UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

FORM 10-Q

(Mark One)

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

For the quarterly period ended March 31, 2022

or

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

For the transition period from to

Commission File Number: 001-39203

1LIFE HEALTHCARE, INC.

(Exact name of registrant as specified in its charter)

Delaware	**76-0707204**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

One Embarcadero Center, Suite 1900
San Francisco, CA 94111
(Address of principal executive offices and zip code)

(415) 814-0927
(Registrant's telephone number, including area code)

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

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, $0.001 par value	ONEM	The Nasdaq Global Select Market

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

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, 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 ☒

As of April 18, 2022, the registrant had 194,047,510 shares of common stock, $0.001 par value per share, outstanding.

Table of Contents

Where You Can Find More Information

Investors and others should note that we announce material financial and other information using our investor relations website, press releases, SEC filings and public conference calls and webcasts. We also post supplemental materials on the "Events" section of our investor relations website at investor.onemedical.com. Except as specifically noted herein, information on or accessible through our website is not, and will not be deemed to be, a part of this Quarterly Report on Form 10-Q or incorporated by reference into any other filings we may make with the U.S. Securities and Exchange Commission (the "SEC").

We also use our Facebook, Twitter and LinkedIn accounts as a means of disclosing material non-public information and for complying with our disclosure obligations under Regulation FD. The information we post through these social media channels may be deemed material. Accordingly, investors should monitor these accounts, in addition to following our press releases, SEC filings and public conference calls and webcasts. This list may be updated from time to time. The information we post through these channels is not a part of this Quarterly Report on Form 10-Q. These channels may be updated from time to time on our investor relations website.

PART I—FINANCIAL INFORMATION

Item 1. Financial Statements.

1LIFE HEALTHCARE, INC.
CONDENSED CONSOLIDATED BALANCE SHEETS
(Amounts in thousands, except par value amounts)
(unaudited)

	March 31, 2022	December 31, 2021
Assets		
Current assets:		
Cash and cash equivalents	$ 239,978	$ 341,971
Short-term marketable securities	141,064	111,671
Accounts receivable, net	142,288	103,498
Inventories	6,021	6,065
Prepaid expenses	31,466	28,055
Other current assets	23,311	21,767
Total current assets	584,128	613,027
Long-term marketable securities	47,438	48,296
Restricted cash	3,801	3,801
Property and equipment, net	199,137	193,716
Right-of-use assets	266,592	256,293
Intangible assets, net	341,200	352,158
Goodwill	1,145,094	1,147,464
Other assets	8,639	12,277
Total assets	$ 2,596,029	$ 2,627,032
Liabilities and Stockholders' Equity		
Current liabilities:		
Accounts payable	$ 15,842	$ 18,725
Accrued expenses	73,534	72,672
Deferred revenue, current	64,317	47,928
Operating lease liabilities, current	33,316	31,152
Other current liabilities	34,088	31,632
Total current liabilities	221,097	202,109
Operating lease liabilities, non-current	283,206	269,641
Convertible senior notes	310,313	309,844
Deferred income taxes	67,141	73,875
Deferred revenue, non-current	27,385	29,317
Other non-current liabilities	11,042	13,663
Total liabilities	920,184	898,449
Commitments and contingencies (Note 13)		
Stockholders' Equity:		
Common stock, $0.001 par value, 1,000,000 and 1,000,000 shares authorized as of March 31, 2022 and December 31, 2021, respectively; 193,483 and 191,722 shares issued and outstanding as of March 31, 2022 and December 31, 2021, respectively	194	193
Additional paid-in capital	2,385,934	2,346,781
Accumulated deficit	(709,057)	(618,198)
Accumulated other comprehensive income	(1,226)	(193)
Total stockholders' equity	1,675,845	1,728,583
Total liabilities and stockholders' equity	$ 2,596,029	$ 2,627,032

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

1LIFE HEALTHCARE, INC.
CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS
(Amounts in thousands, except per share amounts)
(unaudited)

	Three Months Ended March 31,	
	2022	2021
Net revenue:		
Medicare revenue	$ 127,422	$ —
Commercial revenue	126,680	121,352
Total net revenue	254,102	121,352
Operating expenses:		
Medical claims expense	104,966	—
Cost of care, exclusive of depreciation and amortization shown separately below	101,377	70,092
Sales and marketing	22,459	12,689
General and administrative	97,036	64,345
Depreciation and amortization	20,893	6,607
Total operating expenses	346,731	153,733
Loss from operations	(92,629)	(32,381)
Other income (expense), net:		
Interest income	157	105
Interest and other expense	(5,119)	(2,843)
Total other income (expense), net	(4,962)	(2,738)
Loss before income taxes	(97,591)	(35,119)
Provision for (benefit from) income taxes	(6,732)	4,199
Net loss	$ (90,859)	$ (39,318)
Net loss per share — basic and diluted	$ (0.47)	$ (0.29)
Weighted average common shares outstanding — basic and diluted	193,019	136,516

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

1LIFE HEALTHCARE, INC.
CONDENSED CONSOLIDATED STATEMENTS OF COMPREHENSIVE LOSS
(Amounts in thousands)
(unaudited)

	Three Months Ended March 31,	
	2022	2021
Net loss	$ (90,859)	$ (39,318)
Other comprehensive loss:		
Net unrealized gain (loss) on marketable securities	(1,033)	12
Comprehensive loss	$ (91,892)	$ (39,306)

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

1LIFE HEALTHCARE, INC.
CONDENSED CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY (DEFICIT)
(Amounts in thousands)
(unaudited)

	Common Stock		Additional Paid-In Capital	Accumulated Deficit	Accumulated Other Comprehensive Income (Loss)	Total Stockholders' Equity (Deficit)
	Shares	Amount				
Balances at December 31, 2021	191,722	$ 193	$ 2,346,781	$ (618,198)	$ (193)	$ 1,728,583
Exercise of stock options	579	1	2,234			2,235
Issuance of common stock for settlement of RSUs	442					—
Issuance of common stock in acquisition	740					—
Stock-based compensation expense			36,919			36,919
Net unrealized gain (loss) on marketable securities					(1,033)	(1,033)
Net loss				(90,859)		(90,859)
Balances at March 31, 2022	193,483	$ 194	$ 2,385,934	$ (709,057)	$ (1,226)	$ 1,675,845

	Common Stock		Additional Paid-In Capital	Accumulated Deficit	Accumulated Other Comprehensive Income (Loss)	Total Stockholders' Equity (Deficit)
	Shares	Amount				
Balances at December 31, 2020	134,472	$ 134	$ 918,118	$ (369,785)	$ 8	$ 548,475
Impact of adoption of ASU 2020-06			(73,393)	6,656		(66,737)
Impact of adoption of ASC 326				(428)		(428)
Exercise of stock options	2,584	3	13,476			13,479
Issuance of common stock for settlement of RSUs	241					—
Stock-based compensation expense			26,328			26,328
Net unrealized gain (loss) on marketable securities					12	12
Net loss				(39,318)		(39,318)
Balances at March 31, 2021	137,297	$ 137	$ 884,529	$ (402,875)	$ 20	$ 481,811

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

1LIFE HEALTHCARE, INC.
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(Amounts in thousands)
(unaudited)

	Three Months Ended March 31,	
	2022	**2021**
Cash flows from operating activities:		
Net loss	$ (90,859)	$ (39,318)
Adjustments to reconcile net loss to net cash used in operating activities:		
Provision for bad debts	281	(60)
Depreciation and amortization	20,893	6,607
Amortization of debt discount and issuance costs	469	468
Accretion of discounts and amortization of premiums on marketable securities, net	338	199
Reduction of operating lease right-of-use assets	7,950	4,156
Stock-based compensation	36,919	26,328
Deferred income taxes	(6,734)	—
Other non-cash items	211	202
Changes in operating assets and liabilities, net of acquisitions:		
Accounts receivable, net	(39,071)	8,583
Inventories	44	2,478
Prepaid expenses and other current assets	(999)	(4,870)
Other assets	2,625	(171)
Accounts payable	(680)	(1,248)
Accrued expenses	2,529	8,168
Deferred revenue	14,457	11,050
Operating lease liabilities	(6,687)	(4,434)
Other liabilities	3,230	3,946
Net cash (used in) provided by operating activities	(55,084)	22,084
Cash flows from investing activities:		
Purchases of property and equipment, net	(19,225)	(14,808)
Purchases of marketable securities	(54,906)	(69,995)
Proceeds from sales and maturities of marketable securities	25,000	339,000
Net cash (used in) provided by investing activities	(49,131)	254,197
Cash flows from financing activities:		
Proceeds from the exercise of stock options	2,235	13,479
Payment of principal portion of finance lease liability	(13)	(14)
Net cash provided by financing activities	2,222	13,465
Net (decrease) increase in cash, cash equivalents and restricted cash	(101,993)	289,746
Cash, cash equivalents and restricted cash at beginning of period	346,054	115,005
Cash, cash equivalents and restricted cash at end of period	$ 244,061	$ 404,751
Supplemental disclosure of non-cash investing and financing activities:		
Purchases of property and equipment included in accounts payable and accrued expenses	$ 6,837	$ 6,115

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

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(Amounts in thousands, except per share amounts)
(unaudited)

1. Nature of the Business and Basis of Presentation

1Life Healthcare, Inc. (“1Life”) was incorporated in Delaware on July 25, 2002. 1Life’s headquarters are located in San Francisco, California. 1Life has developed a modernized healthcare membership model based on direct consumer enrollment and third-party sponsorship across commercially insured and Medicare populations. Our membership model includes access to 24/7 digital health services paired with in-office care routinely covered by most health care payers, and allows the Company to engage in value-based care across all age groups, including through At-Risk arrangements as defined in Note 2 “Summary of Significant Accounting Policies” with Medicare Advantage payers and the Center for Medicare & Medicaid Services ("CMS"), in which the Company is responsible for managing a range of healthcare services and associated costs of its members. 1Life is also an administrative and managerial services company that provides services pursuant to contracts with physician-owned professional corporations (“One Medical PCs”) that provide medical services virtually and in-office.

On September 1, 2021, 1Life completed the acquisition of Iora Health, Inc. ("Iora Health"), a human-centered, value-based primary care group with built-for-purpose technology focused on serving the Medicare population.

Iora Health and Iora Senior Health, Inc. (“Iora Senior Health”) are administrative and managerial service companies that provide services pursuant to contracts with physician-owned professional corporations (“Iora PCs”, together with the One Medical PCs, the “PCs”) that provide medical services virtually and in-office.

Iora Health is an administrative and managerial services company that provides services pursuant to contracts with Iora Health NE DCE, LLC, a limited liability company that participates in the Center for Medicare and Medicaid Services’ direct contracting model (the “DCE entity”). Iora Health, Iora Senior Health, the Iora PCs and the DCE entity are collectively referred to herein as “Iora”. See Note 7 "Business Combinations" to the unaudited condensed consolidated financial statements.

1Life, Iora Health, Iora Senior Health, the PCs and the DCE entity are collectively referred to herein as the “Company”. 1Life and the One Medical PCs operate under the brand name One Medical.

Basis of Presentation

The Company has prepared the accompanying unaudited condensed consolidated financial statements in accordance with generally accepted accounting principles in the United States of America ("U.S. GAAP") and applicable rules and regulations of the Securities and Exchange Commission (“SEC”) regarding interim financial reporting. Pursuant to these rules and regulations, the Company has condensed or omitted certain information and footnote disclosures it normally includes in its annual consolidated financial statements prepared in accordance with U.S. GAAP.

The accompanying condensed consolidated financial statements include the accounts of 1Life, Iora Health and Iora Senior Health, their wholly owned subsidiaries, and variable interest entities (“VIE”) in which 1Life, Iora Health and Iora Senior Health have an interest and are the primary beneficiaries. See Note 3, “Variable Interest Entities”. All significant intercompany balances and transactions have been eliminated in consolidation.

In management’s opinion, the Company has made all adjustments (consisting only of normal, recurring adjustments, except as otherwise indicated) necessary to fairly state its condensed consolidated financial position, results of operations, comprehensive loss and cash flows. The Company’s interim period operating results do not necessarily indicate the results that may be expected for any other interim period or for the full fiscal year. These financial statements and accompanying notes should be read in conjunction with the consolidated financial statements and notes thereto in the Company’s Annual Report on Form 10-K for the fiscal year ended December 31, 2021 as filed with the SEC on February 23, 2022 (the “Form 10-K”).

Use of Estimates

The preparation of condensed consolidated financial statements and related disclosures in conformity with U.S. GAAP and regulations of the SEC requires management to make estimates and assumptions that affect the amounts reported in the condensed consolidated financial statements and accompanying notes. Estimates include, but are not limited to, revenue recognition, liability for medical claims incurred in the period but not yet reported (“IBNR”), valuation of certain assets and liabilities acquired from business combinations, and stock-based compensation. Actual results could differ from these estimates and may result in material effects on the Company’s operating results and financial position.

Due to the COVID-19 global pandemic, the global economy and financial markets have been disrupted and there continues to be a significant amount of uncertainty about the length and severity of the consequences caused by the pandemic. The Company has considered information available to it as of the date of issuance of these financial statements and is not aware of any specific events or circumstances that would require an update to its estimates or judgments, or an adjustment to the carrying value of its assets or liabilities. The accounting estimates and other matters assessed include, but were not limited to, allowance for credit losses, goodwill and other long-lived assets, and revenue recognition. These estimates may change as new events occur and additional information becomes available. Actual results could differ materially from these estimates.

The Coronavirus Aid, Relief, and Economic Security Act ("CARES Act") was enacted on March 27, 2020. Intended to provide economic relief to those impacted by the COVID-19 pandemic, the CARES Act includes various tax and lending provisions, among others. Under the CARES Act, the Company received an income grant from the Provider Relief Fund administered by the Department of Health and Human Services ("HHS"), which we recognized as Grant income during the three months ended March 31, 2021. The Company did not receive any income grant from the HHS for the three months ended March 31, 2022. See Note 5, "Revenue Recognition".

Cash, Cash Equivalents and Restricted Cash

The Company considers all short-term, highly liquid investments purchased with an original maturity of three months or less at the date of purchase to be cash equivalents. Cash deposits are all in financial institutions in the United States. Cash and cash equivalents consist of cash on deposit, investments in money market funds and commercial paper. Restricted cash represents cash held under letters of credit for various leases and certain At-Risk arrangements. The expected duration of restrictions on the Company's restricted cash generally ranges from 1 to 8 years.

The reconciliation of cash, cash equivalents and restricted cash reported within the applicable balance sheet line items that sum to the total of the same such amount shown in the condensed consolidated statements of cash flows is as follows:

	March 31, 2022	December 31, 2021	March 31, 2021	December 31, 2020
Cash and cash equivalents	$ 239,978	$ 341,971	$ 402,721	$ 112,975
Restricted cash, current (included in other current assets)	282	282	119	119
Restricted cash, non-current	3,801	3,801	1,911	1,911
Total cash, cash equivalents, and restricted cash	$ 244,061	$ 346,054	$ 404,751	$ 115,005

Concentration of Credit Risk and Significant Customers

Financial instruments that potentially subject the Company to concentration of credit risk consist of cash, cash equivalents, marketable securities and accounts receivable. The Company's cash balances with individual banking institutions might be in excess of federally insured limits. Cash equivalents are invested in highly rated money market funds and commercial paper. The Company's marketable securities are invested in U.S. Treasury obligations and commercial paper. The Company is not exposed to any significant concentrations of credit risk from these financial instruments. The Company has not experienced any losses on its deposits of cash, cash equivalents or marketable securities. The Company grants unsecured credit to patients, most of whom reside in the service area of the One Medical or Iora facilities and are largely insured under third-party payer agreements. The Company's concentration of credit risk is limited by the diversity, geography and number of patients and payers.

The table below presents the customers or payers that individually represented 10% or more of the Company's accounts receivable, net balance as of March 31, 2022 and December 31, 2021.

	March 31, 2022	December 31, 2021
Customer F	39 %	38 %
Customer I	19 %	23 %

* Represents percentages below 10% of the Company's accounts receivable in the period.

The table below presents the customers or payers that individually represented 10% or more of the Company's net revenue for the three months ended March 31, 2022 and 2021.

	Three Months Ended March 31,	
	2022	2021
Customer A	*	12 %
Customer F	*	12 %
Customer I	27 %	N/A
Customer J	18 %	N/A

* Represents percentages below 10% of the Company's net revenue in the period.

2. Summary of Significant Accounting Policies

The Company's significant accounting policies are discussed in Note 2 "Summary of Significant Accounting Policies" in Item 15 of its Form 10-K for the fiscal year ended December 31, 2021.

Recently Adopted Pronouncements as of March 31, 2022

In November 2021, the FASB issued ASU 2021-10, Government Assistance (Topic 832): Disclosures by Business Entities about Government Assistance which requires annual disclosures that increase the transparency of transactions involving government grants, including (1) the types of transactions, (2) the accounting for those transactions, and (3) the effect of those transactions on an entity's financial statements. The amendments in this update are effective for financial statements issued for annual periods beginning after December 15, 2021. The Company adopted the standard on January 1, 2022 on a prospective basis. The adoption did not have a material impact to the Company's condensed consolidated financial statements.

Recently Issued Accounting Pronouncements Not Yet Adopted as of March 31, 2022

There have been no recent accounting pronouncements or changes in accounting pronouncements that are of significance or potential significance to the Company as of March 31, 2022.

3. Variable Interest Entities

1Life, Iora Health and Iora Senior Health's agreements with the PCs generally consist of both Administrative Services Agreements ("ASAs"), which provide for various administrative and management services to be provided by 1Life, Iora Health or Iora Senior Health, respectively, to the PCs, and succession agreements, which provide for transition of ownership of the PCs under certain conditions ("Succession Agreements").

The ASAs typically provide that the term of the arrangements is ten to twenty years with automatic renewal for successive one-year terms, subject to termination by the contracting parties in certain specified circumstances. The outstanding voting equity instruments of the PCs are owned by nominee shareholders appointed by 1Life, Iora Health or Iora Senior Health (or the PC in one instance) under the terms of the Succession Agreements or other shareholders who are also subject to the terms of the Succession Agreements. 1Life, Iora Health and Iora Senior Health have the right to receive income as an ongoing administrative fee in an amount that represents the fair value of services rendered and has provided all financial support through loans to the PCs. 1Life, Iora Health and Iora Senior Health have exclusive responsibility for the provision of all nonmedical services including facilities, technology and intellectual property required for the day-to-day operation and management of each of the PCs, and makes recommendations to the PCs in establishing the guidelines for the employment and compensation of the physicians and other employees of the PCs. In addition, the agreements provide that 1Life, Iora Health and Iora Senior Health have the right to designate a person(s) to purchase the stock of the PCs for a nominal amount in the event of a succession event. Based upon the provisions of these agreements, 1Life determined that the PCs are variable interest entities due to its equity holder having insufficient capital at risk, and 1Life has a variable interest in the PCs.

The contractual arrangement to provide management services allows 1Life, Iora Health or Iora Senior Health to direct the economic activities that most significantly affect the PCs. Accordingly, 1Life, Iora Health or Iora Senior Health is the primary beneficiary of the PCs and consolidates the PCs under the VIE model. Furthermore, as a direct result of nominal initial equity contributions by the physicians, the financial support 1Life, Iora Health or Iora Senior Health provides to the PCs (e.g. loans) and the provisions of the nominee shareholder succession arrangements described above, the interests held by noncontrolling interest holders lack economic substance and do not provide them with the ability to participate in the residual

profits or losses generated by the PCs. Therefore, all income and expenses recognized by the PCs are allocated to 1Life stockholders. The aggregate carrying value of the assets and liabilities included in the condensed consolidated balance sheets for the PCs after elimination of intercompany transactions and balances were $136,405 and $122,520, respectively, as of March 31, 2022 and $129,474 and $115,744, respectively, as of December 31, 2021.

4. Fair Value Measurements and Investments

Fair Value Measurements

The following tables present information about the Company's financial assets measured at fair value on a recurring basis:

	Fair Value Measurements as of March 31, 2022 Using:			
	Level 1	Level 2	Level 3	Total
Cash equivalents:				
Money market fund	$ 195,964	$ —	$ —	$ 195,964
Short-term marketable securities:				
U.S. Treasury obligations	107,619	—	—	107,619
Commercial paper	—	33,445	—	33,445
Long-term marketable securities:				
U.S. Treasury obligations	47,438	—	—	47,438
Total financial assets	$ 351,021	$ 33,445	$ —	$ 384,466

	Fair Value Measurements as of December 31, 2021 Using:			
	Level 1	Level 2	Level 3	Total
Cash equivalents:				
Money market fund	$ 315,817	$ —	$ —	$ 315,817
Short-term marketable securities:				
U.S. Treasury obligations	58,232	—	—	58,232
Foreign government bonds	—	5,012	—	5,012
Commercial paper	—	48,427	—	48,427
Long-term marketable securities:				
U.S. Treasury obligations	48,296	—	—	48,296
Total financial assets	$ 422,345	$ 53,439	$ —	$ 475,784

Our financial assets are valued using market prices on both active markets (Level 1) and less active markets (Level 2). Level 1 instrument valuations are obtained from real-time quotes for transactions in active exchange markets involving identical assets. Level 2 instrument valuations are obtained from readily available pricing sources for comparable instruments, identical instruments in less active markets, or models using market observable inputs.

During the three months ended March 31, 2022 and 2021, there were no transfers between Level 1, Level 2 and Level 3.

Valuation of Convertible Senior Notes

The Company has $316,250 aggregate principal amount outstanding of 3.0% convertible senior notes due in 2025 (the "2025 Notes"). See Note 9, "Convertible Senior Notes" for details.

The fair value of the 2025 Notes was $275,210 and $288,461 as of March 31, 2022 and December 31, 2021, respectively. The fair value was determined based on the closing trading price of the 2025 Notes as of the last day of trading for the period. The fair value of the 2025 Notes is primarily affected by the trading price of the Company's common stock and market interest rates. The fair value of the 2025 Notes is considered a Level 2 measurement as they are not actively traded.

Investments

At March 31, 2022 and December 31, 2021, the Company's cash equivalents and marketable securities were as follows:

	March 31, 2022		
	Amortized cost	Gross unrealized gains (losses)	Fair value
Cash equivalents:			
Money market fund	$ 195,964	$ —	$ 195,964
Total cash equivalents	195,964	—	195,964
Short-term marketable securities:			
U.S. Treasury obligations	108,020	(401)	107,619
Commercial paper	33,445	—	33,445
Total short-term marketable securities	141,465	(401)	141,064
Long-term marketable securities:			
U.S. Treasury obligations	48,263	(825)	47,438
Total cash equivalents and marketable securities	$ 385,692	$ (1,226)	$ 384,466

	December 31, 2021		
	Amortized cost	Gross unrealized gains (losses)	Fair value
Cash equivalents:			
Money market fund	$ 315,817	$ —	$ 315,817
Total cash equivalents	315,817	—	315,817
Short-term marketable securities:			
U.S. Treasury obligations	58,293	(61)	58,232
Foreign government bonds	5,013	(1)	5,012
Commercial paper	48,427	—	48,427
Total short-term marketable securities	111,733	(62)	111,671
Long-term marketable securities:			
U.S. Treasury obligations	48,427	(131)	48,296
Total cash equivalents and marketable securities	$ 475,977	$ (193)	$ 475,784

5. Revenue Recognition

The following table summarizes the Company's net revenue by primary source:

	Three Months Ended March 31,	
	2022	2021
Net revenue:		
Capitated revenue	$ 124,630	$ —
Fee-for-service and other revenue	2,792	—
Total Medicare revenue	127,422	—
Partnership revenue	60,935	54,931
Net fee-for-service revenue	41,514	44,462
Membership revenue	24,231	20,196
Grant income	—	1,763
Total commercial revenue	126,680	121,352
Total net revenue	$ 254,102	$ 121,352

Net fee-for-service revenue (previously reported as net patient service revenue) is primarily generated from commercial third-party payers with which the One Medical entities have established contractual billing arrangements. The following table summarizes net fee-for-service revenue by source:

	Three Months Ended March 31,	
	2022	2021
Net fee-for-service revenue:		
Commercial and government third-party payers	$ 36,606	$ 42,235
Patients, including self-pay, insurance co-pays and deductibles	4,908	2,227
Net fee-for-service revenue	$ 41,514	$ 44,462

The CARES Act was enacted on March 27, 2020 to provide economic relief to those impacted by the COVID-19 pandemic. The CARES Act includes various tax and lending provisions, among others. Under the CARES Act, the Company received an income grant of $1,763 from the Provider Relief Fund administered by the Health and Human Services ("HHS") during the three months ended March 31, 2021. The Company did not receive any income grants from the HHS for the three months ended March 31, 2022. Management has concluded that the Company met conditions of the grant funds and has recognized it as Grant income for the three months ended March 31, 2021.

During the three months ended March 31, 2022, the Company recognized revenue of $19,015, which was included in the beginning deferred revenue balances as of January 1, 2022. During the three months ended March 31, 2021, the Company recognized revenue of $14,321, which was included in the beginning deferred revenue balances as of January 1, 2021.

As of March 31, 2022, a total of $5,571 is included within deferred revenue related to variable consideration, of which $4,425 is classified as non-current as it will not be recognized within the next twelve months. The estimate of variable consideration is based on the Company's assessment of historical, current, and forecasted performance.

As summarized in the table below, the Company recorded contract assets and deferred revenue as a result of timing differences between the Company's performance and the customer's payment.

	March 31, 2022	December 31, 2021
Balances from contracts with customers:		
Capitated accounts receivable, net	$ 34,083	$ 23,903
All other accounts receivable, net	108,205	79,595
Contract asset (included in other current assets)	382	458
Deferred revenue	$ 91,702	$ 77,245

Capitated accounts receivable and payable related to At-Risk arrangements are recorded net in the condensed consolidated balance sheets when a legal right of offset exists. A right of offset exists when all of the following conditions are met: 1) each of two parties (the Company and the third-party payer) owes the other determinable amounts; 2) the reporting party (the Company) has the right to offset the amount owed with the amount owed by the other party (the third-party payer); 3) the reporting party (the Company) intends to offset; and 4) the right of offset is enforceable by law. All of the aforementioned conditions were met as of March 31, 2022.

The capitated accounts receivable and payable are recorded at the contract level and consist of the Company's Capitated Revenue attributed from enrolled At-Risk members less actual paid medical claims expense. If the Capitated Revenue exceeds the actual medical claims expense at the end of the reporting period, such surplus is recorded as capitated accounts receivable within accounts receivable, net in the condensed consolidated balance sheets. If the actual medical claims expense exceeds the Capitated Revenue, such deficit is recorded as capitated accounts payable within other current liabilities in the condensed consolidated balance sheets. As of March 31, 2022, the Company has capitated accounts receivable, net, of $34,083 and capitated accounts payable, net, of $6,132, representing amounts due from and to Medicare Advantage payers and CMS in At-Risk arrangements, respectively.

The capitated accounts receivable and payable are presented net of IBNR claims liability and other adjustments. There were no significant prior period adjustments or changes to the assumptions used in estimating the IBNR claims liability as of March 31, 2022. The Company believes the amounts accrued to cover IBNR claims as of March 31, 2022 are adequate.

Components of capitated accounts receivable, net is summarized below:

	March 31, 2022	December 31 2021
Capitated accounts receivable	$ 72,286	$ 56,384
IBNR claims liability	(36,989)	(32,320)
Other adjustments	(1,214)	(161)
Capitated accounts receivable, net	$ 34,083	$ 23,903

Components of capitated accounts payable, net is summarized below:

	March 31, 2022	December 31 2021
Capitated accounts payable	$ 4,874	$ 5,483
IBNR claims liability	1,315	1,438
Other adjustments	(57)	299
Capitated accounts payable, net	$ 6,132	$ 7,220

Activity in IBNR claims liability from December 31, 2021 through March 31, 2022 is summarized below:

	Amount
Balance as of December 31, 2021	$ 33,758
Incurred related to:	
Current period	102,864
Prior periods	2,102
	104,966
Paid related to:	
Current period	(67,755)
Prior periods	(32,665)
	(100,420)
Balance as of March 31, 2022	$ 38,304

The Company does not disclose the value of remaining performance obligations for (i) contracts with an original contract term of one year or less, (ii) contracts for which the Company recognizes revenue at the amount to which it has the right to invoice when that amount corresponds directly with the value of services performed, and (iii) variable consideration allocated entirely to a wholly unsatisfied performance obligation or to a wholly unsatisfied distinct service that forms part of a single performance obligation. For those contracts that do not meet the above criteria, the Company's remaining performance obligation as of March 31, 2022, is expected to be recognized as follows:

	Less than or equal to 12 months	Greater than 12 months	Total
As of March 31, 2022	$ 15,671	$ 30,279	$ 45,950

6. Leases

Most leases contain clauses for renewal at the Company's option with renewal terms that generally extend the lease term from 1 to 7 years. Certain lease agreements contain options to terminate the lease before maturity. The Company does not have any lease contracts with the option to purchase as of March 31, 2022. The Company's lease agreements do not contain any significant residual value guarantees or material restrictive covenants imposed by the leases.

Certain of the Company's furniture and fixtures and lab equipment are held under finance leases. Finance-lease-related assets are included in property and equipment, net in the condensed consolidated balance sheets and are immaterial as of March 31, 2022.

The components of operating lease costs were as follows:

	Three Months Ended March 31, 2022	2021
Operating lease costs	$ 13,004	$ 7,333
Variable lease costs	2,047	1,311
Total lease costs	$ 15,051	$ 8,644

Other information related to leases was as follows:

Supplemental Cash Flow Information

	Three Months Ended March 31,	
	2022	2021
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows from operating leases	$ 12,066	$ 7,855
Non-cash leases activity:		
Right-of-use lease assets obtained in exchange for new operating lease liabilities	$ 18,249	$ 16,086

Lease Term and Discount Rate

	March 31, 2022	December 31, 2021
Weighted-average remaining lease term (in years)	8.08	8.02
Weighted-average discount rate	6.61 %	6.55 %

At the lease commencement date, the discount rate implicit in the lease is used to discount the lease liability if readily determinable. If not readily determinable or leases do not contain an implicit rate, the Company's incremental borrowing rate is used as the discount rate. Management determines the appropriate incremental borrowing rates for each of its leases based on the remaining lease term at lease commencement.

Future minimum lease payments under non-cancellable operating leases as of March 31, 2022 were as follows (excluding the effect of lease incentives to be received that are recorded in other current assets of $13,990 which serve to reduce total lease payments):

	March 31, 2022
Remainder of 2022	$ 39,186
2023	55,546
2024	53,831
2025	50,127
2026	46,658
Thereafter	168,984
Total lease payments	414,332
Less: interest	(97,810)
Total lease liabilities	$ 316,522

7. Business Combinations

Acquisition of Iora

On September 1, 2021 ("Acquisition Date"), 1Life acquired all outstanding equity and capital stock of Iora Health, a human-centered, value-based primary care group with built-for-purpose technology focused on serving the Medicare population, for an aggregate purchase consideration of $1,424,836, which was paid through the issuance of 1Life common shares with a fair value of $1,313,312, in part by cash of $62,881, and in part by stock options of Iora assumed by 1Life towards pre-combination services of $48,643. The acquisition was accounted for as a business combination. Subsequent to the Acquisition Date, the Company recorded $2,370 decrease to goodwill during the measurement period in the first quarter of 2022. The preliminary purchase price allocations resulted in $1,117,913 of goodwill and $363,031 of acquired identifiable intangible assets related to Iora trade name and contracts in existing geographies valued using the income method. Goodwill recorded in the acquisition is not expected to be deductible for tax purposes. Goodwill was primarily attributable to the planned growth in new geographies, synergies expected to be achieved in the combined operations of 1Life and Iora, and assembled workforce of Iora.

The acquisition expanded the Company's reach to become a premier national human-centered, technology-powered, value-based primary care platform across all age groups. The acquisition allows the Company to participate in At-Risk arrangements with Medicare Advantage payers and CMS, in which the Company is responsible for managing a range of healthcare services and associated costs of its members.

Preliminary Purchase Price Allocation

The purchase price components are summarized in the following table:

Consideration in 1Life common stock (1)	$	1,313,312
Cash consideration (2)		62,881
Stock options of Iora assumed by 1Life towards pre-combination services (3)		48,643
Total Purchase Price	$	1,424,836

(1) Represents the fair value of 53,583 shares of 1Life common stock transferred as consideration consisting of 53,146 shares issued and 437 shares to be issued to former Iora shareholders for outstanding Iora capital stock based on 77,687 Iora shares with the Exchange Ratio of 0.69 for a share of Iora and 1Life's stock price of $24.51 as of the closing date. The fair value of the 53,583 shares transferred as consideration was determined on the basis of the closing market price of the Company's common stock one business day prior to the Acquisition Date.

(2) Included in the cash consideration are:

- $5,993 for the settlement of vested phantom stock awards and cash bonuses contingent on the completion of the merger. Iora's unvested phantom stock awards, to the extent they relate to post-combination services, will be paid out and expensed as they vest subsequent to the acquisition and will be treated as stock-based compensation expense.
- $30,253 of loans made by the Company to Iora prior to the Acquisition Date.
- $5,391 of repayment of the existing Silicon Valley Bank (“SVB”) loan, which was not legally assumed as part of the merger.
- The remainder of the cash consideration primarily relates to transaction expenses incurred by Iora and paid by the Company as of the closing date.

(3) Represents the fair value of Iora’s equity awards assumed by 1Life for pre-combination services. Pursuant to the terms of the merger agreement, Iora’s outstanding equity awards that are vested and unvested as of the effective time of the merger were replaced by 1Life equity awards with the same terms and conditions. The vested portion of the fair value of 1Life’s replacement equity awards issued represents consideration transferred, while the unvested portion represents post-combination compensation expense based on the vesting terms of the equity awards. The awards that include a provision for accelerated vesting upon a change of control are included in the vested consideration. The fair value of the stock options of Iora assumed by 1Life was determined by using a Black-Scholes option pricing model with the applicable assumptions as of the Acquisition Date. The fair value of the unvested stock awards, for which post-combination service is required, will be recorded as share-based compensation expense over the respective vesting period of each award. See Note 10, "Stock-Based Compensation".

