UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark One)

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

For the fiscal year ended December 31, 2025

or

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

For the transition period from _____ to _____

Commission file number: 001-31826

Centene Corporation

(Exact name of registrant as specified in its charter)

Delaware		**42-1406317**
(State or other jurisdiction of incorporation or organization)		**(I.R.S. Employer Identification Number)**
7700 Forsyth Boulevard		
St. Louis,	**Missouri**	**63105**
(Address of principal executive offices)		**(Zip Code)**

Registrant's telephone number, including area code: (314) 725-4477

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

Title of Each Class	**Trading Symbol(s)**	**Name of Each Exchange on Which Registered**
Common Stock, $0.001 Par Value	**CNC**	**New York Stock Exchange**

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

None

(Title of Class)

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

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

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

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐	Smaller reporting company	☐
		Emerging growth company	☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

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

If securities are registered pursuant to Section 12(b) of the Act, indicate by check mark whether the financial statement of the registrant included in the filing reflect the correction of an error to the previously issued financial statements. ☐

Indicate by check mark whether any of those error corrections are restatements that required a recovery analysis of incentive-based compensation received by any of the registrant's executive officers during the relevant recovery period pursuant to §240.10D-1(b) ☐

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, based upon the last reported sale price of the common stock on the New York Stock Exchange on June 30, 2025, was $26.7 billion.

As of February 13, 2026, the registrant had 491,771 thousand shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the registrant's 2026 annual meeting of stockholders are incorporated by reference in Part III, Items 10, 11, 12, 13 and 14.

CENTENE CORPORATION
ANNUAL REPORT ON FORM 10-K
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CAUTIONARY STATEMENT ON FORWARD-LOOKING STATEMENTS

All statements, other than statements of current or historical fact, contained in this filing are forward-looking statements. Without limiting the foregoing, forward-looking statements often use words such as "believe," "anticipate," "plan," "expect," "estimate," "predict," "intend," "seek," "target," "goal," "potential," "may," "will," "would," "could," "should," "can," "continue" and other similar words or expressions (and the negative thereof). Centene Corporation and its subsidiaries (Centene, the Company, our or we) intends such forward-looking statements to be covered by the safe-harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe-harbor provisions. In particular, these statements include, without limitation, statements about our expected future operating or financial performance, changes in laws and regulations, market opportunity, expectations concerning pricing actions, competition, expected contract start dates and terms, expected activities in connection with completed and future acquisitions and dispositions, our investments and the adequacy of our available cash resources. These statements may be found in the various sections of this filing, such as Part I, Item 1. "Business," Part I, Item 1A "Risk Factors," Part I, Item 3. "Legal Proceedings," and Part II, Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations."

These forward-looking statements reflect our current views with respect to future events and are based on numerous assumptions and assessments made by us in light of our experience and perception of historical trends, current conditions, business strategies, operating environments, future developments and other factors we believe appropriate. By their nature, forward-looking statements involve known and unknown risks and uncertainties and are subject to change because they relate to events and depend on circumstances that will occur in the future, including economic, regulatory, competitive and other factors that may cause our or our industry's actual results, performance or achievements to be materially different from any future results, performance, or achievements expressed or implied by these forward-looking statements. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions.

All forward-looking statements included in this filing are based on information available to us on the date of this filing. Except as may be otherwise required by law, we undertake no obligation to update or revise the forward-looking statements included in this filing, whether as a result of new information, future events, or otherwise, after the date of this filing. You should not place undue reliance on any forward-looking statements, as actual results may differ materially from projections, estimates, or other forward-looking statements due to a variety of important factors, variables and events including, but not limited to:

- our ability to design and price products that are competitive and/or actuarially sound;
- our ability to accurately predict and effectively manage health benefits and other operating expenses and reserves, including fluctuations in medical costs;
- rate cuts, insufficient rate changes or other payment reductions or delays by government payors affecting our government businesses;
- the effect of social, economic, and political conditions, geopolitical events and state and federal policies, including the amount and terms of state and federal funding for government-sponsored healthcare programs, including as a result of changes in U.S. presidential administrations or Congress;
- changes in federal or state laws or regulations, including changes with respect to income tax reform or government healthcare programs as well as changes with respect to the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act (collectively referred to as the ACA) and any regulations enacted thereunder, including the timing and terms of renewal or modification of the enhanced advance premium tax credits or program integrity initiatives that could have the effect of reducing membership or profitability of our products;
- unanticipated increased healthcare costs, including due to changes in consumer and provider behaviors, inflation and tariffs;
- our ability to maintain or achieve improvement in the Centers for Medicare and Medicaid Services (CMS) Star ratings and maintain or achieve improvement in other quality scores in each case that could impact revenue and future growth;
- competition, including for providers, broker distribution networks, contract reprocurements and organic growth;
- our ability to adequately anticipate demand and timely provide for operational resources to maintain service level requirements in compliance with the terms of our contracts and state and federal regulations;
- our ability to comply with the terms of our contracts and state and federal regulations and our ability to effectively oversee our third-party vendors to comply with the terms of their contracts with us and state and federal regulations;
- our ability to manage our information systems effectively;
- disruption, unexpected costs, or similar risks from business transactions, including acquisitions, divestitures, and changes in our relationships with third-party vendors;
- impairments to real estate, investments, goodwill and intangible assets;
- changes in senior management, loss of one or more key personnel or an inability to attract, hire, integrate and retain skilled personnel;
- membership and revenue declines or unexpected trends;

- changes in healthcare practices, new technologies, and advances in medicine;
- our ability to effectively and ethically use artificial intelligence and machine learning in compliance with applicable laws;
- changes in macroeconomic conditions, including inflation, interest rates and volatility in the financial markets;
- negative public perception of the Company and the managed care industry;
- uncertainty concerning government shutdowns, debt ceilings or funding;
- tax matters;
- disasters, climate-related incidents, acts of war or aggression or major epidemics;
- changes in expected contract start dates and terms;
- changes in provider, broker, vendor, state federal and other contracts and delays in the timing of regulatory approval of contracts, including due to protests and our ability to timely comply with any such changes to our contractual requirements or manage any unexpected delays in regulatory approval of contracts;
- the expiration, suspension, or termination of our contracts with federal or state governments (including, but not limited to, Medicaid, Medicare or other customers);
- the difficulty of predicting the timing or outcome of legal or regulatory audits, investigations, proceedings or matters including, but not limited to, our ability to resolve claims and/or allegations on acceptable terms, or at all, or whether additional claims, reviews or investigations will be brought;
- challenges to our contract awards;
- cyber-attacks or other data security incidents or our failure to comply with applicable privacy, data or security laws and regulations;
- the exertion of management's time and our resources, and other expenses incurred and business changes required in connection with complying with the terms of our contracts and the undertakings in connection with any regulatory, governmental, or third-party consents or approvals for acquisitions or dispositions;
- any changes in expected closing dates, estimated purchase price, or accretion for acquisitions or dispositions;
- losses in our investment portfolio;
- restrictions and limitations in connection with our indebtedness;
- a downgrade of our corporate family rating, issuer rating or credit rating of our indebtedness; and
- the availability of debt and equity financing on terms that are favorable to us.

This list of important factors is not intended to be exhaustive. We discuss certain of these matters more fully, as well as certain other factors that may affect our business operations, financial condition, and results of operations, in our filings with the Securities and Exchange Commission (SEC), including our quarterly reports on Form 10-Q and current reports on Form 8-K. Due to these important factors and risks, we cannot give assurances with respect to our future performance, including without limitation our ability to maintain adequate premium levels or our ability to control our future medical and selling, general and administrative costs.

SUMMARY OF RISK FACTORS

Our business is subject to numerous risks and uncertainties that you should be aware of in evaluating our business, including risks that may prevent us from achieving our business objectives or may adversely affect our business, financial condition, results of operations, cash flows and prospects. These risks include, but are not limited to, the following, all of which are more fully described in Part 1, Item 1A "Risk Factors". This summary should be read in conjunction with the Risk Factors section and should not be relied upon as an exhaustive summary of the material risks facing our business.

Risks Relating to Our Business

- Failure to timely and effectively identify and mitigate medical cost trends and receive adequate rate adjustments to account for increased acuity could have a material adverse effect on our business;
- Any failure to adequately and timely price or anticipate demand for products offered, anticipate changes to the competitive landscape or any reduction in products offered for Medicare and in the Health Insurance Marketplace may have a material adverse effect on our business;
- Our Medicare programs are subject to a variety of unique risks that could adversely impact our financial results;
- Risk-adjustment payment systems make our revenue and results of operations more difficult to estimate and could result in retroactive adjustments that have a material adverse effect on our business;
- If we are not successful in procuring new government contracts or renewing existing government contracts, or if we receive an adverse finding or review resulting from an audit or investigation, our business may be adversely affected;
- We derive a portion of our cash flow and gross margin from our prescription drug plan (PDP) operations, for which we submit annual bids for participation. The results of our bids and the design of the risk-sharing program could have a material adverse effect on our business;
- Increases in our pharmaceutical costs could have a material adverse effect on the level of our medical costs and our results of operations;
- Ineffectiveness of state-operated systems and subcontractors could adversely affect our business;
- Our encounter data may be inaccurate or incomplete, which could have a material adverse effect on our business and ability to bid for, and continue to participate in, certain programs;
- If state regulators do not approve payments of dividends and distributions by our subsidiaries to us, we may not have sufficient funds to implement our business strategy;
- We derive a significant portion of our premium revenues from operations in a number of states, and our business could be materially adversely affected by a decrease in premium revenues or profitability in any one of those states;
- Competition may limit our ability to increase penetration of the markets that we serve;
- We operate in a highly competitive, dynamic and rapidly evolving industry and our failure to adapt could negatively impact our business;
- If we are unable to maintain relationships with our provider networks and timely update our provider directories, our profitability may be materially adversely affected;
- If our third-party vendors fail to meet their contractual obligations to us or fail to comply with applicable laws or regulations, our results of operations may be adversely affected and we may be exposed to brand and reputational harm, litigation and/or regulatory action;
- If we or our third-party vendors are unable to integrate and manage information systems and networks effectively, our operations could be disrupted;
- A failure in or breach of our operational or security systems, networks or infrastructure, or those of third-party vendors with which we do business, including as a result of cyber-attacks and other data security incidents, could have a material adverse effect on our business;
- We may be unable to attract, retain or effectively manage the succession of key personnel;
- An impairment charge with respect to our recorded goodwill, intangible assets and real estate portfolio could have a material impact on our results of operations and shareholders' equity;

Risks Relating to Regulatory and Legal Matters

- Reductions or delays in funding of, changes to eligibility requirements for, government-sponsored healthcare programs in which we participate, and any inability on our part to effectively adapt to changes to these programs could have a material adverse effect on our business;
- Significant changes to the ACA and the other government-sponsored healthcare programs in which we participate could materially and adversely affect our business;
- Negative public perception of the managed care industry, including industry practices, could adversely affect our business, operating results, cash flows and prospects;
- Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could force us to change how we operate and could harm our reputation and business;

- Our ability to provide services and support to manage our members' pharmacy benefits face regulatory risks and uncertainties which could materially and adversely affect our business;
- We have been and may from time to time become involved in costly and time-consuming litigation and other regulatory proceedings, which require significant attention from our management and could adversely affect our business;
- If we fail to comply with applicable data privacy and security laws, regulations, rules, standards and contractual obligations, including with respect to third-party vendors that utilize sensitive personal information on our behalf, our business could be materially and adversely affected;
- If we fail to comply with the extensive federal and state fraud, waste and abuse laws, our business could be materially and adversely affected;
- We might be adversely impacted by tax legislation or challenges to our tax positions;

Risks Relating to Conditions in the Financial Markets and Economy

- Our investment portfolio may suffer losses which could materially and adversely affect our results of operations or liquidity;
- Adverse credit market conditions may have a material adverse effect on our liquidity or our ability to obtain credit on acceptable terms;
- We have substantial indebtedness outstanding and may incur additional indebtedness in the future. Such indebtedness could reduce our agility and may adversely affect our financial condition;

Risks Associated with Mergers, Acquisitions, and Divestitures

- Our business and results of operations may be materially adversely affected if we fail to manage and complete divestitures;
- Previous or future acquisitions may not perform as expected and we may not realize the financial results expected from acquisitions or divestitures; and
- We may be unable to successfully integrate our existing business with acquired businesses and realize the anticipated benefits of such acquisitions.

Non-GAAP Financial Presentation

The Company is providing certain non-GAAP financial measures in this report as the Company believes that these figures are helpful in allowing investors to more accurately assess the ongoing nature of the Company's operations and measure the Company's performance more consistently across periods. The Company uses the presented non-GAAP financial measures internally in evaluating the Company's performance and for planning purposes, by allowing management to focus on period-to-period changes in the Company's core business operations, and in determining employee incentive compensation. Therefore, the Company believes that this information is meaningful in addition to the information contained in the GAAP presentation of financial information. The Company strongly encourages investors to review its consolidated financial statements and publicly filed reports in their entirety and cautions investors that the non-GAAP financial measures used by the Company may differ from similar measures used by other companies, even when similar terms are used to identify such measures. The presentation of non-GAAP financial measures is not intended to be considered in isolation or as a substitute for the financial information prepared and presented in accordance with GAAP.

Specifically, the Company believes the presentation of non-GAAP financial measures that excludes amortization of acquired intangible assets, acquisition and divestiture related expenses, as well as other items, allows investors to develop a more meaningful understanding of the Company's core performance over time.

The tables below provide reconciliations of non-GAAP items ($ in millions, except per share data):

	Year Ended December 31,		
	2025	**2024**	**2023**
GAAP net earnings (loss) attributable to Centene	$ (6,674)	$ 3,305	$ 2,702
Amortization of acquired intangible assets	685	692	718
Acquisition and divestiture related expenses	4	82	70
Other adjustments [(1)]	7,328	(117)	464
Income tax effects of adjustments [(2)]	(315)	(209)	(308)
Adjusted net earnings	$ 1,028	$ 3,753	$ 3,646
GAAP diluted earnings (loss) per share attributable to Centene	$ (13.53)	$ 6.31	$ 4.95
Amortization of acquired intangible assets	1.39	1.32	1.32
Acquisition and divestiture related expenses	0.01	0.16	0.13
Other adjustments [(1)]	14.86	(0.22)	0.85
Income tax effects of adjustments [(2)]	(0.64)	(0.40)	(0.57)
Effect of basic to diluted shares [(3)]	(0.01)	—	—
Adjusted diluted earnings per share (EPS)	$ 2.08	$ 7.17	$ 6.68

[(1)] Other adjustments include the following pre-tax items:

2025:

(a) goodwill impairment of $6,723 million, or $13.63 per share ($13.62 after-tax), Magellan Health, Inc. (Magellan Health) impairment of $513 million, or $1.04 per share ($0.79 after-tax), intangible asset impairment related to the wind-down of certain contracts in the Other segment of $55 million, or $0.11 per share ($0.08 after-tax), exit costs related to the wind-down of certain contracts in the Other segment of $22 million, or $0.04 per share ($0.03 after-tax), a net loss on real estate transactions of $18 million, or $0.04 per share ($0.03 after-tax), a favorable adjustment to the gain on sale of Magellan Rx of $2 million, or $0.00 per share ($0.00 after-tax), and net gain on debt extinguishment of $1 million, or $0.00 per share ($0.00 after-tax).

2024:

(b) net gain on the previously reported divestiture of Magellan Specialty Health due to the achievement of contingent consideration and finalization of working capital adjustments of $83 million, or $0.16 per share ($0.12 after-tax), net gain on the sale of property of $24 million, or $0.04 per share ($0.03 after-tax), gain on the previously reported divestiture of Circle Health Group (Circle Health) of $20 million, or $0.04 per share ($0.12 after-tax), gain on the sale of Collaborative Health Systems (CHS) of $17 million, or $0.03 per share ($0.02 after-tax), Health Net Federal Services asset impairment due to the 2024 final ruling on the TRICARE Managed Care Support Contract of $14 million, or $0.03 per share ($0.02 after-tax), severance costs due to a restructuring of $13 million, or $0.02 per share ($0.01 after-tax), an additional loss on the divestiture of our Spanish and Central European businesses of $7 million, or $0.01 per share ($0.01 after-tax) and gain on the previously reported divestiture of HealthSmart due to the finalization of working capital adjustments of $7 million, or $0.01 per share ($0.01 after-tax).

2023:

(c) Circle Health impairment of $292 million, or $0.53 per share ($0.47 after-tax), Operose Health Group (Operose Health) impairment of $140 million, or $0.26 per share ($0.24 after-tax), real estate impairments of $105 million, or $0.19 per share ($0.16 after-tax), gain on the sale of Apixio of $93 million, or $0.17 per share ($0.12 after-tax), severance costs due to a restructuring of $79 million, or $0.15 per share ($0.11 after-tax), gain on the sale of Magellan Specialty Health of $79 million, or $0.14 per share ($0.11 after-tax), a reduction to the previously reported gain on the sale of Magellan Rx of $22 million, or $0.04 per share ($0.02 after-tax), gain on the previously reported divestiture of Centurion of $15 million, or $0.03 per share ($0.02 after-tax) and an additional loss on the divestiture of our Spanish and Central European businesses of $13 million, or $0.02 per share ($0.01 after-tax).

(2) The income tax effects of adjustments are based on the effective income tax rates applicable to each adjustment. In addition, the year ended December 31, 2025, includes a tax benefit of $4 million, or $0.01 per share, related to tax adjustments on previously reported divestitures and impacts of the One Big Beautiful Bill Act (OBBBA). The year ended December 31, 2024, includes a tax benefit of $1 million, or $0.00 per share, related to tax adjustments on previously reported divestitures. The year ended December 31, 2023, includes a one-time income tax benefit of $69 million, or $0.13 per share, resulting from the distribution of long-term stock awards to the estate of the Company's former CEO and tax expense of $3 million, or $0.01 per share, related to tax adjustments on previously reported divestitures.

(3) Reflects the $0.01 impact of using 494,502 thousand shares in the calculation of adjusted diluted EPS for the year ended December 31, 2025. The additional 1,386 thousand shares for the year ended December 31, 2025 were excluded from the calculation of the GAAP net loss per share and related adjustments due to their anti-dilutive effect.

	Year Ended December 31,		
	2025	**2024**	**2023**
GAAP selling, general and administrative expenses	$ 12,904	$ 12,400	$ 12,563
Less:			
Acquisition and divestiture related expenses	4	82	69
Restructuring costs	22	13	79
Real estate optimization	2	—	8
Adjusted selling, general and administrative expenses	$ 12,876	$ 12,305	$ 12,407

PART I

Item 1. *Business*

OVERVIEW

Our mission is to transform the health of the communities we serve, one person at a time. As the nation's largest managed care company focused on underserved populations, Centene is committed to helping people live healthier lives. Centene offers affordable and high-quality products to more than 1 in 15 individuals across the nation, including Medicaid and Medicare members (including Medicare Prescription Drug Plans) as well as individuals and families served by the Health Insurance Marketplace.

Centene provides access to high-quality healthcare, innovative programs and a wide range of health solutions that help families and individuals get well, stay well and be well. We believe the best way to deliver healthcare is with a personal approach, with local brands and local teams who live in, care about and directly influence the communities they serve – a key differentiator in our ability to provide access to quality care for our members. Our state-based plans are built on community expertise and backed by the depth, breadth, and experience of a leading national company. Our model is structured around partnership. By working hand-in-hand with providers, policymakers, and communities, we connect people to what matters most – not just healthcare, but essentials like food, housing, utilities, and transportation – to drive meaningful health outcomes.

With our scale and expertise, we are not only improving lives but also shaping the future of healthcare. From leveraging data to drive better outcomes across the nation to creating innovative programs to address barriers to care, we hope to redefine the healthcare experience. Our data and insights give us a powerful opportunity to anticipate needs, personalize care, and build a more affordable and effective healthcare system for tomorrow.

During 2025, we operated in four segments: Medicaid, Medicare, Commercial and Other.

- **Medicaid -** includes the Temporary Assistance for Needy Families (TANF) program; Medicaid Expansion programs; the Aged, Blind or Disabled (ABD) program; the Children's Health Insurance Program (CHIP); Long-Term Services and Supports (LTSS); Foster Care; Medicare-Medicaid Plans (MMP), which cover beneficiaries who are dually eligible for Medicaid and Medicare; and other state-based programs.
- **Medicare -** includes Medicare Advantage, Dual Eligible Special Needs Plans (D-SNPs), Medicare Prescription Drug Plans (PDP), also known as Medicare Part D, and Medicare Supplement.
- **Commercial -** includes the Health Insurance Marketplace product along with individual and commercial group, Individual Coverage Health Reimbursement Arrangement (ICHRA) and other off-exchange individual products.
- **Other -** includes our specialty pharmacy operations, vision and dental services, clinical healthcare, behavioral health, and centralized services, among others. We signed a definitive agreement to divest the remaining Magellan Health businesses in December 2025.

For the year ended December 31, 2025, our Medicaid, Commercial, Medicare and Other segments accounted for 57%, 21%, 19% and 3%, respectively, of our total external revenues. Our membership totaled 27.6 million as of December 31, 2025. For the year ended December 31, 2025, our total revenues were $194.8 billion and our total cash flow from operations was $5.1 billion.

Based on the most recent publicly available membership data, we are the nation's largest Medicaid and Marketplace insurer, as well as the largest stand-alone PDP provider. Our Medicare Advantage business includes one of the highest concentrations of D-SNP members among our peers, aligned with our focus on low-income, complex populations.

Our initial health plan commenced operations in Wisconsin in 1984. We were organized in Wisconsin in 1993 as a holding company for our initial health plan and reincorporated in Delaware in 2001. Our stock is publicly traded on the New York Stock Exchange under the ticker symbol "CNC."

INDUSTRY AND OPERATIONS

We provide a full spectrum of managed healthcare products and services, primarily through Medicaid, Medicare and commercial products.

Medicaid

Medicaid is the largest publicly funded program in the United States and provides health insurance to low-income families and individuals with disabilities. Medicaid is funded jointly by federal and state governments, with the majority of funding provided by the federal government and administered by the states. Each state establishes its own eligibility standards, benefit packages, payment rates and program administration within federal standards. As a result, there are 56 Medicaid programs - one for each U.S. state, each U.S. territory and the District of Columbia. Eligibility is based on a combination of household income and assets, often determined by an income level relative to the federal poverty level. Many states have selected Medicaid managed care as a means of delivering quality healthcare and controlling costs.

Medicaid helps meet the needs of various populations through the following products and programs:

- The TANF program covers low-income families with children.
- Medicaid Expansion covers individuals under age 65 with incomes up to 138% of the federal poverty level, subject to each state's election.
- The ABD program covers low-income individuals with chronic physical disabilities or behavioral health impairments. ABD beneficiaries represent a growing portion of all Medicaid recipients and typically utilize more services as a result of their more complicated health status.
- CHIP helps to expand coverage primarily to children whose families earn too much to qualify for Medicaid, yet not enough to afford private health insurance. Historically, children have represented the largest Medicaid eligible population. Costs are primarily composed of pediatrics and family care, which tend to be more predictable than those associated with other healthcare issues predominantly affecting the adult population.
- LTSS refers to a set of Medicaid-covered services that include Institutional/Residential Care (such as Nursing and Intermediate Care Facilities) and Home and Community Based Services (HCBS) for individuals who need assistance with activities of daily living. The largest share of LTSS spending is for older adults and individuals with physical disabilities, followed by individuals with intellectual and developmental disabilities, serious mental illness or other complex needs. Many states are increasingly adopting managed care models (MLTSS) to provide coordinated, person-centered care and expand access to HCBS.
- Most children in foster care are categorically eligible for Medicaid under federal law. Federal child welfare legislation requires states to address the health and well-being of children in foster care and provides funding and technical assistance to support these efforts in coordination with Medicaid. Under the Affordable Care Act (ACA), youth who age out of foster care at 18 and were in Medicaid at the time, are eligible for Medicaid coverage until age 26.
- A portion of Medicaid beneficiaries are dual-eligible, low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare. According to CMS, there were approximately 12 million dual-eligible enrollees in 2025. These members may receive assistance from Medicaid for benefits, such as nursing home care, HCBS and/or assistance with Medicare premiums and cost-sharing depending on their income level. Dual-eligibles use more services due to their tendency to have more chronic health conditions. We serve dual-eligibles primarily through our ABD and LTSS programs and through integrated Medicare products such as Medicare Advantage D-SNPs. We operated MMPs, which ended on December 31, 2025, as CMS transitioned to D-SNP-based integration.

While Medicaid programs have directed funds to many individuals who cannot afford or otherwise maintain health insurance coverage, they did not initially address the inefficient and costly manner in which the Medicaid population tends to access healthcare. Medicaid recipients in non-managed care programs typically have not sought preventive care or routine treatment for chronic conditions, such as asthma and diabetes. When they do seek care, it is typically fragmented and not coordinated such as seeking healthcare in hospital emergency departments, which is typically more expensive. As a result, many states without managed care programs have found that the costs of providing Medicaid benefits have increased while the medical outcomes for the recipients remained unsatisfactory.

Accordingly, in an effort to improve quality of care and the affordability of healthcare, the majority of states have mandated that their TANF recipients enroll in managed care plans and many are considering moving to a mandated managed care approach for additional populations and products. CMS estimates Medicaid spending will grow at an average annual rate of 7% to $1.5 trillion by 2031. Based on continued market growth, we believe a significant market opportunity exists for managed care organizations (MCOs) with operations and programs focused on the distinct socio-economic, cultural and healthcare needs of the uninsured population and the Medicaid populations.

We are the largest Medicaid health insurer in the country, serving 12.5 million Medicaid members in 30 states as of December 31, 2025. Our Medicaid contracts with the states of Florida and New York accounted for approximately 10% or more of our consolidated Medicaid premium revenues individually in the year ended December 31, 2025.

The One Big Beautiful Bill Act (OBBBA), passed in July 2025, includes requirements that may reduce the number of members eligible for state Medicaid Expansion programs by requiring work or community engagement by members and for state Medicaid agencies to redetermine member eligibility at more frequent intervals, along with adding a "Cost Sharing" or "Co-Pay" for certain medical services. These changes could have the effect of increasing the overall morbidity of the Medicaid Expansion population largely beginning in 2027, subject to state implementation plans. Several other provisions of the OBBBA, such as adjustments to provider taxes and state directed payments beginning in 2028, may have the effect of reducing the amount of federal funding for Medicaid, which could result in changes in the design of Medicaid programs, including coverage of benefits, eligibility, and/or provider payment rates. In particular, New York intends to terminate its Essentials Plan-5, which provided state-subsidized healthcare for individuals from 200% to 250% of the Federal Poverty Level (FPL) by July 1, 2026. The OBBBA also includes a restriction against paying certain providers designated as "prohibited entities" as of October 1, 2025, which has the potential to create access to care issues and network gaps. The timing of regulatory guidance and other rulemaking changes will be critical to ensuring state and MCO implementation readiness.

Medicare

Medicare is the federal health insurance program for people ages 65 and over, which was expanded to cover people under 65 with certain disabilities and people with end-stage renal disease requiring dialysis or kidney transplant. Medicare consists of four parts, labeled A through D. Part A provides hospitalization benefits financed largely through Social Security taxes and requires beneficiaries to pay out-of-pocket deductibles and coinsurance. Part B provides benefits for medically necessary services and supplies including outpatient care, physician services and home health care. Parts A and B are referred to as Original Medicare. Revenues from CMS are significant to the segment.

CMS estimates Medicare spending will grow at an average annual rate of 8% to $1.9 trillion by 2031. Over 40% of Medicare spend in 2024 was in Medicare fee-for-service, representing a notable market opportunity to increase penetration of the Medicare Advantage products.

Medicare Advantage

As an alternative to Original Medicare, beneficiaries may elect to receive their Medicare benefits through Part C, also known as Medicare Advantage. Under Medicare Advantage, MCOs contract with CMS to provide services directly to Medicare beneficiaries as well as through employer and union groups. MCOs typically receive fixed monthly premium per member from CMS that varies based upon the county in which the member resides, demographic factors of the member such as age, gender and institutionalized status and the health status of the member. Any benefits that are not covered by Medicare may result in an additional monthly premium charged to the enrollee or through portions of payments received from CMS that may be allocated to these benefits, according to CMS regulations and guidance. Typically, as our Medicare Advantage members reach their deductibles and out-of-pocket maximums, our medical costs rise, creating seasonality in the business with a higher percentage of earnings in the first half of the year.

As of December 31, 2025, we served 1.0 million Medicare Advantage members across 32 states, primarily under the brand name Wellcare.

Medicare Prescription Drug Plan

Medicare prescription drug coverage, or Medicare Part D, is a voluntary benefit for Medicare beneficiaries. The Medicare Part D prescription drug benefit is supported by risk sharing with the federal government through risk corridors designed to limit the losses and gains of the participating drug plans by providing a portion of reinsurance for catastrophic drug costs. The government subsidy is based on the national weighted average monthly bid for this coverage, adjusted for risk factor payments. Additional subsidies are provided for dually eligible beneficiaries and specified low-income beneficiaries.

MCOs contract with CMS to serve as plan sponsors offering stand-alone Medicare Part D PDPs to Medicare-eligible beneficiaries. PDPs offer national in-network prescription drug coverage, and may include a preferred pharmacy network, subject to limitations in certain circumstances. Unless CMS is notified of non-renewal and the non-renewal is effectuated by not filing a bid in June, Medicare Advantage and PDP contracts with CMS are renewed for successive one-year terms each September. Should CMS decide not to renew a contract, CMS must notify MCOs on or before August 1, and the plan would be terminated effective December 31 of that year. Our 2026 PDP bids were below the benchmarks for all 34 CMS regions, compared to our 2025 PDP bids, which resulted in 33 of 34 CMS regions for which we were below the benchmarks and one region for which we were above the benchmark.

The Inflation Reduction Act (IRA) significantly changed Medicare Part D, impacting stand-alone Medicare PDPs as well as the Part D benefit in many of our Medicare Advantage plans beginning in 2025, most notably by eliminating the coverage gap and capping members' annual out-of-pocket costs at $2,000 in order to provide more predictable and affordable prescription drug coverage for Medicare beneficiaries. The members' Part D annual out-of-pocket cap for 2026 is $2,100. The IRA changes effective for 2025 resulted in a meaningful shift in cost-sharing responsibilities between members, drug companies, CMS, and PDPs and have resulted in a significant increase in our premiums in consideration for our PDPs' responsibility for a larger portion of total Part D benefit costs. Starting in 2026, CMS created a Drug Subsidy to compensate plans for the loss of the Manufacturer Discount Program (MDP) for maximum fair price drugs. To help mitigate significant premium impacts and address these changes, CMS introduced the Medicare Part D Premium Stabilization Demonstration program. This program began in calendar year 2025 and was intended by CMS to exist for three years. The parameters of the program are expected to be different each year. For example, in 2025, participating PDPs operated under narrowed risk corridor thresholds as part of the supports CMS introduced to limit market volatility. For 2026, CMS eliminated these narrowed risk corridors entirely, shifting PDPs back toward standard program financial risk-sharing. We continue to advocate for policies that promote cost-effective, high-quality care for our PDP enrolled members.

We began providing PDP coverage in 2006 and have continued to prioritize plans offering low premiums, deductibles and cost sharing. We offer stand-alone PDPs in 50 states and the District of Columbia and served 8.1 million members as of December 31, 2025, making us the country's largest stand-alone PDP provider.

Dual-Eligible Alignment

CMS regulations are promoting greater alignment and integration for dual-eligible members across both programs, whereby full dual beneficiaries would be enrolled under the same company's Medicaid and Medicare plan, improving the quality of care and overall member experience. With over 70% of the approximately 12 million fully-eligible duals population not in integrated care plans, we see significant opportunity to advance care management, improve member engagement and improve the affordability of healthcare through this process. D-SNPs offer various levels of integration of benefits, care coordination (e.g., care management), and processes (e.g., appeals and grievances, claims, materials) depending on the plan type. Fully Integrated Dual Eligible (FIDE) plans provide Medicaid and Medicare benefits, including LTSS and behavioral health through one plan under one legal entity. Highly Integrated Dual Eligible (HIDE) plans can offer Medicaid and Medicare benefits from different plans under different legal entities owned by the same parent organization. These HIDE plans have some differences in the Medicaid benefit offering requirements compared to FIDE plans. Lastly, Coordination-Only Dual Eligible plans can coordinate care with Medicaid fee-for-service or Medicaid MCOs from different parent organizations and in some states can also serve partial dual-eligibles who do not receive full Medicaid benefits. Accordingly, we have been refining our Medicare footprint to overlap more closely with our Medicaid presence to provide D-SNP offerings that support alignment and have one of the highest D-SNP concentrations among our peers.

CMS regulations will require beneficiaries dually enrolled in Medicare and in a Medicaid managed care plan to receive integrated care through the Medicaid company's Medicare Advantage D-SNPs beginning in 2030, with certain restrictions beginning in 2027. Integrated D-SNPs are designed to enhance the coordination of care and streamline services while delivering improved outcomes. We believe we are positioned well given our overlapping Medicaid and Medicare Advantage footprints and we will continue to place enterprise-level focus on the D-SNP opportunity to drive long-term growth.

Commercial

We offer commercial health insurance products to individuals through the ACA Health Insurance Marketplace, and through large and small employer groups in limited areas. These plans offer differing benefit designs and varying levels of co-payments at different premium rates. These plans facilitate access to healthcare services for our members through network contracts with physicians, hospitals and other providers. Coverage typically is subject to copays and can also be subject to deductibles and coinsurance. As our commercial members reach their deductibles and out-of-pocket maximums, our medical costs rise, creating seasonality in the business with a higher percentage of earnings in the first half of the year.

The ACA created the Health Insurance Marketplace, which is a key component of the ACA and provides an opportunity for individuals and families to obtain health insurance. States have the option of operating their own Marketplace or partnering with the federal government. States choosing neither option default to the federally-facilitated Marketplace. Insurers are required to offer a minimum level of benefits with coverage that varies based on premiums and out-of-pocket costs.

Premium subsidies are provided to individuals and families without access to other coverage and with incomes above 100% of the federal poverty level to make coverage more affordable. Consumers who qualify for subsidies may choose how much of the tax credit to apply to their premiums each month, up to the maximum amount for which they are eligible. The amount of subsidy an enrollee may receive depends on household income and the cost of the second lowest cost silver plan available to enrollees in their local area. Temporary enhanced subsidies were made available by the American Rescue Plan Act (ARPA), which were further extended through 2025 pursuant to the IRA. The enhanced eligibility extended by the IRA expired at the end of 2025. While enhanced eligibility has expired, APTCs are still in force and provide meaningful subsidies to eligible members.

We are the largest Marketplace carrier, serving 5.5 million members across 29 states as of December 31, 2025, under the brand name Ambetter Health. Revenues from CMS are significant to the segment.

The Marketplace Integrity and Affordability Final Rule (Final Rule) was published in the Federal Register on June 25, 2025. The Final Rule makes changes to policies to strengthen program integrity measures in the Marketplace. For example, the Special Enrollment Period for those under 150% of the FPL has been repealed beginning August 25, 2025. Several of the provisions of the Final Rule have been stayed due to ongoing litigation. These include a requirement for certain consumers who automatically re-enroll into a fully subsidized Marketplace plan to be re-enrolled into the same plan with a $5 premium until the consumer updates their exchange application to confirm APTC eligibility. Additionally, exchanges may no longer accept a consumer's self-attestation of projected annual household income when the Internal Revenue Service (IRS) cannot verify it due to lack of tax return data; rather, exchanges must verify household income using other trusted data sources.

In addition, the OBBBA placed additional restrictions on APTC requirements. For example, beginning January 1, 2026, should individuals mis-estimate their projected income, the OBBBA requires them to reimburse the IRS for the full amount of excess tax credit received. In addition, as of January 1, 2026, the OBBBA prohibits individuals from receiving APTCs if they enroll in health coverage through a Special Enrollment Period associated with their income. We anticipate that the combined effect of the expiration of the Enhanced APTCs, the Final Rule, and the OBBBA will reduce 2026 Marketplace membership and continue to increase the overall morbidity of the Marketplace population. During the third quarter of 2025, we reacted to an evolving regulatory and market environment and took corrective pricing actions for 2026 in states covering 95% of Marketplace membership. We continue to advocate for legislation and regulations aimed at leveraging Medicaid and the Health Insurance Marketplace to maintain health insurance coverage and affordability for consumers.

Individual Coverage Health Reimbursement Arrangement (ICHRA)

We see an opportunity for market disruption of employer-sponsored insurance through ICHRAs. An ICHRA allows employers of all sizes to directly reimburse employees for individual health insurance premiums and qualifying medical expenses tax free in lieu of traditional employer-sponsored health insurance. The ICHRA model relies heavily on off-exchange, individual health insurance coverage as the most efficient way to use the funds. These off-exchange plans often mimic employer-provided coverage in benefit design. They are designed to provide comprehensive, consistent coverage and benefits that meet members' needs.

Using an ICHRA allows employees to tap into a competitive marketplace and a risk pool larger than the employer's risk pool creating the opportunity for lower, more consistent premiums each year. At the same time, this approach allows employees to find products that better fit their needs. Given the full commercial group market covers over 170 million Americans, we see a significant addressable market over the long term. Ambetter Health Solutions, our off-exchange marketplace business offerings, delivers individual health insurance plans that are compatible with ICHRAs. Ambetter Health Solutions supports employers who choose to adopt this reimbursement model by providing employees with access to affordable, customizable and dependable coverage options. We operated plans designed to attract ICHRA membership in off-exchange plans in 6 states in 2025, and expanded coverage to 13 states in 2026.

Other

Our Other segment includes:

- *Specialty Pharmacy.* AcariaHealth provides specialty pharmacy services for patients with complex and chronic conditions. Leveraging national scale and personalized clinical support, AcariaHealth collaborates with providers and payers to improve access and optimize patient outcomes. AcariaHealth also administers free drug programs for pharmaceutical manufacturers and operates a full-service wholesale distribution pharmacy.

- *Behavioral Health.* Magellan Health, Inc. (Magellan Health) supports innovative ways of accessing better health through technology, while remaining focused on the critical personal relationships that are necessary to achieve a healthy, vibrant life. Magellan's customers include health plans and other MCOs, employers, labor unions, various military and state and federal governmental agencies, and third-party administrators. We signed a definitive agreement to divest the remaining Magellan Health businesses in December 2025.

- *Vision and Dental Services.* Our fully integrated vision and dental health programs include benefits beyond traditional medical benefits. Our vision benefit program administers routine and surgical eye care benefits through a contracted national network of eye care providers. Through the dental benefit, we are dedicated to improving oral health through a contracted network of dental healthcare providers.

- *Clinical Healthcare.* Community Medical Group (CMG) provides clinical healthcare, encompassing primary care, access to certain specialty services and a suite of social and other support services. CMG operates in Florida through an at-risk primary care provider model, focusing on clinical and social care for at-risk beneficiaries. Additionally, Denova Collaborative Health provides outpatient primary care and behavioral healthcare services.

- *Centralized Services.* Each of our health plans contracts with our corporate management companies to provide certain functions required to manage the health plan which often include salaries and wages for personnel, rent, utilities, population health management, provider contracting, compliance, member services, claims processing, pharmacy oversight services, information technology, cash management, finance and accounting and other services.

