in the past, and could in the future, result in marketing and advertising expenses being significantly higher than our expectations.

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

	Three Months Ended March 31,		Change	
	2025	2024	$	%
Marketing and advertising	$ 41,189	$ 38,737	$ 2,452	6 %
% of total revenue	36 %	42 %		

Three Months Ended March 31, 2025 and 2024 – Marketing and advertising expenses increased $2.5 million, or 6%, during the three months ended March 31, 2025 compared to the same period in 2024, primarily driven by a $3.9 million increase in variable advertising costs, partly offset by a $1.0 million decrease in fixed marketing costs. The increase in variable advertising costs was due to an increased investment in our direct marketing channels and an increase in affiliate partner channels.

Customer Care and Enrollment

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

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

	Three Months Ended March 31,		Change	
	2025	2024	$	%
Customer care and enrollment	$ 37,221	$ 32,901	$ 4,320	13 %
% of total revenue	33 %	35 %		

Three Months Ended March 31, 2025 and 2024 – Customer care and enrollment expenses increased $4.3 million, or 13%, during the three months ended March 31, 2025 compared to the same period in 2024. This increase was primarily due to a $5.8 million increase in personnel and compensation costs associated with a higher number of screeners, licensed benefit advisors and retention advisors, partially offset by a $1.3 million decrease in other operating expenses due to lower consulting and licensing costs.

Technology and Content

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

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

	Three Months Ended March 31,		Change	
	2025	2024	$	%
Technology and content	$ 12,601	$ 13,305	$ (704)	(5)%
% of total revenue	11 %	14 %		

Three Months Ended March 31, 2025 and 2024 – Technology and content expenses decreased $0.7 million, or 5%, during the three months ended March 31, 2025 compared to the same period in 2024, primarily driven by a $0.4 million decrease in amortization of internally developed software, a $0.3 million decrease in personnel and compensation costs and a $0.3 million decrease in stock-based compensation expense, partly offset by an increase of $0.4 million in other operating costs, particularly consulting expenses.

General and Administrative

General and administrative expenses include compensation and benefits costs for personnel working in our executive, finance, investor relations, government affairs, legal, compliance, human resources, facilities and internal information technology departments. These expenses also include fees paid for outside professional services, including audit, tax, legal, government affairs and information technology fees.

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

	Three Months Ended March 31,		Change	
	2025	2024	$	%
General and administrative	$ 17,310	$ 19,619	$ (2,309)	(12)%
% of total revenue	15 %	21 %		

Three Months Ended March 31, 2025 and 2024 – General and administrative expenses decreased $2.3 million, or 12%, during the three months ended March 31, 2025 compared to the same period in 2024, primarily driven by a $1.1 million decrease in professional fees and a $1.1 million decrease in stock-based compensation expense.

Impairment, Restructuring and Other Charges

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

	Three Months Ended March 31,		Change	
	2025	2024	$	%
Impairment, restructuring and other charges	$ —	$ 6,313	$ (6,313)	(100)%
% of total revenue	— %	7 %		

Three Months Ended March 31, 2025 and 2024 – We incurred no impairment, restructuring and other charges for the three months ended March 31, 2025 compared to $6.3 million of impairment, restructuring and other charges for the same period in 2024. These charges in 2024 consisted of $5.5 million of impairment related to several of our leased office spaces, which comprised of $5.1 million of operating lease right-of-use asset impairments and $0.4 million of property and equipment impairments. We also incurred $0.8 million of restructuring charges which were primarily related to employee termination benefits as a result of our cost-reduction efforts during the first quarter of fiscal 2024.

Interest Expense

Interest expense primarily consists of interest expense and amortization of debt issuance costs related to our Credit Agreement. See *Note 12 – Debt* in our *Notes to Condensed Consolidated Financial Statements* for additional information. Our interest expense is summarized as follows (dollars in thousands):

	Three Months Ended March 31,		Change	
	2025	2024	$	%
Interest expense	$ (2,648)	$ (2,809)	$ 161	6 %
% of total revenue	(2)%	(3)%		

Three Months Ended March 31, 2025 and 2024 – Interest expense decreased by $0.2 million, or 6%, during the three months ended March 31, 2025 compared to the same period in 2024, primarily driven by lower interest rates.

Other Income, Net

Other income, net, primarily consisted of interest income and margin earned on commissions received from Medicare plan members transferred to us in 2010 through 2012 by a broker partner.

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

	Three Months Ended March 31,		Change	
	2025	2024	$	%
Other income, net	$ 1,576	$ 2,391	$ (815)	(34)%
% of total revenue	1 %	3 %		

Three Months Ended March 31, 2025 and 2024 – Other income, net, was $1.6 million during the three months ended March 31, 2025, compared to $2.4 million during the three months ended March 31, 2024. The change was primarily due to a $0.8 million decrease in interest income as a result of less favorable short-term investment returns and a decline in average short-term investment balances during the three months ended March 31, 2025.

Provision for (Benefit from) Income Taxes

Our provision for (benefit from) income taxes is summarized as follows (dollars in thousands):

	Three Months Ended March 31,		Change	
	2025	2024	$	%
Provision for (benefit from) income taxes	$ 1,776	$ (1,345)	$ 3,121	(232)%
Effective tax rate	47.7 %	7.3 %		

Three Months Ended March 31, 2025 and 2024 – Our effective tax rate of 47.7% for the three months ended March 31, 2025 was higher than our 7.3% effective tax rate for the three months ended March 31, 2024 primarily due to fluctuations in stock-based compensation adjustments, research and developments credits and state taxes. Our effective tax rate for the three months ended March 31, 2025 was higher than the statutory federal tax rate due primarily to state taxes, nondeductible stock-based compensation, lobbying expenses and prior year discrete adjustments, partially offset by research and development credits.

Segment Information

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 in the annual budget and forecasting process along with evaluation of actual performance. Our CODM considers budget-to-actual variances on a monthly basis for our segment performance measures when making decisions about allocating capital and personnel to our segments. These performance measures include total segment revenue and segment gross profit (loss). Prior to the fourth quarter of 2024, we reported our measure of segment profitability as segment profit (loss). Accordingly, prior period amounts have been reclassified to conform to the current period presentation, in all material respects.

Our business structure is comprised of two operating segments:

- Medicare; and
- Employer and Individual.

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

The Medicare segment consists primarily of commissions earned as the broker of record 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 beneficiaries, including but not limited to, dental and vision insurance and hospital indemnity plans. Our commissions may include certain bonus payments, which are generally based on attaining predetermined target sales levels or other objectives, as determined by the health insurance carriers. The Medicare segment also consists of amounts earned in connection with our advertising program that allows Medicare-related carriers to purchase advertising on a separate website developed, hosted and maintained by us or pursuant to which we perform other services as marketing and our delivery and sale to third parties of Medicare-related health insurance leads generated by our ecommerce platforms and our marketing activities. The Medicare segment also generates revenue from our fee-based BPO services where we are not the broker of record and cash is collected in advance or in close proximity to when revenue is recognized.

The E&I segment consists primarily of commissions earned from our sale of individual and family plans, including qualified and non-qualified plans, small business health insurance plans and ancillary products sold to our non-Medicare-eligible consumers, including but not limited to, dental, vision and short-term insurance. To a lesser extent, the E&I segment includes amounts earned from our online sponsorship program that allows carriers to purchase advertising space in specific markets on our website as well as our technology licensing activities.

Segment gross profit (loss) is calculated as total revenue for the applicable segment less variable marketing and advertising expenses, segment CC&E expenses and cost of revenue for the applicable segment. Variable marketing and advertising expenses represent costs incurred in member acquisition from our direct marketing and marketing partner channels and exclude fixed overhead costs, such as personnel related costs, consulting expenses and other operating costs allocated to the marketing and advertising department. Segment CC&E expenses include expenses we incur in assisting applicants during the enrollment process and exclude operating costs allocated to the CC&E department.

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

	Three Months Ended March 31,		
	2025	2024	% Change
Medicare:			
Total revenue	$ 103,669	$ 82,388	26 %
Variable marketing and advertising	(33,753)	(30,248)	(12)%
Medicare CC&E	(34,469)	(29,949)	(15)%
Cost of revenue	300	(143)	310 %
Medicare segment gross profit	$ 35,747	$ 22,048	62 %

	Three Months Ended March 31,		
	2025	2024	% Change
Employer and Individual:			
Total revenue	$ 9,450	$ 10,576	(11)%
Variable marketing and advertising	(1,190)	(776)	(53)%
E&I CC&E	(2,180)	(2,277)	4 %
Cost of revenue	(92)	(118)	22 %
E&I segment gross profit	$ 5,988	$ 7,405	(19)%

	Three Months Ended March 31,		
	2025	2024	% Change
Consolidated:			
Total revenue	$ 113,119	$ 92,964	22 %
Variable marketing and advertising	(34,943)	(31,024)	(13)%
Segment CC&E	(36,649)	(32,226)	(14)%
Cost of revenue	208	(261)	180 %
Total segment gross profit	$ 41,735	$ 29,453	42 %

A reconciliation of our segment gross profit to the Condensed Consolidated Statements of Comprehensive Income (Loss) for the periods presented is as follows (in thousands):

	Three Months Ended March 31,	
	2025	2024
Total segment gross profit	$ 41,735	$ 29,453
Other marketing and advertising [1]	(6,454)	(7,452)
Other CC&E [2]	(572)	(675)
Technology and content	(12,601)	(13,305)
General and administrative	(17,310)	(19,619)
Impairment, restructuring and other charges	—	(6,313)
Interest expense	(2,648)	(2,809)
Other income, net	1,576	2,391
Income (loss) before income taxes	$ 3,726	$ (18,329)

(1) Other marketing and advertising costs consist of fixed marketing and advertising, previously capitalized labor, depreciation and share-based compensation costs.

(2) Other CC&E costs consist of previously capitalized labor, depreciation and share-based compensation costs.

Medicare Segment

Three Months Ended March 31, 2025 and 2024 – Revenue from our Medicare segment increased $21.3 million, or 26%, during the three months ended March 31, 2025 compared to the same period in 2024, primarily driven by:

- a $19.0 million increase in Medicare segment commission revenue due to:
  - a $13.0 million increase in Medicare Advantage plan commission revenue, driven by 26% growth in Medicare Advantage plan approved members, and
  - higher net adjustment revenue which was $8.0 million for the three months ended March 31, 2025 compared to $1.0 million for the three months ended March 31, 2024.
- a $2.3 million increase in Medicare segment other revenue driven by a $4.2 million increase from growth in our fee-based BPO arrangements, partially offset by a $2.0 million decline in sponsorship and advertising revenue.

Our Medicare segment gross profit was $35.7 million for the three months ended March 31, 2025, an increase of $13.7 million or 62%, compared to the same period in 2024 primarily driven by:

- a $21.3 million increase in Medicare segment revenue,
- partially offset by increases of $3.5 million in variable marketing and advertising expenses and $4.5 million in segment CC&E expenses primarily due to the continued execution of our initiatives to attract and retain beneficiaries, including having a larger group of screeners and benefit advisors compared to 2024.

Employer and Individual Segment

Three Months Ended March 31, 2025 and 2024 – Revenue from our E&I segment decreased $1.1 million, or 11%, during the three months ended March 31, 2025 compared to the same period in 2024, primarily driven by a $0.9 million decrease in commission revenue as a result of:

- a 19% and 28% decline in individual and family plan and small business plan approved members, respectively, compared to the same period in 2024;
- partially offset by higher net adjustment revenue year-over-year, which was $2.5 million for the three months ended March 31, 2025 compared to $1.5 million in three months ended March 31, 2024;

Our E&I segment gross profit was $6.0 million for the three months ended March 31, 2025, a decrease of $1.4 million, or 19%, compared to the same period in 2024 primarily driven by:

- a $1.1 million decrease in E&I segment revenue; and
- an increase of $0.4 million in variable marketing and advertising expenses mostly due to investments in our operational enhancements for our E&I segment that are underway.