The following table presents the preliminary purchase price allocation recorded in the Company's unaudited condensed consolidated balance sheet as of the Acquisition Date:

Cash and cash equivalents acquired	$	17,808
Accounts receivable, net		20,451
Prepaid expenses and other current assets		3,043
Restricted cash		2,069
Property and equipment, net		29,565
Right-of-use assets		70,249
Intangible assets, net		363,031
Other assets (1)		7,405
Total assets		513,621
Accounts payable		1,974
Accrued expenses		9,819
Deferred revenue, current		5,989
Operating lease liabilities, current		6,617
Operating lease liabilities, non-current		63,558
Deferred revenue, non-current		24,316
Deferred income taxes		80,537
Other non-current liabilities (1)		13,888
Total liabilities		206,698
Net assets acquired		306,923
Estimated Merger Consideration		1,424,836
Estimated goodwill attributable to Merger	$	1,117,913

(1) Included in the other assets was an escrow asset of $2,875 related to 1Life common stock held by a third-party escrow agent to be released to the former stockholders of Iora, less any amounts that would be necessary to satisfy any then pending and unsatisfied or unresolved claim for indemnification for any 1Life indemnifiable loss pursuant to the indemnity provisions of the Merger Agreement. A corresponding indemnification liability of $9,600 was recorded in other non-current liabilities in the Company's unaudited condensed consolidated balance sheet. During the three months ended March 31, 2022, a reduction in escrow asset and indemnification liability of $1,013 and $3,383, respectively was recorded as part of the measurement period adjustment. The indemnification asset is subject to remeasurement at each reporting date due to changes to the underlying value of the escrow shares until the shares are released from escrow, with the remeasurement adjustment reported in the Company's condensed consolidated statement of operations as interest and other expense. During the three months ended March 31, 2022, the fair value of the escrow asset had reduced and the unrealized loss recorded was $2,277 for the period.

The Company allocated the purchase price to tangible and identified intangible assets acquired and liabilities assumed based on the preliminary estimates of fair values, which were determined primarily using the income method based on estimates and assumptions made by management at the time of the Iora acquisition and are subject to change during the measurement period which is not expected to exceed one year. The primary tasks that are required to be completed include valuation of certain assets and liabilities, including any related tax impacts. Any adjustments to the preliminary purchase price allocation identified during the measurement period will be recognized in the period in which the adjustments are determined.

The Company recognized a net deferred tax liability of $80,537 in this business combination that is included in long-term liabilities in the accompanying condensed consolidated balance sheet. This primarily related to identified intangible assets recorded in acquisition for which there is no tax basis.

Identifiable intangible assets are comprised of the following:

	Preliminary Fair Value	Estimated Useful Life (in years)
Intangible Asset:		
Medicare Advantage contracts - existing geographies	$ 298,000	9
CMS Direct Contracting contract - existing geographies	52,000	9
Trade name: Iora	13,031	3
Total	$ 363,031	

Net tangible assets were valued at their respective carrying amounts as of the Acquisition Date, which approximated their fair values. Medicare Advantage contracts and CMS Direct Contracting contract represent the At-Risk arrangements that Iora has with Medicare Advantage plans or directly with CMS. Trade names represent the Company's right to the Iora trade names and associated design.

Loan Agreement

Under the Merger Agreement, 1Life and Iora have also entered into a Loan and Security Agreement on June 21, 2021. See Note 15 "Note Receivable" for more details.

Iora had an existing credit facility with SVB, which is referred to as the SVB Facility. The SVB facility of $5,391 was repaid on September 1, 2021, of which $50 is related to the prepayment penalty. Repayment of the existing SVB loan is accounted for as part of the acquisition purchase consideration.

Supplemental Unaudited Pro Forma Information

The following unaudited pro forma financial information summarizes the combined results of operations for 1Life and Iora as if the companies were combined as of the beginning of fiscal year 2020. The unaudited pro forma information includes transaction and integration costs, adjustments to amortization and depreciation for intangible assets and property and equipment acquired, stock-based compensation costs and tax effects.

The table below reflects the impact of material adjustments to the unaudited pro forma results for the three months ended March 31, 2021 that are directly attributable to the acquisition:

Material Adjustments	Three Months Ended March 31, 2021
(Decrease) / increase to expense as result of transaction costs	$ (3,237)
(Decrease) / increase to expense as result of amortization and depreciation expenses	11,541
(Decrease) / increase to expense as a result of stock-based compensation costs	698
(Decrease) / increase to expense as result of changes in tax effects	$ (4,909)

The unaudited pro forma information presented below is for informational purposes only and is not necessarily indicative of our condensed consolidated results of operations of the combined business had the acquisition actually occurred at the beginning of fiscal year 2020 or the results of our future operations of the combined businesses.

	Three Months Ended March 31, 2021
Revenue	$ 183,620
Net Loss	$ (62,374)

Other Acquisitions

In 2021, the Company completed three other acquisitions for $9,908 of total cash consideration. The acquisitions were each accounted for as business combinations. The Company does not consider these acquisitions to be material, individually or in aggregate, to the Company's condensed consolidated financial statements. The purchase price allocations resulted in $5,880 of goodwill and $3,921 of acquired identifiable intangible assets related to customer relationships valued using the income method. Intangible assets are being amortized over their respective useful lives of three or seven years. Acquisition-related costs were immaterial and were expensed as incurred in the condensed consolidated statements of operations.

8. Goodwill and Intangible Assets

Goodwill

As of March 31, 2022 and December 31, 2021, goodwill was $1,145,094 and $1,147,464, respectively. Due to the recent decline in the Company's stock price and uncertainties in general economic conditions, the Company considered the recoverability of its goodwill and determined, during three months ended March 31, 2022, there were no events or circumstances that have changed since the last annual test that could more likely than not reduce the fair value of the Company's reporting unit below its carrying value. No goodwill impairments were recorded during the three months ended March 31, 2022. Changes in economic and operating conditions and any further decline in the Company's stock price could result in potential goodwill impairment in future periods.

Goodwill balances as of March 31, 2022 and December 31, 2021 were as follows:

		Goodwill
Balance as of December 31, 2021	$	1,147,464
Measurement period adjustments		(2,370)
Balance as of March 31, 2022	$	1,145,094

Intangible Assets

The following summarizes the Company's intangible assets and accumulated amortization as of March 31, 2022:

	March 31, 2022		
	Original Cost	Accumulated Amortization	Net Book Value
Medicare Advantage contracts - existing geographies	$ 298,000	$ (19,315)	$ 278,685
CMS Direct Contracting contract - existing geographies	52,000	(3,370)	48,630
Trade name: Iora	13,031	(2,534)	10,497
Customer relationships	3,921	(533)	3,388
Total intangible assets	$ 366,952	$ (25,752)	$ 341,200

The following summarizes the Company's intangible assets and accumulated amortization as of December 31, 2021:

	December 31, 2021		
	Original Cost	Accumulated Amortization	Net Book Value
Medicare Advantage contracts - existing geographies	$ 298,000	$ (11,037)	$ 286,963
CMS Direct Contracting contract - existing geographies	52,000	(1,926)	50,074
Trade name: Iora	13,031	(1,448)	11,583
Customer relationships	3,921	(383)	3,538
Total intangible assets	$ 366,952	$ (14,794)	$ 352,158

The Company did not record any amortization expense of intangible assets for the three months ended March 31, 2021.

Purchased intangible assets are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset or asset group may not be recoverable.

As of March 31, 2022, estimated future amortization expense related to intangible assets were as follows:

	March 31, 2022
Remainder of 2022	$ 32,876
2023	43,835
2024	42,356
2025	39,417
2026	39,417
Thereafter	143,299
Total	$ 341,200

9. Convertible Senior Notes

In May 2020, the Company issued and sold $275,000 aggregate principal amount of 3.0% convertible senior notes due 2025 in a private offering exempt from the registration requirements of the Securities Act of 1933, and in June 2020, the Company issued an additional $41,250 aggregate principal amount of such notes pursuant to the exercise in full of the over-allotment option by the initial purchasers of the notes (the “2025 Notes”). The 2025 Notes are unsecured obligations and bear interest at a fixed rate of 3.0% per annum, payable semi-annually in arrears on June 15 and December 15 of each year, commencing on December 15, 2020. The 2025 Notes will mature on June 15, 2025, unless earlier converted, redeemed or repurchased. The total net proceeds from the debt offering, after deducting the initial purchasers’ commissions and other issuance costs, were $306,868.

Each $1 principal amount of the 2025 Notes will initially be convertible into 0.0225052 shares of the Company’s common stock, which is equivalent to an initial conversion price of $44.43 per share, subject to adjustment upon the occurrence of specified events but not for any accrued and unpaid interest.

Holders may convert the 2025 Notes at their option at any time prior to the close of business on the business day immediately preceding March 15, 2025 only under the following circumstances: (1) during any calendar quarter commencing after the calendar quarter ending on September 30, 2020 (and only during such calendar quarter), if the last reported sale price of the Company’s common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on, and including, the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day; (2) during the five business day period after any ten consecutive trading day period (the “measurement period”) in which the trading price (as defined below) per $1 principal amount of the 2025 Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of the Company’s common stock and the conversion rate on each such trading day; (3) if the Company calls such 2025 Notes for redemption, at any time prior to the close of business on the scheduled trading day immediately preceding the

redemption date; or (4) upon the occurrence of specified corporate events. It is the Company's current intent to settle conversions through combination settlement comprising of cash and equity.

On or after March 15, 2025 until the close of business on the business day immediately preceding the maturity date, holders may convert all or any portion of their 2025 Notes at any time, regardless of the foregoing circumstances. Upon conversion, the Company will pay or deliver, as the case may be, cash, shares of the Company's common stock or a combination of cash and shares of the Company's common stock, at the Company's election and in accordance with the terms of the indenture governing the 2025 Notes. If the Company satisfies its conversion obligation solely in cash or through payment and delivery, as the case may be, of a combination of cash and shares of the Company's common stock, the amount of cash and shares of common stock, if any, due upon conversion will be based on a daily conversion value calculated on a proportionate basis for each trading day in a 40 trading day observation period. In addition, following certain corporate events that occur prior to the maturity date or if the Company delivers a notice of redemption, the Company will, in certain circumstances, increase the conversion rate for a holder who elects to convert its 2025 Notes in connection with such a corporate event or notice of redemption, as the case may be. If the Company undergoes a fundamental change prior to the maturity date, holders of the 2025 Notes may require the Company to repurchase for cash all or any portion of their notes at a repurchase price equal to 100% of the principal amount of the 2025 Notes to be repurchased, plus accrued and unpaid interest to, but excluding, the fundamental change repurchase date.

In addition, if specific corporate events occur prior to the applicable maturity date, the Company will increase the conversion rate for a holder who elects to convert their 2025 Notes in connection with such a corporate event in certain circumstances. The Company may not redeem the 2025 Notes prior to June 20, 2023. The Company may redeem for cash all or any portion of the 2025 Notes, at the Company's option, on or after June 20, 2023 and prior to March 15, 2025, if the last reported sale price of the Company's common stock has been at least 130% of the conversion price then in effect for at least 20 trading days (whether or not consecutive) during any 30 consecutive trading day period (including the last trading day of such period) ending on, and including, the trading day immediately preceding the date on which the Company provides notice of redemption at a redemption price equal to 100% of the principal amount of the 2025 Notes to be redeemed, plus accrued and unpaid interest to, but excluding, the redemption date. No sinking fund is provided for the notes. During the three months ended March 31, 2022, the conditions allowing holders of the 2025 Notes to convert have not been met. The 2025 Notes are therefore not convertible as of March 31, 2022 and are classified in long term liabilities in the condensed consolidated balance sheet.

The Company incurred issuance costs of $9,374 and amortizes the issuance costs to interest expense over the contractual term of the 2025 Notes at an effective interest rate of 0.65%.

The net carrying amount of the 2025 Notes was as follows:

	March 31, 2022	December 31, 2021
Liabilities:		
Principal	$ 316,250	$ 316,250
Unamortized issuance costs	(5,937)	(6,406)
Net carrying amount	$ 310,313	$ 309,844

The following table sets forth the interest expense recognized related to the 2025 Notes:

	Three Months Ended March 31,	
	2022	2021
Contractual interest expense	$ 2,372	$ 2,372
Amortization of issuance costs	469	469
Total interest expense related to the 2025 Notes	$ 2,841	$ 2,841

10. Stock-Based Compensation

Stock Incentive Plan

The Company has the following stock-based compensation plans: the 2007 Equity Incentive Plan (the "2007 Plan"), the 2017 Equity Incentive Plan (the "2017 Plan"), and the 2020 Equity Incentive Plan (the "2020 Plan", and, together with the 2007 Plan and the 2017 Plan, the "Plans").

In January 2020, the Company's stockholders approved the 2020 Plan, which took effect upon the execution of the underwriting agreement for the Company's IPO in January 2020. The 2020 Plan is intended as the successor to and continuation of the 2007 Plan and the 2017 Plan. The number of shares of common stock reserved for issuance under the Company's 2020 Plan will automatically increase on January 1 of each year, beginning on January 1, 2021, and continuing through and including January 1, 2030, by 4% of the total number of shares of common stock outstanding on December 31 of the immediately preceding calendar year, or a lesser number of shares determined by the Company's board prior to the applicable January 1st. The number of shares issuable under the Plans is adjusted for capitalization changes, forfeitures, expirations and certain share reacquisitions. The Plan provides for the grants of incentive stock options ("ISOs"), non-statutory stock options ("NSOs"), restricted stock awards, and restricted stock unit awards ("RSUs"). ISOs may be granted only to employees, including officers. All other awards may be granted to employees, including officers, non-employee directors and consultants. The 2020 Plan provides that grants of ISOs will be made at no less than the estimated fair value of common stock, as determined by the Board of Directors, at the date of grant. Stock options granted to employees and nonemployees under the Plans generally vest over 4 years. Options granted under the Plans generally expire 10 years after the date of grant.

At March 31, 2022, 2,950 shares were available for future grants.

2020 Employee Stock Purchase Plan

In January 2020, the Company's stockholders approved the 2020 Employee Stock Purchase Plan ("ESPP"), which became effective upon the execution of the underwriting agreement for the Company's IPO in January 2020. The ESPP provides for separate six-month offering periods beginning on May 16 and November 16 of each year. At March 31, 2022, 4,246 shares were available for future issuance. The stock-based compensation expense recognized for the ESPP was $425 and $621 during the three months ended March 31, 2022 and 2021, respectively.

Stock Options

The following table summarizes stock option activity under the Plans:

	Number of Options	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Term (Years)	Aggregate Intrinsic Value
Outstanding as of December 31, 2021	28,312	$ 19.32	7.57	$ 192,955
Granted	1,819	12.11		
Exercised	(579)	3.86		
Canceled	(444)	15.51		
Outstanding as of March 31, 2022	29,108	$ 19.24	7.49	$ 79,748
Options exercisable as of March 31, 2022	12,146	$ 5.95	6.08	$ 71,253
Options vested and expected to vest as of March 31, 2022	18,893	$ 8.60	6.83	$ 79,303

At March 31, 2022 and 2021, there was $24,640 and $17,897, respectively, in unrecognized compensation expense related to service-based options, net of forfeitures, that is expected to be recognized over a weighted-average period of 1.6 and 1.9 years, respectively.

The fair value of stock option grants with service-based vesting conditions was $11,598 and $12,168 for the three months ended March 31, 2022 and 2021, respectively.

Assumed Equity Awards

As of the Acquisition Date, the Company assumed Iora's outstanding equity awards related to stock options and phantom stock. The awards under the assumed equity plan were generally settled as follows:

- Options: All Iora options outstanding on the close date were assumed by 1Life and converted into options to acquire shares of 1Life common stock. The vested and unvested options, to the extent related to pre-combination services were included in the consideration transferred. Iora's unvested options, to the extent they relate to post-combination services, will be expensed as they vest post the acquisition and will be treated as stock-based compensation expense. See Note 7 "Business Combinations".
- Phantom stock: Each Iora vested phantom stock award has been settled in cash. Each Iora unvested phantom stock award has been assumed by the Company and converted into the right to receive the unvested phantom cash award. Each unvested phantom cash award will remain subject to the same terms and conditions as were applicable to the underlying unvested phantom stock award immediately prior to the close date. The unvested phantom stock award is considered a liability-classified award as the settlement involves a cash payment upon the dates when these awards vest. The entire vested award and unvested phantom stock, to the extent they relate to pre-combination services, were included in the consideration transferred. Iora's unvested phantom stock awards, to the extent they relate to post-combination services, will be expensed as they vest post acquisition and will be treated as stock-based compensation expense. See Note 7 "Business Combinations".

As of the Acquisition Date, the estimated fair value of the assumed equity awards was $60,856, of which $52,662 was allocated to the purchase price and the balance of $8,194 will be recognized as stock-based compensation expense over the remainder term of the assumed equity awards. The fair value of the assumed equity awards for service rendered through the Acquisition Date was recognized as a component of the acquisition consideration, with the remaining fair value related to post combination services to be recorded as stock-based compensation over the remaining vesting period.

Market-based Stock Options

During the year ended December 31, 2020, the Board of Directors ("Board") approved the grant of a long-term market-based stock option (the "Performance Stock Option") to the Company's Chief Executive Officer and President. The Performance Stock Option was granted to acquire up to 8,645 shares of the Company's common stock upon exercise. The Performance Stock Option consists of four separate tranches and each tranche will vest over a seven-year time period and only if the Company's stock price sustains achievement of pre-determined increases for a period of 90 consecutive calendar days and the Chief Executive Officer remains employed with the Company. The exercise price per share of the Stock Option is the closing price of a share of the Company's common stock on the date of grant. The vesting of the Performance Stock Option can also be triggered upon a change in control. The following table presents additional information relating to each tranche of the Performance Stock Option:

Tranche	Stock Price Milestone	Number of Options
Tranche 1	$55 per share	1,330
Tranche 2	$70 per share	1,995
Tranche 3	$90 per share	2,660
Tranche 4	$110 per share	2,660

As of March 31, 2022, no stock price milestones have been achieved. Consequently, no shares subject to the Performance Stock Option have vested as of the date of this filing. The entire 8,645 shares granted are excluded from options vested and expected to vest from the options activity table presented above.

The Company will recognize aggregate stock-based compensation expense of $197,469 over the derived service period of each tranche using the accelerated attribution method as long as the service-based vesting conditions are satisfied. If the market conditions are achieved sooner than the derived service period, the Company will adjust its stock-based compensation to reflect the cumulative expense associated with the vested awards. The Company recorded stock-based compensation expense of $14,089 and $14,926 related to the award for the three months ended March 31, 2022 and 2021, which is included in general and administrative on the condensed consolidated statements of operations. Unamortized stock-based compensation expense related to the award was $122,863 as of March 31, 2022.

Restricted Stock Units

The following table summarizes restricted stock unit activity under the 2020 Plan:

	Number of Shares	Grant Date Fair Value
Unvested and outstanding as of December 31, 2021	3,249	$ 27.90
Granted	4,693	11.78
Vested	(434)	31.76
Canceled and forfeited	(292)	17.78
Unvested and outstanding as of March 31, 2022	7,216	$ 17.60

Stock-Based Compensation Expense

Stock-based compensation expense was classified in the condensed consolidated statements of operations as follows:

	Three Months Ended March 31,	
	2022	2021
Sales and marketing	$ 943	$ 1,023
General and administrative	35,976	25,305
Total	$ 36,919	$ 26,328

A tax benefit of $1,938 and $30,394 for the three months ended March 31, 2022 and 2021, respectively, was included in the Company's net operating loss carry-forward that could potentially reduce future tax liabilities.

11. Income Taxes

The Company recorded an income tax benefit of $6,732 and an income tax provision of $4,199 for the three months ended March 31, 2022 and 2021, respectively. This represents an effective tax rate for the respective periods of 6.9% and (12.0)%, respectively. The Company reassessed the ability to realize deferred tax assets by considering the available positive and negative evidence. As of March 31, 2022, the Company maintains a full valuation allowance against its net deferred tax assets. Amortization of book identified intangibles from that acquisition resulted in a decrease to deferred tax liabilities; the associated income tax benefit during the period was $6,745. The effective tax rate differs in 2022 from the federal statutory rate due to the change in need for valuation allowance and amortization of identified intangibles. The effective tax rate differs in 2021 from the federal statutory rate due to increased taxable income in profitable entities and the change in need for valuation allowance.

12. Net Loss Per Share

Basic and diluted net loss per share were calculated as follows:

	Three Months Ended March 31,	
	2022	2021
Numerator:		
Net loss	$ (90,859)	$ (39,318)
Denominator:		
Weighted average common shares outstanding — basic and diluted	193,019	136,516
Net loss per share — basic and diluted	$ (0.47)	$ (0.29)

The Company's potentially dilutive securities, which include stock options, unvested RSUs, 2025 Notes and shares held in special indemnity escrow account in connection with Iora acquisition, have been excluded from the computation of diluted net loss per share as the effect would be to reduce the net loss per share. Therefore, the weighted average number of common shares outstanding used to calculate both basic and diluted net loss per share is the same. The Company excluded the following

potential common shares, presented based on amounts outstanding at each period end, from the computation of diluted net loss per share for the periods indicated because including them would have had an anti-dilutive effect:

	As of March 31,	
	2022	2021
Options to purchase common stock	29,108	26,160
Unvested restricted stock	7,207	1,847
2025 Notes (1)	7,117	7,117
Shares held in special indemnity escrow account in connection with Iora acquisition	405	—
	43,837	35,124

(1) During the three months ended March 31, 2022, the conditions allowing holders of the 2025 Notes to convert have not been met. The 2025 Notes are therefore not convertible as of March 31, 2022.

13. Commitments and Contingencies

Indemnification Agreements

In the ordinary course of business, the Company may provide indemnification of varying scope and terms to vendors, lessors, business partners and other parties with respect to certain matters including, but not limited to, losses arising out of breach of such agreements or from intellectual property infringement claims made by third parties. In addition, the Company has entered into indemnification agreements with members of its Board of Directors and executive officers that will require the Company, among other things, to indemnify them against certain liabilities that may arise by reason of their status or service as directors or officers. The maximum potential amount of future payments the Company could be required to make under these indemnification agreements is, in many cases, unlimited. As of March 31, 2022 and December 31, 2021, the Company has not incurred any material costs as a result of such indemnifications.

Legal Matters

In May 2018, a class action complaint was filed by two former members against the Company in the Superior Court of California for the County of San Francisco, or the Court, alleging that the Company made certain misrepresentations resulting in them paying the Annual Membership Fee, or AMF, in violation of California’s Consumers Legal Remedies Act, California’s False Advertising Law and California’s Unfair Competition Law, and seeking damages and injunctive relief. Following certain trial court proceedings and certain appeals, arbitration proceedings, and court-ordered mediation proceedings, in June 2021, the parties filed a joint notice of settlement and request for a six month stay before the appellate court in light of reaching a settlement in principle. The parties later executed a class action settlement agreement and release effective June 30, 2021, which requires trial court approval. A preliminary class settlement approval hearing was scheduled to take place in August 2021, but the trial court requested supplemental briefing and vacated the previously scheduled hearing. Plaintiffs filed their supplemental brief and supporting documents on October 12, 2021. The trial court granted the motion for preliminary approval on November 12, 2021. Under the terms of the settlement and the trial court’s order, the settlement will proceed to the class notice phase, which is expected to happen in early 2022. The final approval hearing on the settlement is currently set for July 25, 2022.

The settlement amount of $11,500 was recorded as other current liabilities in the condensed consolidated balance sheets as of June 30, 2021. The Company's insurers committed to pay $5,950 towards the settlement amount. The settlement amount, net of expected insurance recovery, of which $5,550 was recorded as general and administrative expenses in the condensed consolidated statements of operations for the three months ended June 30, 2021. Class payout is expected to occur in 2022. There was no material change to the liability amount or any incremental expenses incurred during the three months ended March 31, 2022.

Government Inquiries and Investigations

In March 2021, the Company received (i) requests for information and documents from the United States House Select Subcommittee on the Coronavirus Crisis, (ii) a request for information from the California Attorney General and the Alameda County District Attorney’s Office and (iii) a request for information and documents from the Federal Trade Commission relating to the Company’s provision of COVID-19 vaccinations. The Company has also received inquiries from state and local

public health departments regarding its vaccine administration practices and has and may continue to receive additional requests for information from other governmental agencies relating to its provision of COVID-19 vaccinations. The Company is cooperating with these requests as well as requests received from other governmental agencies, including with respect to the Company's compensation practices and membership generation during the relevant periods. The majority staff of the Subcommittee released a memorandum of findings in December 2021. No further disclosures, testimony or other responses have been requested by the Subcommittee. In addition, in February 2022, the Federal Trade Commission advised us that they were closing their inquiry on our provision of COVID-19 vaccinations. The Company is unable to predict the outcomes or timeline of the residual government inquiries or if any additional requests, inquiries, investigations or other government actions may arise relating to such circumstances. Legal fees have been recorded as general and administrative expenses in the consolidated statements of operations.

Sales and Use Tax

During 2017 and 2018, a state jurisdiction engaged in an audit of 1Life’s sales and use tax records applicable to that jurisdiction from March 2011 through February 2017. The Company disputed the finding representing the majority of the state's proposed audit change and successfully overturned the sales tax assessment resulting from the audit in December 2021. As of March 31, 2022, the audit was closed and the payment remitted was not material.

In addition, from time to time, the Company has been and may be involved in various legal proceedings arising in the ordinary course of business. The Company currently believes that the outcome of these legal proceedings, either individually or in the aggregate, will not have a material effect on its consolidated financial position, results of operations or cash flows.

14. Related Party Transactions

Certain of the Company’s investors are also affiliated with customers of the Company. Revenue recognized under contractual obligations from such customers was immaterial for the three months ended March 31, 2022 and March 31, 2021, respectively. The outstanding receivable balance from such customers was immaterial as of March 31, 2022 and December 31, 2021, respectively.

15. Note Receivable

In connection with the Iora acquisition, on June 21, 2021, 1Life and Iora entered into a loan agreement under which the Company may advance secured loans to Iora to fund working capital, at Iora's request from time to time, in outstanding amounts not to exceed $75,000 in the aggregate. Amounts drawn under the loan agreement are secured by all assets of Iora and were subordinated to Iora's obligations under its then-existing credit facility with SVB. The loan agreement is effective through the maturity date of borrowed amounts under the loan agreement. Such maturity date is the later of 90 days following the earliest of certain maturity dates set forth in the SVB Facility. Amounts drawn bear interest at a rate equal to 10% per year, payable monthly.

As of the Acquisition Date, there was $30,000 drawn and outstanding under the loan agreement. Pursuant to the consummation of Iora's acquisition by 1Life, this note receivable was eliminated as part of intercompany eliminations. $30,253 of note receivable including accrued interests prior to the Acquisition Date was treated as purchase consideration. See Note 7 "Business Combinations" for additional details.

Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations.

Forward-Looking Statements

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, and Section 21E of the Securities Exchange Act of 1934, as amended, which are subject to the "safe harbor" created by those sections. Forward-looking statements are based on our management's beliefs and assumptions and on information currently available to our management. In some cases, you can identify forward-looking statements by terms such as "may," "will," "should," "could," "goal," "would," "expect," "plan," "anticipate," "believe," "estimate," "project," "predict," "potential" and similar expressions intended to identify forward-looking statements. These statements involve known and unknown risks, uncertainties and other factors, which may cause our actual results, performance, time frames or achievements to be materially different from any future results, performance, time frames or achievements expressed or implied by the forward-looking statements. In addition, statements including "we believe" and similar statements reflect our beliefs and opinions on the relevant subject. These statements are based upon information available to us as of the filing date of this Quarterly Report on Form 10-Q, and while we believe such information forms a reasonable basis for such statements, such information may be limited or incomplete, and our statements should not be read to indicate that we have conducted an exhaustive inquiry into, or review of, all potentially available relevant information. These statements are inherently uncertain and investors are cautioned not to unduly rely upon these statements.

The following Management's Discussion and Analysis of Financial Condition and Results of Operations should be read together with our condensed consolidated financial statements and accompanying notes included elsewhere in this Quarterly Report. This discussion includes both historical information and forward-looking statements based upon current expectations that involve risk, uncertainties and assumptions. Our results of operations include the results of operations of Iora since the close of our acquisition on September 1, 2021. Our actual results may differ materially from management's expectations and those anticipated in these forward-looking statements as a result of various factors, including, but not limited to, our ability to timely and successfully achieve the anticipated benefits and potential synergies of our acquisition of Iora Health, Inc. and the continuing impact of the COVID-19 pandemic and societal and governmental responses as well as those discussed in "Risk Factors" and elsewhere in this Quarterly Report on Form 10-Q.

Overview

Our mission is to transform health care for all through our human-centered, technology-powered model. Our vision is to delight millions of members with better health and better care while reducing the total cost of care. We are a membership-based primary care platform with seamless digital health and inviting in-office care, convenient to where people work, shop, live and click. We are disrupting health care from within the existing ecosystem by simultaneously addressing the frustrations and unmet needs of key stakeholders, which include consumers, employers, providers, and health networks.

We have developed a modernized healthcare membership model based on direct consumer enrollment and third-party sponsorship across commercially insured and Medicare populations. Our membership model includes seamless access to 24/7 digital health services paired with inviting in-office care routinely covered by most health care payers. Our technology drives high monthly active usage within our membership, promoting ongoing and longitudinal patient relationships for better health outcomes and high member retention. Our technology also helps our service-minded team in building trust and rapport with our members by facilitating proactive digital health outreach as well as responsive on-demand virtual and in-office care. Our digital health services and our well-appointed offices, which tend to be located in highly convenient locations, are staffed by a team of clinicians who are not paid on a fee-for-service basis, and therefore free of misaligned compensation incentives prevalent in health care. Additionally, we have developed clinically and digitally integrated partnerships with health networks, better coordinating more timely access to specialty care when needed by members. Together, this approach allows us to engage in value-based care across all age groups, including through At-Risk arrangements with Medicare Advantage payers and CMS, in which One Medical is responsible for managing a range of healthcare services and associated costs of our members.

Our focus on simultaneously addressing the unfulfilled needs and frustrations of key stakeholders has allowed us to consistently grow the number of members we serve. As of March 31, 2022, we have grown to approximately 767,000 total members including 728,000 Consumer and Enterprise members and 39,000 At-Risk members, 188 medical offices in 25 markets, and have greater than 8,500 enterprise clients across the United States.

Impact of COVID-19 on Our Business

The COVID-19 pandemic has impacted and may continue to impact our operations, and net revenues, expenses, collectability of accounts receivables and other money owed, capital expenditures, liquidity, and overall financial condition.

While we experienced negative impacts to our business from the COVID-19 pandemic during the first half of 2020, beginning in the second half of 2020 and through 2021, we believe the COVID-19 pandemic helped drive an increase in Consumer and Enterprise membership and increase in commercial revenue due to new and expanded service offerings, and an increase in our aggregate billable services primarily driven by COVID-19 related visits.

For example, we believe COVID-19 caused our value proposition to resonate with a broader audience of consumers seeking access to primary care, as well as with a broader audience of employers focusing on safely reopening their workplaces and managing the ongoing health and well-being of employees and their families. As a result, we experienced increased demand for our memberships beginning in the second half of 2020 and through 2021.

In addition, we expanded our service offering in part as a response to COVID-19 and launched several new billable services, including:

- COVID-19 testing, and counseling across all of our markets, including in our offices and in several mobile COVID-19 testing sites;
- COVID-19 vaccinations in select geographies;
- Healthy Together, our COVID-19 screening and testing program for employers, schools and universities;
- Mindset by One Medical, our behavioral health service integrated within primary care;
- One Medical Now, an expansion of our 24/7 on-demand digital health solutions to employees of enterprise clients located in geographies where we are not yet physically present; and,
- Remote Visits, where our providers perform typical primary care visits with our members remotely

Towards the tail end of 2021, we started to experience a decline in COVID-related visits while we have not yet seen non-COVID-related primary care visits return to their pre-COVID levels, which negatively impacted our commercial revenue. Starting in the fourth quarter of 2021, the Omicron variant caused a spike in COVID-19 cases. This caused an increase in hospitalizations among At-Risk members, which negatively impacted our medical claims expense. We also saw an increase in the number of providers who were required to quarantine as a result of potential exposure to the virus, which caused some supply constraint in our ability to meet member demand for appointments. The effects of the Omicron variant appeared to peak in mid-January 2022, and the impact has since decreased. However, future COVID-19 outbreaks or variants may cause additional reductions in visits and increased hospitalizations of At-Risk members, which may negatively impact our results of operations and cause our revenue and margins to fluctuate across periods.

We believe some of the precautionary measures and challenges resulting from the COVID-19 pandemic may continue or be reinstated upon the occurrence of future outbreaks of variants. Such actions or events may present additional challenges to our business, financial condition and results of operations. As a result, we cannot assure you that any increase in membership, aggregate reimbursement and revenue or reduction in medical claims expense, or any increased trends in visits, are indicative of future results or will be sustained, including following the COVID-19 pandemic, or that we will not experience additional impacts associated with COVID-19, which could be significant. Our results may also continue to fluctuate across periods due to the future COVID-19 outbreaks or variants. Additionally, it is unclear what the impact of the COVID-19 pandemic will be on future utilization, medical expense patterns, and the associated impact on our business and results of operations.

