Teladoc, Inc.
Form 424B1
July 02, 2015

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Filed Pursuant to Rule 424(b)(1)
Registration No. 333-204577
Registration No. 333-205387

Prospectus

8,250,000 Shares

Common Stock

This is the initial public offering of shares of common stock of Teladoc, Inc. We are selling 8,250,000 shares of common stock.

Prior to this offering, there has been no public market for our common stock. The public offering price is $19.00 per share. We have been approved for listing of our common stock on the New York Stock Exchange, or the NYSE, under the symbol "TDOC."

We are an "emerging growth company" as defined by the Jumpstart Our Business Startups Act of 2012 and, as such, we have elected to comply with certain reduced public company reporting requirements for this prospectus and future filings. See "Prospectus Summary Implications of Being an Emerging Growth Company."

Investing in our common stock involves risks that are described in the "Risk Factors" section beginning on page 20 of this prospectus.

	Per Share	Total
Public offering price	$ 19.00	$ 156,750,000
Underwriting discount	$ 1.33	$ 10,972,500
Proceeds, before expenses, to us	$ 17.67	$ 145,777,500

We have granted the underwriters an option for a period of 30 days to purchase up to an additional 1,237,500 shares of common stock.

Neither the Securities and Exchange Commission nor any state securities commission has approved or disapproved of these securities or determined if this prospectus is truthful or complete. Any representation to the contrary is a criminal offense.

The underwriters expect to deliver the shares to purchasers on or about July 7, 2015.

J.P. Morgan **Deutsche Bank Securities**

William Blair

Wells Fargo Securities **SunTrust Robinson Humphrey**

June 30, 2015

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You should rely only on the information contained in this prospectus and in any related free-writing prospectus we prepare or authorize. We have not, and the underwriters have not, authorized anyone to give you any other information and take no responsibility for any other information that others may give you. We are offering to sell, and seeking offers to buy, the common stock only in jurisdictions where offers and sales are permitted. The information in this document may only be accurate on the date of this document, regardless of its time of delivery or of any sales of the common stock. Our business, financial condition, results of operations or cash

flows may have changed since such date.

Market, Industry and Other Data

This prospectus includes estimates regarding market and industry data and forecasts, which are based on publicly available information, industry publications and surveys, reports from government agencies, reports by market research firms or other independent sources and our own estimates based on our management's knowledge of and experience in the market sectors in which we compete.

Certain monetary amounts, percentages and other figures included in this prospectus have been subject to rounding adjustments. Accordingly, figures shown as totals in certain tables or charts may not be the arithmetic aggregation of the figures that precede them, and figures expressed as percentages in the text may not total 100% or, as applicable, when aggregated may not be the arithmetic aggregation of the percentages that precede them.

Trademarks

We own or otherwise have rights to the trademarks and service marks, including those mentioned in this prospectus, used in conjunction with the marketing and sale of our products and services. This prospectus includes trademarks, such as Teladoc and AmeriDoc, which are protected under applicable intellectual property laws and are our property and the property of our subsidiaries. This prospectus also contains trademarks, service marks, copyrights and trade names of other companies, which are the property of their respective owners. We do not intend our use or display of other companies' trademarks, copyrights or trade names to imply a relationship with, or endorsement or sponsorship of us by any other companies. Solely for convenience, our trademarks and trade names referred to in this prospectus may appear without the ® or symbols, but such references are not intended to indicate, in any way, that we will not assert, to the fullest extent under applicable law, our rights or the right of the applicable licensor to these trademarks and trade names.

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PROSPECTUS SUMMARY

This summary highlights information contained elsewhere in this prospectus. Because this is only a summary, it does not contain all of the information that may be important to you. You should read this entire prospectus and should consider, among other things, the matters set forth under "Risk Factors," "Selected Historical Financial Information" and "Management's Discussion and Analysis of Financial Condition and Results of Operations," and our audited consolidated financial statements and related notes thereto appearing elsewhere in this prospectus before making your investment decision. Unless otherwise indicated or the context otherwise requires, references in this prospectus to "Teladoc," the "Company," "our company," "we," "us" and "our" refer to Teladoc, Inc., a Delaware corporation, together with its consolidated subsidiary. References herein to "fiscal year" refer to our fiscal years, which end on December 31.

Overview

We are the nation's first and largest telehealth platform, delivering on-demand healthcare anytime, anywhere, via mobile devices, the internet, video and phone. Our solution connects consumers, or our Members, with our over 1,100 board-certified physicians and behavioral health professionals, or our Providers, who treat a wide range of conditions and cases from acute diagnoses such as upper respiratory infection, urinary tract infection and sinusitis to dermatological conditions, anxiety and smoking cessation. Nearly 11 million unique Members now benefit from access to Teladoc 24 hours a day, seven days a week, 365 days a year, at a cost of $40 per visit. Our solution is delivered with a median response time of less than ten minutes from the time a Member requests a telehealth visit to the time they speak with a Teladoc physician. We completed approximately 300,000 telehealth visits in 2014.

The Teladoc solution is transforming the access, cost and quality dynamics of healthcare delivery for all of our market participants. Our Members rely on Teladoc to remotely access affordable, on-demand healthcare whenever and wherever they choose. Employers, health plans and health systems, or our Clients, purchase our solution to reduce their healthcare spending while at the same time offering convenient, affordable, high-quality healthcare to their employees or beneficiaries. Our Providers have the ability to generate meaningful income and deliver their services more efficiently with no administrative burden. We believe the value proposition of our solution is evidenced by our overall Member satisfaction rate, which has exceeded 95% over the last six years, and a 104% annual net dollar retention rate among our Clients on average over the last three years. We further believe any consumer, employer or health plan or practitioner interested in a better approach to healthcare is a potential Teladoc Member, Client or Provider.

According to the Centers for Disease Control and Prevention, or the CDC, there are approximately 1.25 billion ambulatory care visits in the United States per year, including those at primary care offices, hospital emergency rooms, outpatient clinics and other settings. We estimate that approximately 417 million, or 33%, of these visits could be treated through telehealth.

The U.S. healthcare system is experiencing a growing crisis of access, cost and quality of care due to inefficiencies in today's healthcare system and barriers between participants. According to the National Association of Community Health Centers, or the NACHC, approximately 62 million individuals in the United States currently have no or inadequate access to primary care as a result of physician shortages. Additionally, according to the Department of Health and Human Services, the Patient Protection and Affordable Care Act, or PPACA, has already expanded coverage to 16.4 million of the 47 million previously uninsured Americans. This number is widely expected to increase over the next several years due to individual and employer mandates, premium subsidies, state health insurance exchanges and ban on withholding coverage due to pre-existing medical conditions, increasing demand for access to primary care physicians. Absent convenient access to a primary care physician, individuals will most likely either not seek care at all or visit emergency

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rooms or urgent care clinics, the most expensive and often inefficient settings for their primary care needs. These market dynamics impact not only the consumers seeking care, but also the health plans and employers that ultimately bear all or a portion of these costs. According to the CDC, 79.7% of emergency room visits not resulting in a hospital admission were due to lack of access to an alternative provider, and a recent study published in The Journal of American Medical Association estimated that approximately $734 billion, or 27%, of all healthcare spending in 2011 was wasted due to factors such as the provision of unnecessary services, inefficient delivery of care and inflated prices.

Innovators in other industries have solved access, cost and quality inefficiencies through the implementation of technology platforms and business models that deliver products and services on-demand and create new economies by connecting and empowering both consumers and businesses. We have taken the same approach to solving the pervasive access, cost and quality challenges facing the current healthcare system. Consumers' ability to access high-quality, affordable care has been limited by many factors such as physician availability, prohibitive costs, physician office hours and geographic locations. Likewise, burdensome administration, cancellations, unfilled appointment slots, geographic constraints and business hour limitations have historically impacted physician efficiency and, as a result, constrained physicians' income. We have created a platform that is uniquely positioned to bridge the supply and demand gap between physicians and consumers by fundamentally changing the way market participants access and deliver healthcare eliminating traditional barriers and inefficiencies between participants and empowering them to engage in a healthcare marketplace anytime, anywhere. Our platform provides our Members with access to board-certified physicians, comprehensive clinical programs and consumer engagement strategies in an economic model that delivers multiple benefits to all participants. The unique combination of these features enables us to dynamically and efficiently match consumer demand and physician availability in real-time.

Our underlying technology platform is complex, deeply integrated and has been purpose-built over the last ten years for the evolving healthcare marketplace. Our platform is highly scalable and can support substantial growth in our current membership base. Our platform provides for broad interconnectivity between healthcare constituents and, we believe, uniquely positions us as a focal point in the rapidly evolving healthcare industry to introduce innovative, technology-based solutions, such as remote patient monitoring, post-discharge treatment plan adherence and in-home and chronic care.

Our solution offers our Clients substantial savings opportunities and an attractive return on investment, or ROI. We recently commissioned Veracity Healthcare Analytics, an independent healthcare data analytics company, to perform an independent study of the nation's largest home-improvement retailer, a Client since 2012, representing over 150,000 of our Members as of December 31, 2014. The study was prepared on behalf of Veracity Healthcare Analytics by two doctors of medicine and a doctor of science and pharmacy, in each case, professors at leading academic institutions. The study found that this Client saved $1,157 on average per employee when its employees received care through Teladoc instead of receiving care in other settings for the same diagnosis. The study also measured the total healthcare expenditure per-Member-per-month during the 16-month period immediately preceding the implementation of Teladoc in order to establish a trend and predict the Client's average monthly expenditure per-Member-per-month over the 20-month period following the introduction of Teladoc. The study demonstrated a meaningful reduction in average per-Member-per-month spending of $21.30 to the Client relative to predicted cost, or a monthly healthcare expenditure savings of 10.2% per Member. Additionally, during 2014 the Client achieved an ROI of approximately $9.00 for every $1.00 spent per Member. Finally, the study demonstrated that 92% of the Client's employees that used Teladoc for a medical issue resolved their issue completely and did not require a follow up visit at a physician's office, emergency room or other location. We believe these results are representative of the results

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achieved by our other Clients as well as the value proposition we can provide the broader U.S. healthcare system.

We currently serve over 4,000 employers, health plans, health systems and other entities. These Clients collectively purchase access to our solution for our nearly 11 million Members. We believe our Business to Business to Consumer, or B2B2C, distribution strategy is the most efficient method by which to reach consumers and deliver telehealth to our Members. We have over 20 health plans as Clients, including some of the largest in the United States such as Aetna, Blue Shield of California, Highmark and Centene. Health plans serve as Clients as well as distribution channels to self-insured employer Clients that contract with us through a health plan relationship. Our over 1,600 direct and administrative services only, or ASO, employer Clients include 160 Fortune 1000 companies and industry leaders such as Accenture, Bank of America, Pepsi and Shell. We also have a number of health system Clients such as Henry Ford, Memorial Hermann and Mount Sinai. The remainder of our Clients are from channel partners such as brokers, resellers and consultants who sell into a range of small, medium and large enterprises. Over the past two years, we have more than doubled our client and membership bases. We believe telehealth is in the early stages of what eventually will become widespread adoption. A 2014 Towers Watson study suggests as many as 71% of employers with more than 1,000 employees are expected to offer telehealth by 2017.

We generate revenue from our Clients on a contractually recurring, per-Member-per-month, subscription access fee basis, which provides us with significant revenue visibility. In addition, under the majority of our Client contracts, we generate additional revenue on a per-telehealth visit basis, through a visit fee. Subscription access fees are paid by our Clients on behalf of their employees, dependents and other beneficiaries, while visit fees are paid by either Clients or Members. We generated $19.9 million and $43.5 million in revenue for the years ended December 31, 2013 and 2014, respectively, representing 119% year-over-year growth, and $9.4 million and $16.5 million for the three months ended March 31, 2014 and 2015, respectively, representing 75% year-over-year growth. For the three months ended March 31, 2015, 80% and 20% of our revenue were derived from subscription access fees and visit fees, respectively, and for the year ended December 31, 2014, 85% and 15% of our revenue were derived from subscription access fees and visit fees, respectively.

Industry Challenges and Our Opportunity

Barriers and inefficiencies in the current U.S. healthcare system present market participants with three major challenges: (i) consumers lack sufficient access to high-quality, cost-effective healthcare at appropriate sites of care, while bearing an increasing share of costs; (ii) employers and health plans lack an effective solution that reduces costs while enhancing healthcare access for beneficiaries and (iii) providers lack flexibility to increase productivity by delivering care on their own terms. Market participants are therefore increasingly unable to effectively and efficiently receive, deliver or administer healthcare. At the same time, the emergence of technology platforms solving massive structural challenges in other industries has highlighted the need for a similar solution in healthcare. We believe there is a significant opportunity to solve these challenges through a trusted solution, such as ours, that matches consumer demand and physician supply in real-time, while offering health plans and employers an attractive, cost-effective healthcare alternative for their beneficiaries.

Growing Healthcare Access Crisis for Consumers

Consumers in the United States are experiencing challenges in obtaining access to affordable, high-quality healthcare at appropriate sites of care. A 2014 NACHC report found that 62 million individuals in the United States have no or inadequate access to primary care as a result of local

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physician shortages. According to a 2014 Merritt Hawkins study, the average lead time to see a primary care physician across various metro areas was 19 days. We believe provider supply is projected to further contract, evidenced by the 2014 Survey of America's Physicians: Practice Patterns and Perspectives, or the 2014 Survey of America's Physicians, where 81% of physicians describe themselves as either over-extended or at full capacity. Additionally, according to a 2010 Association of American Medical Colleges, or AAMC, report, the healthcare system will have a shortage of approximately 131,000 physicians by 2025, including a shortage of approximately 52,000 primary care physicians. Given expected population growth and aging in the United States, as well as the projected increase in healthcare demand from PPACA implementation, the supply and demand gap for access to healthcare services is expected to further widen, placing additional pressure on an already overburdened healthcare system that lacks physician capacity and diagnoses-appropriate access points.

This access crisis has resulted in U.S. consumers either seeking care at inappropriate, more costly settings, such as hospital emergency rooms, or foregoing needed care entirely. According to the CDC, there are approximately 1.25 billion in-person ambulatory care visits in the United States per year, including those at primary care offices, hospital emergency rooms, outpatient clinics and other settings. We estimate that approximately 417 million, or 33%, of these visits could be treated through telehealth.

Healthcare Cost Burden and Lack of Viable Options for Health Plans and Employers

The U.S. healthcare system is burdened by significant waste and extreme variations in access, cost and quality of care. A recent study published in The Journal of American Medical Association estimates that approximately $734 billion, or 27%, of all healthcare spending in 2011 was wasted due to factors such as the provision of unnecessary services, inefficient delivery of care and inflated prices. When consumers are forced to seek care at inappropriate and more costly sites of care, those cost inefficiencies impact not only the consumer, but also the health plans and employers that ultimately bear all or a portion of these costs.

The costs and associated burdens on health plans, employers and consumers are only expected to increase. The Centers for Medicare & Medicaid Services, or CMS, forecasted U.S. national health expenditures to reach $3.1 trillion, or approximately 18% of the U.S. Gross Domestic Product, or GDP, in 2014, and approximately 20% of GDP by 2022. A 2013 survey by the National Business Group on Health and Towers Watson indicated that employers bear on average approximately two-thirds of their employee's healthcare costs and CMS forecasted U.S. employers to spend approximately $660 billion on healthcare in 2015. Despite the significant amount of dollars spent, U.S. healthcare outcomes remain inferior relative to those of many other countries.

The unsustainable levels of spending on healthcare and extreme inefficiencies in the system have driven an increased focus by employers and health plans to control healthcare expenditures. Governments, private insurance companies and self-insured employers are implementing meaningful cost containment measures, including shifting financial responsibility to patients through higher co-pays and deductibles and delivering healthcare through alternative, more cost-effective methods. The increasing shift of financial responsibility to patients coupled with increased pricing transparency has, in turn, heightened beneficiary focus on healthcare alternatives. According to a 2013 survey for Prudential Insurance by MRops, Inc. and Oxygen Research Inc., 49% of employers are extremely or very likely to eventually offer only high deductible health plans, or HDHPs. As consumers take responsibility for a larger share of their healthcare costs and spend more on healthcare services, they are also demanding higher quality care, greater control in how and where they receive care, increased convenience and more service for every dollar spent.

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Challenging Environment for Physicians is Constraining Supply

Physicians face declining compensation paired with diminishing productivity due to a combination of reimbursement cuts and an increasing administrative burden. These factors have contributed to physician dissatisfaction and negatively impacted their desire to practice medicine. Medscape's 2014 Physician Compensation Report shows that 50% of all physicians do not feel fairly compensated and 42% would not choose medicine as their career today.

In response to this growing dissatisfaction, physicians are reducing access to healthcare in a number of different ways. The 2014 Survey of America's Physicians indicated that 44% of physicians plan to take steps to limit access to their practices, including cutting back on the number of patients seen, working part-time, closing their practices to new members, seeking non-clinical jobs or retiring. Notably, 39% of surveyed physicians indicated they plan to accelerate retirement given changes in the healthcare environment. Further, administrative challenges are expected to increase. According to the same survey, 50% of physicians anticipate the implementation of the tenth revision of the International Statistical Classification of Diseases and Related Health Problems, or ICD-10, to cause severe administrative problems in their practices. This is expected to further increase the 20% of daily time surveyed physicians indicated they already spend on non-clinical paperwork, which is constraining their productivity. These constraints have driven physicians to seek more control over the way they deliver care to new and existing patients, increase their income and reduce the amount of time they spend on administration.