OUR COMPETITIVE STRENGTHS

Our approach is based on the following key competitive strengths:

- *Focus and Experience*. Centene was established as a Medicaid company, anchored around long-lasting, trusted relationships, with a continual focus on low-income populations. Since our founding more than 40 years ago, we have forged new paths developing innovative solutions and addressing the evolving needs of our members, earning Centene an important seat at the table and a powerful voice to shape the conversation at the state and federal level. As a result of these efforts, we are the nation's largest Medicaid and Marketplace insurer as well as the largest stand-alone PDP provider, based on the most recent publicly available membership data. Additionally, our Medicare Advantage business includes one of the highest concentrations of D-SNP members among our peers, aligned with our focus on low-income, complex populations. As states increasingly move to integrate care for individuals who are dually eligible for both Medicaid and Medicare, our expertise uniquely positions us to serve this population of 12 million beneficiaries nationwide. We are positioned at the nexus of affordability and choice, ready to meet the needs of consumers who increasingly seek innovative products like ICHRAs.

- *Local Approach*. Our local approach to delivering healthcare enables us to meet members and providers in the communities where they are to facilitate member access to high-quality, culturally sensitive healthcare services. Our programs and services are tailored to the unique individuals we serve and include a broad range of initiatives to address upstream drivers of health such as food insecurity, housing instability, unemployment and access to transportation, which contribute to health disparities among underserved communities. With local leadership owning all three lines of business within each health plan, we are able to translate local best practices from our Medicaid business into product development, distribution, network and pricing decisions we make for our Marketplace and Medicare businesses. We know what our customers will value because we live and work alongside them every day.

- *Partnerships*. Centene's partnership mindset allows us to design solutions for our members that integrate the most relevant, most local and most innovative capabilities in an agile and capital-efficient way. Partnership has become both a strategy and discipline: finding, measuring and maintaining the best partners over time. That includes building partnerships with the best providers for our members and investing in data and engagement models that empower them to deliver better health outcomes. For example, we entered into a partnership with the National Association of Community Health Centers to enhance value-based care adoption, further strengthening Community Health Centers' ability to deliver high-quality, patient-centered care and improve maternal child health outcomes.

- *People.* Through an intentional focus on building a One CenTeam culture, we have elevated and unleashed the power of 61,100 team members who uniquely understand how to serve our members and are committed to our mission of transforming the health of the communities we serve, one person at a time.

Benefits to Customers

We feel that our ability to establish and maintain a leadership position in the markets we serve results primarily from our demonstrated success in providing quality care while improving the affordability of healthcare, and from our specialized programs with state governments.

The following are among the benefits we provide to our government partners, providers and members:

- *Accurate and timely claims payments.* We are committed to ensuring that our information systems and claims payment systems meet or exceed state requirements. We continuously improve our claims processing strategies, expertise, configuration and tools to achieve operational excellence, including timely payments to our providers.

- *Care management for complex populations.* Through our experience with Medicaid populations and long-time presence in states with experience in long-term care for children and adolescents in the foster care system, we have developed care management, service coordination and crisis prevention/response programs that improve healthcare outcomes through decreasing preventable emergency department utilization and improving access to primary care and behavioral health intervention.

- *Commitment to quality and improved health outcomes.* We demonstrate this through obtaining health plan accreditations, such as National Committee for Quality Assurance (NCQA), which assesses the effectiveness of our structure and operational processes, clinical quality and member satisfaction. We have developed care coordination, case management and clinical programs focused on key prevention and chronic conditions. Additionally, we have launched a multi-year plan to improve quality across the enterprise with a strong focus on enhanced patient experience and access to care, which lays the foundation for strong quality ratings in the future, including Medicare Star ratings, Medicaid Health Plan Rating (HPR) and Marketplace Quality Rating System (QRS).

- *Community-specific healthcare programs and a focus on addressing healthcare gaps.* Our expertise in government-sponsored programs has helped us establish and maintain strong relationships with community-based organizations and local providers, as well as our state and federal partners. Our health plans develop tailored, local programs and campaigns to support members through solutions that promote whole-person care and enhance healthcare for all.

- *Data-driven approach to improve health outcomes.* We have employed an investment strategy designed to increase our capability to collect and analyze data and insights. We gather data from multiple sources including medical, vision and behavioral health claims and encounter data, pharmacy data, dental vendor claims and authorization data. We use this data to track utilization trends, identify health disparities, monitor quality of care and evaluate the effectiveness of our programs. Through these analyses, we identify and implement interventions that improve health outcomes, advance health equity and ensure members receive timely, appropriate services. The value and accuracy in the data we collect is important in demonstrating an auditable program for federal and state agencies.

- *Member programs and services*. Our comprehensive set of programs and services help members achieve whole-person health while supporting the overall goals of the government program. Covered healthcare benefits vary from customer to customer but cover a wide range of services, including transportation assistance, provision of durable medical equipment, behavioral health and substance use disorder services, 24-hour nurse advice line, social work services and telehealth services.

- *Value-based arrangements.* Our health plans offer a combination of value-based contracting models, including quality incentives and risk arrangements, that address the continuum of whole-person care. We believe value-based collaboration with providers leads to improved health outcomes, reduced costs and better member and provider experiences.

Providers

For each of our service areas, we establish a provider network consisting of primary and specialty care physicians, hospitals, behavioral health practitioners and ancillary providers. Our network of primary care physicians is a critical component of care delivery, healthcare affordability, and the attraction and retention of new members. Primary care physicians include family and general practitioners, pediatricians and internal medicine physicians. Specialty care physicians provide medical care to members generally upon referral by primary care physicians. Specialty care physicians include a wide array of provider types including, but not limited to, orthopedic surgeons, cardiologists and otolaryngologists. We also build robust networks of mental health providers, such as psychiatrists, social workers, substance abuse disorder facilities, and inpatient behavioral health facilities. We also contract with providers on a negotiated fee arrangement for physical therapy, home healthcare, diagnostic laboratory tests, x-ray examinations, ambulance services and durable medical equipment.

Our health plans facilitate access to healthcare services for our members primarily through contracts with our providers. Our contracts with primary and specialty care physicians and hospitals are usually for a term of one to three years and usually renew automatically for successive one-year terms, but generally are subject to termination by either party upon prior written notice. In the absence of a contract, we typically pay providers at applicable state or federal reimbursement levels and guidelines, depending on the product (for example, Medicaid or Medicare). We pay providers under a variety of methods, including fee-for-service, capitation arrangements and value-based arrangements.

- Under our fee-for-service contracts with providers, we pay a negotiated fee for covered services, which may include a case rate or fee-for service. This model is characterized as having no financial risk for the provider.

- Under our capitated contracts, providers can be paid a set amount for their services as outlined in their respective provider agreements, usually on a per member per month basis and sometimes including different rates depending on the age of the population.

- Under value-based arrangements, providers can be paid under either a capitated or fee-for-service model. The arrangement, however, contains provisions for additional payments to the providers or reimbursement from the providers based on their performance against quality and other measures. We are committed to value-based contracting, upside and downside risk, assigning members to the highest quality providers and capitation. This is done in partnership with our providers to increase quality outcomes and overall member satisfaction. We anticipate our membership in upside and downside risk arrangements will continue to grow.

The continuum of value-based contracting includes the following models: pay-for-performance, shared savings, shared risk and full risk. We often start our provider relationships in a pay-for-performance model, in which providers are reimbursed for the fair market value of services provided. Providers benefit from this model as it gives complete transparency and clarity on actions that earn incentives.

We then transition to a risk-sharing model, in which providers are reimbursed based on the total cost of care. As we advance along this continuum, it strengthens our partnerships with our providers, enabling the delivery of high-quality care. We believe having the strongest provider partners who know how to operate well in a value-based model and who can help us drive positive outcomes for our members and good member experience is more important than owning providers, which occurs on an exception basis. Prioritizing partnership over ownership allows us to be agile and capital-efficient, focusing our resources on what we do best.

We work with physicians to help them operate efficiently by providing actionable financial and utilization information, physician and patient educational programs and disease and population health management programs. Our programs are also designed to help physicians coordinate care rendered by other providers.

We believe our local and collaborative approach with physicians and other providers gives us a competitive advantage in entering new markets. Our contracted physicians serve on local committees that assist us in implementing preventive care programs, optimizing costs and improving the overall quality of care delivered to our members, while also simplifying the administrative burdens on our providers. This approach has enabled us to strengthen our provider networks through improved physician recruitment and retention which, in turn, has helped to increase our membership base.

The following are among the services we provide to support physicians:

- *Provider Engagement Performance Tools and Processes* can lead to measurable improvements in quality and health outcomes, healthcare costs and member satisfaction. High-quality provider support and service levels are important as our key customers are increasingly using performance-based measures to select and pay health plans. We have a suite of network performance tools for use by physicians and other providers which monitor the outcomes and care gaps of their individual patient panels. Provider Engagement and Quality teams meet with the providers to review their performance issues and recommend strategies for improvements in their patient panel outcome, including disease management and quality initiatives. Our tools also allow the physician and others to see where they stand within their value-based contract.

- *Our Integrated Care Model* is member-centric and managed by one care manager assigned to a member who looks at the care for the member in a holistic manner. This single care manager will coordinate all care for that member including behavioral health, medical health and home-based primary care in accordance with an individualized, integrated care plan. This care manager also coordinates meetings with the member's integrated care team to assess and alter the care plan as needed. This results in better clinical outcomes and improved member satisfaction.

- *The Provider Portal* delivers claims and eligibility information, prior authorization submissions and status, member panels, care gaps, patient analytics and provider analytics to contracted providers to drive provider engagement and improve patient outcomes. Data and reporting are delivered via our secure, user-friendly web-based provider portal or a third-party, payor-agnostic portal which supports a more streamlined workflow for providers.

Our contracted physicians also benefit from several of the services offered to our members and population health management programs, which assist physicians in managing their patients with chronic diseases.

Quality Improvement

Quality improvement is foundational for our organization. Our commitment to achieving better health outcomes for our members has led to expanded focus and investment on key initiatives involving people, processes, technology and partnership management.

Through these initiatives, we have:

- continued to standardize core quality processes and programs, including those focused on member engagement and care gap closure, encouraging members' active participation with primary care physicians and their care team;

- expanded the use of advanced analytics and enhanced our real-time operational dashboards to strategically track numerous quality performance and benchmarks;

- enhanced data availability to improve our ability to identify and analyze member care gaps, enabling more informed decision-making and personalized interventions to improve member satisfaction;

- advanced local relationships with providers to improve access and quality of care for our members as this will drive greater quality care outcomes.

In connection with these initiatives, we have utilized artificial intelligence (AI), Machine Learning (ML), and predictive modeling in ways that lower costs, advance access to value-based care and increase operational efficiencies for each of our employees, members, vendors and provider partners. We have developed policies and a governance structure to review appropriate use and evaluate model output to consistently keep "Humans in the Loop". We serve a diverse and largely vulnerable member population, and our data science team collaborates closely in the development of the use of AI technology to ensure that the risks of harmful bias are appropriately mitigated. Importantly, we do not use AI to deny requests for prior authorization. Our clinicians are at the forefront of member-facing model development and evaluation, and we employ a layered approach to keep "Humans in the Loop" through model training, monitoring, and active human engagement in decision-making.

We believe these initiatives will improve members' overall health and healthcare experience and help us achieve stronger quality scores overall, such as Medicare Star ratings, Medicaid HPR and Marketplace QRS.

CMS developed the Medicare Advantage Five-Star Quality Rating System to help consumers choose among competing plans, awarding between 1.0 and 5.0 Stars to Medicare Advantage plans based on performance on composite measures of quality. The parent organization's Star rating is used for new Medicare Advantage contracts while existing contracts follow their individual Star ratings to determine bonus payments.

Plans receive additional Medicare revenue related to the achievement of higher Star ratings that can be used to offer more attractive benefit packages to members and/or achieve higher profit margins. In addition, plans with Star ratings of 5.0 are eligible for year-round open enrollment, whereas plans with lower Star ratings have more restrictions on enrollment criteria and timing. Part C or Part D Medicare plans with Star ratings of fewer than three stars for three consecutive years are denoted as "low performing" plans on the CMS website and in the CMS "Medicare and You" handbook. In addition, CMS has the authority to terminate the Medicare Advantage and PDP contracts for plans rated below three Stars for three consecutive years for any Part (C or D). As a result, plans that achieve higher Star ratings may have a competitive advantage over plans with lower Star ratings.

As further validation of our quality objectives, we pursue accreditation by independent organizations that have been established to promote healthcare quality. NCQA Health Plan programs provide unbiased, third-party reviews to verify and publicly report results on specific quality metrics including Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS). We pursue and achieve accreditation in the majority of states where we currently have health plan operations. We also verify the credentials and backgrounds of our partner providers using standards supported by NCQA to ensure the quality of our networks.

Accreditation is another way to demonstrate our ability to provide access to quality care for our members as well as supporting state specific requirements. The majority of state Medicaid programs also have specific quality measures that drive our clinical quality improvement efforts. Performance is monitored by health plan quality improvement committees and our corporate population health management and quality improvement teams.

We remain committed to our quality initiatives and continue to focus on investments that we expect to translate into value over the next few years.

ETHICS AND COMPLIANCE

Our Ethics and Compliance Program assists the organization in developing effective internal controls that promote the prevention, detection and correction of fraud, waste and abuse and instances of conduct that do not conform to federal and state law, private payor healthcare program requirements or our ethics and business policies. Responsibilities also include the ongoing maintenance of our privacy program and oversight of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as it pertains to us and our business units from a compliance, business and technical perspective.

CMS sets forth requirements that govern corporate compliance programs in the healthcare industry. Additionally, compliance programs are assessed against regulations and guidelines such as: the Federal Organizational Sentencing Guidelines, the Department of Justice's Evaluation of Corporate Compliance Programs, and the Compliance Program Guidance series issued by the Department of Health and Human Services' Office of the Inspector General. There are seven elements suggested by these authorities to ensure an effective compliance program.

These seven elements are:

- written standards of conduct;
- designation of compliance officers and compliance committees;
- effective training and education;
- effective lines for reporting and communication;
- enforcement of standards through well-publicized disciplinary guidelines and actions;
- internal monitoring and auditing; and
- prompt response to detected offenses and development of corrective action plans.

The goal of our Ethics and Compliance Program is to build a culture of integrity, ethics and compliance, which is assessed periodically to measure engagement and effectiveness. Our Ethics and Compliance intranet site, accessible to all team members, links to our Code of Conduct and guidance for team members to assist them in reporting concerns or asking questions. Our Ethics and Compliance Helpline is a toll-free number and web-based reporting tool operated by a third-party independent of the Company and allows team members or other persons to anonymously report suspected incidents of misconduct, fraud, waste, abuse or other compliance violations, concerns or questions. Furthermore, our Board of Directors' Audit and Compliance Committee reviews ethics and compliance report data quarterly.

CORPORATE SUSTAINABILITY

Our steadfast commitment to the health and social well-being of our communities, fostering a healthy environment and our culture of sound and ethical corporate governance, extends far beyond individual programs or initiatives. We provide access to high-quality healthcare, innovative programs, and a wide range of health solutions that help people live healthier lives. Our mission is to transform the health of the communities we serve, one person at a time. Our Corporate Sustainability Framework (the Framework) is comprised of areas of focus core to our mission, our strategy, and to delivering positive impact and long-term value to our stakeholders. The Framework highlights our commitment to healthy individuals and healthy communities and builds upon our long history of identifying and removing barriers to health. Implementation of the Framework is overseen by the Board of Directors' Governance Committee and corporate sustainability initiatives throughout the organization are driven by a cross-functional network of executives.

We issue an annual Corporate Responsibility Report, which highlights how we advance our strategy in a way that proudly reflects our mission and values. Our Corporate Sustainability Framework and Inclusive Business Practices are core to these efforts, guiding us to operate responsibly across economic, social, and environmental dimensions while embedding inclusion and experiential intelligence throughout our business decisions, strategies, and workforce development. This report shows how these principles shape operations, strengthen access, and improve outcomes for the diverse populations we serve. We also annually issue a Task Force on Climate-related Financial Disclosures (TCFD) Index report outlining our governance structure, strategy, risks, opportunities and metrics related to managing climate change, and a SASB Index report aligned with the SASB Managed Care standards maintained by the International Sustainability Standards Board providing corporate sustainability disclosures to our stakeholders. Corporate sustainability financial reporting disclosures are overseen by the Board of Directors' Audit and Compliance Committee. Interested parties can find our corporate sustainability-related reports within the Investors section of our website at https://investors.centene.com/sustainability. *Please note: Nothing on our website, including our corporate sustainability reports or sections thereof, shall be deemed incorporated by reference into this Annual Report.*

COMPETITION

We operate in a highly competitive and evolving industry characterized by business consolidations, strategic partnerships, market pressures, and ongoing regulatory and legislative changes at both at the federal and state levels, including healthcare reform initiatives described under the heading "Regulation." Shifts in the political environment may further influence the competitive landscape.

We compete with MCOs, specialty providers and emerging non-traditional entrants to secure and retain state, county, federal, and commercial contracts. Government agencies evaluate multiple factors before awarding contracts, including quality of care, provider network access, administrative efficiency, financial strength, prior performance, and local market investments.

Competition also extends to member acquisition and retention. Individuals typically select health plans based on quality of care and services, provider network inclusion, ease of access, and supplemental benefits. Key drivers of our competitive position include:

- Breadth and pricing of benefit plans
- Size and quality of provider networks
- Service quality and responsiveness
- Quality ratings and reputation
- Financial stability and resources
- Comprehensive coverage and product diversity
- Local market presence

We also compete to build and maintain provider networks. Providers consider member volume, reimbursement rates, experience with value-based payment programs, speed of payment, and administrative support when contracting with health plans. See "Risk Factors - ***Competition may limit our ability to increase penetration of the markets that we serve.***"

The relative importance of these factors and the identity of our competitors vary by geography and product line. We believe that our scale, diversified offerings, strong provider relationships and commitment to quality position us to compete effectively across markets.

REGULATION

Our operations are comprehensively regulated at the local, state and federal levels. Government regulation of the provision of healthcare products and services is a changing area of law that varies from jurisdiction to jurisdiction. States have implemented National Association of Insurance Commissioners (NAIC) model laws and regulations, requiring governance practices and risk and solvency assessment reporting. States have adopted these or similar measures to enhance oversight relating to corporate governance and internal controls of health maintenance organizations (HMOs) and insurance companies. We are required to maintain a risk management framework and file reports with state insurance regulators.

Regulatory agencies have substantial discretion to issue regulations and to interpret and enforce laws and rules. Changes in the regulatory environment and applicable laws and rules also may occur periodically, including in connection with changes in political party or administration at the state and federal levels. The ultimate content, timing or effect of any potential future legislation enacted under new administrations remains uncertain.

Our regulated subsidiaries are licensed to operate as HMOs, preferred provider organizations (PPOs), third-party administrators (TPAs), utilization review organizations, pharmacies, direct care providers and/or insurance companies in their respective states. In each of the jurisdictions in which we operate, we are regulated by the relevant health and/or human services departments, Medicaid agencies, boards of pharmacy and other healthcare providers, departments of insurance, and departments of health that oversee the activities of MCOs and health plans providing or arranging to provide services to enrollees.

The process for obtaining authorization to operate as an MCO, health insurance plan, PDP, pharmacy or provider organization is complex and requires us to demonstrate to the regulators the adequacy of the health plan's organizational structure, financial resources, utilization review, quality assurance programs, billing protocols, complaint procedures, provider network and procedures for covering emergency medical conditions. For example, under state MCO statutes and insurance laws, our health plan subsidiaries, as well as companies within our Other segment, must comply with minimum statutory capital and other financial solvency requirements, such as deposit and surplus requirements. Insurance regulations may also require prior state approval of acquisitions of other MCO businesses and the payment of dividends, as well as notice for loans or the transfer of funds. Our subsidiaries are also subject to periodic state and federal reporting requirements. In addition, each health plan and individual healthcare provider must meet criteria to secure the approval of state regulatory authorities before implementing certain operational changes, including, without limitation, changes to existing offerings, the development of new product offerings, certain organizational restructurings and, in some states, the expansion of service areas.

States have adopted a number of laws and regulations that may affect our business and results of operations. These laws and regulations, in certain states, include:

- premium taxes or similar assessments imposed on us;
- stringent prompt payment laws requiring us to pay claims within a specified period of time;
- mandated coverage of specific drugs or services;
- state-specific medical loss ratios that may be more stringent than federal requirements;
- disclosure requirements regarding provider fee schedules and coding procedures; and
- programs to monitor and supervise the activities and financial solvency of provider groups.

We are regulated as an insurance holding company and are subject to the insurance holding company acts of the states in which our insurance company and HMO subsidiaries are domiciled. These acts contain certain reporting requirements as well as restrictions on transactions between an insurer or HMO and its affiliates. These holding company laws and regulations generally require insurance companies and HMOs within an insurance holding company system to register with the insurance department of each state where they are domiciled and to file with those states' insurance departments reports describing their capital structure, ownership, financial condition, intercompany transactions and general business operations. In addition, depending on the size and nature of the transaction, various notice and reporting requirements generally apply to transactions between insurance companies and HMOs and their affiliates within an insurance holding company structure. Some insurance holding company laws and regulations require prior regulatory approval or, in certain circumstances, prior notice of certain material intercompany transfers of assets as well as certain transactions between insurance companies, HMOs, their parent holding companies and affiliates. Among other provisions, state insurance and HMO laws may restrict the ability of our regulated subsidiaries to pay dividends.

Additionally, the holding company regulations of the states in which our subsidiaries are domiciled restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes, without such approval or an exemption, no person may acquire any voting security of an insurance holding company that controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would "control" the insurance holding company. "Control" is generally defined in state insurance laws as the direct or indirect power to direct or cause the direction of the management and policies of a company and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of a company.

PPO laws and regulations also vary by state and cover all or most of the subject areas referred to above.

Our pharmacies must be licensed to do business as pharmacies in the states in which they are located. Our pharmacies must also register with the U.S. Drug Enforcement Administration and individual state-controlled substance authorities to dispense controlled substances.

Our healthcare providers must be licensed to practice medicine and do business as care providers in the state in which they are located. In addition, they must be in good standing with the applicable medical board, board of nursing or other applicable entity. Furthermore, they must not be excluded from participation at either the state or federal levels. Our facilities are periodically reviewed by state departments of health and other regulatory agencies to ensure the environments are safe to provide care.

Federal law has also implemented other health programs that are partially funded by the federal government, such as Medicaid and Medicare programs. Our Medicaid programs are regulated and administered by various state regulatory bodies. Federal funding remains critical to the viability of these programs. Federal law permits the federal government to oversee and, in some cases, to enact, regulations and other requirements that must be followed by states with respect to these programs. Medicare is administered at the federal level by CMS. Comprehensive legislation, specifically Title XVIII of the Social Security Act, governs our Medicare program. In addition, our Medicare contracts are subject to regulation by CMS. CMS has the right to audit Medicare contractors and the healthcare providers and administrative contractors who provide certain services on their behalf to determine the quality of care being rendered and the degree of compliance with CMS contracts and regulations.

The ACA transformed the U.S. healthcare system through a series of complex initiatives. Some of the ACA's most significant provisions include the imposition of fees, assessments and taxes; the establishment of federally-facilitated and state-based Health Insurance Marketplaces where individuals and small groups may purchase health coverage; the implementation of certain premium stabilization programs designed to apportion risk amongst insurers; and optional Medicaid Expansion. State and federal regulators have continued to provide additional guidance and specificity to the ACA, and we continue to monitor this new information and evaluate its potential impact on our business. For a further discussion of the ACA, see "Risk Factors - ***Significant changes to the ACA and the other government-sponsored healthcare programs in which we participate could materially and adversely affect our results of operations, financial condition, and cash flows.***"

We must also comply with laws and regulations related to the award, administration and performance of U.S. Government contracts. Government contract laws and regulations affect how we do business with our customers and, in some instances, impose added costs on our business. For example, money laundering is a method of attempting to conceal the origins of money gained through illegal activity and is itself a crime that can result in substantial criminal and civil sanctions including fines and imprisonment. To ensure compliance with anti-money laundering laws and regulations, it is our policy to conduct business only with legitimate customers and counterparties whose funds are derived from legitimate commercial activity. A violation of specific laws and regulations by us and/or our agents could result in, among other things, the imposition of fines and penalties on us, changes to our business practices, the termination of our contracts or debarment from bidding on contracts.

State and Federal Businesses; Contracts

In addition to being a licensed insurance company or HMO, in order to be a Medicaid MCO in each of the states in which we operate, we generally must operate under a contract with the state's Medicaid agency. States generally either use a formal request for proposal process, reviewing a number of bidders, or award individual contracts to qualified applicants that apply for entry to the program. Under these state Medicaid program contracts, we receive monthly payments based on specified capitation rates determined on an actuarial basis. These rates differ by membership category and by state depending on the specific benefits and policies adopted by each state. In addition, several of our Medicaid contracts require us to maintain Medicare Advantage D-SNPs, which are regulated by CMS and the state Medicaid agency, for dual-eligible individuals within the state.

We provide Medicare Advantage, PDPs, D-SNPs and MMPs pursuant to contracts with CMS and subject to federal regulation regarding the award, administration and performance of such contracts. CMS also has the right to audit our performance to determine our compliance with these contracts, other CMS regulations, and the quality of care we provide to Medicare beneficiaries under these contracts.

As of December 31, 2025, we operated in 29 states under federally-facilitated Marketplace contracts with CMS and state-based exchanges. We also operate under a Memorandum of Understanding with the Arkansas Department of Human Services Division of Medical Services and the Arkansas Insurance Department to participate in the Medicaid expansion model that Arkansas has adopted (referred to as AR Health and Opportunity for Me program).

Our state and federal contracts and the legal and regulatory provisions applicable to us generally set forth requirements for operating, including provisions relating to:

- eligibility, enrollment and dis-enrollment processes;
- covered services;
- eligible providers;
- subcontractors;
- record-keeping and record retention;
- periodic financial and informational reporting;
- quality assurance;
- accreditation;
- health education and wellness and prevention programs;
- timeliness of claims payment;
- financial standards;
- safeguarding of member information;
- fraud, waste and abuse detection and reporting;
- grievance procedures;
- use and compensation of brokers; and
- organization and administrative systems.

A health plan or individual health insurance provider's compliance with these requirements is subject to significant monitoring by state regulators and by CMS, including monthly, quarterly and annual reporting, all of which are generally state-specific. A health plan is also subject to periodic comprehensive quality assurance evaluations by a third-party reviewing organization and generally by the insurance department of the jurisdiction that licenses the health plan. A health plan or individual health insurance provider must also submit reports to various regulatory agencies, including quarterly and annual statutory financial statements and utilization reports.

Our health plans operate through individual state contracts, generally with an initial term of one to five years. The contracts often have renewal or extension terms or are renewable through the state's reprocurement process. The contracts generally are subject to termination for cause, an event of default or lack of funding, among other things.

Our federally-facilitated Marketplace contracts and state-based exchanges are renewable on an annual basis.

Other Fraud, Waste and Abuse Laws

Investigating and prosecuting healthcare fraud, waste and abuse continues to be a top priority for state and federal law enforcement agencies. These efforts span multiple products, including Medicare, Medicaid, Health Insurance Marketplace and commercial plans. Pertinent fraud, waste and abuse laws include the federal False Claims Act, which prohibits the known filing of a false claim or the known use of false statements to obtain payment from the federal government. Many states have their own statutes that closely resemble the federal False Claims Act. A plan or provider may engage in other activities that violate fraud, waste and abuse laws, such as paying or receiving kickbacks or other inducements for the referral of members or coverage of products (such as prescription drugs), billing for unnecessary medical services or making false or misleading sales-related representations.

Our program integrity efforts aim to detect, prevent and correct fraud, waste and abuse. In addition to investigating leads from members, providers and our own team members, we use data analytics to identify suspicious activity and, as appropriate, will deny improperly billed claims, recover improperly made payments and make referrals to regulatory entities and law enforcement for further review. The laws and regulations relating to fraud, waste and abuse and the requirements applicable to health plans, PDPs and providers participating in these programs are complex and change regularly. Compliance with these laws may require substantial resources. We are constantly looking for ways to improve our fraud, waste and abuse detection methods through new technology and enhanced analytics. While we have both prospective and retrospective processes to identify abusive patterns and fraudulent billing, our anti-fraud strategy continues to focus on increasing our capabilities to proactively detect inappropriate billing prior to payment.

Privacy Regulations

We are subject to various federal, state and local laws and rules regarding the use, security and disclosure of protected health information, personal information and other categories of confidential or legally protected data that our businesses handle. Such laws and rules include, without limitation, HIPAA, the Federal Trade Commission Act, the Gramm-Leach-Bliley Financial Modernization Act of 1999 (Gramm-Leach-Bliley Act) and state privacy and security laws such as the California Confidentiality of Medical Information Act and the California Online Privacy Protection Act. Privacy and security laws and regulations often change due to new or amended legislation, regulations or administrative interpretation. A variety of state and federal regulators enforce these laws, including but not limited to the U.S. Department of Health and Human Services (HHS), the Federal Trade Commission, state attorneys general and other state regulators.

HIPAA is designed to improve the portability and continuity of health insurance coverage, simplify the administration of health insurance through standard transactions and ensure the privacy and security of individual health information. Among the requirements of HIPAA are the Administrative Simplification provisions which include: standards for processing health insurance claims and related transactions (Transactions Standards); requirements for protecting the privacy and limiting the use and disclosure of medical records and other personal health information (Privacy Rule); and standards and specifications for safeguarding personal health information which is maintained, stored or transmitted in electronic format (Security Rule). The Health Information Technology for Economic and Clinical Health (HITECH) Act amended certain provisions of HIPAA and enhanced data security obligations for covered entities and their business associates. HITECH also mandated individual notifications in instances of a data breach, provided enhanced penalties for HIPAA violations and granted enforcement authority to states' Attorneys General in addition to the HHS Office for Civil Rights. The HIPAA Omnibus Rule further enhanced the changes under the HITECH Acts and the Genetic Information Nondiscrimination Act of 2008 which clarified that genetic information is protected under HIPAA and prohibits most health plans from using or disclosing genetic information for underwriting purposes. These regulations also establish significant criminal penalties and civil sanctions for non-compliance. The preemption provisions of HIPAA provide that the federal standards will not preempt state laws that are more stringent than the related federal requirements.

The Privacy and Security Rules and HITECH/Omnibus enhancements established requirements to protect the privacy of medical records and safeguard personal health information maintained and used by healthcare providers, health plans, healthcare clearinghouses and their business associates.

The Security Rule requires healthcare providers, health plans, healthcare clearinghouses and their business associates to implement administrative, physical and technical safeguards to ensure the privacy and confidentiality of health information electronically stored, maintained or transmitted. The HITECH Act and Omnibus Rule enhanced a federal requirement for notification when the security of protected health information is breached. In addition, there are state laws that have been adopted to provide for, among other things, private rights of action for breaches of data security and mandatory notification to persons whose identifiable information is obtained without authorization.

The requirements of the Transactions Standards apply to certain healthcare-related transactions conducted using "electronic media." Since "electronic media" is defined broadly to include "transmissions that are physically moved from one location to another using portable data, magnetic tape, disk or compact disk media," many communications are considered to be electronically transmitted. Under HIPAA, health plans and providers are required to have the capacity to accept and send all covered transactions in a standardized electronic format. Penalties can be imposed for failure to comply with these requirements. The Transactions Standards were modified in October 2015 with the implementation of the ICD-10 coding system.

In addition, we process and maintain personal card data, particularly in connection with our Marketplace business. As a result, we must maintain compliance with the Payment Card Industry Data Security Standard, which is a multifaceted security standard intended to optimize the security of credit, debit and cash card transactions and protect cardholders against misuse of their personal information.

HUMAN CAPITAL RESOURCES

As of December 31, 2025, we had approximately 61,100 team members. Our team members are guided by our mission-driven culture. Our culture values of accountability, courage, curiosity, trust and service guide our workforce and foster high-performing teams that serve our customers and key stakeholders each day while delivering against our long-term strategic goals. We intentionally attract, develop and retain top talent who bring a broad range of voices and experiences, passion and vision to help us transform the health of the communities we serve.

Compensation and Other Benefits

We have a pay-for-performance compensation philosophy and are committed to fair and competitive compensation practices designed to retain and attract top talent. We align our team members' compensation with their skills, experiences, contributions and performance. We offer benefits to our team members to help them achieve optimum work-life balance and meet their needs as well as the needs of their families. In addition to traditional healthcare benefits, we also offer various wellness programs, an employee assistance program, tuition reimbursement/educational assistance, a 401(k) retirement plan, an employee stock purchase plan, as well as programs for family support such as adoption assistance, back-up dependent care, parental leave and caregiver leave. Our parental leave offers six weeks of fully compensated time for caregivers with an additional eight weeks for mothers, providing up to 14 weeks of fully compensated maternity leave. In addition, we offer paid community volunteer time to encourage our team members to participate in volunteer programs and support local communities.

Talent Acquisition and Development

Through our robust talent infrastructure, we continue working to deepen and prepare our talent bench and workforce, which is instrumental to executing our long-term business strategy. Our talent advisors and hiring leaders recruit from across the country to develop a workforce possessing outstanding capabilities and a wide range of perspectives and lived experiences. We are committed to developing a skill-rich workforce who can thrive in the evolving world of work, enabling our organization to further accelerate growth, inclusivity and innovation. Through Centene University, accessible to our team members, we have designed learning and development at scale, using new digital tools, real-time virtual learnings and customized leadership development programs in a modern learning environment. In addition to building new workforce skills, we utilize our ongoing enterprise talent reviews, succession planning, career development planning and comprehensive workforce analytics to provide insights to senior leaders to inform actions and drive intentional talent results. We have a dynamic approach to performance reviews, discussing performance at key milestones throughout the year to support our team members' continuous career growth and talent development. Additionally, our employee engagement tool allows team members to provide candid feedback to the organization throughout the year, enabling leaders to measure, monitor, and improve employee engagement and workforce culture.

Modernized and Connected Workforce

We have adopted a modern work environment with the majority of our team members leveraging remote and hybrid work arrangements, allowing them to do their best work in the way they work best. We are intentional in our efforts to foster a collaborative and engaging work environment, including forums for people leaders, robust weekly communications for all team members, and virtual all-employee meetings. Additionally, we have a wide range of Centene Professional Networks. Open to all employees, these voluntary, employee-led groups provide professional connections and leadership opportunities for all team members and drive impact by supporting the attraction, development and retention of the best talent at all levels.

INFORMATION ABOUT OUR EXECUTIVE OFFICERS

The following table sets forth information regarding our executive officers, including their ages, at February 13, 2026:

Name	Age	Position
Sarah M. London	45	Chief Executive Officer
Andrew L. Asher	57	Executive Vice President, Chief Financial Officer
Katie N. Casso	44	Senior Vice President, Finance, Corporate Controller and Chief Accounting Officer
Christopher A. Koster	61	Executive Vice President, Secretary and General Counsel
Tanya M. McNally	52	Chief People Officer
Susan R. Smith	50	Chief Operating Officer

Sarah M. London. Ms. London has served as our Chief Executive Officer since March 2022. From September 2021 to March 2022, she served as Vice Chairman. She served as President, Centene Health Care Enterprises and Executive Vice President, Advanced Technology from March 2021 to September 2021. From September 2020 to February 2021, she served as Senior Vice President, Technology Innovation and Modernization. Prior to joining Centene, she served as both Senior Principal and Partner for Optum Ventures from May 2018 to March 2020 and Chief Product Officer of Optum from March 2016 to May 2018.

Andrew L. Asher. Mr. Asher has served as our Executive Vice President, Chief Financial Officer since May 2021. From January 2020 to May 2021, he served as Executive Vice President, Specialty. Prior to joining Centene, he served as the Chief Financial Officer of WellCare from November 2014 to January 2020.

Katie N. Casso. Ms. Casso has served as our Senior Vice President, Finance, Corporate Controller and Chief Accounting Officer since September 2024. Prior to that, she served as our Senior Vice President, Corporate Controller and Chief Accounting Officer from April 2021 to September 2024. From January 2016 to March 2021, she served as Vice President, Assistant Controller.

Christopher A. Koster. Mr. Koster has served as our Executive Vice President, Secretary and General Counsel since December 2021. From February 2020 to December 2021, he served as Senior Vice President, Secretary and General Counsel. From February 2017 to February 2020, he served as Senior Vice President, Corporate Services. Prior to joining Centene, Mr. Koster served as Missouri Attorney General for eight years.

Tanya M. McNally. Ms. McNally has served as our Chief People Officer since March 2023. Prior to that, she served as our Interim Chief People Officer from January 2023 to March 2023. Prior to that, she served as our Regional Vice President, Human Resources from May 2022 to December 2022. From January 2020 to May 2022, she served as Vice President, Global Human Resource Business Partner. From August 2018 to January 2020, she served as Vice President, Human Resources for WellCare Health Plans, Inc.

Susan R. Smith. Ms. Smith has served as our Chief Operating Officer since January 2024. Ms. Smith has been an employee of the Company since June 2023. From August 2022 through December 2022, she served as Senior Vice President of Clinical, Quality and Enterprise Solutions President at Humana Inc. From July 2021 through July 2022, she served as Senior Vice President of Clinical Solutions at Humana Inc. She also previously served as Senior Vice President of Medicare at Humana Inc. from August 2019 through June 2021. From October 2016 through July 2019, she served as Senior Vice President of Healthcare Quality Reporting and Improvement at Humana Inc.

Available Information

We are subject to the reporting and information requirements of the Securities Exchange Act of 1934, as amended (Exchange Act) and, as a result, we file periodic reports and other information with the Securities and Exchange Commission (SEC). We make these filings available on our website free of charge, the URL of which is https://www.centene.com, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. The SEC maintains a website (https://www.sec.gov) that contains our annual, quarterly and current reports and other information we file electronically with the SEC. Stockholders may obtain a copy of this Annual Report on Form 10-K, without charge, by writing: Investor Relations, Centene Corporation, 7700 Forsyth Boulevard, St. Louis, MO 63105. *Please note: Information on our website does not constitute part of this Annual Report on Form 10-K.*

Item 1A. ***Risk Factors.***

You should carefully consider the risks described below before making an investment decision. The trading price of our common stock could decline, and our results of operations, financial condition and cash flows could be materially adversely affected due to any of these risks, in which case you could lose all or part of your investment. You should also refer to the other information in this filing, including our consolidated financial statements and related notes. The risks and uncertainties described below are those that we currently believe may materially affect our Company. Additional risks and uncertainties that we are unaware of or that we currently deem immaterial also may become important factors that affect our Company.

Risks Relating to Our Business

Failure to timely and effectively identify and mitigate medical cost trends and receive adequate rate adjustments to account for increased acuity could have a material adverse effect on our results of operations, financial condition and cash flows.