Our Business Model

Our business is driven by growth in Consumer and Enterprise members, and At-Risk members (see also "Key Metrics and Non-GAAP Financial Measures"). We have developed a modernized membership model based on direct consumer enrollment and third-party sponsorship. Our membership model includes seamless access to 24/7 digital health paired with inviting in-office care routinely covered by most health care payers. Consumer and Enterprise members join either individually as consumers by paying an annual membership fee or are sponsored by a third party. At-Risk members are members for whom we are responsible for managing a range of healthcare services and associated costs. Digital health services are delivered via our mobile app and website, through such modalities as video and voice encounters, chat and messaging. Our in-office care is delivered in our medical offices, and as of March 31, 2022, we had 188 medical offices, compared to 110 medical offices as of March 31, 2021.

We derive net revenue, consisting of Medicare revenue and commercial revenue, from multiple stakeholders, including consumers, employers and health networks such as health systems and government and private payers.

Medicare Revenue

Medicare revenue consists of (i) Capitated Revenue and (ii) fee-for-service and other revenue that is not generated from Consumer and Enterprise members.

We generate Capitated Revenue from At-Risk arrangements with Medicare Advantage payers and CMS. Under these At-Risk arrangements, we generally receive capitated payments, consisting of each eligible member's risk adjusted health care premium per member per month ("PMPM"), for managing a range of healthcare services and associated costs for such members. The risk adjusted health care premium PMPM is determined by payers and based on a variety of patients' factors such as age and demographic benchmarks, and further adjusted to reflect the underlying complexity of a member's health conditions. These fees give us revenue economics that are contractually recurring in nature for a majority of our Medicare revenue. Capitated Revenue represents 98% of Medicare revenue and 49% of total net revenue, respectively, for the three months ended March 31, 2022.

We generate fee-for-service and other revenue from fee-for-service visits for Other Patients not covered under At-Risk arrangements and from certain payers for clinical start-up, administration, or on-going coordination of care activities associated with providing care to At-Risk members and other Medicare patients.

Commercial Revenue

Commercial revenue consists of (i) partnership revenue (ii) net fee-for-service revenue and (iii) membership revenue.

We generate our partnership revenue from (i) our health network partners with whom we have clinically and digitally integrated, on a PMPM basis, (ii) largely fixed price or fixed price per employee contracts with enterprise clients for medical services and (iii) COVID-19 on-site testing services for enterprise clients, schools and universities where we typically bill such customers a fixed price per service performed. For our health network arrangements that provide for PMPM payments, when our medical offices provide professional clinical services to covered members, we, as administrator, perform billing and collection services on behalf of the health network, and the health network receives the fees for services provided, including those paid by members' insurance plans. In those circumstances, we earn and receive PMPM payments from the health network partners in lieu of per visit fees for services from member office visits.

Our net fee-for-service revenue primarily consists of reimbursements received from our members' or other patients' health insurance plans or those with billing rates based on our agreements with our health network partners for healthcare services delivered to Consumer and Enterprise members on a fee-for-service basis.

We generate our membership revenue through the annual membership fees charged to either consumer members or enterprise clients, as well as fees paid for our One Medical Now service offering. As of March 31, 2022, our list price for new members for an annual consumer membership was $199. Our enterprise clients typically pay a discounted fee collected in advance, based on a rate per employee per month.

Our membership fee revenue and partnership revenue are contractual and, with the exception of our COVID-19 on-site testing services, generally recurring in nature. Membership revenue and partnership revenue as a percentage of commercial revenue was 67% and 62% for each of the three months ended March 31, 2022 and 2021, respectively. Membership revenue and partnership revenue as a percentage of total net revenue was 34% and 62% for the three months ended March 31, 2022 and 2021, respectively.

Key Factors Affecting Our Performance

- ***Acquisition of Net New Members.*** Our ability to increase our membership will enable us to drive financial growth as members drive our commercial revenue and Medicare revenue. We believe that we have significant opportunities to increase members in our existing geographies through (i) new sales to consumers and enterprise clients, (ii) expansion of the number of enrolled members, including dependents, within our enterprise clients, (iii) expansion of the number of At-Risk members including Medicare Advantage participants or Medicare members for which we are at risk as a result of CMS' Direct Contracting Program, (iv) expansion of Medicare Advantage payers, with whom we contract and (v) adding other potential services.
- ***Components of Revenue***. Our ability to maintain or improve pricing levels for our memberships and the pricing under our contracts with health networks will also impact our total revenue. As of March 31, 2022, our list price for new members for an annual consumer membership was $199. Our enterprise clients typically pay a discounted fee collected in advance, based on a rate per employee

per month. In geographies where our health network partners pay us on a PMPM basis for Consumer and Enterprise members, to the extent that the PMPM rate changes, our partnership revenue will change. Similarly, if the largely fixed price or number of employees covered by fixed price per employee arrangements change or the number of COVID-19 on-site tests or vaccinations changes, our partnership revenue will also change. Our net fee-for-service revenue is dependent on (i) our billing rates and third-party payer contracted rates through agreements with health networks, (ii) the mix of members who are commercially insured and (iii) the nature of visits. Our net fee-for-service revenue may also change based on the services we provide to commercially insured Other Patients as defined in "Key Metrics and Non-GAAP Financial Measures" below. Our Medicare revenue is dependent on (i) the percentage of members in at-risk contracts, (ii) our contracted percentage of premium, (iii) our ability to accurately document the acuity of our At-Risk members, and (iv) the services we provide to Other Patients who are Medicare participants. In the future, we may add additional services for which we may charge in a variety of ways. To the extent the net amounts we charge our members, patients, partners, payers and clients change, our net revenue will also change.

- ***Medical Claims Expense.*** The nature of our contracting with Medicare Advantage payers and CMS requires us to be financially responsible for a range of healthcare services of our At-Risk members. Our care model focuses on leveraging the primary care setting as a means of reducing unnecessary or avoidable health care costs and balancing the cost of care with the impact of our service on medical claims expense. We are liable for potentially large medical claims should we not effectively manage our At-Risk members' health. We call the ratio between medical claims expense divided by Capitated Revenue the "Medical Claims Expense Ratio". As we sign up new At-Risk members, our Medical Claims Expense Ratio is likely to increase initially due to a potential increase in medical claims expense from a lag in improvement in health outcomes with member tenure. Similarly, there may be a lag in adequately documenting the health status of our members, resulting in different Capitated Revenue compared to what is indicated by the health status of an At-Risk member. We believe that the Medical Claims Expense Ratio for a given set of At-Risk members can improve over time as we help improve their health outcomes relative to their underlying health conditions, though the ratio may fluctuate for any given customers or cohort of customers depending on future outbreaks or variants of COVID-19 and associated increases in medical claims expense.

- ***Cost of Care, Exclusive of Depreciation and Amortization.*** Cost of care primarily includes our provider and support employee-related costs for both virtual and in-office care, occupancy costs, medical supplies, insurance and other operating costs. Providers include doctors of medicine, doctors of osteopathy, nurse practitioners, physician assistants and behavioral health specialists. Support employees include registered nurses, phlebotomists, health coaches, and administrative assistants assisting our members with all non-medical related services. Virtual care includes video visits and other synchronous and asynchronous communication via our app and website. A large portion of these costs are relatively fixed regardless of member utilization of our services. Our care model focuses on leveraging the primary care setting as a means of reducing unnecessary or avoidable health care costs and balancing the cost of care with the impact of increased service levels on medical claims expense. An increase in cost of care may help us in reducing total health care costs for our members. For Consumer and Enterprise members, this reduction in total health care costs typically accrues to the benefit of our enterprise clients or our members' health insurance plans through lower claims costs, or our members through lower deductibles, making our membership more competitive. For our At-Risk members, reductions in total health care costs typically accrue directly to us, to our health network partners such as Medicare Advantage payers and CMS, or to our At-Risk members, making our membership more competitive. As a result, we seek to balance the cost of care based on a variety of considerations. For example, cost of care as a percentage of net revenue may decrease if our net revenue increases. Similarly, our cost of care as a percentage of net revenue may increase if we decide to increase our investments in our providers or support employees to try to reduce our medical claims expense. As we open new offices, and expand into new geographies, we expect cost of care to increase. Our cost of care, exclusive of depreciation and amortization, also excludes stock-based compensation.

- ***Care Margin.*** Care Margin is driven by net revenue, medical claims expense, and cost of care. We believe we can (i) improve revenue over time by signing up more members and increasing the revenue per member, (ii) reduce Medical Claims Expense Ratio over time from primary care engagement and population health management, improving member health and satisfaction, while

reducing the need for avoidable and costly care, and (iii) reduce cost of care as a percentage of revenue by better leveraging our fixed cost base and technology.

- ***Investments in Growth.*** We expect to continue to focus on long-term growth through investments in sales and marketing, technology research and development, and existing and new medical offices. We are working to enhance our digital health and technology offering and increase the potential breadth of our modernized platform solution. In particular, we plan to launch new offices and enter new geographies. As we expand to new geographies, we expect to make significant upfront investments in sales and marketing to establish brand awareness and acquire new members. Additionally, we intend to continue to invest in new offices in new and existing geographies. As we invest in new geographies, in the short term, we expect these activities to increase our operating expenses and cost of care; however, in the long term we anticipate that these investments will positively impact our results of operations.

- ***Seasonality.*** Seasonality affects our business in a variety of ways. In the near term, we expect these typical seasonal trends to fluctuate due to future outbreaks or variants of the COVID-19 pandemic.

  Medicare Revenue: We recognize Capitated Revenue from At-Risk members ratably over their period of enrollment. We typically experience the largest portion of our At-Risk member growth in the first quarter, as the Medicare Advantage enrollment from the prior Medicare Annual Enrollment Period ("AEP") becomes effective January 1. Throughout the remainder of year, we can continue to enroll new At-Risk members predominantly through (i) new Medicare Advantage enrollees joining us outside AEP, (ii) through expanding the Medicare Advantage plans we are participating in, and (iii) adding additional geographies where we participate in At-Risk arrangements.

  Commercial Revenue: Our partnership and membership revenue are predominantly driven by the number of Consumer and Enterprise members, and recognized ratably over the period of each contract. While Consumer and Enterprise members have the opportunity to buy memberships throughout the year, we typically experience the largest portion of our Consumer and Enterprise member growth in the first and fourth quarter of each year, when enterprise customers tend to make and implement decisions on their employee benefits. Our net fee-for-service revenue is typically highest during the first and fourth quarter of each year, when we generally experience the highest levels of reimbursable visits.

  Medical Claims Expense: Medical claims expense is driven by our At-Risk members and varies seasonally depending on a number of factors, including the weather and the number of business days in a quarter. Typically, we experience higher utilization levels during the first and fourth quarter of the year.

Key Metrics and Non-GAAP Financial Measures

We review a number of operating and financial metrics, including members, Medical Claims Expense Ratio, Care Margin and Adjusted EBITDA, to evaluate our business, measure our performance, identify trends affecting our business, formulate our business plan and make strategic decisions. These key metrics are presented for supplemental informational purposes only and should not be considered a substitute for financial information presented in accordance with GAAP. Care Margin and Adjusted EBITDA are not financial measures of, nor do they imply, profitability. We have not yet achieved profitability and, even in periods when our net revenue exceeds our cost of care, exclusive of depreciation and amortization, we may not be able to achieve or maintain profitability. The relationship of operating loss to cost of care, exclusive of depreciation and amortization is also not necessarily indicative of future performance.

Other companies may not publish similar metrics, or may present similarly titled key metrics that are calculated differently. As a result, similarly titled measures presented by other companies may not be directly comparable to ours and these key metrics should be considered in addition to, not as a substitute for, or in isolation from, measures prepared in accordance with GAAP, such as net loss. We provide investors and other users of our financial information with a reconciliation of Care Margin and Adjusted EBITDA to their most closely comparable GAAP financial measure. We encourage investors and others to review our financial information in its entirety, not to rely on any single financial measure and to view Care Margin and Adjusted EBITDA in conjunction with loss from operations and net loss, respectively.

	Three Months Ended March 31,	
	2022	2021
	(in thousands except for members)	
Members (as of the end of the period)		
Consumer and Enterprise	728,000	598,000
At-Risk	39,000	—
Total	767,000	598,000
Net revenue	$ 254,102	$ 121,352
Medical Claims Expense Ratio	84 %	N/A
Care Margin	$ 47,759	$ 51,260
Adjusted EBITDA	$ (28,944)	$ 4,839

Members

Members include both Consumer and Enterprise members as well as At-Risk members as defined below. Our number of members depends, in part, on our ability to successfully market our services directly to consumers including Medicare-eligible as well as non-Medicare eligible individuals, to Medicare Advantage health plans and Medicare Advantage enrollees, to employers that are not yet enterprise clients, as well as our activation rate within existing enterprise clients. We define estimated activation rate for any enterprise client at a given time as the percentage of eligible lives enrolled as members. While growth in the number of members is an important indicator of expected revenue growth, it also informs our management of the areas of our business that will require further investment to support expected future member growth. Member numbers as of the end of each period are rounded to the thousands.

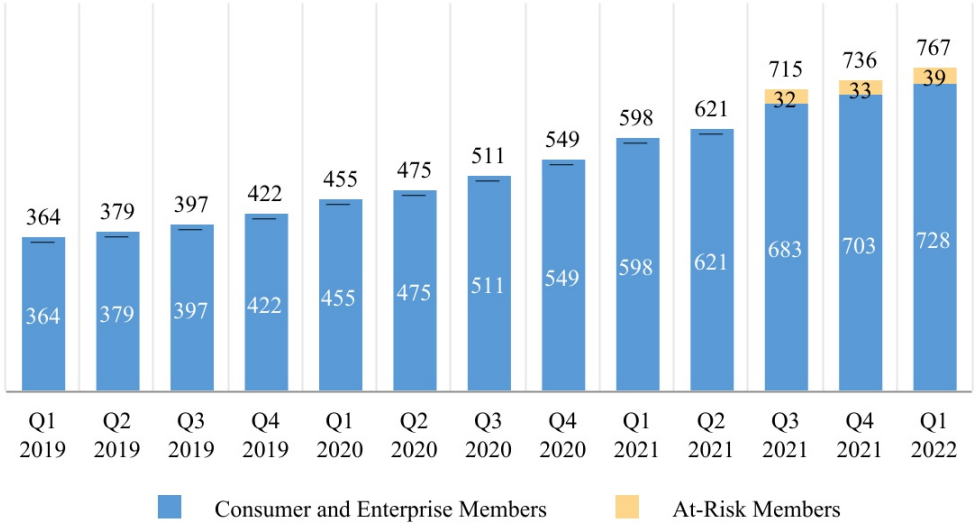
Consumer and Enterprise Members

A Consumer and Enterprise member is a person who has registered with us and has paid for membership for a period of at least one year or whose membership has been sponsored by an enterprise or other third party under an agreement having a term of at least one year. Consumer and Enterprise members do not include trial memberships, our virtual only One Medical Now users, or any temporary users. Our number of Consumer and Enterprise members depends, in part, on our ability to successfully market our services directly to consumers and to employers that are not yet enterprise clients and our activation rate within existing clients. Consumer and Enterprise members may include individuals who are: (i) Medicare-eligible and (ii) have paid for a membership or whose membership has been sponsored by an enterprise or other third party. Consumer and Enterprise members do not include any At-Risk members as defined below. Consumer and Enterprise members help drive commercial revenue. As of March 31, 2022, we had 728,000 Consumer and Enterprise members.

At-Risk Members

An At-Risk member is a person for whom we are responsible for managing a range of healthcare services and associated costs. At-Risk members help drive Medicare revenue. As of March 31, 2022, we had 39,000 At-Risk members.

Members (in thousands)*



* Number of members is shown as of the end of each period.

Other Patients

An "Other Patient" is a person who is neither a Consumer and Enterprise member nor an At-Risk member, and who has received digital or in-person care from us over the last twelve months. As of December 31, 2021, we had 21,000 Other Patients.

Medical Claims Expense Ratio

We define Medical Claims Expense Ratio as medical claims expense divided by Capitated Revenue. The nature of our contracting with Medicare Advantage payers and CMS requires us to be financially responsible for a range of healthcare services of our At-Risk members. Our care model focuses on leveraging the primary care setting as a means of reducing unnecessary or avoidable health care costs and balancing our cost of care with the impact of our service levels on medical claims expense. We are liable for potentially large medical claims should we not effectively manage our At-Risk members' health. We therefore consider the Medical Claims Expense Ratio to be an important measure to monitor our performance. As we sign up new At-Risk members or open new offices to serve these members, our Medical Claims Expense Ratio is likely to increase initially due to a potential increase in medical claims expense from a lag in improvement in health outcomes with member tenure. Similarly, there may be a lag in adequately documenting the health status of our members, resulting in different Capitated Revenue compared to what is indicated by the health status of an At-Risk member. We believe that the Medical Claims Expense Ratio for a given set of At-Risk members can improve over time as we help improve their health outcomes relative to their underlying health conditions, though the ratio may fluctuate for any given customers or cohort of customers depending on future outbreaks or variants of COVID-19 and associated increases in medical claims expense.

The following table provides a calculation of the Medical Claims Expense Ratio for the three months ended March 31, 2022 and 2021.

	Three Months Ended March 31,			
	2022		2021	
	(in thousands)			
Medical claims expense	$ 104,966		$	—
Capitated Revenue	$ 124,630		$	—
Medical Claims Expense Ratio	84	%		N/A

Care Margin

We define Care Margin as income or loss from operations excluding depreciation and amortization, general and administrative expense and sales and marketing expense. We consider Care Margin to be an important measure to monitor our performance, specific to the direct costs of delivering care. We believe this margin is useful to both us and investors to measure whether we are effectively pricing our services and managing the health care and associated costs, including medical claims expense and cost of care, of our At-Risk members successfully.

The following table provides a reconciliation of loss from operations, the most closely comparable GAAP financial measure, to Care Margin:

	Three Months Ended March 31,	
	2022	2021
	(in thousands)	
Loss from operations	$ (92,629)	$ (32,381)
Sales and marketing*	22,459	12,689
General and administrative*	97,036	64,345
Depreciation and amortization	20,893	6,607
Care Margin	$ 47,759	$ 51,260
Care Margin as a percentage of net revenue	19 %	42 %

* Includes stock-based compensation

Adjusted EBITDA

We define Adjusted EBITDA as net income or loss excluding interest income, interest and other expense, depreciation and amortization, stock-based compensation, provision for (benefit from) income taxes, certain legal or advisory costs, and acquisition and integration costs that we do not consider to be expenses incurred in the normal operation of the business. Such legal or advisory costs may include but are not limited to expenses with respect to evaluating potential business combinations, legal investigations, or settlements. Acquisition and integration costs include expenses incurred in connection with the closing and integration of acquisitions, which may vary significantly and are unique to each acquisition. We started to exclude prospectively from our presentation certain legal or advisory costs from the first quarter of 2021 and acquisition and integration costs from the second quarter of 2021, because amounts incurred in the prior periods were insignificant relative to our consolidated operations. We include Adjusted EBITDA in this Quarterly Report because it is an important measure upon which our management assesses and believes investors should assess our operating performance. We consider Adjusted EBITDA to be an important measure to both management and investors because it helps illustrate underlying trends in our business and our historical operating performance on a more consistent basis.

Adjusted EBITDA has limitations as an analytical tool, including:

- although depreciation and amortization are non-cash charges, the assets being depreciated and amortized may have to be replaced in the future, and Adjusted EBITDA does not reflect cash used for capital expenditures for such replacements or for new capital expenditures;

- Adjusted EBITDA does not include the dilution that results from stock-based compensation or any cash outflows included in stock-based compensation, including from our purchases of shares of outstanding common stock; and
- Adjusted EBITDA does not reflect interest expense on our debt or the cash requirements necessary to service interest or principal payments.

The following table provides a reconciliation of net loss, the most closely comparable GAAP financial measure, to Adjusted EBITDA, calculated as set forth above:

	Three Months Ended March 31,	
	2022	2021
	(in thousands)	
Net loss	$ (90,859)	$ (39,318)
Interest income	(157)	(105)
Interest and other expense	5,119	2,843
Depreciation and amortization	20,893	6,607
Stock-based compensation	36,919	26,328
Provision for (benefit from) income taxes	(6,732)	4,199
Legal or advisory costs	547	4,285
Acquisition and integration costs	5,326	—
Adjusted EBITDA	$ (28,944)	$ 4,839

Components of Our Results of Operations

Net Revenue

We generate net revenue through Medicare revenue and commercial revenue. We generate Medicare revenue from Capitated Revenue and fee-for-service and other revenue. We generate commercial revenue from partnership revenue, net fee-for-service revenue, and membership revenue.

Capitated Revenue. We generate Capitated Revenue from At-Risk arrangements with payers including Medicare Advantage plans and CMS. Under these At-Risk arrangements, we receive capitated payments, consisting of each eligible member's risk adjusted health care premium PMPM, for managing a range of healthcare services and associated costs for such members. The risk adjusted health care premium per month is determined by payers and based on a variety of a patient's factors such as age and demographic benchmarks, and further adjusted to reflect the underlying complexity of a member's health conditions. Capitated Revenue is recognized in the month in which eligible members are entitled to receive healthcare benefits during the contract term. We expect our Capitated Revenue to increase as a percentage of total net revenue in future periods.

Fee-For-Service and Other Revenue. We generate fee-for-service and other revenue from fee-for-service visits for Other Patients not covered under At-Risk arrangements and from certain payers for clinical start-up, administration, on-going coordination of care activities associated with providing care to At-Risk members and other Medicare patients.

Partnership Revenue. We generate partnership revenue from (i) our health network partners on a PMPM basis, (ii) largely fixed price or fixed price per employee contracts with enterprise clients for medical services and (iii) COVID-19 on-site testing services for enterprise clients, schools and universities for which we typically bill such customers a fixed price per service performed. Under our partnership arrangements, we generally receive fees that are linked to PMPM, fixed price, fixed price per employee, fixed price per service, or capitation arrangements. All partnership revenue is recognized during the period in which we are obligated to provide professional clinical services to the member, employee, or participant, as applicable, and associated management, operational and administrative services to the health network partner, enterprise client, schools and universities.

Net fee-for-service revenue. We generate net fee-for-service revenue from providing primary care services to patients in our offices when we bill the member or their insurance plan on a fee-for-service basis as medical services are rendered. While significantly all of our patients are members, we occasionally also provide care to non-members.

Membership Revenue. We generate membership revenue from the annual membership fees charged to either consumer members or enterprise clients, who purchase access to memberships for their employees and dependents. Membership revenue also includes fees we receive from enterprise clients for trial memberships or for access to our One Medical Now service offering. Membership revenue is recognized ratably over the contract period with the individual member or enterprise client.

Grant Income. Under the CARES Act, we were eligible for and received grant income from the Provider Relief Fund administered by HHS during the three months ended March 31, 2021. The purpose of the payment is to reimburse us for healthcare-related expenses or lost revenues attributable to COVID-19.

The following table summarizes our net revenue by primary source as a percentage of net revenue. Amounts may not sum due to rounding.

	Three Months Ended March 31,	
	2022	2021
Net revenue:		
Capitated revenue	49 %	— %
Fee-for-service and other revenue	1 %	— %
Total Medicare revenue	50 %	— %
Partnership revenue	24 %	45 %
Net fee-for-service revenue	16 %	37 %
Membership revenue	10 %	17 %
Grant income	— %	1 %
Total commercial revenue	50 %	100 %
Total net revenue	100 %	100 %

Operating Expenses

Medical Claims Expense

Medical claims expenses primarily consist of certain third-party medical expenses paid by payers contractually on behalf of us, including costs for inpatient and outpatient services, certain pharmacy benefits and physician services but excludes cost of care, exclusive of depreciation and amortization. We expect our medical claims expense to increase in absolute dollars as our Capitated Revenue increases in future periods.

Cost of Care, Exclusive of Depreciation and Amortization

Cost of care primarily includes provider and support employee-related costs for both virtual and in-office care, occupancy costs, medical supplies, insurance and other operating costs. Providers include doctors of medicine, doctors of osteopathy, nurse practitioners, physician assistants, and behavioral health specialists. Support employees include registered nurses, phlebotomists, health coaches, and administrative assistants assisting our members with all non-medical related services. Virtual care includes video visits and other synchronous and asynchronous communication via our app and website. A large portion of these costs are relatively fixed regardless of member utilization of our services. As we open new offices, and expand into new geographies, we expect cost of care to increase. Our cost of care, exclusive of depreciation and amortization, also excludes stock-based compensation.

Sales and Marketing

Sales and marketing expenses consist of employee-related expenses, including salaries and related costs, commissions and stock-based compensation costs for our employees engaged in marketing, sales, account management and sales support. Sales and marketing expenses also include advertising production and delivery costs of communications materials that are produced to generate greater awareness and engagement among our clients and members, third-party independent research, trade shows and brand messages and public relations costs.

We expect our sales and marketing expenses to increase as we strategically invest to expand our business. We expect to hire additional sales personnel and related account management and sales support personnel to capture an increasing amount of our market opportunity. We also expect to continue our brand awareness and targeted marketing campaigns. As we scale our sales and marketing, we expect these expenses to increase in absolute dollars.

General and Administrative

General and administrative expenses include employee-related expenses, including salaries and related costs and stock-based compensation for all employees except sales and marketing teams, which are included in the sales and marketing expenses. In addition, general and administrative expenses include corporate technology, occupancy costs, legal and professional services expenses.

We expect our general and administrative expenses to increase over time due to the additional costs associated with continuing to grow our business.

Depreciation and Amortization

Depreciation and amortization consist primarily of depreciation of property and equipment and amortization of capitalized software development costs.

Other Income (Expense)

Interest Income

Interest income consists of income earned on our cash and cash equivalents, restricted cash and marketable securities.

Interest and Other Expense

Interest and other expense consists of interest costs associated with our notes payable issued pursuant to the loan and security agreement with an institutional lender (the "LSA") and our convertible senior notes (the "2025 Notes"). On September 1, 2020, the term loans pursuant to the LSA matured and the remaining outstanding principal was repaid, plus accrued and unpaid interests. Interest and other expense also consists of remeasurement adjustment related to our indemnification asset. Upon the close of the Iora acquisition, as part of the Merger Agreement, certain shares of our common stock were placed into a third-party escrow account to satisfy any then pending and unsatisfied or unresolved claim for indemnification for any indemnifiable loss incurred by us pursuant to the indemnity provisions of the Merger Agreement. The indemnification asset is subject to remeasurement at each reporting date until the shares are released from escrow, with the remeasurement adjustment reported as interest and other expense in our condensed consolidated statement of operations.

Provision for (Benefit from) Income Taxes

We account for income taxes using an asset and liability approach. Deferred income taxes reflect the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes. Valuation allowances are provided when necessary to reduce net deferred tax assets to an amount that is more likely than not to be realized.

In determining whether a valuation allowance for deferred tax assets is necessary, we analyze both positive and negative evidence related to the realization of deferred tax assets and inherent in that, assess the likelihood of sufficient future taxable income. We also consider the expected reversal of deferred tax liabilities and analyze the period in which these would be expected to reverse to determine whether the taxable temporary difference amounts serve as an adequate source of future taxable income to support the realizability of the deferred tax assets.

Results of Operations

The following tables set forth our results of operations for the periods presented and as a percentage of our net revenue for those periods. Percentages presented in the following tables may not sum due to rounding.

Comparison of the Three Months Ended March 31, 2022 and 2021

	Three Months Ended March 31,			
	2022		2021	
	Amount	% of Revenue	Amount	% of Revenue
	(dollar amounts in thousands)			
Net revenue				
Medicare revenue	$ 127,422	50 %	$ —	— %
Commercial revenue	126,680	50 %	121,352	100 %
Total net revenue	254,102	100 %	121,352	100 %
Operating expenses:				
Medical claims expense	104,966	41 %	—	— %
Cost of care, exclusive of depreciation and amortization shown separately below	101,377	40 %	70,092	58 %
Sales and marketing (1)	22,459	9 %	12,689	10 %
General and administrative (1)	97,036	38 %	64,345	53 %
Depreciation and amortization	20,893	8 %	6,607	5 %
Total operating expenses	346,731	136 %	153,733	127 %
Loss from operations	(92,629)	(36)%	(32,381)	(27)%
Other income (expense), net:				
Interest income	157	— %	105	— %
Interest and other expense	(5,119)	(2)%	(2,843)	(2)%
Total other income (expense), net	(4,962)	(2)%	(2,738)	(2)%
Loss before income taxes	(97,591)	(38)%	(35,119)	(29)%
Provision for (benefit from) income taxes	(6,732)	(3)%	4,199	3 %
Net loss	$ (90,859)	(36)%	$ (39,318)	(32)%

(1) Includes stock-based compensation, as follows:

	Three Months Ended March 31,			
	2022		2021	
	Amount	% of Revenue	Amount	% of Revenue
	(dollar amounts in thousands)			
Sales and marketing	$ 943	— %	$ 1,023	1 %
General and administrative	35,976	14 %	25,305	21 %
Total	$ 36,919	15 %	$ 26,328	22 %

Net Revenue

	Three Months Ended March 31,			
	2022	2021	$ Change	% Change
	(dollar amounts in thousands)			
Net revenue:				
Capitated revenue	$ 124,630	$ —	$ 124,630	nm
Fee-for-service and other revenue	2,792	—	2,792	nm
Total Medicare revenue	127,422	—	127,422	nm
Partnership revenue	60,935	54,931	6,004	11 %
Net fee-for-service revenue	41,514	44,462	(2,948)	(7)%
Membership revenue	24,231	20,196	4,035	20 %
Grant income	—	1,763	(1,763)	(100)%
Total commercial revenue	126,680	121,352	5,328	4 %
Total net revenue	$ 254,102	$ 121,352	$ 132,750	109 %

nm – not meaningful

Medicare revenue increased $127.4 million for the three months ended March 31, 2022 compared to the same period in 2021. The increase was due to revenue contribution from our acquired Iora business.

Commercial revenue increased $5.3 million, or 4%, for the three months ended March 31, 2022 compared to the same period in 2021. The increase was primarily due to an increase in Consumer and Enterprise members by 130,000, or 22%, from 598,000 as of March 31, 2021 to 728,000 as of March 31, 2022, partially offset by a decrease in total billable visits.

Partnership revenue increased $6.0 million, or 11%, for the three months ended March 31, 2022 compared to the same period in 2021. The increase was primarily a result of the new and expanded partnerships with health networks, new and expanded on-site medical services for enterprise clients and increased members, partially offset by a decrease in COVID-19 on-site testing services for employers, schools and universities during the three months ended March 31, 2022.

Net fee-for-service revenue decreased $2.9 million, or 7%, for the three months ended March 31, 2022 compared to the same period in 2021. The decrease was primarily due to a decrease in total billable visits as a result of a decrease in COVID-19 testing visits, partially offset by a higher average reimbursement rate per visit and increased members for the three months ended March 31, 2022.

Membership revenue increased $4.0 million, or 20%, for the three months ended March 31, 2022 compared to the same period in 2021. The increase was primarily due to an increase in Consumer and Enterprise members of 130,000, or 22%, from 598,000 as of March 31, 2021 to 728,000 as of March 31, 2022.

Operating Expenses

Medical claims expense

	Three Months Ended March 31,			
	2022	2021	$ Change	% Change
	(dollar amounts in thousands)			
Medical claims expense	$ 104,966	$ —	$ 104,966	nm

Medical claims expense increased $105.0 million for the three months ended March 31, 2022 compared to the same period in 2021. The increase was due to medical claims expenses from our acquired Iora business.

Cost of Care, Exclusive of Depreciation and Amortization

	Three Months Ended March 31,			
	2022	2021	$ Change	% Change
	(dollar amounts in thousands)			
Cost of care, exclusive of depreciation and amortization	$ 101,377	$ 70,092	$ 31,285	45 %

The $31.3 million, or 45%, increase in cost of care, exclusive of depreciation and amortization, for the three months ended March 31, 2022 compared to the same period in 2021 was primarily due to increases in provider employee and support employee-related expenses of $22.2 million, occupancy costs of $8.3 million, and medical supply costs of $0.6 million. In addition to growth in our existing offices, we added 78 offices since March 31, 2021, bringing our total number of offices to 188 as of March 31, 2022. The cost of care and total offices in 2022 includes the result from our acquired Iora business.

Cost of care, exclusive of depreciation and amortization, as a percentage of net revenue decreased from 58% for the three months ended March 31, 2021 to 40% for the three months ended March 31, 2022. The decrease was due to the impact of our acquired Iora business.

Sales and Marketing

	Three Months Ended March 31,			
	2022	2021	$ Change	% Change
	(dollar amounts in thousands)			
Sales and marketing	$ 22,459	$ 12,689	$ 9,770	77 %

Sales and marketing expenses increased $9.8 million, or 77%, for the three months ended March 31, 2022 compared to the same period in 2021. This increase was primarily due to a $5.8 million increase in advertising expenses and a $3.0 million increase in employee-related expenses. The sales and marketing expenses in 2022 included sales and marketing expenses from our acquired Iora business.

General and Administrative

	Three Months Ended March 31,			
	2022	2021	$ Change	% Change
	(dollar amounts in thousands)			
General and administrative	$ 97,036	$ 64,345	$ 32,691	51 %

The $32.7 million, or 51%, increase in general and administrative expenses for the three months ended March 31, 2022 compared to the same period in 2021 was primarily due to higher employee-related expenses of $25.6 million, as we expanded our team to support our growth, and a $3.0 million increase in enterprise software costs. The general and administrative expenses in 2022 included general and administrative expenses from our acquired Iora business.

Depreciation and Amortization

	Three Months Ended March 31,			
	2022	2021	$ Change	% Change
	(dollar amounts in thousands)			
Depreciation and amortization	$ 20,893	$ 6,607	$ 14,286	216 %

Depreciation and amortization expenses increased $14.3 million, or 216%, for the three months ended March 31, 2022 compared to the same period in 2021. This increase was primarily due to depreciation and amortization expenses recognized

related to new medical offices, capitalization of software development, upgraded office software, and the Iora acquisition during the three months ended March 31, 2022.