Opportunity to Remove Barriers Through an Innovative Platform that Benefits All Participants

We believe we have a significant opportunity to solve access, cost and quality of care challenges through a platform that matches consumer demand and physician availability in real-time, while offering health plans and employers an attractive, cost-effective alternative for their beneficiaries through our platform. As consumerism in healthcare increases and consumers and providers become accustomed to on-demand services in other industries, they are similarly demanding technology-powered solutions for their healthcare needs. The emergence and subsequent rapid adoption of technologies such as big data and analytics, cloud-based solutions, online video and mobile applications represents an enormous opportunity for healthcare innovation. We believe the confluence of consumer empowerment, emergence of broad technology solutions and focus by all constituents on providing high-quality, cost-effective healthcare creates a unique opportunity for a disruptive platform that transforms the way consumers access, providers deliver and employers and health plans administer high-quality, cost-efficient healthcare.

Our Value Proposition

We focus exclusively on delivering on-demand healthcare anytime, anywhere, via mobile devices, the internet, video and phone. We believe our solution provides market participants a value proposition that is differentiated from the traditional healthcare system.

Value Proposition for Members

Our philosophy is to center care around the Member. We believe we offer our Members the following value proposition.

On-Demand Care. We offer our Members 24 hours a day, seven days a week, 365 days a year access to high-quality, on-demand care without the burdens associated with travel and wait times. We provide our Members with access to our Providers with a median response time of less than ten minutes from the time a Member requests a telehealth visit, as compared to an average primary care appointment lead time of 19 days.

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Access to High-Quality Physician Network. We have secured our Providers' services through a long-term services agreement with Teladoc Physicians, P.A., or Teladoc PA, a professional association, that has agreed to provide our Members, through its physicians, access to telehealth services and recommended treatment 24 hours per day, 365 days per year. Our contracted physician network is comprised of approximately 675 board-certified physicians with an average of 20 years of experience, and, according to a 2014 RAND study, Teladoc increased access for Members who used it, as more than one-third of Teladoc visits occurred on weekends and holidays when primary care physicians were not available.

Ease of Use. Our user-friendly interface offers Members access to care via mobile devices, the internet, video and phone, whenever and wherever each individual chooses.

Cost-Efficient Care. The average primary care physician visit costs $145 and the average emergency room visit costs $1,957 according to the Agency for Healthcare Research and Quality and PLoS ONE, respectively. At $40 per Teladoc visit, we offer our Members substantial savings, which is meaningful as employers and health plans shift costs to cost conscious consumers.

Superior Experience. We recently commissioned Veracity Healthcare Analytics, an independent healthcare data analytics company, to perform resource utilization and health spending analyses on two of our largest Clients, the nation's largest home-improvement retailer and Rent-A-Center. The related studies were prepared on behalf of Veracity Healthcare Analytics by two doctors of medicine and a doctor of science and pharmacy, in each case, professors at leading academic institutions. Each study demonstrated that 92% of participating Members' diagnoses were completely resolved during the 30-day period following the initial Teladoc visit, which we believe evidences the overall enhanced consumer experience we provide all of our Members and is reflected in over 95% of our Members indicating by survey that they were satisfied with our services over each of the past six years.

Value Proposition for Clients

We believe we offer our Clients the following value proposition.

Proven Return on Investment. Our solution offers our Clients substantial savings opportunities and a proven ROI. We recently commissioned independent studies on each of two of our large Clients collectively representing approximately 175,000 of our Members. These studies demonstrated meaningful client-savings and substantial client-ROI resulting from the use of our solution. We believe these findings are representative of the results achieved by our other Clients and the value proposition we offer the broader U.S. healthcare system.

High-Quality Care. Our solution is backed by over 100 proprietary Evidence Based clinical guidelines that assist Provider and Member decisions and criteria regarding diagnosis, management and treatment. These guidelines were specifically designed for telehealth using clinical expertise and the best available clinical evidence derived from systematic research. We also deploy the telehealth industry's highest credentialing requirements, which, together with our clinical guidelines, lead to quality interactions and reliable resolutions.

Consumer Engagement. Our predictive models allow us to identify Members most likely to use our solution and to increase adoption by Members, which in turn drives ROI for Clients. We use claims data, plan design and other metrics to influence behavior. For example, we identify Members who have been high utilizers of emergency rooms and urgent care and seek to re-direct their non-emergency visits to our lower-cost solution. Our engagement strategies are supported by our self-service communications portals for Provider and Member

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interaction as well as our initiatives to promote worksite marketing and executive sponsorship to drive awareness and adoption by Members.

Beneficiary Satisfaction. We believe our Clients also benefit from Member satisfaction with us and our solution, as evidenced by our overall Member satisfaction rate of over 95% over the last six years and 104% annual net dollar retention rate among our Clients on average over the last three years.

Value Proposition for Providers

We believe we offer our Providers the following value proposition.

Meaningful Income. Our solution empowers physicians and other healthcare professionals with the convenience of immediate access to new patients without the administrative burden. Teladoc physicians have the ability to earn approximately $150 per hour on our platform, representing an over 50% increase to the average full-time physician hourly wage of $99.00 according to a 2013 Becker's Healthcare Report. Further, a number of Teladoc physicians generate income in excess of $100,000 per year on our platform.

Enhanced Work Flexibility and Productivity. We offer physicians and other healthcare professionals control and scheduling flexibility to determine when and where they practice medicine. Our solution enables physicians to be more productive by performing telehealth visits outside of office hours and during down-time in their schedules as nearly 50% of our visits occur outside of normal business hours when many traditional care settings are not accessible. Our Providers are able to work while traveling, on weekends or on holidays.

Simple Reimbursement and Significantly Reduced Administration. We reimburse physicians and healthcare providers electronically, twice per month, which significantly reduces their administrative burden. With no claims forms or paperwork to complete and no physical office to manage, our model allows physicians to focus their attention on delivering high-quality care to their patients.

Our Competitive Strengths

We believe the following are our key competitive strengths.

Leading Solution and First-Mover Advantage

Our solution is composed of an integrated technology platform, high-quality Provider network, sophisticated consumer engagement strategies and entrenched distribution channels. We have developed a strong brand, established strong relationships with Clients and have become a leading telehealth platform in the United States. Our history of innovation and long-standing operating history provide us with a significant first-mover advantage, including what we believe are the following telehealth industry firsts:

Integrated Technology Platform. We were the first to build a scalable, integrated technology platform for telehealth with an Application Program Interface, or API, that powers direct connectivity between Providers and Members and multiple real-time payor integrations.

High-Quality Provider Network. We were the first to deliver nationwide access to board-certified physicians 24 hours a day, seven days a week, 365 days a year and establish over 100 proprietary Evidence Based clinical guidelines specifically designed for telehealth. In addition, we are the first and only telehealth company that has received certification by the National Committee for Quality Assurance, or NCQA, an independent, not-for-profit,

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healthcare-oriented organization founded in 1990 dedicated to improving healthcare quality and verifying adherence to national standards of excellence in the provision of healthcare.

Consumer Engagement Strategies. We were the first to implement sophisticated behavioral analytics and predictive modeling to better understand our Members and to drive increased engagement with Teladoc.

Innovative Technology Platform

Our integrated solution positions us at the center of the patient, provider and payor relationship and as a key participant in the rapidly emerging, technology-powered healthcare industry. We continually incorporate new product features into our platform to meet the evolving needs of the highly complex healthcare industry. We believe our technology platform contains several differentiating features, including the following:

Purpose-Built. Our platform is built specifically to serve the needs of consumers, employers and health plans and providers. We believe that ours is the only platform that incorporates the core functionality required to offer telehealth in a single system.

Integration and Interoperability. Our fully functional API powers external connectivity, and we have deep integration with other premier healthcare solutions, including electronic prescribing, HSA payment and administration, care coordination and cost transparency. In addition, we pride ourselves on what we believe is unmatched integration with the payor community that enables us to uniquely provide real-time eligibility, checking, real-time Member financial liability calculations and clinical data exchange.

Customization for Members, Clients and Providers. Each of our constituents has their own purpose-built interface.

Significant and Measureable Return on Investment

Our solution offers our Clients substantial savings opportunities and an attractive ROI. We recently commissioned an independent study of the nation's largest home-improvement retailer, a Client that represented over 150,000 of our Members as of December 31, 2014. The study found that this Client saved $1,157 on average per telehealth visit when its employees received care through Teladoc instead of receiving care in other settings for the same diagnosis. The study also measured the total healthcare expenditure per-Member-per-month during the 16-month period immediately preceding the implementation of Teladoc in order to establish a trend and predict the Client's average monthly expenditure per-Member-per-month over the 20-month period following the introduction of Teladoc. The study demonstrated a meaningful reduction in average per-Member-per-month spending of $21.30 to the Client relative to predicted cost, or a monthly healthcare expenditure savings of 10.2% per Member. Additionally, during 2014 the Client achieved an ROI of approximately $9.00 for every $1.00 spent per Member. Finally, the study demonstrated that 92% of the Client's employees that used Teladoc for a medical issue resolved their issue completely and did not require a follow up visit at a physician's office, emergency room or other location. We believe these results are representative of the results achieved by our other Clients as well as the value proposition we can provide the broader U.S. healthcare system.

Highly Scalable Platform

Our platform is highly scalable and can currently provide the same level of Member support and response time for upwards of 10,000 visits per day versus our current rate of approximately 1,500 visits per day on average. Similarly, our platform is currently equipped to serve over 100 million Members and can be scaled quickly to serve even higher volumes. Further, our platform has been built to accommodate the seamless and quick introduction of new services and products,

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such as behavioral health, dermatology and other services that are currently in development stages. We believe our highly scalable platform provides us with significant growth opportunities within our existing membership and client bases and allows us to grow with low capital expenditure requirements.

Clinical Capabilities Tailored to Telehealth

We believe that by directly recruiting, credentialing, training and contracting with our Providers we have built our clinical capabilities in a manner that supports the operational complexity of and commitment to clinical quality required in telehealth. Our Providers are board-certified with an average of 20 years of experience and are credentialed through an NCQA-certified process. The NCQA's accreditation process involves a comprehensive on-site and off-site review by a team of physicians and managed care experts that evaluates more than 60 quality-related healthcare standards, including quality management and improvement and utilization management. The results of the evaluation are reviewed by the NCQA's National Review Oversight Committee prior to their assigning an accreditation level. The NCQA's requirements are developed with the input and support of health plans, providers, purchasers, unions and consumer groups. Our clinical capabilities are designed specifically for telehealth. For example, our Members have the option to share a record of every visit and their electronic medical record, or EMR, with their existing physicians. Prior to every visit, the Provider reviews the Member's proprietary EMR and certifies to this review by completing a multi-step checklist. During and following the visit, the Provider references our over 100 proprietary Evidence Based clinical guidelines and other telehealth-specific content. In addition, Members and Providers remain connected following visits. Members receive personalized notes, patient education materials and are able to ask questions of our clinical team via the Teladoc Message Center. Over 10% of all visits are reviewed by our clinical quality assurance staff to ensure adherence to appropriate treatment and prescription patterns. We believe our track record of zero medical malpractice claims is a testament to our Providers' clinical quality.

Well-Established Distribution Channels and Strategic Alliances

We have spent over ten years developing sales channels and strategic alliances, which we believe provide an opportunity to sell our solution through trusted partners and are not easily replicated. Our solution is sold through a highly efficient and effective B2B2C distribution network wherein we reach consumers through our Clients and channel partners rather than marketing our solution directly to potential Members. We sell through a direct sales force to our Clients who in turn buy our solution on behalf of their beneficiaries. In addition, a range of third-parties including brokers, agents, benefits consultants and resellers, whom we refer to as channel partners, sell our solution to various end markets. Notably, many of our health plan Clients also act as channel partners because they resell our solution to their ASO accounts and other customers. We believe the breadth of our distribution strategy allows us to reach employers of nearly every size and in nearly every market, which are capable of purchasing our solution for a large number of beneficiaries, rather than attempting to sell our solution one consumer at a time.

Our Growth Strategies

The following are our key growth strategies.

Expand our Membership with New and Existing Clients

We intend to increase our membership by adding additional Members from both existing Clients and from new Clients. We plan to execute this strategy by further penetrating existing relationships and by pursuing new relationships through our distribution channels and an expanded sales team. Within existing accounts, we believe our current membership represents only a fraction of the potential Members available to us. Our existing health plan Clients and self-insured Clients

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associated with these health plans currently purchase our solution for only 9% of their beneficiaries in the aggregate, which provides us the opportunity to grow our membership base by more than 50 million individuals within these existing Clients alone. Similarly, we have 160 Fortune 1000 Clients, representing a significant opportunity for new Client growth with large employers. We are investing heavily in new marketing technologies and support staff to aid our sales force in penetrating existing accounts, lead generation, new Client generation and implementations. We further believe that as market leader in the telehealth industry, we have a strong, established brand and are uniquely positioned to capitalize on the Business to Consumer, or B2C, channel in the future.

Expand into New Clinical Specialties

We currently offer our Clients access to over 1,100 board-certified physicians who treat a wide range of conditions and cases from acute diagnoses such as upper respiratory infection, urinary tract infection and sinusitis to dermatological conditions. We also currently offer direct-to-Member access to behavioral health professionals who treat conditions such as anxiety and smoking cessation. We intend to leverage our highly scalable platform by expanding into new clinical specialties, such as standalone dermatology services, second opinions and chronic conditions such as diabetes, and by focusing on expanding our services amongst current Clients such as by offering behavioral health as a commercial service to our Clients. As we expand our clinical offerings, we intend to further eliminate gaps in continuity of care in order to provide coordinated care along the healthcare delivery continuum.

Leverage Existing Sales Channels and Penetrate New Markets

We have developed a highly effective distribution network to target large employers and we are committing incremental sales and marketing resources to the small and medium business, or SMB, sales channel to increase our penetration within this market. Additionally, we intend to further penetrate the provider market, notably hospitals and group physician practices, as we believe our solution offers these markets an attractive platform from which to generate substantial income by acquiring new patients and to better participate in emerging risk-sharing and value-based payment models, such as Accountable Care Organizations and Patient-Centered Medical Homes. Lastly, with expanded access to available health insurance as a result of PPACA implementation, we intend to pursue health insurance exchanges, which represent an attractive new sales channel.

Expand Across Care Settings and Use Cases

We intend to expand our solution across use cases and additional care settings. We also continually explore ancillary opportunities to broaden our business, including by expanding our relationship with Medicare Advantage and Medicaid Managed Care plans. We believe our services have wide applicability across new use cases, including home care, post discharge, wellness/screening and chronic care. We are also currently extending the number, range and functionality of our benefits applications, and will continue to respond quickly to evolving market needs with innovative solutions, including broadened health kiosk access, mobile applications, biometric devices and at-home testing.

Increase Engagement by Our Members

We believe there is significant opportunity within our existing membership base to increase engagement by continually increasing awareness of and loyalty to our solution. We believe our solution can become the single source for on-demand healthcare for our Members by continuing to add new and complementary products and services, third-party connections and other strategic alliances. We will continually refine and enhance our user experience, which is a critical driver of new and repeat engagement and we will continue validating our Member satisfaction with surveys

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and other proactive tools. We are also building robust data repositories to strengthen our predictive models and multi-channel marketing strategies to provide a more complete picture of our Members, enhancing our ability to lead targeted and purposeful campaigns, and we will continue to invest heavily in marketing technologies that allow us to increase Member touch-points. Lastly, we will continue to actively engage Clients in benefit design, worksite marketing and executive sponsorship strategies to drive awareness about our solution.

Expand through Focused Acquisitions

We plan to continue to leverage our know-how and the scale of our platform to selectively pursue acquisitions. To date, we have completed three acquisitions that have expanded our distribution capabilities and broadened our service offering, including into areas such as behavioral health. Our acquisition strategy is centered on acquiring technologies, products, capabilities, clinical specialties and distribution channels that are highly scalable and rapidly growing. We will continue to evaluate and pursue acquisition opportunities that are complementary to our business.