Our profitability depends to a significant degree on our ability to accurately estimate and effectively manage expenses related to health benefits through, among other things, our ability to contract favorably with hospitals, physicians and other healthcare providers, as well as related administrative costs. For example, our government-sponsored health programs revenue is often based on bids submitted before the start of the initial contract year. If our actual medical expenses exceed our estimates for any reason, our health benefits ratio (HBR), or our expenses related to medical services as a percentage of premium revenues, would increase and our profits would decline. For example, late in the second quarter of 2025, data from an independent actuarial firm suggested a materially higher implied aggregate morbidity of the Marketplace membership as a whole than anticipated, resulting in a significant reduction of our expected net risk adjustment revenue for 2025. In addition, during 2025, our Medicaid membership had higher than expected medical costs, including due to unanticipated increased costs in behavioral health, home health and high-cost drugs. Because of the narrow margins of our health plan business, relatively small changes in our HBR can create significant changes in our financial results. Changes in healthcare regulations and practices, including due to the OBBBA, the level of utilization of healthcare services, including due to eligibility changes, benefit design, provider or consumer behavior changes, out-of-network utilization and pricing, medical claim submission patterns, including due to the use of artificial intelligence, hospital and pharmaceutical costs, including new high-cost specialty drugs, unexpected events, such as natural disasters, the effects of climate change, acts of war or aggression, geopolitical instability, major epidemics, pandemics and their resurgence, or newly emergent diseases, new medical technologies, increases in provider fraud, tariffs, unexpected increases in taxes and fees, including provider taxes, and other external factors, including general economic conditions such as interest rates, inflation and unemployment levels, are generally beyond our control and could reduce our ability to accurately predict and effectively control the costs of providing health benefits. Also, member and provider behavior could continue to be influenced by the uncertainty surrounding the availability, affordability, funding and access to health insurance, whether under Medicaid programs or the Affordable Care Act (ACA) or the OBBBA, including due to the expiration of the Enhanced Advance Premium Tax Credits (APTCs) and additional program integrity initiatives for Marketplace products.

In addition, as a result of the expiration of the public health emergency (PHE) due to the COVID-19 pandemic, and the resulting Medicaid redeterminations process, as well as changes in state benefit designs, we have continued to experience a higher HBR related to the remaining members, due to the acuity profile of this membership, as well as the gaps in eligibility for certain members who have rejoined the Medicaid plans. In particular, as part of the Medicaid rate setting process, state actuaries determine actuarial soundness of rates based on historical data. The delay in time between making claims payments and receiving rate adjustments when we experience an increased rate of change in medical expenses, whether due to the increased acuity profile of the membership or the increased utilization of health care services, such as behavioral health, home health and high-cost drugs, may cause the profitability of our Medicaid plans to be reduced. While we continue to work with our state partners to match rates to acuity to reflect more recent experience, such rate adjustments may be delayed or insufficient to offset the increased acuity.

Our medical expenses include claims reported but not paid, estimates for claims incurred but not reported, and estimates for the costs necessary to process unpaid claims at the end of each period. Our development of the medical claims liability estimate is a continuous process that we monitor and refine on a monthly basis as claims receipts and payment information as well as inpatient acuity information becomes available. As more complete information becomes available, we adjust the amount of the estimate, and include the changes in estimates in medical expenses in the period in which the changes are identified. Given the extensive judgment and uncertainties inherent in such estimates, there can be no assurance that our medical claims liability estimate will be accurate, and any adjustments to the estimate may unfavorably impact our results of operations and financial condition and may be material.

Assumptions and estimates are utilized in establishing premium deficiency reserves, when necessary. In the instance a premium deficiency reserve is necessary, if our assumptions are inaccurate, we may be required to increase our premium deficiency reserves which could have a material adverse effect on our results of operations and financial condition.

Additionally, when we commence operations in a new state or region or launch a new product, we have limited information with which to estimate our medical claims liability and continuity of care requirements, which can affect our ability to accurately predict medical claims. For a period of time after the inception of the new business, we base our estimates on government-provided historical actuarial data and limited actual incurred and received claims and inpatient acuity information. In addition, we have limited ability to manage the utilization of services until continuity of care requirements expire. For example, in 2025, we had higher utilization than we expected in several applied behavioral health services programs. The addition of new categories of eligible individuals, as well as evolving Health Insurance Marketplace plans and eligibility changes, may pose difficulty in estimating our medical claims liability.

From time to time in the past, our actual results have varied from our estimates, particularly in times of significant changes in the number and acuity profile of our members. If it is determined that our estimates are significantly different than actual results, our results of operations and financial condition could be materially adversely affected. In addition, if there is a significant delay in our receipt of premiums, our business operations, cash flows or earnings could be negatively impacted.

Any failure to adequately and timely price or anticipate demand for products offered, anticipate changes to the competitive landscape or any reduction in products offered for Medicare and in the Health Insurance Marketplace may have a material adverse effect on our results of operations, financial condition and cash flows.

In the Health Insurance Marketplace, we may be adversely impacted if we have not accurately and timely predicted the health needs of our members, including individuals exiting or entering the market, causing the morbidity of the risk pool to rise without a proportionate change to risk adjustment. The premium rates we charge are typically determined in the summer prior to the next plan year, and delays in receiving data upon which the assumptions our based may impact our ability to timely adjust and receive state approval for these rates. In addition, the risk adjustment provisions of the ACA established to apportion risk amongst insurers may not be effective in appropriately mitigating the financial risks related to the Health Insurance Marketplace product, are affected by our members' acuity relative to the membership acuity of other insurers and are subject to a high degree of estimation and variability, including estimation of the ultimate level of program funding based on the financial performance of other insurers. For example, late in the second quarter of 2025, we made a significant negative adjustment to our expected net risk adjustment revenue attributable to the 2025 Marketplace plan year. Further, changes in the competitive market for both Health Insurance Marketplace and the Medicare products over time, unanticipated changes to member eligibility requirements or verification processes in the program design, including due to changes to the expiration of the Enhanced APTCs and the timing of those changes, additional program integrity initiatives that have the effect of reducing membership or causing the morbidity of the risk pool to rise, changes in consumer or provider behavior, or changes in the financial incentives of individuals, brokers and competitors to participate in such products may make pricing difficult to predict. For example, competitors may introduce pricing, broker incentives or broker distribution channels that we may not be able to match, which may adversely affect our ability to compete effectively. Competitors may also choose to exit the market altogether or otherwise suffer financial difficulty, which could adversely impact the pool of potential insured, affect collectability of risk adjustment payable or require us to increase premium rates. Any significant variation from our expectations regarding acuity of our members, the Marketplace membership as a whole, enrollment levels, adverse selection, out-of-network costs or other increased costs, including due to tariffs or other assumptions utilized in setting adequate premium rates could have a material adverse effect on our results of operations, financial condition and cash flows for both our Health Insurance Marketplace and Medicare products. While we have received approvals in the vast majority of states for our 2026 refiled Marketplace rates reflecting the increased medical expenses we experienced in 2025 and adjusted our benefit design and strategy, these actions may not be sufficient to maintain or increase the profitability of these products, which may unfavorably impact our results of operations and financial condition and may be material.

In addition, we may be unable to accurately predict demand for both our Health Insurance Marketplace and Medicare products, as demand depends on factors outside of our control such as the competitiveness of our bids, the broker distribution channels, additional program integrity initiatives that have the effect of reducing membership and the entry and exit of other competitors in the markets. If we experience higher demand for our products than anticipated, we may not have adequate staffing to be able to adequately meet service level requirements in our call centers, which could negatively impact our quality scores, our relationships with our members and providers, as well as our regulators.

Our Medicare programs are subject to a variety of unique risks that could adversely impact our financial results.

If we fail to design and maintain programs that are attractive to Medicare participants; if our Medicare operations are subject to negative outcomes from program audits, sanctions, penalties or other actions; if we do not submit adequate bids in our existing markets or any expansion markets; if our existing contracts are modified or terminated; or if we fail to maintain or improve our quality Star ratings, our current Medicare business and our ability to expand our Medicare operations could be materially and adversely affected, negatively impacting our results of operations and financial performance. As of December 2025, approximately 60% of our Medicare Advantage membership was associated with contracts rated 3.5 stars or better. While we continue to focus on Star rating improvement, we may not be able to improve or maintain our Star ratings. Additionally, although we expect to have a higher percentage of D-SNP members than most of our competitors, we may be unsuccessful in advocating for adjustments in the Star score rating system or other risk adjustment criteria to reflect the socio-economic barriers to health for this population.

Star ratings are subject to change annually by CMS, and despite our operational efforts to improve our Star ratings, there can be no assurances that we will be successful in maintaining or improving our Star ratings in future years, which could negatively impact our quality bonus and rebates. In addition, our Medicare Advantage and PDP contracts may be terminated by CMS if our Medicare Advantage contracts receive Star ratings of below 3.0 stars for three consecutive years. For example, two of our Medicare Advantage contracts received notice of termination for plan year 2025. The attractiveness of our Medicare Advantage plans may be reduced if we are unable to maintain or improve these ratings, if there are changes to the ratings system that make achieving and maintaining ratings of 3.0 stars or higher more difficult, or if our performance does not improve compared to our competitors.

CMS establishes annually different pricing components of the Medicare Advantage program that may not adequately reflect changes in the underlying health care costs, and which may reduce the profitability or desirability of various Medicare Advantage plans. For calendar year 2026, CMS again applied a negative rate adjustment for risk model revisions and fee for service normalization. On January 26, 2026, CMS released its draft 2027 Medicare rate announcement. We believe these rates are insufficient to reflect the increases in continuing medical cost trend. In addition, CMS' risk model may not account for the full severity of several chronic conditions, which could also disproportionately affect the dual-eligible population which is more medically complex and faces additional socio-economic barriers to health compared to others. As a result of these changes and potential future changes to Medicare Advantage pricing components, we may not be able to design products that will be profitable, attractive or competitive for this population.

In addition, CMS regulations will require beneficiaries dually enrolled in Medicare and in a Medicaid managed care plan to receive integrated care through the Medicaid company's Medicare Advantage D-SNPs beginning in 2030, with certain restrictions beginning in 2027, which may restrict our product offerings in some geographic service areas. However, some states have already moved or are planning to exclusively align dual-eligible enrollment under an aligned D-SNP before this timeframe.

There are also specific additional risks under Title XVIII, Part D of the Social Security Act associated with our provision of Medicare Part D prescription drug benefits as part of our Medicare Advantage plan offerings. These risks include potential uncollectibility of receivables, inadequacy of pricing assumptions, inability to receive and process information and increased pharmaceutical costs, as well as the underlying seasonality of this business, and extended settlement periods for claims submissions. Our failure to comply with Part D program requirements can result in financial and/or operational sanctions on our Part D products, as well as on our Medicare Advantage products that offer no prescription drug coverage.

Risk-adjustment payment systems make our revenue and results of operations more difficult to estimate and could result in retroactive adjustments that have a material adverse effect on our results of operations, financial condition and cash flows.

Most of our government customers employ risk-adjustment models to determine the premium amount they pay for each member. This model pays more for members with predictably higher costs according to the health status of each beneficiary enrolled. Premium payments are generally established at fixed intervals according to the contract terms and then adjusted on a retroactive basis. We reassess the estimates of the risk adjustment settlements each reporting period and any resulting adjustments are made to premium revenue. In addition, revisions by our government customers to the risk-adjustment models have reduced and may continue to reduce our premium revenue.

As a result of the variability of certain factors that determine estimates for risk-adjusted premiums, including plan risk scores and competitor positioning, the actual amount of retroactive payments could be materially more or less than our estimates. Consequently, our estimate of our plans' risk scores for any period, and any resulting change in our accrual of premium revenues related thereto, could have a material adverse effect on our results of operations, financial condition and cash flows. The data provided to our government customers to determine the risk score is subject to audit by them even after the annual settlements occur. These audits may result in the refund of premiums to the government customer previously received by us, which could be significant and would reduce our premium revenue in the year that repayment is required. This in turn could have a material adverse effect on our results of operations, financial condition and cash flows.

Government customers have performed and continue to perform audits of selected plans to validate the provider coding practices under the risk adjustment model used to calculate the premium paid for each member. In 2023, CMS announced the removal of the fee-for-service adjuster from the risk adjustment data validation audit methodology beginning for audit year 2018, which could increase our audit error scores. Additionally in 2025, CMS announced the intent to accelerate the timing and expand the scope of risk adjustment data validation audits. We anticipate that CMS will continue to conduct audits of our Medicare contracts and contract years on an on-going basis with increased focus. An audit may result in the refund of premiums to CMS. It is likely that a payment adjustment could occur as a result of these audits; and any such adjustment could have a material adverse effect on our results of operations, financial condition and cash flows.

If we are not successful in procuring new government contracts or renewing existing government contracts, or if we receive an adverse finding or review resulting from an audit or investigation, our business may be adversely affected.

A substantial portion of our business relates to the provision of managed care programs and selected services to individuals receiving benefits under governmental assistance or entitlement programs. We provide these and other healthcare services under contracts with government entities in the geographic areas in which we operate. Our government contracts are generally intended to run for a fixed number of years and may be extended for an additional specified number of years if the contracting entity or its agent elects to do so. Initial bids for these contracts and initial implementation of these contracts can have substantial start-up costs and may ultimately be unsuccessful. For example, prior to obtaining a certificate of authority in most jurisdictions, we must establish a provider network and have systems in place to administer a state contract and process claims. Once a new contract is awarded, we may experience delays in operational start dates. As a result of these factors, start-up operations may decrease our profitability, or we may not grow as quickly as we anticipated.

When our contracts with government entities expire, they may be opened for bidding by competing healthcare providers, and there is no guarantee that our contracts will be renewed or extended. For example, we are currently protesting the Texas and Georgia Medicaid reprocurements in which we were not a successful bidder. In addition, as part of the normal course of business, our Medicaid contracts are routinely up for reprocurement. Competitors may be more aggressive in the descriptions of their capabilities and the assumptions utilized in their bids or more willing to accept the financial and other terms offered by the states. Even if our responsive bids are successful, the bids may be based upon assumptions or other factors which could result in the contracts being less profitable than we had anticipated. Further, our government contracts contain certain provisions regarding readiness review, eligibility, enrollment and dis-enrollment processes for covered services, eligible providers, periodic financial and informational reporting, financial standards, quality assurance, timeliness of claims payment, compliance with contract terms and law and our agreement to maintain a Medicare plan in the state, among other things, and are subject to cancellation if we fail to perform in accordance with the standards set by regulatory agencies.

We are also subject to various reviews, audits and investigations, as well as self-reporting requirements, to verify our compliance with the terms of our contracts with various governmental agencies, as well as compliance with applicable laws and regulations. Any non-compliance with our government contracts or with applicable laws and regulations, adverse review, audit or investigation, could result in, among other things: cancellation of our contracts; refunding of amounts we have been paid pursuant to our contracts; imposition of fines, penalties and other sanctions on us; loss of our right to participate in various programs; increased difficulty in selling our products and services; loss or suspension of one or more of our licenses; lowered quality Star ratings; harm to our reputation; or required changes to the way we do business. In addition, under government procurement regulations and practices, a negative determination resulting from a government audit of our business practices could result in a contractor being fined, debarred and/or suspended from being able to bid on, or be awarded, new government contracts for a period of time.

If any of our government contracts are terminated, not renewed, renewed on less favorable terms, or not renewed on a timely basis, or if we receive an adverse finding or review resulting from an audit or investigation, our business and reputation may be adversely impacted, our goodwill could be impaired and our results of operations, financial condition or cash flows may be materially adversely affected.

In addition, we contract with independent third-party vendors, brokers and service providers who provide services to us and our subsidiaries or to whom we delegate selected functions. Violations of, or noncompliance with, laws and regulations governing our business by such third-party vendors, or governing our dealings with such parties, could, among other things, subject us to additional audits, reviews, investigations, self-reporting requirements and other adverse effects.

We derive a portion of our cash flow and gross margin from our PDP operations, for which we submit annual bids for participation. The results of our bids and the design of the risk-sharing program could have a material adverse effect on our results of operations, financial condition and cash flows.

A significant portion of our PDP membership is obtained from the auto-assignment of beneficiaries in CMS-designated regions where our PDP premium bids are below benchmarks of other plans' bids. In general, our premium bids are based on assumptions regarding PDP membership, utilization, drug costs, drug rebates and other factors for each region. Our 2026 PDP bids were below the benchmarks for all 34 CMS regions, compared to our 2025 PDP bids, which resulted in 33 of 34 CMS regions for which we were below the benchmarks and one region for which we were above the benchmark. As of January 1, 2026, we experienced an increase to over 8.7 million PDP members compared to 8.1 million in December 2025, due to our 2026 bid positioning. If our future Part D premium bids are not below the CMS benchmarks, we risk losing PDP members who were previously assigned to us and we may not have additional PDP members auto-assigned to us, which could materially reduce our revenue.

In addition, the IRA has substantially increased PDP's risk exposure. Under the IRA, PDP plan costs increased significantly due to a reduction in members cost share (close of coverage gap, and the $2,000 cap on member out-of-pocket expenses) and a decrease in federal reinsurance (from 80% to 20%, while a greater portion of the plan drug costs fall into the catastrophic phase). These changes have led to heightened underwriting risks and increased market volatility and uncertainty for future bids, which could materially reduce our revenue and profit. The IRA also offers Part D enrollees the option to defer payment of out-of-pocket prescription drug costs across monthly payments throughout the benefit year instead of to the pharmacy at the point of sale under the Medicare Prescription Payment Plan (M3P). This change may lead to increased bad debt exposure along with potential challenges with collecting deductibles and other cost-sharing amounts from beneficiaries. The change may also lead to estimation uncertainty as we develop our experience with the M3P. Due to the uncertainty of the new Part D pricing structure, Centene has elected into the Part D Premium Stabilization Demonstration program, which subsidizes member premiums and provides additional protection through the risk corridor in the event of unforeseen losses, but such election may not be sufficient to offset the uncertainty or risks relating to our experience with M3P as well as the increased risk exposure.

Increases in our pharmaceutical costs could have a material adverse effect on the level of our medical costs and our results of operations.

Introduction of new high-cost specialty drugs and sudden cost spikes for existing drugs increase the risk that the pharmacy cost assumptions used to develop our capitation rates are not adequate to cover the actual pharmacy costs, which jeopardizes the overall actuarial soundness of our rates. Bearing the high costs of new specialty drugs or the high-cost inflation of drugs without an appropriate rate adjustment or other reimbursement mechanism could have an adverse impact on our financial condition and results of operations. In addition, evolving regulations and state and federal mandates regarding coverage, including state-managed pharmacy benefit programs, may impact the ability of our health plans to continue to receive existing price discounts on pharmaceutical products for our members. Other factors affecting our pharmaceutical costs include, but are not limited to, geographic variation in utilization of new and existing pharmaceuticals, changes in discounts, civil investigations and litigation. Although we will continue to work with state Medicaid agencies in an effort to ensure that we receive appropriate and actuarially sound reimbursement for all new drug therapies and pharmaceuticals trends, there can be no assurance that we will be successful in that regard.

Ineffectiveness of state-operated systems and subcontractors could adversely affect our business.

A number of our health plans rely on other state-operated systems or subcontractors to qualify, solicit, educate and assign eligible members into managed care plans. The effectiveness of these state operations and subcontractors can have a material effect on a health plan's enrollment in a particular month or over an extended period. When a state implements either new programs to determine eligibility or new processes to assign or enroll eligible members into health plans, or when it chooses new subcontractors, or has not adequately maintained systems, there is an increased potential for an unanticipated impact on the overall number of members assigned to managed care plans.

Additionally, we rely on the accuracy of eligibility lists provided by state governments and their vendors. Inaccuracies in those lists would negatively affect our results of operations. Premium payments to our health plans are based upon eligibility lists produced by state governments and their vendors. From time to time, states require us to reimburse them for premiums paid to us based on an eligibility list that a state later discovers contains individuals who are not in fact eligible for a government sponsored program or are eligible for a different premium category or a different program. Our results of operations would be adversely affected as a result of such reimbursement to the state if we make or have made related payments to providers and are unable to recoup such payments from the providers. Alternatively, a state could fail to pay us for members for whom we are entitled to payment. Such factors could have an adverse effect on our premium revenues and results of operations, financial condition and cash flows.

Our encounter data may be inaccurate or incomplete, which could have a material adverse effect on our results of operations, financial condition and cash flows and ability to bid for, and continue to participate in, certain programs.

Our contracts require the submission of complete and correct encounter data. The accurate and timely reporting of encounter data is increasingly important to the success of our programs because more states are using encounter data to determine compliance with performance standards and to set premium rates. We have expended and may continue to expend additional effort and incur significant additional costs to collect or correct inaccurate or incomplete encounter data from our existing health plans and any health plans we may acquire in the future and have been and continue to be, exposed to operating sanctions and financial fines and penalties for noncompliance. In some instances, our government clients have established retroactive requirements for the encounter data we must submit. There also may be periods of time in which we are unable to meet existing requirements. In either case, it may be prohibitively expensive or impossible for us to collect or reconstruct this historical data.

We may experience challenges in obtaining complete and accurate encounter data, due to difficulties with providers and third-party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data, these difficulties could adversely affect the premium rates we receive and how membership is assigned to us and subject us to financial penalties, which could have a material adverse effect on our results of operations, financial condition cash flows and our ability to bid for, and continue to participate in, certain programs.

If state regulators do not approve payments of dividends and distributions by our subsidiaries to us, we may not have sufficient funds to implement our business strategy.

We principally operate through our health plan subsidiaries. As part of normal operations, we may make requests for dividends and distributions from our subsidiaries to fund our operations. In addition to state corporate law limitations, these subsidiaries are subject to more stringent state insurance and HMO laws and regulations that limit the amount of dividends and distributions that can be paid to us without prior approval of, or notification to, state regulators. If these regulators were to deny or delay our subsidiaries' requests to pay dividends, the funds available to us would be limited, which could harm our ability to implement our business strategy.

We derive a significant portion of our premium revenues from operations in a number of states, and our results of operations, financial condition or cash flows could be materially adversely affected by a decrease in premium revenues or profitability in any one of those states.

Operations in a number of states have accounted for a significant portion of our premium revenues to date. If we were unable to continue to operate in any of those states or if our current operations in any portion of one of those states were significantly curtailed, our revenues could decrease materially. For example, as part of the normal course of business, our Medicaid contracts are routinely up for reprocurement. Our reliance on operations in a limited number of states could cause our revenues and profitability to change suddenly and unexpectedly depending on legislative or other governmental or regulatory actions and decisions or changes in governmental administrations, economic conditions and similar factors in those states. Government entities in states we currently serve could open the bidding for their Medicaid or other healthcare programs to other health insurers through a request for proposal process. For example, we are currently protesting the Texas and Georgia Medicaid reprocurements in which we were not a successful bidder. Reductions in our service area or services provided in any of the states in which we operate could harm our business.

Competition may limit our ability to increase penetration of the markets that we serve.

We compete for members principally on the basis of size and quality of provider networks, the design and cost of benefits provided and quality of service. We compete with numerous types of competitors, including other health plans and traditional state Medicaid programs that reimburse providers as care is provided, as well as other non-traditional competitors. In addition, the administration of the ACA has the potential to shift the competitive landscape in our segment.

Some of the health plans with which we compete have greater financial and other resources and offer a broader scope of products than we do. In addition, significant merger and acquisition activity continues to occur in the managed care industry, as well as complementary industries, such as the hospital, physician, pharmaceutical, medical device and health information systems businesses. To the extent that competition intensifies in any market that we serve, as a result of industry consolidation or otherwise, our ability to retain or increase members and providers, or maintain or increase our revenue growth, pricing flexibility and control over medical cost trends may be adversely affected.

We operate in a highly competitive, dynamic and rapidly evolving industry and our failure to adapt could negatively impact our business.

The health service industry continues to be competitive, dynamic and rapidly evolving. Any significant shifts in the structure of the industry could alter industry dynamics and adversely affect our ability to compete, attract or retain clients and customers. Industry shifts could result (and have resulted) from, among other things:

- a large intra- or inter-industry merger or industry consolidation;
- strategic alliances;
- change in broker distribution channels and requirements;
- continuing consolidation among physicians, hospitals and other health care providers, as well as changes in the organizational structures chosen by physicians, hospitals and health care providers;
- new market entrants, including those not traditionally in the health service industry; and
- innovations in technology in the health service industry, including the use of artificial intelligence and machine learning.

Our failure to anticipate or appropriately adapt to changes in the industry could negatively impact our competitive position and adversely affect our business and results of operations.

If we are unable to maintain relationships with our provider networks and timely update our provider directories, our profitability may be materially adversely affected.

Our profitability depends, in large part, upon our ability to contract at competitive prices with hospitals, physicians, and other healthcare providers. Our provider arrangements with our primary care physicians, specialists and hospitals generally may be canceled by either party without cause upon 90 to 120 days prior written notice. We cannot provide any assurance that we will be able to continue to renew our existing contracts or enter into new contracts on a timely basis or under favorable terms enabling us to service our members profitably. Healthcare providers with whom we contract may not properly manage the costs of, and access to services, be able to provide effective telehealth services, maintain financial solvency, pay secondary providers for services rendered (which could lead secondary providers to demand payment from us even though we have made our regular capitated payments to the provider group) or avoid disputes with other providers. Depending on state law and the regulatory environment, it may be necessary for us to pay such claims. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

In any particular market, physicians and other healthcare providers could refuse to contract, demand higher payments or take other actions that could result in higher medical costs or difficulty in meeting regulatory or accreditation requirements, among other things. In some markets, certain healthcare providers, particularly hospitals, physician/hospital organizations or multi-specialty physician groups, may have significant market positions or near monopolies that could result in diminished bargaining power on our part. In addition, accountable care organizations, practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage and other organizational structures that physicians, hospitals and other healthcare providers choose may change the way in which these providers interact with us and may change the competitive landscape. Such organizations or groups of healthcare providers may compete directly with us, which could adversely affect our operations, and our results of operations, financial condition and cash flows by impacting our relationships with these providers or affecting the way that we price our products and estimate our costs, which might require us to incur costs to change our operations. Provider networks may consolidate or be acquired by our direct competitors, resulting in a reduction in the competitive environment or in our competitive position. In addition, if these providers refuse to contract with us, use their market position to negotiate contracts that are unfavorable to us, or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

From time to time, healthcare providers assert or threaten to assert claims seeking to terminate non-cancelable agreements due to alleged actions or inactions by us. If we are unable to retain our current provider contract terms or enter into new provider contracts timely or on favorable terms, our profitability may be materially adversely affected. In addition, from time to time, we may be subject to class action or other lawsuits by healthcare providers with respect to claim payment procedures or similar matters. In addition, regardless of whether any such lawsuits brought against us are successful or have merit, they will still be time-consuming and costly and could distract our management's attention. As a result, under such circumstances, we may incur significant expenses and may be unable to operate our business effectively.

In addition, we are subject to certain state and federal regulations and contractual provisions regarding provider directory accuracy. If we are determined to be out of compliance with such accuracy requirements or other contractual operational requirements, we may be subject to penalties, sanctions, damages or other consequences resulting from regulatory audits and investigations and/or litigation and otherwise suffer competitive harm, which could have a material adverse impact on our business reputation, financial condition, cash flows or results of operations.

If our third-party vendors fail to meet their contractual obligations to us or fail to comply with applicable laws or regulations, our results of operations may be adversely affected and we may be exposed to brand and reputational harm, litigation and/or regulatory action.

We are subject to risks associated with outsourcing services and functions to third-party vendors. We contract with various third-party vendors to perform certain functions and services, including for pharmacy benefits management, medical management and other member-related services as well as technology services, including AI. Our arrangements with these third-party vendors may expose us to public scrutiny, adversely affect our brand and reputation, expose us to litigation or regulatory action, and otherwise make our operations vulnerable if we fail to adequately oversee, monitor and regulate their performance or if they fail to meet their contractual obligations to us, including successfully and timely transitioning services, delivering expected cost savings, guarantees or commitments, increasing their service levels to us, or complying with applicable laws or regulations.

Any failure of these third-party vendors' prevention, detection or control systems related to regulatory compliance, compliance with our internal policies, data security and/or cybersecurity or any incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, members' or other constituents' sensitive information could require us to expend significant resources to remediate any damage, interrupt our operations and adversely affect our brand and reputation and also expose us to whistleblower, class action and other litigation, other proceedings, prohibitions on marketing or active or passive enrollment of members, corrective actions, fines, sanctions and/or penalties, any of which could adversely affect our business results of operations, financial condition or cash flows. If the third-party vendors cannot adequately perform services to us due to lack of adequate staffing, infrastructure, experience, operational maturity, funding, bankruptcy, insolvency, or other credit failure, it could have a material adverse effect on our results of operations if we are not able to contract with other service providers on a timely basis or at all.

If we or our third-party vendors are unable to integrate and manage information systems and networks effectively, our operations could be disrupted.

Our operations depend significantly on effective information systems and networks. The information gathered and processed by information systems and networks assists us in, among other things, monitoring utilization and other cost factors, processing provider claims and providing data to our regulators. Our healthcare providers also depend upon our information systems and networks for membership verifications, claims status and other information. Our information systems, networks and applications require continual maintenance, upgrading and enhancement to meet our operational needs and regulatory requirements. We regularly upgrade and expand our information systems' and networks' capabilities. If we, our healthcare providers, brokers or our third-party vendors experience difficulties with the transition to or from information systems or networks or do not appropriately integrate, maintain, enhance, secure or expand information systems or networks, we could suffer, among other things, operational disruptions, loss of existing members and providers and difficulty in attracting new members and providers, complaints, regulatory problems and increases in administrative expenses. In addition, our healthcare providers', our brokers' or our third-party vendors' ability to integrate and manage information systems and networks may be impaired as the result of events outside our control, including natural disasters, such as earthquakes or fires, or acts of wars, aggression or terrorism, which may include cyber-attacks or other data security incidents by terrorists or other governmental or non-governmental actors. Further, as connectivity of technology advances, artificial intelligence and business processes supported by large language models that are used by us, our healthcare providers, our brokers, or our third-party vendors may not operate as expected or may give rise to risks related to accuracy, bias, discrimination, intellectual property infringement, cybersecurity and data privacy, among others. The development and use of artificial intelligence technologies is still in its early stages, and as a result it is not possible to predict all of the risks and potentially unintended consequences related to the use of artificial intelligence by us, our health care providers, our brokers or our third-party vendors.

We may also from time to time obtain significant portions of our systems-related or other services or facilities from independent third-party vendors, which may make our operations vulnerable if such third-party vendors fail to perform adequately. In addition, our ability to use outsourcing resources in certain jurisdictions might be limited by legislative action or contracts, with the result that the work must be performed at greater expense or we may be subject to sanctions for non-compliance. Any of these risks might have a materially adverse impact on our business, results of operations and financial condition.

A failure in or breach of our operational or security systems, networks or infrastructure, or those of third-party vendors with which we do business, including as a result of cyber-attacks and other data security incidents, could have a material adverse effect on our business.

Data security risks have significantly increased in recent years in part because of the proliferation of new technologies, the use of the internet and telecommunications technologies to conduct our operations and the increased sophistication and activities of organized crime, hackers, terrorists and other external parties, including foreign states and state-supported actors. Data security risks also may derive from fraud or malice on the part of our team members or third-party vendors, or may result from human error, software bugs, server malfunctions, software or hardware failure or other technological failure. As these threats continually evolve, we may be required to devote substantial additional resources to modify or enhance our operational or security systems and networks and our cybersecurity program.

Our operations rely on the secure transmission, storage and other processing of confidential, personal, proprietary, sensitive and other information in our computer systems and networks as well as third-party vendors with which we do business.

Security breaches of such systems and networks may arise from external or internal threats. External breaches may result from, among other things, a threat actor hacking personal information for financial gain, attempting to fraudulently induce our employees into disclosing usernames, passwords or other sensitive information to obtain unauthorized access to our systems, attempting to cause harm or interruption to our operations or intending to obtain competitive information. Internal breaches may result from, among other things, inappropriate security access to confidential information by rogue team members, consultants or third-party vendors. In addition, the rapid evolution and increased adoption of artificial intelligence technologies may intensify these risks by making such security breaches more difficult to detect, contain or mitigate. Any security breach could result in the misappropriation, loss or other unauthorized access, disclosure or use of confidential member information, including personal information, financial data, competitively sensitive information or other proprietary data, whether by us or a third party, and could have a material adverse effect on our business reputation, financial condition, cash flows or results of operations.

We maintain a system of prevention and detection controls through our security programs; however, our prevention and detection controls may not prevent or identify all such attacks on a timely basis, or at all. Despite our best attempts to maintain adherence to data privacy and security best practices, as well as compliance with applicable laws, regulations, rules, standards and contractual requirements, our facilities, systems and networks, and those of our third-party vendors, may be vulnerable to data privacy or security breaches, acts of vandalism or theft, malware, ransomware, social engineering attacks (including phishing attacks), denial-of-service attacks or other forms of cyber-attack, misplaced or lost data including paper or electronic media, programming and/or human errors or other similar events. We experience attempted external hacking or malicious attacks on a regular basis. In the past, we have experienced cyber-attacks and data breaches, and our third-party vendors have experienced cyber-attacks and security incidents, resulting in disclosure of confidential or protected health information that have not resulted in any material financial loss or penalty to date. For example, in 2024, Change Healthcare, Inc. experienced a cybersecurity incident that disrupted its ability to provide services, impacting payers, providers and pharmacies nationwide, including Centene and some of its subsidiaries. While this incident did not have a material impact on Centene, there can be no assurance that this incident and other privacy or security breaches will not require us to expend significant resources to remediate any damage, interrupt our operations and damage our business or reputation, subject to state or federal agency review, and result in enforcement actions, material fines and penalties, litigation or other actions which could have a material adverse effect on our business, reputation, results of operations, financial condition and cash flows.

While we generally perform data security due diligence on our key service providers, we do not control our service providers and our ability to monitor their data security practices is limited. Some of our third-party vendors may store or have access to our data and may not have effective controls, processes, or practices to protect our information from loss, unauthorized disclosure, unauthorized use or misappropriation, cyber-attacks or other data security incidents. For example, hardware, software, and other applications and updates procured from service providers may contain defects that have and may in the future unexpectedly restrict or prevent access to or interfere with the proper operation of our information systems and hardware. A vulnerability in our service providers' hardware, software or systems, a failure of our service providers' safeguards, policies or procedures, or a cyber-attack or other data security incident affecting any of these third-party vendors could harm our business. Additionally, we cannot be certain that our insurance coverage will be adequate for data security liabilities actually incurred, that insurance will continue to be available to us on economically reasonable terms, or at all, or that our insurer will not deny coverage as to any future claim.

We may be unable to attract, retain or effectively manage the succession of key personnel.

We are highly dependent on our ability to attract, develop and retain qualified personnel to operate and expand our business. We face intense competition for experienced and highly skilled team members, and we may be unable to attract and retain such team members, or competition among potential employers may result in increasing compensation. In addition, we may be adversely impacted if we are unable to adequately plan for the succession of our executives and senior management. While we have succession plans in place for members of our executive and senior management team, these plans do not guarantee that the services of our executive and senior management team will continue to be available to us. Our ability to replace any departed members of our executive and senior management team or other key team members may be difficult and may take an extended period of time because of the limited number of individuals in the Managed Care industry with the breadth of skills and experience required to successfully operate and expand a business such as ours. Competition to hire from this limited pool is intense, and we may be unable to hire, train, retain or motivate these personnel. Further, the availability of hybrid or remote working arrangements has expanded the pool of companies that can compete for our team members and employment candidates. Our modern work environment, including remote and hybrid work arrangements which is utilized by the majority of our team members, may present operational, cybersecurity and workplace culture challenges. If we are unable to attract, retain and effectively manage the succession plans for key personnel, executives and senior management, our business and financial condition, results of operations or cash flows could be harmed.

An impairment charge with respect to our recorded goodwill, intangible assets and real estate portfolio could have a material impact on our results of operations and shareholders' equity.

Changes in business strategy, divestitures, government regulations or economic or market conditions and non-renewal of government contracts have resulted and may result in impairments of our real estate portfolio, goodwill and other intangible assets at any time in the future. For example, as a result of market conditions in July 2025, including the OBBBA and the decline in our stock price, we performed a quantitative impairment analysis during the third quarter to determine whether goodwill was impaired, which resulted in a non-cash goodwill impairment of $6.7 billion in the third quarter of 2025. For additional information, see Note 6. *Property, Software and Equipment*, Note 7. *Goodwill and Intangible Assets,* and Note 11. *Leases* to the consolidated financial statements included in Part II of this Annual Report on Form 10-K. We may have additional impairment charges in connection with our periodic evaluation of our goodwill and intangible assets using assumptions and judgments regarding the estimated fair value of our reporting units. Our assumptions and judgments regarding the existence of impairment indicators are based on, among other things, legal factors, contract terms, market conditions and operational performance. Further, the estimated value of our reporting units may be impacted because of business decisions we make associated with any future changes to laws and regulations, which could unfavorably affect the carrying value of certain goodwill and other intangible assets and result in impairment charges in future periods. If an event or events occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill and other intangible assets, such revision could result in a non-cash impairment charge that could have a material impact on our results of operations and shareholders' equity in the period in which the impairment occurs.

Risks Relating to Regulatory and Legal Matters

Reductions or delays in funding of, changes to eligibility requirements for, government-sponsored healthcare programs in which we participate, and any inability on our part to effectively adapt to changes to these programs could have a material adverse effect on our results of operations, financial condition and cash flows.

The majority of our revenues come from government subsidized healthcare programs including Medicaid, Medicare, CHIP, LTSS, ABD, Foster Care and Health Insurance Marketplace premiums. Changes in these programs, including due to executive orders or other regulatory actions from the current political administration, could change the number of persons enrolled in or eligible for these programs, reduce funding, delay funding and increase our administrative and healthcare costs under these programs. For example, due to the declaration of the end of the PHE and the subsequent expiration of the eligibility determination waivers, the resumption of the Medicaid eligibility redeterminations significantly reduced our membership in our Medicaid programs, and we did not fully offset the loss of this membership by increased enrollment in our Health Insurance Marketplace products. In addition, as a result of the expiration of the PHE due to the COVID-19 pandemic, and the resulting Medicaid redeterminations process, we have experienced a higher HBR related to the remaining members, due to the acuity profile of this membership, as well as the gaps in eligibility for certain members who have rejoined the Medicaid plans. While we continue to work with our state partners to match rates to acuity post-redeterminations, such rate adjustments may be delayed or insufficient to offset the increased acuity. In some cases, states may decide to reduce reimbursement or reduce benefits. If any state in which we operate were to decrease premiums paid to us or pay us less than the amount necessary to keep pace with our cost trends, it could have a material adverse effect on our results of operations, financial condition and cash flows.

The Final Rule was published in the Federal Register on June 25, 2025. The Final Rule makes changes to policies to strengthen program integrity measures in the Marketplace. For example, the Special Enrollment Period for those under 150% of the FPL has been repealed beginning August 25, 2025. Several of the provisions of the Final Rule have been stayed due to ongoing litigation. These include a requirement for certain consumers who automatically re-enroll into a fully subsidized Marketplace plan to be re-enrolled into the same plan with a $5 premium until the consumer updates their exchange application to confirm APTC eligibility. Additionally, exchanges may no longer accept a consumer's self-attestation of projected annual household income when the IRS cannot verify it due to lack of tax return data; rather, exchanges must verify household income using other trusted data sources.

Extended eligibility for the Enhanced APTC for Marketplace members expired on December 31, 2025. In July 2025, the OBBBA placed additional restrictions on APTC requirements. For example, beginning January 1, 2026, should individuals mis-estimate their projected income, the OBBBA requires them to reimburse the IRS for the full amount of excess tax credit received. In addition, as of January 1, 2026, the OBBBA prohibits individuals from receiving APTCs if they enroll in health coverage through a Special Enrollment Period associated with their income. We anticipate that the combined effect of the expiration of the Enhanced APTCs, the Final Rule, and the OBBBA will reduce 2026 Marketplace membership and continue to increase the overall morbidity of the Marketplace population.