Other Income (Expense)

Interest Income

	Three Months Ended March 31,			
	2022	2021	$ Change	% Change
	(dollar amounts in thousands)			
Interest income	$ 157	$ 105	$ 52	50 %

Interest income increased $0.05 million, or 50%, for the three months ended March 31, 2022 compared to the same period in 2021. The increase was primarily due to higher interest rates and investment yields, partially offset by amortization of premiums from marketable securities.

Interest and Other Expense

	Three Months Ended March 31,			
	2022	2021	$ Change	% Change
	(dollar amounts in thousands)			
Interest and other expense	$ (5,119)	$ (2,843)	$ (2,276)	80%

Interest and other expense increased $2.3 million, or 80%, for the three months ended March 31, 2022 compared to the same period in 2021. The increase was primarily due to an unrealized loss recorded for the indemnification asset recognized as a result of the Iora acquisition.

Provision for (Benefit from) Income Taxes

	Three Months Ended March 31,			
	2022	2021	$ Change	% Change
	(dollar amounts in thousands)			
Provision for (benefit from) income taxes	$ (6,732)	$ 4,199	$ (10,931)	(260)%

Provision for (benefit from) income taxes decreased $10.9 million from a provision of $4.2 million for the three months ended March 31, 2021 to a benefit of $6.7 million for the three months ended March 31, 2022 due primarily to amortization of identified intangibles.

Liquidity and Capital Resources

Since our inception, we have financed our operations primarily with the issuance of the 2025 Notes, our initial public offering, the sale of redeemable convertible preferred stock, and to a lesser extent, the issuance of term notes under credit facilities. As of March 31, 2022, we had cash, cash equivalents and marketable securities of $428.5 million, compared to $501.9 million as of December 31, 2021. We believe that our existing cash, cash equivalents and marketable securities will be sufficient to meet our working capital and capital expenditure needs for at least the next twelve months. We believe we will meet longer-term expected future cash requirements and obligations through a combination of available cash, cash equivalents and marketable securities, cash flows from operating activities, and access to private and public financing sources. Our principal commitments consist of the principal amount of debt outstanding from convertible senior notes due June 2025 and obligations under our operating leases for office space. We expect capital expenditures to increase in future periods to support growth initiatives in existing and new markets.

We may be required to seek additional equity or debt financing. Our future capital requirements will depend on many factors, including our pace of new member growth and expanded enterprise client and health network relationships, our pace and timing of expansion of new medical offices or services in existing and new markets, the timing and extent of spend to support the expansion of sales, marketing and development activities, acquisitions and related costs, and the impact of the COVID-19 pandemic. In the event that additional financing is required from outside sources, we may not be able to raise it on terms acceptable to us or at all. If we are unable to raise additional capital when desired, our business, financial condition and results of operations would be harmed, and we may be forced to adjust our growth plans and capital expenditures as a result. See "Part II—Item 1A—Risk Factors — In order to support the growth of our business, we may need to incur additional indebtedness or seek capital through new equity or debt financings, which sources of additional capital may not be available to us on acceptable terms or at all."

In addition, given the uncertainty around the duration and extent of the COVID-19 pandemic, we cannot accurately predict at this time the future potential impact of the pandemic on our business, results of operations, financial condition or liquidity.

There have been no material changes to our material cash requirements from contractual and other obligations as of March 31, 2022 as compared to those disclosed as of December 31, 2021 in our Annual Report on Form 10-K for the fiscal year ended December 31, 2021, as filed with the SEC on February 23, 2022.

Summary Statement of Cash Flows

The following table summarizes our cash flows:

	Three Months Ended March 31,	
	2022	2021
Net cash (used in) provided by operating activities	$ (55,084)	$ 22,084
Net cash (used in) provided by investing activities	(49,131)	254,197
Net cash provided by financing activities	2,222	13,465
Net (decrease) increase in cash, cash equivalents and restricted cash	$ (101,993)	$ 289,746

Cash Flows from Operating Activities

For the three months ended March 31, 2022, our net cash used in operating activities was $55.1 million, resulting from our net loss of $90.9 million and cash used in working capital of $24.6 million, mostly offset by non-cash charges of $60.3 million. Cash used in our working capital consisted primarily of a $39.1 million increase in accounts receivable, a $6.7 million decrease in operating lease liabilities, a $1.0 million increase in prepaid expenses and other current assets and a $0.7 million decrease in accounts payable, partially offset by an increase of $14.5 million in deferred revenue, an increase of $3.2 million in other liabilities, a decrease of $2.6 million in other assets, and an increase of $2.5 million in accrued liabilities. The changes in accounts receivable and deferred revenue are primarily due to timing of billing and cash collections from our health network partners and enterprise clients. The changes in accounts payable and accrued expenses are primarily related to timing of payments.

For the three months ended March 31, 2021, our net cash provided by operating activities was $22.1 million, resulting from net cash provided by our working capital of $23.5 million and adjustments for non-cash charges of $37.9 million, partially offset by our net loss of $39.3 million. The cash increase resulting from changes in our working capital for the three months ended March 31, 2021 consisted primarily of a $12.1 million increase in accrued expenses and other liabilities, a $11.1 million increase in deferred revenue, a $8.6 million decrease in accounts receivables, net, a $2.5 million decrease in inventory, partially offset by a $4.9 million increase in prepaid expenses and other current assets, a $4.4 million decrease in operating lease liabilities and a $1.2 million decrease in accounts payable. The changes in accounts receivable and deferred revenue are primarily due to timing of billing and cash collections from our health network partners and enterprise clients. The changes in accounts payable and accrued expenses are primarily related to timing of payments.

Cash Flows from Investing Activities

For the three months ended March 31, 2022, our net cash used in investing activities was $49.1 million, resulting primarily from purchases of marketable securities of $54.9 million and purchases of property and equipment of $19.2 million related to leasehold improvements, computer equipment, and furniture and fixtures for new offices, remodels and improvements

to existing offices, capitalization of internal-use software development costs, and office hardware and software. This is partially offset by sales and maturities of marketable securities of $25.0 million.

For the three months ended March 31, 2021, our net cash provided by investing activities was $254.2 million, resulting primarily from sales and maturities of short-term marketable securities of $339.0 million, partially offset by purchases of short-term marketable securities of $70.0 million and purchases of property and equipment, of $14.8 million related to leasehold improvements, computer equipment, and furniture and fixtures for new offices, remodels and improvements to existing offices, capitalization of internal-use software development costs, and office hardware and software.

Cash Flows from Financing Activities

For the three months ended March 31, 2022, our net cash provided by financing activities was $2.2 million, resulting primarily from exercise of stock options of $2.2 million.

For the three months ended March 31, 2021, our net cash provided by financing activities was $13.5 million, resulting primarily from exercise of stock options of $13.5 million.

Critical Accounting Policies and Significant Judgments and Estimates

Our condensed consolidated financial statements have been prepared in accordance with U.S. GAAP. The preparation of these condensed consolidated financial statements requires us to make estimates and assumptions that affect the reported amounts of assets, liabilities, revenue and expenses, and related disclosures. We base our estimates on historical experience and on various other factors that we believe are reasonable under the circumstances. We evaluate our estimates and assumptions on an ongoing basis. Actual results may differ from these estimates. To the extent that there are material differences between these estimates and our actual results, our future financial statements will be affected.

During the three months ended March 31, 2022, there were no significant changes to our critical accounting policies and estimates as described in the "Management's Discussion and Analysis of Financial Condition and Results of Operations" contained in the Annual Report on Form 10-K for the year ended December 31, 2021, as filed with the SEC on February 23, 2022.

Recent Accounting Pronouncements

Please see Note 2, “Summary of Significant Accounting Policies” to our condensed consolidated financial statements in Part I, Item 1 of this Quarterly Report on Form 10-Q.

Item 3. Quantitative and Qualitative Disclosures About Market Risk.

Interest Rate Sensitivity

We had cash and cash equivalents of $240.0 million as of March 31, 2022, compared to $342.0 million as of December 31, 2021, held primarily in cash deposits and money market funds for working capital purposes.

We had marketable securities of $188.5 million as of March 31, 2022, compared to $160.0 million as of December 31, 2021, consisting of U.S. Treasury obligations, U.S. government agency securities, foreign government bonds and commercial paper. Our investments are made for capital preservation purposes. We do not enter into investments for trading or speculative purposes. All our investments are denominated in U.S. dollars.

In May 2020, we issued the 2025 Notes which bear interest at a fixed rate of 3.0% per annum. As of March 31, 2022, the principal amount of debt outstanding from the 2025 Notes was $316.3 million.

Our cash and cash equivalents, marketable securities and debt are subject to market risk due to changes in interest rates. Fixed rate securities may have their market value negatively impacted due to a rise in interest rates, while floating rate securities may produce less income than expected if interest rates fall. Due in part to these factors, our future investment income may fall short of expectation due to changes in interest rates or we may suffer losses in principal if we are forced to sell securities that decline in market value due to changes in interest rates.

We do not believe that an increase or decrease in interest rates of 100 basis points would have a material effect on our business, financial condition or results of operations.

Item 4. Controls and Procedures.

Evaluation of Disclosure Controls and Procedures

Our management, with the participation of our Chief Executive Officer and Chief Financial Officer, has evaluated the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) of the Exchange Act) as of the end of the period covered by this Quarterly Report. Any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving the desired control objective and management necessarily applies its judgment in evaluating the cost-benefit relationship of possible controls and procedures. Based on that evaluation, our Chief Executive Officer and Chief Financial Officer have concluded, as of March 31, 2022, that our disclosure controls and procedures were effective to provide reasonable assurance that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the SEC's 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 disclosures.

Changes in Internal Control over Financial Reporting

There have been no changes in our internal control over financial reporting during the quarter ended March 31, 2022 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Inherent Limitation on the Effectiveness of Internal Control

The effectiveness of any system of internal control over financial reporting, including ours, is subject to inherent limitations, including the exercise of judgment in designing, implementing, operating and evaluating the controls and procedures, and the inability to eliminate misconduct completely. Accordingly, in designing and evaluating the disclosure controls and procedures, management recognizes that any system of internal control over financial reporting, including ours, no matter how well designed and operated, can only provide reasonable, not absolute assurance of achieving the desired control objectives. In addition, the design of disclosure controls and procedures must reflect the fact that there are resource constraints and that management is required to apply its judgment in evaluating the benefits of possible controls and procedures relative to their costs. Moreover, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate. We intend to continue to monitor and upgrade our internal controls as necessary or appropriate for our business, but cannot assure you that such improvements will be sufficient to provide us with effective internal control over financial reporting.

PART II—OTHER INFORMATION

Item 1. Legal Proceedings.

We are currently involved in, and may in the future become involved in, legal proceedings, claims and investigations in the ordinary course of our business, including medical malpractice and consumer claims. Although the results of these legal proceedings, claims and investigations cannot be predicted with certainty, we do not believe that the final outcome of any matters that we are currently involved in are reasonably likely to have a material adverse effect on our business, financial condition or results of operations. Regardless of final outcomes, however, any such proceedings, claims, and investigations may nonetheless impose a significant burden on management and employees and be costly to defend, with unfavorable preliminary or interim rulings.

Please see Note 13, “Commitments and Contingencies” to our condensed consolidated financial statements in Part I, Item 1 of this Quarterly Report on Form 10-Q for a discussion of our legal proceedings, claims and investigations.

Item 1A. Risk Factors.

Investing in our common stock involves a high degree of risk. You should consider and read carefully all of the risks and uncertainties described below, as well as other information included in this Quarterly Report, including our condensed consolidated financial statements and related notes included elsewhere in this Quarterly Report, before making an investment decision. If any of the following risks actually occur, it could harm our business, prospects, operating results and financial condition. Unless otherwise indicated, references to our business being harmed in these risk factors will include harm to our business, reputation, financial condition, results of operations, net revenue and future prospects. In such event, the trading price of our common stock could decline and you might lose all or part of your investment.

Risk Factor Summary

Our business is subject to a number of risks and uncertainties which may prevent us from achieving our business and strategic objectives or may adversely impact our business, financial condition, results of operations, cash flows and prospects. These risks include but are not limited to the following:

Risks Related to Our Business and Our Industry

- the impact of the ongoing COVID-19 pandemic;
- our dependence on a limited number of key existing payers;
- our reliance on reimbursements from certain third-party payers for the services we provide;
- the impact of reviews and audits by CMS in accordance with Medicare's risk adjustment payment system;
- the impact of assuming some or all of the risk that the cost of providing services will exceed our compensation for such services under certain third-party payer agreements;
- the impact of reduced reimbursement rates paid by third-party payers, or federal or state healthcare programs due to rule changes or other restrictions;
- the impact of regulatory or policy changes in Medicare or other federal or state healthcare programs;
- our dependence on the success of our strategic relationships with third parties;
- the impact of a decline in the prevalence of private health insurance coverage;
- our ability to cost-effectively develop widespread brand awareness and to maintain our reputation and market acceptance for our healthcare services;
- our history of losses and uncertainty about our future profitability;
- our ability to maintain and expand member utilization of our services;
- our ability to compete effectively in the geographies in which we participate;
- our ability to grow at the rates we historically have achieved;
- the impact of current or future litigation against us, including medical liability claims and class actions;

- our ability to attract and retain quality primary care providers to support our services;
- fluctuations in our quarterly results and our ability to meet the expectations of securities analysts and investors; and
- the loss of key members of our senior management team and our ability to attract and retain executive officers, employees, providers and medical support personnel.

Risks Related to Government Regulation

- the impact of healthcare reform legislation and changes in the healthcare industry and healthcare spending;
- the impact of governmental or regulatory scrutiny of or challenge to our arrangements with health networks;
- our dependence on our relationships with affiliated professional entities that we may not own, to provide healthcare services;
- our ability to comply with rules related to billing and related documentation for healthcare services; and
- our ability to comply with regulations governing the use and disclosure of personal information, including protected health information, or PHI.

Risks Related to Information Technology

- our reliance on internet infrastructure, bandwidth providers, other third parties and our own systems to provide a proprietary services platform to our members and providers;
- our reliance on third-party vendors to host and maintain our technology platform;
- any breaches of our systems or those of our vendors or unauthorized access to employee, contractor, member, client or partner data;
- our ability to maintain and enhance our proprietary technology platform; and
- our ability to optimize our technology solutions for members, integrate our systems with health network partners or resolve technical issues in a timely manner.

Risks Related to Our Intellectual Property

- our ability to obtain, maintain, protect and enforce our intellectual property rights.

Risks Related to Our Acquisition of Iora

- our ability to successfully integrate Iora's business and realize the benefits of the merger; and
- the incurrence of substantial expenses related to the integration of Iora's business.

Risks Related to Our Business and Our Industry

The ongoing coronavirus (COVID-19) pandemic has significantly impacted, and may continue to significantly impact our business, financial condition, results of operations and growth.

The global COVID-19 pandemic and measures introduced by local, state and federal governments to contain the virus and mitigate its public health effects have significantly impacted and may continue to significantly impact our business, our industry and the global economy. While the full extent of the impacts of the COVID-19 pandemic may be difficult to predict or determine due to numerous evolving factors, including emerging variant strains of the virus and their degree of vaccine resistance as well as reinstatements or potential reinstatements of measures to curb the spread of COVID-19, we have seen and may continue to see adverse impacts on our operations, net revenues, expenses, collectability of accounts receivables and other money owed, capital expenditures, liquidity, and overall financial condition, including from:

- reduced total billable visit volumes, temporary closures of certain offices, delays in openings of new medical offices, and delayed entry into new or expansion into existing geographies (in response to self-isolation practices, sustained remote work policies, quarantines, shelter-in-place requirements and similar government orders);
- higher proportions of lower-revenue generating services and products, including billable remote visits, COVID-19 testing and COVID-19 vaccinations, which may not be reimbursable or have lower average reimbursements relative to traditional in-office visits;

- deferral of healthcare by members and patients, which may result in difficulties completing comprehensive annual documentation of Medicare patient health conditions, future cost increases, deferred costs and inability to accurately estimate costs for incurred but not yet reported medical services claims for our At-Risk members, and may negatively impact the health of our patients;

- increase in internal and third-party medical costs for care provided to At-Risk members suffering from COVID-19, which may be particularly significant given many of our members are under At-Risk arrangements in which we receive capitated payments and may be more pronounced as a result of future outbreaks or variants of COVID-19;

- negative impacts to the business, results of operations and financial condition of our health network partners and their ability or willingness to continue to pay us a fixed price PMPM if they receive reduced visit revenue due to decreases in billable utilization;

- inquiries, regulatory or governmental investigations or other disputes that result from our provision of COVID-19 vaccinations, arrangements entered into in reliance on related orders, laws and regulations, or the failure of various waivers for limitations of liability or other provisions under such orders, laws and regulations that apply to us;

- supply, resource and capital constraints related to the treatment of COVID-19 patients and disruptions or delays in the delivery of materials and products in the supply chain for our offices and increased capital expenditures due to the need to buy incremental materials or services;

- staffing shortages and increased risk for workers' compensation claims; or

- increased costs, diversion of resources from managing our business and growth and reputational harm due to (i) implementation of new services and products in reliance on continuously evolving regulatory standards, (ii) alterations to our operations to address the changing needs of our members during the pandemic, or (iii) member or enterprise client dissatisfaction due to inaccurate results from testing or other services, overburdening of our medical offices and virtual care teams with inquiries and requests, which may result in longer phone wait times or service delays.

Any continuation of the above factors and outcomes could harm our business, financial condition, results of operations and growth.

We cannot assure you that our current billable volumes and membership levels will be sustained or that average reimbursement for billable services will return to pre-COVID-19 levels. As more of the U.S. population receives the COVID-19 vaccination, our COVID-19 testing volumes may also decline, which may negatively impact our membership and revenue. Further, while vaccines have become available in certain countries and many economies have reopened, new shelter-in-place, quarantine, executive order or related measures or practices may be reinstated by governments and authorities, including due to future waves of outbreak or emerging variant strains of COVID-19, such as the Delta and Omicron variant. Such measures and practices, if reinstated, could reduce our total billable volumes, negatively impact our health network partners and harm our results of operations, business and financial condition.

We have continued to adjust many of our new programs to rapidly respond to the COVID-19 pandemic, including telehealth visits, testing and vaccine administration arrangements, in reliance on continuously evolving regulatory standards such as emergency orders, laws and regulations from federal, state and local authorities and the relaxation of certain licensure requirements and privacy restrictions for telehealth intended to permit health care providers to provide care and distribute COVID-19 vaccines to patients during the COVID-19 pandemic. To continue providing some of these new services and products, we will be required to comply with federal, state and local rules, mandates and guidelines, which are subject to rapid change and may vary across jurisdictions. We cannot assure you that such orders, laws, regulations, mandates or guidelines will continue to apply or that regulators or other governmental entities will agree with our interpretations of these orders, laws, regulations, mandates and guidelines. Failure to remain in compliance, or even the perception of non-compliance, may curtail or result in restrictions on our ability to provide any such services, result in time-consuming and potentially costly inquiries, disputes, or investigations (such as the vaccine inquiries discussed in Note 13, "Commitments and Contingencies" to our condensed consolidated financial statements included elsewhere in this Quarterly Report on Form 10-Q, or the Vaccine Inquiries, or inquiries from state and local public health departments), as well as damage to our reputation, any of which could harm our business, financial condition and results of operations. We are cooperating with the requests from the Vaccine Inquiries as well as requests received from other governmental agencies, including with respect to our compensation practices and membership generation during the relevant periods. We are unable to predict the outcome or timeline of any residual inquiries or if any additional requests, inquiries, investigations or other government actions may arise relating to such circumstances. The Vaccine Inquiries, together with any additional inquiries, regulatory or governmental investigations or other disputes that result from our provision of COVID-19 vaccinations or any other arrangements entered into in reliance on these

orders, laws and regulations, or the failure or reversal of various waivers for limitations of liability or other provisions under such orders, laws and regulations to apply to us could require us to divert resources or adjust certain new programs to ensure compliance and harm our reputation, business, financial condition and results of operations.

The pandemic has also resulted in, and may continue to result in, significant disruption of global financial markets, potentially reducing our ability to access capital and reducing the liquidity and value of our marketable securities, which could in the future negatively affect our liquidity. In addition, due to our At-Risk arrangements for the care of Medicare Advantage participants, the full impact of the COVID-19 pandemic may not be fully reflected in our results of operations and overall financial condition until future periods. The COVID-19 pandemic may continue to impact our operations, and net revenues, expenses, collectability of accounts receivables and other money owed, capital expenditures, liquidity, and overall financial condition.

We are dependent upon a limited number of key existing payers and loss of contracts with those payers, disruptions in those relationships or the inability of such payers to maintain their contracts with CMS, could adversely affect our business, financial condition, results of operations and prospects.

We are dependent on a concentrated number of third-party payers with whom we contract to provide services to At-Risk Members. Contracts with one such payer across multiple markets accounted for 27% of net revenue for the three months ended March 31, 2022. We believe that a majority of our net revenue will continue to be derived from a limited number of key payers, who may terminate their contracts with us for convenience on short-term notice, or upon the occurrence of certain events, some of which may not be within our control. The loss of any of our payer partners or the renegotiation of any of our payer contracts could adversely affect our operating results. In the ordinary course of business, we engage in active discussions and renegotiations with payers in respect of the services we provide and the terms of our payers' agreements. As the payers' businesses respond to market dynamics, regulatory developments and financial pressures, and as payers make strategic business decisions in respect of the lines of business they pursue and programs in which they participate, certain of our payers may seek to renegotiate or terminate their agreements with us. These discussions could result in reductions to the fees and changes to the scope of services contemplated by our original payer contracts and consequently could negatively impact our net revenue, business, financial condition, results of operations and prospects.

Because we rely on a limited number of these payers for a substantial portion of our revenue, we depend on the creditworthiness of these payers. Our payers are subject to a number of risks, including reductions in payment rates from governmental programs, higher than expected health care costs and lack of predictability of financial results when entering new lines of business, particularly with high-risk populations. If the financial condition of our payer partners declines, our credit risk could increase. Should one or more of our significant payer partners declare bankruptcy, be declared insolvent or otherwise be restricted by state or federal laws or regulation from continuing in some or all of their operations, this could adversely affect our ongoing revenues, the collectability of our accounts receivable, our bad debt reserves and our net income. If a payer with which we contract loses its Medicare contracts with CMS, receives reduced or insufficient government reimbursement under the Medicare program, decides to discontinue its Medicare Advantage and/or commercial plans, decides to contract with another company to provide capitated care services to its patients, decides to directly provide care, or otherwise makes or announces an adjustment to its business or strategies, our contract with that payer could be at risk and we could lose revenue or members, and our stock price could decline.

We are reliant upon reimbursements from certain third-party payers for the services we provide in our business and reliance on these third-party payers could lead to delays and uncertainties in the reimbursement process.

We are reliant upon contracts with certain third-party payers in order to receive reimbursement for some of the services we provide to patients, including value-based contracts from health insurance plans. The reimbursement process is complex and can involve lengthy delays. Although we recognize certain revenue when we provide services to our patients, we may from time to time experience delays in receiving the associated capitation payments or, for our patients on fee-for-service arrangements, the reimbursement for the service provided. In addition, third-party payers may disallow, in whole or in part, requests for reimbursement based on determinations that the member is not eligible for coverage, certain amounts are not reimbursable under plan coverage or were for services provided that were not medically necessary or additional supporting documentation is necessary. Retroactive adjustments may change amounts realized from third-party payers. We are also subject to claims reviews and/or audits by such third-party payers, including governmental audits of our Medicare claims, and may be required to repay these payers if a finding is made that we were incorrectly reimbursed. See "—Noncompliance with billing and documentation requirements could result in non-payment or subject us to audits, billing or other compliance investigations by government authorities, private payers or health network partners." Third-party payers are also increasingly focused on controlling health care costs, and such efforts, including any revisions to reimbursement policies, may further complicate and delay our reimbursement claims. Furthermore, our business may be adversely affected by legislative initiatives aimed at or

having the effect of reducing health care costs associated with Medicare and other changes in reimbursement policies. Delays and uncertainties in the reimbursement process may adversely affect our collection of accounts receivable, increase the overall costs of collection and cause us to incur additional borrowing costs to support our liquidity needs, which could harm our business, financial condition and results of operations.

A significant portion of our net revenue is based on Medicare's risk adjustment payment system and is subject to review and audit, which could result in material adjustments to our results of operations.

CMS has implemented a risk adjustment payment system for Medicare health plans to improve the accuracy of payments and establish appropriate compensation for Medicare plans that enroll and treat less healthy Medicare beneficiaries. CMS' risk adjustment model bases a portion of the total CMS reimbursement payments on various clinical and demographic factors, including hospital inpatient diagnoses, diagnosis data from hospital outpatient facilities and physician visits, gender, age and Medicaid eligibility. CMS requires that all managed care companies capture, collect and report the necessary diagnosis code information to CMS, which information is subject to review and audit for accuracy by CMS. This risk adjustment payment system has an indirect impact on the payments we receive from our contracted Medicare Advantage payers. Although we, and the payers with which we contract, have auditing and monitoring processes in place to collect and provide accurate risk adjustment data to CMS for these purposes, that program may not be sufficient to ensure accuracy.

If the risk adjustment data submitted by us or our payers incorrectly overstates the health risk of our patients, we might be required to return to the payer or CMS, overpayments and/or be subject to penalties or sanctions, or if the data incorrectly understates the health risk of our members, we might be underpaid for the care that it must provide to its patients, any of which could harm our reputation and have a negative impact on our results of operations and financial condition. CMS may also change the way that they measure risk, and the impact of any such changes could harm our business.

As a result of the COVID-19 pandemic, risk adjustment scores may also fall as a result of reduced data collection, decreased patient visits or delayed medical care and limitations on payments for certain telehealth services. As a result of the variability of factors affecting our patients' risk scores, the actual payments we receive from our payers, after all adjustments, could be materially more or less than our estimates. Consequently, our estimate of our patients' aggregate member risk scores for any period may result in favorable or unfavorable adjustments to our Medicare premium revenues, which may harm our results of operations.

Under our At-Risk arrangements with certain third-party payers, we assume the risk that the cost of providing services will exceed our compensation for such services.

A substantial portion of our net revenue consists of Capitated Revenue, which, in the case of third party payers or health insurance plans, is based on a pre-negotiated percentage of the premium that the payer receives from CMS. While there are variations specific to each agreement, we sometimes contract with payers to receive recurring PMPM revenue and assume the financial responsibility for the healthcare expenses of our patients. This type of contract is referred to as a "capitation" contract. CMS pays capitation using risk adjustment scores. See "–A significant portion of our net revenue is based on Medicare's risk adjustment payment system and is subject to review and audit, which would result in material adjustments to our results of operations." To the extent we encounter delays in documenting patients' acuity or patients requiring more care than initially anticipated and/or the cost of care increases, aggregate fixed compensation amounts, or capitation payments, may be insufficient to cover the costs associated with treatment. If medical costs and expenses exceed estimates, except in very limited circumstances, we will not be able to increase the fee received under these capitation agreements during their then-current terms and we could suffer losses with respect to such agreements. In addition, while we maintain stop-loss insurance that helps protect us for medical claims per patient in excess of certain levels, future claims could exceed our applicable insurance coverage limits or potential increases in insurance premiums may require us to decrease its level of coverage.

Changes in our anticipated ratio of medical expense to revenue can significantly impact our financial results. Accordingly, the failure to adequately predict and control medical costs and expenses and to make reasonable estimates and maintain adequate accruals for incurred but not reported claims could have a material adverse effect on our business, results of operations, financial condition and cash flows. Additionally, the Medicare expenses of our At-Risk members may be outside of our control in the event that such members take certain actions that increase such expenses, such as unnecessary hospital visits. These actions or events also make it more difficult for us to estimate medical expenses and may cause delays in reporting them to payers. Any delays or failures to adequately predict and control medical costs may also result in delayed negative impacts to our Capitated Revenue, including as compared to our estimates of cost of care and capitation payments. Historically, our medical costs and expenses as a percentage of revenue have fluctuated. Factors that may cause medical expenses to exceed estimates include:

- the health status of our At-Risk members;
- higher levels of hospitalization among our At-Risk members;
- higher than expected utilization of new or existing healthcare services or technologies;
- an increase in the cost of healthcare services and supplies, whether as a result of inflation or otherwise;
- changes to mandated benefits or other changes in healthcare laws, regulations and practices;
- increased costs attributable to specialist physicians, hospitals and ancillary providers;
- changes in the demographics of our At-Risk members and medical trends;
- contractual or claims disputes with providers, hospitals or other service providers within and outside a health plan's network;
- the occurrence of catastrophes, major epidemics or pandemics, including COVID-19, or acts of terrorism; and
- the reduction of health plan premiums.

If reimbursement rates paid by private third-party payers are reduced or if these third-party payers otherwise restrain our ability to obtain or provide services to patients, our business could be harmed.

Private third-party payers, including health maintenance organizations, or HMOs, preferred provider organizations and other managed care plans, as well as medical groups and independent practice associations that contract with HMOs, pay for the services that we provide to many of our members. As a substantial proportion of our members are commercially insured or covered under Medicare Advantage plans with our contracted payers, if any third-party payers reduce their reimbursement rates or elect not to cover some or all of our services, our business may be harmed. Typically, our affiliated professional entities that provide medical services enter into contracts with certain of these payers either directly, or indirectly through certain of our health network partners, which allow them to participate in the payers' respective networks and set forth reimbursement rates for services rendered thereunder. As a result, our ability to maintain or increase patient volumes covered by private third-party payers and to maintain and obtain favorable contracts with private third-party payers significantly affects our revenue and operating results. See also "—We are dependent upon a limited number of key existing payers and loss of contracts with those payers, disruptions in those relationships or the inability of such payers to maintain their contracts with CMS, could adversely affect our business, financial condition, results of operations and prospects."

Private third-party payers often use plan structures, such as narrow networks or tiered networks, to encourage or require members to use in-network providers. In-network providers typically provide services through private third-party payers for a negotiated lower rate or other less favorable terms. Private third-party payers generally attempt to limit use of out-of-network providers by requiring members to pay higher copayment and/or deductible amounts for out-of-network care. Additionally, private third-party payers have become increasingly aggressive in attempting to minimize the use of out-of-network providers by disregarding the assignment of payment from members to out-of-network providers (i.e., sending payments directly to members instead of to out-of-network providers), capping out-of-network benefits payable to members, waiving out-of-pocket payment amounts and initiating litigation against out-of-network providers for interference with contractual relationships, insurance fraud and violation of state licensing and consumer protection laws. If we become out of network for payers, our business could be harmed and our revenue could be reduced because patients could stop using our services.

If reimbursement rates paid by Medicare or other federal or state healthcare programs are reduced, if changes in the rules governing such programs occur, or if government payers otherwise restrain our ability to obtain or provide services to patients, our business, financial condition and results of operations could be harmed.

A significant portion of our revenue comes from government healthcare programs, principally Medicare, either through Medicare Advantage plans or directly, including through the Center for Medicare and Medicaid Innovation's, or CMMI's, Global and Professional Direct Contracting Model, or the GPDC Model, which CMMI announced has been redesigned and renamed the ACO Realizing Equity, Access, and Community Health Model, or the ACO REACH Model, to take effect January 1, 2023 for both new applicants who are approved to participate and current GPDC Model participants that have maintained a strong compliance record and meet the requirements of the ACO REACH Model. In addition, many commercial payers base

their reimbursement rates on the published Medicare rates or are themselves reimbursed by Medicare for the services we provide. As a result, our results of operations are, in part, dependent on the continuation of Medicare programs, including Medicare Advantage, the GPDC Model (through December 31, 2022) or the ACO REACH Model (starting January 1, 2023), as well as the levels of government funding provided therewith. Any changes that limit or reduce the GPDC Model or the ACO REACH Model, Medicare Advantage, or general Medicare reimbursement levels, such as reductions in or limitations of reimbursement amounts or rates under programs, reductions in funding of programs, expansion of benefits without adequate funding, elimination of coverage for certain benefits, or elimination of coverage for certain individuals or treatments under programs, could have a material adverse effect on our business, results of operations, financial condition and cash flows.

The Medicare program and its reimbursement rates and rules, are also subject to frequent change. These include statutory and regulatory changes, rate adjustments (including retroactive adjustments), administrative rulings or executive orders, interpretations and determinations, requirements for utilization review and government funding restrictions, each of which may materially and adversely affect the rates at which CMS reimburses us for our services, as well as affect the cost of providing service to patients and the timing of payments to our affiliated professional entities. Budget pressures often lead the federal government to reduce or place limits on reimbursement rates under Medicare. Implementation of these and other types of measures has in the past and could in the future result in substantial reductions in our revenue and operating margins. The final impact of the Medicare Advantage rates can vary from any estimate we may have and may be further impacted by the relative growth of our Medicare Advantage patient volumes across certain geographies as well as by the benefit plan designs submitted. It is possible that we may underestimate the impact of the Medicare Advantage rates on our business, which could have a material adverse effect on our business, results of operations, financial condition and cash flows. In addition, our Medicare Advantage revenues may continue to be volatile in the future which could have a material adverse impact on our business, results of operations, financial condition and cash flows.

In addition, CMS often changes the rules governing the Medicare program, including those governing reimbursement. Changes that could adversely affect our business include:

- administrative or legislative changes to base rates or the bases of payment;
- limits on the services or types of providers for which Medicare will provide reimbursement;
- changes in methodology for patient assessment and/or determination of payment levels;
- the reduction or elimination of annual rate increases; or
- an increase in co-payments or deductibles payable by beneficiaries.

We are unable to predict the effect of recent and future policy changes on our operations. Recent legislative, judicial and executive efforts to enact further healthcare reform legislation have also caused many core aspects of the current U.S. healthcare system to be unclear. While specific changes and their timing are not yet apparent, enacted reforms and future legislative, regulatory, judicial, or executive changes, particularly any changes to the Medicare Advantage program, could have a material adverse effect on our business, results of operations, financial condition and cash flows.