Liquidity and Capital Resources

As of March 31, 2025, we had cash, cash equivalents and short-term marketable securities of $155.6 million. During the three months ended March 31, 2025, we generated operating cash flow of $77.1 million as summarized below. We have historically financed our operations primarily through cash generated from our operations, equity issuances and debt financing. Our principal uses of cash in recent periods have been funding working capital, purchases of short-term investments, the satisfaction of tax withholding obligations in connection with the settlement of restricted stock units, making payments on our operating lease obligations and service and licensing obligations, and complying with our debt servicing requirements and preferred stock dividend payment obligations.

Cash and Cash Equivalents

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

	March 31, 2025	December 31, 2024
Cash and cash equivalents	$ 121,092	$ 39,197
Short-term marketable securities	34,495	43,043
Total cash, cash equivalents and short-term marketable securities	$ 155,587	$ 82,240

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, commercial paper and government securities. We also maintained $3.1 million in restricted cash as of March 31, 2025 and December 31, 2024.

Material Cash Requirements

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

Short-term obligations were $8.4 million for leases and $7.6 million for service and licensing as of March 31, 2025. Long-term obligations were $21.3 million for leases and $2.9 million for service and licensing as of March 31, 2025. We expect to fund these obligations through our existing cash and cash equivalents and cash generated from operations.

Convertible Preferred Stock

Pursuant to an investment agreement dated February 17, 2021 with Echelon Health SPV, LP ("H.I.G.") (the "H.I.G. Investment Agreement"), we issued and sold 2,250,000 shares of Series A convertible preferred stock ("Series A Preferred Stock") at an aggregate purchase price of $225.0 million to H.I.G. in a private placement and received $214.0 million net proceeds on April 30, 2021. As of March 31, 2025, we have accrued $1.4 million for cash dividends. The H.I.G. Investment Agreement also provides certain redemption rights on or after April 2027. In addition, the Company is required to maintain an Asset Coverage Ratio (as defined in the H.I.G. Investment Agreement) of at least 2.5x (the "Minimum Asset Coverage Ratio") and a Minimum Liquidity Amount (as defined in the H.I.G. Investment Agreement). Failure to maintain the Minimum Asset Coverage Ratio or the Minimum Liquidity Amount as of the date or the time period required by the H.I.G. Investment Agreement, for as long as H.I.G. continues to own at least 30% of the Series A Preferred Stock originally issued to it in the private placement, entitles H.I.G., subject to the conditions and restrictions specified therein, to additional rights including the right to nominate one additional member to the Company's Board of Directors, the right to approve the Company's annual budget, the right to approve hiring or termination of certain key executives and the right to approve the incurrence of certain indebtedness. See *Note 6 — Convertible Preferred Stock* in our *Notes to Condensed Consolidated Financial Statements* included in this Quarterly Report on Form 10-Q for more information.

As of September 30, 2023, we failed to maintain the Minimum Asset Coverage Ratio, which entitles H.I.G. to the additional rights set forth above. On March 13, 2024, the Nominating and Corporate Governance Committee of our Board of Directors approved the appointment of a board observer designated by H.I.G. As of November 30, 2024, we were no longer in compliance with the Minimum Liquidity Amount. The non-compliance with the Minimum Asset Coverage Ratio or the Minimum Liquidity Amount does not entitle H.I.G. to accelerate the redemption of the Series A Preferred Stock nor is it expected to materially impact our ability to generate and obtain adequate amounts of cash to meet our short-term or long-term requirements.

Term Loan Credit Agreement

On February 28, 2022, we entered into a term loan credit agreement providing for a $70.0 million secured term loan credit facility with Blue Torch Finance LLC, as administrative agent and collateral agent, and other lenders party thereto (the "Original Credit Agreement), which agreement was subsequently amended on August 16, 2022 (the "First Amendment") to update our borrowing benchmark from LIBOR to SOFR (as amended by the First Amendment, the "First Amended Credit Agreement"). On November 1, 2024, we entered into a second amendment (the "Second Amendment") to the First Amended Credit Agreement (as amended by the Second Amendment, the "Credit Agreement") which extends the maturity date of the Credit Agreement from February 2025 to February 2026 and, among other things, reduces the overall interest rate of the term loan beginning on the effective date of the Second Amendment. The outstanding obligations under the Credit Agreement are payable in full on the maturity date. As part of the Credit Agreement, we incur a $0.3 million fee per annum, payable annually. The loans under the Credit Agreement bear interest, at our option, at either a rate based on the Adjusted Term SOFR or a base rate, in each case plus a margin. The base rate is the highest of the prime rate, the federal funds rate plus 0.50% and the three-month Adjusted Term SOFR plus 1.00%. The Second Amendment reduced the margin from 7.50% to 7.00% for Adjusted Term SOFR loans and from 6.50% to 6.00% for base rate loans. As of March 31, 2025, the interest rate was 11.57%. For the three months ended March 31, 2025 and 2024 we incurred interest expense of $2.0 million and $2.3 million, respectively. As of March 31, 2025, the carrying value of the loan under the Credit Agreement was $68.8 million and we were in compliance with our loan covenants. See *Note 12 – Debt* in our *Notes to Condensed Consolidated Financial Statements* included in this Quarterly Report on Form 10-Q for additional information regarding the Credit Agreement.

Availability and Use of Cash

We believe our current cash, cash equivalents and short-term marketable securities, including the proceeds from the equity financing we obtained on April 30, 2021 under the H.I.G. Investment Agreement and the term loan we obtained on February 28, 2022 under the Credit Agreement, and expected cash collections will be sufficient to fund our operations for at least 12 months after the filing date of this Quarterly Report on Form 10-Q, including to refinance or select other alternative arrangements based on market conditions for our term loan under our Credit Agreement that matures in February 2026.

Our future capital requirements will depend on many factors, including our enrollment volume, membership, retention rates, telesales conversion rates, and our level of investment in technology and content, marketing and advertising, customer care and enrollment and other initiatives. In addition, our cash position could be impacted by the level of investments we make to pursue our strategy. To the extent that available funds are insufficient to fund our future activities or to execute our financial strategy, we may raise additional capital through bank debt, or public or private capital financing to the extent such funding sources are available. In the event that additional financing is required from outside sources, we may not be able to raise it on terms acceptable to us or at all.

Cash Activities

Our cash flows for the three months ended March 31, 2025 and 2024 are summarized as follows (in thousands):

	Three Months Ended March 31,	
	2025	**2024**
Net cash provided by operating activities	$ 77,121	$ 70,761
Net cash provided by (used in) investing activities	5,472	(10,287)
Net cash used in financing activities	(699)	(1,259)

Operating Activities

Net cash provided by operating activities primarily consists of net income (loss), adjusted for certain non-cash items, including, deferred income taxes, stock-based compensation expense, depreciation and amortization, amortization of 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 significant health insurance carrier within a quarter, our operating cash flows for that quarter could be adversely impacted.

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 and generally paid as incurred. As a result, the net cash flow resulting from approved applications is generally negative in the period of revenue recognition and 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 and could adversely impact our operating cash flows.

Our fee-based BPO arrangements generate fee-based revenue, which is recorded in other revenue, and cash is collected in advance or in close proximity to when revenue is recognized.

Three Months Ended March 31, 2025 – Net cash provided by operating activities was $77.1 million during the three months ended March 31, 2025 driven by changes in net operating assets and liabilities of $66.2 million, adjustments for non-cash items of $8.9 million and net income of $2.0 million. Cash provided by changes in net

operating assets and liabilities during the three months ended March 31, 2025 primarily consisted of decreases of $77.0 million in contract assets – commissions receivable and $13.4 million in accounts receivable, partially offset by decreases of $16.0 million in accounts payable and $7.5 million in accrued marketing expenses. Adjustments for non-cash items primarily consisted of $3.8 million of stock-based compensation expense, $3.5 million of amortization of internally developed software and a $1.5 million increase due to the change in deferred income taxes.

Three Months Ended March 31, 2024 – Net cash provided by operating activities was $70.8 million during the three months ended March 31, 2024, primarily driven by changes in net operating assets and liabilities of $73.8 million and adjustments for non-cash items of $14.0 million, partially offset by a net loss of $17.0 million. Cash provided by changes in net operating assets and liabilities during the three months ended March 31, 2024 primarily consisted of decreases of $73.1 million in contract assets – commissions receivable and $2.6 million in accounts receivable and an $8.1 million increase in deferred revenue, partly offset by a decrease of $10.9 million in accrued marketing expenses. Adjustments for non-cash items primarily consisted of $5.5 million of impairment charges, $5.5 million of stock-based compensation expense and $3.9 million of amortization of internally developed software, partially offset by a $1.4 million decrease due to the change in deferred income taxes.

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 advisor enrollment center operations and capitalized internal-use software.

Three Months Ended March 31, 2025 – Net cash provided by investing activities of $5.5 million for the three months ended March 31, 2025 mainly consisted of $36.3 million in proceeds from the maturities and redemptions of marketable securities, partially offset by $27.4 million used to purchase marketable securities and $3.1 million in capitalized internal-use software and website development costs.

Three Months Ended March 31, 2024 – Net cash used in investing activities of $10.3 million for the three months ended March 31, 2024 mainly consisted of $13.8 million used to purchase marketable securities and $2.3 million in capitalized internal-use software and website development costs, partially offset by $6.0 million in proceeds from the maturities and redemptions of marketable securities.

Financing Activities

Three Months Ended March 31, 2025 – Net cash used in financing activities of $0.7 million for the three months ended March 31, 2025 was due to $0.7 million in repurchases of shares to satisfy employee tax withholding obligations.

Three Months Ended March 31, 2024 – Net cash used in financing activities of $1.3 million for the three months ended March 31, 2024 was primarily due to $1.3 million in repurchases of shares to satisfy employee tax withholding obligations.

Seasonality

Open enrollment periods drive the seasonality of our business. The majority of our commission revenue is typically recognized in the fourth quarter of each calendar year under ASC 606, *Revenue from Contracts with Customers*. We have historically sold a significant portion of Medicare plans for the year in the fourth quarter during the Medicare AEP, which occurs from October 15th to December 7th, 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, we generate a significant portion of our commission revenue related to new Medicare plan-related enrollments in the fourth quarter. Additionally, our Medicare Advantage plan-related commission revenue is also elevated in the first quarter compared to the second and third quarters as a result of the Medicare Advantage open enrollment period that occurs from January 1st to March 31st, when Medicare Advantage plan enrollees may enroll in

another Medicare Advantage plan or disenroll from their Medicare Advantage plan and return to the Original Medicare program. Any changes to or additional enrollment periods may change the seasonality of our business.

The annual open enrollment period for IFP plans takes place in the fourth quarter of the calendar year, as prescribed under the federal Patient Protection and Affordable Care Act and related amendments in the Health Care and Education Reconciliation Act. As a result, we generate a significant portion of our commission revenue related to IFP plan-related enrollments in the fourth quarter. In the states where the Federally Facilitated marketplace operates as the state health insurance exchange, individuals and families generally are not able to purchase individual and family health insurance outside of the annual enrollment period, unless they qualify for a special enrollment period as a result of certain qualifying events, such as losing employer-sponsored health insurance or moving to another state. Extended open enrollment or special enrollment periods may change the seasonality of our individual and family health insurance business.