Payments from government payors may be delayed in the future, which, if extended for any significant period of time, could have a material adverse effect on our results of operations, financial condition, cash flows or liquidity. For example, we have a receivable due to us from CMS for Part D risk-sharing programs attributable to the 2025 plan year that we expect to be paid by CMS within a year after the plan year closes. If the payments from CMS are delayed, our cash flows may be materially adversely affected. In addition, delays in obtaining, or failure to obtain or maintain, governmental approvals, or moratoria imposed by regulatory authorities, could adversely affect our revenues or membership, increase costs or adversely affect our ability to bring new products to market as forecasted. Other changes to our government programs could affect our willingness or ability to participate in any of these programs or otherwise have a material adverse effect on our business, financial condition or results of operations.

Under most of these programs, the base premium rate paid for each program differs, depending on a combination of factors such as defined upper payment limits, a member's health status, age, gender, county or region and benefit mix. Since Medicaid was created in 1965, the federal government and states have shared the costs for this program, with the federal government share currently averaging approximately 60%. We are therefore exposed to risks associated with federal and state government contracting or participating in programs involving a government payor, including but not limited to the general ability of the federal and/or state governments to terminate or modify contracts with them, in whole or in part, without prior notice, for convenience or for default based on performance; potential regulatory or legislative action that may materially modify amounts owed; our dependence upon Congressional or legislative appropriation and allotment of funds and the impact that delays in government payments could have on our operating cash flow and liquidity; responses to pandemics, resurgences and new emergent diseases and other regulatory, legislative or judicial actions that may have an impact on the operations of government subsidized healthcare programs, including ongoing litigation involving the ACA.

Future levels of funding and premium rates may be affected by continuing government efforts to contain healthcare costs and may further be affected by state and federal budgetary constraints and spending initiatives or changes in control of the legislative or executive branches at the state and federal level. Governments periodically consider reducing or reallocating the amount of money they spend for Medicaid, Medicare, CHIP, LTSS, ABD and Foster Care. For example, the OBBBA includes requirements that may reduce the number of members eligible for state Medicaid Expansion programs by requiring work or community engagement by members and for state Medicaid agencies to redetermine member eligibility at more frequent intervals, along with adding a "Cost Sharing" or "Co-Pay" for certain medical services. These changes could have the effect of increasing the overall morbidity of the Medicaid Expansion population largely beginning in 2027, subject to state implementation plans. Several other provisions of the OBBBA, such as adjustments to provider taxes and state directed payments beginning in 2028, may have the effect of reducing the amount of federal funding for Medicaid, which could result in changes in the design of Medicaid programs, including coverage of benefits, eligibility, and/or provider payment rates. In particular, New York intends to terminate its Essentials Plan-5, which provided state-subsidized healthcare for individuals from 200% to 250% of the FPL by July 1, 2026.

Medicare remains subject to the automatic spending reductions imposed by the Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012 (sequestration), subject to a 2% cap, which was extended by the Bipartisan Budget Act of 2019 through 2029, which was reinstated on July 1, 2022, after a temporary suspension due to the COVID pandemic. Additional changes to the funding or eligibility criteria for these programs could materially impact our membership, revenues, financial condition and cash flows.

The IRA enacted significant changes to the Medicare Part D program beginning on January 1, 2025. These changes created additional uncertainty for 2025 Medicare Part D bids, including their profitability and the competitive market landscape. If our future Part D premium bids are not profitable or below the CMS benchmarks or competitors price their products with significantly lower premiums, membership, revenue and profitability of this product could be materially reduced, which in turn could have a material adverse effect on our results of operations and financial conditions. Further, changes in the Medicare Part D program could impact membership and cause the timing of our cash flows to be impacted, which in turn could impact the timing and level of our interest expense.

In addition, CMS regulations will require beneficiaries dually enrolled in Medicare and in a Medicaid managed care plan to receive integrated care through the Medicaid company's Medicare Advantage D-SNPs beginning in 2030, with certain restrictions beginning in 2027, which may restrict our product offerings in some geographic service areas. However, some states have already moved or are planning to exclusively align dual-eligible enrollment under an aligned D-SNP before this timeframe.

In addition, adverse economic conditions may put pressures on state budgets as tax and other state revenues decrease while the population that is eligible to participate in these programs remains steady or increases, creating more need for funding. We anticipate this will require government agencies to find funding alternatives, which may result in reductions or delays in funding for programs, contraction of covered benefits, increases to taxes and fees and limited or no premium rate increases or premium rate decreases. A reduction (or less than expected increase), a protracted delay or a change in allocation methodology in government funding for these programs, as well as termination of one or more contracts for the convenience of the government, may materially and adversely affect our results of operations, financial condition and cash flows.

Also, if legislation increasing the federal debt ceiling is not enacted and the debt ceiling is reached, the federal government may stop or delay making payments on its obligations. In addition, if another federal government shutdown were to occur for a prolonged period of time, federal government payment obligations, including its obligations under Medicaid, Medicare, CHIP, LTSS, ABD, Foster Care and the Health Insurance Marketplace, may be delayed. Similarly, if state government shutdowns were to occur, state payment obligations may be delayed. If the federal or state governments fail to make payments under these programs on a timely basis, our business could suffer, and our financial condition, results of operations or cash flows may be materially affected.

Significant changes to the ACA and the other government-sponsored healthcare programs in which we participate could materially and adversely affect our results of operations, financial condition, and cash flows.

The enactment of the ACA in March 2010 transformed the U.S. healthcare delivery system through a series of complex initiatives; however, the ACA has faced, and continues to face, administrative, judicial and legislative challenges to repeal or change certain of its significant provisions. Changes to portions or the entirety of the ACA or significant changes to the other government-sponsored healthcare programs in which we participate, as well as judicial interpretations in response to constitutional and other legal challenges, as well as the uncertainty generated by such actual or potential challenges, could materially and adversely affect our business and financial condition, results of operations or cash flows. The ultimate content, timing or effect of any potential future legislation or litigation and the outcome of other lawsuits cannot be predicted.

Among the most significant of the ACA's provisions was the establishment of the Health Insurance Marketplace for individuals and small employers to purchase health insurance coverage that included a minimum level of benefits and restrictions on coverage limitations and premium rates, as well as the expansion of Medicaid coverage to all individuals under age 65 with incomes up to 138% of the federal poverty level beginning January 1, 2014, subject to each state's election. Several states in which we operate have obtained Section 1115 waivers to implement the ACA's Medicaid expansion in ways that extend beyond the flexibility provided by the federal law. In July 2025, CMS indicated that it would no longer approve new Section 1115 waivers for continuous care coverage or workforce assistance.

In addition, the OBBBA includes requirements that may reduce the number of members eligible for state Medicaid Expansion programs by requiring work or community engagement by members and for state Medicaid agencies to redetermine member eligibility at more frequent intervals, along with adding a "Cost Sharing" or "Co-Pay" for certain medical services. These changes could have the effect of increasing the overall morbidity of the Medicaid Expansion population largely beginning in 2027, subject to state implementation plans. Several other provisions of the OBBBA, such as adjustments to provider taxes and state directed payments beginning in 2028, may have the effect of reducing the amount of federal funding for Medicaid, which could result in changes in the design of Medicaid programs, including coverage of benefits, eligibility, and/or provider payment rates. In particular, New York intends to terminate its Essentials Plan-5, which provided state-subsidized healthcare for individuals from 200% to 250% of the FPL by July 1, 2026.

The Final Rule was published in the Federal Register on June 25, 2025. The Final Rule makes changes to policies to strengthen program integrity measures in the Marketplace. For example, the Special Enrollment Period for those under 150% of the FPL has been repealed beginning August 25, 2025. Several of the provisions of the Final Rule have been stayed due to ongoing litigation. These include a requirement for certain consumers who automatically re-enroll into a fully subsidized Marketplace plan to be re-enrolled into the same plan with a $5 premium until the consumer updates their exchange application to confirm APTC eligibility. Additionally, exchanges may no longer accept a consumer's self-attestation of projected annual household income when the IRS cannot verify it due to lack of tax return data; rather, exchanges must verify household income using other trusted data sources.

Extended eligibility for the Enhanced APTC for Marketplace members expired on December 31, 2025. For example, beginning January 1, 2026, should individuals mis-estimate their projected income, the OBBBA requires them to reimburse the IRS for the full amount of excess tax credit received. In addition, as of January 1, 2026, the OBBBA prohibits individuals from receiving APTCs if they enroll in health coverage through a Special Enrollment Period associated with their income. We anticipate that the combined effect of the expiration of the Enhanced APTCs, the Final Rule, and the OBBBA will reduce 2026 Marketplace membership and continue to increase the overall morbidity of the Marketplace population.

These changes and other potential changes involving the functioning of the Health Insurance Marketplace as a result of additional new state and federal legislation, regulation, executive action or litigation, including those related to extending enrollment periods, increasing eligibility in the program design, changing the eligibility and amount of the advanced premium tax credit, additional payment integrity initiatives that have the effect of reducing membership and expanding navigator services the timing of those changes and our ability to respond to any changes in compliance with our state and federal timing requirements, could impact our business and results of operations adversely or in other ways that we do not currently anticipate.

Negative public perception of the managed care industry, including industry practices, could adversely affect our business, operating results, cash flows and prospects.

The managed care industry in which we operate has been and may be negatively perceived by the public from time to time. This negative publicity can lead to increased legislation, regulation, review of industry practices and private litigation in the commercial sector. Negative publicity could come as a result of adverse media coverage, including on social media, litigation against us or other industry participants, actual or perceived shortfalls regarding our industry's or our own products or services, and actual or perceived failures to meet customer or member expectations. Negative publicity resulting from any of these risks could adversely affect our business, our ability to attract and retain talent, our results of operations, stock price, brand, reputation, and our ability to retain our existing customers and members, and significantly change the regulatory and legislative requirements with which we must comply.

Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could force us to change how we operate and could harm our reputation and business.

Our business is extensively regulated by the states in which we operate and by the federal government. Changes in political party, or administrations at the state or federal level may change the attitude or public commentary towards healthcare programs and result in changes to the existing legislative or regulatory environment, changes in the application of existing laws and regulations, or changes to funding available for healthcare programs. In each of the jurisdictions in which we operate, we are regulated by the relevant insurance, health, and/or human services or government departments that oversee the activities of MCOs providing or arranging to provide services to Medicaid, Medicare, Health Insurance Marketplace enrollees or other beneficiaries.

The frequent enactment of, changes to, or interpretations of laws and regulations could, among other things: force us to restructure our relationships with providers within our network; require us to implement additional or different programs and systems; restrict revenue and enrollment growth; increase our healthcare and administrative costs; impose additional capital and surplus requirements; modify how we contract, pay and interact with brokers, enact additional payment integrity initiatives that have the effect of reducing membership and increase or change our liability to members in the event of malpractice by our contracted providers. In 2023, HHS finalized transparency requirements for artificial intelligence and other predictive algorithms used in certified health information technology, such as decision support interventions. Changes to laws and regulations regarding how we may use artificial intelligence could make it harder for us to conduct our business using artificial intelligence; require us to retrain our artificial intelligence; or prevent or limit our use of artificial intelligence. Our use of artificial intelligence technologies could also result in additional compliance costs; regulatory investigations, actions, fines or penalties; and consumer or other lawsuits. To the extent that we rely on or use the output of artificial intelligence, any inaccuracies, biases or errors could have unfavorable impacts on us, our business and our results of operations or financial condition.

Additionally, the taxes and fees paid to federal, state, and local governments may increase due to several factors, including: enactment of, changes to or interpretations of tax laws and regulations, audits by government authorities, and geographic expansions into higher taxing jurisdictions.

We are often required to maintain a minimum medical loss ratio (MLR) or share profits in excess of certain levels, which may be retroactive. In certain circumstances, our plans have returned premiums back to the states, enrollees or other beneficiaries in the event profits exceed established levels or MLR does not meet the minimum requirement. The amount of premium returned may include transparent pharmacy pricing and rebate initiatives. Other states may require us to meet certain performance and quality metrics in order to maintain our contracts or receive additional or full contractual revenue. In addition, our health plan subsidiaries must comply with minimum statutory capital and other financial solvency requirements, such as deposit and surplus requirements.

The governmental healthcare programs in which we participate are subject to the satisfaction of certain regulations and performance standards. Regulators require numerous steps for continued implementation of the ACA, including the promulgation of a substantial number of potentially more onerous federal regulations. If we fail to effectively or timely implement or appropriately adjust our operational and strategic initiatives with respect to the implementation of healthcare reform, or do not do so as effectively as our competitors, our results of operations may be materially adversely affected. For example, CMS regulations will require beneficiaries dually enrolled in Medicare and in a Medicaid managed care plan to receive integrated care through the Medicaid company's Medicare Advantage D-SNPs beginning in 2030, with certain restrictions beginning in 2027, which may restrict our product offerings in some geographic service areas. However, some states have already moved or are planning to exclusively align dual-eligible enrollment under an aligned D-SNP before this timeframe. Our inability to improve or maintain adequate quality scores and Star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs. Specifically, several of our Medicaid contracts require us to maintain a Medicare health plan.

In April 2016, CMS issued final regulations that revised existing Medicaid managed care rules by establishing a minimum MLR standard for Medicaid of 85% and strengthening provisions related to network adequacy and access to care, enrollment and disenrollment protections, beneficiary support information, continued service during beneficiary appeals, and delivery system and payment reform initiatives, among others. In May 2024, CMS issued further revisions to the Medicaid managed care regulations which become effective between July 2024 and July 2027. The 2024 Final Rule focused on changes in areas including access to care, delivery system and payment reform initiatives, MLR standards and quality oversight. Although we strive to comply with all existing regulations and to meet performance standards applicable to our business, failure to meet these requirements could result in financial fines and penalties. Also, states or other governmental entities may carve out certain services and benefits from the government programs in which we participate, or they may not allow us to continue to participate in their government programs or we may fail to win procurements to participate in such programs, any of which could materially and adversely affect our results of operations, financial condition and cash flows. See also Note 17. *Contingencies* to the consolidated financial statements included in Part II of this Annual Report on Form 10-K.

Our ability to provide services and support to manage our members' pharmacy benefits face regulatory risks and uncertainties which could materially and adversely affect our results of operations, financial condition and cash flows.

We provide services and support to manage our members' pharmacy benefits. These services are subject to extensive federal, state and local laws and regulations. In addition, federal and state legislatures and regulators regularly consider new regulations for the industry that could materially and adversely affect current industry practices, including ownership of pharmacies by insurance companies, the receipt or disclosure of rebates from pharmaceutical companies, the development and use of formularies and the use of average wholesale prices.

Our specialty pharmacy business would be materially and adversely affected by an inability to contract on favorable terms with pharmaceutical manufacturers and other suppliers, though we use a network of specialty pharmacies beyond AcariaHealth. Disruptions at any of our specialty pharmacies due to an event that is beyond our control could affect our ability to process and dispense prescriptions in a timely manner and could materially and adversely affect our results of operations, financial condition and cash flows.

Contracts in the prescription drug industry generally use pricing metrics published by third parties as benchmarks to establish pricing for prescription drugs. If these benchmarks are no longer published by third parties, or we, or our contractual partners, adopt other pricing benchmarks for establishing prices within the industry, or legislation or regulation requires the use of other pricing benchmarks, or future changes in drug prices substantially deviate from our expectations, the short- or long-term impacts may have a material adverse effect on our business and results of operations.

We have been and may from time to time become involved in costly and time-consuming litigation and other regulatory proceedings, which require significant attention from our management and could adversely affect our business.

From time to time, we are a defendant in lawsuits and regulatory actions and are subject to investigations relating to our business, including, without limitation, claims that may have retroactive application and periodic compliance and other reviews and investigations by various federal and state regulatory agencies with respect to requirements applicable to our business, including, without limitation, those related to payment of claims, compliance with the CMS Medicare and Marketplace regulations, including risk adjustment, prior authorizations and broker compensation, compliance with the False Claims Act, the calculation of minimum MLR and rebates related thereto, submissions to state agencies related to payments or state false claims acts, pre-authorization penalties, timely review of grievances and appeals, timely and accurate payment of claims, provider directory accuracy, network adequacy, cybersecurity issues, including those related to our or our third-party vendors' information systems, HIPAA and other federal and state fraud, waste and abuse laws; litigation arising out of general business activities, such as tax matters, disputes related to healthcare benefits coverage or reimbursement, putative securities class actions and related derivative lawsuits, and medical malpractice, privacy, real estate, intellectual property, vendor disputes and employment-related claims; and disputes regarding reinsurance arrangements, claims arising out of the acquisition or divestiture of various assets, class actions and claims relating to the performance of contractual and non-contractual obligations to providers, members, employer groups, vendors and others, including, but not limited to, the alleged failure to properly pay claims and challenges to the manner in which we processes claims, claims related to network adequacy and claims alleging that we have engaged in unfair business practices; and protests and appeals related to Medicaid procurement awards. Although we maintain some third-party insurance coverage, including excess liability insurance with third-party insurance carriers, certain liabilities or types of damages, such as punitive damages, may not be covered by insurance, insurers may dispute coverage or the amount of insurance may be insufficient to cover the entire damages awarded. In addition, regardless of the outcome of any litigation or regulatory proceedings, such proceedings are costly and time-consuming and require significant attention from our management and could therefore have a material adverse effect on our business and financial condition, results of operations or cash flows.

If we fail to comply with applicable data privacy and security laws, regulations, rules, standards and contractual obligations, including with respect to third-party vendors that utilize sensitive personal information on our behalf, our business, reputation, results of operations, financial condition and cash flows could be materially and adversely affected.

As part of our normal operations, we and our third-party vendors collect, retain and otherwise process confidential member information, including personal information. We and our third-party vendors are subject to various federal and state laws, regulations, rules, standards and contractual requirements regarding the use, disclosure and other processing of confidential member information (including personal information), including HIPAA, the HITECH Act, the Gramm-Leach-Bliley Act, which require us to protect the privacy of medical records and safeguard personal health information we maintain, use and otherwise process. Additionally, legislative and regulatory action at the federal, state and local levels is emerging in the areas of artificial intelligence and automation. These laws, rules and contractual requirements are subject to change and the regulatory environment surrounding data privacy and security laws is increasingly demanding. Compliance with existing or new data privacy and security laws, regulations and requirements may result in increased operating costs, and may constrain or require us to alter our business model or operations. In some cases, such laws, rules, regulations and contractual requirements also apply to our third-party vendors and require us to obtain written assurances of their compliance with such requirements. Certain of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data as mandated by payment card industry entities.

From time to time, Congress also has considered, and may currently be considering, various proposals for other data privacy and security laws to which we may become subject if passed. We expect there will continue to be new proposed laws, regulations and industry standards concerning privacy, data protection, information security, and artificial intelligence and automation in the U.S. and other jurisdictions, and we cannot yet determine the impacts such future laws, regulations and standards may have on our businesses or the businesses of our customers.

At the U.S. state level, we may be subject to laws and regulations such as the California Consumer Privacy Act (as amended by the California Privacy Rights Act, collectively, the CCPA), which broadly defines personal information and gives California residents expanded privacy rights and protections, such as affording them the right to access and request deletion of their information and to opt out of certain sharing and sales of personal information. Numerous other states also have enacted, or are in the process of enacting or considering, comprehensive state-level data privacy and security laws and regulations that share similarities with the CCPA. Moreover, laws in all 50 U.S. states require businesses to provide notice under certain circumstances to consumers whose personal information has been disclosed as a result of a data breach.

Further, while we strive to publish and prominently display privacy policies that are accurate, comprehensive, and compliant with applicable laws, regulations, rules and industry standards, we cannot ensure that our privacy policies and other statements regarding our practices will be sufficient to protect us from claims, proceedings, liability or adverse publicity relating to data privacy and security. Although we endeavor to comply with our privacy policies and to obtain written assurances of our third-party vendors' compliance, we may at times fail to do so or be alleged to have failed to do so. The publication of our privacy policies and other documentation that provide promises and assurances about data privacy and security can subject us to potential government or legal action if they are found to be deceptive, unfair, or misrepresentative of our actual practices. Any concerns about our data privacy and security practices, even if unfounded, could damage our reputation and adversely affect our business.

We increasingly rely on new and evolving technologies, including those powered by or incorporating artificial intelligence, as part of our internal operations and in the delivery of our products and services. These new technologies could present ethical, technological, legal, regulatory and other risks. We are required by certain regulators to develop and implement policies and procedures to promote and sustain the responsible design, development, and use of artificial intelligence. Any inadequacy or failure in designing, implementing or complying with such policies and procedures, or failure in complying with emerging laws, regulations and standards governing artificial intelligence, could adversely affect our operations that use or rely on artificial intelligence, or could materially and adversely affect our business, reputation, results of operations, financial position and cash flows.

Any failure or perceived failure by us to comply with our privacy policies, or applicable data privacy and security laws, regulations, rules, standards or contractual obligations, or any compromise of security that results in unauthorized access to, or unauthorized loss, destruction, use, modification, acquisition, disclosure, release or transfer of personal information, may result in requirements to modify or cease certain operations or practices, the expenditure of substantial costs, time and other resources, proceedings or actions against us, legal liability, governmental investigations, enforcement actions, claims, fines, judgments, awards, penalties, sanctions and costly litigation (including class actions). Any of the foregoing could harm our reputation, distract our management and technical personnel, increase our costs of doing business, adversely affect the demand for our products and services, and ultimately result in the imposition of liability, any of which could have a material adverse effect on our business, financial condition and results of operations.

If we fail to comply with the extensive federal and state fraud, waste and abuse laws, our business, reputation, results of operations, financial condition and cash flows could be materially and adversely affected.

We, along with other companies involved in public healthcare programs, have been, and from time to time are, the subject of federal and state fraud, waste and abuse investigations. The regulations and contractual requirements applicable to participants in these public sector programs are complex and subject to change. Violations of fraud, waste and abuse laws applicable to us could result in civil monetary penalties, criminal fines and imprisonment and/or exclusion from participation in Medicaid, Medicare, and other federal healthcare programs and federally funded state health programs. Fraud, waste and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, incorrect and unsubstantiated billing or billing for unnecessary medical services, improper marketing and violations of patient privacy rights. These fraud, waste and abuse laws include the federal False Claims Act, which prohibits the known filing of a false claim or the known use of false statements to obtain payment from the federal government, and the federal anti-kickback statute, which prohibits the payment or receipt of remuneration to induce referrals or recommendations of healthcare items or services. Many states have fraud, waste and abuse laws, including false claim act and anti-kickback statutes that closely resemble the federal False Claims Act and the federal anti-kickback statute. In addition, the Deficit Reduction Act of 2005 encouraged states to enact state-versions of the federal False Claims Act that establish liability to the state for false and fraudulent Medicaid claims and that provide for, among other things, claims to be filed by *qui tam* relators (private parties acting on the government's behalf). Federal and state governments have made investigating and prosecuting healthcare fraud, waste and abuse a priority. In the event we fail to comply with the extensive federal and state fraud, waste and abuse laws, our business, reputation, results of operations, financial condition and cash flows could be materially and adversely affected.

At the federal level, HIPAA and the HITECH Act broadened the scope of fraud, waste and abuse laws under HIPAA applicable to healthcare companies and established enforcement mechanisms to combat fraud, waste and abuse, including civil and, in some instances, criminal penalties for failure to comply with specific standards relating to the privacy, security and electronic transmission of protected health information. The HITECH Act expanded the scope of these provisions by mandating individual notification in instances of breaches of protected health information, providing enhanced penalties for HIPAA violations, and granting enforcement authority to states' Attorneys General in addition to the HHS Office for Civil Rights. It is possible that Congress may enact additional legislation in the future to increase the amount or application of penalties and to create a private right of action under HIPAA, which could entitle patients to seek monetary damages for violations of the privacy and security provisions.

We might be adversely impacted by tax legislation or challenges to our tax positions.

We are subject to the tax laws in the U.S. at the federal, state and local government levels and to the tax laws of other jurisdictions in which we operate. Tax laws might change in ways that adversely affect our tax positions, effective tax rate and cash flow. For example, on November 14, 2025, CMS issued guidance to implement the OBBBA's requirement that states can no longer impose higher tax rates on Medicaid MCOs than commercial insurance by the end of the fiscal year ending in 2026. If the states increase the tax rates applicable to our Marketplace line of business during 2026, we cannot offset those increases by increasing premiums, as our Marketplace rates were approved and determined in 2025, which could have a material impact on the profitability of our Marketplace products, results of operations, financial condition and cash flows.

We are also subject to tax examinations in various jurisdictions that might assess additional tax liabilities against us. Our tax reporting positions might be challenged by relevant tax authorities, we might incur significant expense in our efforts to defend those challenges and we might be unsuccessful in those efforts. Developments in examinations and challenges might materially change our provision for taxes in the affected periods and might differ materially from our historical tax accruals. Any of these risks might have a material adverse impact on our business, results of operations, financial condition and cash flows.

Risks Relating to Conditions in the Financial Markets and Economy

Our investment portfolio may suffer losses which could materially and adversely affect our results of operations or liquidity.

We maintain a significant investment portfolio of cash equivalents and short-term and long-term investments in a variety of securities, which are subject to general credit, liquidity, market and interest rate risks and will decline in value if interest rates increase or one of the issuers' credit ratings is reduced. As a result, we may experience a reduction in value or loss of our investments, which may have an adverse effect on our results of operations, liquidity and financial condition. In addition, changes in the economic environment, including periods of increased volatility in the securities markets, and changes in interest rates, can increase the difficulty of assessing investment impairment and increase the risk of potential impairment of these assets. There is continuing risk that declines in the fair value of our investments may occur and material impairments may be charged to income in future periods, resulting in recognized losses.

Adverse credit market conditions may have a material adverse effect on our liquidity or our ability to obtain credit on acceptable terms.

In the past, the securities and credit markets have experienced volatility and disruption. The availability of credit, from virtually all types of lenders, has at times been restricted. In the event we need access to additional capital to pay our operating expenses, fund subsidiary surplus requirements, make payments on or refinance our indebtedness, pay capital expenditures or fund acquisitions, our ability to obtain such capital may be limited and the cost of any such capital may be significant, particularly if we are unable to access our existing Revolving Credit Facility.

Our access to additional financing will depend on a variety of factors such as prevailing economic and credit market conditions, the general availability of credit, the overall availability of credit to our industry, our credit ratings and credit capacity and perceptions of our financial prospects. Similarly, our access to funds may be impaired if regulatory authorities or rating agencies take negative actions against us. If one or any combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and in such case, we may not be able to successfully obtain sufficient additional financing on favorable terms, within an acceptable time, or at all.

We have substantial indebtedness outstanding and may incur additional indebtedness in the future. Such indebtedness could reduce our agility and may adversely affect our financial condition.

As of December 31, 2025, we had consolidated indebtedness of $17.4 billion. We may further increase or refinance our indebtedness in the future.

This may have the effect, among other things, of subjecting us to additional restrictive covenants and reducing our flexibility to respond to changing business and economic conditions and increasing borrowing costs.

Among other things, our Revolving Credit Facility and Term Loan Facility (collectively, the Company Credit Facility) and the indentures governing our notes require us to comply with various covenants that impose restrictions on our operations, including our ability to incur additional indebtedness, create liens, pay dividends, make certain investments or other restricted payments, sell or otherwise dispose of substantially all of our assets and engage in other activities. We are also exposed to interest rate risk to the extent of our variable rate indebtedness. Changes in interest rates can increase our cost of borrowing, and volatility in U.S. and global financial markets could impact our access to, or further increase the cost of, financing. The Company Credit Facility also requires us to comply with a maximum debt-to-capital ratio. This restrictive covenant could limit our ability to pursue our business strategies. In addition, any failure by us to comply with this restrictive covenant could result in an event of default under the Company Credit Facility and, in some circumstances, under the indentures governing our notes, which, in any case, could have a material adverse effect on our financial condition.

Risks Associated with Mergers, Acquisitions, and Divestitures

Our business and results of operations may be materially adversely affected if we fail to manage and complete divestitures.

We regularly evaluate our portfolio to determine whether an asset or business is still consistent with our business strategy or whether there may be a more advantaged owner for that asset or business. When we decide to sell assets or a business, we may encounter difficulty finding buyers or alternative exit strategies, which could delay the achievement of our business strategy. Further, divestitures may be delayed due to failure to obtain required approvals on a timely basis, if at all, from governmental authorities, or may become more difficult to execute due to conditions placed upon approval that could, among other things, delay or prevent us from completing a transaction, or otherwise restrict our ability to realize the expected financial or strategic goals of a transaction. We might have financial exposure in a divested business, such as through minority equity ownership, financial or performance guarantees, indemnities or other obligations, such that conditions outside of our control might negate the expected benefits of the disposition. The impact of a divestiture on our results of operations could also be greater than anticipated.

Previous or future acquisitions may not perform as expected and we may not realize the financial results expected from acquisitions or divestitures.

The market price of our common stock is generally subject to volatility, and there can be no assurances regarding the level or stability of our share price at any time. The market price of our common stock may decline as a result of previous or future acquisitions and divestitures if, among other things, we are unable to achieve the expected cost and revenue synergies or growth in earnings, the operational cost savings estimates are not realized as rapidly or to the extent anticipated, the transaction costs related to the acquisitions or divestitures are greater than expected or if any financing related to the transactions is on unfavorable terms. The market price of our common stock also may decline if we do not achieve the perceived benefits of such acquisitions and divestitures as rapidly or to the extent anticipated by financial or industry analysts or if the effect of the acquisitions and divestitures on our financial condition, results of operations or cash flows is not consistent with the expectations of financial or industry analysts.

We may be unable to successfully integrate our existing business with acquired businesses and realize the anticipated benefits of such acquisitions.

We have acquired or may acquire in the future health plans participating in government-sponsored healthcare programs, contract rights and related assets of other health plans both in our existing service areas and in new markets and start-up operations in new markets or new products in existing markets. Although we review the records of companies or businesses we plan to acquire, it is possible that we could assume unanticipated liabilities or adverse operating conditions. In addition, the success of acquisitions we make will depend, in part, on our ability to successfully combine our existing business with such acquired businesses and realize the anticipated benefits, including synergies, cost savings, growth in earnings, innovation and operational efficiencies, from the combinations. In addition, we may be restricted in our ability to realize these synergies as a result of regulatory requirements. If we are unable to achieve these objectives within the anticipated time frame, or at all, the anticipated benefits may not be realized fully or at all or may take longer to realize than expected and the value of our common stock may decline.

The integration of acquired businesses with our existing business is a complex, costly and time-consuming process. The integration may result in material challenges, including, without limitation:

- the diversion of management's attention from ongoing business concerns and performance shortfalls as a result of the devotion of management's attention to the integration;
- managing a larger company;
- maintaining team member morale and retaining key management and other team members;
- the possibility of faulty assumptions underlying expectations regarding the integration process;
- retaining existing business and operational relationships and attracting new business and operational relationships;
- consolidating corporate and administrative infrastructures and eliminating duplicative operations;
- coordinating geographically separate organizations;
- unanticipated issues in integrating information technology, communications, and other systems;
- unanticipated changes in federal or state laws or regulations, including the ACA and any regulations enacted thereunder;
- unforeseen expenses or delays associated with the acquisition and/or integration, including due to regulatory approval requirements and delays;
- achieving actual cost savings at the anticipated levels; and
- decreases in premiums paid under government-sponsored healthcare programs by any state in which we operate.

Many of these factors would be outside of our control and any one of them could materially affect our financial condition, results of operations and cash flows. Our ability to successfully manage the expanded business following any given acquisition will depend, in part, upon management's ability to design and implement strategic initiatives that address the increased scale and scope of the combined business with its associated increased costs and complexity. There can be no assurances that we will be successful in managing our expanded operations as a result of acquisitions or that we will realize the expected growth in earnings, operating efficiencies, cost savings and other benefits.

Item 1B. ***Unresolved Staff Comments***

None.

Item 1C. ***Cybersecurity***

Cybersecurity Risk Management and Strategy

Our cybersecurity risk management and privacy programs play a central role in the protection of the confidential information of our members, team members, and business partners, and, as such, are critical to the successful operation of our business.

Our cybersecurity risk management program is part of our enterprise-wide risk management practices. Based on the National Institute of Standards and Technology (NIST) Cybersecurity Framework, the program utilizes policies, processes, and technologies to assess, identify, and manage the cybersecurity threats that we face. Specifically, we use these policies, processes and technologies to identify internal and external threats, establish access control, data privacy and security measures, detect unauthorized activity, and respond to and recover from incidents. For example, we leverage external experts and our internal threat and risk teams to assess potential threats, retain external consultants to conduct penetration tests and health checks on our information systems, conduct cyber security and awareness training to help team members identify and manage common categories of cybersecurity threats, utilize multiple protective and detective tools to identify active threats and have a 24/7 Security Operations Center to manage incident response.

Our cybersecurity risk management program also includes processes and controls to assess the cybersecurity risk associated with third-party vendors and partners. Following an initial assessment of the level of enterprise risk potentially posed by use of the third party, the vendor is then subject to further risk-based assessments, the level of which depends upon the assigned risk value of the service being provided, which may include the completion of security questionnaires and the provision of independent security certifications.

On a bi-annual schedule, we use an external firm to assess our cybersecurity risk management program using the Capability Maturity Model Integration (CMMI) process and behavioral model. In addition, elements of the program are subject to Service Organization Control Type 2 (SOC 2) and ISO 27001 audits by a third party.

While we have not identified any cybersecurity threats that have materially affected or that we believe are reasonably likely to materially affect our business strategy, results of operations, or financial condition, our cybersecurity risk management program cannot eliminate all risks from cybersecurity threats or provide assurances that we have not experienced an undetected material cybersecurity incident or will not experience a material cybersecurity incident in the future. For more information about these risks, please see "Risk Factors - ***A failure in or breach of our operational or security systems, networks or infrastructure, or those of third-party vendors with which we do business, including as a result of cyber-attacks and other data security incidents, could have a material adverse effect on our business.***"

Cybersecurity Risk Governance

Role of our Board of Directors

Our Board of Directors has primary responsibility for the oversight of our enterprise-wide risk management and exercises its oversight function in respect of cybersecurity risk through two of its committees. Specifically, our Board Audit and Compliance Committee has oversight responsibility for the Company's enterprise risk management process, including the Company's programs to identify, manage, respond to and mitigate the Company's IT risks, including risks related to cybersecurity, artificial intelligence, privacy, critical infrastructure assets and disaster recovery, as well as identifying the potential likelihood, frequency and severity of cyberattacks and breaches. Our Board Quality Committee has oversight responsibility for overall data and technology strategy. Each committee reports to the full Board on a regular basis.

The oversight responsibility of our Board of Directors and its committees is facilitated through quarterly management risk reporting designed to provide visibility to the Board and its committees on the processes for the identification, assessment, prioritization and management of critical risks and management's risk mitigation strategies, including those related to cybersecurity. Such reporting includes providing quarterly updates to the Board Audit and Compliance Committee regarding the evolving cybersecurity threat environment, updates to our cybersecurity risk management program to address and mitigate such threats and providing regular reports to the Quality Committee on the Company's execution of its data and technology strategy. Management also escalates significant cybersecurity events to the Audit and Compliance Committee and the Board on a real time basis, as appropriate. Further, our Board also receives quarterly enterprise-wide risk management reports, which include significant cybersecurity risks, from our risk department. In addition, our Board and management have conducted tabletop cybersecurity crisis simulation exercises.

Role of Management

While our Board of Directors has overall responsibility for the oversight of our enterprise-wide risk management, of which cybersecurity risk management is one component, our management team is responsible for day-to-day risk management, including the implementation of our cybersecurity risk management program.

Our enterprise risk management committee, which operates within our risk department and comprises certain of our senior leaders including operations, finance, information technology, government relations, legal, marketing, health plan leadership, health operations, and communications meets at least four times per year to discuss significant risks to the Company identified by our enterprise-wide risk management process, including cybersecurity risks identified by our cybersecurity risk management program. The enterprise risk management committee also discusses the steps management has taken to identify, monitor, assess, and control or avoid such exposures and reviews performance measures against the Company's risk appetite and tolerance and provides recommendations of corrective action where appropriate.

At an operational level, our Chief Security and Privacy Officer (CSPO) and our Chief Information Security Officer (CISO) lead the management of our cybersecurity risk management program.

Our CSPO is responsible for overseeing the day-to-day operation of our cybersecurity risk management program, including reporting systemic cybersecurity risk matters to our senior management and, as appropriate, to the Board of Directors. Our CISO oversees our cybersecurity operations, including all identity and access management functions, cybersecurity incident response operations and the effective operation of the suite of security tools we employ. The CISO and CSPO track key cybersecurity metrics across the enterprise, including metrics related to threat and vulnerability management, cybersecurity incidents and asset management and protection. Our CISO reports the status and efficacy of our cybersecurity operations to our senior management and, as appropriate, to the Board of Directors.

Using our cybersecurity incident response plan, each incident receives a severity rating using a scale approved by management. Based on that rating, we employ an escalation matrix that provides appropriate notifications to management, as well as to our Board of Directors.

The cybersecurity incident response plan is integrated into our overall crisis management plan and process, for which our CSPO has ultimate day-to-day responsibility. Our CSPO and CISO share joint responsibility for providing regular cybersecurity updates to our Audit and Compliance Committee, including updates on our key technology initiatives, including those involving cybersecurity, and their status.

Our CSPO, CISO and other dedicated cybersecurity risk management personnel are certified and experienced information systems security professionals and information security managers. Our CSPO has over 30 years of experience in information security having 16 years of experience leading information security programs and obtained the Certified Information Systems Security Professional certification from ISC2. Our CISO, who has over 34 years of experience in cyber operations, communications, crisis management and command and control, holds multiple graduate degrees, obtained the Certified Information Systems Security Professional certification from ISC2 and holds the Qualified Technical Expert certification from the Digital Director's Network.

Item 2. ***Properties***

We own our corporate office headquarters buildings and land located in St. Louis, Missouri, which are used by each of our reportable segments. We generally lease space in the states where our health plans and claims processing facilities operate. We are required by various insurance and regulatory authorities to have offices in the service areas where we provide benefits.

We believe our current facilities are adequate to meet our operational needs for the foreseeable future.

Item 3. ***Legal Proceedings***

A description of the legal proceedings to which we and our subsidiaries are a party is contained in Note 17. *Contingencies* to the consolidated financial statements included in Part II of this Annual Report on Form 10-K, and is incorporated herein by reference.

Item 4. ***Mine Safety Disclosures***

Not applicable.

PART II

Item 5. ***Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities***

Market for Common Stock

Our common stock has been traded and quoted on the New York Stock Exchange (NYSE) under the symbol "CNC" since October 16, 2003.

Stockholders

As of February 13, 2026, there were 944 holders of record of our common stock.

Issuer Purchases of Equity Securities

In November 2005, our Board of Directors announced a stock repurchase program, which was most recently increased in December 2023. We are authorized to repurchase up to $10.0 billion, inclusive of past authorizations, of which $1.8 billion remains as of December 31, 2025.

The stock repurchase program is effected primarily through regular open-market purchases (which may include repurchase plans designed to comply with Rule 10b5-1 and accelerated share repurchases), the amounts and timing of which are subject to our discretion as part of our capital allocation strategy and may be based upon general market conditions and the prevailing price and trading volumes of our common stock. No duration has been placed on the repurchase program. We reserve the right to discontinue the repurchase program at any time.