There is additional uncertainty around the future of the ACO REACH Model. The ACO REACH Model has been developed by CMS as a means to test various financial risk sharing arrangements in the Medicare program over a four-year period, from January 1, 2023 through December 31, 2026. CMS may make additional, material changes to the ACO REACH Model in the intervening years or, at the end of that four-year period, CMS may not extend or replace the ACO REACH Model with a similar program that we can participate in, which may have a material adverse effect on our business.

The GPDC Model and the ACO REACH Model are new CMS programs and we therefore may not be able to realize the expected benefits of either model.

In 2021, CMMI announced the GPDC Model to create value-based payment arrangements directly with Direct Contracting Entities, or DCEs, which is part of CMMI's' strategy to test the next evolution of risk-sharing arrangement to produce value and high quality health care by permitting DCEs to participate in value-based care arrangements with beneficiaries in Medicare fee-for-service. The GPDC Model began its first performance period on April 1, 2021.

Our wholly owned subsidiary, Iora Health NE DCE, LLC, was one of a limited number of companies chosen by CMMI as a DCE. In February 2022, CMS announced that the GPDC Model had been redesigned and renamed the ACO REACH Model, with such changes to take effect beginning January 1, 2023. Current Direct Contracting Entities, or DCEs, like us, will participate in the current GPDC Model until December 31, 2022. To participate in the ACO REACH Model, we must (i) agree to meet all of the ACO REACH requirements as of January 1, 2023, including new requirements related to corporate governance, health equity and data collection and reporting and (ii) maintain a strong compliance record during 2022, as determined by CMS.

Given the recent enactment of the ACO REACH Model, we cannot assure you that we will be able to participate in and/or comply with the new requirements of the ACO REACH Model. We have no experience serving as an ACO under the new ACO REACH Model and may not be able to realize the expected benefits of the new model. For example, we may encounter difficulties calibrating our historical medical expense estimates to this new beneficiary population, which has not chosen to participate in risk-based care arrangements (unlike Medicare Advantage beneficiaries) and thus may utilize medical services differently than our current members.

While we have invested and expect to continue to invest significant time and resources to meet the requirements of the GPDC Model and adapt to the ACO REACH Model, beneficiaries assigned to us under either model may not generate revenue as expected, initially or at all, and we cannot assure you that direct contracting will allow us to achieve the same financial outcomes on Medicare fee-for-service beneficiaries as we do on our existing patients. Additionally, adding new members through either model will also require absorbing new members into our affiliated professional entities, which may strain resources or negatively affect our quality of care.

We cannot assure you that our current participation in the GPDC Model will be successful or that we will be able to participate in the ACO REACH Model in the future. We also cannot assure you that our participation in either model will expand our total addressable market in the manner that we expect.

Our business model and future growth are substantially dependent on the success of our strategic relationships with health network partners, enterprise clients and distribution partners.

We will continue to substantially depend on our relationships with third parties, including health network partners, enterprise clients and distribution partners to grow our business. In particular, our growth depends on maintaining existing, and developing new, strategic affiliations with health network partners, including health systems and private and government payers. We also rely on a number of partners such as benefits enrollment platforms, professional employment organizations, consultants and other distribution partners in order to sell our solutions and services and enroll members onto our platform.

Our agreements with our enterprise clients often provide for fees based on the number of members that are covered by such clients' programs each month, known as capitation arrangements. Certain of our enterprise clients and partners also pay us a fixed fee per year regardless of the number of registered members. The number of individuals who register as members through our enterprise clients is often affected by factors outside of our control, such as plan endorsement by the employer, member outreach and retention initiatives. Enterprise clients may also prohibit us from engaging in direct outreach with employees as potential members, or we may be unsuccessful in spreading brand awareness among employees who perceive competitors as offering better solutions and services, which would decrease growth in membership and reduce our net revenue. Increasing rates of unemployment may also result in loss of members at our enterprise clients, and economic recessions or slowdowns can result in our enterprise clients terminating their employee sponsorship arrangements with us. In addition, during periods of economic slowdown, enterprise clients may face less competition for new hires or may not need to hire as many employees and as a result, they may not need to sponsor memberships with us as a means to attract new hires. Even if the geographies in which our enterprise clients operate experience growth, it is possible that such client's program membership could fail to grow at similar rates, if at all. If the number of members covered by one or more of such clients' programs were to be reduced, including due to benefits reductions or layoffs during and after the COVID-19 pandemic, it would lead to a reduction of membership fees, a decrease in our net fee-for-service revenue and partnership revenue, and may also result in the enterprise client electing not to renew our contract for another year. In addition, the growth forecasts of our clients are subject to significant uncertainty, including after the COVID-19 pandemic and any prolonged ensuing economic recession, and are based on assumptions and estimates that may prove to be inaccurate. Further, historical activation rates within a given enterprise client may not be indicative of future membership levels at that enterprise client or activation rates of similarly situated enterprise clients. High activation rates (i.e., the percentage of individuals eligible for membership who are enrolled as members) do not necessarily result in increased net fee-for-service revenue and do not typically result in increased membership revenue.

Health network partnerships also comprise a significant portion of our revenue. For example, under certain health network partnership contracts, we closely collaborate with a health network on certain strategic initiatives such as the expansion of practice sites in a particular jurisdiction or service area, and clinical and digital integration between our primary care and their specialty care services. Our contracts with health network partners can sometimes be bespoke, with varying terms across health network partners. However, many contracts provide for fees on a PMPM basis or a fee-for-service basis. Under contracts providing for PMPM fees, when our medical offices provide professional clinical services to covered members, we, as administrator, perform billing and collection services on behalf of the health network, and the health network receives the fees for services provided, including those paid by members' insurance plans. If we do not adequately satisfy the objectives of our partners or perform against contractual obligations, we may lose revenue under the applicable health network partner contract and the health network partner may become dissatisfied with the terms or our performance under the contract, which could result in its early termination or amendment, if permitted, and as a result, harm to our business and results of operations, including a reduction in net revenue. Even regardless of our performance under the contracts, we cannot guarantee that our health network partners will continue to be satisfied with the terms or circumstances under existing contracts, particularly given constraints and challenges posed by the COVID-19 pandemic. We have experienced contractual disputes and renegotiations, including with respect to delays in payments due to us, with health network partners in the past and may experience additional disputes and renegotiations in the future. In certain situations, we may need to take legal or other action to enforce our contractual rights, which may strain relationships with our partners, further delay payments owed to us, make us less attractive for potential or future partners and harm our business, results of operations and reputation. Certain contracts with health network partners can be exclusive in the applicable jurisdiction; as a result, in new potential geographies, should we pursue a health network partnership, we would need to successfully contract with a sufficiently competitively viable health network partner, as we may not be able to terminate any such contract for several years without penalty or be able to partner with other health network partners in the same geographies due to competitive pressures or lack of counterparties. If we are unable to successfully continue our strategic relationships with our health network partners on terms favorable to us or at all, or if we do not successfully contract with health network partners in new jurisdictions, our business and results of operations could be harmed.

Most of our enterprise clients and health network partners have no obligation to renew their agreements with us after the initial term expires. In addition, our health network partners and enterprise clients may negotiate terms less advantageous to us upon renewal, which may reduce our revenue from these entities. If our health network partners or enterprise clients fail to renew their contracts, or renew their contracts upon less favorable terms or at lower fee levels, our revenue may decline or our future revenue growth may be constrained. In addition, certain of our health network partners and enterprise clients may terminate their contracts with us early for various reasons. If a partner or customer terminates its contract early and revenue and cash flows expected from a partner or enterprise client are not realized in the time period expected or not realized at all, our business could be harmed.

Identifying partners, and negotiating and documenting relationships with them, requires significant time and resources. Our competitors may be more effective in executing such relationships and performing against them. If we are unsuccessful in establishing or maintaining our relationships with third parties, our ability to compete in the marketplace or to grow our net revenue could be impaired and our results of operations may suffer. Even if we are successful, we cannot assure you that these relationships will result in increased member use of our solutions and services or increased net revenue.

We conduct business in a heavily regulated industry, and any failure to comply with applicable healthcare laws and government regulations, could result in financial penalties, exclusion from participation in government healthcare programs and adverse publicity, or could require us to make significant operational changes, any of which could harm our business.

The U.S. healthcare industry is heavily regulated and closely scrutinized by federal, state and local authorities. Comprehensive statutes and regulations govern the manner in which we provide and bill for services and collect reimbursement from governmental programs and private payers, our contractual relationships with our providers, vendors, health network partners, enterprise clients, members and patients, our marketing activities and other aspects of our operations. Of particular importance are:

- state laws that prohibit general business corporations, such as us, from practicing medicine, controlling physicians' medical decisions or engaging in practices such as splitting fees with physicians;

- federal and state laws pertaining to non-physician practitioners, such as nurse practitioners and physician assistants, including requirements for physician supervision of such practitioners and licensure and reimbursement-related requirements;

- Medicare and Medicaid billing and reimbursement rules and regulations;

- the federal physician self-referral law, commonly referred to as the Stark Law, which, subject to certain exceptions, prohibits physicians from referring Medicare or Medicaid patients to an entity for the provision of certain "designated health services" if the physician or a member of the physician's immediate family has a direct or indirect financial relationship (including an ownership interest or a compensation arrangement) with the entity;

- the federal Anti-Kickback Statute, which, subject to certain exceptions known as "safe harbors," prohibits the knowing and willful offer, payment, solicitation or receipt of any bribe, kickback, rebate or other remuneration, in cash or in kind, in return for the referral of an individual for, or the lease, purchase, order or recommendation of, items or services covered, in whole or in part, by government healthcare programs such as Medicare and Medicaid;

- the federal False Claims Act, which imposes civil and criminal liability on individuals or entities that knowingly or recklessly submit false or fraudulent claims to Medicare, Medicaid, and other government-funded programs or make or cause to be made false statements in order to have a claim paid;

- a provision of the Social Security Act that imposes criminal penalties on healthcare providers who fail to disclose or refund known overpayments;

- the criminal healthcare fraud provisions of the federal Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act, or HITECH, and their implementing regulations, or collectively, HIPAA, and related rules that prohibit knowingly and willfully executing a scheme or artifice to defraud any healthcare benefit program or falsifying, concealing or covering up a material fact or making any material false, fictitious or fraudulent statement in connection with the delivery of or payment for healthcare benefits, items or services;

- the Civil Monetary Penalties Law, which prohibits the offering or giving of remuneration to Medicare and Medicaid beneficiaries that is likely to influence the beneficiary's selection of a particular provider or supplier;

- federal and state laws that prohibit providers from billing and receiving payment from Medicare and Medicaid for services unless the services are medically necessary, adequately and accurately documented, and billed using codes that accurately reflect the type and level of services rendered;

- federal and state laws and policies related to healthcare providers' licensure, certification, accreditation, Medicare and Medicaid program enrollment and reassignment of benefits;

- federal and state laws and policies related to the prescribing and dispensing of pharmaceuticals and controlled substances;

- state laws related to the advertising and marketing of services by healthcare providers;

- federal and state laws related to confidentiality, privacy and security of personal information, including medical information and records, that limit the manner in which we may use and disclose that information, impose obligations to safeguard such information and require that we notify third parties in the event of a breach;

- federal laws that impose civil administrative sanctions for, among other violations, inappropriate billing of services to government healthcare programs or employing or contracting with individuals who are excluded from participation in government healthcare programs;

- laws and regulations limiting the use of funds in health savings accounts for individuals with high deductible health plans;

- state laws pertaining to anti-kickback, fee splitting, self-referral and false claims, some of which are not limited to relationships involving government-funded programs; and

- state laws governing healthcare entities that bear financial risk.

Because of the breadth of these laws and the narrowness of the statutory exceptions and safe harbors available, it is possible that some of our business activities could be subject to challenge under one or more of such laws. Achieving and sustaining compliance with these laws requires us to implement controls across our entire organization and it may prove costly

and challenging to monitor and enforce compliance. In particular, given the prevalence of laws, rules and regulations restricting the corporate practice of medicine in certain of the states that we operate, we are prohibited from interfering with or inappropriately influencing providers' professional judgment and are typically reliant on the providers and other healthcare professionals at our affiliated professional entities to operate in compliance with applicable laws related to the practice of medicine and the provision of healthcare services. The risk of our being found in violation of healthcare laws and regulations is increased by the fact that many of them have not been fully interpreted by regulatory authorities or the courts, and their provisions are sometimes complex and open to a variety of interpretations. Failure to comply with these laws and other laws can result in civil and criminal penalties such as fines, damages, recoupments of overpayments, imprisonment, loss of enrollment status and exclusion from the Medicare and Medicaid programs.

To enforce compliance with the federal laws, the U.S. Department of Justice and the Office of Inspector General for the HHS regularly scrutinize healthcare providers, which has led to a number of investigations, prosecutions, convictions and settlements in the healthcare industry. The operation of medical practices is also subject to various state laws enforced by state regulators, including state attorneys general, boards of professional licensure and departments of health. A review of our business by judicial, law enforcement, regulatory or accreditation authorities could result in challenges or actions against us that could harm our business and operations. Responding to and managing government investigations or any action against us for violation of these laws or regulations, even if we successfully defend against it, could cause us to incur significant legal expenses, divert resources and management's attention from the operation of our business and result in adverse publicity. Moreover, if one of our health system partners or another third party fails to comply with applicable laws and becomes the target of a government investigation, government authorities could require our cooperation in the investigation, which could cause us to incur additional legal expenses and result in adverse publicity.

In addition, because of the potential for large monetary exposure under the federal False Claims Act, which provides for treble damages and penalties of $12,537 to $25,076 per false claim or statement (as of January 2022, and subject to annual adjustments for inflation), healthcare providers often resolve allegations without admissions of liability for significant amounts to avoid the uncertainty of treble damages that may be awarded in litigation proceedings. Such settlements often contain additional compliance and reporting requirements as part of a consent decree, settlement agreement or corporate integrity agreement. Given the significant size of actual and potential settlements, it is expected that the government will continue to devote substantial resources to investigating healthcare providers' compliance with the healthcare reimbursement rules and fraud and abuse laws.

Further, our ability to provide our full range of services in each state is dependent upon a state's treatment of telehealth and emerging technologies (such as digital health services), which are subject to changing political, regulatory and other influences. Many states have laws that limit or restrict the practice of telehealth, such as laws that require a provider to be licensed and/or physically located in the same state where the patient is located. Failure to comply with these laws could result in denials of reimbursement for our services (to the extent such services are billed), recoupments of prior payments, professional discipline for our providers or civil or criminal penalties.

The laws, regulations and standards governing the provision of healthcare services may change significantly in the future and may harm our business and operations. For example, we have had to adapt our business as a result of the CARES Act and other emergency orders, laws and regulations enacted in response to the COVID-19 pandemic. While some of these changes have allowed us to rapidly respond to the COVID-19 pandemic including via expanded telehealth visits and testing arrangements, they have also required us to adapt to new offerings, processes and procedures. We cannot assure you that such emergency orders, laws and regulations will continue to apply or that regulators or other governmental entities will agree with our interpretation of these arrangements under applicable law. The Vaccine Inquiries or any other regulatory or governmental investigations or other disputes as a result of these arrangements, or the failure of various waivers for limitations of liability or other provisions under such emergency orders, laws and regulations to apply to us could divert resources and harm our reputation, business, financial condition and results of operations.

If the prevalence of private health insurance coverage declines, including due to a decline in the prevalence of employer-sponsored health care, our revenue may be reduced.

We currently derive a significant portion of our revenue from members acquired under contracts with enterprise clients that purchase health care for their employees (either via insurance or self-funded benefit plans). A large part of the demand for our solutions and services among enterprise clients depends on the need of these employers to manage the costs of healthcare services that they pay on behalf of their employees. While the percentage of employers who are self-insured has been increasing over the past decade, this trend may not continue. Over time, employees may also increasingly decide to obtain their own insurance through state-sponsored insurance marketplaces rather than through their employers. While such employees may remain members, our reimbursement from providing services to these members would likely decrease. Employees who obtain

their own insurance may also cancel their memberships, which may decrease the fees we receive under our contracts with health network partners as fewer members engage in their healthcare networks. If any of these trends accelerate, there is no guarantee that we would be able to compensate for the loss in revenue derived from enterprise clients and health network partners by increasing retail member acquisition. A decline in overall prevalence of private health insurance coverage, including due to the passage of healthcare reform proposals such as "Medicare for All," could further harm our revenue, particularly if accompanied by a reduction in employer-sponsored health insurance. In addition, health network partners who rely on patient use of their networks, particularly specialty care, through our contracts with them, may become dissatisfied with the terms under the applicable contract and seek to amend or terminate, or elect not to renew, these contracts. In these cases, our business, financial condition and results of operations would be harmed.

If we fail to cost-effectively develop widespread brand awareness and maintain our reputation, or if we fail to achieve and maintain market acceptance for our healthcare services, our business could suffer.

We believe that developing and maintaining widespread awareness of our brand and maintaining our reputation for providing access to high quality and efficient health care in a cost-effective manner is critical to attracting new members, enterprise clients, and health network partners, maintaining existing members, clients and partners and thus growing our business and revenue. Market acceptance of our solutions and services and member acquisition depends on educating people, as well as enterprise clients and health networks, as to the distinct features, ease-of-use, positive lifestyle impact, cost savings, quality, and other perceived benefits of our solutions and services as compared to traditional or competing healthcare access options and our ability to directly market our solutions or services to the employees of our enterprise clients. In particular, market acceptance is highly dependent on sufficient geographic market saturation of medical offices, whether we are in-network with payers, customization of healthcare services, and word of mouth and informal member referrals. While we are in-network with CMS and our health network partners, shortfalls in any of the above areas, the loss or dissatisfaction of a significant contingent of our members or patients, adverse media reports or negative feedback about our solutions and services may substantially harm our brand and reputation, inhibit widespread adoption of our solutions and services, reduce our revenue from enterprise clients and health networks, and impair our ability to attract new or maintain existing members and patients.

Our brand promotion activities may not generate awareness or increase revenue and, even if they do, any increase in revenue may not offset the expenses we incur in building our brand. We also cannot guarantee the quality and efficiency of healthcare service, particularly specialty healthcare, from our health network partners, over which we have no control. Many of our health network partners are large institutions with significant operations across a wide network of patients and may be unable to provide consistent levels of service to our members. Patients who experience poor quality healthcare provision from such partners may impute such dissatisfaction to our solutions and services, which could negatively impact member retention and acquisition, reduce our revenue and harm our business.

We have a history of losses, which we expect to continue, and we may never achieve or sustain profitability.

We have incurred significant losses in each period since our inception. We incurred net losses of $90.9 million, $89.4 million and $254.6 million for the three months ended March 31, 2022 and the years ended December 31, 2020 and 2021 respectively. As of March 31, 2022, we had an accumulated deficit of $709.1 million. Our net losses and accumulated deficit reflect the substantial investments we made to acquire new health network partners and members, build our proprietary network of healthcare providers and develop our technology platform. We intend to continue scaling our business to increase our enterprise client, member and provider bases, broaden the scope of our health network and other partnerships and expand our applications of technology through which members can access our services. Accordingly, we anticipate that our cost of care and other operating expenses will continue to increase in the foreseeable future. Moreover, as we sign up new At-Risk members for whom we are responsible for managing a range of healthcare services and associated costs, our medical claims expense for such members may be higher relative to the Capitated Revenue earned or any excess revenue over medical claims expense may not be enough to cover our cost of care or other operating expenses. Our efforts to scale our business and manage the health of At-Risk members may prove more expensive than we currently anticipate, and we may not succeed in increasing our revenue sufficiently to offset these higher expenses. We cannot assure you that we will achieve profitability in the future or that, if we do become profitable, we will be able to sustain or increase profitability. Our prior net losses, combined with our expected future net losses, have had and will continue to have a negative impact on our total (deficit) equity and working capital. As a result of these factors, we may need to raise additional capital through debt or equity financings in order to fund our operations, and such capital may not be available on reasonable terms, if at all.

Our net revenue depends in part on the number of members enrolled or patient visits, and a decrease in member utilization of our services could harm our business, financial condition and results of operations.

Historically, we have relied on patient visits for a substantial portion of our net revenue. For the three months ended March 31, 2022 and the years ended December 31, 2020 and 2021, net fee-for-service revenue accounted for 16%, 39% and 29% of our net revenue, respectively. As we develop additional digital health solutions through our mobile platform and continue providing and expanding availability of remote visits, we cannot guarantee that our members will consistently make in-office visits in addition to using our digital health solutions, particularly after the COVID-19 pandemic and as related shelter-in-place and quarantine measures and orders are relaxed or lifted. Further, it may be difficult for us to accurately forecast future patient in-office visits over time, which may vary across geographies and depend on patient demographics within a given market. In part due to the reduction of in-office visits observed due to COVID-19, we have introduced billable remote visits. We cannot predict with any certainty the number of remote billable services and their impact on our in-office visits. As remote billable services on average generate lower reimbursement than in-office visits, this may impact our operations and financial results. In addition, we will continue to rely on our reputation and recommendations from members and key enterprise clients to promote our solutions and services to potential new members. A substantial portion of our members hold subscriptions through their respective employers with which we have membership arrangements. The loss of any of our key enterprise clients, or a failure of some of them to renew or expand their arrangements with us, could have a significant impact on the growth rate of our revenue. If we are unable to attract and retain sufficient members in any given market, we may have reduced visits, which could harm our results of operations, reduce our revenue and harm our business.

In addition, under certain of our contracts with enterprise clients, we base our fees on the number of individuals to whom our clients provide benefits. Under certain of our health network partner agreements, we also collect fees from members who receive healthcare services within the health network partner's network. Many factors, most of which we do not control, may lead to a decrease in the number of individuals covered by our enterprise clients, including, but not limited to, the following:

- changes in the nature or operations of our enterprise clients or the failure of our enterprise clients to adopt or maintain effective business practices;
- changes of control of our enterprise clients;
- reduced demand in particular geographies;
- shifts away from employer-sponsored health plans toward employee self-insurance;
- shifting regulatory climate and new or changing government regulations; and
- increased competition or other changes in the benefits marketplace.

If the number of members covered by our enterprise clients and health network partners decreases, our revenue will likely decrease.

We operate in a competitive industry, and if we are not able to compete effectively our business would be harmed.

The market for healthcare solutions and services is highly fragmented and intensely competitive, with direct and indirect competitors offering varying levels of impact to key stakeholders such as consumers, employers, providers, and health networks. We compete across various segments within the healthcare market and currently face competition from a range of companies and providers for market share and for quality providers and personnel, including:

- traditional healthcare providers and medical practices nationally, regionally and locally, that offer similar services, often at lower prices, and that are continuing to develop additional products and becoming more sophisticated and effective;
- health networks, including our health network partners, who employ or affiliate with primary care providers, unaffiliated freestanding outpatient centers and specialty hospitals (some of which are physician-owned);
- episodic, consumer-driven point solutions such as telemedicine as well as urgent care providers, which may typically pay providers on a fee-for-service basis rather than the salary-based model we employ;
- health care or expert medical service tools developed by well-financed health plans which may be provided to health plan customers at discounted prices; and

- other companies providing healthcare-focused products and services, including companies offering specialized software and applications, technology platforms, care management and coordination, digital health, telehealth and telemedicine and health information exchange.

Our competitive success and growth, which can be measured in part by retention of existing members and gaining of new members in both existing and target geographies, are contingent on our ability to simultaneously address the needs of key stakeholders efficiently while delivering superior outcomes at scale compared with competitors. Over the years, the number of freestanding specialty hospitals, surgery centers, emergency departments, urgent care centers and diagnostic imaging centers has increased significantly in the geographic areas in which we serve and may provide services similar to those we offer. Some of our existing and potential competitors may be larger, have greater name recognition, have longer operating histories, offer a broader array of services or a larger or more specialized medical staff, provide newer or more desirable facilities or have significantly greater resources than we do. Some of the clinics and medical offices that compete with us are also owned by government agencies or not-for-profit organizations that can finance capital expenditures and operations on a tax-exempt basis. In addition, our current or potential competitors may be acquired by third parties with greater available resources. As a result, our competitors may be able to respond more quickly and effectively than we can to new or changing opportunities, technologies, standards or customer requirements and may have the ability to initiate or withstand substantial price competition. In light of the COVID-19 pandemic, existing or new competitors have developed or further invested in telemedicine and remote medicine programs and ventures, which would compete with our virtual care offerings. Also, current and potential competitors have established, and may in the future establish, cooperative relationships with vendors of complementary technologies or services to increase the availability of their solutions in the marketplace. Accordingly, new competitors or alliances may emerge that have greater market share, a larger member or patient base, more widely adopted proprietary technologies, greater marketing expertise, greater financial resources and larger sales forces than we have, which could put us at a competitive disadvantage. Our competitors could also be better positioned to serve certain segments of the healthcare market, which would limit our member and patient growth. In light of these factors, even if our solution is more effective than those of our competitors, current or potential members, health network partners and enterprise clients may accept competitive solutions in lieu of purchasing our solution.

Our enterprise clients or health network partners may also elect to terminate their arrangements with us and enter into arrangements with our competitors, particularly in primary care, to the extent they are more favorable from a fee or price perspective or provide greater exposure to, or volume of, patients. In addition, in any geographic area, we may enter into an exclusive contractual arrangement with a single health network partner, which could allow competitors to contract with other health network partners in the same area and gain market share for potential patients. Competitors may also be better positioned to contract with leading health network partners in our target geographies, including existing geographies, after our current contracts expire. If our competitors are better able to attract patients, contract with health network partners, recruit providers, expand services or obtain favorable managed care contracts at their facilities than we are, we may experience an overall decline in member volumes and net revenue. Competition from specialized providers, health plans, medical practices, digital health companies and other parties will result in continued member acquisition and patient visit and utilization volume pressure, which could negatively impact our revenue and market share.

Competition in our industry also involves consumer perceptions of quality and pricing, rapidly changing technologies, evolving regulatory requirements and industry expectations, frequent new product and service introductions and changes in customer requirements. As access to hospital performance data on quality measures, patient satisfaction surveys, and standard charges for services increases, healthcare consumers also have more tools to compare competing providers. If any of our affiliated professional entities achieve poor results (or results that are lower than our competitors') on quality measures or patient satisfaction surveys, or if our standard charges are or are perceived to be higher than our competitors, we may attract fewer members. Moreover, if we are unable to keep pace with the evolving needs of our clients, members and partners and continue to develop, enhance and market new applications and services in a timely and efficient manner, demand for our solutions and services may be reduced and our business and results of operations would be harmed. We cannot guarantee that we will possess the resources, either financial or personnel, for the research, design and development of new applications or services, or that we will be able to utilize these resources successfully and avoid technological or market obsolescence. Further, we cannot assure you that technological advances by one or more of our competitors or future competitors will not result in our present or future applications and services becoming uncompetitive or obsolete. If we are unable to successfully compete in the healthcare market, our business would be harmed.

We may not grow at the rates we historically have achieved or at all, even if our key metrics may imply future growth, which could have a negative impact on our business, financial condition and results of operations.

We have experienced significant growth in our recent history. Future revenue may not grow at these same rates or may decline. Our future growth will depend, in part, on our ability to grow members in existing geographies, expand into new

geographies, expand our service offerings and grow our health network partnerships while maintaining high quality and efficient services. We are continually executing a number of growth initiatives, strategies and operating plans designed to enhance our business. For example, we are expanding our strategic relationships with health network partners to build integrated delivery networks for broad access to their networks of specialists and hospitals. The anticipated benefits from these efforts are based on several assumptions that may prove to be inaccurate. We may not be able to successfully complete these growth initiatives, strategies and operating plans and realize all of the benefits, including growth targets and cost savings, that we expect to achieve, or it may be more costly to do so than we anticipate. We can provide no assurances that even if our key metrics indicate future growth, we will continue to grow our revenue or to generate net income. Moreover, our continued implementation of these programs may disrupt our operations and performance. If, for any reason, the benefits we realize are less than our estimates or the implementation of these growth initiatives, strategies and operating plans negatively impact our operations or cost more or take longer to effectuate than we expect, or if our assumptions prove inaccurate, our business, financial condition and results of operations may be harmed.

If we fail to manage our growth effectively, our expenses could increase more than expected, our revenue may not increase proportionally or at all, and we may be unable to implement our business strategy.

We have experienced significant growth in recent periods, which puts strain on our business, operations and employees. For example, we grew from 1,340 employees as of December 31, 2018 to 3,090 employees as of December 31, 2021 (including 791 employees from our acquisition of Iora). We have also increased our customer and membership bases significantly over the past two years. We anticipate that our operations will continue to rapidly expand. To manage our current and anticipated future growth effectively, we must continue to maintain and enhance our IT infrastructure, financial and accounting systems and controls. In particular, in order for our providers to provide quality healthcare services and longitudinal care to patients and avoid burn-out, we need to provide them with adequate IT and technology support, which requires sufficient staffing for these areas. In addition, as we expand in existing geographies and move into new geographies, we will need to attract and retain an increasing number of quality healthcare professionals and providers. Failure to retain a sufficient number of providers may result in overworking of existing personnel leading to burn-out or poor quality of healthcare services. In addition, our strategy is to provide longitudinal care to members and patients, which requires substantial time and attention from our providers. We must also attract, train and retain a significant number of qualified sales and marketing personnel, customer support personnel, professional services personnel, software engineers, technical personnel and management personnel, and the availability of such personnel, in particular software engineers, may be constrained.

A key aspect to managing our growth is our ability to scale our capabilities to implement our solutions and services satisfactorily with respect to both large and demanding enterprise clients and health network partners as well as individual consumers. Large clients and partners often require specific features or functions unique to their membership base, which, at a time of significant growth or during periods of high demand, may strain our implementation capacity and hinder our ability to successfully provide our services to our clients and partners in a timely manner. We may also need to make further investments in our technology to decrease our costs. If we are unable to address the needs of our clients, partners or members, or our clients, partners or members are unsatisfied with the quality of our solutions or services, they may not renew their contracts or memberships, seek to cancel or terminate their relationship with us or may renew on less favorable terms, any of which could harm our business and results of operations.

Failure to effectively manage our growth could also lead us to over-invest or under-invest in development and operations, result in weaknesses in our infrastructure, internal systems, processes or controls, give rise to operational mistakes, financial losses, loss of productivity or business opportunities and result in loss of employees and reduced productivity of remaining employees. In order to manage the increasing complexities of our business, we will need to continue to scale and adapt our operational, financial and management controls, as well as our reporting systems and procedures. We may not be able to successfully implement and scale improvements to our systems, processes and controls or in connection with third party software in a timely or efficient manner or in a manner that does not negatively affect our operating results. For example, we may not be able to effectively monitor certain extraordinary contract requirements or provisions that are individually negotiated as the number of transactions continues to grow. In addition, our systems and processes may not prevent or detect all errors, omissions, or fraud, including any fraudulent activities conducted or facilitated by our employees or the providers or staff at our affiliated professional entities. Any of these events could result in our expenses increasing more than expected, lack of growth or slower than expected growth in our revenue, and inability to implement our business strategies. The quality of our services may also suffer, which could negatively affect our reputation and harm our ability to attract and retain members, clients and partners.

Investment of significant capital expenditures to support our growth may also divert financial resources from other projects such as the development of new applications and services. In particular, as we enter new geographies or seek to expand our presence in existing geographies, we will need to make upfront capital expenditures, including to lease and furnish medical

office space, acquire medical equipment, staff providers at such medical offices and incur related expenses. As we do not recognize patient revenue until those offices open and begin receiving patients, our margins may be reduced during the periods in which such capital expenditures were incurred. Expansion in new or existing geographies can be lengthy and cost-intensive, and we may encounter difficulties or unanticipated issues during the process of opening such new medical offices. We cannot assure you that we will be able to open our planned new medical offices, in existing or new geographies, within our operating budgets and planned timelines, or at all. Cost overruns in the process of opening new offices can result in higher than expected cost of care, exclusive of depreciation and amortization, and operating expenses as compared to revenue in the applicable quarter. In addition, we cannot assure you that new medical offices will operate efficiently or be strategically placed to attract the optimal number of patients. If an office is underperforming for any reason, we could incur additional costs to relocate or shut down that office.

It is essential to our ongoing business that our affiliated professional entities attract and retain an appropriate number of quality primary care providers to support our services and that we maintain good relations with those providers.

The success of our business depends in significant part on the number, availability and quality of licensed primary care providers employed or contracted by our affiliated professional entities. Providers employed or contracted with our affiliated professional entities are free to terminate their association at any time. In addition, although providers who own interests in affiliated professional entities are generally subject to agreements restricting them from owning an interest in competitive facilities or transferring their ownership interests in the affiliated professional entity without our consent, we may not learn of, or may be unsuccessful in preventing, our provider partners from acquiring interests in competitive facilities or making transfers without our consent. Moreover, in certain states in which we operate, such as California, non-competition and other restrictive covenants may be limited in their enforceability, particularly against physicians and providers.

If we are unable to recruit and retain providers and other healthcare professionals, our business and results of operations could be harmed and our ability to grow could be impaired. In any particular geographical location, providers could demand higher payments or take other actions that could result in higher medical costs, less attractive service for our members or difficulty meeting regulatory or accreditation requirements. Our ability to develop and maintain satisfactory relationships with providers also may be negatively impacted by other factors not associated with us, such as changes in Medicare reimbursement levels and other pressures on healthcare providers and consolidation activity among hospitals, provider groups and healthcare providers.