We incur a significant portion of our marketing and advertising expenses in the fourth quarter as a result of the Medicare AEP and the open enrollment period under the Affordable Care Act. We expect this seasonal trend in marketing and advertising expenses to continue in the foreseeable future.

Full-time internal benefit advisors represent the majority of our telesales capacity. We plan to maintain our internal telesales benefit advisors year-round, net of natural attrition, and expect to increase our internal benefit advisors' utilization outside of the enrollment periods by expanding our offerings of ancillary products and carrier call center outsourcing programs. We also engage seasonal advisors who are not full-time employees to support our seasonally high volume. The magnitude of new agent hiring is driven by our enrollment growth goals for that year. Our customer care and enrollment expenses are typically highest in the fourth quarter and lowest in the second quarter.

Recent Accounting Pronouncements

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

ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

As a "smaller reporting company", as defined in Rule 12b-2 of the Exchange Act, we are not required to provide the information called for by this Item.

ITEM 4. CONTROLS AND PROCEDURES

Evaluation of Our Disclosure Controls and Procedures

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

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

Changes in Internal Control over Financial Reporting

There were no changes in our internal control over financial reporting that occurred during the three months ended March 31, 2025 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Inherent Limitations on Effectiveness of Controls

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

PART II. OTHER INFORMATION

ITEM 1. LEGAL PROCEEDINGS

In the ordinary course of our business, we have received and may continue to receive inquiries from state and federal regulators relating to various matters. We have become, and may in the future become, involved in litigation in the ordinary course of our business. If we are found to have violated laws or regulations in any jurisdiction, we could be subject to various fines and penalties, including revocation of our license to sell insurance in those states, and our business, operating results and financial condition would be harmed. Revocation of any of our licenses or penalties in one jurisdiction could cause our license to be revoked or for us to face penalties in other jurisdictions. In addition, without a health insurance license in a jurisdiction, carriers would not pay us commissions for the products we sold in that jurisdiction, and we would not be able to sell new health insurance products in that jurisdiction. We could also be harmed to the extent that related publicity damages our reputation as a trusted source of objective information relating to health insurance and its affordability. It could also be costly to defend ourselves regardless of the outcome.

Our material legal proceedings are described in Part I, Item I of this Quarterly Report on Form 10-Q in our *Notes to Condensed Consolidated Financial Statements* in *Note 8 – Commitments and Contingencies.*

ITEM 1A. RISK FACTORS

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

Risks Related to Our Business

The markets in which we participate are intensely competitive. If we cannot compete effectively against current and future competitors, including government-run health insurance exchanges, our business, operating results and financial condition could suffer.

The market for selling health insurance plans is characterized by intense competition, and we face challenges associated with evolving distribution models, industry and regulatory standards, consumer price sensitivity and macro-economic conditions. To remain competitive against our current and future competitors, we need to continue to enhance the online and mobile health insurance shopping experience and functionalities of our website and advisor enrollment operations that our current and future consumers may use to purchase health insurance products from us. We also need to work with the health insurance carriers to be able to offer a variety of quality health insurance plans on our platform from which our consumers may choose. We will also need to market our services effectively and drive a substantial number of consumers interested in purchasing health insurance to our website and advisor enrollment centers during the relevant enrollment periods in a cost-effective manner.

We compete with government-run health insurance exchanges, among others, with respect to our sale of Medicare-related and employer and individual health insurance plans. 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 federal government also operates websites where individuals and small businesses can purchase health insurance, and they also have offline customer support and enrollment capabilities. Our competitors also include local insurance agents across the United States who sell health insurance plans in their communities, companies

that advertise primarily through television, and companies that operate call centers or websites that provide quote information or the opportunity to purchase health insurance telephonically or online, including lead aggregator services. Although we work with many health insurance carriers on marketing and selling their insurance plans on their behalf, many of them also compete with us by directly marketing and selling their plans to consumers through call centers, Internet advertising and their own websites. In recent years, we have also seen increased competition from national telesales insurance brokers.

Some of our current and potential competitors have longer operating histories, larger customer bases, greater brand recognition and significantly greater financial, technical, marketing and other resources than we do. As compared to us, our current and future competitors may be able to undertake more extensive marketing campaigns for their brands and services, devote more resources to website and systems development, negotiate more favorable commission rates and commission override payments and make more attractive offers to potential employees, marketing partners and third-party service providers. Competitive pressures from government-run health insurance exchanges and other competitors may result in our experiencing increased marketing costs, especially during the Medicare annual enrollment period which may harm our business, operating results and financial condition.

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

The success of our business depends upon our ability to enter into new and maintain existing relationships with health insurance carriers on favorable economic terms. Any impairment of our relationship with, or the material financial impairment of, these health insurance carriers or our inability to enter into new relationships with other health insurance carriers could adversely affect our business, operating results and financial condition.

Our contractual relationships with health insurance carriers are typically non-exclusive and terminable on short notice by either party for any reason. In many cases, health insurance carriers may also amend the terms of our agreements unilaterally, including commission rates, on short notice. Health insurance carriers may decide to reduce our commissions, rely on their own internal distribution channels to sell their own plans, determine not to sell their plans or otherwise limit or prohibit us from selling their plans. Carriers may also amend our agreements with them for a variety of reasons, including for competitive or regulatory reasons, dissatisfaction with the economics of the members that we place with them or because they do not want to be associated with our brand. In particular, the laws and regulations applicable to the business of selling Medicare-related plans are complex and frequently change. If we or our benefit advisors violate any of the requirements imposed by the U.S. Centers for Medicare & Medicaid Services (“CMS”), or applicable federal or state laws or regulations, health insurance carriers may terminate their relationship with us or require us to take corrective action if our Medicare product sales or marketing give rise to too many complaints.

The termination of our relationship with a health insurance carrier, the reduction of commission rates, or the amendment of or change in our relationship with a carrier has in the past reduced, and may in the future reduce, the variety, quality and affordability of health insurance plans we offer, cause a loss of commissions, 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. Any of these could harm our business, operating results and financial condition. Health insurance carriers may also determine to exit certain states or markets, change benefit offerings, or increase premiums to a significant degree, which could cause our members’ health insurance plans to be terminated or our members to purchase new health insurance plans 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.

We derive a significant portion of our revenue from a small number of health insurance carriers. Any impairment of our relationships with them or impairment of their businesses could adversely affect our business, operating results and financial condition.

Our revenue has been concentrated in a small number of health insurance carriers and we expect that a small number of health insurance carriers will continue to account for a significant portion of our revenue for the

foreseeable future. For example, Humana, Aetna and UnitedHealthcare accounted for 24%, 14%, and 24%, respectively, of our total revenue for the three months ended March 31, 2025, and accounted for 26%, 23%, and 15%, respectively, of our total revenue for the three months ended March 31, 2024. As discussed elsewhere in this Risk Factors section, our contractual relationships with health insurance carriers are typically non-exclusive and terminable on short notice by either party for any reason. In particular, 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 or their ability to conduct business is otherwise impaired, our business, operating results and financial condition could be harmed.

If we are unable to successfully attract and convert qualified prospects into members for whom we receive commissions, our business, operating results and financial condition would be harmed.

We derive our revenues primarily from commissions paid to us by health insurance carriers for Medicare-related health insurance and individual and family health insurance plans that have been purchased by members through our services. Our business success depends in large part on our ability to attract qualified prospects into our enrollment platform and provide a relevant and reliable experience in a cost-effective manner to convert such prospects into paying members for whom we receive commissions. We employ different marketing channels and may from time to time adjust our member acquisition strategy to attract visitors to our website and communicate with consumers who contact our advisor enrollment centers. If our ability to market and sell Medicare-related health insurance and individual and family health insurance is constrained during the Medicare or individual and family health insurance enrollment periods for any reason, such as technology failures, interruptions in the operation of our ecommerce or telephony platforms, reduced allocation of resources, delayed, reduced, or ineffective delivery of our marketing efforts, or any inability to timely employ, license, train, certify and retain our benefit advisors 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. Our business may also be adversely affected by changes in the mix of products and services that we offer on our platform, changes in the mix of consumers who are referred to us through our direct marketing, marketing partners and strategic partner marketing member acquisition channels, including the quality of sales leads, and by seasonal influences. In addition, adverse market events or economic conditions, such as changes in inflation or unemployment levels, or political events such as elections, could impact consumer behavior and demand for health insurance. If more consumers decide to delay enrollment or decrease or discontinue coverage under plans sold through us, our business, operating results and financial condition would be adversely affected.

We have taken and may take additional actions to improve the consumer experience, enhance accuracy of plan recommendations, reduce rapid disenrollment and beneficiary complaints, and improve the quality of our enrollments and conversion rates. Although we have in the past invested, and may from time to time invest, in various areas of our business, including technology and content, customer care and enrollment, and marketing and advertising to improve the quantity and quality of our membership enrollment in advance of enrollment periods, such investment may not result in a significantly improved number of approved and paying members or may not be as cost-effective as we anticipated.

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, we must meet certain conditions, such as receiving permission to do so from the applicable government health insurance exchange, entering into or maintaining an agreement with the health insurance exchange or a partner of the exchange, ensuring that the enrollment and subsidy application is completed through the health insurance exchange and complying with privacy, security and other standards. If Internet-based agents and brokers such as us use the Internet for completion of qualified health plan selection purposes, their websites may be required to meet certain additional requirements. To help manage additional expenses and regulatory burdens associated with enrolling individuals and families into qualified health plans, we rely on a third-party vendor to help comply with certain aspects of the relevant requirements, and our qualified plan enrollments are made predominantly through the Federally Facilitated Marketplace (“FFM”), which currently runs all or part of the health insurance exchange in most 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 or any similar state-based exchange. The FFM may at any time cease allowing us or our third-party vendor to enroll individuals in qualified health plans or change the requirements for doing so. Also, relevant government regulations or agencies may prevent us from efficiently working with our third-party vendor, including timely receiving and using data from our third-party vendor. In addition, we may be unsuccessful in maintaining a relationship with our third-party vendor that is approved to use the process, and 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. The number of states using the FFM may also decrease in the future, reducing our ability to enroll members through the FFM.

In addition, if we are not able to 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.

Similarly for states that use state-based exchanges instead of the FFM, we may not be able to establish or maintain stable, consumer friendly, efficient or compatible legal arrangements or technical processes to enroll members in qualified health plans through such state-based exchanges, either directly with the governmental entities running such state-based exchanges or through appropriate third parties that allow us to access such state-based exchanges.

If we are not able to satisfy the conditions and requirements for offering qualified health plans and enrolling members through the FFM or similar state-based exchanges, or if we are not able to successfully adopt and maintain solutions in a timely, efficient and cost-effective manner to respond to changing circumstances to allow us to continue to effectively enroll large numbers of members through the FFM and state-based exchanges, we could lose existing members and fail to attract new members and may incur additional expense, which would harm our business, operating results and financial condition.

Our business, operating results and financial condition will be adversely impacted if we are unable to retain our existing members.

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. Health insurance carriers may choose to discontinue their health insurance plans for a variety of reasons, and when members update their health insurance plan, they may also select a different plan that is not sold through us, or we are otherwise no longer the agent on the plan. 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.

Our ability to grow and retain our membership depends on various factors, including agent productivity and enrollment experience, the ability of carriers to offer plans that are attractive to members, the ability and propensity of enrollees to change their health plan both inside and outside of the Medicare annual enrollment period, and the source of referrals. If agent productivity, enrollment rates, and member retention rates decline, our business, operating results and financial condition could be harmed. 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. 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.