The following table discloses purchases of our common stock for the quarter ended December 31, 2025.

Issuer Purchases of Equity Securities
Fourth Quarter 2025
(Shares in thousands)

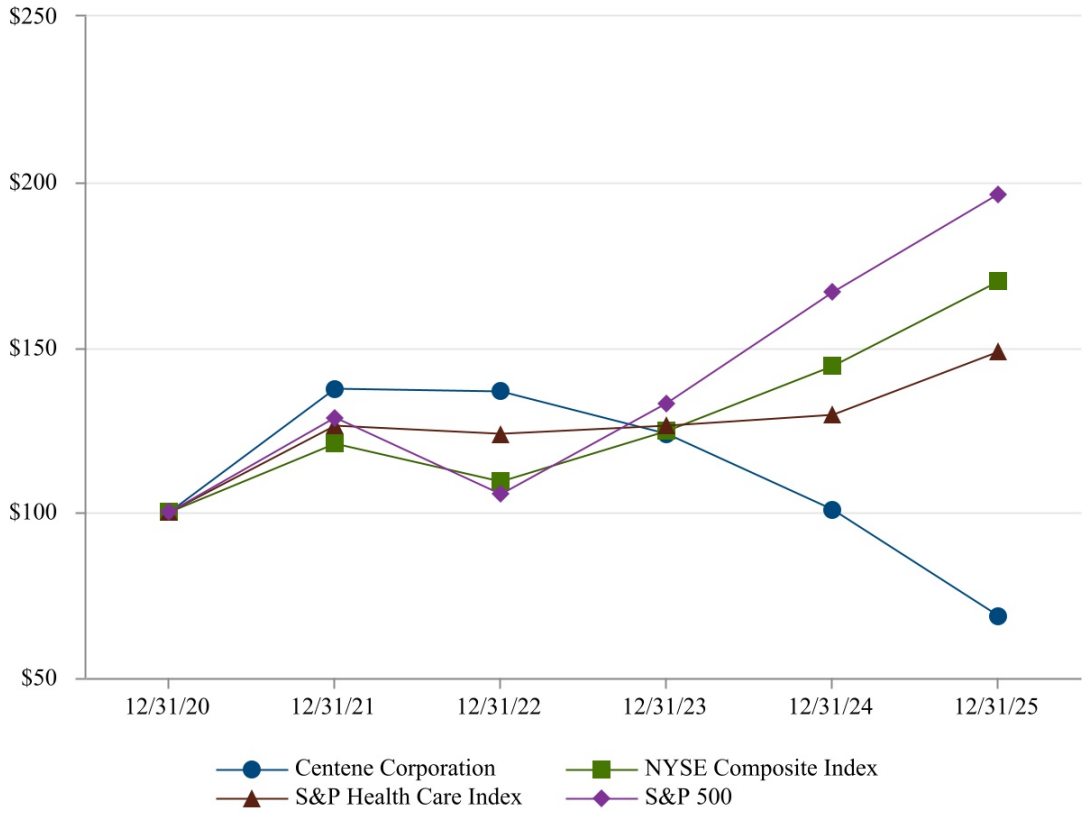
Execution Date	Total Number of Shares Purchased[1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs ($ in millions)[2]
October 1, 2025 - October 31, 2025	47	$ 33.58	—	$ 1,830
November 1, 2025 - November 30, 2025	5	34.93	—	1,830
December 1, 2025 - December 31, 2025	8	39.62	—	1,830
Total	60	$ 34.53	—	$ 1,830

[1] Includes 60 thousand shares relinquished to the Company by certain employees for payment of taxes.

[2] A remaining amount of $1.8 billion is available under the stock repurchase program as of December 31, 2025.

Stock Performance Graph

The graph below compares the cumulative total stockholder return on our common stock for the period from December 31, 2020 to December 31, 2025, with the cumulative total return of the NYSE Composite Index, the Standard & Poor's (S&P) Health Care Index and the S&P 500 over the same period. S&P 500 is included because our common stock is within the index. The graph assumes an investment of $100 on December 31, 2020 in our common stock (at the last reported sale price on such day), the NYSE Composite Index, the S&P Health Care Index and the S&P 500 and assumes the reinvestment of any dividends.



	2020	2021	2022	2023	2024	2025
Centene Corporation	$ 100.00	$ 137.26	$ 136.62	$ 123.62	$ 100.92	$ 68.55
NYSE Composite Index	100.00	120.68	109.39	124.50	144.28	169.87
S&P Health Care Index	100.00	126.13	123.67	126.21	129.47	148.37
S&P 500	100.00	128.71	105.40	133.11	166.38	196.10
Centene Corporation closing stock price	$ 60.03	$ 82.40	$ 82.01	$ 74.21	$ 60.58	$ 41.15
Centene Corporation annual stockholder return	(4.5)%	37.3%	(0.5)%	(9.5)%	(18.4)%	(32.1)%

In accordance with the rules of the Securities and Exchange Commission (SEC), the information contained in the Stock Performance Graph on this page shall not be deemed to be "soliciting material," or to be "filed" with the SEC or subject to the SEC's Regulation 14A or to the liabilities of Section 18 of the Exchange Act, except to the extent that Centene specifically requests that the information be treated as soliciting material or specifically incorporates it by reference into a document filed under the Securities Act or the Exchange Act.

Item 6. ***Reserved.***

ITEM 7. ***Management's Discussion and Analysis of Financial Condition and Results of Operations***

The following discussion of our financial condition and results of operations should be read in conjunction with our consolidated financial statements and the related notes included elsewhere in this filing. The discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth under Part I, Item 1A."Risk Factors" of this Form 10-K. The following discussion and analysis does not include certain items related to the year ended December 31, 2023, including year-to-year comparisons between the year ended December 31, 2024 and the year ended December 31, 2023. For a comparison of our results of operations for the fiscal years ended December 31, 2024 and December 31, 2023, see Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations of our Annual Report on Form 10-K for the year ended December 31, 2024, filed with the SEC on February 18, 2025.

EXECUTIVE OVERVIEW

General

As the nation's largest managed care company focused on underserved populations, we are committed to helping people live healthier lives. Centene offers affordable and high-quality products to more than 1 in 15 individuals across the nation, including Medicaid and Medicare members (including Medicare Prescription Drug Plans) as well as individuals and families served by the Health Insurance Marketplace.

We provide access to high-quality healthcare, innovative programs and a wide range of health solutions that help families and individuals get well, stay well and be well. We believe the best way to deliver healthcare is with a personal approach, with local brands and local teams who live in, care about and directly influence the communities they serve – a key differentiator in our ability to provide access to quality care for our members. Our state-based plans are built on community expertise and backed by the depth, breadth, and experience of a leading national company. Our model is structured around partnership. By working hand-in-hand with providers, policymakers, and communities, we connect people to what matters most – not just healthcare, but essentials like food, housing, utilities, and transportation – to drive meaningful health outcomes.

With our scale and expertise, we are not only improving lives but also shaping the future of healthcare. From leveraging data to drive better outcomes across the nation to creating innovative programs to address barriers to care, we hope to redefine the healthcare experience. Our data and insights give us a powerful opportunity to anticipate needs, personalize care, and build a more affordable and effective healthcare system for tomorrow.

Based on the most recent publicly available membership data, we are the nation's largest Medicaid and Marketplace insurer, as well as the largest stand-alone PDP provider. Our Medicare Advantage business includes one of the highest concentrations of D-SNP members among our peers, aligned with our focus on low-income, complex populations. As of December 31, 2025, we served 12.5 million Medicaid members in 30 states, 5.5 million Marketplace members across 29 states, 1.0 million Medicare Advantage members across 32 states and 8.1 million Medicare Prescription Drug Plan (PDP) members in 50 states and the District of Columbia.

Our results of operations depend on our ability to manage expenses associated with health benefits (including estimated costs incurred) and selling, general and administrative (SG&A) costs. We measure operating performance based upon two key ratios. The health benefits ratio (HBR) represents medical costs as a percentage of premium revenues, excluding premium tax revenues that are separately billed, and reflects the direct relationship between the premiums received and the medical services provided. The SG&A expense ratio represents SG&A costs as a percentage of premium and service revenues, excluding premium taxes separately billed.

Divestitures

In December 2022, we completed the divestiture of Magellan Rx for $1.3 billion and recognized a gain of $269 million, or $99 million after-tax. During 2023, we recorded a reduction to the previously reported gain of $22 million, or $10 million after-tax. During 2025, we recorded a favorable adjustment to the gain on sale of Magellan Rx of $2 million, or $1 million after-tax.

In January 2023, we sold Magellan Specialty Health for $646 million in cash and stock, including an estimated working capital adjustment, and recognized a gain of $79 million, or $63 million after-tax. During 2024, we recorded an additional gain on sale of $83 million for achievement of contingent consideration related to the sale and finalization of working capital adjustments.

In January 2024, we completed the divestiture of Circle Health Group (Circle Health) for $931 million. Upon closing the divestiture, we settled the foreign currency swap associated with the divestiture and recorded a corresponding gain of $20 million.

In October 2024, we completed the divestiture of Collaborative Health Systems (CHS) and recognized a pre-tax gain of $17 million, or $13 million after-tax.

In December 2025, we signed a definitive agreement to divest the remaining Magellan Health businesses. As a result, we recorded non-cash impairment charges associated with the pending divestiture totaling $513 million, or $389 million after-tax.

The above-noted divestitures are drivers of certain year-over-year variances discussed throughout this section.

Trends and Uncertainties

Operating

In 2025, we have experienced an accelerated increase in medical cost trend. The drivers of this trend include increasing medical demand, expanded access to care facilitated by program changes at the state level, and the rapid release and availability of new, high-cost pharmaceuticals. Increasingly, state healthcare policies are providing for expanded access through carve-ins for incremental coverage (for example, behavioral healthcare and home and community-based services).

The medical cost drivers are likely intensified by an environment where legislative changes to the United States healthcare model have been widely publicized (and with increasing intensity over the last year). Changes to the model include references to members in certain programs who may lose eligibility and certain provider reimbursement models that may be reduced in the future. Changes in Medicaid and Marketplace, including changes in the availability of Enhanced Advance Premium Tax Credits (APTCs) for Marketplace products coupled with the One Big Beautiful Bill Act (OBBBA), create member uncertainty surrounding the future availability, affordability, funding, and access to health insurance. This backdrop may be prompting members to seek care at an increased rate (given potential eligibility and subsidy funding shifts) and providers may be modifying operations and billing practices, all further exacerbating the medical cost trend.

We continue to work with our state partners to establish Medicaid premium rates that appropriately match the acuity of the population as well as reflect the most recent medical cost trend. We also provide states with data to help them analyze the implications of policy decisions as well as design effective risk adjustment programs. In Marketplace, we completed the process of refiling 2026 policy year rates during the third quarter of 2025 to reflect a higher projected baseline of Marketplace morbidity than previously expected. During the third quarter of 2025, we reacted to an evolving regulatory and market environment and took corrective pricing actions for 2026 in states covering 95% of Marketplace membership.

Additionally, we are committed to ensuring that the affordability of healthcare is maintained for our government partners and members and continue to address the cost trend through the implementation of new clinical initiatives and care management plans, thoughtful network design, and ongoing rigor and innovation to combat fraud, waste and abuse.

Regulatory: Medicaid

The COVID-19 pandemic impacted our business as it relates to Medicaid eligibility changes. From the onset of the public health emergency (PHE) through March 2023, our Medicaid membership increased by 3.6 million members (excluding new states North Carolina and Delaware and various state product expansions or managed care organization changes). Since March 31, 2023, redeterminations are the primary driver of our Medicaid membership decline. We anticipate that future reductions could occur resulting from ongoing state redetermination processes. We continue to work with our state partners to match rates to acuity post-redeterminations.

The OBBBA, passed in July 2025, includes requirements that may reduce the number of members eligible for state Medicaid Expansion programs by requiring work or community engagement by members and for state Medicaid agencies to redetermine member eligibility at more frequent intervals, along with adding a "Cost Sharing" or "Co-Pay" for certain medical services. These changes could have the effect of increasing the overall morbidity of the Medicaid Expansion population largely beginning in 2027, subject to state implementation plans. Several other provisions of the OBBBA, such as adjustments to provider taxes and state directed payments beginning in 2028, may have the effect of reducing the amount of federal funding for Medicaid, which could result in changes in the design of Medicaid programs, including coverage of benefits, eligibility, and/or provider payment rates. In particular, New York intends to terminate its Essentials Plan-5, which provided state-subsidized healthcare for individuals from 200% to 250% of the Federal Poverty Level (FPL). The OBBBA also includes a restriction against paying certain providers designated as "prohibited entities" as of October 1, 2025, which has the potential to create access to care issues and network gaps. The timing of regulatory guidance and other rulemaking changes will be critical to ensuring state and MCO implementation readiness.

Regulatory: Commercial

The American Rescue Plan Act (ARPA), enacted in March 2021, initially enhanced eligibility for APTCs for enrollees in the Health Insurance Marketplace. The enhanced eligibility extended by the Inflation Reduction Act (IRA), enacted in August 2022, expired at the end of 2025. While enhanced eligibility has expired, APTCs are still in force and provide meaningful subsidies to eligible members.

The Marketplace Integrity and Affordability Final Rule (Final Rule) was published in the Federal Register on June 25, 2025. The Final Rule makes changes to policies to strengthen program integrity measures in the Marketplace. For example, the Special Enrollment Period for those under 150% of the FPL has been repealed beginning August 25, 2025. Several of the provisions of the Final Rule have been stayed due to ongoing litigation. These include a requirement for certain consumers who automatically re-enroll into a fully subsidized Marketplace plan to be re-enrolled into the same plan with a $5 premium until the consumer updates their exchange application to confirm APTC eligibility. Additionally, exchanges may no longer accept a consumer's self-attestation of projected annual household income when the Internal Revenue Service (IRS) cannot verify it due to lack of tax return data; rather, exchanges must verify household income using other trusted data sources.

In addition, the OBBBA placed additional restrictions on APTC requirements. For example, beginning January 1, 2026, should individuals mis-estimate their projected income, the OBBBA requires them to reimburse the IRS for the full amount of excess tax credit received. In addition, as of January 1, 2026, the OBBBA prohibits individuals from receiving APTCs if they enroll in health coverage through a Special Enrollment Period associated with their income. We anticipate that the combined effect of the expiration of the Enhanced APTCs, the Final Rule, and the OBBBA will reduce 2026 Marketplace membership and continue to increase the overall morbidity of the Marketplace population. During the third quarter of 2025, we reacted to an evolving regulatory and market environment and took corrective pricing actions for 2026 in states covering 95% of Marketplace membership. We continue to advocate for legislation and regulations aimed at leveraging Medicaid and the Health Insurance Marketplace to maintain health insurance coverage and affordability for consumers.

Regulatory: Medicare

The IRA significantly changed Medicare Part D, impacting stand-alone Medicare PDPs as well as the Part D benefit in many of our Medicare Advantage plans beginning in 2025, most notably by eliminating the coverage gap and capping members' annual out-of-pocket costs at $2,000 in order to provide more predictable and affordable prescription drug coverage for Medicare beneficiaries. The members' Part D annual out-of-pocket cap for 2026 is $2,100. The IRA changes effective for 2025 resulted in a meaningful shift in cost-sharing responsibilities between members, drug companies, Centers for Medicare and Medicaid Services (CMS), and PDPs and have resulted in a significant increase in our premiums in consideration for our PDPs' responsibility for a larger portion of total Part D benefit costs. Starting in 2026, CMS created a Drug Subsidy to compensate plans for the loss of the Manufacturer Discount Program (MDP) for maximum fair price drugs. To help mitigate significant premium impacts and address these changes, CMS introduced the Medicare Part D Premium Stabilization Demonstration program. This program began in calendar year 2025 and was intended by CMS to exist for three years. The parameters of the program are expected to be different each year. For example, in 2025, participating PDPs operated under narrowed risk corridor thresholds as part of the supports CMS introduced to limit market volatility. For 2026, CMS eliminated these narrowed risk corridors entirely, shifting PDPs back toward standard program financial risk-sharing. We continue to advocate for policies that promote cost-effective, high-quality care for our PDP enrolled members. We have receivables due to us from CMS for Part D risk-sharing programs attributable to the 2025 plan year that we expect to be paid by CMS within a year after the plan year closes. If the payments from CMS are delayed, our cash flows may be materially adversely affected.

Regulatory: Dual-Eligible

In addition, the CMS calendar year 2025 Medicare and Part D policy rule and finalized regulations will require beneficiaries dually enrolled in Medicare and in a Medicaid managed care plan to receive integrated care through the Medicaid company's Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) beginning in 2030, with certain restrictions beginning in 2027. Integrated D-SNPs are designed to enhance the coordination of care and streamline services while delivering improved outcomes. We believe we are positioned well given our overlapping Medicaid and Medicare Advantage footprints and we will continue to place enterprise-level focus on the D-SNP opportunity to drive long-term growth.

Summary

We remain focused on our promise of delivering high-quality healthcare services on behalf of states and the federal government to under-insured families and commercial organizations. Our decades of experience and deep industry knowledge have allowed us to deliver cost-effective services to our government partners and our members. With a focus on the personalization of healthcare technology, we continue the use of data and analytics to improve the provider and member experience. We continue to believe we have both the capacity and capability to successfully navigate industry changes to the benefit of our members, customers, providers and shareholders through program and bid design, product placement and other strategic factors.

For additional information regarding regulatory trends and uncertainties, see Part I, Item 1 "*Business - Regulation*" and Item 1A, "*Risk Factors*."

2025 Highlights

Our financial performance for 2025 is summarized as follows:

- Year-end membership of 27.6 million, a decrease of 967 thousand members, or 3% over 2024.
- Total revenues of $194.8 billion, representing 19% growth year-over-year.
- Premium and service revenues of $174.6 billion, representing 20% growth year-over-year.
- HBR of 91.9% for 2025, compared to 88.3% for 2024.
- SG&A expense ratio of 7.4% for 2025, compared to 8.5% for 2024.
- Adjusted SG&A expense ratio of 7.4% for 2025, compared to 8.5% for 2024.
- Operating cash flows of $5.1 billion for 2025, compared to $154 million for 2024.
- In October 2025, we completed our quantitative goodwill impairment analysis and recorded a non-cash goodwill impairment of $6.7 billion in the third quarter of 2025.
- GAAP diluted loss per share of $(13.53) for 2025, driven by the goodwill impairment.
- Adjusted diluted earnings per share (EPS) of $2.08 for 2025.

A reconciliation from GAAP diluted earnings (loss) per share to adjusted diluted EPS is highlighted below, and additional detail is provided under the heading "*Non-GAAP Financial Presentation*":

We reference the adjusted SG&A expense ratio defined as adjusted SG&A expenses, which excludes acquisition and divestiture related expenses and other items, divided by premium and service revenues. We also reference effective tax rate on adjusted earnings, defined as GAAP income tax expense (benefit) excluding the income tax effects of adjustments to net earnings divided by adjusted earnings (loss) before income tax expense.

	Year Ended December 31,	
	2025	**2024**
GAAP diluted earnings (loss) per share attributable to Centene	$ (13.53)	$ 6.31
Amortization of acquired intangible assets	1.39	1.32
Acquisition and divestiture related expenses	0.01	0.16
Other adjustments [(1)]	14.86	(0.22)
Income tax effects of adjustments [(2)]	(0.64)	(0.40)
Effect of basic to diluted shares [(3)]	(0.01)	—
Adjusted diluted EPS	$ 2.08	$ 7.17

[(1)] Other adjustments include the following pre-tax items:

2025:

(a) goodwill impairment of $6,723 million, or $13.63 per share ($13.62 after-tax), Magellan Health impairment of $513 million, or $1.04 per share ($0.79 after-tax), intangible asset impairment related to the wind-down of certain contracts in the Other segment of $55 million, or $0.11 per share ($0.08 after-tax), exit costs related to the wind-down of certain contracts in the Other segment of $22 million, or $0.04 per share ($0.03 after-tax), a net loss on real estate transactions of $18 million, or $0.04 per share ($0.03 after-tax), a favorable adjustment to the gain on sale of Magellan Rx of $2 million, or $0.00 per share ($0.00 after-tax), and net gain on debt extinguishment of $1 million, or $0.00 per share ($0.00 after-tax).

2024:

(b) net gain on the previously reported divestiture of Magellan Specialty Health due to the achievement of contingent consideration and finalization of working capital adjustments of $83 million, or $0.16 per share ($0.12 after-tax), net gain on the sale of property of $24 million, or $0.04 per share ($0.03 after-tax), gain on the previously reported divestiture of Circle Health of $20 million, or $0.04 per share ($0.12 after-tax), gain on the sale of CHS of $17 million, or $0.03 per share ($0.02 after-tax), Health Net Federal Services asset impairment due to the 2024 final ruling on the TRICARE Managed Care Support Contract of $14 million, or $0.03 per share ($0.02 after-tax), severance costs due to a restructuring of $13 million, or $0.02 per share ($0.01 after-tax), an additional loss on the divestiture of our Spanish and Central European businesses of $7 million, or $0.01 per share ($0.01 after-tax) and gain on the previously reported divestiture of HealthSmart due to the finalization of working capital adjustments of $7 million, or $0.01 per share ($0.01 after-tax).

(2) The income tax effects of adjustments are based on the effective income tax rates applicable to each adjustment. In addition, the year ended December 31, 2025, includes a tax benefit of $4 million, or $0.01 per share, related to tax adjustments on previously reported divestitures and impacts of the OBBBA. The year ended December 31, 2024, includes a tax benefit of $1 million, or $0.00 per share, related to tax adjustments on previously reported divestitures.

(3) Reflects the $0.01 impact of using 494,502 thousand shares in the calculation of adjusted diluted EPS for the year ended December 31, 2025. The additional 1,386 thousand shares for the year ended December 31, 2025 were excluded from the calculation of the GAAP net loss per share and related adjustments due to their anti-dilutive effect.

Current and Future Operating Drivers

The following items contributed to our 2025 results of operations as compared to the previous year:

Medicaid

- In July 2025, our subsidiary, Iowa Total Care, commenced the contract to continue providing Medicaid managed care services under the Iowa Health Link program. The contract has a four-year term, with an optional two-year extension, for a total of six possible contract years.

- In July 2025, our subsidiary, Magnolia Health Plan, commenced the Mississippi Division of Medicaid contract to continue serving the state's Coordinated Care Organization Program consisting of the Mississippi Coordinated Access Network and the Mississippi Children's Health Insurance Program (CHIP). The contract has a four-year term, with two optional one-year extensions, for a total of six possible contract years.

- In February 2025, our subsidiary, Sunshine Health, commenced the expanded Statewide Medicaid Managed Care (SMMC) program, including integrated Managed Medical Assistance, Long-Term Care services, Serious Mental Illness, Child Welfare and HIV specialty products. The expanded SMMC program now includes coverage for Behavior Analysis services. The contract has a six-year term. Additionally, coverage for Behavior Analysis services was also added to the existing Children's Medical Services contract beginning February 2025.

- In January 2025, our subsidiary, Sunflower Health Plan, commenced the contract to continue providing managed health care services through KanCare, the State of Kansas' Medicaid and CHIP. The contract has a three-year term, with two optional one-year extensions, for a total of five possible contract years.

- In October 2024, our subsidiary, Meridian Health Plan of Michigan, commenced the contract awarded by the Michigan Department of Health and Human Services (MDHHS) to continue serving as a Medicaid health plan for the Comprehensive Health Care Program. The contract has a five-year term, with three optional one-year extensions, for a total of eight possible contract years.

- In September 2024, our subsidiary, Superior HealthPlan (Superior), commenced the contract awarded by the Texas Health and Human Services Commission to continue to provide healthcare coverage to the aged, blind or disabled (ABD) population in the state's STAR+PLUS program. The contract has a six-year term with a maximum of three additional two-year extensions.

- In September 2024, our subsidiary, NH Healthy Families, commenced the contract awarded by the New Hampshire Department of Health and Human Services to continue providing physical health, behavioral health and pharmacy services for New Hampshire's Medicaid managed care program, known as Medicaid Care Management. The contract has a five-year term.

- In July 2024, our subsidiaries, Carolina Complete Health and WellCare of North Carolina, began coordinating physical and other health services with Local Management Entities/Managed Care Organizations under the state's new Tailored Plan program. The Tailored Plans are integrated health plans designed for individuals with significant behavioral health needs or intellectual/developmental disabilities.

- In June 2024, our subsidiary, Western Sky Community Care, concluded serving members upon the expiration of its New Mexico Medicaid managed care contract.

- In April 2024, our subsidiary, Oklahoma Complete Health, commenced the statewide contracts to provide managed care for the SoonerSelect and SoonerSelect Children's Specialty Plan programs. The new contracts have a one-year term with five, one-year renewal options.

Medicare / Dual-Eligible

- Given our strong bid positioning, PDP membership increased 17% year-over-year. Additionally, the IRA changes effective for 2025 result in a meaningful shift in cost-sharing responsibilities between members, drug companies, CMS, and PDPs and have led to a significant increase in our premiums in consideration for our PDPs responsibility for a larger portion of total Part D benefit costs. These changes also result in a change to the quarterly progression of the Medicare segment HBR.

- In December 2024, we recorded a premium deficiency reserve of $92 million related to the 2025 Medicare Advantage contract year. The premium deficiency reserve was increased to $270 million in the first quarter of 2025, to $389 million in the second quarter of 2025 and decreased by $107 million to $282 million in the third quarter of 2025 based on the progression of earnings during the year (with higher earnings at the beginning of the year and lower at the end of the year, given cost sharing progression). The premium deficiency reserve related to the 2025 Medicare Advantage contract year was released in the fourth quarter of 2025 and no premium deficiency reserve related to the 2026 Medicare Advantage contract year was recorded.

- In 2025, Wellcare offered Medicare Advantage plans in 32 states, including its newest state, Iowa. Wellcare discontinued offering Medicare Advantage products in Alabama, Massachusetts, New Hampshire, New Mexico, Rhode Island and Vermont in 2025. Consistent with our strategic positioning and bid strategy, Medicare Advantage membership declined 10% year-over-year.

Commercial

- In July 2025, we announced a reduction to our expectation for the 2025 benefit year net risk adjustment revenue transfer as a result of significantly higher estimated aggregate market morbidity, with a corresponding decrease in our earnings expectations for 2025. The twelve months ended December 31, 2024, benefited from outperformance in Marketplace risk adjustment for the 2023 benefit year as well as a Marketplace cost sharing reduction (CSR) settlement related to prior years.

- In 2025, our Health Insurance Marketplace product, Ambetter Health, expanded its geographic footprint, adding 60 new counties across 10 states, which included expansion into Iowa. During 2025, Ambetter Health served members in 29 states. Marketplace membership increased 26% year-over-year due to the expanded footprint, strong open enrollment results, as well as overall market growth. Ambetter Health Solutions, our off-exchange marketplace business offerings, operated plans designed to attract Individual Coverage Health Reimbursement Arrangement (ICHRA) membership in off-exchange plans in 6 states in 2025.

Other

- In December 2025, we signed a definitive agreement to divest the remaining Magellan Health businesses. As a result, we recorded non-cash impairment charges associated with the pending divestiture totaling $513 million, or $389 million after-tax.

- In December 2024, Health Net Federal Services concluded serving members upon the expiration of its TRICARE Managed Care Support Contract.

- In October 2024, we completed the sale of CHS, a management services organization.

- In July 2024, our subsidiary, Magellan Health, commenced the Idaho Behavioral Health Plan contract.

The implementation of our third-party pharmacy benefits management (PBM) contract, which commenced in January 2024, along with SG&A initiatives have impacted our current results of operations and will continue to impact future results of operations.

In addition to the strategic and regulatory factors discussed in Trends and Uncertainties above, the following items are also expected to impact our future results of operations, cash flows and membership, subject to the resolution of various third-party protests within the Medicaid segment:

Medicaid

- In January 2026, our subsidiary, Health Net Community Solutions, commenced the contract with the California Department of Health Care Services to provide managed dental health care services to beneficiaries of Medi-Cal, the State's Medicaid program, in Los Angeles and Sacramento counties. The new contract has a 54-month term.

- In January 2026, our subsidiary, SilverSummit Healthplan, Inc., commenced the contract with the Nevada Department of Health and Human Services to continue providing services for its Medicaid managed care program. For the first time the program includes expansion of Medicaid Managed Care into rural and frontier service areas, communities that were previously fee-for-service. The contract has a five-year term, with the option of a two-year extension, for a total of seven possible contract years.

- In August 2024, our subsidiary, PA Health and Wellness, was selected by the Pennsylvania Department of Human Services to continue to administer Pennsylvania's Community HealthChoices program, the Medicaid managed care program that covers adults who are dually eligible for Medicare and Medicaid or who qualify to receive Medicaid long-term services and supports due to a need for the level of care provided in a nursing facility. A bid protest continues to be litigated and, at this time, it is unclear when the contract could be implemented.

- In December 2023, our subsidiary, Arizona Complete Health, was selected by the Arizona Health Care Cost Containment System – Arizona's single state Medicaid agency – to provide managed care for the Arizona Long Term Care System (ALTCS). The program supports Arizonans who are elderly and/or have a physical disability (E/PD) with physical and behavioral healthcare, as well as provides pharmacy benefits and home and community-based services. A prolonged bid protest has led the agency to cancel the original awards and issue a rebid. The rebid is expected to be open for submissions in late summer 2026 with a new contract effective date of October 2027.

- New York intends to terminate its Essentials Plan-5, which provides state-subsidized healthcare for individuals from 200% to 250% of the federal poverty line by July 1, 2026.

In addition, we were not selected to continue providing services under the Florida Children's Medical Services (Florida CMS) program. Our current Florida CMS contract is scheduled to conclude at the end of September 2026. Further, we are in the process of protesting the results of Medicaid procurement awards in Georgia and Texas. If these protests are not successful, our future results of operations would be impacted.

Medicare / Dual-Eligible

- In October 2024, CMS issued 2025 Medicare Advantage Star Ratings on the Medicare Plan Finder. Based on the data, we had approximately 55% of our Medicare Advantage membership enrolled in plans rated 3.5 stars or higher – compared to approximately 23% in the prior year. These ratings impact our 2026 plan year revenues.

- In January 2026, our subsidiary, Meridian Health Plan of Illinois, Inc., commenced the contract with the Illinois Department of Healthcare and Family Services to continue providing Medicare and Medicaid services for dually eligible Illinoisans through a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP). The contract has a four-year term, with optional extensions of six months to five and a half years.

- In January 2026, our subsidiary, Buckeye Health Plan, commenced the contract with the Ohio Department of Medicaid to continue providing Medicare and Medicaid services for dually eligible individuals through a FIDE SNP. The contract has a three-year term.

- In January 2026, our subsidiary, Meridian Health Plan of Michigan, Inc., commenced the contract with the MDHHS to provide highly integrated Medicare and Medicaid services for dually eligible Michiganders through a Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP). The contract has a seven-year term, with three optional one-year extensions, for a total of 10 possible contract years.

- In 2026, Wellcare is offering Medicare Advantage plans in 32 states and PDP products across all 50 states. We expect that our strategic positioning and bid strategy will have continued impacts on Medicare Advantage and PDP results of operations.

- CMS regulations will require beneficiaries dually enrolled in Medicare and in a Medicaid managed care plan to receive integrated care through the Medicaid company's Medicare Advantage D-SNPs beginning in 2030, with certain restrictions beginning in 2027. Integrated D-SNPs are designed to enhance the coordination of care and streamline services while delivering improved outcomes. We believe we are positioned well given our overlapping Medicaid and Medicare Advantage footprints and we will continue to place enterprise-level focus on the D-SNP opportunity to drive long-term growth.

- In October 2025, CMS issued 2026 Medicare Advantage Star Ratings on the Medicare Plan Finder. Based on the data, we had approximately 60% of our Medicare Advantage membership enrolled in plans rated 3.5 stars or higher, including approximately 20% in 4-star rated plans. This compares to approximately 55% rated in 3.5 stars (and 1% in 4-star) in the prior year. These ratings impact our 2027 plan year revenues.

Commercial

- In 2026, Ambetter Health, is offered in 29 states. Ambetter Health Solutions is operating plans designed to attract ICHRA membership in off-exchange plans in 13 states in 2026.

- In the third quarter of 2025, we completed the process of refiling 2026 policy year rates to reflect a higher projected baseline of Marketplace morbidity than previously expected. During the third quarter of 2025, we reacted to an evolving regulatory and market environment and took corrective pricing actions for 2026 in states covering 95% of Marketplace membership.

Other

- In December 2025, we signed a definitive agreement to divest the remaining Magellan Health businesses.

MEMBERSHIP

From December 31, 2024 to December 31, 2025, our managed care membership decreased by 967 thousand, or 3%. The following table sets forth our membership by line of business:

	December 31,	
	2025	**2024**
Traditional Medicaid [1]	10,932,600	11,408,100
High Acuity Medicaid [2]	1,585,800	1,595,400
Total Medicaid	12,518,400	13,003,500
Marketplace	5,541,400	4,382,100
Individual and Commercial Group [3]	452,500	431,400
Total Commercial	5,993,900	4,813,500
Medicare [4]	1,002,600	1,110,900
Medicare PDP	8,118,600	6,925,700
Total at-risk membership	27,633,500	25,853,600
TRICARE eligibles	—	2,747,000
Total	27,633,500	28,600,600

[1] Membership includes Temporary Assistance for Needy Families (TANF), Medicaid Expansion, Children's Health Insurance Program (CHIP), Foster Care and Behavioral Health.

[2] Membership includes Aged, Blind or Disabled (ABD), Intellectual and Developmental Disabilities (IDD), Long-Term Services and Supports (LTSS) and Medicare-Medicaid Plans (MMP) Duals.

[3] Membership includes Commercial Group, Individual Coverage Health Reimbursement Arrangement (ICHRA) and Other Off-Exchange Individual.

[4] Membership includes Medicare Advantage and Medicare Supplement.

RESULTS OF OPERATIONS

The following discussion and analysis is based on our Consolidated Statements of Operations, which reflect our results of operations for years ended December 31, 2025 and 2024, respectively, prepared in accordance with generally accepted accounting principles in the United States (GAAP) ($ in millions, except per share data in dollars):

	2025	2024	% Change 2024-2025
Premium	$ 171,556	$ 142,303	21 %
Service	3,025	3,202	(6)%
Premium and service revenues	174,581	145,505	20 %
Premium tax	20,196	17,566	15 %
Total revenues	194,777	163,071	19 %
Medical costs	157,702	125,707	25 %
Cost of services	2,670	2,729	(2)%
Selling, general and administrative expenses	12,904	12,400	4 %
Depreciation expense	590	549	7 %
Amortization of acquired intangible assets	685	692	(1)%
Premium tax expense	20,538	17,806	15 %
Impairment	7,311	13	n.m.
Earnings (loss) from operations	(7,623)	3,175	(340)%
Investment and other income	1,572	1,784	(12)%
Debt extinguishment	1	—	n.m.
Interest expense	(678)	(702)	(3)%
Earnings (loss) before income tax expense	(6,728)	4,257	(258)%
Income tax (benefit) expense	(51)	963	(105)%
Net earnings (loss)	(6,677)	3,294	(303)%
Loss attributable to noncontrolling interests	3	11	(73)%
Net earnings (loss) attributable to Centene Corporation	$ (6,674)	$ 3,305	(302)%
Diluted earnings (loss) per common share attributable to Centene Corporation	$ (13.53)	$ 6.31	(314)%

n.m.: not meaningful

Year Ended December 31, 2025 Compared to Year Ended December 31, 2024

Total Revenues

Total revenues increased 19% in the year ended December 31, 2025, over the corresponding period in 2024 primarily driven by premium yield and membership growth in the PDP business, overall market growth in the Marketplace business, rate increases in the Medicaid business and increased premium tax revenue, partially offset by lower Medicaid membership and lower Marketplace estimated risk adjustment revenue. The full year 2024 benefited from outperformance in Marketplace risk adjustment for the 2023 benefit year.

Operating Expenses

Medical Costs/HBR

The HBR for the year ended December 31, 2025 was 91.9%, compared to 88.3% in 2024. The increase was primarily driven by lower Marketplace estimated risk adjustment revenue, increased Marketplace medical costs, program changes in the PDP business as a result of the IRA and higher medical costs in Medicaid driven primarily by behavioral health, home health and high-cost drugs, partially offset by Medicaid rate increases.

Cost of Services

Cost of services decreased by $59 million in the year ended December 31, 2025, compared to the corresponding period in 2024. The cost of service ratio for the year ended December 31, 2025 was 88.3%, compared to 85.2% in 2024.

Selling, General and Administrative Expenses

The SG&A expense ratio was 7.4% for the year ended December 31, 2025, compared to 8.5% for the year ended December 31, 2024. The adjusted SG&A expense ratio was 7.4% for the year ended December 31, 2025, compared to 8.5% for the year ended December 31, 2024. The decreases were primarily driven by continued discipline, leveraging of expenses over higher revenues, and growth in the PDP business, which operates at a meaningfully lower SG&A expense ratio as compared to the overall company. The decreases were partially offset by growth in the Marketplace business, which operates at a meaningfully higher SG&A expense ratio.

Impairment

During the year ended December 31, 2025, we recorded total impairment charges of $7.3 billion driven by a $6.7 billion goodwill impairment, $513 million Magellan Health impairment, $55 million intangible asset impairment related to the wind-down of certain contracts in the Other segment, and $20 million owned real estate impairment.

During the year ended December 31, 2024, we recorded total impairment charges of $13 million driven by Health Net Federal Services property, software and equipment related to the TRICARE Managed Care Support Contract that was no longer recoverable following the 2024 final ruling.

Other Income (Expense)

The following table summarizes the components of other income (expense) for the year ended December 31, ($ in millions):

	2025	2024
Investment and other income	$ 1,572	$ 1,784
Debt extinguishment	1	—
Interest expense	(678)	(702)
Other income (expense), net	$ 895	$ 1,082

Investment and other income. Investment and other income decreased by $212 million for the year ended December 31, 2025 compared to 2024. The decrease was driven by lower interest rates and lower average investment balances during 2025, partially offset by increased equity earnings and net gains on private equity investments. The year ended December 31, 2024 included net gains on divestitures described above, partially offset by a private equity investment reduction.

Interest expense. Interest expense for the year ended December 31, 2025 was $678 million compared to $702 million for the corresponding period in 2024.

Income Tax Expense

For the year ended December 31, 2025, we recorded an income tax benefit of $51 million on a pre-tax loss of $6.7 billion, or an effective tax rate of 0.8%. The effective tax rate for the year ended December 31, 2025 reflects the non-deductible nature of the goodwill impairment and the release of state uncertain tax position liabilities resulting from statute of limitations expirations. For the year ended December 31, 2025, our effective tax rate on adjusted earnings was 20.4%.

For the year ended December 31, 2024, we recorded income tax expense of $963 million on pre-tax earnings of $4.3 billion, or an effective tax rate of 22.6%. The effective tax rate for the year ended December 31, 2024 reflects tax effects of the Circle Health divestiture, settlements with tax authorities and valuation allowance releases. For the year ended December 31, 2024, our effective tax rate on adjusted earnings was 23.8%.