We expect to encounter increased competition from health insurers and private equity companies seeking to acquire providers in the geographies where we operate practices and, where permitted by law, employ providers. In some geographies, provider recruitment and retention are affected by a shortage of providers and the difficulties that providers can experience in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance. Providers may also leave our affiliated professional entities or perceive them as providing a poor quality of life if our affiliated professional entities do not adequately manage causes of provider burnout and workload, some of which we have little to no control over under the administrative services agreements, or ASAs. Our business is dependent on providing longitudinal and long-term care for members and requires providers to consistently follow members over time, track overall long-term health and, in certain geographies, be available 24/7 for virtual care questions and services. If we are unable to efficiently manage provider workload and capacity to provide longitudinal and long-term care, our providers may depart and our patients may experience lower quality of care, which would harm our business. Furthermore, our ability to recruit and employ providers is closely regulated. For example, the types, amount and duration of compensation and assistance we can provide to recruited providers are limited by the Stark law, the Anti-kickback Statute, state anti-kickback statutes and related regulations. If we are unable to attract and retain sufficient numbers of quality providers by providing adequate support personnel, technologically advanced equipment and facilities that meet the needs of those providers and their patients, memberships and patient visits may decrease, our enterprise clients may alter or terminate their membership contracts with us and our operating performance may decline.

We incur significant upfront costs in our enterprise client and health network partner relationships, and if we are unable to maintain and grow these relationships over time, we are likely to fail to recover these costs, which could have a negative impact on our business, financial condition and results of operations.

Our business model and growth depend heavily on achieving economies of scale because our initial upfront investment for any enterprise client or certain health network partners is costly and the associated revenue is recognized on a ratable basis. We devote significant resources to establishing relationships with our clients and partners and implementing our solutions and services. This is particularly so in the case of large enterprises that, to date, have contributed a large portion of our membership base and revenue as well as health network partners, who may require specific features or functions unique to their particular processes or under the terms of their contracts with us, including significant systems integration and interoperability undertakings. Accordingly, our results of operations will depend in substantial part on our ability to deliver a successful

experience for these clients and related members and partners to persuade our clients and partners to maintain and grow their relationship with us over time. Additionally, as our business is growing significantly, our new customer and partner acquisition costs could outpace our revenue growth and we may be unable to reduce our total operating costs through economies of scale such that we are unable to achieve profitability. Our costs of doing business could also increase significantly due to labor shortages and inflationary pressures, which could increase the cost of labor, healthcare services and supplies and rental payments for our office locations. If we fail to achieve appropriate economies of scale or if we fail to manage or anticipate the evolution and in future periods, demand of our clients and partners, our business may be harmed.

Our marketing cycle can be long and unpredictable and requires considerable time and expense, which may cause our results of operations to fluctuate.

The marketing cycle for our solutions and services from initial contact with a potential enterprise client or health network partner to contract execution and implementation varies widely by enterprise client or partner. Some of our partners undertake a significant and prolonged evaluation process, including to determine whether our solutions and services meet their unique healthcare needs, which evaluation can be complex given the size and scale of our clients and partners. Our contractual arrangements with our health network partners are often highly specific to each partner depending on their needs, the characteristics and patient demographics of the geographical region they serve, their growth plans and their operations, among other things. As a result, our marketing efforts to any new health network partner must be tailored to meet its specific strategic demands, which can be time consuming and require significant upfront cost. These efforts also must address interoperability between our IT infrastructure and systems and such partner's systems, which can result in substantial cost without any assurance that we will ultimately enter into a contractual arrangement with any such partner.

Our large enterprise clients often initially restrict direct access by us to their employees to curb information overflow. As a result, we may not be able to directly market our solutions and services to, and educate, employees at our enterprise clients until much later after execution of an agreement with such clients. This can result in limited membership acquisition at any such enterprise client for a significant period of time following contract execution, and we cannot assure you that we will be able to gain sufficient membership acquisition to justify our upfront investments. Further, even after contract execution with a particular enterprise client, we generally compete with other health service providers who market to the same employees at such enterprise client, and our marketing and employee education efforts may not be successful in winning members from other competing services, many of which are traditional healthcare models that employees are more familiar with. We also incur significant marketing costs to grow awareness of our solution and services in both existing and new geographical locations for potential new members. Our marketing efforts for member acquisition are dependent in part on word of mouth, which may take substantial time to spread. In addition, for both new and existing geographic locations, we will need to continuously open medical offices in targeted locations to build awareness, which is both time-intensive and requires substantial upfront fixed costs. If our substantial upfront marketing and implementation investments do not result in sufficient sales to justify our investments, it could harm our business and results of operations.

We could experience losses or liability, including medical liability claims, causing us to incur significant expenses and requiring us to pay significant damages if not covered by insurance.

Our business entails the risk of medical liability claims against our affiliated professional entities, their providers, and 1Life and its subsidiaries and we have in the past been subject to such claims in the ordinary course of business. Although 1Life, its subsidiaries, our affiliated professional entities and individual providers may carry insurance at the entity level and at the provider level covering medical malpractice claims in amounts that we believe are appropriate in light of the risks attendant to our business, successful medical liability claims could result in substantial damage awards that exceed the limits of our affiliated professional entities' insurance coverage. Professional liability insurance is expensive and insurance premiums may increase significantly in the future, particularly as we expand our services and as the professional liability insurance market becomes more challenging due to COVID-19. As a result, adequate professional liability insurance may not be available to our providers or to us in the future at acceptable costs or at all. Any claims made against us that are not fully covered by insurance could be costly to defend against, result in substantial damage awards against us and divert the attention of our management and our providers from our operations, which could harm our business. In addition, any claims may significantly harm our business or reputation.

Moreover, we do not control the providers and other healthcare professionals at our affiliated professional entities with respect to the practice of medicine and the provision of healthcare services. While we seek to attract high quality professionals, the risk of liability, including through unexpected medical outcomes, is inherent in the healthcare industry, and negative outcomes may result for any of our members. We attempt to limit our liability to members, clients and partners by contract; however, the limitations of liability set forth in the contracts may not be enforceable or may not otherwise protect us from liability for damages. Additionally, we may be subject to claims that are not explicitly covered by such contractual limits.

We also maintain general liability coverage for certain risks, claims and litigation proceedings. However, this coverage may not continue to be available on acceptable terms or in sufficient amounts to cover one or more large claims against us, and may include larger self-insured retentions or exclusions. In addition, the insurer might deny coverage for the claims we submit or disclaim coverage as to any future claim. Any liability claim brought against us, or any ensuing litigation, regardless of merit, could result in a substantial cost to us, divert management's attention from operations and could also result in an increase of our insurance premiums and damage to our reputation. A successful claim not fully covered by our insurance could have a negative impact on our liquidity, financial condition, and results of operations.

Current or future litigation against us could be costly and time-consuming to defend.

We are subject, and in the future may become subject from time to time, to legal proceedings and claims that arise in the ordinary course of business such as claims brought by our members, clients or partners in connection with commercial disputes, consumer class action claims, employment claims made by our current or former employees, technology errors or omissions, medical malpractice, professional negligence or other related actions or claims inherent in the provision of healthcare services as well as other litigation matters. In particular, as we grow our base of consumer members, we may be subject to an increasing number of consumer claims, disputes and class action complaints, including an ongoing claim alleging misrepresentations with respect to our membership fees. While our membership terms generally require individual arbitration, we cannot assure you that such terms will be enforced, which may result, and has resulted in the past, in costly class action litigation. Litigation may result in substantial costs, settlement and judgments and may divert management's attention and resources, which may substantially harm our business, financial condition and results of operations. Insurance may not cover such claims, may not provide sufficient payments to cover all of the costs to resolve one or more such claims and may not continue to be available on terms acceptable to us. A claim brought against us that is uninsured or underinsured could result in unanticipated costs, thereby leading analysts or potential investors to reduce their expectations of our performance, which could reduce the market price of our common stock.

Our labor costs could be negatively impacted by competition for staffing, the shortage of experienced nurses and providers and labor union activity.

The operations of our affiliated professional entities are dependent on the efforts, abilities and experience of our management and medical support personnel, including nurses, therapists and lab technicians, as well as our providers. We compete with other healthcare providers in recruiting and retaining employees, and, like others in the healthcare industry, we continue to experience a shortage of nurses and providers in certain disciplines and geographic areas. As a result, from time to time, we may be required to enhance wages and benefits to recruit and retain experienced employees, make greater investments in education and training for newly licensed medical support personnel, or hire more expensive temporary or contract employees. Furthermore, state-mandated nurse-staffing ratios in California affect not only our labor costs, but, if we are unable to hire the necessary number of experienced nurses to meet the required ratios, they may also cause us to limit patient volumes, which would have a corresponding negative impact on our net revenue. In addition, while none of our employees are represented by a labor union as of March 31, 2022, our employees may seek to be represented by one or more labor unions in the future. If some or all of our employees were to become unionized, it could increase labor costs, among other expenses, and may require us to adjust our employee policies and protocols. Further, labor is subject to external factors that are beyond our control, including the competitive market for skilled workers and leaders in the healthcare industry, cost inflation, the COVID-19 pandemic and workforce participation rates. In general, our failure to recruit and retain qualified management, experienced nurses and other medical support personnel, or to control labor costs, could harm our business.

In order to support the growth of our business, we may need to incur additional indebtedness or seek capital through new equity or debt financings, which sources of additional capital may not be available to us on acceptable terms or at all.

Our operations have consumed substantial amounts of cash since inception and we intend to continue to make significant investments to support our business growth, respond to business challenges or opportunities, expand our services in new geographic locations, enhance our operating infrastructure and existing solutions and services and potentially acquire complementary businesses and technologies. For the three months ended March 31, 2022 and the years ended December 31, 2020 and 2021, our net cash used in operating activities was $55.1 million, $4.4 million and $88.6 million, respectively. As of March 31, 2022, we had $240.0 million of cash and cash equivalents and $188.5 million of marketable securities, which are held for working capital purposes. As of March 31, 2022, we had $316.3 million aggregate principal amount of debt outstanding under our convertible senior notes issued in May 2020, or the 2025 Notes.

As of March 31, 2022, we have also deferred payroll taxes in the amount of $5.0 million and received $4.3 million in grants as part of the Coronavirus Aid, Relief and Economic Security Act, or CARES Act, through the Provider Relief Fund, or

PRF, of the U.S. Department of Health and Human Services, or HHS, to help offset the impact of increased healthcare related expenses and lost revenues attributable to the COVID-19 pandemic. We are not required to repay this grant, provided we attest to and comply with certain terms and conditions, including the use of PRF funds for only permitted purposes and only after funds from other sources obligated to reimburse recipients have been applied. If we are unable to attest to or comply with current or future terms and conditions, our ability to retain some or all of the PRF funds received may be impacted.

Our future capital requirements may be significantly different from our current estimates and will depend on many factors, including our growth rate, membership renewal activity and growth, the timing and extent of spending to support development efforts, the expansion of sales and marketing activities, the introduction of new or enhanced services, expansion of services to new geographic locations, addition of new health network partners and the continuing market acceptance of our healthcare services. Accordingly, we may need to engage in equity or debt financings or collaborative arrangements to secure additional funds. If we raise additional funds through further issuances of equity or convertible debt securities, our existing stockholders could suffer significant dilution, and any new equity securities we issue could have rights, preferences and privileges superior to those of holders of our common stock. Moreover, while we are not restricted from incurring additional debt, securing existing or future debt, recapitalizing our debt or taking a number of other actions under the terms of the indenture governing the 2025 Notes, such actions could have the effect of diminishing our ability to make payments on the notes when due.

Any debt financing secured by us in the future could involve additional restrictive covenants relating to our capital-raising activities and other financial and operational matters, which may make it more difficult for us to obtain additional capital and to pursue business opportunities, including potential acquisitions. In addition, during times of economic instability, including the recent disruptions to, and volatility in, the credit and financial markets in the United States and worldwide resulting from the ongoing COVID-19 pandemic, it has been difficult for many companies to obtain financing in the public markets or to obtain debt financing, and we may not be able to obtain additional financing on commercially reasonable terms, if at all. If we are unable to obtain adequate financing or financing on terms satisfactory to us, it could harm our business and growth prospects.

Our revenues have historically been concentrated among our top customers, and the loss of any of these customers could reduce our revenues and adversely impact our operating results.

Historically, our revenue has been concentrated among a small number of customers. In 2020 and 2021, our top three customers accounted for 35% and 32% of our net revenue, respectively. These customers included commercial payers and a health network partner. This customer mix may also shift in the near and medium term as a result of our recent acquisition of Iora. The loss of one or more of these customers could reduce our revenue, harm our results of operations and limit our growth.

Our quarterly results may fluctuate significantly, which could adversely impact the value of our common stock.

Our quarterly results of operations, including our net revenue, loss from operations, net loss and cash flows, have varied and may vary significantly in the future, and period-to-period comparisons of our results of operations may not be meaningful. Accordingly, our quarterly results should not be relied upon as an indication of future performance. Our quarterly financial results have fluctuated, and may fluctuate in the future, as a result of a variety of factors, many of which are outside of our control, including, without limitation, the following:

- the addition or loss of health network partners or enterprise clients, including through acquisitions or consolidations of such entities;
- the addition or loss of contracts with, or modification of contract terms with, payers, including the reduction of reimbursements for our services or the termination of our network contracts with payers;
- seasonal and other variations in the timing and volume of patient visits, such as the historically higher volume of use of our service during peak cold and flu season months or due to COVID-19 outbreaks or variants;
- fluctuations in unemployment rates resulting in reductions in total members;
- slowdown in the overall economy resulting in losses of enterprise clients as they scale back on expenses;
- new enterprise sponsorships and renewal of existing enterprise sponsorships and the timing thereof as well as enterprise and consumer member activation and renewal and timing thereof;

- the timing of recognition of revenue;

- the amount and timing of operating expenses related to the maintenance and expansion of our business, operations and infrastructure, including upfront capital expenditures and other costs related to expanding in existing or entering new geographical locations, as well as providing administrative and operational services to our affiliated professional entities under the ASAs;

- our ability to effectively estimate the potential costs of medical services incurred, including under our at-risk arrangements, and the adequacy of our reserves for such incurred but not reported claims for medical services, in either case including due to increased visits and costs following a future COVID-19 outbreak or variant, which could result in fluctuations in our quarterly results and may not accurately reflect the underlying performance of our business within a given period;

- our ability to effectively manage the size and composition of our proprietary network of healthcare professionals relative to the level of demand for services from our members;

- the timing and success of introductions of new applications and services by us or our competitors, including well-known competitors with significant market clout and perceived ability to compete favorably due to access to resources and overall market reputation;

- changes in the competitive dynamics of our industry, including consolidation among competitors, health network partners or enterprise clients; and

- the timing of expenses related to the development or acquisition of technologies or businesses and potential future charges for impairment of goodwill from acquired companies.

Most of our net revenue in any given quarter is derived from contracts entered into with our partners and clients during previous quarters as well as membership fees that are recognized ratably over the term of each membership. Consequently, a decline in new or renewed contracts or memberships in any one quarter may not be fully reflected in our net revenue for that quarter. Such declines, however, would negatively affect our net revenue in future periods and the effect of loss of members, and potential changes in our rate of renewals or renewal terms, may not be fully reflected in our results of operations until future periods. While we encourage enterprise clients to purchase memberships off of their periodic enrollment cycle, we cannot guarantee that they will do so. Accordingly, the effect of changes in the industry impacting our business or loss of members may not be reflected in our short-term results of operations.

In addition, revenues associated with our At-Risk arrangements are subject to significant estimation risk related to reserves for incurred but not reported claims. If the actual claims expense differs significantly from the estimated liability due to differences in utilization of healthcare services, the amount of charges and other factors, it could negatively impact our revenue and have a material adverse impact on our business, results of operations, financial condition and cash flows. For example, future outbreaks or variants of COVID-19 may significantly increase actual claims which are difficult to forecast or predict, and as a result, may cause estimated liability to differ significantly. Any fluctuation in our quarterly results may not accurately reflect the underlying performance of our business and could cause a decline in the trading price of our common stock.

If we lose key members of our senior management team or are unable to attract and retain executive officers and employees we need to support our operations and growth, our business and growth may be harmed.

Our success depends largely upon the continued services of our key executive officers, particularly our Chair, Chief Executive Officer and President and 1Life's Chief Medical Officer. These executive officers are at-will employees and therefore they may terminate employment with us at any time with no advance notice. We also do not maintain any key person life insurance policies. Further, we rely on our leadership team in the areas of research and development, marketing, services and general and administrative functions. From time to time, there may be changes in our executive management team resulting from the hiring or departure of executives, which could disrupt our business. The replacement of one or more of our executive officers or other key employees would likely involve significant time and costs and may significantly delay or prevent the achievement of our business objectives. We are particularly dependent on 1Life's Chief Medical Officer, who is the sole director and officer of many of the affiliated professional entities and is responsible for overseeing the operation of several of such entities, among other roles. While we have succession plans in place and have employment or service arrangements with a limited number of key executives, these measures do not guarantee that the services of these or suitable successor executives will continue to be available to us.

To continue to execute our growth strategy, we also must attract and retain highly skilled personnel. Competition is intense for qualified professionals and we may not be successful in continuing to attract and retain qualified personnel. We have from time to time in the past experienced, and we expect to continue to experience in the future, difficulty in hiring and retaining highly skilled personnel with appropriate qualifications. The pool of qualified personnel with experience working in the healthcare market is limited overall. In addition, many of the companies with which we compete for experienced personnel have greater resources than we have. Further, labor is subject to external factors that are beyond our control, including the competitive market for skilled workers and leaders in the healthcare industry, cost inflation, the COVID-19 pandemic and workforce participation rates. As a result, our success is dependent on our ability to evolve our culture, align our talent with our business needs, engage our employees and inspire our employees to be open to change, to innovate and to maintain member- and customer-focus when delivering our services.

In addition, job candidates often consider the value of the stock options or other equity-based awards they are to receive in connection with their employment. Volatility in the price of our stock may, therefore, negatively impact our ability to attract or retain highly skilled personnel. Further, the requirement to expense stock options and other equity-based compensation may discourage us from granting the size or type of stock option or equity awards that job candidates require to join our company. Our business would be harmed if we fail to adequately plan for succession of our executives and senior management; or if we fail to effectively recruit, integrate, retain and develop key talent and/or align our talent with our business needs and the current rapidly changing environment.

We may acquire other companies or technologies, which could divert our management's attention, result in dilution to our stockholders and otherwise disrupt our operations and we may have difficulty integrating any such acquisitions successfully or realizing the anticipated benefits therefrom, any of which could harm our business.

We may seek to acquire or invest in businesses, applications and services or technologies that we believe could complement or expand our business, enhance our technical capabilities or otherwise offer growth opportunities. For example, we recently completed our acquisition of Iora in an all-stock transaction and our stockholders incurred substantial dilution. For additional risks related to the acquisition of Iora, please refer to "—Risks Related to the Acquisition of Iora." The pursuit of potential acquisitions may divert the attention of management and cause us to incur various expenses in identifying, investigating and pursuing suitable acquisitions, whether or not they are consummated. We do not have a history of acquiring or investing in businesses, applications and services or technologies and may not have the experience or capabilities to successfully execute such transactions or integrate them following consummation.

In addition, if we acquire additional businesses, we may not be able to integrate the acquired personnel, operations and technologies successfully, or effectively manage the combined business following the acquisition. We also may not achieve the anticipated benefits from the acquired business due to a number of factors, including, but not limited to:

- inability to integrate or benefit from acquired technologies or services in a profitable manner;
- lack of experience in making acquisitions and integrating acquired businesses or assets;
- unanticipated costs or liabilities associated with the acquisition;
- difficulty integrating the accounting systems, operations and personnel of the acquired business;
- difficulties and additional expenses associated with supporting legacy products and hosting infrastructure of the acquired business;
- diversion of management's attention from other business concerns;
- negative impacts to our existing relationships with enterprise clients or health network partners as a result of the acquisition;
- the potential loss of key employees;
- use of resources that are needed in other parts of our business;
- deficiencies associated with the assets or companies we acquire or ineffective or inadequate controls, procedures or policies at any acquired business that were not identified in advance and may result in significant unanticipated costs; and

- use of substantial portions of our available cash to consummate the acquisition.

The effectiveness of our due diligence review of potential acquisitions and assessments of potential benefits or synergies are dependent upon the accuracy and completeness of statements and disclosures made or actions taken by the companies we acquire or their representatives. We may fail to accurately forecast the financial impact of an acquisition transaction, including tax and accounting charges. In addition, a significant portion of the purchase price of companies we acquire may be allocated to acquired goodwill and other intangible assets, which must be assessed for impairment at least annually. In the future, if our acquisitions do not yield expected returns, we may be required to take charges to our results of operations based on this impairment assessment process, which could harm our results of operations.

Acquisitions could also result in dilutive issuances of equity securities or the incurrence of debt, which could harm our results of operations. In addition, if an acquired business fails to meet our expectations, our business may be harmed.

The estimates of market opportunity and forecasts of market and revenue growth included in this Quarterly Report may prove to be inaccurate, and even if the market in which we compete achieves the forecasted growth, our business could fail to grow at similar rates, if at all.

Market opportunity estimates and growth forecasts are subject to significant uncertainty and are based on assumptions and estimates that may not prove to be accurate. In particular, the size and growth of the overall U.S. healthcare market is subject to significant variables, including a changing regulatory environment and population demographic, which can be difficult to measure, estimate or quantify. Our business depends on member acquisition and retention, which further drives revenue from our contracts with health network partners. Estimates and forecasts of these factors in any given market is difficult and affected by multiple variables such as population growth, concentration of enterprise clients and population density, among other things. Further, we cannot assure you that we will be able to sufficiently penetrate certain market segments included in our estimates and forecasts, including due to limited deployable capital, ineffective marketing efforts or the inability to develop sufficient presence in a given market to gain members or contract with employers and health network partners in that market. Once we acquire a consumer or enterprise member, apart from fixed annual membership fees and payments from health care partners, we primarily derive revenue from patient in-office visits, which may be difficult to forecast over time, particularly as our billable service mix continues to expand, including due to the COVID-19 pandemic. Finally, our contractual arrangements with health network partners typically have highly tailored capitation and other fee structures which vary across health network partners and are dependent on either the number of members that receive healthcare services in a health network partner's network or the volume and expense of the care received by At-Risk members. As a result, we may not be able to accurately forecast revenue from our health network partners. For these reasons, the estimates and forecasts in this Quarterly Report relating to the size and expected growth of our target markets may prove to be inaccurate. Even if the markets in which we compete meet our size estimates and forecasted growth, our business could fail to grow at similar rates, if at all.

Natural or man-made disasters and other similar events may significantly disrupt our business and negatively impact our business, financial condition and results of operations.

Our offices and facilities may be harmed or rendered inoperable by natural or man-made disasters, including earthquakes, extreme weather conditions (including adverse weather conditions caused by global climate change or otherwise), power outages, fires, floods, protests and civil unrest, nuclear disasters and acts of terrorism or other criminal activities, which may result in physical damage to our offices, temporary office closures and could render it difficult or impossible for us to operate our business for some period of time. In particular, certain of the facilities we lease to house our computer and telecommunications equipment are located in the San Francisco Bay Area, a region known for seismic activity, and our insurance coverage may not compensate us for losses that may occur in the event of an earthquake or other significant natural disaster. Any disruptions in our operations related to the repair or replacement of our offices, could negatively impact our business and results of operations and harm our reputation. Although we maintain an insurance policy covering damages to our property and, in certain situations, interruptions to our business, such insurance may not be available or sufficient to compensate for the different types of associated losses that may occur, including business interruption losses. Any such losses or damages could harm our business, financial condition and results of operations. In addition, our health network partners' facilities may be harmed or rendered inoperable by such natural or man-made disasters, which may cause disruptions, difficulties or other negative effects on our business and operations.

Risks Related to Government Regulation

The impact of healthcare reform legislation and other changes in the healthcare industry and in healthcare spending is currently unknown, but may harm our business.

Our revenue is dependent on the healthcare industry and could be affected by changes in healthcare spending and policy. The healthcare industry is subject to changing political, regulatory and other influences. The Patient Protection and Affordable Care Act, or ACA, made major changes in how health care is delivered and reimbursed, and increased access to health insurance benefits to the uninsured and underinsured populations in the United States. ACA, among other things, increased the number of individuals with Medicaid and private insurance coverage.

ACA has been subject to legislative and regulatory changes and court challenges and there is uncertainty regarding whether, when, and how ACA may be changed, the ultimate outcome of court challenges and how the law will be interpreted and implemented. Changes by Congress or government agencies could eliminate or alter provisions beneficial to us, while leaving in place provisions reducing our reimbursement or otherwise negatively impacting our business.

In addition, current and prior healthcare reform proposals have included the concept of creating a single payer such as “Medicare for All” or a public option for health insurance. If enacted, these proposals could have an extensive impact on the healthcare industry, including us and may impact our business, financial condition, results of operations, cash flows and the trading price of our security. We are unable to predict whether such reforms may be enacted or their impact on our operations.

We are also impacted by the Medicare Access and CHIP Reauthorization Act, under which physicians must choose to participate in one of two payment formulas, Merit-Based Incentive Payment System, or MIPS, or Alternative Payment Models, or APMs. Beginning in 2019, MIPS allows eligible physicians to receive upward or downward adjustments to their Medicare Part B payments based on certain quality and cost metrics, among other measures. As an alternative, physicians can choose to participate in an Advanced APM. Advanced APMs are exempt from the MIPS requirements, and physicians who are meaningful participants in APMs will receive bonus payments from Medicare pursuant to the law.

We expect that additional state and federal healthcare reform measures will be adopted in the future, any of which could limit the number of individuals who qualify for health care coverage and amounts that federal and state governments and other third-party payers will pay for healthcare services, which could harm our business, financial condition and results of operations.

Our arrangements with health networks may be subject to governmental or regulatory scrutiny or challenge.

Some of our relationships with health networks involve risk arrangements, such as capitated payments designed to achieve alignment of financial incentives and to encourage close collaboration on clinical care for patients. Although we believe that our health network contracts involving capitated payments comply with the federal Anti-Kickback Statute and the Stark Law, we cannot assure you that regulators or other governmental entities will agree with our interpretation of these arrangements under applicable law. Our health network partnerships may be subject to scrutiny or investigation from time to time by regulators or other governmental entities, which may be lengthy, costly, and divert resources and our management’s attention from managing our business and growth. If our health network partnerships are challenged and found to violate the Anti-Kickback Statute or the Stark Law, we could incur substantial financial penalties, reimbursement denials, repayments or recoupments, or exclusion from participation in government healthcare programs, any of which could harm our business.

Evolving government regulations may increase costs or negatively impact our results of operations.

Our operations may be subject to direct and indirect adoption, expansion, revision or reinterpretation of various laws and regulations. In the event any such changes in law or interpretation impacts our services or contractual arrangements, we may be required to modify such services, or revise our arrangements, in a manner that undermines the attractiveness of services or may not preserve the same economics, or may be required to discontinue such arrangements. In each case, our revenue may decline and our business may be harmed. Compliance with changes in interpretation of laws and regulations may require us to change our practices at an undeterminable and possibly significant initial and recurring monetary expense. These additional monetary expenditures may increase future overhead, which could harm our results of operations.

We have identified what we believe are areas of government regulation that, if changed, could be costly to us. These include: fraud, waste and abuse laws; rules governing the practice of medicine by providers; licensure standards for primary care providers and behavioral health professionals; laws limiting the corporate practice of medicine and professional fee splitting; laws, regulations, and other requirements applicable to the Medicare program (including any CMMI programs in which we may participate); tax laws and regulations applicable to our annual membership fees; cybersecurity and privacy laws; laws and rules relating to the distinction between independent contractors and employees (including recent developments in

California that have expanded the scope of workers that are treated as employees instead of independent contractors); and tax and other laws encouraging employer-sponsored health insurance and group benefits. There could be laws and regulations applicable to our business that we have not identified or that, if changed, may be costly to us, and we cannot predict all the ways in which implementation of such laws and regulations may affect us.

We are dependent on our relationships with affiliated professional entities that we may not own to provide healthcare services and our business would be harmed if those relationships were disrupted or if our arrangements with these affiliated professional entities become subject to legal challenges.

The corporate practice of medicine prohibition exists in some form, by statute, regulation, board of medicine or attorney general guidance, or case law, in certain of the states in which we operate. These laws generally prohibit the practice of medicine by lay persons or entities and are intended to prevent unlicensed persons or entities from interfering with or inappropriately influencing providers' professional judgment. As a result, many of our affiliated professional entities that deliver healthcare services to our members are wholly owned by providers licensed in their respective states, including Andrew Diamond, M.D., Ph.D., 1Life's Chief Medical Officer who oversees the operation of several of the affiliated professional entities as the sole director and officer of many of the affiliated professional entities. Under the ASAs between 1Life and/or its subsidiaries with each affiliated professional entity, we provide various administrative and operations support services in exchange for scheduled fees at the fair market value of our services provided to each affiliated professional entity. As a result, our ability to receive cash fees from the affiliated professional entities is limited to the fair market value of the services provided under the ASAs. To the extent our ability to receive cash fees from the affiliated professional entities is limited, our ability to use that cash for growth, debt service or other uses at the affiliated professional entity may be impaired and, as a result, our results of operations and financial condition may be adversely affected.

Our ability to perform medical and digital health services in a particular U.S. state is directly dependent upon the applicable laws governing the practice of medicine, healthcare delivery and fee splitting in such locations, which are subject to changing political, regulatory and other influences. The extent to which a U.S. state considers particular actions or contractual relationships to constitute the practice of medicine is subject to change and to evolving interpretations by medical boards and state attorneys general, among others, each of which has broad discretion. There is a risk that U.S. state authorities in some jurisdictions may find that our contractual relationships with the affiliated professional entities, which govern the provision of medical and digital health services and the payment of administrative and operations support fees, violate laws prohibiting the corporate practice of medicine and fee splitting. Accordingly, we must monitor our compliance with laws in every jurisdiction in which we operate on an ongoing basis, and we cannot provide assurance that our activities and arrangements, if challenged, will be found to be in compliance with the law. Additionally, it is possible that the laws and rules governing the practice of medicine, including the provision of digital health services, and fee splitting in one or more jurisdictions may change in a manner adverse to our business. While the ASAs prohibit us from controlling, influencing or otherwise interfering with the practice of medicine at each affiliated professional entity, and provide that physicians retain exclusive control and responsibility for all aspects of the practice of medicine and the delivery of medical services, we cannot assure you that our contractual arrangements and activities with the affiliated professional entities will be free from scrutiny from U.S. state authorities, and we cannot guarantee that subsequent interpretation of the corporate practice of medicine and fee splitting laws will not circumscribe our business operations. State corporate practice of medicine doctrines also often impose penalties on physicians themselves for aiding the corporate practice of medicine, which could discourage providers from participating in our network of physicians. If a successful legal challenge or an adverse change in relevant laws were to occur, and we were unable to adapt our business model accordingly, our operations in affected jurisdictions would be disrupted, which could harm our business.

Any material changes in our relationship with or among the affiliated professional entities, whether resulting from a dispute among the entities, a challenge from a governmental regulator, a change in government regulation, or the loss of these relationships or contracts with the affiliated professional entities, could impair our ability to provide services to our members and could harm our business. For example, our arrangements in place to help ensure an orderly succession of the owner or owners of certain of the affiliated professional entities upon the occurrence of certain events may be challenged, which may impact our relationship with the affiliated professional entities and harm our business and results of operations. The ASAs and these succession arrangements could also subject us to additional scrutiny by federal and state regulatory bodies regarding federal and state fraud and abuse laws. Any scrutiny, investigation or litigation with regard to our arrangement with the affiliated professional entities, and any resulting penalties, including monetary fines and restrictions on or mandated changes to our current business and operating arrangements, could harm our business.

Noncompliance with billing and documentation requirements could result in non-payment or subject us to audits, billing or other compliance investigations by government authorities, private payers or health network partners.

Payers typically have differing and complex billing and documentation requirements. If we fail to comply with these payer-specific requirements, we may not be paid for our services or payment may be substantially delayed or reduced. Moreover, federal and state laws, rules and regulations impose substantial penalties, including criminal and civil fines, monetary penalties, exclusion from participation in government healthcare programs and imprisonment, on entities or individuals (including any individual corporate officers or physicians deemed responsible) that fraudulently or wrongfully bill government-funded programs or other third-party payers for healthcare services. Both federal and state government agencies have heightened and coordinated civil and criminal enforcement efforts as part of numerous ongoing investigations of healthcare companies, as well as their executives and managers, with enforcement actions covering a variety of topics, including referral and billing practices. Further, the federal False Claims Act and a growing number of state laws allow private parties to bring qui tam or "whistleblower" lawsuits against companies for false billing violations. Some of our activities could become the subject of governmental investigations or inquiries.

From time to time in the ordinary course of business, governmental agencies and private payers also conduct audits of healthcare providers like us. For example, as a result of our participation in the Medicare program, including through CMS' Direct Contracting Program, we are also subject to various governmental inspections, reviews, audits and investigations to verify our compliance with the Medicare program and applicable laws and regulations. We also periodically conduct internal audits and reviews of our regulatory compliance and our health network partners can also conduct audits under their agreements with us. Such audits could result in the incurrence of additional costs and diversion of management's time and attention. In addition, such audits could trigger repayment demands based on findings that our services were not medically necessary, were billed at an improper level or otherwise violated applicable billing requirements or contractual terms. Our failure to comply with rules related to billing or adverse findings from such audits could result in, among other penalties:

- non-payment for services rendered or recoupments or refunds of amounts previously paid for such services by our health network partners;
- refunding amounts we have been paid pursuant to the Medicare program or from payers;
- state or federal agencies imposing fines, penalties and other sanctions on us;
- temporary suspension of payment from payers for new patients to the facility or agency;
- decertification or exclusion from participation in the Medicare program or one or more payer networks;
- self-disclosure of violations to applicable regulatory authorities;
- damage to our reputation;
- the revocation of a facility's or agency's license; and
- loss of certain rights under, or termination of, our contracts with and health network partners.