Risks Related to Our Business

Investing in our common stock involves substantial risk. You should carefully consider all of the information in this prospectus prior to investing in our common stock. There are several risks related to our business and our ability to leverage our strengths described elsewhere in this prospectus that are described under "Risk Factors" elsewhere in this prospectus. Among these important risks are the following:

- ongoing legal challenges to our business model that assert that our business model does not meet applicable legal requirements in order for our affiliated physicians to prescribe medications for our Members, and new state actions against our business model;
- the inability, or potential inability, of our providers to conduct visits in certain states due to our ongoing legal challenges regarding the prescription of medication in connection with a telehealth visit;
- our dependence on our relationships with affiliated professional entities to contract for the clinical and professional services provided to our Members;
- evolving government regulations and our ability to stay abreast of new or modified laws and regulations that currently apply or become applicable to or our business, compliance with which may require us to change our practices at an undeterminable and possibly significant monetary cost;
- our ability to operate in the heavily regulated healthcare industry, failure of which could result in penalties, significant changes to our operations or adverse publicity;
- our history of net losses and accumulated deficit;
- the impact of recent healthcare reform legislation and other changes in the healthcare industry;
- risks of the loss of any of our significant Clients;
- risks associated with the immaturity of the telehealth market and limited consumer acceptance of telehealth;
- risks associated with a decrease in the number of individuals offered benefits by our Clients or the number of products and services to which they subscribe;

our ability to establish and maintain strategic relationships with third parties;

our ability to recruit and retain a network of qualified Providers;

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- risk that the insurance we maintain may not fully cover all potential exposures;
- rapid technological change in the telehealth market;
- risks associated with federal and state privacy regulations regarding the use and disclosure of personally identifiable information or medical information and the significant liability that could result from a cybersecurity breach or our failure to comply with such regulations;
- our ability to compete in the growing telehealth industry among both established companies and new entrants;
- risks associated with a material weakness in internal control over financial reporting related to the breadth of our internal accounting team that has been identified; and
- the amount of the costs, fees, expenses and charges related to this initial public offering and the related costs of being a public company.

Implications of Being an Emerging Growth Company

As a company with less than $1.0 billion in revenue during our last fiscal year, we qualify as an "emerging growth company" as defined in the Jumpstart Our Business Startups Act of 2012, or the JOBS Act, enacted in April 2012. An "emerging growth company" may take advantage of exemptions from some of the reporting requirements that are otherwise applicable to public companies that are not emerging growth companies. These exemptions include:

- being permitted to present only two years of audited consolidated financial statements and only two years of related Management's Discussion and Analysis of Financial Condition and Results of Operations in this prospectus;
- not being required to comply with the auditor attestation requirements of Section 404 of the Sarbanes-Oxley Act of 2002, as amended, or the Sarbanes-Oxley Act, in the assessment of our internal control over financial reporting;
- reduced disclosure obligations regarding executive compensation in our periodic reports, proxy statements and registration statements; and
- exemption from the requirements of holding a nonbinding advisory vote on executive compensation and obtaining stockholder approval of any golden parachute payments not previously approved.

We may take advantage of these reporting exemptions until we are no longer an emerging growth company. We will remain an emerging growth company until the last day of our fiscal year following the fifth anniversary of the completion of this offering. However, if certain events occur prior to the end of such five-year period, including, but not limited to, if we become a "large accelerated filer," or if our annual gross revenue exceeds $1.0 billion or we issue more than $1.0 billion of non-convertible debt in any three-year period, we will cease to be an emerging growth company prior to the end of such five-year period.

We have elected to take advantage of certain of the reduced disclosure obligations in the registration statement of which this prospectus is a part and may elect to take advantage of some, but not all, of the reduced reporting requirements in future filings. As a result, the information that we provide to our stockholders may be different than you might receive from other public reporting companies in which you hold equity interests.

In addition, the JOBS Act provides that an emerging growth company can take advantage of an extended transition period for complying with new or revised accounting standards until such time as those standards apply to private companies. We have irrevocably elected not to avail ourselves of this exemption and, therefore, we will be subject to the same new or revised accounting standards as other public companies that are not emerging growth companies.

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Company Information

Teladoc, Inc. was incorporated in the State of Texas on June 13, 2002 and changed its state of incorporation to the State of Delaware on October 16, 2008. Our principal executive offices are located at 2 Manhattanville Road, Suite 203, Purchase, New York 10577, and our telephone number is (203) 635-2002. We also maintain offices and our physician network operations center at several facilities in the Dallas, Texas area. Our website address is www.teladoc.com. Information on, or accessible through, our website is not part of this prospectus, nor is such content incorporated by reference herein, and should not be relied upon in determining whether to make an investment in our common stock.

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THE OFFERING

Common stock offered by us	8,250,000 shares.
Common stock outstanding after this offering	37,046,346 shares.
Option to purchase additional shares	We have granted the underwriters a 30-day option to purchase up to an additional 1,237,500 shares of common stock.
Use of proceeds	We estimate the proceeds to us from this offering will be approximately $141.6 million, after deducting estimated underwriting discounts and commissions and estimated offering expenses payable by us. We intend to use the net proceeds from this offering for working capital and other general corporate purposes, including to expand our current business through acquisitions of, or investments in, other businesses, products or technologies. However, we have no commitments with respect to any such acquisitions or investments at this time. See "Use of Proceeds."
Dividend policy	We do not currently pay and do not currently anticipate paying dividends on our common stock following this offering. Any declaration and payment of future dividends to holders of our common stock may be limited by restrictive covenants in our debt agreements, and will be at the sole discretion of our board of directors. See "Dividend Policy," "Management's Discussion and Analysis of Financial Condition and Results of Operations Liquidity and Capital Resources Indebtedness" and "Description of Capital Stock."
Proposed NYSE symbol	"TDOC"
LOYAL3 platform	At our request, the underwriters have reserved up to 5% of the shares of common stock in this offering, for sale at the public offering price, through the LOYAL3 platform. See "Underwriting The LOYAL3 Platform."
Risk factors	See "Risk Factors" beginning on page 20 of this prospectus for a discussion of factors you should carefully consider before deciding to invest in our common stock.

Unless we specifically state otherwise, throughout this prospectus the number of shares of our common stock to be outstanding after completion of this offering is based on 28,796,346 shares outstanding as of June 17, 2015 and excludes:

shares of common stock sold or issued pursuant to the exercise of options subsequent to June 17, 2015;

3,733,279 shares of common stock issuable upon the exercise of options outstanding as of June 17, 2015 at a weighted average exercise price of $5.68 per share;

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131,239 shares of common stock issuable upon the exercise of warrants outstanding as of June 4, 2015 at a weighted average exercise price of $2.95 per share;

2,186,447 shares of common stock reserved for issuance under our 2015 Incentive Award Plan, which we plan to adopt in connection with this offering; and

364,407 shares of common stock reserved for issuance under our Employee Stock Purchase Plan, which we plan to adopt in connection with this offering.

Unless we specifically state otherwise, all information in this prospectus assumes:

the automatic conversion of all outstanding shares of our preferred stock into 25,450,441 shares of our common stock, which will occur immediately prior to the closing of this offering;

no exercise of the option to purchase additional shares by the underwriters;

the filing of our fifth amended and restated certificate of incorporation, or our amended and restated certificate of incorporation, and the adoption of our amended and restated bylaws immediately prior to the closing of this offering; and

the completion of a one-for-2.2859 reverse split of our common stock effected on June 17, 2015.

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SUMMARY HISTORICAL FINANCIAL INFORMATION

The following table sets forth our summary historical consolidated financial information for the periods and as of the dates indicated. The balance sheet data as of December 31, 2013 and 2014 and the statement of operations data for the years ended December 31, 2013 and 2014 have been derived from our audited consolidated financial statements included elsewhere in this prospectus. The balance sheet data as of March 31, 2015 and the statement of operations data for the three months ended March 31, 2014 and 2015 have been derived from our unaudited consolidated financial statements included elsewhere in this prospectus. The balance sheet data as of March 31, 2014 have been derived from our unaudited consolidated financial statements not included in this prospectus. We completed our acquisitions of Consult A Doctor, Inc., or Consult A Doctor, on August 29, 2013, AmeriDoc, LLC, or AmeriDoc, on May 1, 2014 and Compile, Inc., d/b/a BetterHelp, or BetterHelp, on January 23, 2015. The results of operations of Consult A Doctor and AmeriDoc since the respective acquisition dates have been included in our audited consolidated financial statements included elsewhere in this prospectus. The results of operations of Consult A Doctor, AmeriDoc and BetterHelp since the respective acquisition dates have been included in our unaudited consolidated financial statements included elsewhere in this prospectus. You should read the information contained in this table in conjunction with "Selected Historical Financial Information," "Capitalization," "Management's Discussion and Analysis of Financial Condition and Results of Operations" and our audited consolidated financial statements and the related notes thereto included elsewhere in this prospectus. The unaudited interim consolidated financial statements have been prepared on the same basis as the audited consolidated financial statements and, in the opinion of our management, include all adjustments, consisting only of normal and recurring adjustments, necessary for a fair presentation of the information set forth herein. Interim financial results are not necessarily indicative of results that may be expected for the full fiscal year, and our historical results are not indicative of the results to be expected in the future.

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	Year Ended December 31,		Three Months Ended March 31,	
	2013	2014	2014	2015
	(dollars in thousands, except share and per share data)			
Consolidated Statements of Operations Data:				
Revenue	$ 19,906	$ 43,528	$ 9,407	$ 16,488
Cost of revenue	4,186	9,929	1,982	5,281
Gross profit	15,720	33,599	7,425	11,207
Operating expenses:				
Advertising and marketing	4,090	7,662	2,518	4,341
Sales	4,441	11,571	2,145	3,682
Technology and development	3,532	7,573	1,192	2,906
General and administrative	8,772	19,623	3,344	11,968
Depreciation and amortization	754	2,320	414	903
Loss from operations	(5,869)	(15,150)	(2,188)	(12,593)
Interest income (expense), net	(56)	(1,499)	(54)	(568)
Net loss before taxes	(5,925)	(16,649)	(2,242)	(13,161)
Income tax provision (benefit)	94	388	72	(458)
Net loss	$ (6,019)	$ (17,037)	$ (2,314)	$ (12,703)
Per Share Data:				
Net loss per share, basic and diluted	$ (8.05)	$ (10.25)	$ (2.35)	$ (5.87)
Weighted-average shares used to compute basic and diluted net loss per share	1,222,268	1,962,845	1,423,732	2,162,413
Pro forma net loss per share, basic and diluted (unaudited)		$ (0.86)		$ (0.46)
Weighted-average shares used to compute basic and diluted pro forma net loss per share (unaudited)		23,506,977		27,612,862
Other Data:				
Visits	127,107	298,833	65,243	148,696
Members	6.2 million	8.1 million	7.1 million	10.6 million
EBITDA(1)	$ (5,115)	$ (12,830)	$ (1,774)	$ (11,690)

	As of March 31, 2015		
	Actual	Pro Forma(2)	Pro Forma as Adjusted(3)
	(in thousands)		
Consolidated Balance Sheets Data:			
Cash and cash equivalents	$ 32,060	$ 18,782	$ 160,410
Working capital	25,617	12,339	153,967
Total assets	87,361	104,583	246,211
Total liabilities	45,994	45,994	45,994
Total stockholders' equity (deficit)	(79,399)	58,588	200,216

(1) To supplement our financial information presented in accordance with generally accepted accounting principles in the United States, or U.S. GAAP, we use the following additional non-U.S. GAAP financial measures to clarify and enhance an understanding of past performance: EBITDA. We believe that the presentation of this financial measure enhances an

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investor's understanding of our financial performance. We further believe that this financial measure is a useful financial metric to assess our operating performance from period-to-period by excluding certain items that we believe are not representative of our core business. We use certain financial measures for business planning purposes and in measuring our performance relative to that of our competitors. We utilize EBITDA as the primary measure of segment performance.

EBITDA consists of net income (loss) before interest, taxes, depreciation and amortization. We believe that making such adjustment provides investors meaningful information to understand our results of operations and ability to analyze financial and business trends on a period-to-period basis.

We believe these financial measures are commonly used by investors to evaluate our performance and that of our competitors. However, our use of the term EBITDA may vary from that of others in our industry. EBITDA should not be considered as an alternative to net loss before taxes, net loss, earnings per share or any other performance measures derived in accordance with U.S. GAAP as measures of performance.

EBITDA has an important limitation as an analytical tool and you should not consider it in isolation or as a substitute for analysis of our results as reported under U.S. GAAP. Some of these limitations are:

EBITDA:

- does not reflect the significant interest expense on our debt; and
- eliminates the impact of income taxes on our results of operations; and

although depreciation and amortization are non-cash charges, the assets being depreciated and amortized will often have to be replaced in the future, and EBITDA does not reflect any expenditures for such replacements; and

other companies in our industry may calculate EBITDA differently than we do, limiting the usefulness of EBITDA as comparative measures.

We compensate for these limitations by using EBITDA along with other comparative tools, together with U.S. GAAP measurements, to assist in the evaluation of operating performance. Such U.S. GAAP measurements include gross profit, net loss, net loss per share and other performance measures.

In evaluating these financial measures, you should be aware that in the future we may incur expenses similar to those eliminated in this presentation. Our presentation of EBITDA should not be construed as an inference that our future results will be unaffected by unusual or nonrecurring items.

The following table reconciles net loss to EBITDA for the periods presented:

	Year Ended December 31,		Three Months Ended March 31,	
	2013	2014	2014	2015
	(in thousands)			
Net loss	$ (6,019)	$ (17,037)	$ (2,314)	$ (12,703)
Interest income (expense), net	(56)	(1,499)	(54)	(568)
Income taxes	94	388	72	(458)
Depreciation and amortization	754	2,320	414	903
EBITDA	$ (5,115)	$ (12,830)	$ (1,774)	$ (11,690)

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(2) The pro forma consolidated balance sheet data gives effect to the automatic conversion of all outstanding shares of our preferred stock into an aggregate of 25,450,441 shares of our common stock, which will occur immediately prior to the closing of this offering, and the consummation of our acquisition of Stat Health Services Inc., or StatDoc, on June 17, 2015.

(3) The pro forma as adjusted consolidated balance sheet data gives further effect to our issuance and sale of 8,250,000 shares of common stock in this offering at the initial public offering price of $19.00 per share, after deducting estimated underwriting discounts and commissions and estimated offering expenses payable by us.

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RISK FACTORS

An investment in our common stock involves a high degree of risk. You should consider carefully the following risks, together with the other information contained in this prospectus before you decide whether to buy our common stock. If any of the events contemplated by the following discussion of risks should occur, our business, financial condition, results of operations and cash flows could suffer significantly. As a result, the market price of our common stock could decline, and you may lose all or part of the money you paid to buy our common stock. The following is a summary of all the material risks known to us.

Risks Related to Our Business

Our business could be adversely affected by ongoing legal challenges to our business model or by new state actions restricting our ability to provide the full range of our services in certain states.

Our ability to conduct business in each state is dependent upon the state's treatment of telemedicine (and of remote healthcare delivery in general, such as the permissibility of, and requirements for, physician cross-coverage practice) under such state's laws, rules and policies governing the practice of medicine, which are subject to changing political, regulatory and other influences. Cross-coverage regulation refers to the state rules under which one doctor is permitted to treat the regular patients of another doctor remotely. Some state medical boards have established new rules or interpreted existing rules in a manner that limits or restricts our ability to conduct our business as currently conducted in other states. Some of these actions have resulted in litigation and the suspension of our operations in certain states.

For instance, the Texas Medical Board, or the TMB, asserted in 2011 that our Providers do not form the required relationships with our Members in the course of telehealth visits that would support the prescription of medications. As a result of this position, we initiated two lawsuits against the TMB, both of which are pending in Texas state courts. On December 31, 2014, the Austin Court of Appeals granted our request for summary judgment in the first suit, invalidating the TMB's prior position that our operations do not comply with the current TMB regulations governing the practice of medicine. This Court of Appeals decision may be subject to an appellate hearing in the Texas Supreme Court. In the second suit, we filed a request for a temporary injunction to restrain the TMB from communicating, implementing and enforcing an "emergency rule" it issued on January 16, 2015, purporting to amend the Texas Administrative Code to require an in-person examination of a patient before a Texas physician may lawfully prescribe medication. On February 2, 2015, the Travis County District Court granted our request for a temporary injunction, which remains in effect and prohibits the TMB from communicating, implementing and enforcing the emergency rule. The TMB's subsequent passage of the rule described below may have mooted one or both of these cases, but they remain active. We are currently unable to make a reasonable estimate of when either of these cases will be resolved, whether we will ultimately prevail, or the amount or range of loss that could result from an unfavorable outcome in either action.

On April 10, 2015, the TMB adopted revisions to the rules governing medical practice that would require, in most instances, in-person examinations prior to prescribing medications. Our present business model does not include in-person examinations of our Members before prescribing medications. We challenged these rule amendments on April 29, 2015 by filing a lawsuit against the TMB in the United States District Court for the Western District of Texas, Austin Division requesting that they be enjoined as unlawful under the Sherman Antitrust Act and the Commerce Clause of the U.S. Constitution, and a related hearing was held on May 22, 2015 on our motion for preliminary injunction. On May 29, 2015, this court granted our request for a preliminary injunction of the rule amendments, pending ultimate trial on the amendments' validity, which trial date has yet to be set, and on June 19, 2015, the TMB filed a motion to dismiss the suit. Accordingly, for so

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long as the preliminary injunction remains in place, the rule amendments as proposed will not go into effect in Texas.

Business in the State of Texas accounted for approximately $3.3 million, or 20%, and $10 million, or 23%, of our revenue during the three months ended March 31, 2015 and the year ended December 31, 2014, respectively. If the TMB's rule revisions go into effect as written and we are unable to adapt our business model in compliance with the TMB rule, our ability to operate our business in the State of Texas could be materially adversely affected, which would have a material adverse effect on our business, financial condition and results of operations.