Segment Results

The following table summarizes our consolidated operating results by segment for the year ended December 31, ($ in millions):

	2025	2024	% Change 2024-2025
Total Revenues			
Medicaid	$ 110,434	$ 101,417	9 %
Medicare	37,210	23,032	62 %
Commercial	42,003	33,702	25 %
Other	5,130	4,920	4 %
Consolidated Total	$ 194,777	$ 163,071	19 %
Gross Margin [(1)]			
Medicaid	$ 5,690	$ 6,246	(9)%
Medicare	2,983	2,595	15 %
Commercial	5,101	7,663	(33)%
Other	435	565	(23)%
Consolidated Total	$ 14,209	$ 17,069	(17)%

(1) Gross margin represents premium and service revenues less medical costs and cost of services.

Medicaid

Total revenues increased 9% in the year ended December 31, 2025, compared to the corresponding period in 2024. The increase in total revenues was primarily driven by increased premium tax revenue and rate increases, partially offset by lower membership, primarily due to redeterminations. Gross margin decreased $556 million in the year ended December 31, 2025, compared to the corresponding period in 2024. Gross margin decreased due to higher medical costs driven primarily by behavioral health, home health and high-cost drugs, partially offset by rate and revenue increases.

Medicare

Total revenues increased 62% in the year ended December 31, 2025, compared to the corresponding period in 2024, primarily driven by increased PDP premium yield and membership, partially offset by lower Medicare Advantage membership. Gross margin increased $388 million in the year ended December 31, 2025, compared to the corresponding period in 2024 primarily driven by program changes in the PDP business as a result of the IRA along with premium yield and membership growth, partially offset by timing impacts of the Medicare Advantage premium deficiency reserves.

Commercial

Total revenues increased 25% in the year ended December 31, 2025, compared to the corresponding period in 2024 primarily driven by 26% membership growth in the Marketplace business, partially offset by lower estimated risk adjustment revenue. Gross margin decreased $2.6 billion in the year ended December 31, 2025, compared to the corresponding period in 2024 due to lower estimated risk adjustment revenue and increased Marketplace medical costs. The year ended December 31, 2024, benefited from a Marketplace CSR settlement related to prior years.

Other

Total revenues increased 4% in the year ended December 31, 2025, compared to the corresponding period in 2024. Gross margin decreased $130 million in the year ended December 31, 2025, compared to the corresponding period in 2024 driven by the Circle Health divestiture in the first quarter of 2024 along with the expiration of the TRICARE Managed Care Support Contract in December 2024.

LIQUIDITY AND CAPITAL RESOURCES

The following table is a condensed schedule of cash flows used in the discussion of liquidity and capital resources ($ in millions):

	Year Ended December 31,	
	2025	2024
Net cash provided by operating activities	$ 5,088	$ 154
Net cash provided by (used in) investing activities	472	(1,052)
Net cash (used in) financing activities	(1,621)	(2,406)
Effect of exchange rate changes on cash, cash equivalents and restricted cash	—	8
Net increase (decrease) in cash, cash equivalents, and restricted cash and cash equivalents	$ 3,939	$ (3,296)

Cash Flows Provided by Operating Activities

Normal operations are funded primarily through operating cash flows and borrowings under our Revolving Credit Facility. In 2025, operating activities provided cash of $5.1 billion compared to providing cash of $154 million in 2024. Cash flows provided by operations in 2025 were primarily driven by net earnings, improved pharmacy rebate timing and higher medical claims liabilities primarily driven by higher membership.

Cash flows provided by operations in 2024 were primarily driven by net earnings, almost entirely offset by an increase in pharmacy receivables driven by pharmacy rebate remittance timing associated with our transition to a new third-party PBM in January 2024, a decrease in net risk adjustment payables and higher state premium receivables for recent rate increases.

Cash Flows Provided by (Used in) Investing Activities

Investing activities provided cash of $472 million for the year ended December 31, 2025 compared to using cash of $1.1 billion in 2024. Cash flows provided by investing activities in 2025 consisted of net reductions to the investment portfolio of our regulated subsidiaries (including transfers from cash and cash equivalents to long-term investments) partially offset by capital expenditures. Cash flows used in investing activities in 2024 primarily consisted of net additions to the investment portfolio of our regulated subsidiaries (including transfers from cash and cash equivalents to long-term investments) and capital expenditures, partially offset by divestiture proceeds.

We spent $767 million and $644 million in the years ended December 31, 2025 and 2024, respectively, on capital expenditures primarily for system enhancements and computer hardware.

As of December 31, 2025, our investment portfolio consisted primarily of fixed-income securities with a weighted average duration of 3.3 years.

At December 31, 2025, we had unregulated cash and investments of $1.5 billion, including $553 million of cash and cash equivalents and $925 million of investments. Of the $553 million unregulated cash and cash equivalents, $400 million was available for general corporate use at December 31, 2025. Unregulated cash and investments at December 31, 2024, was $1.1 billion, including $248 million of cash and cash equivalents and $823 million of investments. Of the $248 million unregulated cash and cash equivalents, $154 million was available for general corporate use at December 31, 2024. Unregulated cash and investments include private equity investments and company owned life insurance contracts.

Cash Flows (Used in) Financing Activities

Financing activities used cash of $1.6 billion in the year ended December 31, 2025, compared to using cash of $2.4 billion in the comparable period in 2024. Financing activities in 2025 were driven by stock repurchases of $475 million, which included $400 million under the stock repurchase program and $48 million of repurchases related to income tax withholding upon the vesting of previously awarded stock grants, and net reduction of long-term debt.

In 2024, financing activities were driven by stock repurchases of $3.1 billion, which included $3.0 billion under the stock repurchase program and $114 million of repurchases related to income tax withholding upon the vesting of previously awarded stock grants, partially offset by net proceeds from long-term debt.

Liquidity Metrics

We have a stock repurchase program authorizing us to repurchase common stock from time to time on the open market or through privately negotiated transactions. In 2023, our Board of Directors authorized up to a cumulative total of $10.0 billion of repurchases under the program.

In 2025, we repurchased a total of 6.7 million shares of common stock for $400 million under the stock repurchase program, primarily funded through divestiture proceeds and free cash flow generated from operations. We have $1.8 billion remaining under the program as of December 31, 2025. No duration has been placed on the repurchase program. We reserve the right to discontinue the repurchase program at any time. Refer to Note 12. *Stockholders' Equity* for further information on stock repurchases.

As of December 31, 2025, we had an aggregate principal amount of $15.5 billion of senior notes issued and outstanding. The indentures governing our various maturities of senior notes contain limited restrictive covenants. As of December 31, 2025, we were in compliance with all covenants.

As part of our capital allocation strategy, we may decide to repurchase debt or raise capital through the issuance of debt in the form of senior notes. In 2022, our Board of Directors authorized a $1.0 billion senior note debt repurchase program. During 2025, we repurchased $189 million of our par value senior notes for $187 million. As of December 31, 2025, there was $513 million available under the senior note debt repurchase program. Refer to Note 10. *Debt* for further information regarding the issuance and redemption of senior notes. In January 2026, we repurchased an additional $29 million of our par value Senior Notes due 2027 through the debt repurchase program.

In February 2026, our Board of Directors authorized an increase under the program of $1.0 billion. With this increase, as of February 2026, there was $1.5 billion available under the senior note debt repurchase program.

The credit agreement underlying our Revolving Credit Facility, in the principal amount of $4.0 billion, and Term Loan Facility, in the principal amount of $2.0 billion, contains customary covenants as well as financial covenants including a debt-to-capital ratio. Our maximum debt-to-capital ratio under the credit agreement may not exceed 0.6 to 1.0. As of December 31, 2025, we had no borrowings outstanding under our Revolving Credit Facility, $2.0 billion of borrowings under our Term Loan Facility, and we were in compliance with all covenants. As of December 31, 2025, there were no limitations on the availability of our Revolving Credit Facility as a result of the debt-to-capital ratio.

We had outstanding letters of credit of $120 million as of December 31, 2025, which were not part of our Revolving Credit Facility. The letters of credit bore weighted interest of 0.8% as of December 31, 2025. In addition, we had outstanding surety bonds of $784 million as of December 31, 2025.

At December 31, 2025, our debt-to-capital ratio, defined as total debt divided by the sum of total debt and total equity, was 46.5%, compared to 41.2% at December 31, 2024. The debt-to-capital ratio increase was driven by the goodwill impairment recorded in the third quarter of 2025, which reduced total stockholders' equity. We utilize the debt-to-capital ratio as a measure, among others, of our leverage and financial flexibility.

At December 31, 2025, we had working capital, defined as current assets less current liabilities, of $3.7 billion, compared to $3.7 billion at December 31, 2024. We manage our short-term and long-term investments aiming to ensure a sufficient portion of the portfolio is highly liquid and can be sold to fund short-term requirements as needed.

During the year ended December 31, 2025, we received dividends of $3.2 billion from and made $2.0 billion of capital contributions to our regulated subsidiaries. During the year ended December 31, 2024, we received dividends of $3.2 billion from and made $752 million of capital contributions to our regulated subsidiaries.

Future Expectations

During 2026, we expect to receive net dividends of approximately $1.2 billion from our regulated subsidiaries and expect to spend approximately $800 million in capital expenditures primarily associated with system enhancements and computer hardware and software.

We have material short-term medical claims, debt and lease obligations. Refer to Note 8. *Medical Claims Liability,* Note 10. *Debt* and Note 11. *Leases,* respectively, for further information.

Based on our operating plan, we expect that our available cash, cash equivalents and investments, cash from our operations and cash available under our Revolving Credit Facility will be sufficient to finance our general operations and capital expenditures for at least 12 months from the date of this filing. While we are currently in a strong liquidity position and believe we have adequate access to capital, we may elect to increase borrowings on our Revolving Credit Facility, which matures in March 2030. Additionally, our senior notes mature between December 2027 and August 2031. From time to time, we may elect to raise additional funds for working capital and other purposes, either through issuance of debt or equity, the sale of investment securities, or otherwise, as appropriate. In addition, we may strategically pursue refinancing or redemption opportunities to extend maturities and/or improve terms of our indebtedness if we believe such opportunities are favorable to us.

We have receivables due from CMS for Part D risk-sharing programs attributable to the 2025 plan year that are expected to be paid by CMS within a year after the plan year closes. As of December 31, 2025, the stand-alone Part D risk-sharing programs receivable balance for the 2025 plan year was $4.0 billion.

On February 13, 2026, we entered into a master receivable purchase agreement (the February 2026 Receivable Purchase Agreement). The February 2026 Receivable Purchase Agreement allows us to from time to time offer up to the full amount of our 2025 plan year stand-alone Part D risk-sharing programs receivable to the purchaser, which the purchaser may elect to purchase. The purchase price for each purchased receivable portion equals the net estimated invoice amount of such portion minus the discount, which is determined by reference to Secured Overnight Financing Rate (SOFR) plus a spread. We will account for the transfer of all or any portion of this receivable as a sale of accounts receivable. The difference between the balance of the receivable (or portion thereof) sold and cash proceeds received will be recorded as a loss on sale of receivables and included in selling, general and administrative expenses in the Consolidated Statements of Operations. We will act as a servicer for the transferred receivable. As of the date of this report, no receivable (or any portions thereof) was transferred pursuant to the February 2026 Receivable Purchase Agreement.

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

Our operations are conducted through our subsidiaries. As managed care organizations (MCOs), most of our subsidiaries are subject to state regulations and other requirements that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to us. Generally, the amount of dividend distributions that may be paid by a regulated subsidiary without prior approval by state regulatory authorities is limited based on the entity's level of statutory net income and statutory capital and surplus.

As of December 31, 2025, our subsidiaries had aggregate statutory capital and surplus of $19.7 billion, compared with the required minimum aggregate statutory capital and surplus requirements of $11.3 billion. During the year ended December 31, 2025, we received dividends of $3.2 billion from and made $2.0 billion of capital contributions to our regulated subsidiaries. For our subsidiaries that file with the National Association of Insurance Commissioners (NAIC), we estimate our Risk Based Capital (RBC) percentage to be in excess of 350% of the Authorized Control Level.

Under the California Knox-Keene Health Care Service Plan Act of 1975, as amended (Knox-Keene), certain of our California subsidiaries must comply with tangible net equity (TNE) requirements. Under these Knox-Keene TNE requirements, actual net worth less unsecured receivables and intangible assets must be more than the greater of (i) a fixed minimum amount, (ii) a minimum amount based on premiums or (iii) a minimum amount based on healthcare expenditures, excluding capitated amounts.

Under the New York State Department of Health Codes, Rules and Regulations Title 10, Part 98, our New York subsidiary must comply with contingent reserve requirements. Under these requirements, net worth based upon admitted assets must equal or exceed a minimum amount based on annual net premium income.

The NAIC has adopted rules which set minimum risk-based capital requirements for insurance companies, MCOs and other entities bearing risk for healthcare coverage. As of December 31, 2025, each of our health plans was in compliance with the risk-based capital requirements enacted in those states.

As a result of the above requirements and other regulatory requirements, certain of our subsidiaries are subject to restrictions on their ability to make dividend payments, loans or other transfers of cash to their parent companies. Such restrictions, unless amended or waived or unless regulatory approval is granted, limit the use of any cash generated by these subsidiaries to pay our obligations. The maximum amount of dividends that can be paid by our insurance company subsidiaries without prior approval of the applicable state insurance departments is subject to restrictions relating to statutory surplus, statutory income and unassigned surplus. As of December 31, 2025, the amount of capital and surplus or net worth that was unavailable for the payment of dividends or return of capital to us was $11.3 billion in the aggregate.

RECENT ACCOUNTING PRONOUNCEMENTS

For this information, refer to Note 2. *Summary of Significant Accounting Policies*, in the Notes to the Consolidated Financial Statements, included herein.

CRITICAL ACCOUNTING ESTIMATES

Our discussion and analysis of our results of operations and liquidity and capital resources are based on our consolidated financial statements which have been prepared in accordance with GAAP. Our significant accounting policies are more fully described in Note 2. *Summary of Significant Accounting Policies,* to our consolidated financial statements included elsewhere herein. Our accounting policies regarding intangible assets, medical claims liability and revenue recognition are particularly important to the portrayal of our financial condition and results of operations and require the application of significant judgment by our management. As a result, they are subject to an inherent degree of uncertainty. We have reviewed these critical accounting policies and related disclosures with the Audit and Compliance Committee of our Board of Directors.

Goodwill and Intangible Assets

We have made several acquisitions that have resulted in the recording of intangible assets. These intangible assets primarily consist of purchased contract rights and customer relationships, provider contracts, trade names, developed technologies and goodwill. Key assumptions used in the valuation of these intangible assets include, but are not limited to, member attrition rates, contract renewal probabilities, revenue growth rates, expectations of profitability, and discount and royalty rates. We allocate the fair value of purchase consideration to the assets acquired and liabilities assumed based on their fair values at the acquisition date. The excess of the fair value of consideration transferred over the fair value of the net assets acquired is recorded as goodwill. Goodwill is generally attributable to the value of the synergies between the combined companies and the value of the acquired assembled workforce, neither of which qualifies for recognition as an intangible asset. At December 31, 2025, we had $10.8 billion of goodwill and $4.5 billion of other intangible assets.

Intangible assets are amortized using the straight-line method over the following periods:

Intangible Asset	Amortization Period
Purchased contract rights and customer relationships	5 - 15 years
Provider contracts	4 - 15 years
Trade names	7 - 20 years
Developed technologies	2 - 5 years

Goodwill is reviewed at least annually during the fourth quarter for impairment or more frequently if we identify impairment indicators. In addition, an impairment analysis of intangible assets would be performed when events or changes in circumstances suggest the carrying amount of the intangible assets may not be recoverable. These factors include significant changes in membership, financial performance, state funding, government contracts and provider networks and contracts.

For our annual goodwill impairment analysis, we may first perform a qualitative assessment for each reporting unit to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount, which is an indication that goodwill may be impaired. These qualitative impairment tests include assessing events and factors that could affect the fair value of the indefinite-lived intangible assets. Our procedures include assessing our financial performance, macroeconomic conditions, industry and market considerations, various asset-specific factors and entity-specific events. If we determine that a reporting unit's goodwill may be impaired after utilizing these qualitative impairment analysis procedures, we are required to perform a quantitative impairment test.

Our quantitative impairment test for goodwill utilizes the discounted cash flow model and guideline public company market approach. Use of the discounted cash flow model and guideline public company market approach for our goodwill impairment test reflects our view that both valuation methodologies provide a reasonable estimate of fair value. The discounted cash flow model is developed using assumptions from our internal planning process to determine the present value of future cash flows generated by the reporting unit. Our assumed discount rate is based on our industry's weighted-average cost of capital. Market valuations are estimated from observed multiples of certain measures including earnings before interest, taxes, depreciation and amortization and include market comparisons to publicly traded companies in our industry.

In addition to our annual goodwill impairment analysis, on an as-needed basis our management evaluates whether events or circumstances have occurred that may affect the estimated useful life or the recoverability of the remaining balance of goodwill and other identifiable intangible assets. If the events or circumstances indicate that the remaining balance of the intangible asset or goodwill may be impaired, the potential impairment will be measured based upon the difference between the carrying amount of the intangible asset or goodwill and the fair value of such asset. Our management must make assumptions and estimates in determining the estimated fair values, such as estimates of forecasted future cash flows, the discount rate applied to each reporting unit, long-term growth rates, statutory capital reinvestment requirements, capital expenditures, and other internal and external factors. While we believe these assumptions and estimates are appropriate, other assumptions and estimates could be applied and might produce significantly different results.

We operate in four segments: (1) a Medicaid segment, (2) a Medicare segment, (3) a Commercial segment and (4) an Other segment. We define our reporting units as our operating segments or one level below the operating segment. If a reporting unit's carrying amount exceeds its fair value, we will record an impairment charge based on that difference. The impairment charge will be limited to the amount of goodwill allocated to that reporting unit. We first assess qualitative factors to determine if a quantitative impairment test is necessary. We generally do not calculate the fair value of a reporting unit unless we determine, based on a qualitative assessment, that it is more likely than not that its fair value is less than its carrying amount. However, in certain circumstances we may elect to perform a quantitative assessment without first assessing qualitative factors.

The passage of the OBBBA in July 2025 had various implications for us, including potential membership impacts to our Medicaid reporting unit as well as the non-renewal of Marketplace Enhanced APTCs. As a result of these market conditions along with the decline in our stock price, we performed a quantitative impairment analysis during the third quarter of 2025 to determine whether goodwill, intangibles or other assets were impaired.

Our quantitative assessment for goodwill indicated that the fair value of certain reporting units had declined, resulting in an impairment of $6.7 billion as outlined within Note 7. *Goodwill and Intangible Assets*, in the Notes to the Consolidated Financial Statements, included herein. In preparing the quantitative assessment, we estimated the fair value of our reporting units using a weighted discounted cash flow model and guideline public company market approach. This analysis involved significant judgment, including estimates of forecasted future cash flows, the discount rate applied to each reporting unit, long-term growth rates, statutory capital reinvestment requirements, capital expenditures, and other internal and external factors. When analyzing the fair value indicated under the guideline public company market approach, we also considered estimates of market-based multiples of earnings from peer public companies. While we believe the assumptions and estimates used in our valuation procedures were appropriate, other assumptions and estimates could be applied and might produce significantly different results.

Following the goodwill impairment in the third quarter of 2025 and upon completion of our annual goodwill impairment analysis, we do not believe any of our reporting units are currently at risk for further impairment.

Medical Claims Liability

Our medical claims liability includes claims reported but not yet paid, or claims inventory, estimates for claims incurred but not reported (IBNR) and estimates for the costs necessary to process unpaid claims at the end of each period. We estimate our medical claims liability using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors such as historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors.

Actuarial Standards of Practice generally require that the medical claims liability estimates be adequate to cover obligations under moderately adverse conditions. Moderately adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of estimate. The claims amounts ultimately settled will most likely be different than the estimate that satisfies the Actuarial Standards of Practice. We include in our IBNR an estimate for medical claims liability under moderately adverse conditions which represents the risk of adverse deviation of the estimates in our actuarial method of reserving.

We use our judgment to determine the assumptions to be used in the calculation of the required estimates. The assumptions we consider when estimating IBNR include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, healthcare service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to fee schedules and the incidence of high-dollar or catastrophic claims.

We apply various estimation methods depending on the claim type and the period for which claims are being estimated. For more recent periods, incurred non-inpatient claims are estimated based on historical per member per month claims experience adjusted for known factors. Incurred hospital inpatient claims are estimated based on known inpatient utilization data and prior claims experience adjusted for known factors. We utilize estimated completion factors based on our historical experience to develop IBNR estimates. The completion factor is an actuarial estimate of the percentage of claims that have been received or adjudicated as of the end of a reporting period relative to the estimate of the total ultimate incurred costs for that same period. When we commence operations in a new state or region or for new product offerings, we have limited information with which to estimate our medical claims liability. See "Risk Factors - ***Failure to timely and effectively identify and mitigate medical cost trends and receive adequate rate adjustments to account for increased acuity could have a material adverse effect on our results of operations, financial condition and cash flows.***" These approaches are consistently applied to each period presented.

Our development of the medical claims liability estimate is a continuous process which we monitor and refine on a monthly basis as additional claims receipts and payment information becomes available. As more complete claims information becomes available, we adjust the amount of the estimates and include the changes in estimates in medical costs in the period in which the changes are identified. In every reporting period, our operating results include the effects of more completely developed medical claims liability estimates associated with previously reported periods. We consistently apply our reserving methodology from period to period. As additional information becomes known to us, we adjust our actuarial models accordingly to establish medical claims liability estimates.

We review actual and anticipated experience compared to the assumptions used to record medical costs. We establish premium deficiency reserves if actual and anticipated experience indicates that existing policy liabilities together with the present value of future gross premiums will not be sufficient to cover the present value of future benefits, settlement and maintenance costs. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with the method of acquiring, servicing and measuring the profitability of such contracts and expected investment income is excluded. We recorded a premium deficiency reserve of $250 million in December 2023 related to the 2024 Medicare Advantage contract year. In December 2024, we recorded a premium deficiency reserve of $92 million related to the 2025 Medicare Advantage contract year. As of December 2025, we have not recorded a premium deficiency reserve related to the 2026 Medicare Advantage contract year.

The paid and received completion factors, claims per member per month and cost trend factors are the most significant factors affecting the IBNR estimate. The following table illustrates the sensitivity of these factors and the estimated potential impact on our operating results caused by changes in these factors based on December 31, 2025 data:

Completion Factors: [1]		**Cost Trend Factors:** [2]	
(Decrease) Increase in Factors	**Increase (Decrease) in Medical Claims Liabilities**	**(Decrease) Increase in Factors**	**Increase (Decrease) in Medical Claims Liabilities**
	(In millions)		**(In millions)**
(1.00)%	$ 1,364	(1.00)%	$ (276)
(0.75)	1,019	(0.75)	(207)
(0.50)	677	(0.50)	(138)
(0.25)	337	(0.25)	(69)
0.25	(334)	0.25	69
0.50	(666)	0.50	138
0.75	(996)	0.75	207
1.00	(1,323)	1.00	276

[1] Reflects estimated potential changes in medical claims liability caused by changes in completion factors.

[2] Reflects estimated potential changes in medical claims liability caused by changes in cost trend factors for the most recent periods.

While we believe our estimates are appropriate, it is possible future events could require us to make significant adjustments for revisions to these estimates. For example, a 1% increase or decrease in our estimated medical claims liability would have affected net earnings by $204 million for the year ended December 31, 2025, excluding the effect of any return of premium, risk corridor or minimum medical loss ratio (MLR) programs. The estimates are based on our historical experience, terms of existing contracts, our observation of trends in the industry, information provided by our providers and information available from other outside sources.

The change in medical claims liability is summarized as follows (in millions):

	Year Ended December 31,		
	2025	**2024**	**2023**
Balance, January 1,	$ 18,308	$ 18,000	$ 16,745
Less: Reinsurance recoverables	65	49	26
Balance, January 1, net	18,243	17,951	16,719
Incurred related to:			
Current year	160,109	128,312	120,680
Prior years	(2,315)	(2,447)	(2,036)
Total incurred	157,794	125,865	118,644
Paid related to:			
Current year	140,691	111,456	104,725
Prior years	14,677	13,959	12,937
Total paid	155,368	125,415	117,662
Plus: Premium deficiency reserve	(92)	(158)	250
Plus: Divestitures	(109)	—	—
Balance, December 31, net	20,468	18,243	17,951
Plus: Reinsurance recoverables	76	65	49
Balance, December 31,	$ 20,544	$ 18,308	$ 18,000
Days in claims payable [1]	46	53	54

[1] Days in claims payable is a calculation of medical claims liability at the end of the period divided by average expense per calendar day for the fourth quarter of each year.

Medical claims are usually paid within a few months of the member receiving service from the healthcare provider. As a result, the liability generally is described as having a "short-tail," which typically causes less than 10% of our medical claims liability as of the end of any given year to be outstanding the following year. We believe that the vast majority of the development of the estimate of medical claims liability as of December 31, 2025 will be known by the end of 2026.

Changes in estimates of incurred claims for prior years are primarily attributable to reserving under moderately adverse conditions. Additionally, as a result of minimum MLR and other return of premium programs, approximately $93 million, $243 million and $382 million of the "Incurred related to: Prior years" was recorded as a reduction to premium revenues in 2025, 2024 and 2023, respectively. Further, claims processing and coordination of benefits initiatives yielded claim payment recoveries related to dates of service from prior years. Changes in medical utilization, claims submission patterns, and cost trends and the effect of population health management initiatives may also contribute to changes in medical claim liability estimates. While we have evidence that population health management initiatives are effective on a case by case basis, these initiatives primarily focus on events and behaviors prior to the incurrence of the medical event and generation of a claim. Accordingly, any change in behavior, leveling of care or coordination of treatment occurs prior to claim generation and as a result, the costs prior to the population health management initiative are not known by us. Additionally, certain population health management initiatives are focused on member and provider education with the intent of influencing behavior to appropriately align the medical services provided with the member's acuity. In these cases, determining whether the population health management initiative changed the behavior cannot be determined. Because of the complexity of our business, the number of states in which we operate and the volume of claims that we process, we are unable to practically quantify the impact of these initiatives on our changes in estimates of IBNR.

Revenue Recognition

Our health plans generate revenues primarily from premiums received from the states in which we operate health plans, premiums received from our members and CMS for our Medicare products and premiums from members of our commercial health plans. In addition to member premium payments, our Marketplace contracts also generate revenues from subsidies received from CMS. We generally receive a fixed premium per member per month pursuant to our contracts and recognize premium revenues during the period in which we are obligated to provide services to our members at the amount reasonably estimable. In some instances, our base premiums are subject to an adjustment, in the form of a risk score or risk adjustment, based on the acuity of our membership. Generally, the risk score or risk adjustment is determined by the state or CMS analyzing submissions of processed claims and medical record data to determine the acuity of our membership, often relative to the respective program's membership. We estimate the amount of risk score and risk adjustment based upon the processed claims and medical record data submitted and expected to be submitted to the state or CMS and record revenues on a risk adjusted basis. Some contracts allow for additional premiums related to certain supplemental services provided such as maternity deliveries.

Our contracts with states and CMS may require us to maintain a minimum MLR or may require us to share cost-savings in excess of certain levels. In certain circumstances our plans may be required to return premium to the state or policyholders in the event costs are below established levels. We estimate the effect of these programs and recognize reductions in revenue in the current period. Other states may require us to meet certain performance and quality metrics in order to receive additional or full contractual revenue. For performance-based contracts, we do not recognize revenue subject to refund until data is sufficient to measure performance.

Revenues are recorded based on membership and eligibility data provided by the states or CMS, which is adjusted on a monthly basis by the states or CMS for retroactive additions or deletions to membership data. These eligibility adjustments are estimated monthly and subsequent adjustments are made in the period known. We review and update those estimates as new information becomes available. It is possible that new information could require us to make additional adjustments, which could be significant, to these estimates.

Our Medicare Advantage contracts are with CMS. CMS deploys a risk adjustment model which apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model pays more for members whose medical history would indicate that they are expected to have higher medical costs. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient, physician treatment settings as well as prescription drug events. We and the healthcare providers collect, compile and submit the necessary and available diagnosis data to CMS within prescribed deadlines. We estimate risk adjustment revenues based upon the diagnosis data submitted and expected to be submitted to CMS and record revenues on a risk adjusted basis.

In addition to premium revenue and risk sharing described above, our Part D business receives prospective payments for reinsurance, manufacturer drug subsidies, and low-income subsidies. Reinsurance and manufacturer drug subsidies payments are received from CMS as a fixed monthly per member amount, based on the estimated costs of providing prescription drug benefits over the plan year, as reflected in our bids. For qualifying low-income prescription drug benefit members, CMS pays for some, or all, of the member's monthly premium. We receive certain Part D prospective subsidy payments from CMS for these members as a fixed monthly per-member amount, based on the estimated costs of providing prescription drug benefits over the plan year, as reflected in our bids. No prospective payments are received for risk sharing. Approximately one year subsequent to the end of the plan year, or later in the case of the drug manufacturer discount subsidy, a settlement payment is made between CMS and our plans based on the difference between the earned premium, risk corridor, reinsurance and subsidies compared to monthly prospective payments.

Our specialty companies generate revenues under contracts with state and federal programs, healthcare organizations and other commercial organizations and from our own subsidiaries. Revenues are recognized when the related services are provided or as ratably earned over the covered period of services. For performance-based measures in our contracts, revenue is recognized as data sufficient to measure performance is available.

Some states enact premium taxes, similar assessments and provider pass-through payments, collectively premium taxes, and these taxes are recorded as a separate component of both revenues and operating expenses. For certain products, premium taxes and state assessments are not pass-through payments and are recorded as premium revenue and premium tax expense in the Consolidated Statements of Operations.

Some states require state directed payments that have minimal risk, but are administered as a premium adjustment. These payments are recorded as premium revenue and medical costs at close to a 100% HBR. In many instances, we have little visibility to the timing of these payments until they are paid by the state.

ITEM 7A. ***Quantitative and Qualitative Disclosures About Market Risk***

Market risk represents the risk of loss that may impact our financial condition due to adverse changes in financial market prices and rates. Our market risk exposure is primarily the result of fluctuations in interest rates.

INVESTMENTS AND DEBT

As of December 31, 2025, we had short-term investments of $2.4 billion and long-term investments of $18.4 billion, including restricted deposits of $1.4 billion. The short-term investments generally consist of highly liquid securities with maturities between three and 12 months. The long-term investments consist of municipal, corporate and U.S. Treasury securities, government-sponsored obligations, life insurance contracts, asset backed securities, equity securities and private equity investments and have maturities greater than one year. Private equity investments include direct investments in private equity securities as well as private equity funds. Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. Due to the nature of the states' requirements, these investments are classified as long-term regardless of the contractual maturity date. Substantially all of our investments are subject to interest rate risk and will decrease in value if market rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2025, the fair value of our fixed income investments would decrease by approximately $650 million. Declines in interest rates over time will reduce our investment income.

For a discussion of the interest rate risk that our investments are subject to, see "Risk Factors - ***Our investment portfolio may suffer losses which could materially and adversely affect our results of operations or liquidity.***"

Item 8. ***Financial Statements and Supplementary Data***

Report of Independent Registered Public Accounting Firm

To the Stockholders and Board of Directors
Centene Corporation:

Opinion on the Consolidated Financial Statements

We have audited the accompanying consolidated balance sheets of Centene Corporation and subsidiaries (the Company) as of December 31, 2025 and 2024, the related consolidated statements of operations, comprehensive earnings (loss), stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2025, and the related notes (collectively, the consolidated financial statements). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2025 and 2024, and the results of its operations and its cash flows for each of the years in the three-year period ended December 31, 2025, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2025, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission, and our report dated February 17, 2026 expressed an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

Basis for Opinion

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

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

Critical Audit Matters

The critical audit matters communicated below are matters arising from the current period audit of the consolidated financial statements that were communicated or required to be communicated to the Audit and Compliance Committee and that: (1) relate to accounts or disclosures that are material to the consolidated financial statements and (2) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

Evaluation of the estimated medical claims liability

As discussed in Note 2 to the consolidated financial statements, the Company's medical claims liability includes claims reported but not yet paid, estimates for claims incurred but not reported, and estimates for the costs necessary to process unpaid claims. As discussed in Note 8 to the consolidated financial statements, the balance at December 31, 2025 was $20,544 million.

We identified the evaluation of the estimated medical claims liability as a critical audit matter. The Company estimates its medical claims liability using actuarial methods. Specialized skills were required to evaluate these actuarial methods, which include analyzing historical claims data in order to estimate the medical claims liability. The medical claims liability included an estimate for medical claims developing under moderately adverse conditions, which represents the risk of adverse deviation in the Company's actuarial methods of reserving, which required auditor judgment to evaluate.

The following are the primary procedures we performed to address this critical audit matter. We evaluated the design and tested the operating effectiveness of certain internal controls related to the critical audit matter. This included controls over the Company's process to evaluate the estimate of the medical claims liability. We involved actuarial professionals with specialized skills and knowledge who evaluated the actuarial methods used by the Company to estimate the medical claims liability. With the assistance of the actuarial professionals, we challenged the Company's estimate of the medical claims liability, including the effects of moderately adverse conditions, by developing an independent estimate for certain health plans using the Company's medical claims data, and relative range. We assessed the potential for management bias by evaluating the Company's position and movement within the actuarial professionals' relative range.

Evaluation of the estimated Affordable Care Act risk adjustment accruals

As discussed in Note 2 to the consolidated financial statements, the Affordable Care Act (ACA) established a permanent risk adjustment program. This program transfers funds from qualified individual and small group insurance plans with below average risk scores to those insurance plans with above average risk scores within each state. The final settlement of the December 31, 2025 ACA risk adjustment accruals is scheduled to be determined by the Centers for Medicare and Medicaid Services (CMS) in June 2026, based on data submitted by insurance companies through April 2026. As discussed in Note 9, the Company recorded an estimated asset and liability (the ACA risk adjustment accruals) of $1,449 million, and $2,087 million, respectively at December 31, 2025.

We identified the evaluation of the estimated ACA risk adjustment accruals as a critical audit matter. Specialized skills and a higher degree of auditor judgment were required to evaluate the Company's estimates. The Company's estimates are based on its analysis of member data, claims data, and projections of claims data expected to be submitted by the Company, and other insurance plans, to CMS for settlement.

The following are the primary procedures we performed to address this critical audit matter. We evaluated the design and tested the operating effectiveness of certain internal controls over the Company's process to develop the estimated ACA risk adjustment accruals. We involved actuarial professionals with specialized skills and knowledge who assisted in evaluating the Company's methodology used in estimating the ACA risk adjustment accruals for consistency with the federally developed risk adjustment methodology. Additionally, the actuarial professionals assisted in evaluating the projections of claims data utilized to estimate the ACA risk adjustment accruals, and assessed the methodologies utilized by the Company for consistency with industry practice. We assessed the Company's process to estimate the ACA risk adjustment accruals, in order to consider the potential for management bias, by performing a retrospective review of the prior period ACA risk adjustment accruals and assessing the consistency of those estimated balances with the subsequent settlement.

Assessment of goodwill impairment for the Medicaid, Medicare, and Commercial reporting units

As discussed in Notes 2 and 7 to the consolidated financial statements, the Company performs goodwill impairment testing for its reporting units on an annual basis during the fourth quarter or more frequently if impairment indicators exist. The Company estimates the fair value of the Medicaid, Medicare, and Commercial reporting units using a weighted discounted cash flow model and guideline public company market approach. During the year ended December 31, 2025, the Company recognized a goodwill impairment charge of $6,723 million, of which $6,398 million relates to the Medicaid and Commercial reporting units.

We identified the evaluation of the goodwill impairment assessment for the Medicaid, Medicare, and Commercial reporting units as a critical audit matter. Subjective auditor judgment was required to evaluate the Company's assumptions, particularly forecasted revenue growth rates and discount rates, due to their sensitivity to changes in market and economic environment. Changes in these assumptions could have a significant effect on the Company's assessment of the fair value of each reporting unit.

The following are the primary procedures we performed to address this critical audit matter. We evaluated the design and tested the operating effectiveness of certain internal controls over the Company's goodwill impairment process, including controls over the forecasted revenue growth rates and development of discount rates. We assessed management's forecasted revenue growth rates by comparing them to historical trends, budget, and market and economic environment. We involved valuation professionals with specialized skills and knowledge, who assisted in evaluating the discount rates by comparing them to a discount rate range that was independently developed using publicly available market data for comparable entities.

/s/ KPMG LLP

We have served as the Company's auditor since 2005.