We will likely be required in the future to refund amounts that have been paid and/or pay fines and penalties as a result of these inspections, reviews, audits and investigations. If adverse inspections, reviews, audits or investigations occur and any of the results noted above occur, it could have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities. Furthermore, the legal, document production and other costs associated with complying with these inspections, reviews, audits or investigations could be significant.

Our use and disclosure of personal information, including PHI, is subject to federal and state privacy and security regulations, and our failure to comply with those regulations or to adequately secure such information we hold could result in significant liability or reputational harm and, in turn, substantial harm to our health network partner and enterprise client base, membership base and revenue.

In the ordinary course of our business, we and third parties upon whom we rely receive, collect, store, process and use personal information as part of our business. Numerous state and federal laws and regulations inside the United States govern the collection, dissemination, use, privacy, confidentiality, security, availability and integrity of personal information including PHI. These laws and regulations include HIPAA, as amended by the HITECH Act, and its implementing regulations, as well as state privacy and data protection laws. HIPAA establishes a set of baseline national privacy and security standards for the protection of PHI, by health plans, healthcare clearinghouses and certain healthcare providers, referred to as covered entities, which includes our affiliated professional entities, and the business associates with whom such covered entities contract for

services that involve the use or disclosure of PHI, which includes 1Life and our affiliated professional entities. States may enforce more stringent privacy and data protection laws exceeding the requirements of HIPAA.

Compliance with privacy, data protection and information security laws and regulations in the United States could cause us to incur substantial costs or require us to change our business practices and compliance procedures in a manner adverse to our business. We strive to comply with applicable laws, regulations, policies and other legal obligations relating to privacy, data protection and information security. However, as the various regulatory frameworks for privacy, data protection and information security continue to develop, uncertainties exist as to their application, and it is possible that these or other actual or alleged obligations may be interpreted and applied in a manner that is inconsistent from one jurisdiction to another and may conflict with other rules and subject our business practices to uncertainty.

Penalties for violations of these laws vary. For example, penalties for violations of HIPAA and its implementing regulations are assessed at varying rates per violation, subject to a statutory cap for violations of the same standard in a single calendar year. Such penalties may be subject to periodic adjustments. However, a single breach incident can result in violations of multiple standards, which could result in significant fines. HIPAA also authorizes state attorneys general to file suit on behalf of their residents. Courts may award damages, costs and attorneys' fees related to violations of HIPAA in such cases, which may be significant. While HIPAA does not create a private right of action allowing individuals to sue us in civil court for violations of HIPAA, its standards have been used as the basis for duty of care in state civil suits such as those for negligence or recklessness in the misuse or breach of PHI. Any such penalties or lawsuits could harm our business, financial condition, results of operations and prospects.

In addition, HIPAA mandates that the Secretary of HHS conduct periodic compliance audits of HIPAA covered entities or business associates for compliance with the HIPAA Privacy and Security Standards and Breach Notification Rule. It also tasks HHS with establishing a methodology whereby harmed individuals who were the victims of breaches of unsecured PHI may receive a percentage of the civil monetary penalty fine or settlement paid by the violator.

HIPAA further requires that patients be notified of any unauthorized acquisition, access, use or disclosure of their unsecured PHI that compromises the privacy or security of such information, with certain exceptions related to unintentional or inadvertent use or disclosure by employees or authorized individuals or where there is a good faith belief that the person who received the impermissible disclosure would not have been able to retain the information. HIPAA specifies that such notifications must be made "without unreasonable delay and in no case later than 60 calendar days after discovery of the breach." If a breach affects 500 patients or more, it must be reported to HHS without unreasonable delay, and HHS will post the name of the breaching entity on its public web site. Breaches affecting 500 patients or more in the same state or jurisdiction must also be reported to the local media. If a breach involves fewer than 500 people, the covered entity must record it in a log and notify HHS at least annually. Any such notifications, including notifications to the public, could harm our business, financial condition, results of operations and prospects.

Numerous other federal and state laws protect the confidentiality, privacy, availability, integrity and security of personal information, including health information. For example, various states, such as California and Massachusetts, have implemented privacy laws and regulations that in many cases are more restrictive than, and may not be preempted by, the HIPAA rules and may be subject to varying interpretations by courts and government agencies, creating complex compliance issues for us and our health network partners and enterprise clients and potentially exposing us to additional expense, adverse publicity and liability. The cost of compliance could be significant and require investments to enhance our technology and security infrastructure. In addition, in certain situations, regulators, partners, clients and consumers may disagree with our analysis of, and response to, data-related incidents and our execution of obligations under the laws, which may cause disputes, liability and negative publicity and harm our business, operations and prospects. In particular, some laws, such as the California Consumer Privacy Act of 2018, or CCPA, allow for a private right of action and statutory damages, which may motivate plaintiffs' attorneys to file class action claims, which can be resource-intensive and costly to defend.

If our security measures, some of which are managed by third parties, are breached or fail, and unauthorized access to personal information or PHI occurs, our reputation could be severely damaged, harming member, client and partner confidence and may result in members curtailing their use of our services. In addition, we could face litigation, significant damages for contract breach, significant penalties and regulatory actions for violation of HIPAA and other applicable laws or regulations and significant costs for remediation, notification to individuals and the public and measures to prevent future occurrences. Any potential security breach could also result in increased costs associated with liability for stolen assets or information, inaccessibility of systems or information, repairing system damage that may have been caused by such breaches, remediation offered to employees, contractors, health network partners, enterprise clients or members in an effort to maintain our business relationships after a breach and implementing measures to prevent future occurrences, including organizational changes,

deploying additional personnel and protection technologies, training employees and engaging third-party experts and consultants.

We outsource important aspects of the storage and transmission of personal information and PHI, and thus rely on third parties to manage functions that have material cybersecurity risks. We require our vendors who handle personal information and PHI to contractually commit to safeguarding personal information and PHI such as by signing information protection addenda and/or business associate agreements, as applicable, to the same extent that applies to us and require such vendors to undergo security examinations. In addition, we periodically hire third-party security experts to assess and test our security posture. However, we cannot assure that these contractual measures and other safeguards will adequately protect us from the risks associated with the storage and transmission of employees', contractors', patients' and members' personal information and PHI. Any violation of applicable laws, regulations or policies by these parties, including violations that cause us to incur significant liability and put sensitive data at risk, could in turn harm our business.

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

As public and regulatory focus on privacy issues continues to increase, we expect that there will continue to be new laws, regulations and industry standards concerning privacy, data protection and information security. For example, the CCPA imposes obligations on businesses to which it applies. These obligations include, without limitation, providing specific disclosures in privacy notices, affording California residents certain rights related to their personal information, and requiring businesses subject to the CCPA to implement certain measures to effectuate California residents' rights to their personal information. The CCPA allows for statutory fines for noncompliance. The California Privacy Rights Act, or the CPRA, approved by California voters in November 2020 and expected to go into effect on January 1, 2023, builds upon the CCPA and affords consumers expanded privacy rights and protections. Colorado and Virginia passed similar consumer privacy laws expected to go into effect in 2023. The potential effects of state privacy, data protection and information security laws are far-reaching and will require us to modify our data processing practices and policies and to incur substantial costs and expenses to comply. Further, obligations under new laws and regulations may not be clear, creating uncertainty and risk despite our efforts to comply. If we fail, or are perceived to have failed, to address or comply with our privacy, data protection and information security obligations, we could be subject to governmental enforcement actions such as investigations, fines, penalties, audits, or inspections, class action or other litigation, contract breach claims, additional reporting requirements and/or oversight, bans on processing personal information, orders to destroy or not use personal information, reputational harm and imprisonment of company officials.

Any significant change to applicable privacy, data protection and information security laws, regulations or industry practices regarding the collection, use, retention, security or disclosure of our members' personal information, or regarding the manner in which the express or implied consent for the collection, use, retention or disclosure of such personal information is obtained, could increase our costs to comply and require us to modify our services and features, possibly in a material manner, which we may be unable to complete and may limit our ability to store and process the personal information of our members, optimize our operations or develop new services and features. Any of the foregoing could harm our competitive position, business, financial condition, results of operations and prospects.

Individuals may claim our call and text messaging services are not compliant with applicable law, including the Telephone Consumer Protection Act.

We call and send short message service, or SMS, text messages to members and potential members who are eligible to use our service. While we obtain consent from these individuals to call and send text messages, federal or state regulatory authorities or private litigants may claim that the notices and disclosures we provide, form of consents we obtain or our call and SMS texting practices are not adequate to comply with, or violate applicable law, including the Telephone Consumer Protection Act, or TCPA. The TCPA imposes specific requirements relating to the marketing to individuals leveraging technology such as telephones, mobile devices and texts. TCPA violations can result in significant financial penalties as businesses can incur civil forfeiture penalties or criminal fines imposed by the Federal Communications Commission or be fined for each violation through private litigation or state attorneys general or other state actor enforcement. Class action suits are the most common method for private enforcement. Our call and SMS texting campaigns are potential sources of risk for class action lawsuits and liability for our company. Numerous class-action suits under federal and state laws have been filed in recent years against companies who conduct call and SMS texting programs, with many resulting in multi-million-dollar settlements to the plaintiffs. While we strive to adhere to strict policies and procedures, the Federal Communications Commission, as the agency

that implements and enforces the TCPA, may disagree with our interpretation of the TCPA and subject us to penalties and other consequences for noncompliance. Determination by a court or regulatory agency that our call or SMS text messaging violate the TCPA could subject us to civil penalties, could require us to change some portions of our business and could otherwise harm our business. Even an unsuccessful challenge by members, consumers or regulatory authorities of our activities could result in adverse publicity and could require a costly response from and defense by us.

Negative publicity regarding the managed healthcare industry generally could adversely affect our results of operations or business.

Negative publicity regarding the managed healthcare industry generally, or the Medicare Advantage program in particular, may result in increased regulation and legislative review of industry practices that further increase the costs of doing business and adversely affect our results of operations or business by:

- requiring us to change our products and services provided to patients;
- increasing the regulatory burdens under which we operate, which may increase the costs of providing services;
- adversely affecting our ability to market our products or services through the imposition of further regulatory restrictions regarding the manner in which plans and providers market to Medicare Advantage enrollees; or
- adversely affecting our ability to attract and retain patients.

Risks Related to Information Technology

We rely on internet infrastructure, bandwidth providers, other third parties and our own systems to provide proprietary service platforms to our members and providers, and any failure or interruption in the services provided by these third parties or our own systems could expose us to liability and hurt our reputation and relationships with members and clients.

Our ability to maintain our proprietary service platform, including our digital health services and our electronic health records systems, is dependent on the development and maintenance of the infrastructure of the internet and other telecommunications services by third parties, including bandwidth and telecommunications equipment providers. This includes maintenance of a reliable network connection with the necessary speed, data capacity and security for providing reliable internet access and services and reliable telephone and facsimile services. We exercise limited control over these third-party providers.

Our platforms are designed to operate without perceptible interruption in accordance with our service level commitments. We have, however, experienced limited interruptions in these systems in the past, including server failures that temporarily slowed down or diminished the performance of our platforms, and we may experience similar or more significant interruptions in the future. We do not currently maintain redundant systems or facilities for some of these services. Interruptions to third party systems or services, whether due to system failures, cyber incidents (the risk of which has been higher due to the significant increase in remote work across the technology industry as a result of the COVID-19 pandemic), ransomware, physical or electronic break-ins, phishing campaigns or other events, could affect the security or availability of our platforms or services and prevent or inhibit the ability of our members or providers to access our platforms or services. In the event of a catastrophic event with respect to one or more of these systems or facilities, we may experience an extended period of system unavailability, which could result in liability, substantial costs to remedy those problems or harm our relationship with our members and our business.

Additionally, any disruption in the network access, telecommunications or co-location services provided by third-party providers or any failure of or by third-party providers' systems or our own systems to handle current or higher volumes of use could significantly harm our business. The reliability and performance of our third-party providers' systems and services may be harmed by increased usage or by ransomware, denial-of-service attacks or related cyber incidents, which has increased due to more opportunities created by remote work necessitated by the COVID-19 pandemic. Any errors, failures, interruptions or delays experienced in connection with these third-party services or our own systems could hurt our ability to deliver our services platform and damage our relationships with health network partners, enterprise clients and members and expose us to third-party liabilities, which could in turn harm our competitive position, business, financial condition, results of operations and prospects.

We rely on third-party vendors to host and maintain our technology platform.

We rely on third-party vendors to host and maintain our technology platform. Our ability to operate our business is dependent on maintaining our relationships with third-party vendors and entering into new relationships to meet the changing needs of our business. Any deterioration in our relationships with such vendors or our failure to enter into agreements with vendors in the future could significantly disrupt our operations or hinder our ability to execute our growth strategies. Because we rely on certain vendors to store and process our data, it is possible that, despite precautions taken at our vendors' facilities, the occurrence of a natural disaster, cyber incident, decision to close the facilities without adequate notice or other unanticipated problems could result in our non-compliance with data protection laws and regulations, loss of proprietary information, personal information, and other confidential information, and disruption to our technology platform. These service interruptions could also cause our platform to be unavailable to our health network partners, enterprise clients and members, and impair our ability to deliver services and negatively impact our relationships with new and existing health network partners, enterprise clients and members.

Some of our vendor agreements may be unilaterally terminated by the vendor for convenience, including with respect to Amazon Web Services, and if such agreements are terminated, we may not be able to enter into similar relationships in the future on reasonable terms or at all. We may also incur substantial costs, delays and disruptions to our business in transitioning such services to ourselves or other third-party vendors. In addition, third-party vendors may not be able to provide the services required in order to meet the changing needs of our business. Any of the foregoing could harm our competitive position, business, financial condition, results of operations and prospects.

Failure or breach of our or our vendors' security measures or inability to meet applicable privacy and security obligations, as well as any instances of unauthorized access to our employees', contractors', members', clients' or partners' data may result in disruption to our business and operations, incurrence of significant liabilities, loss of members, clients and partners and damage to our reputation.

Our services and operations involve the storage and transmission of personal information and other sensitive data, including proprietary and confidential business data, trade secrets and intellectual property and the personal information (including health information) of employees, contractors, clients, partners, members and others. Because of the sensitivity of the information we store and transmit, the security features of our and our third-party vendors' computer, network, and communications systems infrastructure are critical to the success of our business.

A breach or failure of our or our third-party vendors' security measures could result from a variety of circumstances and events, including, but not limited to, social engineering attacks (including through phishing attacks), malicious code (such as viruses and worms), malware (including as a result of advanced persistent threat intrusions), denial-of-service attacks (such as credential stuffing), ransomware attacks, supply-chain attacks, employee negligence or human errors, software bugs, server malfunction, software or hardware failures, loss of data or other information technology assets, adware, telecommunications failures, earthquakes, fire, flood, and other similar threats. Ransomware attacks, including those perpetrated by organized criminal threat actors, nation-states, and nation-state supported actors, are becoming increasingly prevalent and severe and can lead to significant interruptions in our operations, loss of data and income, reputational harm, and diversion of funds. Extortion payments may alleviate the negative impact of a ransomware attack, but we may be unwilling or unable to make such payments due to, for example, strategic security objectives or applicable laws or regulations prohibiting payments. Similarly, supply-chain attacks have increased in frequency and severity, and we cannot guarantee that third parties and infrastructure in our supply chain have not been compromised or that they do not contain exploitable defects or bugs that could result in a breach of or disruption to our information technology systems (including our services) or the third-party information technology systems that support us and our services. The COVID-19 pandemic and our remote workforce pose increased risks to our information technology systems and data, as more of our employees work from home, utilizing network connections outside our premises.

Any of the previously identified or similar threats could cause a security incident. If our or our third-party vendors experience a security incident, it could result in unauthorized, unlawful or accidental acquisition, modification, destruction, loss, alteration, encryption, disclosure of or access to data. A security incident could disrupt our (and third parties upon whom we rely) ability to provide our services. We may expend significant resources or modify our business activities in an effort to protect against security incidents. While we have implemented security measures designed to protect against a security incident, there can be no assurance that these measures will always be effective. We have not always been able in the past and may be unable in the future to detect vulnerabilities in our information technology systems because such threats and techniques change frequently, are often sophisticated in nature, and may not be detected until after a security incident has occurred. Some security incidents may remain undetected for an extended period of time. Despite our efforts to identify and remediate vulnerabilities, if any, in our information technology systems (including our products), our efforts may not be successful. Further, as cyber threats continue to evolve, we may be required to expend additional resources to enhance our information security measures and/or to

investigate and remediate any information security vulnerabilities and we may experience delays in developing and deploying remedial measures designed to address any such identified vulnerabilities.

Certain privacy, data protection and information security obligations, whether imposed by law or by clients, partners or vendors with whom we work, may require us to implement and maintain specific security and data privacy measures, industry-standard or reasonable security measures to protect our information technology systems and data, and to provide certain end-user rights in connection with their data. Our vendors, clients, partners and members may also demand that we adopt additional security or data privacy measures or make further security or data privacy investments, which may be costly and time-consuming. Such failures or breaches of our or our third-party vendors', clients' and partners' security or data privacy measures, or our or our third-party vendors', clients' and partners' inability to effectively resolve such failures or breaches in a timely manner, could disrupt the operation of our technology and business, adversely affect customer, partner, member or investor confidence in us, result in breach of contract claims, severely damage our reputation and reduce the demand for our services. Under certain circumstances, it could also impact the availability of our mobile app or related updates on various software platforms. Applicable privacy, data protection and security information obligations may require us to notify relevant stakeholders of security incidents. Such disclosures are costly, and the disclosures or the failure to comply with such requirements, could lead to adverse impacts. In addition, we could face litigation, significant damages for contract breach or other breaches of law, significant monetary penalties, or regulatory actions for violation of applicable laws or regulations, and incur significant costs for remedial or preventive measures. Although we maintain insurance covering certain security and privacy damages and claim expenses, we may not carry insurance or maintain coverage sufficient to compensate for all liability. Adequate insurance may not be available in the future at acceptable costs or at all and coverage disputes could also occur with our insurers. If security and privacy claims are not fully covered by insurance, they could result in substantial costs to us, which could harm our business. Insurance coverage would also not address the reputational damage that could result from a security incident. If an actual or perceived breach or inadequacy of our or our third-party vendors' security occurs, or if we or our third-party vendors are unable to effectively resolve a breach in a timely manner, we could lose current and potential members, partners and clients, which could harm our business, results of operations, financial condition and prospects.

Our proprietary technology platforms may not operate properly, which could damage our reputation, subject us to claims or require us to divert application of our resources from other purposes, any of which could harm our business and growth.

Our proprietary technology platforms provide members with the ability to, among other things, register for our services, request a visit (either scheduled or on demand) and communicate and interact with providers, and allows our providers to, among other things, chart patient notes, maintain medical records, and conduct visits (via video, phone or the internet). Proprietary software development is time-consuming, expensive and complex, and may involve unforeseen difficulties. We may encounter technical obstacles, and it is possible that we may discover additional problems that prevent our proprietary software from operating properly. Due to the COVID-19 pandemic, use of virtual care, including remote visits, has increased, which places a heavier demand on our technology platform and may cause performance levels to deteriorate. When we launch new features and functions within our technology platform, we could inadvertently introduce bugs or errors, including latent ones, into our platforms which could impact usability as well as technology and clinical operations. We continue to implement software with respect to a number of new applications and services. The operation of our technology also depends in part on the performance of third-party service providers. If our technology platform does not function reliably or fails to achieve member, provider, partner or client expectations in terms of performance, we may be required to divert resources allocated for other business purposes to address these issues, may suffer reputational harm, lose or fail to grow member usage, fail to retain or grow provider talent, members, partners and clients, and may be subject to liability claims.

The information that we provide to our health network partners, enterprise clients and members could be inaccurate or incomplete, which could harm our business, financial condition and results of operations.

We provide healthcare-related information for use by our health network partners, enterprise clients and members. Because data in the healthcare industry is fragmented in origin, inconsistent in format and often incomplete, the overall quality of data in the healthcare industry is poor, and we frequently discover data issues and errors. If the data that we provide to our health network partners, enterprise clients and members is incorrect or incomplete or if we make mistakes in the capture or input of this data, our reputation may suffer and our ability to attract and retain health network partners, enterprise clients and members may be harmed. In addition, a court or government agency may take the position that our storage and display of health information exposes us to personal injury liability or other liability for wrongful delivery or handling of healthcare services or erroneous health information, which could harm our business, financial condition and results of operations.

If we cannot implement or optimize our technology solutions for members, integrate our systems with health network partners or resolve technical issues in a timely manner, we may lose clients and partners and our reputation may be harmed.

Our health network partners utilize a variety of data formats, applications, systems and infrastructure. Moreover, each health network partner may have a unique technology ecosystem and infrastructure or have specific technology or certification requirements. To maintain our relationships with such partners and to continue to grow our business and membership, we may be required to meet such requirements and, in certain circumstances, our services must be seamlessly integrated and interoperable with our partners' complex systems, which may cause us to incur significant upfront and maintenance costs. Additionally, we do not control our partners' integration schedules. As a result, if our partners do not allocate the internal resources necessary to meet their integration responsibilities, which resources can be significant as many of them are large healthcare institutions with substantial operations to manage, or if we face unanticipated integration difficulties, the integration may be delayed. In addition, competitors with more efficient operating models with lower integration costs could jeopardize our partner relationships. If the integration process with our partners is not executed successfully or if execution is delayed, we could incur significant costs, partners could become dissatisfied and decide not to continue a strategic contractual relationship with us beyond an initial period during their term commitment or, in some cases, revenue recognition could be delayed, any of which could harm our business and results of operations.

Our members depend on our digital health platform, including our mobile app, web portal, and support services to access on-demand digital health services or schedule in-office visits. We may be unable to quickly accommodate increases in member technology usage, particularly as we increase the size of our membership base, grow our services and as the COVID-19 pandemic drives more member demand for our digital health services and virtual care. We also may be unable to modify the format of our technology solutions and support services to compete with developments from our competitors. If we are unable to further develop and enhance our technology solutions or maintain effective technical support services to address members' needs or preferences in a timely fashion, our members, clients and partners may become dissatisfied, which could damage our ability to maintain or expand our membership and business. While any refunds or credits we have issued historically have not had a significant impact on net revenue, we cannot assure you as to whether we may need to issue additional refunds or credits for membership fees in the future as a result of member or client dissatisfaction. For example, our members expect on-demand healthcare services through our mobile app and rapid in-office visit scheduling. Failure to maintain these standards or negative publicity related to our technology solutions, regardless of its accuracy, may reduce our overall NPS, harm our reputation and cause us to lose current or potential members, enterprise clients or partners. In addition, our enterprise clients expect our technology solutions to facilitate long-term cost of care reductions through high employee digital engagement, which we market as potential benefits for employers in providing employees with One Medical memberships. If employers do not perceive our solutions and services as providing such efficiencies and cost savings, they may terminate their contracts with us or elect not to renew. Any such outcomes could also negatively affect our ability to contract with new enterprise clients through damage to our reputation. If any of these were to occur, our revenue may decline and our business, results of operations, financial condition and prospects could be harmed.

Risks Related to Taxation and Accounting Standards

Certain U.S. state tax authorities may assert that we have a state nexus and seek to impose state and local income taxes which could harm our results of operations.

As of December 31, 2021, we are qualified to operate in, and file income tax returns in, 23 states as well as Washington, D.C. There is a risk that certain state tax authorities where we do not currently file a state income tax return could assert that we are liable for state and local income taxes based upon income or gross receipts allocable to such states. States are becoming increasingly aggressive in asserting a nexus for state income tax purposes. We could be subject to state and local taxation, including penalties and interest attributable to prior periods, if a state tax authority successfully asserts that our activities give rise to a nexus. Such tax assessments, penalties and interest to the extent the Company has taxable income in prior periods may adversely impact our results of operations.

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

In general, under Section 382 of the U.S. Internal Revenue Code of 1986, as amended, or the Code, a corporation that undergoes an "ownership change" is subject to limitations on its ability to utilize its pre-change net operating losses, or NOLs, to offset future taxable income. A Section 382 "ownership change" generally occurs if one or more stockholders or groups of stockholders who own at least 5% of our stock increase their ownership by more than 50 percentage points over their lowest ownership percentage within a rolling three-year period. Similar rules may apply under state tax laws. As of December 31, 2021, we have $894.3 million of federal net operating loss carryforwards and $598.5 million of state and local net operating loss carryforwards. The federal net operating loss carryforwards of $687.1 million arising after 2017 carry forward indefinitely, but the deduction for these carryforwards is limited to 80% of post-2020 current-year taxable income. The federal net operating loss carryforwards of $136.7 million from prior years will begin to expire in 2025. The state and local net operating loss carryforwards begin to expire in 2024. The Company has identified $25.2 million and $31.0 million of the above federal and

state net operating losses, respectively, in certain affiliated professional entities that will expire unused due to prior ownership changes. In addition, future changes in our stock ownership, some of which are outside of our control, could result in an ownership change under Section 382 of the Code, further limiting our ability to utilize NOLs arising prior to such ownership change in the future. There is also a risk that due to statutory or regulatory changes, such as suspensions on the use of NOLs, or other unforeseen reasons, our existing NOLs could expire or otherwise be unavailable to offset future income tax liabilities. We have recorded a full valuation allowance against the deferred tax assets attributable to our NOLs.

Taxing authorities may successfully assert that we should have collected or in the future should collect sales and use or similar taxes for our membership, enterprise and other service offerings, which could negatively impact our results of operations.

We do not collect sales and use and similar taxes in any states for our membership, enterprise and other service offerings based on our belief that our services are not subject to such taxes in any state. Sales and use and similar tax laws and rates vary greatly from state to state. Certain states in which we do not collect such taxes may assert that such taxes are applicable, which could result in tax assessments, penalties and interest with respect to past services, and we may be required to collect such taxes for services in the future. We have received, and may in the future continue to receive proposed assessments or determinations that we owe back taxes, penalties and interest for sales and use and similar taxes. If we are not successful in disputing such proposed assessments, we may be required to make payments in tax assessments, penalties or interest, and may be required to collect sales and use taxes in the future. Such tax assessments, penalties and interest or future requirements may negatively impact our results of operations.

Our financial results may be adversely impacted by changes in accounting principles applicable to us.

Generally accepted accounting principles in the United States are subject to interpretation by the Financial Accounting Standards Board, or FASB, the SEC and other various bodies formed to promulgate and interpret appropriate accounting principles. For example, in May 2014, the FASB issued accounting standards update No. 2014-09 (Topic 606), Revenue from Contracts with Customers, which supersedes nearly all existing revenue recognition guidance under GAAP and specifies that an entity should recognize revenue from the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services; this new accounting standard also impacted the recognition of sales commissions. Changes in accounting standards and interpretations or in our accounting assumptions and judgments could significantly impact our consolidated financial statements and our reported financial position and financial results may be harmed if our estimates or judgments prove to be wrong, assumptions change, or actual circumstances differ from those in our assumptions. Any difficulties in implementing these pronouncements could cause us to fail to meet our financial reporting obligations, which could result in regulatory discipline and harm our business.

If our estimates or judgments relating to our critical accounting policies prove to be incorrect, our results of operations could be harmed.

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. We base our estimates on historical experience and on various other assumptions that we believe to be reasonable under the circumstances, as provided in “Management’s Discussion and Analysis of Financial Condition and Results of Operations—Critical Accounting Estimates” in Part II, Item 7 of our Annual Report on Form 10-K for the fiscal year ended December 31, 2021, as filed with the SEC on February 23, 2022. The results of these estimates form the basis for making judgments about the carrying values of assets, liabilities, and equity and the amount of revenue and expenses that are not readily apparent from other sources. Significant assumptions and estimates used in preparing our consolidated financial statements include those related to revenue recognition, liability for medical claims incurred in the period but not yet reported (“IBNR”), valuation and related impairment recognition of intangible assets and goodwill, and stock-based compensation. Our results of operations may be harmed if our assumptions change or if actual circumstances differ from those in our assumptions, which could cause our results of operations to fall below the expectations of securities analysts and investors, resulting in a decline in the trading price of our common stock.

There are significant risks associated with estimating revenue under our At-Risk arrangements with certain payers, and if our estimates of revenues are materially inaccurate, it could negatively impact the timing and the amount of our revenue recognition or have a material adverse effect on our business, results of operations, financial condition and cash flows.

We recognize revenue net of risk shares and adjustments in the month in which eligible members are entitled to receive healthcare benefits during the contract term. Due to reporting lag times and other factors, significant judgment is required to estimate risk adjustments to PMPM fees received from payers for At-Risk members. The billing and collection process with

payers is complex due to ongoing insurance coverage changes, geographic coverage differences, differing interpretations of contract coverage and other payer issues, such as ensuring appropriate documentation. Determining applicable primary and secondary coverage for our patients, together with the changes in patient coverage that occur each month, requires complex, resource-intensive processes. Errors in determining the correct coordination of benefits may result in refunds to payers. Revenues associated with Medicare programs are also subject to estimation risk related to the amounts not paid by the primary government payer that will ultimately be collectible from other government programs paying secondary coverage, the patient's commercial health insurance plan secondary coverage or the patient. Collections, refunds and payer retractions typically continue to occur for up to three years and longer after services are provided. Inaccurate estimates of revenues could negatively impact the timing and the amount of our revenue recognition and have a material adverse impact on our business, results of operations, financial condition and cash flows.

If our goodwill, intangible assets or other long-lived assets become impaired, we may be required to record a significant charge to earnings.

Consummation of the acquisition of Iora resulted in us recognizing additional goodwill, intangible assets and other long-lived assets such as leases and fixed assets on our consolidated balance sheet. Intangible assets with finite lives will be amortized using the method that best reflects how their economic benefits are utilized or, if a pattern of economic benefits cannot be reliably determined, on a straight-line basis over their estimated useful lives. Goodwill will not be amortized, but instead tested for potential impairment at least annually. Goodwill, intangible assets and other long-lived assets will also be tested for impairment whenever events or changes in circumstances indicate that the carrying value may not be recoverable. If our goodwill, intangible assets or other long-lived assets are determined to be impaired in the future, we may be required to record additional significant, non-cash charges to earnings during the period in which the impairment is determined to have occurred.

Risks Related to Our Intellectual Property

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

Our business depends on proprietary technology and other business assets, including software, processes, databases, confidential information and know-how, the protection of which is crucial to the success of our business. We rely on a combination of trademark, trade-secret and copyright laws, confidentiality policies and procedures, cybersecurity practices and contractual provisions to protect our intellectual property. We do not currently own any issued patents. Third parties, including our competitors, may have or obtain patents relating to technologies that overlap or compete with our technology, which they may assert against us to seek licensing fees or preclude the use of our technology.

We may, over time, increase our investment in protecting our intellectual property through additional trademark, patent, copyright and other intellectual property filings, which could be expensive and time-consuming. While our operations are currently based in the United States, we may also be required to protect our intellectual property in foreign jurisdictions, a process that can be prolonged and costly, and one that we may choose not to pursue in every instance. We may not be able to obtain protection for our technology and even if we are successful, it is expensive to maintain intellectual property rights and the costs of defending our rights could be substantial. Moreover, these measures may not be sufficient to offer us meaningful protection or provide us with any competitive advantage. Furthermore, changes to U.S. intellectual property laws may jeopardize the enforceability and validity of our intellectual property portfolio and harm our ability to obtain patent protection of certain inventions.

If we are unable to adequately protect our intellectual property and other proprietary rights, our competitive position and our business could be harmed, as competitors may be able to commercialize similar offerings without having incurred the development and licensing costs that we have incurred. Any of our owned or licensed intellectual property rights could be challenged, invalidated, circumvented, infringed, misappropriated or violated, our trade secrets and other confidential information could be disclosed in an unauthorized manner to third parties, which could result in costly redesign efforts, business disruptions, discontinuance of some of our offerings or other competitive harm.

We may become involved in lawsuits to protect or enforce or defend our intellectual property rights, which could be expensive, time consuming and unsuccessful.

Third parties, including our competitors, could infringe, misappropriate or otherwise violate our intellectual property rights. Monitoring unauthorized use of our intellectual property is difficult and costly. From time to time, we seek to analyze

our competitors' solutions and services, and may in the future seek to enforce our rights against potential infringement, misappropriation or violation of our intellectual property. However, the steps we have taken to protect our proprietary rights may not be adequate to enforce our rights as against such infringement, misappropriation or violation of our intellectual property. We may not be able to detect unauthorized use of, or take appropriate steps to enforce, our intellectual property rights. Any inability to meaningfully enforce our intellectual property rights could harm our ability to compete and reduce demand for our services.

In recent years, companies are increasingly bringing and becoming subject to lawsuits and proceedings alleging infringement, misappropriation or violation of intellectual property rights, particularly patent rights. Our competitors and other third parties may hold patents or other intellectual property rights, which could be related to our business. We expect that we may receive in the future notices that claim we or our partners, clients or members using our solutions and services have misappropriated or misused other parties' intellectual property rights, particularly as the number of competitors in our market grows and the functionality of applications amongst competitors overlaps. If we are found to infringe, misappropriate or violate another party's intellectual property rights, we could be prohibited, including by court order, from further use of the intellectual property asset or be required to obtain a license from such third party to continue commercializing or using such technologies, solutions or services, which may not be available on commercially reasonable terms or at all. Even if we were able to obtain a license, it could be non-exclusive, thereby giving our competitors and other third parties access to the same technologies licensed to us, and it could require us to make substantial licensing and royalty payments. Accordingly, we may be forced to design around such violated intellectual property, which may be expensive, time-consuming or infeasible. In addition, we could be found liable for significant monetary damages, including treble damages and attorneys' fees, if we are found to have willfully infringed a patent or other intellectual property right. Claims that we have misappropriated the confidential information or trade secrets of third parties could similarly harm our business. Any adverse outcome in such cases could affect our competitive position, business, financial condition, results of operations and prospects.