Our marketing efforts may not be successful or may become more expensive, either of which could adversely affect our business, operating results and financial condition.

We spend significant resources on our marketing efforts, which may not be successful or may become more expensive, either of which could adversely affect our business, operating results and financial condition. Any decrease in the amount or effectiveness of our marketing efforts could lead to lower revenue or growth and profitability of this business.

We have recently refreshed our brand identity and expect to continue to invest in maintaining our brand identity. We believe our brand identity will strengthen our relationships with existing, and help attract, new members, marketing partners and health insurance carriers. Some of our current and potential competitors have greater brand recognition and significantly greater financial, technical, marketing and other resources than we do, and they may try to replicate our efforts, competitively bid against our branded search terms to redirect traffic seeking our brand, or undertake more extensive marketing campaigns for their brands and services. Our brand promotion activities may not be successful in maintaining or attracting new members, marketing partners or health insurance carriers, and as a result, may not yield increased revenue. To the extent that these activities yield increased revenue, the increased revenue may not offset the expenses we incur, which could harm our business, operating results and financial condition.

It is critical to the success of our business that we reach out to consumers in our target audience through direct channels, including direct mail, television, internet search, social media and email. We rely on media platforms that can effectively reach our target audience in a cost-efficient manner, and these media venue continue to be places where our consumer audience are active and receptive to our message. We anticipate that, as our market becomes increasingly competitive, these media platforms may become increasingly expensive. Our direct channel marketing activities may not be successful or yield increased revenue, and to the extent that these activities yield increased revenue, the increased revenue may not offset the expenses we incur, and our business, operating results and financial condition could be harmed.

We depend upon Internet search engines and social media platforms to attract a significant portion of the consumers who visit our website. If we are unable to effectively advertise on search engines or social media platforms on a cost-effective basis, our business, operating results and financial condition could be harmed. We derive a significant portion of our website traffic from consumers who search for health insurance through Internet search engines, such as Google, and 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. If we are listed less prominently in, or removed altogether from, search result listings or if Internet search engines become unavailable, 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. The use of alternative marketing channels could cause us to increase our marketing expenditures, which would also increase our cost of member acquisition and harm our business, operating results and financial condition.

We depend on our marketing partners for referring potential consumers to our ecommerce platform and advisor enrollment centers. The success of our relationship with a marketing partner is dependent on a number of factors, including but not limited to the continued positive market presence, reputation and growth of the marketing partner, the effectiveness of the marketing partner in marketing our website and services, the compliance of each marketing partner with applicable laws, regulations and guidelines, the contractual terms we negotiate with our marketing partners, including the marketing fees we agree to pay, and our ability to accurately and timely track, pay and manage marketing partners. 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 other provider groups, wellness, and other digital and affinity groups. We compensate many of our marketing partners for their referrals on either a submitted health insurance application basis or a per-referral basis or, if they are licensed to sell health insurance, we may share a percentage of the commission we earn from the health insurance carrier for each member referred by the marketing partner. We also have

relationships with marketing partners that utilize aspects of our platform and tools. 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 high volume marketing partners as a result of increased competition for referrals or less commercially favorable terms.

As discussed elsewhere in this Risk Factors section, the marketing and sale of Medicare plans are subject to numerous laws, regulations and guidelines at the federal and state level. Recent changes to the CMS marketing guidelines have resulted in a more complicated and time-consuming process for marketing material filing and the need to file a significantly greater number of our and our marketing partners' marketing materials with CMS. If our marketing partners' marketing materials do not comply with the CMS marketing guidelines or other Medicare program related laws, rules and regulations, such non-compliance could result in our losing the ability to receive referrals of individuals interested in purchasing Medicare-related plans from that marketing material or being delayed in doing so. If CMS or a health insurance carrier requires changes to, disapproves or delays approval of these materials, we could lose a significant source of Medicare plan demand, and the operations of our Medicare business could be adversely affected. 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 significant.

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

We develop, host and maintain carrier-dedicated Medicare plan websites and may undertake other marketing and advertising initiatives or perform other services through our Medicare plan advertising program. We also allow health insurance carriers to purchase advertising space for non-Medicare products on our website through our sponsorship program. The success of our sponsorship and advertising program depends on a number of factors, including the amount that health insurance carriers are willing to pay for advertising services, the effectiveness of the sponsorship and advertising program as a cost-effective method for carriers to obtain additional members, consumer demand for the health insurance carrier's product, our ability to attract consumers to our ecommerce platform or our advisor enrollment centers 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. 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, increased carrier focus on the quality of enrollments and reduction in member complaints could adversely impact our ability to successfully negotiate and operate our sponsorship and advertising programs. Moreover, in light of the regulations applicable to the marketing and sale of Medicare plans, and given that these regulations are often complex, change frequently and are subject to changing interpretations or enforcement actions, we may in the future not be permitted to sell Medicare plan-related advertising services. If we are not successful in these areas or these factors are unfavorable to us, our business, operating results and financial condition could be harmed. 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.

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

Our subsidiary in China conducts a portion of our operations, including the maintenance and update of our ecommerce platform and performance of specific tasks within our finance, customer care and enrollment functions. We rely on third-party vendors to communicate with our subsidiary in China. Our business would be harmed if our ability to communicate via these vendors 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. Still, we may be required to implement further security measures to continue aspects of our operations in China. We may also be

required 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 our China operations, which would harm our business, operating results and financial condition.

Our operations in China also expose us to different 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 certain laws, rules and regulations in China and the United States, including those related to anti-bribery and anti-corruption, privacy, data transfer, data security, labor, tax, foreign exchange controls and cash repatriation. In recent years, both China the United States have adopted and proposed laws regulating these areas. Such laws, regulations and standards are complex, ambiguous and subject to change or interpretation, which create uncertainty regarding compliance and enforcement. 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, any of which could harm our business, operating results and financial condition.

Our business may be adversely impacted by changes in China's economic or political condition, the relationship between China and the United States or other countries, and our ability to continue to conduct our current operations in China. Any such changes may be caused by geopolitical issues, natural disasters, war or other events or circumstances. For example, President Trump has indicated that his administration would potentially impose greater restrictions on trade with China through significant increases in tariffs on goods imported into the United States. Any deterioration in U.S.-China relations could increase tensions and create greater uncertainty in our business dealings in China and with Chinese companies and could require us to bring aspects of our operations in China back to the United States, which could be time-consuming, expensive and disruptive.

These risks could cause us to incur increased expenses and could harm our ability to manage our operations effectively and successfully in China. Moreover, any significant or prolonged deterioration in the relationship between the United States and China could adversely affect our operations in China. Certain risks and uncertainties of doing business in China are solely within the control of the Chinese government, and Chinese law regulates the scope of our foreign investments and business conducted within China. The escalation of international tensions has increased the risk associated with our operations in China. Either the U.S. or the Chinese government may limit or sever our ability to communicate with our China operations or may take actions that force us to close our operations in China. We employ many of our technology and content employees in China, and we have other employees in China that support our business. Any disruption of our operations in China would adversely impact our business. If we are required to move aspects of our operations out of China because of political or geopolitical issues, 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.

Our business is seasonal in nature, and if we are not successful in responding to changes in the seasonality of our business, our business, operating results and financial condition could be harmed.

Due to the timing of Medicare and individual and family health plan annual enrollment periods, which may be subject to change from time to time, our financial results fluctuate and are not comparable from quarter to quarter. The Medicare annual enrollment period occurs from October 15 to December 7 each year, the individual and family health insurance open enrollment period typically occurs from November 1 through December or January 15 each year for most states, and the Medicare Advantage open enrollment period, during which Medicare-eligible individuals enrolled in a Medicare Advantage plan can switch to the Original Medicare program or switch to a different Medicare Advantage plan, runs from January 1 through March 31 of each year. As a result, we have traditionally experienced an increase in the number of submitted Medicare-related applications and approved members during the fourth quarter and, to a lesser extent, in the first quarter, and an increase in Medicare plan-related expense, including marketing and advertising expenses, during the third and fourth quarters in connection with the open enrollment periods. However, because commissions from approved consumers are paid to us over

time, our operating results, and in particular, our operating cash flows, could be adversely impacted by a substantial increase in marketing and advertising expense.

Changes in timing of the Medicare or individual and family health plan enrollment periods, adoption of new or special enrollment periods, changes in eligibility and subsidies applicable to the purchase of health insurance, and changes in the laws and regulations that govern the sale of health insurance may occur from time to time, and we may not be able to timely adjust to changes in the seasonality of our business, which could harm our business, operating results and financial condition.

Changes in our senior management or other key employees could affect our business, operating results and financial condition.

Our success is dependent upon the performance of our senior management and other key employees, as well as 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. Our executive officers and other employees can terminate their employment at any time, and the loss of these individuals could harm our business, especially if we are not successful in developing adequate succession plans. In recent years, we have appointed several new executive officers and other senior leaders across multiple functions, and we may experience additional changes in the future. For example, in 2024, we appointed a new chief revenue officer and a new chief financial officer. In addition, in August 2024, our Chief Executive Officer notified the Company of his decision to retire from his position as the Company's chief executive officer upon appointment of a successor, and we are currently engaged in a search process to identify his successor. The transition and the departure of members of our senior management or other key employees could result in additional attrition. Any significant change in leadership could be detrimental to our business, operating results and financial condition.

We also depend on a relatively small number of employees for certain key roles, and the loss of such 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 agents and each employee that acts as a writing agent does so for a number of carriers. When an employee who acts as a writing agent terminates their employment with us, we need to replace the 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 in the future, 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 could be harmed.

Our business success depends on our ability to timely recruit, train and retain qualified licensed insurance agents, or benefit advisors, and other personnel to provide superior customer service and support our strategic initiatives while also controlling our labor costs.

Our omnichannel consumer engagement platform enables consumers to discover, compare and purchase a health insurance plan using our proprietary online search engine as well as receive assistance of a licensed insurance agent, or benefit advisor, by telephone, online chat or through a hybrid online assisted interaction such as co-browsing. Our advisor enrollment center operations are critical to our success and dependent on our ability to recruit, train and effectively manage our licensed benefit advisors and other personnel who support the operation of our advisor enrollment centers. To sell Medicare-related health insurance products, our benefit advisors must be licensed by the states in which they are selling plans and certified and appointed with the health insurance carrier that offers the plans in each applicable state. We depend upon our staff, state departments of insurance, government exchanges and health insurance carriers for the licensing, certification and appointment of our benefit advisors. We may experience difficulties recruiting and retaining a sufficient number of benefit advisors and support staff during the year and especially for the Medicare annual enrollment period.

Even if we are successful in recruiting licensed benefit advisors and support staff, failure to retain, train and ensure the productivity of our benefit advisors and other individuals that operate our advisor enrollment centers could result in lower-than-expected sold plans, conversion rates and revenue, higher costs of acquisition per

member and higher plan termination rates, any of which could harm our business, operating results and financial condition. If our benefit advisors do not perform to the standards we expect of them or if we do not generate sufficient call volumes for our benefit advisors to remain productive, our sold plan volume, conversion and retention rates could be negatively impacted, and our business, operating results and financial condition would be harmed. If investments we make in our advisor enrollment center operations do not result in the returns we expected when making those investments, we could acquire fewer members, suffer a reduction in our membership, and our business, operating results and financial condition could be harmed.