In addition, during 2014, we voluntarily suspended our business operations in the States of Arkansas and Idaho in response to formal and informal communications among us, our affiliated physicians, and the respective boards of medicine in each state. In each state, the board of medicine took the position that our business model did not meet the state's applicable legal requirements in order for our affiliated physicians to prescribe medications for our Members. In March 2015, Idaho Governor Otter signed the Idaho Telehealth Access Act, which redefined telehealth services in Idaho in a manner that will allow us to resume operations in Idaho in July 2015. In addition, in April 2015, Arkansas enacted its own Telemedicine Act allowing a telehealth provider to establish a relationship with a patient through an in-person examination or through another manner adopted by rule of the Arkansas State Medical Board. We remain in active discussions with the relevant authorities in Arkansas to demonstrate the safety and benefits inherent to our business. Despite these discussions, we cannot guarantee that we will be able to resume operations in Arkansas.

It is possible that the laws and rules governing the practice of medicine in one or more states may change in a manner analogous to what occurred in Texas and Arkansas. If this were to happen, and we were unable to adapt our business model accordingly, our operations in such states would be disrupted, which could have a material adverse effect on our business, financial condition and results of operations.

We are dependent on our relationships with affiliated professional entities, which we do not own, to provide physician services, and our business would be adversely affected if those relationships were disrupted.

There is a risk that state authorities in some jurisdictions may find that our contractual relationships with our physicians violate laws prohibiting the corporate practice of medicine. 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 the physician's professional judgment. The extent to which each state considers particular actions or contractual relationships to constitute improper influence of professional judgment varies across the states and is subject to change and to evolving interpretations by state boards of medicine and state attorneys general, among others. As such, we must monitor our compliance with laws in every jurisdiction in which we operate on an ongoing basis and we cannot guarantee that subsequent interpretation of the corporate practice of medicine laws will not further 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 physicians from participating in our network of providers.

The corporate practice of medicine prohibition exists in some form, by statute, regulation, board of medicine or attorney general guidance, or case law, in at least 42 states, all of which we operate in, though the broad variation between state application and enforcement of the doctrine makes an exact count difficult. Due to the prevalence of the corporate practice of medicine doctrine, including in the states where we predominantly conduct our business, we contract for Provider services through a services agreement with Teladoc Physicians, P.A., or Teladoc PA, which is a 100% physician-owned independent entity that has agreements with several professional

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corporations, to contract with physicians and professional corporations that contract with physicians for the clinical and professional services provided to our Members. See "Business Physicians and Healthcare Professionals" for a more detailed discussion of the Services Agreement. We do not own Teladoc PA or the professional corporations with which it contracts. Teladoc PA is owned by Dr. Timothy Howard, one of our Providers, and the professional corporations are owned by physicians licensed in their respective states. While we expect that these relationships will continue, we cannot guarantee that they will. A material change in our relationship with Teladoc PA, or among Teladoc PA and the contracted professional corporations, whether resulting from a dispute among the entities, a change in government regulation, or the loss of these affiliations, could impair our ability to provide services to our Members and could have a material adverse effect on our business, financial condition and results of operations. In addition, the arrangement in which we have entered to comply with state corporate practice of medicine doctrines could 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 Teladoc PA could have a material adverse effect on our business, financial condition and results of operations.

Evolving government regulations may require increased costs or adversely affect our results of operations.

In a regulatory climate that is uncertain, our operations may be subject to direct and indirect adoption, expansion or reinterpretation of various laws and regulations. Compliance with these future laws and regulations may require us to change our practices at an undeterminable and possibly significant initial monetary and annual expense. These additional monetary expenditures may increase future overhead, which could have a material adverse effect on our results of operations.

We have identified what we believe are the areas of government regulation that, if changed, would be costly to us. These include: rules governing the practice of medicine by physicians; licensure standards for doctors and behavioral health professionals; laws limiting the corporate practice of medicine; cybersecurity and privacy laws; laws and rules relating to the distinction between independent contractors and employees; and tax and other laws encouraging employer-sponsored health insurance. 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.

In the states in which we operate, we believe we are in compliance with all applicable regulations, but, due to the uncertain regulatory environment, certain states may determine that we are in violation of their laws and regulations. In the event that we must remedy such violations, we may be required to modify our services and products in such states in a manner that undermines our solution's attractiveness to Clients, Members or Providers, we may become subject to fines or other penalties or, if we determine that the requirements to operate in compliance in such states are overly burdensome, we may elect to terminate our operations in such states. In each case, our revenue may decline and our business, financial condition and results of operations could be materially adversely affected.

Additionally, the introduction of new services may require us to comply with additional, yet undetermined, laws and regulations. Compliance may require obtaining appropriate state medical board licenses or certificates, increasing our security measures and expending additional resources to monitor developments in applicable rules and ensure compliance. The failure to adequately comply with these future laws and regulations may delay or possibly prevent some of our products or services from being offered to Clients and Members, which could have a material adverse effect on our business, financial condition and results of operations.

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We conduct business in a heavily regulated industry and if we fail to comply with these laws and government regulations, we could incur penalties or be required to make significant changes to our operations or experience adverse publicity, which could have a material adverse effect on our business, financial condition, and results of operations.

The healthcare industry is heavily regulated and closely scrutinized by federal, state and local governments. Comprehensive statutes and regulations govern the manner in which we provide and bill for services and collect reimbursement from governmental programs and private payors, our contractual relationships with our Providers, vendors and Clients, our marketing activities and other aspects of our operations. Of particular importance are:

- the federal physician self-referral law, commonly referred to as the Stark Law, that, subject to limited 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 such physician's immediate family has a direct or indirect financial relationship (including an ownership interest or a compensation arrangement) with the entity, and prohibit the entity from billing Medicare or Medicaid for such designated health services;

- the federal Anti-Kickback Statute that prohibits the knowing and willful offer, payment, solicitation or receipt of any bribe, kickback, rebate or other remuneration for referring an individual, in return for ordering, leasing, purchasing or recommending or arranging for or to induce the referral of an individual or the ordering, purchasing or leasing of items or services covered, in whole or in part, by any federal healthcare program, such as Medicare and Medicaid. A person or entity does not need to have actual knowledge of the statute or specific intent to violate it to have committed a violation. In addition, the government may assert that a claim including items or services resulting from a violation of the federal Anti-Kickback Statute constitutes a false or fraudulent claim for purposes of the False Claims Act;

- the criminal healthcare fraud provisions of 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. Similar to the federal Anti-Kickback Statute, a person or entity does not need to have actual knowledge of the statute or specific intent to violate it to have committed a violation;

- the federal False Claims Act that imposes civil and criminal liability on individuals or entities that knowingly submit false or fraudulent claims for payment to the government or knowingly making, or causing to be made, a false statement in order to have a false claim paid, including *qui tam* or whistleblower suits;

- reassignment of payment rules that prohibit certain types of billing and collection practices in connection with claims payable by the Medicare or Medicaid programs;

- similar state law provisions pertaining to anti-kickback, self-referral and false claims issues, some of which may apply to items or services reimbursed by any third-party payor, including commercial insurers;

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

- laws that regulate debt collection practices as applied to our debt collection practices;

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

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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; and

federal and state laws and policies that require healthcare providers to maintain licensure, certification or accreditation to enroll and participate in the Medicare and Medicaid programs, to report certain changes in their operations to the agencies that administer these programs.

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 may prove costly. Failure to comply with these laws and other laws can result in civil and criminal penalties such as fines, damages, overpayment recoupment loss of enrollment status and exclusion from the Medicare and Medicaid programs. The risk of our being found in violation of these laws and regulations is increased by the fact that many of them have not been fully interpreted by the regulatory authorities or the courts, and their provisions are sometimes open to a variety of interpretations. Our failure to accurately anticipate the application of these laws and regulations to our business or any other failure to comply with regulatory requirements could create liability for us and negatively affect our business. 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 our management's attention from the operation of our business and result in adverse publicity.

To enforce compliance with the federal laws, the U.S. Department of Justice and the Department of Health and Human Services Office of Inspector General, or OIG, have recently increased their scrutiny of healthcare providers, which has led to a number of investigations, prosecutions, convictions and settlements in the healthcare industry. Dealing with investigations can be time- and resource-consuming and can divert management's attention from the business. Any such investigation or settlement could increase our costs or otherwise have an adverse effect on our business. In addition, because of the potential for large monetary exposure under the federal False Claims Act, which provides for treble damages and mandatory minimum penalties of $5,500 to $11,000 per false claim or statement, healthcare providers often resolve allegations without admissions of liability for significant and material 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.

The laws, regulations and standards governing the provision of healthcare services may change significantly in the future. We cannot assure you that any new or changed healthcare laws, regulations or standards will not materially adversely affect our business. We cannot assure you that a review of our business by judicial, law enforcement, regulatory or accreditation authorities will not result in a determination that could adversely affect our operations.

We have a history of cumulative 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 $6.0 million and $17.0 million for the years ended December 31, 2013 and 2014, respectively, and $2.3 million and $12.7 million for the three months ended March 31, 2014 and 2015, respectively. As of March 31, 2015, we had an accumulated deficit of $85.2 million. These losses and accumulated deficit reflect the substantial investments we made to acquire new Clients, build our proprietary network of healthcare providers and develop our technology platform. We intend to

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continue scaling our business to increase our client, member and provider bases, broaden the scope of services we offer and expand our applications of technology through which Members can access our services. Accordingly, we anticipate that cost of revenue and operating expenses will increase substantially in the foreseeable future. These efforts 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 losses, combined with our expected future losses, have had and will continue to have an adverse effect on our stockholders' 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. See " We may require additional capital to support business growth, and this capital may not be available to us on acceptable terms or at all."

The impact of recent healthcare reform legislation and other changes in the healthcare industry and in healthcare spending on us is currently unknown, but may adversely affect our business, financial condition and results of operations.

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 PPACA made major changes in how healthcare is delivered and reimbursed, and increased access to health insurance benefits to the uninsured and underinsured population of the United States.

The PPACA, among other things, increased the number of individuals with Medicaid and private insurance coverage, implemented reimbursement policies that tie payment to quality, facilitated the creation of accountable care organizations that may use capitation and other alternative payment methodologies, strengthened enforcement of fraud and abuse laws and encouraged the use of information technology. Many of these changes require implementing regulations which have not yet been drafted or have been released only as proposed rules.

Such changes in the regulatory environment may also result in changes to our payor mix that may affect our operations and revenue. While the PPACA is expected to increase the number of persons with covered health benefits, we cannot accurately estimate the payment rates for any additional persons that are expected to be covered by health benefits. For example, the PPACA's expansion of Medicaid coverage could cause patients who otherwise would have selected private healthcare to participate in government sponsored healthcare programs, and Medicaid and other government programs typically reimburse providers at substantially lower rates than private payors. Our revenue may be adversely impacted if states pursue lower rates or cost-containment strategies as a result of any expansion of their existing Medicaid programs to include additional persons, particularly in states experiencing budget deficits. Exchanges created to facilitate coverage for new persons to be covered by health benefits may also place additional pricing pressure on all providers, regardless of payor. The full impact of many of the provisions under the PPACA is unknown at this time. For example, the PPACA established an Independent Payment Advisory Board that, beginning January 16, 2014, can recommend changes in payment for physicians under certain circumstances, which the Department of Health and Human Services, or HHS, generally would be required to implement unless Congress enacts superseding legislation. The PPACA also requires HHS to develop a budget-neutral, value-based payment modifier that provides for differential payment under the Medicare Physician Fee Schedule, or the MPFS, for physicians or groups of physicians that is linked to quality of care furnished compared to cost. Physicians in groups of 100 or more eligible professionals who submit claims to Medicare under a single tax identification number will be subject to the value modifier in 2015, based on their performance in calendar year 2013; the modifier will apply to all other physicians by 2017. HHS has not yet

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developed a value-based payment modifier option for hospital-based physicians. We cannot assure you that our Clients will not impose similar payment modifiers for services that we provide.

Physician payments under the MPFS are updated on an annual basis according to a statutory formula. Because application of the statutory formula for the update factor would have resulted in a decrease in total physician payments for the past several years, Congress has intervened with interim legislation to prevent the reductions. For 2014, CMS projected a rate reduction of 20.1% from 2013 levels and earlier estimates had projected a 24.4% reduction. A series of laws was enacted that delayed the scheduled reduction in physician payments and provided for a 0.5% increase through December 31, 2014, and a zero percent update from 2014 payment amounts to the 2015 Physician Fee Schedule through March 31, 2015.

President Obama signed the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA, on April 16, 2015, which repealed and replaced the SGR formula for Medicare payment adjustments to physicians. MACRA provides a permanent end to the annual interim legislative updates that had previously been necessary to delay or prevent significant reductions to payments under the Physician Fee Schedule. MACRA extended existing payment rates under PAMA through June 30, 2015, with a 0.5% update for July 1, 2015, through December 31, 2015 and for each calendar year through 2019, after which there will be a 0% annual update each year through 2025. In addition, MACRA requires the establishment of the Merit-Based Incentive Payment System, beginning in 2019, under which physicians may receive performance-based payment incentives or payment reductions based on their performance with respect to clinical quality, resource use, clinical improvement activities, and meaningful use of electronic health records. MACRA also requires CMS, beginning in 2019, to provide incentive payments for physicians and other eligible professionals that participate in alternative payment models, such as accountable care organizations, that emphasize quality and value over the traditional volume-based fee-for-service model. MACRA is still new and the manner in which it will be implemented is not certain, but at this time, we do not believe that this law will have a material effect on our future revenues.

In November 2012, CMS adopted a rule under the PPACA that generally allowed physicians in certain specialties who provide eligible primary care services to be paid at the Medicare reimbursement rates in effect in calendar years 2013 and 2014 instead of state-established Medicaid reimbursement rates, referred to as the Medicaid-Medicare Parity. Generally, state Medicaid reimbursement rates are lower than federally established Medicare rates. During 2013, state agencies were required to submit their state plan amendments, or SPAs, outlining how they will implement the rule, including frequency and timing of payments to CMS for review and approval. In December 2013, CMS indicated that all SPAs had been approved for enhanced Medicaid-Medicare Parity reimbursement through December 2014. Congress did not act before the end of the year to extend the Medicaid-Medicare Parity and the rule expired. Legislation has been proposed to retroactively extend Medicaid-Medicare Parity for calendar year 2015 but has not yet been enacted. Certain states have decided to fully or partially extend the Medicaid-Medicare Parity. It is unclear at this time how these limited state increases or the continued failure to extend the rule at the federal level will impact our business.

In addition, certain provisions of the PPACA authorize voluntary demonstration projects, which include the development of bundling payments for acute, inpatient hospital services, physician services and postacute services for episodes of hospital care. The Medicare Acute Care Episode Demonstration is currently underway at several healthcare system demonstration sites. Further, the PPACA may adversely affect payors by increasing medical costs generally, which could have an effect on the industry and potentially impact our business and revenue as payors seek to offset these increases by reducing costs in other areas. The full impact of these changes on us cannot be determined at this time.

Finally, other legislative changes have been proposed and adopted in the United States since the PPACA was enacted. On August 2, 2011, the Budget Control Act of 2011 was enacted, which,

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among other things, created the Joint Select Committee on Deficit Reduction, or the Joint Committee, to recommend proposals in spending reductions to Congress. The Joint Committee did not achieve a targeted deficit reduction of at least $1.2 trillion for the years 2013 through 2021, triggering the legislation's automatic reduction to several government programs. This included aggregate reductions to Medicare payments to providers of 2% per fiscal year, which went into effect on April 1, 2013 and, due to subsequent legislative amendments to the statute, will remain in effect through 2024 unless additional Congressional action is taken. On January 2, 2013, the American Taxpayer Relief Act was signed into law, which, among other things, further reduced Medicare payments to several providers, including hospitals, imaging centers and cancer treatment centers. We expect that additional state and federal healthcare reform measures will be adopted in the future, any of which could limit the amounts that federal and state governments and other third-party payors will pay for healthcare products and services, which could adversely affect our business, financial condition and results of operations.

A significant portion of our revenue comes from a limited number of Clients, the loss of which would have a material adverse effect on our business, financial condition and results of operations.

Historically, we have relied on a limited number of Clients for a substantial portion of our total revenue. For the year ended December 31, 2014, one Client represented approximately 4.5% of our total revenue. In addition, for the years ended December 31, 2014 and 2013, our top ten Clients by revenue accounted for 28.1% and 41.1% of our total revenue, respectively. We also rely on our reputation and recommendations from key Clients in order to promote our solution to potential new Clients. The loss of any of our key Clients, or a failure of some of them to renew or expand their subscriptions, could have a significant impact on the growth rate of our revenue, reputation and our ability to obtain new Clients. In addition, mergers and acquisitions involving our Clients could lead to cancellation or non-renewal of our contracts with those Clients or by the acquiring or combining companies, thereby reducing the number of our existing and potential Clients and Members.

The telehealth market is immature and volatile, and if it does not develop, if it develops more slowly than we expect, if it encounters negative publicity or if our solution does not drive Member engagement, the growth of our business will be harmed.