St. Louis, Missouri
February 17, 2026

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
(In millions, except shares in thousands and per share data in dollars)

	December 31, 2025	December 31, 2024
ASSETS		
Current assets:		
Cash and cash equivalents	$ 17,888	$ 14,063
Premium and trade receivables	18,105	19,713
Short-term investments	2,432	2,622
Other current assets	1,945	1,601
Total current assets	40,370	37,999
Long-term investments	17,035	17,429
Restricted deposits	1,412	1,390
Property, software and equipment, net	2,037	2,067
Goodwill	10,835	17,558
Intangible assets, net	4,530	5,409
Other long-term assets	528	593
Total assets	$ 76,747	$ 82,445
LIABILITIES, REDEEMABLE NONCONTROLLING INTERESTS AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liability	$ 20,544	$ 18,308
Accounts payable and accrued expenses	13,774	13,174
Return of premium payable	1,592	2,008
Unearned revenue	736	661
Current portion of long-term debt	50	110
Total current liabilities	36,696	34,261
Long-term debt	17,351	18,423
Deferred tax liability	833	684
Other long-term liabilities	1,811	2,567
Total liabilities	56,691	55,935
Commitments and contingencies		
Redeemable noncontrolling interests	23	10
Stockholders' equity:		
Preferred stock, $0.001 par value; authorized 10,000 shares; no shares issued or outstanding at December 31, 2025 and December 31, 2024	—	—
Common stock, $0.001 par value; authorized 800,000 shares; 623,463 issued and 491,757 outstanding at December 31, 2025, and 620,195 issued and 495,907 outstanding at December 31, 2024	1	1
Additional paid-in capital	20,777	20,562
Accumulated other comprehensive (loss)	(58)	(504)
Retained earnings	8,674	15,348
Treasury stock, at cost (131,706 and 124,288 shares, respectively)	(9,441)	(8,997)
Total Centene stockholders' equity	19,953	26,410
Nonredeemable noncontrolling interest	80	90
Total stockholders' equity	20,033	26,500
Total liabilities, redeemable noncontrolling interests and stockholders' equity	$ 76,747	$ 82,445

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

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF OPERATIONS
(In millions, except shares in thousands and per share data in dollars)

	Year Ended December 31,		
	2025	**2024**	**2023**
Revenues:			
Premium	$ 171,556	$ 142,303	$ 135,636
Service	3,025	3,202	4,459
Premium and service revenues	174,581	145,505	140,095
Premium tax	20,196	17,566	13,904
Total revenues	194,777	163,071	153,999
Expenses:			
Medical costs	157,702	125,707	118,894
Cost of services	2,670	2,729	3,564
Selling, general and administrative expenses	12,904	12,400	12,563
Depreciation expense	590	549	575
Amortization of acquired intangible assets	685	692	718
Premium tax expense	20,538	17,806	14,226
Impairment	7,311	13	529
Total operating expenses	202,400	159,896	151,069
Earnings (loss) from operations	(7,623)	3,175	2,930
Other income (expense):			
Investment and other income	1,572	1,784	1,393
Debt extinguishment	1	—	—
Interest expense	(678)	(702)	(725)
Earnings (loss) before income tax	(6,728)	4,257	3,598
Income tax (benefit) expense	(51)	963	899
Net earnings (loss)	(6,677)	3,294	2,699
Loss attributable to noncontrolling interests	3	11	3
Net earnings (loss) attributable to Centene Corporation	$ (6,674)	$ 3,305	$ 2,702
Net earnings (loss) per common share attributable to Centene Corporation:			
Basic earnings (loss) per common share	$ (13.53)	$ 6.33	$ 4.97
Diluted earnings (loss) per common share	$ (13.53)	$ 6.31	$ 4.95
Weighted average number of common shares outstanding:			
Basic	493,116	521,790	543,319
Diluted	493,116	523,744	545,704

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

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF COMPREHENSIVE EARNINGS (LOSS)
(In millions)

	Year Ended December 31,		
	2025	**2024**	**2023**
Net earnings (loss)	$ (6,677)	$ 3,294	$ 2,699
Change in unrealized gain (loss) on investments	565	94	520
Change in unrealized gain (loss) on investments, tax effect	(134)	(29)	(128)
Change in unrealized gain (loss) on investments, net of tax	431	65	392
Reclassification adjustment, net of tax	15	83	62
Foreign currency translation adjustments, net of tax	—	—	36
Net unrealized (loss) on cash flow hedge, net of tax	—	—	(10)
Other comprehensive earnings (loss)	446	148	480
Comprehensive earnings (loss)	(6,231)	3,442	3,179
Comprehensive loss attributable to noncontrolling interests	3	11	3
Comprehensive earnings (loss) attributable to Centene Corporation	$ (6,228)	$ 3,453	$ 3,182

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

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(In millions, except shares in thousands and per share data in dollars)

	Centene Stockholders' Equity								
	Common Stock					Treasury Stock			
	$0.001 Par Value Shares	Amt	Additional Paid-in Capital	Accumulated Other Comprehensive Earnings (Loss)	Retained Earnings	$0.001 Par Value Shares	Amt	Noncontrolling Interest	Total
Balance, December 31, 2022	607,847	$ 1	$ 20,060	$ (1,132)	$ 9,341	57,093	$ (4,213)	$ 124	$ 24,181
Net earnings (loss)	—	—	—	—	2,702	—	—	(3)	2,699
Other comprehensive earnings, net of $144 tax	—	—	—	480	—	—	—	—	480
Common stock issued for employee benefit plans	7,444	—	44	—	—	—	—	—	44
Common stock repurchases	—	—	—	—	—	23,714	(1,643)	—	(1,643)
Stock compensation expense	—	—	216	—	—	—	—	—	216
Purchase of redeemable noncontrolling interest	—	—	(12)	—	—	—	—	—	(12)
Purchase of non-redeemable noncontrolling interest	—	—	(4)	—	—	—	—	(24)	(28)
Balance, December 31, 2023	615,291	$ 1	$ 20,304	$ (652)	$ 12,043	80,807	$ (5,856)	$ 97	$ 25,937
Net earnings (loss)	—	—	—	—	3,305	—	—	(5)	3,300
Other comprehensive earnings, net of $31 tax	—	—	—	148	—	—	—	—	148
Common stock issued for employee benefit plans	4,904	—	46	—	—	—	—	—	46
Common stock repurchases	—	—	—	—	—	43,481	(3,141)	—	(3,141)
Stock compensation expense	—	—	212	—	—	—	—	—	212
Divestiture of noncontrolling interest	—	—	—	—	—	—	—	(2)	(2)
Balance, December 31, 2024	620,195	$ 1	$ 20,562	$ (504)	$ 15,348	124,288	$ (8,997)	$ 90	$ 26,500
Net earnings (loss)	—	—	—	—	(6,674)	—	—	(6)	(6,680)
Other comprehensive earnings, net of $137 tax	—	—	—	446	—	—	—	—	446
Common stock issued for employee benefit plans	3,409	—	37	—	—	—	—	—	37
Common stock repurchases	(141)	—	(7)	—	—	7,418	(444)	—	(451)
Stock compensation expense	—	—	204	—	—	—	—	—	204
Purchase of redeemable noncontrolling interests	—	—	(19)	—	—	—	—	—	(19)
Contribution to non-redeemable non-controlling interest	—	—	—	—	—	—	—	(4)	(4)
Balance, December 31, 2025	623,463	$ 1	$ 20,777	$ (58)	$ 8,674	131,706	$ (9,441)	$ 80	$ 20,033

The accompanying notes to the consolidated financial statements are an integral part of this statement.

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS
(In millions)

	Year Ended December 31,		
	2025	**2024**	**2023**
Cash flows from operating activities:			
Net earnings (loss)	$ (6,677)	$ 3,294	$ 2,699
Adjustments to reconcile net earnings (loss) to net cash provided by operating activities			
Depreciation and amortization	1,275	1,241	1,293
Stock compensation expense	204	212	216
Impairment	7,311	13	529
(Gain) on debt extinguishment	(1)	—	—
Deferred income taxes	(60)	13	(78)
(Gain) loss on divestitures, net	(2)	(120)	(152)
Changes in assets and liabilities			
Premium and trade receivables	1,480	(4,333)	(2,380)
Other assets	(230)	46	5
Medical claims liabilities	2,336	368	1,261
Unearned revenue	80	(54)	238
Accounts payable and accrued expenses	(657)	(528)	3,398
Other long-term liabilities	(46)	(70)	856
Other operating activities, net	75	72	168
Net cash provided by operating activities	5,088	154	8,053
Cash flows from investing activities:			
Capital expenditures	(767)	(644)	(799)
Purchases of investments	(4,541)	(7,183)	(6,622)
Sales and maturities of investments	5,780	5,785	5,523
Divestiture proceeds, net of divested cash	—	990	707
Net cash provided by (used in) investing activities	472	(1,052)	(1,191)
Cash flows from financing activities:			
Proceeds from long-term debt	750	1,300	2,335
Payments and repurchases of long-term debt	(1,895)	(622)	(2,316)
Common stock repurchases	(475)	(3,124)	(1,633)
Proceeds from common stock issuances	37	46	44
Purchase of noncontrolling interest	(19)	—	(88)
Other financing activities, net	(19)	(6)	—
Net cash used in financing activities	(1,621)	(2,406)	(1,658)
Effect of exchange rate changes on cash, cash equivalents and restricted cash	—	8	(32)
Net increase (decrease) in cash, cash equivalents and restricted cash and cash equivalents	3,939	(3,296)	5,172
Cash and cash equivalents reclassified (to) from held for sale	(138)	—	(50)
Cash, cash equivalents and restricted cash and cash equivalents, beginning of period	14,156	17,452	12,330
Cash, cash equivalents and restricted cash and cash equivalents, end of period	$ 17,957	$ 14,156	$ 17,452
Supplemental disclosures of cash flow information:			
Interest paid	$ 647	$ 688	$ 688
Income taxes paid, net	$ 448	$ 1,002	$ 887

The following table provides a reconciliation of cash, cash equivalents and restricted cash and cash equivalents reported within the Consolidated Balance Sheets to the totals above:

	2025	**2024**	**2023**
Cash and cash equivalents	$ 17,888	$ 14,063	$ 17,193
Restricted cash and cash equivalents, included in restricted deposits	69	93	259
Total cash, cash equivalents, and restricted cash and cash equivalents	$ 17,957	$ 14,156	$ 17,452

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

CENTENE CORPORATION AND SUBSIDIARIES
NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS

1. Organization and Operations

Centene Corporation, or the Company, is a leading provider of government-sponsored healthcare. Centene's focus is on improving health and health care for low-income populations with complex needs. The Company provides access to high-quality healthcare, innovative programs and a wide range of health solutions that help families and individuals get well, stay well and be well.

The Company operates in four segments: (1) a Medicaid segment, (2) a Medicare segment, (3) a Commercial segment and (4) an Other segment. The Medicaid, Medicare and Commercial segments primarily represent the government-sponsored or subsidized programs under which the Company offers managed healthcare services. Specifically, the Medicaid segment includes the Temporary Assistance for Needy Families (TANF) program, Medicaid Expansion programs, the Aged, Blind or Disabled (ABD) program, the Children's Health Insurance Program (CHIP), Long-Term Services and Supports (LTSS), Foster Care, Medicare-Medicaid Plans (MMP), which cover beneficiaries who are dually eligible for Medicaid and Medicare and other state-based programs. The Company operated MMPs, which ended on December 31, 2025 as the Centers for Medicare and Medicaid Services (CMS) transitions to Dual Eligible Special Needs Plans (D-SNPs) based integration. The Medicare segment includes Medicare Advantage, D-SNPs, Medicare Prescription Drug Plans (PDPs), also known as Medicare Part D, and Medicare Supplement. The Commercial segment includes the Health Insurance Marketplace product along with individual and commercial group, Individual Coverage Health Reimbursement Arrangement (ICHRA) and other off-exchange individual products. The Other segment includes the Company's pharmacy operations, vision and dental services, clinical healthcare, behavioral health, and centralized services, among others. The Company signed a definitive agreement to divest the remaining Magellan Health, Inc. (Magellan Health) businesses in December 2025.

2. Summary of Significant Accounting Policies

Basis of Presentation

The accompanying consolidated financial statements include the accounts of Centene Corporation and all majority owned subsidiaries and subsidiaries over which the Company exercises the power and control to direct activities significantly impacting financial performance. All material intercompany balances and transactions have been eliminated.

Certain 2023 and 2024 amounts in the consolidated financial statements and notes to the consolidated financial statements have been reclassified to conform to the 2025 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

During the fourth quarter of 2025, the Company signed a definitive agreement to sell Magellan Health, which was accounted for as held for sale as of December 31, 2025. During 2024, the Company completed the divestitures of Circle Health Group (Circle Health) and Collaborative Health Systems (CHS). See Note 3. *Acquisitions and Divestitures* for further details.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles in the United States (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Future events and their effects cannot be predicted with certainty; accordingly, the accounting estimates require the exercise of judgment. The accounting estimates used in the preparation of the consolidated financial statements will change as new events occur, as more experience is acquired, as additional information is obtained, and as the operating environment changes. The Company evaluates and updates its assumptions and estimates on an ongoing basis and may employ outside experts to assist in its evaluation, as considered necessary. Actual results could differ from those estimates.

Business Combinations

Business combinations are accounted for using the acquisition method of accounting. The Company allocates the fair value of purchase consideration to the assets acquired and liabilities assumed based on their fair values at the acquisition date. The excess of the fair value of consideration transferred over the fair value of the net assets acquired is recorded as goodwill. Goodwill is generally attributable to the value of the synergies between the combined companies and the value of the acquired assembled workforce, neither of which qualifies for recognition as an intangible asset.

The Company uses its best estimates and assumptions to value assets acquired and liabilities assumed at the acquisition date; however, these estimates are sometimes preliminary and, in some instances, all information required to value the assets acquired and liabilities assumed may not be available or final as of the end of a reporting period subsequent to the business combination. If the accounting for the business combination is incomplete, provisional amounts are recorded. The provisional amounts are updated during the period determined, up to one year from the acquisition date. The Company includes the results of operations of acquired businesses in the Company's consolidated results prospectively from the date of acquisition.

Acquisition related expenses and post-acquisition restructuring costs are recognized separately from the business combination and are expensed as incurred.

Cash and Cash Equivalents

Investments with original maturities of three months or less are considered to be cash equivalents. Cash equivalents consist of money market funds, bank certificates of deposit and savings accounts.

The Company maintains amounts on deposit with various financial institutions, which may exceed federally insured limits. However, management periodically evaluates the credit-worthiness of those institutions, and the Company has not experienced any losses on such deposits.

Investments

Short-term investments include securities with maturities greater than three months to one year. Long-term investments include securities with maturities greater than one year.

Short-term and long-term investments are generally classified as available-for-sale and are carried at fair value. Certain equity investments are recorded using the fair value or equity method. The Company monitors the difference between the carrying value and fair value of its available-for-sale debt investments and whether declines in fair value are credit related. Unrealized gains and losses on debt investments available-for-sale are excluded from earnings and reported in accumulated other comprehensive earnings (loss), a separate component of stockholders' equity, net of income tax effects. If a loss is deemed to be credit related, the Company recognizes an allowance through earnings. For each security in an unrealized loss position, the Company assesses whether it intends to sell the security or if it is more likely than not the Company will be required to sell the security before recovery of the amortized cost basis for reasons such as liquidity, contractual or regulatory purposes. If the security meets this criterion, the decline in fair value is recorded in earnings through investment and other income. Premiums and discounts are amortized or accreted over the life of the related security using the effective interest method. To calculate realized gains and losses on the sale of investments, the Company uses the specific amortized cost of each investment sold. Realized gains and losses are recorded in investment and other income.

The Company uses the equity method to account for investments in entities that it does not control but has the ability to exercise significant influence over operating and financial policies. Generally, under the equity method, original investments in these entities are recorded at cost and subsequently adjusted by the Company's share of equity in income or losses after the date of acquisition as well as capital contributions to and distributions from these companies.

Restricted Deposits

Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. These investments are classified as long-term, regardless of the contractual maturity date, due to the nature of the states' requirements. The Company is required to annually adjust the amount of the deposit pledged to certain states.

Fair Value Measurements

In the normal course of business, the Company invests in various financial assets and incurs various financial liabilities. Fair values are disclosed for all financial instruments, whether or not such values are recognized in the Consolidated Balance Sheets. Management obtains quoted market prices and other observable inputs for these disclosures. The carrying amounts reported in the Consolidated Balance Sheets for cash and cash equivalents, premium and trade receivables, medical claims liability, accounts payable and accrued expenses, unearned revenue and certain other current assets and liabilities are carried at cost, which approximates fair value because of their short-term nature.

The following methods and assumptions were used to estimate the fair value of each financial instrument:

- Available-for-sale investments and restricted deposits: The carrying amount is stated at fair value, based on quoted market prices, where available. For securities not actively traded, fair values were estimated using values obtained from independent pricing services or quoted market prices of comparable instruments.
- Senior unsecured notes: Estimated based on third-party quoted market prices for the same or similar issues.
- Variable rate debt: The carrying amount of the Company's floating rate debt approximates fair value since the interest rates adjust based on market rate adjustments.
- Contingent consideration: Estimated based on expected achievement of metrics included in the acquisition agreement considering circumstances that exist as of the acquisition date.

Property, Software and Equipment

Property, software and equipment are stated at cost less accumulated depreciation. Computer hardware and software includes certain costs incurred in the development of internal-use software, including external direct costs of materials and services and payroll costs of team members devoted to specific software development. Depreciation is calculated principally by the straight-line method over estimated useful lives. Leasehold improvements are depreciated using the straight-line method over the shorter of the expected useful life or the remaining term of the lease. Property, software and equipment are depreciated over the following periods:

Fixed Asset	Depreciation Period
Buildings and improvements	10 - 40 years
Computer hardware and software	3 - 5 years
Furniture and equipment	5 - 10 years
Land improvements	10 - 25 years
Leasehold improvements	1 - 20 years

The carrying amounts of all long-lived assets are evaluated to determine if adjustment to the depreciation and amortization period or to the unamortized balance is warranted. Such evaluation is based principally on the expected utilization of the long-lived assets.

The Company retains fully depreciated assets in property and accumulated depreciation accounts until it removes them from service. In the case of sale, retirement or disposal, the asset cost and related accumulated depreciation balance is removed from the respective account, and the resulting net amount, less any proceeds, is included in investment and other income in the Consolidated Statements of Operations.

Goodwill and Intangible Assets

Intangible assets represent assets acquired in purchase transactions and consist primarily of purchased contract rights and customer relationships, provider contracts, trade names, developed technologies and goodwill. Intangible assets are amortized using the straight-line method over the following periods:

Intangible Asset	Amortization Period
Purchased contract rights and customer relationships	5 - 15 years
Provider contracts	4 - 15 years
Trade names	7 - 20 years
Developed technologies	2 - 5 years

Goodwill is reviewed at least annually during the fourth quarter for impairment or more frequently if the Company identifies impairment indicators. In addition, an impairment analysis of intangible assets would be performed when events or changes in circumstances suggest the carrying amount of the intangible assets may not be recoverable. These factors include significant changes in membership, financial performance, state funding, government contracts and provider networks and contracts.

For the annual goodwill impairment analysis, the Company may first perform a qualitative assessment for each reporting unit to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount, which is an indication that goodwill may be impaired. These qualitative impairment tests include assessing events and factors that could affect the fair value of the indefinite-lived intangible assets. The Company's procedures include assessing its financial performance, macroeconomic conditions, industry and market considerations, various asset-specific factors and entity-specific events. If the Company determines that a reporting unit's goodwill may be impaired after utilizing these qualitative impairment analysis procedures, it is required to perform a quantitative impairment test.

The Company's quantitative impairment test for goodwill utilizes the discounted cash flow model and guideline public company market approach. Use of the discounted cash flow model and guideline public company market approach for the goodwill impairment test reflects the Company's view that both valuation methodologies provide a reasonable estimate of fair value. The discounted cash flow model is developed using assumptions from its internal planning process to determine the present value of future cash flows generated by the reporting unit. The Company's assumed discount rate is based on the industry's weighted-average cost of capital. Market valuations are estimated from observed multiples of certain measures including earnings before interest, taxes, depreciation and amortization and include market comparisons to publicly traded companies in the industry.

In addition to the annual goodwill impairment analysis, on an as-needed basis the Company evaluates whether events or circumstances have occurred that may affect the estimated useful life or the recoverability of the remaining balance of goodwill and other identifiable intangible assets. If the events or circumstances indicate that the remaining balance of the intangible asset or goodwill may be impaired, the potential impairment will be measured based upon the difference between the carrying amount of the intangible asset or goodwill and the fair value of such asset. The Company must make assumptions in determining the estimated fair values, such as estimates of forecasted future cash flows, the discount rate applied to each reporting unit, long-term growth rates, statutory capital reinvestment requirements, capital expenditures, and other internal and external factors.

The Company operates in four segments: (1) a Medicaid segment, (2) a Medicare segment, (3) a Commercial segment and (4) an Other segment. The Company defines its reporting units as its operating segments or one level below the operating segment. If a reporting unit's carrying amount exceeds its fair value, the Company will record an impairment charge based on that difference. The impairment charge will be limited to the amount of goodwill allocated to that reporting unit. The Company first assesses qualitative factors to determine if a quantitative impairment test is necessary. The Company generally does not calculate the fair value of a reporting unit unless it determines, based on a qualitative assessment, that it is more likely than not that its fair value is less than its carrying amount. However, in certain circumstances the Company may elect to perform a quantitative assessment without first assessing qualitative factors.

The passage of the One Big Beautiful Bill Act (OBBBA) in July 2025 had various implications for the Company, including potential membership impacts to the Company's Medicaid reporting unit as well as the non-renewal of Marketplace Enhanced Advance Premium Tax Credits (APTCs). As a result of these market conditions along with the decline in the Company's stock price, the Company performed a quantitative impairment analysis during the third quarter to determine whether goodwill, intangibles or other assets were impaired.

The goodwill impairment analysis utilized a weighted discounted cash flow model and guideline public company market approach to measure the fair value of the Company's reporting units. As a result of the analysis, the Company recorded a $6,723 million impairment to goodwill in the third quarter of 2025.

Medical Claims Liability

Medical claims liability includes claims reported but not yet paid, or claims inventory, estimates for claims incurred but not reported, or IBNR, and estimates for the costs necessary to process unpaid claims at the end of each period. The Company estimates its medical claims liability using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors such as historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors.

Actuarial Standards of Practice generally require that the medical claims liability estimates be adequate to cover obligations under moderately adverse conditions. Moderately adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of estimate. The claims amounts ultimately settled will most likely be different than the estimate that satisfies the Actuarial Standards of Practice. The Company includes in its IBNR an estimate for medical claims liability under moderately adverse conditions which represents the risk of adverse deviation of the estimates in its actuarial method of reserving.

The Company uses its judgment to determine the assumptions to be used in the calculation of the required estimates. The assumptions it considers when estimating IBNR include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, healthcare service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to fee schedules and the incidence of high-dollar or catastrophic claims.

The Company's development of the medical claims liability estimate is a continuous process which it monitors and refines on a monthly basis as additional claims receipts and payment information becomes available. As more complete claims information becomes available, the Company adjusts the amount of the estimates, and includes the changes in estimates in medical costs in the period in which the changes are identified. In every reporting period, the operating results include the effects of more completely developed medical claims liability estimates associated with previously reported periods. The Company consistently applies its reserving methodology from period to period. As additional information becomes known, it adjusts the actuarial models accordingly to establish medical claims liability estimates.

The Company reviews actual and anticipated experience compared to the assumptions used to establish medical costs. The Company establishes premium deficiency reserves if actual and anticipated experience indicates that existing policy liabilities together with the present value of future gross premiums will not be sufficient to cover the present value of future benefits, settlement and maintenance costs. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with the method of acquiring, servicing and measuring the profitability of such contracts and expected investment income is excluded. In December 2023, the Company recorded a premium deficiency reserve of $250 million related to the 2024 Medicare Advantage contract year. In December 2024, the Company recorded a premium deficiency reserve of $92 million related to the 2025 Medicare Advantage contract year. As of December 2025, the Company did not record a premium deficiency reserve related to the 2026 Medicare Advantage contract year.

Revenue Recognition

The Company's health plans generate revenues primarily from premiums received from the states in which it operates health plans, premiums received from its members and CMS for its Medicare products and premiums from members of its commercial health plans. In addition to member premium payments, its Marketplace contracts also generate revenues from subsidies received from CMS. The Company generally receives a fixed premium per member per month pursuant to its contracts and recognizes premium revenues during the period in which it is obligated to provide services to its members at the amount reasonably estimable. In some instances, the Company's base premiums are subject to an adjustment, in the form of a risk score or risk adjustment, based on the acuity of its membership. Generally, the risk score or risk adjustment is determined by the state or CMS analyzing submissions of processed claims and medical record data to determine the acuity of the Company's membership, often relative to the respective program's membership. The Company estimates the amount of risk score and risk adjustment based upon the processed claims and medical record data submitted and expected to be submitted to the state or CMS and records revenues on a risk adjusted basis. Some contracts allow for additional premiums related to certain supplemental services provided such as maternity deliveries.

The Company's contracts with states and CMS may require it to maintain a minimum medical loss ratio (MLR) or may require it to share cost-savings in excess of certain levels. In certain circumstances, including commercial plans, its plans may be required to return premium to the state or policyholders in the event costs are below established levels. The Company estimates the effect of these programs and recognizes reductions in revenue in the current period. Other states may require us to meet certain performance and quality metrics in order to receive additional or full contractual revenue. For performance-based contracts, the Company does not recognize revenue subject to refund until data is sufficient to measure performance.

Revenues are recorded based on membership and eligibility data provided by the states or CMS, which is adjusted on a monthly basis by the states or CMS for retroactive additions or deletions to membership data. These eligibility adjustments are estimated monthly and subsequent adjustments are made in the period known. The Company reviews and updates those estimates as new information becomes available. It is possible that new information could require us to make additional adjustments, which could be significant, to these estimates.

The Company's Medicare Advantage contracts are with CMS. CMS deploys a risk adjustment model which apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model pays more for members whose medical history would indicate that they are expected to have higher medical costs. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient, physician treatment settings as well as prescription drug events. The Company and the healthcare providers collect, compile and submit the necessary and available diagnosis data to CMS within prescribed deadlines. The Company estimates risk adjustment revenues based upon the diagnosis data submitted and expected to be submitted to CMS and records revenues on a risk adjusted basis.

In addition to premium revenue and risk sharing described above, the Company's Part D business receives prospective payments for reinsurance, manufacturer drug subsidies, and low-income subsidies. Reinsurance and manufacturer drug subsidies payments are received from CMS as a fixed monthly per member amount, based on the estimated costs of providing prescription drug benefits over the plan year, as reflected in the bids. For qualifying low-income prescription drug benefit members, CMS pays for some, or all, of the member's monthly premium. The Company receives certain Part D prospective subsidy payments from CMS for these members as a fixed monthly per-member amount, based on the estimated costs of providing prescription drug benefits over the plan year, as reflected in the bids. No prospective payments are received for risk sharing. Approximately one year subsequent to the end of the plan year, or later in the case of the drug manufacturer discount subsidy, a settlement payment is made between CMS and the Company's plans based on the difference between the earned premium, risk corridor, reinsurance and subsidies compared to monthly prospective payments.

The Company's specialty companies generate revenues under contracts with state and federal programs, healthcare organizations and other commercial organizations, as well as from its own subsidiaries. Revenues are recognized when the related services are provided, when inventory is shipped, or as ratably earned over the covered period of services. For performance-based measures in the Company's contracts, revenue is recognized as data sufficient to measure performance is available.

Some states enact premium taxes, similar assessments and provider pass-through payments, collectively premium taxes, and these taxes are recorded as a separate component of both revenues and operating expenses. For certain products, premium taxes and state assessments are not pass-through payments and are recorded as premium revenue and premium tax expense in the Consolidated Statements of Operations.

Some states require state directed payments that have minimal risk, but are administered as a premium adjustment. These payments are recorded as premium revenue and medical costs at close to a 100% health benefits ratio (HBR). In many instances, the Company has little visibility to the timing of these payments until they are paid by the state.

Affordable Care Act

The Affordable Care Act (ACA) established risk spreading premium stabilization programs as well as minimum MLR and cost sharing reductions (CSRs). The Company's accounting policies for the programs are as follows:

Risk Adjustment

The permanent risk adjustment program established by the ACA transfers funds from qualified individual and small group insurance plans with below average risk scores to those plans with above average risk scores within each state. The Company estimates the receivable or payable under the risk adjustment program based on its estimated risk score compared to the state average risk score. The Company may record a receivable or payable as an adjustment to premium revenues to reflect the year-to-date impact of the risk adjustment based on its best estimate. The Company refines its estimate as new information becomes available.

Minimum Medical Loss Ratio

The ACA established a minimum MLR for commercial insurance plans, including the Health Insurance Marketplace. The risk adjustment program described above is taken into consideration to determine if the Company's estimated annual medical costs are less than the minimum MLR and require an adjustment to premium revenues to meet the minimum MLR.

Cost Sharing Reductions

The ACA directs issuers to reduce the Company's members' cost sharing for essential health benefits for individuals with Federal Poverty Levels (FPLs) between 100% and 250% who are enrolled in a silver tier product; eliminate cost sharing for Indians/Alaska Natives with a FPL less than 300% and eliminate cost sharing for Indians/Alaska Natives regardless of FPL when services are provided by an Indian Health Service. In October 2017, the Trump Administration issued an executive order that immediately ceased payments of CSRs to issuers, and beginning in 2018, premium rates for Health Insurance Marketplace were set without factoring in the cost sharing subsidy payments from the federal government. In 2024, the Company reached an agreement with the federal government to retroactively compensate the Company for the difference between its actual CSR experience and its pricing assumptions for 2018 through 2020.

Premium and Trade Receivables and Unearned Revenue

Premium and service revenues collected in advance of being earned are recorded as unearned revenue. For performance-based contracts, the Company does not recognize revenue subject to refund until data is sufficient to measure performance. Premiums and service revenues due to the Company are recorded as premium and trade receivables and are recorded net of an allowance based on historical trends and management's judgment on the collectability of these accounts. As the Company generally receives payments during the month in which services are provided, the allowance is typically not significant in comparison to total revenues and does not have a material impact on the presentation of the financial condition or results of operations. Amounts receivable under federal contracts are comprised primarily of contractually defined billings, accrued contract incentives under the terms of the contract and amounts related to change orders for services not originally specified in the contract.

The Company has receivables due from CMS for Part D risk-sharing programs attributable to the 2025 plan year that are expected to be paid by CMS within a year after the plan year closes. As of December 31, 2025, the stand-alone Part D risk-sharing programs receivable balance for the 2025 plan year was $3,992 million.

Activity in the allowance for uncollectible accounts is summarized below ($ in millions):

	Year Ended December 31,		
	2025	**2024**	**2023**
Balance, January 1	$ 111	$ 120	$ 130
Amounts charged to expense	99	68	58
Recoveries	(3)	—	—
Write-offs of uncollectible receivables	(73)	(77)	(68)
Balance, December 31	$ 134	$ 111	$ 120

Significant Customers

The Company receives the majority of its revenues under contracts or subcontracts with state Medicaid managed care programs. None of the Company's customers exceeded 10% of total annual revenues for the years ended December 31, 2025, 2024 and 2023.

Other Income (Expense)

Other income (expense) consists routinely of investment income, interest expense and equity method earnings from investments. Investment income is derived from the Company's cash, cash equivalents, restricted deposits and investments. Interest expense relates to borrowings under the senior notes, credit facilities, mortgage and construction loans and capital leases. Further, other income (expense) includes gains or losses on sales of investments, divestitures and acquisitions as well as debt extinguishment costs.

Income Taxes

Deferred tax assets and liabilities are recorded for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax law or tax rates is recognized in income in the period that includes the enactment date.

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. In determining if a deductible temporary difference or net operating loss can be realized, the Company considers future reversals of existing taxable temporary differences, future taxable income, taxable income in prior carryback periods and tax planning strategies.

Contingencies

The Company accrues for loss contingencies associated with outstanding litigation, claims and assessments for which it has determined it is probable that a loss contingency exists and the amount of loss can be reasonably estimated. The Company expenses professional fees associated with litigation claims and assessments as incurred.

Stock Based Compensation

Stock based compensation expense is recognized at grant date fair value over the period during which an employee is required to provide service in exchange for the award. Excess tax benefits/detriments related to stock compensation are presented as a cash inflow/outflow from operating activities. The Company accounts for forfeitures when they occur.

Recent Accounting Guidance Not Yet Adopted

In November 2024, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2024-03 – Income Statement – Reporting Comprehensive Income: Disaggregation of Income Statement Expenses which expands disclosures about specific expense categories presented on the face of the Statement of Operations. The new standard is effective for annual periods beginning after December 15, 2026, and interim periods beginning after December 15, 2027. The Company is currently evaluating the effect of the new disclosure requirements.

In September 2025, the FASB issued ASU 2025-06 – Intangibles – Goodwill and Other – Internal-Use Software. The standard update modernizes and clarifies the threshold for when an entity is required to start capitalizing software costs by removing stage-based and linear capitalization rules and is based on when (i) management has authorized and committed to funding the software project and (ii) it is probable that the project will be completed and the software will be used to perform the function intended. The new standard is effective for fiscal years and interim periods beginning after December 15, 2027, with early adoption permitted. The Company is currently evaluating the impact of this standard update.

In December 2025, the FASB issued ASU 2025-11 – Interim Reporting – Narrow-Scope Improvements which clarifies interim disclosure requirements and the applicability of Topic 270. The objective of the standard update is to provide clarity about current interim requirements. The amendments in this standard update also include a disclosure principle that requires entities to disclose events since the end of the last annual reporting period that have a material impact on the entity. The new standard is effective for interim periods within annual reporting periods beginning after December 15, 2027, with early adoption permitted. The Company is currently evaluating the impact of this standard update.

3. Acquisitions and Divestitures

Magellan Rx Divestiture

On December 2, 2022, the Company completed the divestiture of Magellan Rx for $1,337 million. The Company recognized a gain of $269 million, or $99 million after-tax, which is included in investment and other income in the Consolidated Statements of Operations.

During 2023, the Company recorded a reduction to the previously reported gain on the sale of $22 million, or $10 million after-tax, due to the finalization of working capital adjustments, which is included in investment and other income in the Consolidated Statements of Operations.

During 2025, the company recorded a favorable adjustment to the gain on sale of Magellan Rx of $2 million, or $1 million after-tax, which is included in investment and other income in the Consolidated Statements of Operations.

Magellan Specialty Health Divestiture

On January 20, 2023, the Company completed the divestiture of Magellan Specialty Health for $646 million in cash and stock, including an estimated working capital adjustment, and recognized a gain of $79 million, or $68 million after-tax. The stock consideration was subsequently sold in April 2023 for cash proceeds of $245 million.

During 2024, the Company recorded an additional gain on the previously reported divestiture of Magellan Specialty Health of $83 million for achievement of contingent consideration related to the sale and finalization of working capital adjustments, which is included in investment and other income in the Consolidated Statements of Operations.

Circle Health Group Divestiture

On August 28, 2023, the Company signed a definitive agreement to sell Circle Health, one of the U.K.'s largest independent hospital operators, which was included in the Other segment. In accordance with the signed definitive agreement in the third quarter of 2023, and subsequently updated in the fourth quarter of 2023, the Company recorded impairment charges related to goodwill associated with the pending divestiture totaling $292 million, or $258 million after-tax.

In order to manage the foreign exchange risk on the sale price associated with the pending divestiture of Circle Health, in August 2023 the Company entered into a foreign currency swap agreement for a notional amount of $931 million, to sell £740 million. The swap agreement was formally designated and qualified as a cash flow hedge. The swap expired on the earlier of the divestiture closing date or March 28, 2024. The gain or loss due to changes in the fair value of the foreign currency swap was recorded in other comprehensive income until the Circle Health divestiture closed, at which time the gain or loss was recorded in earnings to the same line in the Consolidated Statements of Operations as the gain or loss on sale.

On January 12, 2024, the Company completed the divestiture for $931 million and settled the foreign currency swap. Upon closing the divestiture, the Company settled the foreign currency swap and recorded a corresponding gain of $20 million, which includes the cumulative translation adjustment previously recorded in accumulated other comprehensive income in the Consolidated Balance Sheet. The gain is included in investment and other income in the Consolidated Statements of Operations. During the year ended December 31, 2024, the Company realized a net tax benefit of approximately $40 million on the loss recognized on the divestiture.

Collaborative Health Systems Divestiture

In July 2024, the Company entered into a definitive agreement to sell CHS, a management services organization, which was included in the Other segment.

On October 4, 2024, the Company completed the previously announced sale of CHS. During 2024, the Company recognized a pre-tax gain of $17 million, or $13 million after-tax, which is included in investment and other income in the Consolidated Statements of Operations.

Magellan Health

In December 2025, the Company signed a definitive agreement to sell the remaining Magellan Health businesses, which is included in the Other segment. As of December 31, 2025, the assets and liabilities of Magellan Health were considered held for sale resulting in $303 million of assets held for sale in other current assets and $303 million of liabilities held for sale in accounts payable and accrued expenses in the Consolidated Balance Sheet. The majority of the held for sale assets were previously reported as cash and cash equivalents, premium and trade receivables, property, software and equipment and intangible assets. The majority of the liabilities were previously reported as medical claims liabilities and accounts payable and accrued expenses.

As a result, the Company recorded impairment charges associated with the pending divestiture totaling $513 million, or $389 million after-tax.

4. Short-term and Long-term Investments, Restricted Deposits

Short-term and long-term investments and restricted deposits by investment type consist of the following ($ in millions):

	December 31, 2025				December 31, 2024			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Debt securities:								
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 533	$ 3	$ (1)	$ 535	$ 593	$ 2	$ (4)	$ 591
Corporate securities	10,642	166	(146)	10,662	10,820	47	(360)	10,507
Restricted certificates of deposit	1	—	—	1	4	—	—	4
Restricted cash equivalents	69	—	—	69	93	—	—	93
Short-term time deposits	205	—	—	205	425	—	—	425
Municipal securities	3,790	37	(69)	3,758	4,174	7	(151)	4,030
Asset-backed securities	1,656	20	(10)	1,666	1,820	13	(21)	1,812
Residential mortgage-backed securities	1,763	21	(70)	1,714	1,807	1	(129)	1,679
Commercial mortgage-backed securities	1,156	9	(29)	1,136	1,298	3	(62)	1,239
Equity securities	1	—	—	1	14	—	—	14
Private equity investments	915	—	—	915	851	—	—	851
Life insurance contracts	217	—	—	217	196	—	—	196
Total	$ 20,948	$ 256	$ (325)	$ 20,879	$ 22,095	$ 73	$ (727)	$ 21,441

The Company's investments are debt securities classified as available-for-sale with the exception of equity securities, certain private equity investments and life insurance contracts. Private equity investments include direct investments in private equity securities as well as private equity funds. In December 2024, the Company impaired a private equity investment for $50 million. The Company's investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets with a focus on high credit quality securities. The Company limits the size of investment in any single issuer other than U.S. treasury securities and obligations of U.S. government corporations and agencies. As of December 31, 2025, 99% of the Company's investments in rated securities carry an investment grade rating by nationally recognized statistical rating organizations. At December 31, 2025, the Company held certificates of deposit, equity securities, private equity investments and life insurance contracts, which did not carry a credit rating. Accrued interest income on available-for-sale debt securities was $180 million and $178 million at December 31, 2025 and 2024, respectively, and is included in other current assets in the Consolidated Balance Sheets.

The Company's residential mortgage-backed securities are primarily issued by the Federal National Mortgage Association, Government National Mortgage Association or Federal Home Loan Mortgage Corporation, which carry implicit or explicit guarantees of the U.S. government. The Company's commercial mortgage-backed securities are primarily senior tranches with a weighted average rating of AA+ and a weighted average duration of 3 years at December 31, 2025.

The fair value of available-for-sale debt securities with gross unrealized losses by investment type and length of time that individual securities have been in a continuous unrealized loss position were as follows ($ in millions):

	December 31, 2025				December 31, 2024			
	Less Than 12 Months		12 Months or More		Less Than 12 Months		12 Months or More	
	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ —	$ 88	$ (1)	$ 43	$ (1)	$ 60	$ (3)	$ 144
Corporate securities	(2)	464	(144)	3,226	(41)	2,621	(319)	4,782
Municipal securities	(1)	241	(68)	1,550	(16)	1,217	(135)	2,073
Asset-backed securities	(2)	114	(8)	180	(4)	301	(17)	331
Residential mortgage-backed securities	—	120	(70)	687	(18)	786	(111)	738
Commercial mortgage-backed securities	—	156	(29)	480	(4)	210	(58)	666
Total	$ (5)	$ 1,183	$ (320)	$ 6,166	$ (84)	$ 5,195	$ (643)	$ 8,734

As of December 31, 2025, the gross unrealized losses were generated from 3,236 positions out of a total of 6,176 positions. The change in fair value of available-for-sale debt securities is primarily a result of movement in interest rates subsequent to the purchase of the security.

For each security in an unrealized loss position, the Company assesses whether it intends to sell the security or if it is more likely than not the Company will be required to sell the security before recovery of the amortized cost basis for reasons such as liquidity, contractual or regulatory purposes. If the security meets this criterion, the decline in fair value is recorded in earnings. The Company does not intend to sell these securities prior to maturity and it is not likely that the Company will be required to sell these securities prior to maturity; therefore, the Company did not record an impairment for these securities.

In addition, the Company monitors available-for-sale debt securities for credit losses. Certain investments have experienced a decline in fair value due to changes in credit quality, market interest rates and/or general economic conditions. The Company recognizes an allowance when evidence demonstrates that the decline in fair value is credit related. Evidence of a credit-related loss may include rating agency actions, adverse conditions specifically related to the security or failure of the issuer of the security to make scheduled payments.