Given that our business is seasonal in nature, if we are not successful in recruiting, training and retaining qualified benefit advisors and other workers, our benefit advisors or other workers do not perform to high standards or our investments in our advisor enrollment center operations do not result in expected returns, among other factors discussed in this risk factor, 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.

Our business could be harmed if we are not successful in executing on our operational and strategic plans.

Our future performance depends in large part upon our ability to execute our operational and strategic plans. Our success depends in large part on our ability to diversify our revenue and scale our business. We have in the past made, and may in the future, make, significant investments in marketing and advertising, technology and content, customer care and enrollment. Our growth strategy also involves continued investment to expand our brand awareness across all products and channels and investment in improving our member retention efforts and conversion rates while continuing to invest in our telesales organization. We may also enter into strategic transactions or partnerships aligned with our business and growth objectives.

Pursuing and investing in these initiatives may increase our expenses and our organizational complexity, divert management's attention from other business concerns and also involve risks and uncertainties described elsewhere in this Risk Factors section, including the failure of our initiatives to achieve our revenue diversification, member retention, growth or profitability targets, inadequate conversion and telesales organization improvements, failure to evolve our brand, our inability to strengthen and expand our health insurance carrier partnerships, our 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. If we are not successful in executing on our operational and strategic plans or if we do not realize the expected benefits of our investments, our business, operating results and financial condition would be harmed.

In addition, we implemented a number of transformation initiatives and programs throughout 2022 and 2023 aimed at increasing the effectiveness of our sales and marketing organizations and rationalizing our cost structure and we may initiate more such plans from time to time in the future. While these initiatives were and are expected to be intended to improve our operations, we may not successfully realize the expected benefits of any such restructuring plans or initiatives that we may undertake, due to a number of factors, including, among others, higher than anticipated costs in implementing such restructuring plans, management distraction from ongoing business activities, damage to our reputation and brand image, including negative publicity, workforce attrition beyond planned reductions and risks and uncertainties described elsewhere in this Risk Factors section. Even if we do implement and administer these plans and initiatives in the manner contemplated, our estimated cost savings resulting from them are based on several assumptions that may prove to be inaccurate and, as a result, we cannot assure you that we will realize these cost savings.

Our self-insurance programs may expose us to significant and unexpected costs and losses.

To help control our overall long-term costs associated with employee health benefits, we began maintaining a substantial portion of our U.S. employee health insurance benefits on a self-insured basis effective January 1, 2023. To limit our exposure, we have third-party stop-loss insurance coverage which sets a limit on our liability for both individual and aggregate claim costs. We record a liability for our estimated cost of U.S. claims incurred but unpaid as of each balance sheet date. Our estimated liability is based on assumptions we believe to be reasonable

under the current circumstances and will be adjusted as warranted based on changing circumstances. It is possible, however, that our actual liabilities may exceed our estimates of losses. We may also experience an unexpectedly large number of claims that result in costs or liabilities in excess of our projections, which could cause us to record additional expenses. Our self-insurance reserves could prove to be inadequate, resulting in liabilities in excess of our available insurance and self-insurance. If a successful claim is made against us and is not covered by our insurance or exceeds our policy limits, our business may be negatively and materially impacted. These fluctuations could have a material adverse effect on our business, operating results and financial condition.

Risks Related to Laws and Regulations

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

The success of our business depends upon the private sector of the U.S. health insurance system, including the Medicare program, which is subject to a changing regulatory environment at both the federal and state level. Changes and developments in the health insurance system and Medicare program in the United States could reduce demand for our services and harm our business. Ongoing health care reform efforts and measures may expand the role of government-sponsored coverage, including proposals for single payer or so called “Medicare-for-All” or other proposals that may have the effect of reducing or eliminating the market for our current range of health insurance products. This 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 or otherwise increase government oversight or competition in the sector or reduce the fees or commissions payable to brokers under the Medicare program. Alternatively, other proposals may increase the role of the private sector in health care but be implemented in ways that reduce eHealth’s role in helping consumers select and enroll in insurance plans. We are unable to predict the full impact of health care reform initiatives or other regulatory changes on our operations in light of the uncertainty of whether initiatives will be successful and the uncertainty regarding the terms and timing of any provisions enacted and the impact of any of those provisions on various healthcare and insurance industry participants. In the event that laws, regulations or rules that eliminate or reduce private sources of health insurance or Medicare are adopted, or otherwise act to reduce eHealth’s role in connecting consumers with insurance plans, the demand for our products could be adversely impacted, and our business, operating results and financial condition would be harmed.

In recent years, the Medicare sector underwent a number of changes, including a gradual shift towards market consolidation and rationalization, with greater focuses on enrollment quality, profitability and longer-term member relationships. These changes were prompted in part by regulatory changes, higher cost of care and other industry developments such as STAR’s methodology changes. For example, certain new CMS rules that were scheduled to become effective October 2024 (“CY 2025 Final Rules”) were set to reduce agent and broker payment amounts and regulate contractual terms with Medicare Advantage and Medicare Part D prescription drug plans and dual eligible special needs plans enrollments. While CMS partially reversed the CY 2025 Final Rules in response to preliminary injunction orders in third-party lawsuits, the pending litigation challenging the CY 2025 Final Rules remains ongoing, and therefore significant uncertainty remains as to how the CY 2025 Final Rules may impact our operations and our business. Each year, CMS publishes reimbursement rates for the Medicare Advantage program, and even if such rates are deemed more favorable, there remains significant uncertainty as to whether such rates would be sufficient for carriers will be able to cover margins or maintain their plan strategies to avoid further disruptions in their benefit offerings, premiums and geographic business goals and coverage.

We expect the Medicare market to remain fluid for the foreseeable future. The election of President Trump and Republican control of both houses of Congress may result in significant changes in, and have resulted in uncertainty with respect to, legislation, regulation, implementation and/or repeal of laws and rules related to government health programs, including Medicare, Medicaid and Affordable Care Act. For example, President Trump has issued various executive orders reversing several Biden administration healthcare policies, and additional executive orders may be forthcoming. Members of the U.S. House of Representatives have also began considering a series of legislative proposals targeting Medicaid, Medicare and other entitlement programs, and we expect there will be continued proposals targeting reimbursement methodologies and the number of individuals eligible for government healthcare programs. In addition, the staff of the Department of Government Efficiency (the "DOGE")

have been provided access to key payment and contracting systems at CMS in connection with DOGE's efforts to identify opportunities for improving efficiency and identifying fraud and ineffective use of government resources. While we cannot predict the actions of the DOGE, there is a possibility that changes will be made to CMS spending, which could ultimately affect our financial condition and results of operation.

The marketing and sale of health insurance plans, including Medicare plans, are subject to numerous, complex and frequently changing laws, regulations and guidelines. Non-compliance with or changes in laws, regulations and guidelines, or changes in their interpretation or the manner in which they are enforced could harm our business, operating results and financial condition.

The U.S. healthcare industry is highly regulated and subject to numerous, complex, and frequently changing laws, regulations and guidelines at the federal and state level. Compliance with these evolving laws and regulations may involve significant costs, cause significant delays in our ability to go to market with new marketing and product initiatives and strategies or require us to change our business practices, which could have an adverse impact on our business, operating results and financial condition. Non-compliance could also harm our business, operating results and financial condition. It also may result in fines, damages, prohibitions on the conduct of our business, and damage to our reputation. In particular, the marketing and sale of Medicare Advantage and Medicare Part D prescription drug plans are principally regulated by CMS but are also subject to state laws. The marketing and sale of Medicare Supplement plans are principally regulated on a state-by-state basis by state departments of insurance. The laws and regulations applicable to the marketing and sale of Medicare plans are numerous, ambiguous and complex, and change frequently, particularly with respect to regulations and guidance issued by CMS for Medicare Advantage and Medicare Part D prescription drug plans. 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 advisor enrollment center call scripts and a large portion of our marketing materials. We must receive these approvals in order to market and sell Medicare plans to Medicare-eligible individuals as an insurance agent. We are also required to file many of these materials on a regular basis with CMS. In addition, certain aspects of our Medicare plan marketing partner relationships have been in the past, and will be in the future, subjected to CMS and health insurance carrier review. CMS, state departments of insurance or health insurance carriers may decide to object to or not to approve aspects of our online platforms, sales function or marketing materials and processes and may determine that certain existing aspects of our Medicare-related business are not in compliance with legal requirements. CMS scrutinizes health insurance carriers whose Medicare plans we sell, and those health insurance carriers may be held responsible for actions that we, our agents and our partners take, including our marketing materials and actions that lead to complaints or disenrollment. Health insurance carriers are increasingly evaluating broker performance based on the quality of their enrollments, including complaints, retention rates, consumer satisfaction and volumes. As a result, health insurance carriers may terminate their relationships with us, or they may require us to take other corrective action if our Medicare product sales, marketing and operations are not in compliance or give rise to too many complaints. The termination of or change in our relationships with health insurance carriers could reduce the products we are able to offer, could result in the loss of commissions for past and future sales and could otherwise harm our business, operating results and financial condition. Changes to the laws, regulations and guidelines relating to the sale of health insurance plans and related products and services, their interpretation or the manner in which they are enforced could impact the manner in which we conduct our business, our ecommerce platforms or our sale of Medicare plans and other products, or we could be prevented from operating certain aspects of our 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 and financial condition.

Each year, CMS releases new rules relating to Medicare plans, which can have a material effect on our operations, our business, operating results and financial condition. For example, CMS has proposed new rules scheduled to become effective in late 2025 ("CY 2026 Proposed Rules") which, among other things, would increase the scope and complexity for required reviews and filing of marketing and communications, and require brokers and

agents to make additional statements or disclosures on calls that will increase the time required to assist beneficiaries and may limit the ability of eHealth to timely assist all beneficiaries. CMS subsequently announced that it is deferring taking actions on certain marketing provisions but may evaluate them for future rule making. These additional requirements, if enacted, may impact the viability of partnerships that we use for marketing efforts, may increase the chance of related litigation, and could impede or otherwise harm our business, operating results and financial condition.

In addition, each state regulates its insurance market, including by regulating the ability of insurance companies to set premiums and prohibiting brokers and agents such as eHealth from competing in certain ways, such as offering price reductions and rebates or marketing in certain ways. 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. Changes in, or enforcement of, or compliance with, these regulations could impact consumers' demand for our services or cause health insurance carriers to lower our commission rates, which could reduce our revenue. Our business, operating results and financial condition may be materially and adversely affected if we are unable to adapt to regulatory changes.

We have been and may in the future be subject to various legal proceedings, including litigation or government enforcement actions, which could adversely affect our business, operating results and financial condition.

We are, and may in the future become, involved in various legal proceedings, litigation, governmental inquiries and enforcement actions, including labor and employment-related claims, claims relating to our marketing or sale of health insurance, intellectual property claims and claims relating to our compliance with securities laws. For example, in January 2022, we received a subpoena from the U.S. Attorney's Office for the District of Massachusetts, seeking, among other things, information regarding our arrangements with insurance carriers, and on May 1, 2025, a *qui tam* action previously filed against us alleging the violation of the Federal False Claims Act in connection with our marketing activities was unsealed and the U.S. Attorney's Office for the District of Massachusetts filed a complaint intervening in part in the *qui tam* action. We may receive similar inquiries or be subject to similar enforcement actions in the future. Such inquiries, enforcement actions, litigation, and any other claims asserted against us, with or without merit, may be time-consuming, may be expensive to address and may divert management's attention and other resources. These claims also could subject us to significant liability for damages, jeopardize our licenses to operate and harm our reputation. Our insurance and indemnities may not cover all claims that have been or 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 and financial condition.