The telehealth market is relatively new and unproven, and it is uncertain whether it will achieve and sustain high levels of demand, consumer acceptance and market adoption. Our success will depend to a substantial extent on the willingness of our Members to use, and to increase the frequency and extent of their utilization of, our solution, as well as on our ability to demonstrate the value of telehealth to employers, health plans, government agencies and other purchasers of healthcare for beneficiaries. Negative publicity concerning our solution or the telehealth market as a whole could limit market acceptence of our solution. If our Clients and Members do not perceive the benefits of our solution, or if our solution does not drive Member engagement, then our market may not develop at all, or it may develop more slowly than we expect. Similarly, individual and healthcare industry concerns or negative publicity regarding patient confidentiality and privacy in the context of telehealth could limit market acceptance of our healthcare services. If any of these events occurs, it could have a material adverse effect on our business, financial condition or results of operations.

If the number of individuals covered by our employer, health plan and other Clients decreases, or the number of applications or services to which they subscribe decreases, our revenue will likely decrease.

Under most of our Client contracts, we base our fees on the number of individuals to whom our Clients provide benefits and the number of applications or services subscribed to by our Clients. Many factors may lead to a decrease in the number of individuals covered by our Clients

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and the number of applications or services subscribed to by our Clients, including, but not limited to, the following:

- failure of our Clients to adopt or maintain effective business practices;
- changes in the nature or operations of our Clients;
- government regulations; and
- increased competition or other changes in the benefits marketplace.

If the number of individuals covered by our employer, health plan and other Clients decreases, or the number of applications or services to which they subscribe decreases, for any reason, our revenue will likely decrease.

Our growth depends in part on the success of our strategic relationships with third parties.

In order to grow our business, we anticipate that we will continue to depend on our relationships with third parties, including our partner organizations and technology and content providers. For example, we partner with a number of price transparency, HSA and other benefits platforms to deliver our solution to their consumers. Identifying partners, and negotiating and documenting relationships with them, requires significant time and resources. Our competitors may be effective in providing incentives to third parties to favor their products or services or to prevent or reduce subscriptions to, or utilization of, our products and services. In addition, acquisitions of our partners by our competitors could result in a decrease in the number of our current and potential Clients, as our partners may no longer facilitate the adoption of our applications by potential Clients. If we are unsuccessful in establishing or maintaining our relationships with third parties, our ability to compete in the marketplace or to grow our 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 Client use of our applications or increased revenue.

Our business and growth strategy depend on our ability to maintain and expand a network of qualified Providers. If we are unable to do so, our future growth would be limited and our business, financial condition and results of operations would be harmed.

Our success is dependent upon our continued ability to maintain a network of qualified Providers. If we are unable to recruit and retain board-certified physicians and other healthcare professionals, it would have a material adverse effect on our business and ability to grow and would adversely affect our results of operations. In any particular market, Providers could demand higher payments or take other actions that could result in higher medical costs, less attractive service for our Clients 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 and/or Medicaid reimbursement levels and other pressures on healthcare providers and consolidation activity among hospitals, physician groups and healthcare providers. The failure to maintain or to secure new cost-effective Provider contracts may result in a loss of or inability to grow our membership base, higher costs, healthcare provider network disruptions, less attractive service for our Clients and/or difficulty in meeting regulatory or accreditation requirements, any of which could have a material adverse effect on our business, financial condition and results of operations.

We may become subject to medical liability claims, which could cause us to incur significant expenses and may require us to pay significant damages if not covered by insurance.

Our business entails the risk of medical liability claims against both our Providers and us. Although we and Teladoc PA carry insurance 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 and Teladoc PA's

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insurance coverage. Teladoc PA carries professional liability insurance covering $1.0 million per claim and $3.0 million in the aggregate for itself and each of its healthcare professionals (our Providers), and we separately carry a general insurance policy, which covers medical malpractice claims, covering $5.0 million per claim and $5.0 million in the aggregate. In addition, professional liability insurance is expensive and insurance premiums may increase significantly in the future, particularly as we expand our services. 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 have a material adverse effect on our business, financial condition and results of operations. In addition, any claims may adversely affect our business or reputation.

Rapid technological change in our industry presents us with significant risks and challenges.

The telehealth market is characterized by rapid technological change, changing consumer requirements, short product lifecycles and evolving industry standards. Our success will depend on our ability to enhance our solution with next-generation technologies and to develop or to acquire and market new services to access new consumer populations. There is no 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, there can be no assurance 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.

A decline in the prevalence of employer-sponsored healthcare or the emergence of new technologies may render our solution obsolete or require us to expend significant resources in order to remain competitive.

The U.S. healthcare industry is massive, with a number of large market participants with conflicting agendas, is subject to significant government regulation and is currently undergoing significant change. Changes in our industry, for example, away from high-deductible health plans, or the emergence of new technologies as more competitors enter our market, could result in our solution being less desirable or relevant.

For example, we currently derive the majority of our revenue from sales to Clients that purchase healthcare for their employees (either via insurance or self-funded benefit plans). A large part of the demand for our solution depends on the need of these employers to manage the costs of healthcare services that they pay on behalf of their employees. Some experts have predicted that the PPACA will encourage employer-sponsored health insurance to become significantly less prevalent as employees migrate to obtaining their own insurance over the state-sponsored insurance marketplaces. Were this to occur, there is no guarantee that we would be able to compensate for the loss in revenue from employers by increasing sales of our solution to health insurance companies or to individuals or government agencies. In such a case, our results of operations would be adversely affected.

If healthcare benefits trends shift or entirely new technologies are developed that replace existing solutions, our existing or future solutions could be rendered obsolete and our business could be adversely affected. In addition, we may experience difficulties with software development, industry standards, design or marketing that could delay or prevent our development, introduction or implementation of new applications and enhancements.

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If our new applications and services are not adopted by our Clients, or if we fail to continue to innovate and develop new applications and services that are adopted by our Clients, our revenue and results of operations will be adversely affected.

To date, we have derived a substantial majority of our revenue from sales of our primary care telehealth solution, and our longer-term results of operations and continued growth will depend on our ability successfully to develop and market new applications and services that our Clients want and are willing to purchase. In addition, we have invested, and will continue to invest, significant resources in research and development to enhance our existing solution and introduce new high-quality applications and services. If existing Clients are not willing to make additional payments for such new applications, or if new Clients and Members do not value such new applications, it could have a material adverse effect on our business, financial condition and results of operations. If we are unable to predict user preferences or if our industry changes, or if we are unable to modify our solution and services on a timely basis, we may lose Clients. Our results of operations would also suffer if our innovations are not responsive to the needs of our Clients, appropriately timed with market opportunity or effectively brought to market.

We rely on data center providers, Internet infrastructure, bandwidth providers, third-party computer hardware and software, other third parties and our own systems for providing services to our Clients and Members, and any failure or interruption in the services provided by these third parties or our own systems could expose us to litigation and negatively impact our relationships with Clients, adversely affecting our brand and our business.

We serve all of our Clients and Members from two data centers, one located in Dallas, Texas and the other located in the Metro New York City area. While we control and have access to our servers, we do not control the operation of these facilities. The owners of our data center facilities have no obligation to renew their agreements with us on commercially reasonable terms, or at all. If we are unable to renew these agreements on commercially reasonable terms, or if one of our data center operators is acquired, we may be required to transfer our servers and other infrastructure to new data center facilities, and we may incur significant costs and possible service interruption in connection with doing so. Problems faced by our third-party data center locations with the telecommunications network providers with whom we or they contract or with the systems by which our telecommunications providers allocate capacity among their clients, including us, could adversely affect the experience of our Clients and Members. Our third-party data center operators could decide to close their facilities without adequate notice. In addition, any financial difficulties, such as bankruptcy faced by our third-party data centers operators or any of the service providers with whom we or they contract may have negative effects on our business, the nature and extent of which are difficult to predict.

Additionally, if our data centers are unable to keep up with our growing needs for capacity, this could have an adverse effect on our business. For example, a rapid expansion of our business could affect the service levels at our data centers or cause such data centers and systems to fail. Any changes in third-party service levels at our data centers or any disruptions or other performance problems with our solution could adversely affect our reputation and may damage our Clients and Members' stored files or result in lengthy interruptions in our services. Interruptions in our services may reduce our revenue, cause us to issue refunds to Clients for prepaid and unused subscriptions, subject us to potential liability or adversely affect Client renewal rates.

In addition, our ability to deliver our internet-based services depends on the development and maintenance of the infrastructure of the Internet by third parties. This includes maintenance of a reliable network backbone with the necessary speed, data capacity, bandwidth capacity and security. Our services are designed to operate without interruption in accordance with our service level commitments. However, we have experienced and expect that we may experience future interruptions and delays in services and availability from time to time. In the event of a catastrophic

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event with respect to one or more of our systems, we may experience an extended period of system unavailability, which could negatively impact our relationship with Clients and Members. To operate without interruption, both we and our service providers must guard against:

- damage from fire, power loss, natural disasters and other force majeure events outside our control;
- communications failures;
- software and hardware errors, failures and crashes;
- security breaches, computer viruses, hacking, denial-of-service attacks and similar disruptive problems; and
- other potential interruptions.

We also rely on computer hardware purchased or leased and software licensed from third parties in order to offer our services, including software from Apple Computer and Microsoft Corporation, and routers and network equipment from Cisco and Hewlett-Packard Company. These licenses are generally commercially available on varying terms. However, it is possible that this hardware and software may not continue to be available on commercially reasonable terms, or at all. Any loss of the right to use any of this hardware or software could result in delays in the provisioning of our services until equivalent technology is either developed by us, or, if available, is identified, obtained and integrated.

We exercise limited control over third-party vendors, which increases our vulnerability to problems with technology and information services they provide. Interruptions in our network access and services may in connection with third-party technology and information services reduce our revenue, cause us to issue refunds to Clients for prepaid and unused subscription services, subject us to potential liability or adversely affect Client renewal rates. Although we maintain a $5.0 million security and privacy damages policy and an additional $2.0 million in coverage under our general liability policy, the coverage under our policies may not be adequate to compensate us for all losses that may occur related to the services provided by our third-party vendors. In addition, we may not be able to continue to obtain adequate insurance coverage at an acceptable cost, if at all.

We could incur substantial costs as a result of any claim of infringement of another party's intellectual property rights.

In recent years, there has been significant litigation in the United States involving patents and other intellectual property rights. Companies in the Internet and technology industries are increasingly bringing and becoming subject to suits alleging infringement of proprietary rights, particularly patent rights, and our competitors and other third parties may hold patents or have pending patent applications, which could be related to our business. These risks have been amplified by the increase in third parties, which we refer to as non-practicing entities, whose sole primary business is to assert such claims. On June 8, 2015, American Well Corporation filed a complaint against our company in the United States District Court for the District of Massachusetts alleging that certain of our operating platform's technology infringes one of its patents that we are currently seeking to invalidate pursuant to a petition for *inter partes* review that we filed with the U.S. Patent and Trademark Office's Patent Trial and Appeals Board in March 2015. See "Business Legal Proceedings." Regardless of the merits of this or any other intellectual property litigation, we may be required to expend significant management time and financial resources on the defense of such claims, and any adverse outcome of any such claim or the above referenced review could have a material adverse effect on our business, financial condition or results of operations. We expect that we may receive in the future additional notices that claim we or our Clients using our solution 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

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competitors overlaps. Our existing or any future litigation, whether or not successful, could be extremely costly to defend, divert our management's time, attention and resources, damage our reputation and brand and substantially harm our business.

In addition, in most instances, we have agreed to indemnify our Clients against certain third-party claims, which may include claims that our solution infringes the intellectual property rights of such third parties. Our business could be adversely affected by any significant disputes between us and our Clients as to the applicability or scope of our indemnification obligations to them. The results of any intellectual property litigation to which we may become a party, or for which we are required to provide indemnification, may require us to do one or more of the following:

cease offering or using technologies that incorporate the challenged intellectual property;

make substantial payments for legal fees, settlement payments or other costs or damages;

obtain a license, which may not be available on reasonable terms, to sell or use the relevant technology; or

redesign technology to avoid infringement.

If we are required to make substantial payments or undertake any of the other actions noted above as a result of any intellectual property infringement claims against us or any obligation to indemnify our Clients for such claims, such payments or costs could have a material adverse effect on our business, financial condition and results of operations.

If our arrangements with our Providers or our Clients are found to violate state laws prohibiting the corporate practice of medicine or fee splitting, our business, financial condition and our ability to operate in those states could be adversely impacted.

The laws of many states, including states in which our Clients are located, prohibit us from exercising control over the medical judgments or decisions of physicians and from engaging in certain financial arrangements, such as splitting professional fees with physicians. These laws and their interpretations vary from state to state and are enforced by state courts and regulatory authorities, each with broad discretion. We enter into agreements with a professional association, Teladoc PA, which enters into contracts with our Providers pursuant to which they render professional medical services. In addition, we enter into contracts with our Clients to deliver professional services in exchange for fees. These contracts include management services agreements with our affiliated physician organizations pursuant to which the physician organizations reserve exclusive control and responsibility for all aspects of the practice of medicine and the delivery of medical services. Although we seek to substantially comply with applicable state prohibitions on the corporate practice of medicine and fee splitting, state officials who administer these laws or other third parties may successfully challenge our existing organization and contractual arrangements. If such a claim were successful, we could be subject to civil and criminal penalties and could be required to restructure or terminate the applicable contractual arrangements. A determination that these arrangements violate state statutes, or our inability to successfully restructure our relationships with our Providers to comply with these statutes, could eliminate Clients located in certain states from the market for our services, which would have a materially adverse effect on our business, financial condition and results of operations.

If our Providers are characterized as employees, we would be subject to employment and withholding liabilities.

We structure our relationships with our Providers in a manner that we believe results in an independent contractor relationship, not an employee relationship. An independent contractor is generally distinguished from an employee by his or her degree of autonomy and independence in providing services. A high degree of autonomy and independence is generally indicative of a contractor relationship, while a high degree of control is generally indicative of an employment

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relationship. Although we believe that our Providers are properly characterized as independent contractors, tax or other regulatory authorities may in the future challenge our characterization of these relationships. If such regulatory authorities or state, federal or foreign courts were to determine that our Providers are employees, and not independent contractors, we would be required to withhold income taxes, to withhold and pay social security, Medicare and similar taxes and to pay unemployment and other related payroll taxes. We would also be liable for unpaid past taxes and subject to penalties. As a result, any determination that our Providers are our employees could have a material adverse effect on our business, financial condition and results of operations.

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

We 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 Clients in connection with commercial disputes or employment claims made by our current or former associates. Litigation may result in substantial costs 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 reducing our revenue and leading analysts or potential investors to reduce their expectations of our performance, which could reduce the market price of our stock.

We will incur significantly increased costs and devote substantial management time as a result of operating as a public company.

As a public company, we will incur significant legal, accounting and other expenses that we do not incur as a private company. For example, we will be subject to the reporting requirements of the Securities Exchange Act of 1934, as amended, or the Exchange Act, and will be required to comply with the applicable requirements of the Sarbanes-Oxley Act and the Dodd-Frank Wall Street Reform and Consumer Protection Act, as well as rules and regulations subsequently implemented by the SEC and the NYSE, including the establishment and maintenance of effective disclosure and financial controls, changes in corporate governance practices and required filing of annual, quarterly and current reports with respect to our business and results of operations. We expect that compliance with these requirements will increase our legal and financial compliance costs and will make some activities more time-consuming and costly. In addition, we expect that our management and other personnel will need to divert attention from operational and other business matters to devote substantial time to these public company requirements. In particular, we expect to incur significant expenses and devote substantial management effort toward ensuring compliance with the requirements of Section 404 of the Sarbanes-Oxley Act, which will increase when we are no longer an emerging growth company. We may also need to hire additional accounting and financial staff with appropriate public company experience and technical accounting knowledge and may need to establish an internal audit function.

We also expect that operating as a public company will make it more expensive for us to obtain director and officer liability insurance, and we may be required to accept reduced coverage or incur substantially higher costs to obtain coverage. This could also make it more difficult for us to attract and retain qualified people to serve on our board of directors, our board committees or as executive officers.

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

We are currently licensed to operate in all fifty states and file state income tax returns in 20 states. There is a risk that certain state tax authorities where we do not currently file a state income

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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 may adversely affect 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 March 31, 2015, we have approximately $65.8 million of federal net operating loss carryforwards available to offset future taxable income which, if not utilized, will begin to expire in 2024. Our ability to utilize NOLs may be currently subject to limitations due to a prior ownership change. In addition, this offering and 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 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.

Our proprietary software may not operate properly, which could damage our reputation, give rise to claims against us or divert application of our resources from other purposes, any of which could harm our business, financial condition and results of operations.

The Teladoc proprietary application platform provides our Members and Providers with the ability to, among other things, register for our services; complete, view and edit medical history; request a visit (either scheduled or on demand) and conduct a visit (via video or phone). 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 applications from operating properly. We are currently implementing software with respect to a number of new applications and services. If our solution does not function reliably or fails to achieve Client expectations in terms of performance, Clients could assert liability claims against us or attempt to cancel their contracts with us. This could damage our reputation and impair our ability to attract or maintain Clients.

Moreover, data services are complex and those we offer have in the past contained, and may in the future develop or contain, undetected defects or errors. Material performance problems, defects or errors in our existing or new software and applications and services may arise in the future and may result from interface of our solution with systems and data that we did not develop and the function of which is outside of our control or undetected in our testing. These defects and errors, and any failure by us to identify and address them, could result in loss of revenue or market share, diversion of development resources, harm to our reputation and increased service and maintenance costs. Defects or errors may discourage existing or potential Clients from purchasing our solution from us. Correction of defects or errors could prove to be impossible or impracticable. The costs incurred in correcting any defects or errors may be substantial and could have a material adverse effect on our business, financial condition and results of operations.