Litigation or other legal proceedings relating to intellectual property claims, regardless of merits and even if resolved in our favor, can be expensive, time consuming, and resource intensive. In addition, there could be public announcements of the results of hearings, motions, or other interim proceedings or developments, and if securities analysts or investors perceive these results to be negative, it could have a substantial adverse effect on the price of our common stock. Such litigation or proceedings could substantially increase our operating losses and reduce the resources available for development activities or any future sales, marketing, or other business activities. We may not have sufficient financial or other resources to conduct such litigation or proceedings adequately. Some of our competitors may be able to sustain the costs of such litigation or proceedings more effectively than we can because of their greater financial resources and more mature and developed intellectual property portfolios. Uncertainties resulting from the initiation and continuation of intellectual property proceedings could harm our ability to compete in the marketplace. In addition, because of the substantial amount of discovery required in connection with intellectual property litigation, there is a risk that some of our confidential information could be compromised by disclosure during this type of litigation. Any of the foregoing could harm our competitive position, business, financial condition, results of operations and prospects.

If we fail to comply with our license obligations, if our license rights are challenged, or if we cannot license rights to use technologies on reasonable terms, we may experience business disruption, increased costs, or inability to commercialize certain services.

We license certain intellectual property, including content, technologies and software from third parties, that are important to our business. In the future we may need to enter into additional agreements that provide us with licenses and rights to valuable intellectual property or technology. If we fail to comply with any of the obligations under our license agreements, or if our use or license rights are challenged, we may be required to pay damages, the licensor may have the right to terminate the license and the owner of the intellectual property asset may assert claims against us. Termination by the licensor or dispute with an owner of an intellectual property asset would cause us to lose valuable rights, and could disrupt or prevent us from providing our services, or adversely impact our ability to commercialize future solutions and services. In addition, our rights to certain technologies are licensed to us on a non-exclusive basis. The owners of these non-exclusively licensed technologies are therefore free to license them to third parties, including our competitors, on terms that may be superior to those offered to us, which could place us at a competitive disadvantage. Our licensors may also own or control intellectual property that has not been licensed to us and, as a result, we may be subject to claims, regardless of their merit, that we are infringing or otherwise violating the licensor's rights. In addition, the agreements under which we license intellectual property or technology from third parties are generally complex, and certain provisions in such agreements may be susceptible to multiple interpretations. The resolution of any contract interpretation disagreement that may arise could narrow what we believe to be the scope of our rights to the relevant intellectual property or technology, or increase what we believe to be our financial or other obligations under the relevant agreement.

Moreover, the licensing or acquisition of third-party intellectual property rights is a competitive area, and established companies may have a competitive advantage over us due to their size, capital resources and greater development or commercialization capabilities. Companies that perceive us to be a competitor may also be unwilling to license or grant rights to us. Even if such licenses are available, we may be required to pay the licensor substantial fees or royalties. Such fees or royalties will become a cost of our operations and may affect our margins. If we are unable to obtain licenses on acceptable terms or at all, if any licenses are subsequently terminated, if our licensors fail to abide by the terms of the licenses, if our licensors fail to prevent infringement by third parties, or if the licensed intellectual property rights are found to be invalid or unenforceable, we could be restricted from commercializing our solutions and services and may be required to incur substantial costs to seek or develop alternatives. Any of the foregoing could harm our business, financial condition, results of operations, and prospects.

If our trademarks and trade names are not adequately protected, we may not be able to build and maintain name recognition in our markets of interest and our competitive position may be harmed.

The registered or unregistered trademarks or trade names that we own may be challenged, infringed, circumvented, declared generic, lapsed or determined to be infringing on or dilutive of other marks. We may not be able to protect our rights in these trademarks and trade names, which we need in order to build and maintain name recognition with the public. In addition, third parties have filed, and may in the future file, for registration of trademarks similar or identical to our trademarks, thereby impeding our ability to build and maintain brand identity and possibly leading to market confusion. If they succeed in registering or developing common law rights in such trademarks, and if we are not successful in challenging such third-party rights, we may not be able to use these trademarks to develop or maintain brand recognition of our services or be required to expend substantial resources and expenses to rebrand. In addition, there could be potential trade name or trademark infringement claims brought by owners of other registered trademarks or trademarks that incorporate variations of our registered or unregistered trademarks or trade names. If we are unable to establish or protect our trademarks and trade names, or if we are unable to build or maintain name recognition based on our trademarks and trade names, we may not be able to compete effectively, which could harm our competitive position, business, financial condition, results of operations and prospects.

If we are unable to protect the confidentiality of our trade secrets, our business and competitive position would be harmed.

We rely heavily on trade secrets and confidentiality agreements to protect our unpatented know-how, technology, and other proprietary information, including our technology platform, and to maintain our competitive position. With respect to our technology platform, we consider trade secrets and know-how to be one of our primary sources of intellectual property. However, trade secrets and know-how can be difficult to protect. We seek to protect these trade secrets and other proprietary technology, in part, by implementing topical policies and processes and by entering into non-disclosure and confidentiality agreements with parties who have access to them, such as our employees, contractors, consultants, advisors, clients, prospects, partners, and other third parties. We also enter into confidentiality and invention or patent assignment agreements with our employees and consultants. We cannot guarantee that we have entered into such agreements with each party that may have or have had access to our trade secrets or proprietary information. Despite these efforts, any of these parties may breach the agreements and disclose our proprietary information, including our trade secrets, and we may not be able to obtain adequate remedies for such breaches. Enforcing a claim that a party illegally disclosed or misappropriated a trade secret is difficult, expensive, and time-consuming, and the outcome is unpredictable. If any of our trade secrets were to be lawfully obtained or independently developed by a competitor or other third party, we would have no right to prevent them from using that technology or information to compete with us. If any of our trade secrets are misappropriated, improperly disclosed, or independently developed by a competitor or other third party, it could harm our competitive position, business, financial condition, results of operations, and prospects.

We may be subject to claims that our employees, consultants, or advisors have wrongfully used or disclosed alleged trade secrets of their current or former employers or claims asserting ownership of what we regard as our own intellectual property.

Many of our employees, consultants, and advisors are currently or were previously employed at other companies in our field, including our competitors or potential competitors. Although we try to ensure that our employees, consultants, and advisors do not use the proprietary information or know-how of others in their work for us, we may be subject to claims that we or these individuals have used or disclosed intellectual property, including trade secrets or other proprietary information, of any such individual’s current or former employer. Litigation may be necessary to defend against these claims. If we fail in defending any such claims, in addition to paying monetary damages, we may lose valuable intellectual property rights or personnel. Even if we are successful in defending against such claims, litigation could result in substantial costs and be a distraction to management.

In addition, while it is our policy to require our employees and contractors who may be involved in the conception or development of intellectual property to execute agreements assigning such intellectual property to us, we may be unsuccessful in executing such an agreement with each party who, in fact, conceives or develops intellectual property that we regard as our own. The assignment of intellectual property rights may not be self-executing, or the assignment agreements may be breached, and we may be forced to bring claims against third parties, or defend claims that they may bring against us, to determine the ownership of what we regard as our intellectual property. Any of the foregoing could harm our competitive position, business, financial condition, results of operations and prospects.

Our use of open source software could compromise our ability to offer our services and subject us to possible litigation.

We use open source software in connection with our solutions and services. Companies that incorporate open source software into their solutions have, from time to time, faced claims challenging the use of open source software and compliance with open source license terms. As a result, we could be subject to suits by parties claiming ownership of what we believe to be open source software or claiming noncompliance with open source licensing terms. Some open source software licenses require users who distribute software containing open source software to publicly disclose all or part of the source code to the licensee's software that incorporates, links or uses such open source software, and make available to third parties for no cost, any derivative works of the open source code created by the licensee, which could include the licensee's own valuable proprietary code. While we monitor our use of open source software and try to ensure that none is used in a manner that would require us to disclose our proprietary source code or that would otherwise breach the terms of an open source agreement, such use could inadvertently occur, or could be claimed to have occurred, in part because open source license terms are often ambiguous. There is little legal precedent in this area and any actual or claimed requirement to disclose our proprietary source code or pay damages for breach of contract could harm our business and could help third parties, including our competitors, develop solutions and services that are similar to or better than ours. Any of the foregoing could harm our competitive position, business, financial condition, results of operations and prospects.

Risks Related to Ownership of Our Common Stock

Our stock price may be volatile, and the value of our common stock may decline.

The market price of our common stock may be highly volatile and may fluctuate or decline substantially as a result of a variety of factors, some of which are beyond our control or are related in complex ways, including:

- actual or anticipated fluctuations in our financial condition and operating results;
- variance in our financial performance from expectations of securities analysts or investors;
- changes in the pricing we offer our members;
- changes in our projected operating and financial results;
- the impact of COVID-19, including future outbreaks or variants, on our financial performance, financial condition and results of operations, and the financial performance and financial condition of our health network partners, our enterprise clients and others;
- the impact of protests and civil unrest;
- our relationships with our health network partners and any changes to or terminations of our contracts with the health network partners;
- changes in laws or regulations applicable to our industry and our solutions and services;
- announcements by us, our health network partners or our competitors of significant business developments, acquisitions, or new offerings;
- publicity associated with issues with our services and technology platform;
- our involvement in litigation, including medical malpractice claims and consumer class action claims;

- any governmental investigations or inquiries into our business and operations or challenges to our relationships with our affiliated professional entities under the ASAs or to our relationships with health network partners;
- future sales of our common stock or other securities, by us or our stockholders;
- changes in senior management or key personnel;
- developments or disputes concerning our intellectual property or other proprietary rights, including allegations that we have infringed, misappropriated or otherwise violated any intellectual property of any third party;
- changes in accounting standards, policies, guidelines, interpretations or principles;
- actual or anticipated developments in our business, our competitors' businesses or the competitive landscape generally, including competition or perceived competition from well-known and established companies or entities;
- our relationships with our health network partners and any changes to or terminations of our contracts with the health network partners;
- the trading volume of our common stock, including effects of inflation;
- changes in the anticipated future size and growth rate of our market;
- rates of unemployment; and
- general economic, regulatory and market conditions, including economic recessions or slowdowns and inflationary pressures.

Broad market and industry fluctuations, as well as general economic, political, regulatory and market conditions, may negatively impact the market price of our common stock, which has recently been volatile. In the past, securities class action litigation has often been brought against a company following a decline in the market price of its securities. This risk is especially relevant for us, because companies reliant on technology solutions have experienced significant stock price volatility in recent years. If we face such litigation, it could result in substantial costs and a diversion of management's attention and resources, which could harm our business.

As a result of being a public company, we are obligated to maintain proper and effective internal control over financial reporting and any failure to maintain the adequacy of these internal controls may negatively impact investor confidence in our company and, as a result, the value of our common stock.

We are subject to the reporting requirements of the Securities Exchange Act of 1934, as amended, or the Exchange Act, the Sarbanes-Oxley Act and the rules and regulations of Nasdaq. In particular, we are required pursuant to Section 404 of the Sarbanes-Oxley Act to furnish a report by management on, among other things, the effectiveness of our internal control over financial reporting. This assessment includes disclosure of any material weaknesses identified by our management in our internal control over financial reporting. In addition, our independent registered public accounting firm is required to attest to the effectiveness of our internal control over financial reporting. The process of compiling the system and process documentation necessary to perform the evaluation required under Section 404 is costly and challenging. Also, we currently do not have an internal audit group, and we may need to hire additional accounting and financial staff with appropriate public company experience and technical accounting knowledge and compile the system and process documentation necessary to support ongoing work to comply with Section 404. Any failure to maintain effective internal control over financial reporting could severely inhibit our ability to accurately report our financial condition or results of operations. If we are unable to conclude that our internal control over financial reporting is effective, or if our independent registered public accounting firm determines we have a material weakness in our internal control over financial reporting, we could lose investor confidence in the accuracy and completeness of our financial reports, the market price of our common stock could decline, we could be subject to sanctions or investigations by Nasdaq, the SEC or other regulatory authorities and our access to the capital markets could be restricted in the future.

We have in the past identified material weaknesses in our internal control over financial reporting, and we cannot assure you that the measures we have taken will be sufficient to avoid potential future material weaknesses, that our remediated controls will continue to operate properly, or that our financial statements will be free from error. Our current controls and any new controls that we develop may become inadequate because of changes in conditions in our business and we may discover

weaknesses in our disclosure controls and internal control over financial reporting in the future. Any failure to develop or maintain effective internal control over financial reporting could severely inhibit our ability to accurately report our financial condition or results of operations. Accordingly, there could continue to be a possibility that a material misstatement of our financial statements would not be prevented or detected on a timely basis.

If we are unable to conclude that our internal control over financial reporting is effective, or if our independent registered public accounting firm determines we have a material weakness in our internal control over financial reporting, we could lose investor confidence in the accuracy and completeness of our financial reports, the market price of our common stock could decline, we could be subject to sanctions or investigations by Nasdaq, the SEC or other regulatory authorities and our access to the capital markets could be restricted in the future.

A significant portion of our total outstanding common stock may be sold into the market in the near future. This could cause the market price of our common stock to drop significantly, even if our business is doing well.

Sales of a substantial number of shares of our common stock in the public market could occur at any time. If our stockholders sell, or the market perceives that our stockholders intend to sell, substantial amounts of our common stock in the public market, the market price of our common stock could decline significantly. All of our outstanding shares of common stock are eligible for sale in the public market, other than shares held by directors, executive officers and other affiliates that are subject to volume and other limitations under Rule 144 under the Securities Act. In addition, we have reserved shares for future issuance under our equity incentive plan.

Certain holders of our common stock, or their transferees, also have rights, subject to some conditions, to require us to file one or more registration statements covering their shares or to include their shares in registration statements that we may file for ourselves or other stockholders. If we were to register the resale of these shares, they could be freely sold in the public market without limitation. If these additional shares are sold, or if it is perceived that they will be sold, in the public market, the trading price of our common stock could decline.

Future sales and issuances of our capital stock or rights to purchase capital stock could result in additional dilution of the percentage ownership of our stockholders and could cause our stock price to decline.

We may issue additional securities in the future and from time to time. Future sales and issuances of our capital stock or rights to purchase our capital stock could result in substantial dilution to our existing stockholders. We may sell or issue common stock, convertible securities and other equity securities in one or more transactions at prices and in a manner as we may determine from time to time, including in connection with future acquisitions or strategic transactions. If we sell any such securities in subsequent transactions, investors may be materially diluted.

If securities or industry analysts do not publish research or publish unfavorable or inaccurate research about our business, our common stock price and trading volume could decline.

Our stock price and trading volume will be heavily influenced by the way analysts and investors interpret our financial information and other disclosures. If securities or industry analysts do not publish research or reports about our business, delay publishing reports about our business or publish negative reports about our business, regardless of accuracy, or cease covering us, our common stock price and trading volume could decline.

Even if our common stock is actively covered by analysts, we do not have any control over the analysts or the measures that analysts or investors may rely upon to forecast our future results. Over-reliance by analysts or investors on any particular metric to forecast our future results may result in forecasts that differ significantly from our own. Regardless of accuracy, unfavorable interpretations of our financial information and other public disclosures could have a negative impact on our stock price. If our financial performance fails to meet analyst estimates, for any of the reasons discussed above or otherwise, or one or more of the analysts who cover us downgrade our common stock or change their opinion of our common stock, our stock price would likely decline.

We do not intend to pay dividends for the foreseeable future and, as a result, your ability to achieve a return on your investment will depend on appreciation in the price of our common stock.

We have never declared or paid any cash dividends on our capital stock, and we do not intend to pay any cash dividends in the foreseeable future. Any determination to pay dividends in the future will be at the discretion of our board of directors and may be restricted by the terms of any outstanding debt obligations. Accordingly, investors must rely on sales of their common stock after price appreciation, which may never occur, as the only way to realize any future gains on their investments.

We incur increased costs as a result of operating as a public company, and our management will be required to devote substantial time to compliance with our public company responsibilities and corporate governance practices.

As a public company, we incur significant legal, accounting and other expenses that we did not incur as a private company. We expect such expenses to further increase now that we are no longer an emerging growth company. The Sarbanes-Oxley Act, the Dodd-Frank Wall Street Reform and Consumer Protection Act, the listing requirements of Nasdaq, and other applicable securities rules and regulations impose various requirements on public companies. Furthermore, the senior members of our management team do not have significant experience with operating a public company. As a result, our management and other personnel will have to devote a substantial amount of time to compliance with these requirements. Moreover, these rules and regulations will increase our legal and financial compliance costs and will make some activities more time-consuming and costly. We cannot predict or estimate the amount of additional costs we will incur as a public company or the timing of such costs. If, notwithstanding our efforts, we fail to comply with new laws, regulations and standards, regulatory authorities may initiate legal proceedings against us and our business may be harmed.

Failure to comply with these rules might also make it more difficult for us to obtain certain types of insurance, including director and officer liability insurance, and we might be forced to accept reduced policy limits and coverage or incur substantially higher costs to obtain the same or similar coverage. The impact of these events could also make it more difficult for us to attract and retain qualified persons to serve on our board of directors, on committees of our board of directors or as members of senior management.

Anti-takeover provisions in our charter documents, under Delaware law and under the indenture governing our 2025 Notes could make an acquisition of our company more difficult, limit attempts by our stockholders to replace or remove our current management and limit the market price of our common stock.

Provisions in our amended and restated certificate of incorporation and amended and restated bylaws may have the effect of delaying or preventing a change of control or changes in our management. Our amended and restated certificate of incorporation and amended and restated bylaws include provisions that:

- provide for a classified board of directors whose members serve staggered terms;
- authorize our board of directors to issue, without further action by the stockholders, shares of undesignated preferred stock with terms, rights, and preferences determined by our board of directors that may be senior to our common stock;
- require that any action to be taken by our stockholders be affected at a duly called annual or special meeting and not by written consent;
- specify that special meetings of our stockholders can be called only by our board of directors, the chairperson of our board of directors, or our chief executive officer;
- establish an advance notice procedure for stockholder proposals to be brought before an annual meeting, including proposed nominations of persons for election to our board of directors;
- prohibit cumulative voting in the election of directors;
- provide that our directors may be removed for cause only upon the vote of the holders of at least 66 2⁄3% of our outstanding shares of common stock;
- provide that vacancies on our board of directors may be filled only by a majority of directors then in office, even though less than a quorum; and
- require the approval of our board of directors or the holders of at least 66 2/3% of our outstanding shares of common stock to amend our bylaws and certain provisions of our certificate of incorporation.

These provisions may frustrate or prevent any attempts by our stockholders to replace or remove our current management by making it more difficult for stockholders to replace members of our board of directors, which is responsible for appointing the members of our management. In addition, because we are incorporated in Delaware, we are governed by the provisions of Section 203 of the Delaware General Corporation Law, which generally, subject to certain exceptions, prohibits a

Delaware corporation from engaging in any of a broad range of business combinations with any "interested" stockholder for a period of three years following the date on which the stockholder became an "interested" stockholder. Furthermore, the indenture governing our 2025 Notes requires us to repurchase such notes for cash if we undergo certain fundamental changes and, in certain circumstances, to increase the conversion rate for a holder of our 2025 Notes. A takeover of us may trigger the requirement that we purchase our 2025 Notes and/or increase the conversion rate, which could make it more costly for a potential acquiror to engage in a business combination transaction with us. Any delay or prevention of a change of control transaction or changes in our management could cause the market price of our common stock to decline.

Our amended and restated certificate of incorporation provides that the Court of Chancery of the State of Delaware and the federal district courts of the United States of America will be the exclusive forums for substantially all disputes between us and our stockholders, which could limit our stockholders' ability to obtain a favorable judicial forum for disputes with us or our directors, officers, employees or agents.

Our amended and restated certificate of incorporation provides that the Court of Chancery of the State of Delaware is the exclusive forum for the following types of actions or proceedings under Delaware statutory or common law:

- any derivative action or proceeding brought on our behalf;
- any action asserting a breach of fiduciary duty;
- any action asserting a claim against us arising under the Delaware General Corporation Law, our amended and restated certificate of incorporation, or our amended and restated bylaws; and
- any action asserting a claim against us that is governed by the internal-affairs doctrine.

This provision would not apply to suits brought to enforce a duty or liability created by the Exchange Act. Furthermore, Section 22 of the Securities Act creates concurrent jurisdiction for federal and state courts over all such Securities Act actions. Accordingly, both state and federal courts have jurisdiction to entertain 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 amended and restated certificate of incorporation further provides that the federal district courts of the United States will be the exclusive forum for resolving any complaint asserting a cause of action arising under the Securities Act. While the Delaware courts have determined that such choice of forum provisions are facially valid and several state trial courts have enforced such provisions and required that suits asserting Securities Act claims be filed in federal court, there is no guarantee that courts of appeal will affirm the enforceability of such provisions and a stockholder may nevertheless seek to bring a claim in a venue other than those designated in the exclusive forum provisions. In such instance, we would expect to vigorously assert the validity and enforceability of the exclusive forum provisions of our amended and restated certificate of incorporation. This may require significant additional costs associated with resolving such action in other jurisdictions and we cannot assure you that the provisions will be enforced by a court in those other jurisdictions. If a court were to find either exclusive forum provision in our amended and restated certificate of incorporation to be inapplicable or unenforceable in an action, we may incur further significant additional costs associated with litigating Securities Act claims in state court, or both state and federal court, which could seriously harm our business, financial condition, results of operations, and prospects.

These exclusive forum provisions may limit a stockholder's ability to bring a claim in a judicial forum that it finds favorable for disputes with us or our directors, officers, or other employees, which may discourage lawsuits against us and our directors, officers and other employees. If a court were to find either exclusive-forum provision in our amended and restated certificate of incorporation to be inapplicable or unenforceable in an action, we may incur further significant additional costs associated with resolving the dispute in other jurisdictions, all of which could seriously harm our business.

Risks Related to Our Outstanding Notes

Servicing our debt requires a significant amount of cash, and we may not have sufficient cash flow from our business to pay our substantial debt.

Our ability to make scheduled payments of the principal of, to pay interest on or to refinance our indebtedness, including the 2025 Notes, depends on our future performance, which is subject to economic, financial, competitive and other factors beyond our control. Our business may not continue to generate cash flow from operations in the future sufficient to service our debt and make necessary capital expenditures. If we are unable to generate such cash flow, we may be required to adopt one or

more alternatives, such as selling assets, restructuring debt or obtaining additional equity capital on terms that may be onerous or highly dilutive. Our ability to refinance our indebtedness will depend on the capital markets and our financial condition at such time. We may not be able to engage in any of these activities or engage in these activities on desirable terms, which could result in a default on our debt obligations.

Regulatory actions and other events may adversely impact the trading price and liquidity of the 2025 Notes.

We expect that many investors in, and potential purchasers of, the 2025 Notes will employ, or seek to employ, a convertible arbitrage strategy with respect to the notes. Investors would typically implement such a strategy by selling short the common stock underlying the 2025 Notes and dynamically adjusting their short position while continuing to hold the notes. Investors may also implement this type of strategy by entering into swaps on our common stock in lieu of or in addition to short selling the common stock.

The SEC and other regulatory and self-regulatory authorities have implemented various rules and taken certain actions, and may in the future adopt additional rules and take other actions, that may impact those engaging in short selling activity involving equity securities (including our common stock). Such rules and actions include Rule 201 of SEC Regulation SHO, the adoption by the Financial Industry Regulatory Authority, Inc. and the national securities exchanges of a “Limit Up-Limit Down” program, the imposition of market-wide circuit breakers that halt trading of securities for certain periods following specific market declines, and the implementation of certain regulatory reforms required by the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010. Any governmental or regulatory action that restricts the ability of investors in, or potential purchasers of, the notes to effect short sales of our common stock, borrow our common stock or enter into swaps on our common stock could adversely impact the trading price and the liquidity of our 2025 Notes.

We may not have the ability to raise the funds necessary to settle conversions of the 2025 Notes in cash or to repurchase the notes upon a fundamental change, and our future debt may contain limitations on our ability to pay cash upon conversion or repurchase of the 2025 Notes.

Subject to limited exceptions, holders of the 2025 Notes will have the right to require us to repurchase all or a portion of their 2025 Notes upon the occurrence of a fundamental change at a fundamental change repurchase price equal to 100% of the principal amount of the 2025 Notes to be repurchased, plus accrued and unpaid interest, if any, as described under Note 9 to our condensed consolidated financial statements included elsewhere in this Quarterly Report on Form 10-Q. In addition, upon conversion of the 2025 Notes, unless we elect to deliver solely shares of our common stock to settle such conversion (other than paying cash in lieu of delivering any fractional share), we will be required to make cash payments in respect of the 2025 Notes being converted as described under Note 9 to our consolidated financial statements included elsewhere in this Quarterly Report on Form 10-Q. However, we may not have enough available cash or be able to obtain financing at the time we are required to make repurchases of 2025 Notes surrendered therefor or 2025 Notes being converted. In addition, our ability to repurchase the 2025 Notes or to pay cash upon conversions of the 2025 Notes may be limited by law, by regulatory authority or by agreements governing our existing or future indebtedness. Our failure to repurchase 2025 Notes at a time when the repurchase is required by the indenture or to pay any cash payable on future conversions of the 2025 Notes as required by the indenture would constitute a default under the indenture governing the 2025 Notes. A default under the indenture or the fundamental change itself could also lead to a default under agreements governing our existing or future indebtedness. If the repayment of the related indebtedness were to be accelerated after any applicable notice or grace periods, we may not have sufficient funds to repay the indebtedness and repurchase the 2025 Notes or make cash payments upon conversions thereof.

The conditional conversion feature of the 2025 Notes, if triggered, may adversely impact our financial condition and operating results.

In the event the conditional conversion feature of the 2025 Notes is triggered, holders of 2025 Notes will be entitled to convert the 2025 Notes at any time during specified periods at their option. If one or more holders elect to convert their 2025 Notes, unless we elect to satisfy our conversion obligation by delivering solely shares of our common stock (other than paying cash in lieu of delivering any fractional share), we would be required to settle a portion or all of our conversion obligation through the payment of cash, which could adversely impact our liquidity. In addition, even if holders do not elect to convert their 2025 Notes, we could be required under applicable accounting rules to reclassify all or a portion of the outstanding principal of the 2025 Notes as a current rather than long-term liability, which would result in a significant reduction of our net working capital.

Risks Related to Our Acquisition of Iora

We may be unable to successfully integrate Iora's business and realize the anticipated benefits of the merger.

We will be required to devote significant management attention and resources to integrating our and Iora's business practices and operations to effectively realize synergies as a combined company, including opportunities to maintain members as they become Medicare eligible, sign up incremental members, reduce combined costs, and reduce combined capital expenditures compared to both companies' standalone plans. Potential difficulties the combined company may encounter in the integration process include the following:

- the inability to successfully combine our and Iora's businesses in a manner that permits the combined company to realize the growth, operations and cost synergies anticipated to result from the merger, which would result in the anticipated benefits of the merger, including projected financial targets, not being realized in the time frames currently anticipated, previously disclosed or at all;

- lost patients or members, or a reduction in the increase in patients or members as a result of certain enterprise clients, patients, members or partners of either of the two companies deciding to terminate or reduce their business with the combined company or not to engage in business in the first place;

- a reduction in the combined company's ability to recruit or maintain providers;

- an inability of the combined company to maintain its health network partnerships or payer contracts on substantially the same terms;

- the complexities associated with managing the larger combined businesses and integrating personnel from the two companies, while at the same time attempting to (i) provide consistent, high quality services under a unified culture and (ii) focus on other ongoing transactions;

- the additional complexities of combining two companies with different histories, regulatory restrictions, operating structures and markets;

- the failure to retain key employees of either of the two companies;

- compliance by us with additional regulatory regimes and with the rules and regulations of additional regulatory entities, including the Centers for Medicare and Medicaid Services, which we refer to as CMS;

- potential unknown liabilities and unforeseen increased expenses, delays or regulatory conditions associated with the merger; and

- performance shortfalls at one or both of the two companies as a result of the diversion of management's attention caused by completing the merger and integrating the companies' operations.

For all these reasons, you should be aware that it is possible that the integration process could result in the distraction of the combined company's management, the disruption of the combined company's ongoing business or inconsistencies in the combined company's services, standards, controls, procedures and policies, any of which could adversely affect the ability of the combined company to maintain relationships with enterprise clients, patients, members, vendors, partners, employees or providers or to achieve the anticipated benefits of the merger, or could otherwise adversely affect the business and financial results of the combined company.

We expect to continue to incur substantial expenses related to the integration of Iora.

We have incurred and expect to continue to incur substantial expenses in connection with integrating Iora's business, operations, networks, systems, technologies, policies and procedures of Iora with our business, operation, networks, systems, technologies, policies and procedures.

While we have assumed that a certain level of integration expenses would be incurred, there are a number of factors beyond our control that could affect the total amount or the timing of our integration expenses. Many of the expenses that were and will be incurred, by their nature, are difficult to estimate accurately at the present time. In addition, the combined company may need significant additional capital in the form of equity or debt financing to implement or expand its business plan and there can be no assurance that such capital will be available to the combined company on terms acceptable to it, or at all. If the combined company issues additional capital stock in the future in connection with financing activities, stockholders will experience dilution of their ownership interests and the per share value of the combined company's common stock may decline.

Due to these factors, the transaction and integration expenses could be greater or could be incurred over a longer period of time than we currently expect.

Item 2. Unregistered Sales of Equity Securities and Use of Proceeds.

Recent Sale of Unregistered Securities and Use of Proceeds

None.

Issuer Purchases of Equity Securities

None.

Use of Proceeds from Registered Securities

On January 30, 2020, our registration statement on Form S-1 (File No. 333- 235792) relating to the initial public offering of our common stock was declared effective by the SEC. Pursuant to such registration statement, we issued and sold an aggregate of 20,125,000 shares of our common stock at a price of $14.00 per share for aggregate cash proceeds of approximately $258.2 million, net of underwriting discounts and commissions and offering costs, which includes the full exercise by the underwriters of their option to purchase additional shares of common stock. No payments for offering expenses were made directly or indirectly to (i) any of our officers or directors or their associates, (ii) any persons owning 10% or more of any class of our equity securities or (iii) any of our affiliates. J.P. Morgan Securities LLC and Morgan Stanley & Co. LLC acted as joint-book running managers for the offering.

There has been no material change in the expected use of the net proceeds from our initial public offering, as described in our final prospectus filed with the SEC on February 3, 2020 pursuant to Rule 424(b) under the Securities Act of 1933, as amended.

Repurchase of Shares of Company Equity Securities

None.

Item 3. Defaults Upon Senior Securities.

Not Applicable.

Item 4. Mine Safety Disclosures.

Not Applicable.

Item 5. Other Information.

None.

Item 6. Exhibits.

Number	Exhibit Description	Form	File No.	Exhibit	Filing Date	Filed Herewith
3.1	Amended and Restated Certificate of Incorporation of the Registrant	8-K	001-39203	3.1	2/4/2020	
3.2	Amended and Restated Bylaws of the Registrant	8-K	001-39203	3.2	2/4/2020	
31.1	Certification of Chief Executive Officer pursuant to Exchange Act Rules 13a-14(a) and 15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002					X
31.2	Certification of Chief Financial Officer pursuant to Exchange Act Rules 13a-14(a) and 15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002					X
32.1†	Certification of Chief Executive Officer and Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002					X
101.INS	Inline XBRL Instance Document					X
101.SCH	Inline XBRL Taxonomy Schema Linkbase Document					X
101.CAL	Inline XBRL Taxonomy Definition Linkbase Document					X
101.DEF	Inline XBRL Taxonomy Calculation Linkbase Document					X
101.LAB	Inline XBRL Taxonomy Labels Linkbase Document					X
101.PRE	Inline XBRL Taxonomy Presentation Linkbase Document					X
104	Cover Page Interactive Data File (formatted as inline XBRL and contained within Exhibit 101).					

† The certification attached as Exhibit 32.1 that accompanies this Quarterly Report on Form 10-Q, is deemed furnished and not filed with the Securities and Exchange Commission and are not to be incorporated by reference into any filing of 1Life Healthcare, Inc. under the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended, whether made before or after the date of this Quarterly Report on Form 10-Q, irrespective of any general incorporation language contained in such filing.

SIGNATURES

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

1LIFE HEALTHCARE, INC.

Date: May 4, 2022

By: /s/ Amir Dan Rubin

Amir Dan Rubin

Chief Executive Officer and President

(Principal Executive Officer)

Date: May 4, 2022

By: /s/ Bjorn Thaler

Bjorn Thaler

Chief Financial Officer

(Principal Financial and Accounting Officer)

Exhibit 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a) AND 15d-14(a) UNDER THE SECURITIES EXCHANGE ACT OF 1934,
AS ADOPTED PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, Amir Dan Rubin, certify that

1. I have reviewed this Quarterly Report on Form 10-Q of 1Life Healthcare, 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(s) 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(s) 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 4, 2022 By: /s/ Amir Dan Rubin

Amir Dan Rubin
Chief Executive Officer and President
(Principal Executive Officer)

Exhibit 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a) AND 15d-14(a) UNDER THE SECURITIES EXCHANGE ACT OF 1934,
AS ADOPTED PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, Bjorn Thaler, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of 1Life Healthcare, 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(s) 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(s) 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 4, 2022 By: /s/ Bjorn Thaler

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

Exhibit 32.1

CERTIFICATION OF CHIEF EXECUTIVE OFFICER AND CHIEF FINANCIAL OFFICER
PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report of 1Life Healthcare, Inc. (the "Company") on Form 10-Q for the period ended March 31, 2022 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), Amir Dan Rubin, Chief Executive Officer and President of the Company, and Bjorn Thaler, Chief Financial Officer of the Company, each hereby certifies, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that to the best of his knowledge:

(1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended, and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: May 4, 2022 By: /s/ Amir Dan Rubin

Amir Dan Rubin
Chief Executive Officer and President
(Principal Executive Officer)

Date: May 4, 2022 By: /s/ Bjorn Thaler

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