We may be unable to operate our business if we fail to maintain our health insurance licenses and otherwise comply with the numerous laws and regulations applicable to the sale of health insurance.

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 maintain health insurance licenses to do business in all 50 states and the District of Columbia, compliance with health insurance-related laws, rules and regulations is difficult and imposes significant costs on our business. Each jurisdiction's insurance department typically has the power, among other things, to:

- grant, limit, suspend and revoke licenses to transact insurance business;

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

Due to the complexity, periodic modification and differing interpretations of insurance laws and regulations, we may not have always been, and we may not always be, in compliance with them. New laws, regulations and guidelines also may not be compatible with the sale of health insurance over the Internet, with modern technologies such as artificial intelligence, or with various aspects of our platform or manner of marketing or selling health insurance plans. Failure to comply with insurance laws, regulations and guidelines or other laws and regulations applicable to our business could result in significant liability, additional department of insurance licensing requirements, required modification of our advertising and business practices, changes to our existing technology or platforms, the limitation, suspension and/or revocation of our licenses to sell health insurance, termination of our relationship with health insurance carriers and loss of commissions and/or our inability to sell health insurance plans, which would harm our business, operating results and financial condition. Moreover, an adverse regulatory action in one jurisdiction could result in penalties and adversely affect our license status, business or reputation in other jurisdictions due to the requirement that adverse regulatory actions in one jurisdiction be reported to other jurisdictions. Even if the allegations in any regulatory or other action against us are proven false, any surrounding negative publicity could harm consumer, marketing partner or health insurance carrier confidence in us, which could significantly damage our brand. In addition, as we expand our product base, we may be subject to additional laws and regulations.

Increasing regulatory focus on privacy and data security issues and expanding laws could impact our business and expose us to increased liability.

Our business is subject to emerging privacy laws being passed at the state and federal levels that create unique compliance challenges. Our services involve the collection and storage of confidential and personally identifiable information of consumers and the transmission of certain personal information to their chosen health insurance carriers and to the government. For example, we collect names, addresses, credit card and social security numbers and health information such as information regarding consumers' prescription drugs and providers. We also hold a significant amount of personal information relating to our current and former employees. As a result, we are subject to various state and federal laws and contractual requirements regarding the access, use and disclosure of personal information. Compliance with state and federal privacy-related laws, particularly state legislation such as the California Consumer Privacy Act and its recent amendments, and increasingly robust industry standard security frameworks will result in cost increases due to an increased need for privacy compliance, oversight and monitoring, and the development of new processes to effectuate and demonstrate compliance. The effects of potential non-compliance by us or third-party service providers, and enforcement actions, may result in increased costs to our business and reputational harm. The privacy and cybersecurity legislative landscape is rapidly evolving on the state and federal level. Such changes create challenges for businesses to comply with the new legal obligations in a systematic fashion. These new legal requirements may change the way we conduct our business and may harm our business, operating results and financial condition.

Any perception that our practices, products or services violate individual privacy or data protection rights may subject us to public criticism, class action lawsuits, reputational harm, or investigations or claims by regulators, industry groups or other third parties, any of which could disrupt or adversely impact our business and expose us to increased liability. If additional data privacy or data security laws are implemented, or our health insurance carrier or other partners determine to impose requirements on us relating to data privacy security, we may not be able to timely comply with such requirements or such requirements may not be compatible with our current processes.

Changing our processes could be time-consuming and expensive, and failure to timely implement required changes could result in our inability to sell health insurance plans in a particular jurisdiction or for a particular health insurance carrier or subject us to liability for non-compliance, any of which would damage our business, operating results and financial condition. Health insurance carriers that we work with may also require us to comply with additional privacy and data security standards to do business with us at all. Compliance with privacy and data security standards is regularly assessed, and we may not always be compliant with the standards. If we are not in compliance, we may not be able to accept information from consumers, and our relationship with health insurance carriers could be adversely impacted or terminated, which would harm our business, operating results and financial condition.

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, telephone and SMS text, among other channels, to market our services to potential members and as the primary means of communicating with our existing members, and some of these communications may be subject to the TCPA and other telemarketing laws, including state laws, that restrict our ability to market using the telephone or SMS text in certain respects. The laws and regulations governing the use of email, telephone calls and SMS text 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, telephone calls or SMS text messages to our members or potential members, we may not be able to communicate with them in a cost-effective manner. While we have policies in place to comply with the TCPA and other telemarketing laws, we have been in the past, and may in the future become, subject to claims that we have violated the TCPA. If we were found to have violated the TCPA, our business, operating results and financial condition could be harmed. The TCPA and other laws and regulations relating to telemarketing are also subject to periodic updates and changes in enforcement and litigation risks.

In addition to legal restrictions on the use of email, Internet service providers, email service providers and others attempt to block the transmission of unsolicited email, commonly known as “spam.” Many Internet and email service providers have relationships with organizations whose purpose is to detect and notify the Internet and email service providers of entities that the organization believes are sending unsolicited email. If an Internet or email service provider identifies email from us as “spam” as a result of reports from these organizations or otherwise, we can be placed on a restricted list that will block our email to members or potential members. Similarly, telephone carriers may block or put consumer warnings on calls or SMS text messages originating from call centers. Consumers increasingly screen their incoming emails, telephone calls and SMS text messages, including by using screening tools and warnings; therefore, our members or potential members may not reliably receive our messages, whether or not such messages constitute marketing. If we are unable to communicate effectively by email, telephone or SMS text with our members and potential members as a result of legislation, legal or regulatory actions, blockage, screening technologies or otherwise, our business, operating results and financial condition would be harmed.

Any legal liability, regulatory penalties, complaints or negative publicity related to us or our services could harm our business, operating results and financial condition.

We provide information on our website, through our advisor enrollment 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 health 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 advisor enrollment centers, in our marketing materials or otherwise is not accurate or is construed as misleading, or if we do not properly assist individuals and businesses in purchasing health insurance, members, health insurance carriers and others could attempt to hold us liable for damages or require us to take corrective actions. In addition, 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. Any of these occurrences could result in our loss of our commission revenue and harm our business, operating results and financial condition.

In the ordinary course of operating our business, we and our health insurance carrier partners have received complaints that the information we provided was not accurate or was misleading. We have received, and may in the future receive, inquiries from health insurance carriers, CMS, state departments of insurance, regulators or other legislative bodies regarding our marketing and business practices and compliance with laws and regulations. We typically respond to these inquiries by explaining how we believe we are in compliance with relevant regulations, or we may modify our practices in connection with the inquiry. For example, in 2024 we received requests from the Committee on Finance of the United States Senate seeking information about our business practices related to lead generation, marketing and enrollment in Medicare Advantage health plans. These types of inquiries and associated claims can be time-consuming and expensive to address, can divert our management's attention and other resources, can impact our relationships with health insurance carriers and can 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.

Risks Related to Finance, Accounting and Tax Matters

Our commission revenue could be negatively impacted by changes in our estimated conversion rate of an approved member to a paying member, our forecast of average plan duration or our forecast of likely commission amounts.

Our commission revenue, which is primarily comprised of commissions from health insurance carriers, is computed using the estimated LTVs of commissions that we expect to receive. We re-compute LTVs for all outstanding cohorts on a quarterly basis. As a result, the rate at which consumers visiting our ecommerce platforms and advisor enrollment 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, recession, inflation, public health crises or illnesses, consumers' ability or willingness to pay for health insurance, adverse events or perceptions affecting the U.S. or international financial systems, adverse weather conditions or natural disasters, unemployment rates, availability of unemployment benefits or proposed or enacted legislative or regulatory changes impacting our business, including health care reform;
- the quality of and changes to the consumer experience on our ecommerce platforms and/or with our advisor enrollment centers;
- regulatory requirements, including those that make the experience on our ecommerce platforms cumbersome or difficult to navigate or reduce the ability of consumers to purchase plans outside of enrollment periods;
- the variety, competitiveness, quality and affordability of the health insurance plans that we offer;
- system failures or interruptions in the operation of our ecommerce platform or advisor enrollment center operations;
- changes in the mix of consumers who are referred to us through our direct, marketing partner and strategic partner marketing member acquisition channels, including the quality of sales leads;
- health insurance carrier guidelines applicable to applications submitted by consumers, the degree to which our technology is integrated with health insurance carriers, the amount of time a carrier takes to make a decision on that application and the percentage of submitted applications approved by health insurance carriers;

- the effectiveness of our benefit advisors in assisting consumers, including the tenure of the health insurance agent; and
- our ability to enroll subsidy-eligible individuals in qualified health plans through government-run health insurance exchanges and the efficacy of the process we are required to use to do so.

Our conversion rates can be impacted by changes in the mix of consumers referred to us through our member acquisition channels and whether they interact with a more seasoned health insurance agent. We have made and may in the future, make changes to our ecommerce platforms, telephonic operations, marketing material or enrollment process in response to regulatory or health insurance carrier requirements or undertake other initiatives in an attempt to improve consumer experience, increase retention, or for other reasons. These changes have had in the past, and may have in the future, the unintended consequence of adversely impacting our conversion rates. A decline in the percentage of consumers who submit health insurance applications on our ecommerce platforms or telephonically via our advisor enrollment 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 advisor enrollment centers into members suffers, our membership may decline, which would harm our business, operating results and financial condition.

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

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

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

The forecasted average plan duration is another important factor in our estimation of constrained LTV. When a plan is canceled, or if we otherwise do not remain the agent on the policy, we no longer receive the related commission. 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 cash collection patterns to our assumptions and analyze the drivers for 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 annual 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. While we have recognized positive net adjustment revenue in the recent past, there can be no assurance that we will continue to recognize positive net adjustment revenue. 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.

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 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, when we reconcile information health insurance carriers provide to us, we 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 commissions 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 commissions due to us in a timely manner or at all, our estimates of constrained LTV may be adversely impacted, which would harm our business, operating results and financial condition. In addition, any inaccuracies in the reporting from and reconciliations with insurance carriers may also impact our estimates of constrained LTV or our estimates of commission revenue for future periods which is based on historical trends, including trends relating to contracted commission rates and expected health insurance plan cancellation.

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

We depend on health insurance carriers and others for data related to our membership. For instance, with respect to health insurance plans, health insurance carriers do not directly report member cancellations to us. Other

than small business health insurance, we infer cancellations from payment data that carriers provide 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 carrier or notifying the carrier, and do not inform us of the cancellation. With respect to our small business membership, groups generally notify the carrier directly of policy cancellations and increases or decreases in group size. 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. As a result of the Medicare annual enrollment and other open enrollment periods, we may not receive information from our carriers on a timely basis due to the significant increase in health insurance transaction volume and for other reasons, which could impair the accuracy of our membership estimates. For these and other reasons, including if current trends in membership cancellation are inconsistent with past cancellation trends that we use to estimate our membership or if carriers subsequently report changes to the commission payments that they previously reported to us, our actual membership could be materially different from our estimates. 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 that we experience in receiving information about our membership, it is difficult for us to determine with any certainty the impact of current conditions on our membership retention. Various circumstances, including market-related factors such as changes in timing of enrollment periods, the ability of enrollees to change their health plan outside of the Medicare annual enrollment period, the source of referrals, their enrollment experience and other factors specific to our business, could cause the assumptions and estimates that we make in connection with estimating our membership to be inaccurate, which would cause our membership estimates to be inaccurate.

Our agreements with our lender and our convertible preferred stock investor contain restrictions that impact our business and expose us to risks that could materially adversely affect our liquidity and financial condition.