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In order to support the growth of our business, we may need to incur additional indebtedness under our current credit facilities 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, develop new applications and services, enhance our existing solution and services, enhance our operating infrastructure and potentially acquire complementary businesses and technologies. For the three months ended March 31, 2014 and 2015, our net cash used in operating activities was $2.2 million and $10.3 million, respectively. For the years ended December 31, 2013 and 2014, our net cash used in operating activities was $6.1 million and $11.4 million, respectively. As of March 31, 2015, we had $32.1 million of cash and cash equivalents, which are held for working capital purposes. As of March 31, 2015, we had borrowings of $22.5 million under our credit facilities and the ability to borrow up to an additional $7.3 million. Borrowings under our credit facilities are secured by substantially all of our properties, rights and assets. Additionally, the credit agreements governing our credit facilities contain certain customary restrictive covenants that limit our ability to incur additional indebtedness and liens, merge with other companies or consummate certain changes of control, acquire other companies, engage in new lines of business, make certain investments, pay dividends and transfer or dispose of assets as well as a financial covenant that requires us to maintain a specified level of recurring revenue growth. These covenants could limit our ability to seek capital through the incurrence of new indebtedness or, if we are unable to meet our recurring revenue growth obligation, require us to repay any outstanding amounts with sources of capital we may otherwise use to fund our business, operations and strategy.

Our future capital requirements may be significantly different from our current estimates and will depend on many factors, including our growth rate, subscription renewal activity, the timing and extent of spending to support development efforts, the expansion of sales and marketing activities, the introduction of new or enhanced services and the continuing market acceptance of telehealth. 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. 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, 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 have a material adverse effect on our business, financial condition and results of operations.

Failure to adequately expand our direct sales force will impede our growth.

We believe that our future growth will depend on the continued development of our direct sales force and its ability to obtain new Clients and to manage our existing client base. Identifying and recruiting qualified personnel and training them requires significant time, expense and attention. It can take six months or longer before a new sales representative is fully trained and productive. Our business may be adversely affected if our efforts to expand and train our direct sales force do not generate a corresponding increase in revenue. In particular, if we are unable to hire and develop sufficient numbers of productive direct sales personnel or if new direct sales personnel are unable to achieve desired productivity levels in a reasonable period of time, sales of our services will suffer and our growth will be impeded.

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We may be unable to successfully execute on our growth initiatives, business strategies or operating plans.

We are continually executing a number of growth initiatives, strategies and operating plans designed to enhance our business. For example, we recently entered into new specialist healthcare professional markets as well as into B2C markets. The anticipated benefits from these efforts are based on several assumptions that may prove to be inaccurate. Moreover, 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. A variety of risks could cause us not to realize some or all of the expected benefits. These risks include, among others, delays in the anticipated timing of activities related to such growth initiatives, strategies and operating plans, increased difficulty and cost in implementing these efforts, including difficulties in complying with new regulatory requirements and the incurrence of other unexpected costs associated with operating the business. Moreover, our continued implementation of these programs may disrupt our operations and performance. As a result, we cannot assure you that we will realize these benefits. If, for any reason, the benefits we realize are less than our estimates or the implementation of these growth initiatives, strategies and operating plans adversely affect 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 materially adversely affected.

Our use and disclosure of personally identifiable information, including health information, is subject to federal and state privacy and security regulations, and our failure to comply with those regulations or to adequately secure the information we hold could result in significant liability or reputational harm and, in turn, a material adverse effect on our client base, membership base and revenue.

Numerous state and federal laws and regulations govern the collection, dissemination, use, privacy, confidentiality, security, availability and integrity of personally identifiable information, or PII, including protected health information, or PHI. These laws and regulations include the Health Information 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 (referred to collectively as HIPAA). HIPAA establishes a set of basic national privacy and security standards for the protection of PHI by health plans, healthcare clearinghouses and certain healthcare providers, referred to as covered entities, and the business associates with whom such covered entities contract for services, which includes us.

HIPAA requires healthcare providers like us to develop and maintain policies and procedures with respect to PHI that is used or disclosed, including the adoption of administrative, physical and technical safeguards to protect such information. HIPAA also implemented the use of standard transaction code sets and standard identifiers that covered entities must use when submitting or receiving certain electronic healthcare transactions, including activities associated with the billing and collection of healthcare claims.

HIPAA imposes mandatory penalties for certain violations. Penalties for violations of HIPAA and its implementing regulations start at $100 per violation and are not to exceed $50,000 per violation, subject to a cap of $1.5 million for violations of the same standard in a single calendar year. However, a single breach incident can result in violations of multiple standards. HIPAA also authorizes state attorneys general to file suit on behalf of their residents. Courts will be able to award damages, costs and attorneys' fees related to violations of HIPAA in such cases. 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.

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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. 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 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. 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.

Numerous other federal and state laws protect the confidentiality, privacy, availability, integrity and security of PII, including PHI. These laws 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 Clients and potentially exposing us to additional expense, adverse publicity and liability.

New health information standards, whether implemented pursuant to HIPAA, congressional action or otherwise, could have a significant effect on the manner in which we must handle healthcare related data, and the cost of complying with standards could be significant. If we do not comply with existing or new laws and regulations related to PHI, we could be subject to criminal or civil sanctions.

Because of the extreme sensitivity of the PII we store and transmit, the security features of our technology platform are very important. If our security measures, some of which are managed by third parties, are breached or fail, unauthorized persons may be able to obtain access to sensitive Client and Member data, including HIPAA-regulated PHI. As a result, our reputation could be severely damaged, adversely affecting Client and Member confidence. Members may curtail their use of or stop using our services or our client base could decrease, which would cause our business to suffer. In addition, we could face litigation, damages for contract breach, penalties and regulatory actions for violation of HIPAA and other applicable laws or regulations and significant costs for remediation, notification to individuals and for measures to prevent future occurrences. Any potential security breach could also result in increased costs associated with liability for stolen assets or information, repairing system damage that may have been caused by such breaches, incentives offered to Clients or other business partners 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. While we maintain insurance covering certain security and privacy damages and claim expenses in the amount of $5.0 million per claim, we may not carry insurance or maintain coverage sufficient to compensate for all liability and in any event, insurance coverage would not address the reputational damage that could result from a security incident.

We outsource important aspects of the storage and transmission of Client and Member information, and thus rely on third parties to manage functions that have material cyber-security risks. We attempt to address these risks by requiring outsourcing subcontractors who handle Client and Member information to sign business associate agreements contractually requiring those subcontractors to adequately safeguard personal health data to the same extent that applies to us and in some cases by requiring such outsourcing subcontractors to undergo third-party security examinations. In addition, we periodically hire third-party security experts to assess and test our

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security posture. However, we cannot assure you that these contractual measures and other safeguards will adequately protect us from the risks associated with the storage and transmission of Client and Members' proprietary and protected health information.

We also publish statements to our Members that describe how we handle and protect personal information. 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 deceptive practices, which could lead to significant liabilities and consequences, including, without limitation, costs of responding to investigations, defending against litigation, settling claims and complying with regulatory or court orders.

We also send SMS text messages to potential end users who are eligible to use our service through certain customers and partners. While we obtain consent from or on behalf of these individuals to 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 SMS texting practices, are not adequate. These 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 the past year against companies who conduct SMS texting programs, with many resulting in multi-million dollar settlements to the plaintiffs. Any future such litigation against us could be costly and time-consuming to defend.

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

Our quarterly results of operations, including our revenue, gross margin, net loss and cash flows, has 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 may fluctuate 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 large Clients, including through acquisitions or consolidations of such Clients;
- seasonal and other variations in the timing of the sales of our services, as a significantly higher proportion of our Clients enter into new subscription contracts with us or renew their existing contracts in the third and fourth quarters of the year compared to the first and second quarters;
- seasonal and other variations in the timing of the sales of our services, as a significantly higher proportion of our Members use our services during peak cold and flu season months;
- the timing of recognition of revenue, including possible delays in the recognition of revenue due to sometimes unpredictable implementation timelines;
- the amount and timing of operating expenses related to the maintenance and expansion of our business, operations and infrastructure;
- 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 or any other change in the competitive dynamics of our industry, including consolidation among competitors, Clients or strategic partners;
- Client renewal rates and the timing and terms of Client renewals;
- the mix of applications and services sold during a period; 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.

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We are particularly subject to fluctuations in our quarterly results of operations because the costs associated with entering into Client contracts are generally incurred up front, while we generally recognize revenue over the term of the contract. Further, most of our revenue in any given quarter is derived from contracts entered into with our Clients during previous quarters. Consequently, a decline in new or renewed contracts in any one quarter may not be fully reflected in our revenue for that quarter. Such declines, however, would negatively affect our revenue in future periods and the effect of significant downturns in sales of and market demand for our solution, and potential changes in our rate of renewals or renewal terms, may not be fully reflected in our results of operations until future periods. Our subscription model also makes it difficult for us to rapidly increase our total revenue through additional sales in any period, with the exception of the first quarter during peak benefits enrollment, as revenue from new Clients must be recognized over the applicable term of the contract. Accordingly, the effect of changes in the industry impacting our business or changes we experience in our new sales may not be reflected in our short-term results of operations. 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 fail to manage our growth effectively, our expenses could increase more than expected, our revenue may not increase 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 95 full-time employees at December 31, 2013 to 222 full-time employees at December 31, 2014 and 259 full-time employees at March 31, 2015. We have also more than doubled our client and membership bases 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. 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 solution satisfactorily with respect to both large and demanding Clients, who currently constitute the substantial majority of our client base, as well as smaller Clients who are becoming an increasingly larger portion of our client base. Large Clients 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 implement our solution to our Clients in a timely manner. We may also need to make further investments in our technology and automate portions of our solution or services to decrease our costs. If we are unable to address the needs of our Clients or Members, or our Clients or Members are unsatisfied with the quality of our solution or services, they may not renew their contracts, seek to cancel or terminate their relationship with us or renew on less favorable terms, any of which could cause our annual net dollar retention rate to decrease.

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, systems 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. Our growth is expected to require significant capital expenditures and may divert financial resources from other projects such as the development of new applications and services. If our management is unable to effectively manage our growth, our expenses may increase more than expected, our revenue may not increase or may grow more slowly than expected and we may be unable to implement our

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business strategy. The quality of our services may also suffer, which could negatively affect our reputation and harm our ability to attract and retain Clients.

We incur significant upfront costs in our Client relationships, and if we are unable to maintain and grow these Client relationships over time, we are likely to fail to recover these costs, which could have a material adverse effect on our business, financial condition and results of operations.

We derive most of our revenue from subscription access fees. Accordingly, our business model depends heavily on achieving economies of scale because our initial upfront investment is costly and the associated revenue is recognized on a ratable basis. We devote significant resources to establish relationships with our Clients and implement our solution and related services. This is particularly so in the case of large enterprises that, to date, have comprised a substantial majority of our client base and revenue and often request or require specific features or functions unique to their particular business processes. Accordingly, our results of operations will depend in substantial part on our ability to deliver a successful experience for both Clients and Members and persuade our Clients to maintain and grow their relationship with us over time. Additionally, as our business is growing significantly, our Client acquisition costs could outpace our build-up of recurring revenue, and we may be unable to reduce our total operating costs through economies of scale such that we are unable to achieve profitability. 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 the subscription access fee model, our business, financial condition and results of operations could be materially adversely affected.

If our existing Clients do not continue or renew their contracts with us, renew at lower fee levels or decline to purchase additional applications and services from us, it could have a material adverse effect on our business, financial condition and results of operations.

We expect to derive a significant portion of our revenue from renewal of existing Client contracts and sales of additional applications and services to existing Clients. As part of our growth strategy, for instance, we have recently focused on expanding our services amongst current Clients. As a result, achieving a high annual net dollar retention rate and selling additional applications and services are critical to our future business, revenue growth and results of operations.

Factors that may affect our annual net dollar retention rate and our ability to sell additional applications and services include, but are not limited to, the following:

- the price, performance and functionality of our solution;
- the availability, price, performance and functionality of competing solutions;
- our ability to develop and sell complementary applications and services;
- the stability, performance and security of our hosting infrastructure and hosting services;
- changes in healthcare laws, regulations or trends; and
- the business environment of our Clients and, in particular, headcount reductions by our Clients.

We enter into subscription access contracts with our Clients. These contracts generally have stated initial terms of one year. Most of our Clients have no obligation to renew their subscriptions for our solution after the initial term expires. In addition, our Clients may negotiate terms less advantageous to us upon renewal, which may reduce our revenue from these Clients and may decrease our annual net dollar retention rate. Our future results of operations also depend, in part, on our ability to expand into new clinical specialties and across care settings and use cases. If our Clients fail to renew their contracts, renew their contracts upon less favorable terms or at lower fee levels or fail to purchase new products and services from us, our revenue may decline or our future revenue growth may be constrained.

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In addition, after the initial contract year, a significant number of our Client contracts allow Clients to terminate such agreements for convenience at certain times, typically with one to three months advance notice. We typically incur the expenses associated with integrating a Client's data into our healthcare database and related training and support prior to recognizing meaningful revenue from such Client. Subscription access revenue is not recognized until our products are implemented for launch, which is generally from one to three months from contract signing. If a Client terminates its contract early and revenue and cash flows expected from a Client are not realized in the time period expected or not realized at all, our business, financial condition and results of operations could be adversely affected.

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

The sales cycle for our solution from initial contact with a potential lead to contract execution and implementation, varies widely by Client, ranging from a number of days to approximately 24 months. Some of our Clients undertake a significant and prolonged evaluation process, including to determine whether our services meet their unique healthcare needs, which frequently involves evaluation of not only our solution but also an evaluation of those of our competitors, which has in the past resulted in extended sales cycles. Our sales efforts involve educating our Clients about the use, technical capabilities and potential benefits of our solution. Moreover, our large enterprise Clients often begin to deploy our solution on a limited basis, but nevertheless demand extensive configuration, integration services and pricing concessions, which increase our upfront investment in the sales effort with no guarantee that these Clients will deploy our solution widely enough across their organization to justify our substantial upfront investment. It is possible that in the future we may experience even longer sales cycles, more complex Client needs, higher upfront sales costs and less predictability in completing some of our sales as we continue to expand our direct sales force, expand into new territories and market additional applications and services. If our sales cycle lengthens or our substantial upfront sales and implementation investments do not result in sufficient sales to justify our investments, it could have a material adverse effect on our business, financial condition and results of operations.

We operate in a competitive industry, and if we are not able to compete effectively, our business, financial condition and results of operations will be harmed.

While the telehealth market is in an early stage of development, it is competitive and we expect it to attract increased competition, which could make it difficult for us to succeed. We currently face competition in the telehealth industry for our solution from a range of companies, including specialized software and solution providers that offer similar solutions, often at substantially lower prices, and that are continuing to develop additional products and becoming more sophisticated and effective. These competitors include MDLIVE, Inc., American Well Corporation and Doctor on Demand, Inc. In addition, large, well-financed health plans have in some cases developed their own telehealth tools and may provide these solutions to their customers at discounted prices. Competition from specialized software and solution providers, health plans and other parties will result in continued pricing pressures, which is likely to lead to price declines in certain product segments, which could negatively impact our sales, profitability and market share.

Some of our competitors may have greater name recognition, longer operating histories and significantly greater resources than we do. Further, 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 addition, current and potential competitors have established, and may in the future establish, cooperative relationships with vendors of complementary products, technologies or services to increase the availability of their solutions in the marketplace.

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Accordingly, new competitors or alliances may emerge that have greater market share, a larger customer 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 telehealth market, which could create additional price pressure. In light of these factors, even if our solution is more effective than those of our competitors, current or potential Clients may accept competitive solutions in lieu of purchasing our solution. If we are unable to successfully compete in the telehealth market, our business, financial condition and results of operations could be materially adversely affected.

If we cannot implement our solution for Clients or resolve any technical issues in a timely manner, we may lose Clients and our reputation may be harmed.

Our Clients utilize a variety of data formats, applications and infrastructure and our solution must support our Clients' data formats and integrate with complex enterprise applications and infrastructures. If our platform does not currently support a Client's required data format or appropriately integrate with a Client's applications and infrastructure, then we must configure our platform to do so, which increases our expenses. Additionally, we do not control our Clients' implementation schedules. As a result, if our Clients do not allocate the internal resources necessary to meet their implementation responsibilities or if we face unanticipated implementation difficulties, the implementation may be delayed. If the Client implementation process is not executed successfully or if execution is delayed, we could incur significant costs, Clients could become dissatisfied and decide not to increase utilization of our solution or not to implement our solution beyond an initial period prior to their term commitment or, in some cases, revenue recognition could be delayed. In addition, competitors with more efficient operating models with lower implementation costs could jeopardize our Client relationships.