On February 28, 2022, we entered into a term loan credit agreement with Blue Torch Finance LLC, as administrative agent and collateral agent, and other lenders party thereto, which was amended on August 16, 2022 and again on November 1, 2024 (as amended, the "Credit Agreement"). The Credit Agreement provides us with $70 million in term loans.

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

our business and the indictment of us or any subsidiary (or any senior officer thereof), or criminal proceedings against the same, which could result in a forfeiture of a material portion of our and our subsidiaries properties.

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

On February 17, 2021, we entered into an investment agreement with Echelon Health SPV, LP ("H.I.G."), pursuant to which H.I.G. purchased 2.25 million shares of Series A convertible preferred stock ("Series A Preferred Stock") for an aggregate price of $225.0 million (the "H.I.G. Investment Agreement"). The H.I.G. Investment Agreement contains certain negative operating covenants that will remain in effect for so long as H.I.G. continues to own at least 30% of the shares of Series A Preferred Stock originally issued to it. The Company is required to maintain an Asset Coverage Ratio and a Minimum Liquidity Amount (in each case, as defined in the H.I.G. Investment Agreement). Failure to maintain the Minimum Asset Coverage Ratio or the Minimum Liquidity Amount as of the date or the time period required by the H.I.G. Investment Agreement, for as long as H.I.G. continues to own at least 30% of the Series A Preferred Stock originally issued to it in the private placement, entitles H.I.G., subject to conditions and restrictions specified therein, to additional rights, including the right to nominate one additional member to our Board of Directors, the right to approve our annual budget, the right to approve the hiring or termination of certain key executives and the right to approve the incurrence of certain indebtedness. We have not met the Minimum Asset Coverage Ratio since the September 30, 2023 measurement date and as of November 30, 2024, we were no longer in compliance with the Minimum Liquidity Amount. As of March 31, 2025, H.I.G. continued to own at least 30% of the shares.

These restrictions on the conduct of our business imposed by our lender or H.I.G. 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 and other stockholders. Even if the Credit Agreement were terminated, additional debt we could incur in the future may subject us to similar or additional covenants, which could place restrictions on the operation of our business. Similarly, our investment or financing arrangement with any future investors may subject us to similar or additional covenants.

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

Operating and growing our business is expected to require further investments in our business. We have generated negative cash from operating activities and may continue to generate negative cash from operating activities in the future. We may from time to time seek to raise additional capital through debt and/or equity financing to pursue strategic initiatives or make investments in our business. If we seek to raise funds through debt or equity financing, those funds may prove to be unavailable, may only be available on terms that are not acceptable to us or may result in significant dilution to our stockholders or higher levels of leverage.

Our term loan under the Credit Agreement matures in February 2026. Our ability to refinance our existing or future indebtedness will depend on the capital markets, including prevailing interest rates, and our financial condition and performance, which, among other things, is subject to economic, financial, competitive and other factors beyond our control. In addition, our Credit Agreement and the H.I.G. Investment Agreement contain restrictions that limit our ability to incur additional indebtedness, issue certain types of equity securities with rights and preferences senior to or pari passu with our Series A Preferred Stock, make certain types of investments or obtain additional financing. Pursuant to the terms of the H.I.G. Investment Agreement, we are currently required to obtain the consent of H.I.G. in order to incur certain indebtedness, which could limit our ability to obtain additional financing. If we are unable to refinance our existing or future indebtedness, obtain adequate financing or obtain

financing on terms satisfactory to us when we require it, we may default on our existing or future indebtedness, and our ability to continue to pursue our business objectives and to respond to business opportunities or challenges could be harmed, and our business, operating results and financial condition could be materially and adversely affected.

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

We have a complex business organization. Ensuring that we have adequate internal control over financial reporting and adequate 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. This process 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 cause 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 attributes prescribed in U.S. generally accepted accounting principles relating to accounting for income taxes. In addition, we are subject to examinations of our income tax returns by the Internal Revenue Service and other tax authorities. We assess the likelihood of adverse outcomes resulting from these examinations to determine the adequacy of our provision for income taxes. There may be exposure that the outcomes from these examinations will have an adverse effect on our operating results and financial condition.

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

We have net operating loss carryforwards for federal and state income tax purposes to offset future taxable income. Certain of our federal and state net operating loss carryforwards begin expiring in 2034 and 2025, respectively. A lack of future taxable income would adversely affect our ability to utilize these net operating loss carryforwards. In addition, utilization of the net operating loss carryforwards may be subject to a substantial annual

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

Risks Related to Our Technology

If we fail to properly maintain existing or implement new information systems, our business may be materially adversely affected.

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

We rely in part upon third-party vendors, including cloud infrastructure and bandwidth providers, to operate our ecommerce platform and advisor enrollment centers. Consumers using our website and accessing our services depend upon online, mobile and other service providers for access to our website and services. Our remote employees rely on third-party service providers to access our systems and other agent productivity tools. 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 significant interruption in access to our advisor enrollment centers or our website or increase in our website's response time as a result of these difficulties could impair our revenue-generating capabilities, damage our reputation and our relationship with insurance carriers, marketing partners and existing and potential members, and harm our business, operating results and financial condition. In addition, any loss of data could result in loss of customers and subject us to potential liability. Our business operations may also be disrupted if our employees are unable to work from home effectively as a result of technical difficulties experienced by these service providers. Many of these service providers have experienced significant outages, delays and other difficulties in the past and could experience them in the future. If these third parties experience difficulty providing the services we require or meeting our standards for those services, it could make it difficult for us to operate some aspects of our business. Our and our vendors' facilities, database and systems are vulnerable to damage or interruption from human error, fire, floods, earthquakes and other natural disasters, power loss, telecommunications failures, physical or electronic break-ins, computer viruses, cyberattacks, acts of terrorism, other attempts to harm our systems and similar events.

In particular, our advisor enrollment center operations' success depends on maintenance of functioning information technology systems. 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 advisor enrollment 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 events. The effectiveness and stability of our advisor enrollment center systems and technology are critical to our ability to sell health insurance plans, particularly during key times, such as 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.

Issues relating to the use of new and evolving technologies, such as AI, in our business operations could result in liability, reputational harm and an adverse impact on our operating results and financial condition.

We plan to utilize our artificial intelligence ("AI") Center of Excellence to help guide and prioritize our AI and technology initiatives for 2025. However, social, ethical and operational issues relating to the use of AI in our business operations could result in liability, reputational harm and additional costs. If our AI implementation, deployment or governance is ineffective or inadequate, it could result in incidents that impair the public acceptance of AI use or cause harm to individuals, customers or society, or result in our operations not working as intended or producing unexpected outcomes. Also, use of third party models can pose security and privacy risks. Jurisdictions around the world are developing and passing new regulations that apply specifically to the use of AI. These regulations and the evolving AI regulatory environment could, among other impacts, result in inconsistencies among AI regulations and frameworks across jurisdictions, increase our compliance, governance and research and development costs and increase our exposure to claims related to our use of AI.

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

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

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

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

Our intellectual property is an essential asset of our business, and we believe that our technology currently gives us a competitive advantage in the distribution of Medicare-related, individual, family and small business health insurance. We rely on a combination of patent, copyright, trademark and trade secret laws, confidentiality procedures and contractual provisions to establish and protect our intellectual property rights in the United States. Our efforts to protect our intellectual property may need to be revised or more effective, and our trademarks or patents 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.

Risks Related to Ownership of Our Common Stock

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

Our operating results are likely to fluctuate as a result of a variety of factors, including the factors described elsewhere in this Risk Factors section, many of which are outside of our control. For example, and among these factors, the assumptions underlying our estimates of commission revenue as required by Accounting Standards Codification ("ASC") 606 may vary significantly over time. As a result, comparing our operating results on a period-to-period basis may not be meaningful and you should not rely on our past results as an indication of our future performance, particularly in light of the fact that our business and industry are undergoing substantial change as a result of health care reform, competition, shifts in carrier and regulator priorities and initiatives we determine to pursue. The guidance that we release from time to time contains forward-looking statements and is based on projections prepared by our management. These projections are 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. Our actual results have, and may in the future, vary from our guidance and the variations may be material. 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.

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. 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 inflation, or political or geopolitical instability and public or market reaction thereto;
- volatility in the market prices and trading volumes of our competitors' shares, including high technology stocks, which have historically experienced high levels of volatility;
- any new debt and/or equity financing that we undertake to raise additional capital;
- any strategic transaction or partnership that we may enter into;
- new laws or regulations or new interpretations of existing laws or regulations applicable to our business, including developments relating to the health care industry and the marketing and sale of Medicare plans;
- actual or anticipated changes in our operating results or the growth rate of our business;
- changes in operating performance and stock market valuations of other technology or insurance brokerage companies generally and of our competitors;
- failure of securities analysts to maintain coverage of us, changes in financial estimates by any securities analysts who follow our company or our failure to meet these estimates or the expectations of investors;
- sales of shares of our common stock by us or our stockholders;

- announcements by us or our competitors of new products or services;
- the public reaction to our press releases, other public announcements and filings with the SEC;
- rumors and market speculation involving us or other companies in our industry;
- negative publicity about us, including accurate and inaccurate third-party commentary or reports regarding us;
- actual or anticipated developments in our business, our competitors' businesses or the competitive landscape generally;
- our ability to control costs, including our operating expenses;
- litigation involving us, our industry or both, or investigations by regulators into our operations or those of our competitors;
- developments or disputes concerning our intellectual property or other proprietary rights;
- announced or completed acquisitions of businesses or technologies by us or our competitors;
- changes in accounting standards, policies, guidelines, interpretations, or principles;
- any significant change in our management;
- adverse events or perceptions affecting the U.S. or international financial systems;
- the imposition of tariffs or other significant changes in relations between the United States and other countries in which we operate our business; and
- general economic conditions, political instability and slow or negative growth of our markets.

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

The value of our investments is subject to significant capital markets risk related to changes in interest rates and credit spreads as well as other investment risks. These factors may adversely affect our business, operating results and financial condition.

Our financial condition and operating results are affected by the performance of our investment portfolio. The value of our investments is exposed to capital markets risks, and our operating results, liquidity, financial condition or cash flows could be adversely affected by realized losses, impairments and changes in unrealized positions as a result of: significant market volatility, changes in interest rates, changes in credit spreads and defaults, a lack of pricing transparency, a reduction in market liquidity, declines in equity prices, changes in national, state/provincial or local laws and the strengthening or weakening of foreign currencies against the U.S. dollar. Levels of write-down or impairment are impacted by our assessment of the intent to sell securities that have declined in value as well as actual losses as a result of defaults or deterioration in estimates of cash flows. If we reposition or realign portions of the investment portfolio and sell securities in an unrealized loss position, we will incur an other-than-temporary impairment charge or realized losses. Any such charge may have a material adverse effect on our business, operating results and financial condition.

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

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

common stock, the issuance of the Series A Preferred Stock effectively reduces the relative voting power of the holders of our common stock.

Any sales in the public market of the common stock issuable upon conversion of the Series A Preferred Stock could adversely affect prevailing market prices of our common stock. Pursuant to the H.I.G. Investment Agreement, holders of our Series A Preferred Stock have customary resale registration rights for common stock issued upon conversion of the Series A Preferred Stock upon closing. Any resale of our common stock would increase the number of shares of our common stock available for public trading. Resales 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 convertible preferred stock investor has rights, preferences and privileges that are not held by, and are preferential to, the rights of our common stockholders and may exercise influence over us. This could adversely affect our liquidity and financial condition, result in the interests of our convertible preferred stock investor differing from those of our common stockholders and make an acquisition of us more difficult.

H.I.G., the initial purchaser and the current holder of our Series A Preferred Stock, has (i) a liquidation preference, (ii) rights to dividends, which are senior to all of our other equity securities, (iii) redemption rights beginning on April 30, 2027, (iv) the right to require us to repurchase any or all of their Series A Preferred Stock in connection with certain change of control events and (v) conversion price adjustments in connection with certain corporate transactions, each subject to the terms, conditions and exceptions contained in the certificate of designations for the Series A Preferred Stock. These dividend and share repurchase and redemption obligations could impact our liquidity and reduce the amount of cash flows available for working capital, capital expenditures, growth opportunities, acquisitions, and other general corporate purposes.

The H.I.G. Investment Agreement entitles H.I.G. to nominate one individual for election to our Board of Directors for so long as it continues to own at least 30% of the common stock issuable or issued upon conversion of the Series A Preferred Stock originally issued to it. The director designated by H.I.G. is also entitled to serve on committees of our Board of Directors, subject to applicable law and stock exchange rules. H.I.G. nominated Aaron C. Tolson to our Board of Directors. Mr. Tolson was appointed to our Board of Directors as a Class I director on August 30, 2021, and as of the date of this report serves as a member of the compensation committee, nominating and corporate governance committee and government and regulatory affairs committee of the Board of Directors.

In addition, failure to maintain the Minimum Asset Coverage Ratio or the Minimum Liquidity Amount as of the date or the time period required by the H.I.G. Investment Agreement, for as long as H.I.G. continues to own at least 30% of the Series A Preferred Stock originally issued to it in the private placement, entitles H.I.G., subject to conditions and restrictions specified therein, to additional rights, including the right to nominate one additional member to our Board of Directors. The interests of any director designated by H.I.G. may differ from the interests of our security holders as a whole or of our other directors.

If the additional rights are used by H.I.G., it could be distracting to our management and disruptive to our operations or hinder our ability to execute our operational and strategic plans. The terms of the H.I.G. Investment Agreement could also limit our ability to obtain additional financing or increase our borrowing costs, which could have an adverse effect on our financial condition. As of the date of this report, pursuant to the terms of the H.I.G. Investment Agreement, we must obtain the consent of H.I.G. in order to incur any indebtedness, which could limit our ability to obtain additional financing. The preferential rights could also result in divergent interests between H.I.G. and holders of our common stock. Furthermore, a sale of our company, as a change of control event, may require us to repurchase Series A Preferred Stock, which could have the effect of making an acquisition of our company more expensive and potentially deterring proposed transactions that may otherwise be beneficial to our stockholders.

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 that could have the effect of rendering more difficult, delaying or preventing an acquisition deemed undesirable by our Board of Directors. Our corporate governance documents include provisions:

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

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

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

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

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

Our bylaws provide that, unless we consent in writing to the selection of an alternative forum, the sole and exclusive forum for (1) any derivative action or proceeding brought on our behalf, (2) any action asserting a claim of breach of a fiduciary duty owed by any of our directors, stockholders, officers or other employees to us or our stockholders, (3) any action arising pursuant to any provision of the Delaware General Corporation Law, our certificate of incorporation or our bylaws or (4) any other action asserting a claim that is governed by the internal affairs doctrine shall be the Court of Chancery of the State of Delaware (or, if the Court of Chancery does not have jurisdiction, another State court in Delaware or the federal district court for the District of Delaware), except for any claim as to which such court determines that there is an indispensable party not subject to the jurisdiction of such court (and the indispensable party does not consent to the personal jurisdiction of such court within ten days following such determination), which is vested in the exclusive jurisdiction of a court or forum other than such court or for which such court does not have subject matter jurisdiction. This provision would not apply to any action brought to enforce a duty or liability created by the Exchange Act and the rules and regulations thereunder.

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

any complaint asserting a cause of action arising under the Securities Act and against any person in connection with an offering of our securities.

Any person or entity purchasing or otherwise acquiring or holding or owning (or continuing to hold or own) any interest in any of our securities shall be deemed to have notice of and consented to the foregoing bylaw provisions. Although we believe these exclusive forum provisions benefit us by providing increased consistency in the application of Delaware law and federal securities laws in the types of lawsuits to which each applies, the exclusive forum provisions may limit a stockholder's ability to bring a claim in a judicial forum of its choosing for disputes with us or our current or former directors, officers, stockholders or other employees, which may discourage such lawsuits against us and our current and former directors, officers, stockholders and other employees. Our stockholders will not be deemed to have waived our compliance with the federal securities laws and the rules and regulations thereunder as a result of our exclusive forum provisions.

Further, the enforceability of similar exclusive forum provisions in other companies' organizational documents have been challenged in legal proceedings, and it is possible that a court of law could rule that these types of provisions are inapplicable or unenforceable if they are challenged in a proceeding or otherwise. If a court were to find either exclusive forum provision contained in our bylaws to be inapplicable or unenforceable in an action, we may incur significant additional costs associated with resolving such action in other jurisdictions, all of which could harm our business, operating results and financial condition.

Macroeconomic and Industry Risks

Our business, operating results and financial condition can be impacted by political events, political instability, trade and other international disputes, geopolitical tensions or natural disasters.

Political events, political instability, trade and other international disputes, geopolitical tensions, conflict, natural disasters, public health issues and other extreme events can have a material adverse effect on the Company and its customers, consumers and other channel partners.

For example, the United States has recently enacted and proposed to enact significant new tariffs. Additionally, President Trump has directed various federal agencies to further evaluate key aspects of U.S. trade policy and there has been ongoing discussion and commentary regarding potential significant changes to U.S. trade policies, treaties and tariffs. While certain of these tariffs have been delayed or rescinded, there continues to exist significant uncertainty about the future relationship between the U.S. and other countries with respect to such trade policies, treaties and tariffs. These developments, or the perception that any of them could occur, could result in the worsening of current global economic conditions and the stability of global financial markets, and may significantly escalate trade tensions and reduce global trade and, in particular, trade between the impacted nations and the U.S. As discussed elsewhere in this Risk Factors section, our subsidiary in China provides supports for certain aspects of our operations and face risk related to trade and other international disputes and geopolitical tensions. Any new or changes in restrictions can be announced with little or no advance notice, which can create uncertainty. Any of these factors could depress economic activity, restrict our access to our operations in China, and have a material adverse effect on our business, operating results and financial condition.

Adverse economic conditions including slow growth, recession, high unemployment, inflation, financial and credit market disruptions, could materially adversely affect our business, operating results and financial condition.

Customer and consumer demand for our health insurance plan offerings may be impacted by adverse macroeconomic conditions, including slow growth or recession, high unemployment, inflation, market volatility or other negative economic factors. Weak economic condition can adversely impact consumer confidence and spending and materially adversely affect demand for our products and services. In addition, consumer confidence and spending can be materially adversely affected in response to changes in fiscal and monetary policy, financial market volatility, declines in income or asset values, and other economic factors.

In addition, limited liquidity, defaults, non-performance or other adverse developments affecting financial institutions, or perceptions regarding these or similar risks, have in the past and may in the future lead to market-wide liquidity problems. Such adverse developments may impact parties with which we do business and their liquidity. These macroeconomic factors could materially and adversely affect our business, operating results and financial condition. Any disruptions in financial institutions, credit markets and/or the broader financial services industry may lead to market-wide liquidity shortages, may limit our access to preferred sources of liquidity when needed or on terms we find acceptable, and our borrowing costs could increase. An economic or credit crisis could occur and impair credit availability and our ability to raise capital when needed.

Large-scale health issues, including pandemics (such as COVID-19), have also had and could in the future have a material adverse effect on our business, operating results and financial condition. For example, we had to adjust our operations in response to the COVID-19 pandemic and resulting disruptions in public and private infrastructure.

Changing our business practices in accordance with new or changed restrictions and challenges could be expensive, time-consuming and disruptive to the Company's operations, and the Company may not be able to effectively mitigate all adverse impacts from such events.

ITEM 5. OTHER INFORMATION

Securities Trading Plans of Directors and Executive Officers

During our last fiscal quarter, no director or officer, as defined in Rule 16a-1(f), adopted or terminated a "Rule 10b5-1 trading arrangement" or a "non-Rule 10b5-1 trading arrangement," each as defined in Regulation S-K Item 408.

ITEM 6. EXHIBITS

(a) Exhibits

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

Exhibit Number		Description of Exhibit	Incorporation by Reference Herein	
			Form	Date
31.1	†	Certification of Francis Soistman, Chief Executive Officer of eHealth, Inc., pursuant to Exchange Act Rule 13a-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002		
31.2	†	Certification of John Dolan, Chief Financial Officer of eHealth, Inc., pursuant to Exchange Act Rule 13a-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002		
32.1	‡	Certification of Francis Soistman, Chief Executive Officer of eHealth, Inc., pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002		
32.2	‡	Certification of John Dolan, Chief Financial Officer of eHealth, Inc., pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002		
101.INS	†	XBRL Instance Document - The instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document		
101.SCH	†	Inline XBRL Taxonomy Extension Schema Document		
101.CAL	†	Inline XBRL Taxonomy Extension Calculation Linkbase Document		
101.DEF	†	Inline XBRL Taxonomy Extension Definition Linkbase Document		
101.LAB	†	Inline XBRL Taxonomy Extension Label Linkbase Document		
101.PRE	†	Inline XBRL Taxonomy Extension Presentation Linkbase Document		
104		The cover page from the Company's Quarterly Report on Form 10-Q for the three months ended March 31, 2025, formatted in Inline XBRL and contained in Exhibit 101		

† Filed herewith.
‡ Furnished herewith.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

EHEALTH, INC.

Date: May 7, 2025

/s/ Francis Soistman

Francis Soistman
Chief Executive Officer
(Principal Executive Officer)

Date: May 7, 2025

/s/ John Dolan

John Dolan
Chief Financial Officer
(Principal Financial Officer)

Exhibit 31.1

CERTIFICATION

I, Francis Soistman, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of eHealth, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
   a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
   b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
   c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
   d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
   a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
   b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: May 7, 2025

/s/ FRANCIS SOISTMAN

Francis Soistman
Chief Executive Officer
(Principal Executive Officer)

Exhibit 31.2

CERTIFICATION

I, John Dolan, certify that:

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

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

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

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

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

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

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

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

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

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

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

Date: May 7, 2025

/s/ JOHN DOLAN

John Dolan

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

Exhibit 32.1

Certification of Principal Executive Officer, Pursuant to

18 U.S.C. Section 1350,

As Adopted Pursuant to

Section 906 of the Sarbanes-Oxley Act of 2002

In connection with the Quarterly Report of eHealth, Inc. on Form 10-Q (the "Form 10-Q") for the quarter ended March 31, 2025, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Francis Soistman, Chief Executive Officer of eHealth, Inc., certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that, to my knowledge:

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

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

/s/ FRANCIS SOISTMAN

Francis Soistman

Chief Executive Officer
(Principal Executive Officer)

May 7, 2025

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

Exhibit 32.2

Certification of Principal Financial Officer, Pursuant to

18 U.S.C. Section 1350,

As Adopted Pursuant to

Section 906 of the Sarbanes-Oxley Act of 2002

In connection with the Quarterly Report of eHealth, Inc. on Form 10-Q (the "Form 10-Q") for the quarter ended March 31, 2025, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, John Dolan, 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-Q, to which this certification is attached as Exhibit 32.2, fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

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

/s/ JOHN DOLAN

John Dolan
Chief Financial Officer
(Principal Financial Officer and Principal Accounting Officer)
May 7, 2025

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.