Our Clients and Members depend on our support services to resolve any technical issues relating to our solution and services, and we may be unable to respond quickly enough to accommodate short-term increases in Member demand for support services, particularly as we increase the size of our client and membership bases. We also may be unable to modify the format of our support services to compete with changes in support services provided by competitors. It is difficult to predict Member demand for technical support services, and if Member demand increases significantly, we may be unable to provide satisfactory support services to our Members. Further, if we are unable to address Members' needs in a timely fashion or further develop and enhance our solution, or if a Client or Member is not satisfied with the quality of work performed by us or with the technical support services rendered, then we could incur additional costs to address the situation or be required to issue credits or refunds for amounts related to unused services, and our profitability may be impaired and Clients' dissatisfaction with our solution could damage our ability to expand the number of applications and services purchased by such Clients. These Clients may not renew their contracts, seek to terminate their relationship with us or renew on less favorable terms. Moreover, negative publicity related to our Client relationships, regardless of its accuracy, may further damage our business by affecting our reputation or ability to compete for new business with current and prospective Clients. If any of these were to occur, our revenue may decline and our business, financial condition and results of operations could be adversely affected.

We depend on our senior management team, and the loss of one or more of our executive officers or key employees or an inability to attract and retain highly skilled employees could adversely affect our business.

Our success depends largely upon the continued services of our key executive officers. These executive officers are at-will employees and therefore they may terminate employment with us at any time with no advance notice. We maintain "key person" insurance in the amount of $4.0 million for Jason Gorevic, our Chief Executive Officer, but not for any of our other executive officers or any

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of our other key employees. We also 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.

To continue to execute our growth strategy, we also must attract and retain highly skilled personnel. Competition is intense for qualified professionals. 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.

In addition, in making employment decisions, particularly in high-technology industries, job candidates often consider the value of the stock options or other equity instruments they are to receive in connection with their employment. Volatility in the price of our stock may, therefore, adversely affect our ability to attract or retain highly skilled personnel. Further, the requirement to expense stock options and other equity instruments may discourage us from granting the size or type of stock option or equity awards that job candidates require to join our company. Failure to attract new personnel or failure to retain and motivate our current personnel, could have a material adverse effect on our business, financial condition and results of operations.

If we fail to develop widespread brand awareness cost-effectively, our business may suffer.

We believe that developing and maintaining widespread awareness of our brand in a cost-effective manner is critical to achieving widespread adoption of our solution and attracting new Clients. Our brand promotion activities may not generate Client awareness or increase revenue, and even if they do, any increase in revenue may not offset the expenses we incur in building our brand. If we fail to successfully promote and maintain our brand, or incur substantial expenses in doing so, we may fail to attract or retain Clients necessary to realize a sufficient return on our brand-building efforts or to achieve the widespread brand awareness that is critical for broad Client adoption of our solution.

Our marketing efforts depend significantly on our ability to receive positive references from our existing Clients.

Our marketing efforts depend significantly on our ability to call upon our current Clients to provide positive references to new, potential Clients. Given our limited number of long-term Clients, the loss or dissatisfaction of any Client could substantially harm our brand and reputation, inhibit widespread adoption of our solution and impair our ability to attract new Clients and maintain existing Clients. Any of these consequences could lower our annual net dollar retention rate and have a material adverse effect on our business, financial condition and results of operations.

Any failure to protect our intellectual property rights could impair our ability to protect our technology and our brand.

Our success depends in part on our ability to enforce our intellectual property and other proprietary rights. We rely upon a combination of trademark and trade secret laws, as well as license and access agreements and other contractual provisions, to protect our intellectual property and other proprietary rights. In addition, we attempt to protect our intellectual property and proprietary information by requiring our employees, consultants and certain of our contractors to execute confidentiality and assignment of inventions agreements. These laws, procedures and restrictions provide only limited protection and any of our intellectual property rights may be challenged, invalidated, circumvented, infringed or misappropriated. To the extent that our

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intellectual property and other proprietary rights are not adequately protected, third parties may gain access to our proprietary information, develop and market solutions similar to ours or use trademarks similar to ours, each of which could materially harm our business. Unauthorized parties may also attempt to copy or obtain and use our technology to develop applications with the same functionality as our solution, and policing unauthorized use of our technology and intellectual property rights is difficult and may not be effective. The failure to adequately protect our intellectual property and other proprietary rights could have a material adverse effect on our business, financial condition and results of operations.

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 have a material adverse effect on our business, financial condition and results of operations.

We may in the future seek to acquire or invest in businesses, applications and services or technologies that we believe could complement or expand our solution, enhance our technical capabilities or otherwise offer growth opportunities. 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.

In addition, we have limited experience in acquiring other businesses. 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;
- 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;
- difficulty converting the clients of the acquired business onto our platform and contract terms, including disparities in the revenue, licensing, support or professional services model of the acquired company;
- diversion of management's attention from other business concerns;
- adverse effects to our existing business relationships with business partners and Clients as a result of the acquisition;
- the potential loss of key employees;
- use of resources that are needed in other parts of our business; and
- use of substantial portions of our available cash to consummate the acquisition.

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 adversely affect our results of operations.

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Acquisitions could also result in dilutive issuances of equity securities or the incurrence of debt, which could adversely affect our results of operations. In addition, if an acquired business fails to meet our expectations, our business, financial condition and results of operations may suffer.

Taxing authorities may successfully assert that we should have collected or in the future should collect sales and use or similar taxes which could adversely affect our results of operations.

We do not collect sales and use and similar taxes in any states 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. Such tax assessments, penalties and interest or future requirements may adversely affect our results of operations.

Economic uncertainties or downturns in the general economy or the industries in which our Clients operate could disproportionately affect the demand for our solution and negatively impact our results of operations.

General worldwide economic conditions have experienced significant downturns during the last ten years, and market volatility and uncertainty remain widespread, making it potentially very difficult for our Clients and us to accurately forecast and plan future business activities. During challenging economic times, our Clients may have difficulty gaining timely access to sufficient credit or obtaining credit on reasonable terms, which could impair their ability to make timely payments to us and adversely affect our revenue. If that were to occur, our financial results could be harmed. Further, challenging economic conditions may impair the ability of our Clients to pay for the applications and services they already have purchased from us and, as a result, our write-offs of accounts receivable could increase. We cannot predict the timing, strength or duration of any economic slowdown or recovery. If the condition of the general economy or markets in which we operate worsens, our business could be harmed.

The estimates of market opportunity and forecasts of market growth included in this prospectus 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. The estimates and forecasts in this prospectus relating to the size and expected growth of the telehealth market may prove to be inaccurate. Even if the market in which we compete meets 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 may be harmed or rendered inoperable by natural or man-made disasters, including earthquakes, power outages, fires, floods, nuclear disasters and acts of terrorism or other criminal activities, which may render it difficult or impossible for us to operate our business for some period of time. For example, our headquarters are located in the greater New York City area, a region with a history of terrorist attacks and hurricanes. 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 a $1.0 million insurance policy covering damage to property we rent and have an additional $2.0 million of coverage under our general

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insurance policy, such insurance may not be sufficient to compensate for losses that may occur. Any such losses or damages could have a material adverse effect on our business, financial condition and results of operations. In addition, our Clients' facilities may be harmed or rendered inoperable by such natural or man-made disasters, which may cause disruptions, difficulties or material adverse effects on our business.

Future sales to Clients outside the United States or with international operations may expose us to risks inherent in international sales that, if realized, could adversely affect our business.

We may in the future expand internationally. Operating in international markets requires significant resources and management attention and will subject us to regulatory, economic and political risks that are different from those in the United States. Because of our limited experience with international operations, our international expansion efforts may not be successful in creating demand for our products and services outside of the United States or in effectively selling our solutions in the international markets we enter. In addition, we will face risks in doing business internationally that could adversely affect our business, including, but not limited to, the following:

- the need to localize and adapt our solutions for specific countries, including translation into foreign languages and associated expenses;
- data privacy laws that require that Client data be stored and processed in a designated territory;
- difficulties in staffing and managing foreign operations;
- different pricing environments, longer sales cycles and longer accounts receivable payment cycles and collections issues;
- new and different sources of competition;
- weaker protection for intellectual property and other legal rights than in the United States and practical difficulties in enforcing intellectual property and other rights outside of the United States;
- laws and business practices favoring local competitors;
- compliance challenges related to the complexity of multiple, conflicting and changing governmental laws and regulations, including employment, healthcare, tax, privacy and data protection laws and regulations;
- increased financial accounting and reporting burdens and complexities;
- restrictions on the transfer of funds;
- adverse tax consequences; and
- unstable regional economic and political conditions.

If we denominate our international contracts in local currencies, fluctuations in the value of the U.S. dollar and foreign currencies may impact our results of operations when translated into U.S. dollars.

Risks Related to this Offering and Ownership of Our Common Stock

After this offering, our executive officers, directors and principal stockholders, if they choose to act together, will continue to retain significant voting power.

Upon the closing of this offering, our executive officers, directors and stockholders who owned more than 5% of our outstanding common stock before this offering and their respective affiliates

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will, in the aggregate, hold shares representing approximately 58.2% of our outstanding common stock. As a result, if these stockholders were to choose to act together, they would be able to control or significantly influence all matters submitted to our stockholders for approval, as well as our management and affairs. For example, these persons, if they choose to act together, would control or significantly influence the election of directors and approval of any merger, consolidation or sale of all or substantially all of our assets. This concentration of ownership control may:

- delay, defer or prevent a change in control;
- entrench our management and our board of directors; or
- impede a merger, consolidation, takeover or other business combination involving us that other stockholders may desire.

We have an unremediated material weakness in internal control over financial reporting. Our failure to establish and maintain effective internal control over financial reporting could result in our failure to meet our reporting obligations and cause investors to lose confidence in our reported financial information, which in turn could cause the trading price of our common stock to decline.

In connection with our most recent audit, we identified a material weakness in our internal control over financial reporting. A material weakness is defined as a deficiency, or a combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of our annual or interim financial statements will not be prevented or detected on a timely basis.

The material weakness pertains to the breadth of our internal accounting team. Specifically, we do not have a sufficient number of accounting personnel to effectively design and operate proper internal controls over financial reporting. We are working to remediate the material weakness. We have begun taking steps and plan to take additional measures to remediate the underlying causes of the material weakness, primarily through the continued hiring of additional accounting personnel. The actions that we are taking are subject to ongoing senior management review, as well as audit committee oversight. Although we plan to complete this remediation process as quickly as possible, we cannot at this time estimate how long it will take to fully remediate the material weakness. If our remedial measures are insufficient to address the material weakness, or if significant deficiencies or material weaknesses in our internal control over financial reporting are discovered or occur in the future, it may adversely affect the results of our management evaluations and, when required, annual auditor attestation reports regarding the effectiveness of our internal control over financial reporting required by Section 404 of the Sarbanes-Oxley Act. In addition, if we are unable to successfully remediate the material weakness and if we are unable to produce accurate and timely financial statements or we are required to restate our financial results, our common stock price may be adversely affected and we may be unable to maintain compliance with the NYSE listing requirements.

If you purchase shares of common stock in this offering, you will suffer immediate dilution of your investment.

The initial public offering price of our common stock will be substantially higher than the net tangible book value per share of our common stock. Therefore, if you purchase shares of our common stock in this offering, you will pay a price per share that substantially exceeds our net tangible book value per share after this offering. To the extent shares subsequently are issued under outstanding options or warrants, you will incur further dilution. Based on the initial public offering price of $19.00 per share, you will experience immediate dilution of $15.55 per share,

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representing the difference between our pro forma net tangible book value per share, after giving effect to this offering, and the assumed initial public offering price.

An active trading market for our common stock may not develop.

Prior to this offering, there has been no public market for our common stock. The initial public offering price for our common stock will be determined through negotiations with the underwriters. Although we have been approved for listing of our common stock on the NYSE, an active trading market for our common stock may never develop or be sustained following this offering. If an active market for our common stock does not develop, it may be difficult for you to sell the shares of our common stock you purchase in this offering without depressing the market price for our common stock or at all.

The price of our common stock may be volatile and fluctuate substantially, which could result in substantial losses for purchasers of our common stock in this offering.

Our stock price is likely to be volatile. The stock market has experienced extreme volatility that has often been unrelated to the operating performance of particular companies. As a result of this volatility, you may not be able to sell your common stock at or above the initial public offering price. The market price for our common stock may be influenced by many factors, including, but not limited to:

- the success of competitive products or technologies;
- developments related to our existing or any future collaborations;
- regulatory or legal developments in the United States and other countries;
- developments or disputes concerning our intellectual property or other proprietary rights;
- the recruitment or departure of key personnel;
- actual or anticipated changes in estimates as to financial results, development timelines or recommendations by securities analysts;
- variations in our financial results or those of companies that are perceived to be similar to us;
- changes in the structure of healthcare payment systems;
- general economic, industry and market conditions; and
- the other factors described in this "Risk Factors" section.

We have broad discretion in the use of the net proceeds from this offering and may not use them effectively.

Our management and board of directors will have broad discretion in the application of the net proceeds from this offering and could spend the proceeds in ways that do not improve our results of operations or enhance the value of our common stock. You may not agree with our decisions, and our use of the proceeds may not yield any return on your investment. We intend to use the net proceeds of this offering for working capital and general corporate purposes, including to expand our current business through acquisitions of, or investments in, other businesses, products or technologies. However, we have no commitments with respect to any such acquisitions or investments at this time, and our use of these proceeds may differ substantially from our current plans. The failure by our management to apply these funds effectively could

result in financial losses that could have a material adverse effect on our business, cause the price of our common stock to decline and delay the development of our new applications and services. Pending their

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use, we may invest the net proceeds from this offering in a manner that does not produce income or that loses value. You will not have the opportunity to influence our decision on how to use our net proceeds from this offering.

A significant portion of our total outstanding shares are eligible to be sold into the market in the near future, which 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, or the perception in the market that the holders of a large number of shares intend to sell shares, could reduce the market price of our common stock. After this offering, we will have outstanding 37,046,346 shares of common stock based on the number of shares outstanding as of June 17, 2015. This includes the shares that we are selling in this offering, which may be resold in the public market immediately without restriction, unless purchased by our affiliates or existing stockholders. Substantially all of the remaining 28,796,346 shares are currently restricted as a result of securities laws or lock-up agreements but will become eligible to be sold at various times beginning 180 days after this offering. Moreover, after this offering, holders of an aggregate of approximately 28,796,346 shares of our common stock will have rights, subject to specified conditions, to require us to file registration statements covering their shares or to include their shares in registration statements that we may file for ourselves or other stockholders. We also intend to register all shares of common stock that we may issue under our equity compensation plans. Once we register these shares, they can be freely sold in the public market upon issuance, subject to volume limitations applicable to affiliates and the lock-up agreements described in the "Underwriting" section of this prospectus.

We are an "emerging growth company," and the reduced disclosure requirements applicable to emerging growth companies may make our common stock less attractive to investors.

We are an "emerging growth company," as defined in the JOBS Act and may remain an emerging growth company for up to five years. For so long as we remain an emerging growth company, we are permitted and intend to rely on exemptions from certain disclosure requirements that are applicable to other public companies that are not emerging growth companies. These exemptions include:

- being permitted to present only two years of audited financial statements and only two years of related Management's Discussion and Analysis of Financial Condition and Results of Operations in this prospectus;
- not being required to comply with the auditor attestation requirements of Section 404 of the Sarbanes-Oxley Act, in the assessment of our internal control over financial reporting;
- reduced disclosure obligations regarding executive compensation in our periodic reports, proxy statements and registration statements; and
- exemption from the requirements of holding a nonbinding advisory vote on executive compensation and obtaining stockholder approval of any golden parachute payments not previously approved.

We have taken advantage of reduced reporting burdens in this prospectus. In particular, in this prospectus, we have provided only two years of audited financial statements and have not included all of the executive compensation related information that would be required if we were not an emerging growth company. We cannot predict whether investors will find our common stock less attractive if we rely on these exemptions. If some investors find our common stock less attractive as a result, there may be a less active trading market for our common stock and our stock price may

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be reduced or more volatile. In addition, the JOBS Act provides that an emerging growth company can take advantage of an extended transition period for complying with new or revised accounting standards. This allows an emerging growth company to delay the adoption of these accounting standards until they would otherwise apply to private companies. We have irrevocably elected not to avail ourselves of this exemption and, therefore, we will be subject to the same new or revised accounting standards as other public companies that are not emerging growth companies.

If securities or industry analysts do not publish research or reports about our business, or if they issue an adverse or misleading opinion regarding our stock, our stock price and trading volume could decline.

The trading market for our common stock will be influenced by the research and reports that industry or securities analysts publish about us or our business. We do not currently have and may never obtain research coverage by securities and industry analysts. If no or few securities or industry analysts commence coverage of us, the trading price for our common stock would be negatively impacted. In the event we obtain securities or industry analyst coverage, if any of the analysts who cover us issue an adverse or misleading opinion regarding us, our business model, our intellectual property or our stock performance, or if our results of operations fail to meet the expectations of analysts, our stock price would likely decline. If one or more of these analysts cease coverage of us or fail to publish reports on us regularly, we could lose visibility in the financial markets, which in turn could cause our stock price or trading volume to decline.

Provisions in our amended and restated certificate of incorporation and amended and restated bylaws and under Delaware law could make an acquisition of our company, which may be beneficial to our stockholders, more difficult and may prevent attempts by our stockholders to replace or remove our current management.

Provisions in our amended and restated certificate of incorporation and our amended and restated bylaws that will become effective upon the closing of this offering may discourage, delay or prevent a merger, acquisition or other change in control of our company that stockholders may consider favorable, including transactions in which you might otherwise receive a premium for your shares. These provisions could also limit the price that investors might be willing to pay in the future for shares of our common stock, thereby depressing the market price of our common stock. In addition, because our board of directors is responsible for appointing the members of our management team, 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. Among other things, these provisions include those establishing:

- a classified board of directors with three-year staggered terms, which may delay the ability of stockholders to change the membership of a majority of our board of directors;

- no cumulative voting in the election of directors, which limits the ability of minority stockholders to elect director candidates;

- the exclusive right of our board of directors to elect a director to fill a vacancy created by the expansion of our board of directors or the resignation, death or removal of a director, which prevents stockholders from filling vacancies on our board of directors;

- the ability of our board of directors to authorize the issuance of shares of preferred stock and to determine the terms of those shares, including preferences and voting rights, without stockholder approval, which could be used to significantly dilute the ownership of a hostile acquirer;

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- the ability of our board of directors to alter our amended and restated bylaws without obtaining stockholder approval;

- the required approval of the holders of at least two-thirds of the shares entitled to vote at an election of directors to adopt, amend or repeal our amended and restated bylaws or repeal the provisions of our amended and restated certificate of incorporation regarding the election and removal of directors;

- a prohibition on stockholder action by written consent, which forces stockholder action to be taken at an annual or special meeting of our stockholders;

- the requirement that a special meeting of stockholders be called only by the chairman of our board of directors, the chief executive officer, the president or our board of directors, which may delay the ability of our stockholders to force consideration of a proposal or to take action, including the removal of directors; and

- advance notice procedures that stockholders must comply with in order to nominate candidates to our board of directors or to propose matters to be acted upon at a stockholders' meeting, which may discourage or deter a potential acquirer from conducting a solicitation of proxies to elect the acquirer's own slate of directors or otherwise attempting to obtain control of us.

Moreover, because we are incorporated in Delaware, we are governed by the provisions of Section 203 of the General Corporation Law of the State of Delaware, or the DGCL, which prohibits a person who owns in excess of 15% of our outstanding voting stock from merging or combining with us for a period of three years after the date of the transaction in which the person acquired in excess of 15% of our outstanding voting stock, unless the merger or combination is approved in a prescribed manner.

Our amended and restated certificate of incorporation provides that the Court of Chancery of the State of Delaware will be the exclusive forum 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 or employees.

Our amended and restated certificate of incorporation provides that the Court of Chancery of the State of Delaware is the exclusive forum for (1) any derivative action or proceeding brought on our behalf, (2) any action asserting a claim of breach of a fiduciary duty or other wrongdoing by any of our directors, officers, employees or agents to us or our stockholders, (3) any action asserting a claim arising pursuant to any provision of the DGCL or our amended and restated certificate of incorporation or amended and restated bylaws, (4) any action to interpret, apply, enforce or determine the validity of our amended and restated certificate of incorporation or amended and restated bylaws or (5) any action asserting a claim governed by the internal affairs doctrine. This choice of forum provision 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 such lawsuits against us and our directors, officers and other employees. Alternatively, if a court were to find the choice of forum provision contained in our amended and restated certificate of incorporation to be inapplicable or unenforceable in an action, we may incur additional costs associated with resolving such action in other jurisdictions, which could have a material adverse effect our business, financial condition or results of operations.

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Because we do not anticipate paying any cash dividends on our capital stock in the foreseeable future, capital appreciation will be your sole source of gain, if any.

We have never declared or paid cash dividends on our capital stock. We currently intend to retain all of our future earnings, if any, to finance the growth and development of our business. Any future debt agreements may preclude us from paying dividends. As a result, capital appreciation, if any, of our common stock will be your sole source of gain for the foreseeable future.

We could be subject to securities class action litigation.

In the past, securities class action litigation has often been brought against a company following a decline in the market price of its securities. If we face such litigation, it could result in substantial costs and a diversion of management's attention and resources, which could have a material adverse effect on our business, financial condition or results of operations.

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SPECIAL NOTE REGARDING FORWARD-LOOKING STATEMENTS

Many statements made in this prospectus that are not statements of historical fact, including statements about our beliefs and expectations, are forward-looking statements and should be evaluated as such. Forward-looking statements include information concerning possible or assumed future results of operations, including descriptions of our business plan and strategies. These statements often include words such as "anticipate," "expect," "suggests," "plan," "believe," "intend," "estimates," "targets," "projects," "should," "could," "would," "may," "will," "forecast," and other similar expressions. These forward-looking statements and projections are contained throughout this prospectus, including the sections entitled "Prospectus Summary," "Risk Factors," "Capitalization," "Management's Discussion and Analysis of Financial Condition and Results of Operations" and "Business." We base these forward-looking statements or projections on our current expectations, plans and assumptions that we have made in light of our experience in the industry, as well as our perceptions of historical trends, current conditions, expected future developments and other factors we believe are appropriate under the circumstances and at such time. As you read and consider this prospectus, you should understand that these statements are not guarantees of performance or results. The forward-looking statements and projections are subject to and involve risks, uncertainties and assumptions and you should not place undue reliance on these forward-looking statements or projections. Although we believe that these forward-looking statements and projections are based on reasonable assumptions at the time they are made, you should be aware that many factors could affect our actual financial results or results of operations and could cause actual results to differ materially from those expressed in the forward-looking statements and projections. Factors that may materially affect such forward-looking statements and projections include, but are not limited to the following:

ongoing legal challenges to or new state actions against our business model;

our dependence on our relationships with affiliated professional entities;

evolving government regulations and our ability to stay abreast of new or modified laws and regulations that currently apply or become applicable to our business;

our ability to operate in the heavily regulated healthcare industry;

our history of net losses and accumulated deficit;

the impact of recent healthcare reform legislation and other changes in the healthcare industry;

risk of the loss of any of our significant Clients;

risks associated with a decrease in the number of individuals offered benefits by our Clients or the number of products and services to which they subscribe;

our ability to establish and maintain strategic relationships with third parties;

our ability to recruit and retain a network of qualified Providers;

risk that the insurance we maintain may not fully cover all potential exposures;

rapid technological change in the telehealth market;

risks associated with a material weakness that has been identified;

the amount of the costs, fees, expenses and charges related to this initial public offering and the related costs of being a public company;

any statements of belief and any statements of assumptions underlying any of the foregoing;

other factors disclosed in this prospectus; and

other factors beyond our control.

These cautionary statements should not be construed by you to be exhaustive and are made only as of the date of this prospectus. We undertake no obligation to update or revise any forward-looking statements, whether as a result of new information, future events or otherwise. You should evaluate all forward-looking statements made in this prospectus in the context of these risks and uncertainties.

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USE OF PROCEEDS

We estimate the proceeds to us from this offering will be approximately $141.6 million, after deducting estimated underwriting discounts and commissions and estimated offering expenses payable by us. If the underwriters' option to purchase additional shares from us is exercised in full, we estimate that we will receive additional net proceeds of $21.9 million.

We intend to use the net proceeds from this offering for working capital and other general corporate purposes, including to expand our current business through acquisitions of, or investments in, other businesses, products or technologies. However, we have no commitments with respect to any such acquisitions or investments at this time.

Our management will have broad discretion in the application of the net proceeds from this offering to us, and investors will be relying on the judgment of our management regarding the application of the proceeds. Pending their use, we plan to invest our net proceeds from this offering in short-term, interest-bearing obligations, investment-grade instruments, certificates of deposit or direct or guaranteed obligations of the U.S. government.

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DIVIDEND POLICY

We have never declared or paid dividends on our common stock. We do not expect to pay dividends on our common stock for the foreseeable future. Instead, we anticipate that all of our earnings, if any, will be used for the operation and growth of our business. Any future determination to declare cash dividends would be subject to the discretion of our board of directors and would depend upon various factors, including our results of operations, financial condition and liquidity requirements, restrictions that may be imposed by applicable law and our contracts and other factors deemed relevant by our board of directors.

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CAPITALIZATION

The following table sets forth our cash and cash equivalents and capitalization as of March 31, 2015, as follows:

- on an actual basis;
- on a pro forma basis to reflect (1) the automatic conversion of all outstanding shares of our preferred stock into 25,450,441 shares of our common stock upon the closing of this offering, (2) the amendment to our fourth amended and restated certificate of incorporation, which was filed with the Secretary of State of the State of Delaware on June 17, 2015, (3) the consummation of our acquisition of StatDoc and (4) the filing of our amended and restated certificate of incorporation upon the closing of this offering, assuming each had occurred on such date; and
- on a pro forma as adjusted basis to give further effect to our issuance and sale of 8,250,000 shares of our common stock in this offering at the initial public offering price of $19.00 per share, after deducting estimated underwriting discounts and commissions and estimated offering expenses payable by us.

Our capitalization following the closing of this offering will be adjusted based on the actual initial public offering price and other terms of this offering determined at pricing. You should read this information in conjunction with our audited consolidated financial statements and the related notes appearing at the end of this prospectus and the "Management's Discussion and Analysis of Financial Condition and Results of Operations" section and other financial information contained in this prospectus.

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	As of March 31, 2015		
	Actual	Pro Forma	Pro Forma As Adjusted
	(in thousands, except par value and share data)		
Cash and cash equivalents	$ 32,060	$ 18,782	$ 160,410
Long-term bank and other debt	$ 25,054	$ 25,054	$ 25,054
Convertible preferred stock, $0.001 par value per share; 50,479,286 shares authorized, 50,452,939 shares issued and outstanding, actual; 1,000,000 shares authorized, no shares issued or outstanding, pro forma and pro forma as adjusted; aggregate liquidation value of $117,914 as of March 31, 2015	117,914		
Redeemable common stock, $0.001 par value: 113,294 common shares issued and outstanding	2,852		
Stockholders' equity(1):			
Common stock, $0.001 par value per share: 32,179,448 shares authorized, 2,060,165 shares issued and outstanding, actual; 75,000,000 shares authorized, pro forma and pro forma as adjusted; 28,796,346 shares issued and outstanding, pro forma; 36,796,346 shares issued and outstanding, pro forma as adjusted	2	29	37
Additional paid in capital	5,792	143,752	285,372
Accumulated deficit	(85,193)	(85,193)	(85,193)
Total stockholders' equity (deficit)	(79,399)	58,588	200,216
Total capitalization	$ 66,421	$ 83,642	$ 225,270

(1) On June 17, 2015, we amended our fourth amended and restated certificate of incorporation to effect a one-for-2.2859 reverse split of our common stock and increase our authorized common stock from 32,179,448 to 75,000,000 (in each case after giving effect to the reverse split of our common stock). Common stock authorized and outstanding, actual, as of March 31, 2015 reflects the reverse stock split.

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DILUTION

If you invest in our common stock, your interest will be diluted to the extent of the difference between the initial public offering price per share and the net tangible book value per share after this offering and the use of proceeds therefrom.

As of March 31, 2015, we had a historical net tangible book value (deficit) of approximately $(1.0) million, or $(0.47) per share. Our historical net tangible book value per share represents total tangible assets less total liabilities divided by the number of shares of common stock outstanding as of March 31, 2015.

Our pro forma net tangible book value (deficit) as of March 31, 2015 was $(14.3) million, or $(0.50) per share, based on shares of our common stock outstanding as of March 31, 2015, after giving effect to the automatic conversion of all outstanding shares of our preferred stock into common stock upon the closing of this offering and the consummation of our acquisition of StatDoc as if it had occurred on such date.

After giving further effect to the sale of 8,250,000 shares of common stock in this offering at the initial public offering price of $19.00 per share, and after deducting estimated underwriting discounts and commissions and estimated offering expenses payable by us, our pro forma as adjusted net tangible book value as of March 31, 2015 would have been approximately $127.3 million, or approximately $3.45 per share. This amount represents an immediate increase in pro forma net tangible book value of $3.95 per share to our existing stockholders and an immediate dilution of approximately $15.55 per share to new investors participating in this offering. We determine dilution by subtracting the pro forma as adjusted net tangible book value per share after this offering from the amount of cash that a new investor paid for a share of common stock. The following table illustrates this dilution:

Assumed initial public offering price per share		$ 19.00
Historical net tangible book value (deficit) per share as of March 31, 2015	$ (0.47)	
Increase (decrease) per share attributable to the conversion of our preferred stock and consummation of acquisition of StatDoc	(0.03)	
Pro forma net tangible book value (deficit) per share as of March 31, 2015	(0.50)	
Increase per share attributable to this offering	3.95	
Pro forma as adjusted net tangible book value per share after this offering		3.45
Dilution per share to new investors in this offering		$ 15.55

If the underwriters exercise their option to purchase additional shares of our common stock in full, the pro forma as adjusted net tangible book value after this offering would be $3.91 per share, the increase in pro forma net tangible book value per share would be $0.46 and the dilution per share to new investors would be $0.46 per share.

The following table summarizes on the pro forma as adjusted basis described above, as of March 31, 2015, the differences between the number of shares purchased from us, the total consideration paid to us in cash and the average price per share that existing stockholders and new investors paid. The calculation below is based on the initial public offering price of $19.00 per

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share, before deducting estimated underwriting discounts and commissions and estimated offering expenses payable by us.

	Shares Purchased		Total Consideration		Average Price Per Share
	Number	Percent	Amount	Percent	
	(in thousands, other than shares and percentages)				
Existing stockholders	28,796,346	77.7%	$ 144,518,717	48.0%	$ 5.02
New investors	8,250,000	22.3	156,750,000	52.0	19.00
Total	37,046,346	100%	$ 301,268,717	100%	

The foregoing tables and calculations are based on the number of shares of our common stock outstanding as of June 17, 2015, after giving effect to the automatic conversion of all outstanding shares of our preferred stock into common stock upon the closing of this offering, and excludes:

- 3,733,279 shares of common stock issuable upon the exercise of options outstanding as of June 17, 2015, at a weighted average exercise price of $5.68 per share; and

- 131,239 shares of common stock issuable upon the exercise of warrants outstanding as of June 17, 2015, at a weighted average exercise price of $2.95 per share.

To the extent any of these outstanding options or warrants is exercised, there will be further dilution to new investors. If all of such outstanding options and warrants had been exercised for cash as of March 31, 2015, the pro forma as adjusted net tangible book value per share after this offering would be $3.65, and total dilution per share to new investors would be $15.35.

If the underwriters exercise their option to purchase additional shares of our common stock in full:

- the percentage of shares of common stock held by existing stockholders will decrease to approximately 75.2% of the total number of shares of our common stock outstanding after this offering; and

- the number of shares held by new investors will increase to 9,487,500, or approximately 24.8% of the total number of shares of our common stock outstanding after this offering.

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SELECTED HISTORICAL FINANCIAL INFORMATION

The following table sets forth our selected historical consolidated financial information. The balance sheet data as of December 31, 2013 and 2014 and the statement of operations and cash flow data for the years ended December 31, 2013 and 2014 have been derived from our audited consolidated financial statements included elsewhere in this prospectus. The balance sheet data as of March 31, 2015 and the statement of operations data for the three months ended March 31, 2014 and 2015 have been derived from our unaudited consolidated financial statements included elsewhere in this prospectus. The balance sheet data as of March 31, 2014 have been derived from our unaudited consolidated financial statements not included in this prospectus. We completed our acquisitions of Consult A Doctor on August 29, 2013, AmeriDoc on May 1, 2014 and BetterHelp on January 23, 2015. The results of operations of Consult A Doctor and AmeriDoc since the respective acquisition dates have been included in our audited consolidated financial statements included elsewhere in this prospectus. The results of operations of Consult A Doctor, AmeriDoc and BetterHelp since the respective acquisition dates have been included in our unaudited consolidated financial statements included elsewhere in this prospectus. You should read the information contained in this table in conjunction with "Capitalization," "Management's Discussion and Analysis of Financial Condition and Results of Operations" and the audited consolidated financial statements and the related notes thereto included elsewhere in this prospectus. The unaudited interim consolidated financial statements have been prepared on the same basis as the audited consolidated financial statements and, in the opinion of our management, include all adjustments, consisting only of normal and recurring adjustments, necessary for a fair presentation of the information set forth herein. Interim financial results are not necessarily indicative of results that may be expected for the full fiscal year, and our historical results are not indicative of the results to be expected in the future.

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	Year Ended December 31,		Three Months Ended March 31,	
	2013	2014	2014	2015
	(dollars in thousands, except share and per share data)			
Consolidated Statements of Operations Data:				
Revenue	$ 19,906	$ 43,528	$ 9,407	$ 16,488
Cost of revenue	4,186	9,929	1,982	5,281
Gross profit	15,720	33,599	7,425	11,207
Operating expenses:				
Advertising and marketing	4,090	7,662	2,518	4,341
Sales	4,441	11,571	2,145	3,682
Technology and development	3,532	7,573	1,192	2,906
General and administrative	8,772	19,623	3,344	11,968
Depreciation and amortization	754	2,320	414	903
Loss from operations	(5,869)	(15,150)	(2,188)	(12,593)
Interest income (expense), net	(56)	(1,499)	(54)	(568)
Net loss before taxes	5,925	(16,649)	(2,242)	(13,161)
Income tax provision (benefit)	94	388	72	(458)
Net loss	$ (6,019)	$ (17,037)	$ (2,314)	(12,703)