The contractual maturities of short-term and long-term debt securities and restricted deposits are as follows ($ in millions):

	December 31, 2025				December 31, 2024			
	Investments		Restricted Deposits		Investments		Restricted Deposits	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value
One year or less	$ 2,201	$ 2,190	$ 464	$ 464	$ 2,383	$ 2,365	$ 477	$ 475
One year through five years	7,266	7,219	574	566	7,799	7,563	610	593
Five years through ten years	4,198	4,252	334	339	4,343	4,172	301	291
Greater than ten years	160	157	43	43	165	160	31	31
Asset-backed securities	4,575	4,516	—	—	4,925	4,730	—	—
Total	$ 18,400	$ 18,334	$ 1,415	$ 1,412	$ 19,615	$ 18,990	$ 1,419	$ 1,390

Actual maturities may differ from contractual maturities due to call or prepayment options. Equity securities, private equity investments and life insurance contracts are excluded from the table above because they do not have a contractual maturity. The Company has an option to redeem substantially all of the securities included in the greater than ten years category listed above at amortized cost.

5. Fair Value Measurements

Assets and liabilities recorded at fair value in the Consolidated Balance Sheets are categorized based upon observable or unobservable inputs used to estimate fair value. Level inputs are as follows:

Level Input:	Input Definition:
Level I	Inputs are unadjusted, quoted prices for identical assets or liabilities in active markets at the measurement date.
Level II	Inputs other than quoted prices included in Level I that are observable for the asset or liability through corroboration with market data at the measurement date.
Level III	Unobservable inputs that reflect management's best estimate of what market participants would use in pricing the asset or liability at the measurement date.

The following table summarizes fair value measurements by level at December 31, 2025, for assets and liabilities measured at fair value on a recurring basis ($ in millions):

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$ 17,888	$ —	$ —	$ 17,888
Investments:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 55	$ —	$ —	$ 55
Corporate securities	—	10,652	—	10,652
Municipal securities	—	2,906	—	2,906
Short-term time deposits	—	205	—	205
Asset-backed securities	—	1,666	—	1,666
Residential mortgage-backed securities	—	1,714	—	1,714
Commercial mortgage-backed securities	—	1,136	—	1,136
Equity securities	—	1	—	1
Total investments	$ 55	$ 18,280	$ —	$ 18,335
Restricted deposits:				
Cash and cash equivalents	$ 69	$ —	$ —	$ 69
U.S. Treasury securities and obligations of U.S. government corporations and agencies	480	—	—	480
Corporate securities	—	10	—	10
Certificates of deposit	—	1	—	1
Municipal securities	—	852	—	852
Total restricted deposits	$ 549	$ 863	$ —	$ 1,412
Total assets at fair value	$ 18,492	$ 19,143	$ —	$ 37,635

The following table summarizes fair value measurements by level at December 31, 2024, for assets and liabilities measured at fair value on a recurring basis ($ in millions):

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$ 14,063	$ —	$ —	$ 14,063
Investments:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 58	$ —	$ —	$ 58
Corporate securities	—	10,505	—	10,505
Municipal securities	—	3,272	—	3,272
Short-term time deposits	—	425	—	425
Asset-backed securities	—	1,812	—	1,812
Residential mortgage-backed securities	—	1,679	—	1,679
Commercial mortgage-backed securities	—	1,239	—	1,239
Equity securities	13	1	—	14
Total investments	$ 71	$ 18,933	$ —	$ 19,004
Restricted deposits:				
Cash and cash equivalents	$ 93	$ —	$ —	$ 93
U.S. Treasury securities and obligations of U.S. government corporations and agencies	533	—	—	533
Corporate securities	—	2	—	2
Certificates of deposit	—	4	—	4
Municipal securities	—	758	—	758
Total restricted deposits	$ 626	$ 764	$ —	$ 1,390
Total assets at fair value	$ 14,760	$ 19,697	$ —	$ 34,457

The Company utilizes matrix pricing services to estimate fair value for securities which are not actively traded on the measurement date. The Company designates these securities as Level II fair value measurements. In addition, the aggregate carrying amount of the Company's private equity investments and life insurance contracts, which approximates fair value, was $1,132 million and $1,047 million as of December 31, 2025 and December 31, 2024, respectively.

6. Property, Software and Equipment

Property, software and equipment consist of the following ($ in millions):

	December 31, 2025	December 31, 2024
Computer software	$ 2,688	$ 3,051
Buildings	492	523
Computer hardware	486	535
Leasehold improvements	277	273
Furniture and office equipment	181	332
Land	145	156
Property, software and equipment, at cost	4,269	4,870
Less: accumulated depreciation	(2,232)	(2,803)
Property, software and equipment, net	$ 2,037	$ 2,067

Depreciation expense for the years ended December 31, 2025, 2024 and 2023 was $590 million, $549 million and $575 million, respectively.

The decrease in property, software and equipment in 2025 was primarily driven by divestiture related activity as discussed in Note 3. *Acquisitions and Divestitures*. Specifically, as of December 31, 2025, Magellan Health was considered held for sale, and accordingly, the associated property, software and equipment of $91 million was reclassified to other current assets.

7. Goodwill and Intangible Assets

The passage of the OBBBA in July 2025 had various implications for the Company, including potential membership impacts to the Company's Medicaid reporting unit as well as the non-renewal of Marketplace Enhanced APTCs. As a result of these market conditions along with the decline in the Company's stock price, the Company performed a quantitative impairment analysis during the third quarter of 2025 to determine whether goodwill, intangibles or other assets were impaired.

The goodwill impairment analysis utilized a weighted discounted cash flow model and guideline public company market approach to measure the fair value of the Company's reporting units. As a result of the analysis, the Company recorded a $6,723 million impairment to goodwill.

The following table summarizes the changes in goodwill by operating segment ($ in millions):

	Medicaid	Medicare	Commercial	Other	Consolidated Total
Balance, December 31, 2023	$ 10,198	$ 1,592	$ 5,424	$ 344	$ 17,558
Current year activity	—	—	—	—	—
Balance, December 31, 2024	$ 10,198	$ 1,592	$ 5,424	$ 344	$ 17,558
Impairments	(6,186)	—	(212)	(325)	(6,723)
Balance, December 31, 2025	$ 4,012	$ 1,592	$ 5,212	$ 19	$ 10,835

Intangible assets at December 31, consist of the following ($ in millions):

	2025	2024	Weighted Average Useful Life in Years 2025	2024
Purchased contract rights and customer relationships	$ 7,737	$ 7,845	13.5	13.5
Trade names	913	943	15.5	15.6
Provider contracts	492	612	13.8	14.0
Developed technologies	227	298	3.8	4.4
Intangible assets	9,369	9,698	13.4	13.4
Less: accumulated amortization				
Purchased contract rights and customer relationships	(3,891)	(3,348)		
Trade names	(438)	(383)		
Provider contracts	(283)	(271)		
Developed technologies	(227)	(287)		
Total accumulated amortization	(4,839)	(4,289)		
Intangible assets, net	$ 4,530	$ 5,409		

As discussed in Note 3. *Acquisitions and Divestitures*, Magellan Health was considered held for sale as of December 31, 2025, and the related intangible assets of $140 million were reclassified to other current assets. Additionally, during 2025 the Company recorded intangible asset impairment related to the wind-down of certain contracts in the Other segment of $55 million.

Amortization expense was $685 million, $692 million and $718 million for the years ended December 31, 2025, 2024 and 2023, respectively. Estimated total amortization expense related to the December 31, 2025 intangible assets for each of the five succeeding fiscal years is as follows ($ in millions):

	Estimated Total Amortization Expense
2026	$ 650
2027	645
2028	644
2029	540
2030	482

8. Medical Claims Liability

The following table summarizes the change in medical claims liability for the year ended December 31, 2025 ($ in millions):

	Medicaid	Medicare	Commercial	Other	Consolidated Total
Balance, January 1, 2025	$ 10,299	$ 3,358	$ 4,463	$ 188	$ 18,308
Less: Reinsurance recoverables	18	—	47	—	65
Balance, January 1, 2025, net	10,281	3,358	4,416	188	18,243
Incurred related to:					
Current year	85,697	34,869	37,397	2,146	160,109
Prior years	(1,247)	(550)	(495)	(23)	(2,315)
Total incurred	84,450	34,319	36,902	2,123	157,794
Paid related to:					
Current year	75,872	30,651	32,213	1,955	140,691
Prior years	8,500	2,533	3,482	162	14,677
Total paid	84,372	33,184	35,695	2,117	155,368
Plus: Premium deficiency reserve	—	(92)	—	—	(92)
Plus: Divestitures	—	—	—	(109)	(109)
Balance, December 31, 2025, net	10,359	4,401	5,623	85	20,468
Plus: Reinsurance recoverables	16	—	60	—	76
Balance, December 31, 2025	$ 10,375	$ 4,401	$ 5,683	$ 85	$ 20,544

The following table summarizes the change in medical claims liability for the year ended December 31, 2024 ($ in millions):

	Medicaid	Medicare	Commercial	Other	Consolidated Total
Balance, January 1, 2024	$ 10,814	$ 3,612	$ 3,460	$ 114	$ 18,000
Less: Reinsurance recoverables	5	—	44	—	49
Balance, January 1, 2024, net	10,809	3,612	3,416	114	17,951
Incurred related to:					
Current year	78,886	21,170	26,548	1,708	128,312
Prior years	(1,370)	(575)	(509)	7	(2,447)
Total incurred	77,516	20,595	26,039	1,715	125,865
Paid related to:					
Current year	69,351	18,036	22,547	1,522	111,456
Prior years	8,693	2,655	2,492	119	13,959
Total paid	78,044	20,691	25,039	1,641	125,415
Plus: Premium deficiency reserve	—	(158)	—	—	(158)
Balance, December 31, 2024, net	10,281	3,358	4,416	188	18,243
Plus: Reinsurance recoverables	18	—	47	—	65
Balance, December 31, 2024	$ 10,299	$ 3,358	$ 4,463	$ 188	$ 18,308

The following table summarizes the change in medical claims liability for the year ended December 31, 2023 ($ in millions):

	Medicaid	Medicare	Commercial	Other	Consolidated Total
Balance, January 1, 2023	$ 11,253	$ 3,431	$ 1,921	$ 140	$ 16,745
Less: Reinsurance recoverables	7	—	19	—	26
Balance, January 1, 2023, net	11,246	3,431	1,902	140	16,719
Incurred related to:					
Current year	79,747	19,487	19,966	1,480	120,680
Prior years	(1,537)	(343)	(150)	(6)	(2,036)
Total incurred	78,210	19,144	19,816	1,474	118,644
Paid related to:					
Current year	69,904	16,631	16,823	1,367	104,725
Prior years	8,743	2,582	1,479	133	12,937
Total paid	78,647	19,213	18,302	1,500	117,662
Plus: Premium deficiency reserve	—	250	—	—	250
Balance, December 31, 2023, net	10,809	3,612	3,416	114	17,951
Plus: Reinsurance recoverables	5	—	44	—	49
Balance, December 31, 2023	$ 10,814	$ 3,612	$ 3,460	$ 114	$ 18,000

Reinsurance recoverables related to medical claims are included in premium and trade receivables. Changes in estimates of incurred claims for prior years were primarily attributable to reserving under moderately adverse conditions, including residual pandemic impacts. Additionally, as a result of minimum MLR and other return of premium programs, the Company recorded approximately $93 million, $243 million and $382 million of the "Incurred related to: Prior years" as a reduction to premium revenues in 2025, 2024 and 2023, respectively. Further, claims processing and coordination of benefits initiatives yielded claim payment recoveries related to dates of service from prior years.

Changes in medical utilization, claims submission patterns, and cost trends and the effect of population health management initiatives may also contribute to changes in medical claim liability estimates. While the Company has evidence that population health management initiatives are effective on a case by case basis, population health management initiatives primarily focus on events and behaviors prior to the incurrence of the medical event and generation of a claim. Accordingly, any change in behavior, leveling of care or coordination of treatment occurs prior to claim generation and as a result, the costs prior to the population health management initiative are not known by the Company. Additionally, certain population health management initiatives are focused on member and provider education with the intent of influencing behavior to appropriately align the medical services provided with the member's acuity. In these cases, determining whether the population health management initiative changed the behavior cannot be determined. Because of the complexity of its business, the number of states in which it operates and the volume of claims that it processes, the Company is unable to practically quantify the impact of these initiatives on its changes in estimates of IBNR.

The Company reviews actual and anticipated experience compared to the assumptions used to establish medical costs. The Company establishes premium deficiency reserves if actual and anticipated experience indicates that existing policy liabilities together with the present value of future gross premiums will not be sufficient to cover the present value of future benefits, settlement and maintenance costs. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with the method of acquiring, servicing and measuring the profitability of such contracts and expected investment income is excluded. In December 2023, the Company recorded a premium deficiency reserve of $250 million related to the 2024 Medicare Advantage contract year. In December 2024, the Company recorded a premium deficiency reserve of $92 million related to the 2025 Medicare Advantage contract year. As of December 2025, the Company did not record a premium deficiency reserve related to the 2026 Medicare Advantage contract year.

Information about incurred and paid claims development as of December 31, 2025 is included in the table below. The claims development information for all periods preceding the most recent reporting period is considered required supplementary information.

Consolidated incurred and paid claims development as of December 31, 2025 is as follows ($ in millions):

Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance			
For the Year Ended December 31,			
Claim Year	**2023 (unaudited)**	**2024 (unaudited)**	**2025**
2023	$ 120,680	$ 118,709	$ 118,324
2024		128,312	126,382
2025			160,109
		Total incurred claims	$ 404,815

Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance			
For the Year Ended December 31,			
Claim Year	**2023 (unaudited)**	**2024 (unaudited)**	**2025**
2023	$ 104,725	$ 117,635	$ 118,114
2024		111,456	125,631
2025			140,691
		Total payment of incurred claims	384,436
		All outstanding liabilities prior to 2023, net of reinsurance	290
		Magellan Health medical claims liabilities held for sale	(109)
		Medical claims liability, net of reinsurance	$ 20,560

Incurred and paid claims development for the Medicaid segment as of December 31, 2025 is as follows ($ in millions):

Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance			
For the Year Ended December 31,			
Claim Year	**2023 (unaudited)**	**2024 (unaudited)**	**2025**
2023	$ 79,747	$ 78,517	$ 78,282
2024		78,885	77,872
2025			85,697
		Total incurred claims	$ 241,851

Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance			
For the Year Ended December 31,			
Claim Year	**2023 (unaudited)**	**2024 (unaudited)**	**2025**
2023	$ 69,904	$ 77,952	$ 78,194
2024		69,351	77,527
2025			75,872
		Total payment of incurred claims	231,593
		All outstanding liabilities prior to 2023, net of reinsurance	101
		Medical claims liability, net of reinsurance	$ 10,359

Incurred and paid claims development for the Medicare segment as of December 31, 2025 is as follows ($ in millions):

Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance			
For the Year Ended December 31,			
Claim Year	**2023 (unaudited)**	**2024 (unaudited)**	**2025**
2023	$ 19,487	$ 19,008	$ 18,830
2024		21,171	20,798
2025			34,869
		Total incurred claims	$ 74,497

Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance			
For the Year Ended December 31,			
Claim Year	**2023 (unaudited)**	**2024 (unaudited)**	**2025**
2023	$ 16,631	$ 18,778	$ 18,783
2024		18,036	20,674
2025			30,651
		Total payment of incurred claims	70,108
		All outstanding liabilities prior to 2023, net of reinsurance	104
		Medical claims liability, net of reinsurance	$ 4,493

Incurred and paid claims development for the Commercial segment as of December 31, 2025 is as follows ($ in millions):

Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance			
For the Year Ended December 31,			
Claim Year	**2023 (unaudited)**	**2024 (unaudited)**	**2025**
2023	$ 19,966	$ 19,698	$ 19,725
2024		26,548	26,027
2025			37,397
		Total incurred claims	$ 83,149

Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance			
For the Year Ended December 31,			
Claim Year	**2023 (unaudited)**	**2024 (unaudited)**	**2025**
2023	$ 16,823	$ 19,420	$ 19,650
2024		22,547	25,748
2025			32,213
		Total payment of incurred claims	77,611
		All outstanding liabilities prior to 2023, net of reinsurance	85
		Medical claims liability, net of reinsurance	$ 5,623

Incurred and paid claims development for the Other segment as of December 31, 2025 is as follows ($ in millions):

Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance			
For the Year Ended December 31,			
Claim Year	**2023 (unaudited)**	**2024 (unaudited)**	**2025**
2023	$ 1,480	$ 1,486	$ 1,487
2024		1,708	1,685
2025			2,146
		Total incurred claims	$ 5,318

Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance			
For the Year Ended December 31,			
Claim Year	**2023 (unaudited)**	**2024 (unaudited)**	**2025**
2023	$ 1,367	$ 1,485	$ 1,487
2024		1,522	1,682
2025			1,955
		Total payment of incurred claims	5,124
		All outstanding liabilities prior to 2023, net of reinsurance	—
		Magellan Health medical claims liabilities held for sale	(109)
		Medical claims liability, net of reinsurance	$ 85

Incurred claims and allocated claim adjustment expenses, net of reinsurance, total IBNR plus expected development on reported claims and cumulative claims data as of December 31, 2025 are included in the following table. For claims frequency information summarized below, a claim is defined as the financial settlement of a single medical event in which remuneration was paid to the servicing provider. Total IBNR plus expected development on reported claims represents estimates for claims incurred but not reported, development on reported claims and estimates for the costs necessary to process unpaid claims at the end of each period. The Company estimates its liability using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors such as historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors.

Consolidated information is summarized as follows (in millions):

	December 31, 2025		
Claim Year	Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance	Total IBNR Plus Expected Development on Reported Claims	Cumulative Paid Claims
2023	$ 118,324	$ 4	624.1
2024	126,382	347	665.0
2025	160,109	13,125	709.9

Information for the Medicaid segment is summarized as follows (in millions):

	December 31, 2025		
Claim Year	Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance	Total IBNR Plus Expected Development on Reported Claims	Cumulative Paid Claims
2023	$ 78,282	$ 4	346.0
2024	77,872	155	317.9
2025	85,697	7,244	308.1

Information for the Medicare segment is summarized as follows (in millions):

	December 31, 2025		
Claim Year	Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance	Total IBNR Plus Expected Development on Reported Claims	Cumulative Paid Claims
2023	$ 18,830	$ —	200.7
2024	20,798	82	255.1
2025	34,869	1,567	282.8

Information for the Commercial segment is summarized as follows (in millions):

	December 31, 2025		
Claim Year	Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance	Total IBNR Plus Expected Development on Reported Claims	Cumulative Paid Claims
2023	$ 19,725	$ —	72.9
2024	26,027	107	86.4
2025	37,397	4,242	112.5

Information for the Other segment is summarized as follows (in millions):

	December 31, 2025		
Claim Year	Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance	Total IBNR Plus Expected Development on Reported Claims	Cumulative Paid Claims
2023	$ 1,487	$ —	4.5
2024	1,685	3	5.6
2025	2,146	72	6.5

9. Affordable Care Act

The ACA established risk spreading premium stabilization programs as well as a minimum annual MLR and CSRs.

The Company's net receivables (payables) for each of the programs are as follows ($ in millions):

	December 31, 2025	December 31, 2024
Risk adjustment receivable	$ 1,449	$ 1,434
Risk adjustment payable	(2,087)	(1,605)
Minimum medical loss ratio	(294)	(688)
Cost sharing reduction receivable	13	305
Cost sharing reduction payable	(15)	(74)

In June 2025, CMS announced the final risk adjustment transfers for the 2024 benefit year. CMS announced an update to the final risk adjustment transfer in July 2025, and the risk adjustment net receivable was decreased by $504 million in the twelve months ended December 31, 2025. After consideration of minimum MLR and other related impacts, which includes the effect to the 2025 benefit year, the net pre-tax benefit recognized was $163 million for the year ended December 31, 2025.

As of December 31, 2025, the Company's 2025 benefit year net risk adjustment payable was $545 million.

10. Debt

Debt consists of the following ($ in millions):

	December 31, 2025	December 31, 2024
$2,500 million 4.25% Senior Notes, due December 15, 2027	$ 2,211	$ 2,398
$2,300 million 2.45% Senior Notes, due July 15, 2028	2,302	2,302
$3,500 million 4.625% Senior Notes, due December 15, 2029	3,277	3,277
$2,000 million 3.375% Senior Notes, due February 15, 2030	2,000	2,000
$2,200 million 3.00% Senior Notes, due October 15, 2030	2,200	2,200
$2,200 million 2.50% Senior Notes, due March 1, 2031	2,200	2,200
$1,300 million 2.625% Senior Notes, due August 1, 2031	1,300	1,300
Total senior notes	15,490	15,677
Term Loan Facility	2,000	2,006
Revolving Credit Agreement	—	950
Debt issuance costs	(89)	(100)
Total debt	17,401	18,533
Less: current portion	(50)	(110)
Long-term debt	$ 17,351	$ 18,423

Senior Notes

During 2025, the Company repurchased $189 million of its par value Senior Notes due 2027 through the Company's senior note debt repurchase program. The Company recognized a $1 million gain on the repurchase of the notes, including the write-off of unamortized debt discount and issuance costs. In January 2026, the Company repurchased an additional $29 million of its par value Senior Notes due 2027 through the debt repurchase program.

The indentures governing the senior notes listed in the table above contain restrictive covenants of Centene Corporation. At December 31, 2025, the Company was in compliance with all covenants.

Revolving Credit Facility and Term Loan Credit Facility

On March 5, 2025, the Company entered into a new Credit Agreement (New Credit Agreement) and terminated all outstanding commitments and repaid all outstanding obligations under the Fourth Amended and Restated Credit Agreement, dated as of August 16, 2021 (as amended).

The New Credit Agreement provides for (i) a revolving credit facility in the principal amount of $4,000 million (the Revolving Credit Facility) and (ii) a term loan facility in the principal amount of $2,000 million (the Term Loan Facility). The maturity date for the New Credit Agreement is March 5, 2030. Loans under the Revolving Credit Facility may be denominated in U.S. dollars, Euros, Sterling, Swiss Francs, Yen, Australian dollars and Canadian dollars and each other currency which has been approved under the terms of the New Credit Agreement.

Borrowings under the New Credit Agreement will bear interest at a fluctuating rate per annum equal to a benchmark rate applicable to the currency composing such borrowing plus an applicable margin. The applicable margin is in each case based on the rating of Centene's corporate debt obligations by S&P and Moody's and is primarily a linear progression corresponding to the Company's credit rating as defined in the New Credit Agreement. The applicable margin for base rate loans changes in increments of 0.25% increasing or decreasing between pricing levels at the corresponding rating level.

The Company is subject to a financial covenant under the New Credit Agreement, tested quarterly, whereby the debt-to-capital ratio may not exceed 0.60 to 1.00, with a step-up, upon the Company's election, following the consummation of a material acquisition, to 0.65 to 1.00 during certain specified periods. As of December 31, 2025, the Company was in compliance with all financial and non-financial covenants under the New Credit Agreement.

As of December 31, 2025, the Company had no borrowings outstanding under the Revolving Credit Facility, with an interest rate of the base rate plus 0.25% margin, and $2,000 million of borrowings outstanding under the Company's Term Loan Facility.

Senior Note Debt Repurchase Program

In June 2022, the Company's Board of Directors authorized a $1,000 million senior note debt repurchase program in preparation for future debt reductions as part of the Company's strategic initiatives. During the year ended December 31, 2025, the Company repurchased $189 million of its par value senior notes, as described above, for $187 million. No repurchases were made during the year ended December 31, 2024. As of December 31, 2025, there was $513 million available under the senior note debt repurchase program. In January 2026, the Company repurchased an additional $29 million of its par value Senior Notes due 2027 for $29 million.

In February 2026, the Company's Board of Directors authorized an increase under the program of $1,000 million. With this increase, as of February 2026, there was $1,484 million available under the senior note debt repurchase program.

Letters of Credit & Surety Bonds

The Company had outstanding letters of credit of $120 million as of December 31, 2025, which were not part of the Revolving Credit Facility. The letters of credit bore interest at 0.8% as of December 31, 2025. The Company had outstanding surety bonds of $784 million as of December 31, 2025.

Aggregate maturities for the Company's debt for the years ending December 31, are as follows ($ in millions):

	Aggregate Maturities
2026	$ 50
2027	2,316
2028	2,400
2029	3,377
2030	5,850
Thereafter	3,500
Total	$ 17,493

The fair value of outstanding debt was approximately $16,273 million and $16,929 million at December 31, 2025 and 2024, respectively.

11. Leases

The Company records right-of-use (ROU) assets and lease liabilities for non-cancelable operating leases primarily for real estate and equipment. Leases with an initial term of 12 months or less are not recorded on the balance sheet. Expense related to leases is recorded on a straight-line basis over the lease term, including rent holidays. The Company recognized operating lease expense of $99 million and $108 million during the years ended December 31, 2025 and 2024, respectively.

The Company considers the existence of options to extend or terminate leases in its analysis of the lease term for the purposes of measuring its ROU assets and lease liabilities. The renewal options are not included in the measurement of the ROU assets and lease liabilities unless the Company is reasonably certain to exercise the optional renewal periods.

The following table sets forth the ROU assets and lease liabilities ($ in millions):

	December 31, 2025	December 31, 2024
Assets		
ROU assets (recorded within other long-term assets)	$ 317	$ 359
Liabilities		
Short-term (recorded within accounts payable and accrued expenses)	$ 146	$ 158
Long-term (recorded within other long-term liabilities)	615	738
Total lease liabilities	$ 761	$ 896

Cash paid for amounts included in the measurement of lease liabilities, recorded as operating cash flows in the Consolidated Statements of Cash Flows, was $195 million and $227 million during the years ended December 31, 2025 and 2024, respectively. New operating leases commenced resulting in the recognition of ROU assets and lease liabilities of $65 million and $69 million during the years ended December 31, 2025 and 2024, respectively. As of December 31, 2025, the Company had additional operating leases that have not yet commenced of $2 million. These operating leases will commence in 2026 with lease terms of approximately six years.

As of December 31, 2025, the weighted average remaining lease term for the Company was 6.9 years. The lease liabilities as of December 31, 2025, reflect a weighted average discount rate of 3.5%.

Lease payments over the next five years and thereafter are as follows ($ in millions):

	Lease Payments
2026	$ 169
2027	137
2028	116
2029	99
2030	86
Thereafter	247
Total lease payments	854
Less: imputed interest	(93)
Total lease liabilities	$ 761

12. Stockholders' Equity

The Company's Board of Directors has authorized a stock repurchase program of the Company's common stock from time to time on the open market or through privately negotiated transactions. The Company is authorized to repurchase up to $10,000 million, inclusive of past authorizations. As of December 31, 2025, the Company had a remaining amount of $1,830 million available under the Company's stock repurchase program. No duration has been placed on the repurchase program. The Company reserves the right to discontinue the repurchase program at any time.

Share repurchases in 2025, 2024 and 2023 were primarily funded through divestiture proceeds and free cash flow generated from operations. The following represents the Company's share repurchase activity ($ in millions, shares in thousands):

	Year Ended December 31,					
	2025		2024		2023	
	Shares	Cost	Shares	Cost	Shares	Cost
Share buybacks	6,713	$ 400	41,987	$ 2,999	22,886	$ 1,577
Income tax withholding	846	48	1,494	114	828	56
Total share repurchases [1]	7,559	$ 448	43,481	$ 3,113	23,714	$ 1,633

[1] Excludes year-to-date share repurchase excise tax of approximately $3 million, $28 million and $10 million accrued as of December 31, 2025, 2024 and 2023 respectively.

Prior to the adoption of the 2025 Stock Incentive Plan in May 2025, shares repurchased for income tax withholding were shares withheld in connection with employee stock plans to meet applicable tax withholding requirements. These shares were typically included in the Company's treasury stock. Following the adoption of the 2025 Stock Incentive Plan, shares repurchased for income tax withholding are typically recorded as a reduction to additional paid-in capital.

13. Statutory Capital Requirements and Dividend Restrictions

Various state laws require Centene's regulated subsidiaries to maintain minimum capital levels specified by each state and restrict the amount of dividends that may be paid without prior regulatory approval. At December 31, 2025 and 2024, Centene's subsidiaries had aggregate statutory capital and surplus of $19,730 million and $20,258 million, respectively, compared with the required minimum aggregate statutory capital and surplus of $11,288 million and $9,083 million, respectively. As of December 31, 2025, the amount of capital and surplus or net worth that was unavailable for the payment of dividends or return of capital to the Company was $11,288 million in the aggregate.

14. Income Taxes

The consolidated income tax expense consists of the following ($ in millions):

	Year Ended December 31,		
	2025	2024	2023
Income (loss) from continuing operations before income tax expense (benefit)			
U.S. Federal	$ (6,727)	$ 3,529	$ 3,686
Foreign [1]	(1)	728	(88)
Total	$ (6,728)	$ 4,257	$ 3,598
Income tax expense (benefit) from continuing operations			
Current tax expense (benefit)			
Federal	$ 77	$ 798	$ 833
State and local	(69)	142	132
Foreign	—	—	1
Total current tax expense	$ 8	$ 940	$ 966
Deferred tax expense (benefit)			
Federal	$ (29)	$ 8	$ (71)
State and local	(30)	7	33
Foreign	—	8	(29)
Total deferred tax expense (benefit)	$ (59)	$ 23	$ (67)
Total income tax expense (benefit)			
Federal	$ 48	$ 806	$ 762
State and local	(99)	149	165
Foreign	—	8	(28)
Total income tax expense (benefit)	$ (51)	$ 963	$ 899

[1] Foreign income from continuing operations includes the Company's Cayman Islands reinsurance entity. The Company has elected for its Cayman Islands entity to be taxed as a U.S. corporation and pays U.S. tax at the 21% tax rate. The U.S. tax resulting from this entity is included in Federal income tax expense. This entity ceased operations in 2025.

The reconciliation of the tax provision at the U.S. federal statutory rate to income tax expense (benefit) is as follows ($ in millions):

	Year Ended December 31,					
	2025		2024		2023	
	Total	%	Total	%	Total	%
Earnings (loss) from continuing operations, before income tax expense	$ (6,728)		$ 4,257		$ 3,598	
Tax provision at the U.S. federal statutory rate	(1,413)	21.0 %	894	21.0 %	756	21.0 %
Federal						
Effect of cross-border tax laws						
Global Intangible Low-Taxed Income (GILTI)	(2)	— %	44	1.0 %	4	0.1 %
Cayman Islands						
Statutory income tax rate differential [1]	—	— %	142	3.3 %	62	1.7 %
Other	2	— %	2	— %	(21)	(0.6)%
Tax credits	—	— %	(14)	(0.3)%	(5)	(0.1)%
Changes in valuation allowances	(1)	— %	(12)	(0.3)%	(2)	(0.1)%
Nontaxable or nondeductible items						
Nondeductible compensation	31	(0.5)%	37	0.9 %	29	0.8 %
Nondeductible goodwill	1,409	(20.9)%	—	— %	—	— %
Nontaxable or nondeductible divestiture (gains) losses	3	— %	(97)	(2.3)%	(9)	(0.3)%
Other nontaxable or nondeductible items	19	(0.3)%	(1)	— %	(6)	(0.2)%
Other						
Excess tax detriment (benefit) on stock awards	4	(0.1)%	(3)	(0.1)%	(59)	(1.6)%
Other	(24)	0.4 %	9	0.2 %	26	0.7 %
Foreign tax effects						
United Kingdom						
Nondeductible goodwill	—	— %	(34)	(0.8)%	83	2.3 %
Other	—	— %	12	0.3 %	(26)	(0.7)%
Cayman Islands						
Statutory income tax rate differential [1]	—	— %	(142)	(3.3)%	(62)	(1.7)%
Other jurisdictions	—	— %	7	0.2 %	(16)	(0.4)%
Changes in unrecognized tax benefits	(92)	1.4 %	24	0.6 %	27	0.8 %
State income taxes, net of federal income tax benefit [2]	13	(0.2)%	95	2.2 %	118	3.3 %
Income tax (benefit) expense	$ (51)	0.8 %	$ 963	22.6 %	$ 899	25.0 %

[1] The Company has elected for its Cayman Islands reinsurance entity to be taxed as a U.S. corporation and pays U.S. tax at the 21% tax rate. The taxability of this entity does not represent a reconciling item between the U.S. federal rate and the Company's effective tax rate. This entity ceased operations in 2025.

[2] During the year ended December 31, 2025, state taxes in Pennsylvania comprised greater than 50% of the tax effect in this category. During the year ended December 31, 2024, state taxes in California, Florida and Illinois comprised greater than 50% of the tax effect in this category. During the year ended December 31, 2023, state taxes in California and Florida comprised greater than 50% of the tax effect in this category.

Income taxes paid are as follows ($ in millions):

	Year Ended December 31,		
	2025	2024	2023
U.S. Federal [1]	$ 364	$ 930	$ 698
California	27	*	*
Florida	23	*	*
Pennsylvania	*	*	53
Other [2]	34	71	138
Total U.S. State and Local	84	71	191
Foreign	—	1	(2)
Total income taxes paid, net	$ 448	$ 1,002	$ 887

[1] Includes amounts paid to purchase transferable tax credits of $78 million, $100 million and $49 million during the years ended December 31, 2025, 2024 and 2023, respectively.

[2] Includes amounts paid to purchase transferable tax credits of $23 million, $15 million and $10 million during the years ended December 31, 2025, 2024 and 2023, respectively.

* The amount of income taxes paid to these jurisdictions during the year does not meet the 5% disaggregation threshold.

The tax effects of temporary differences which give rise to deferred tax assets and liabilities are presented below ($ in millions):

	December 31, 2025	December 31, 2024
Deferred tax assets:		
Medical claims liability	$ 178	$ 178
Nondeductible liabilities	69	81
Net operating loss and other carryforwards	106	70
Compensation accruals	105	93
Premium and trade receivables	88	72
Operating lease liability	196	231
Unrealized gain/loss	13	153
Software development costs	178	246
Other	48	92
Deferred tax assets	981	1,216
Valuation allowance	(67)	(77)
Net deferred tax assets	$ 914	$ 1,139
Deferred tax liabilities:		
Goodwill and intangible assets	$ 1,376	$ 1,518
Fixed assets	198	135
Investments in subsidiaries and joint ventures (outside basis)	68	—
Right-of-use asset	78	88
Other	27	82
Deferred tax liabilities	1,747	1,823
Net deferred tax liabilities	$ (833)	$ (684)

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain state net operating loss and capital loss carryforwards and federal and state tax credit carryforwards.

State net operating loss and tax credit carryforwards of $45 million expire beginning in 2026 through 2044, while the remaining $16 million have indefinite carryforward periods.

The Company maintains a reserve for uncertain tax positions that may be challenged by a tax authority. A rollforward of the beginning and ending amount of uncertain tax positions, exclusive of related interest and penalties, is as follows ($ in millions):

	Year Ended December 31,	
	2025	2024
Gross unrecognized tax benefits, January 1	$ 340	$ 439
Gross increases:		
Current year tax positions	12	16
Prior year tax positions	4	31
Gross decreases:		
Settlements [1]	(8)	(133)
Prior year tax positions	(8)	(6)
Statute of limitation lapses	(110)	(7)
Gross unrecognized tax benefits, December 31	$ 230	$ 340

[1] Settlements for the year ended December 31, 2024 primarily reflected the resolution of an item that had no net impact on the Consolidated Statement of Operations.

As of December 31, 2025, $120 million of unrecognized tax benefits would impact the Company's effective tax rate in future periods, if recognized.

The table above excludes interest and penalties, net of related tax benefits, which are treated as income tax expense (benefit) under the Company's accounting policy. The Company recognized a net reduction of interest expense and penalties related to uncertain positions of $37 million for the year ended December 31, 2025. For the year ended December 31, 2024, the Company recognized net interest expense and penalties related to uncertain positions of $13 million. The Company had $61 million and $98 million of accrued interest and penalties for uncertain tax positions as of December 31, 2025 and 2024, respectively.

The Company files federal tax returns as well as returns for numerous state tax jurisdictions and is engaged in multiple audit proceedings for its state filings. Generally, no further state audit activity is expected for years prior to 2016. Additionally, the Company's tax returns are under federal examination for tax years 2021 through 2022.

15. Stock Incentive Plans

The Company's stock incentive plans allow for the granting of restricted stock or restricted stock unit awards and options to purchase common stock. Both incentive stock options and nonqualified stock options can be awarded under the plans. However, an immaterial amount of options were granted, exercised or outstanding in 2025. The plans have 12 million shares available for future awards.

Compensation expense for stock options and restricted stock unit awards is recognized on a straight-line basis over the vesting period, generally three to five years for stock options and one to three years for restricted stock or restricted stock unit awards. Vesting is accelerated by one year for individuals who qualify under the Company's retirement eligible provisions. Certain restricted stock unit awards contain performance-based or market-based provisions as well as service-based provisions. The fair value of restricted stock and restricted stock units with only service-based or performance-based provisions is determined using the previous day's market close price at the time of grant. The fair value of restricted stock units with market-based provisions is determined using a Monte Carlo simulation model. The fair value of stock options is determined based on the Black-Scholes option-pricing model. Forfeitures for all stock awards are recognized as they occur. The total compensation cost that has been charged against income for the stock incentive plans was $204 million, $212 million and $216 million for the years ended December 31, 2025, 2024 and 2023, respectively. The total income tax benefit recognized in the Statements of Operations for stock-based compensation arrangements was $20 million, $26 million and $101 million for the years ended December 31, 2025, 2024 and 2023, respectively.

A summary of the Company's non-vested restricted stock and restricted stock unit shares as of December 31, 2025, and changes during the year ended December 31, 2025, is presented below (shares in thousands):

	Shares	Weighted Average Grant Date Fair Value
Non-vested balance, December 31, 2024	6,352	$ 73.10
Granted	8,836	44.75
Vested	(2,593)	70.79
Forfeited	(1,047)	66.52
Non-vested balance, December 31, 2025	11,548	$ 52.53

The total fair value of restricted stock and restricted stock units vested during the years ended December 31, 2025, 2024 and 2023, was $147 million, $317 million and $185 million, respectively.

As of December 31, 2025, there was $356 million of total unrecognized compensation cost related to non-vested share-based compensation arrangements granted under the plans; that cost is expected to be recognized over a weighted-average period of 2.1 years.

The Company maintains an employee stock purchase plan and issued 796 thousand shares, 572 thousand shares and 607 thousand shares in 2025, 2024 and 2023, respectively.

16. Retirement Plan

Centene has a defined contribution plan which covers substantially all team members who are at least 21 years of age. Under the plan, eligible team members may contribute a percentage of their base salary, subject to certain limitations. Centene may elect to match a portion of the employee's contribution. Company expense related to matching contributions to the plan was $138 million, $136 million and $131 million during the years ended December 31, 2025, 2024 and 2023, respectively.

17. Contingencies

The Company is routinely subjected to legal and regulatory proceedings in the normal course of business. These matters can include, without limitation:

- periodic compliance and other reviews and investigations by various federal and state regulatory agencies with respect to requirements applicable to the Company's business, including, without limitation, those related to payment of claims, compliance with the CMS Medicare and Marketplace regulations, including risk adjustment, prior authorizations and broker compensation, compliance with the False Claims Act, the calculation of minimum MLR and rebates related thereto, submissions to state agencies related to payments or state false claims acts, pre-authorization penalties, timely review of grievances and appeals, timely and accurate payment of claims, provider directory accuracy, network adequacy, cybersecurity issues, including those related to the Company's or the Company's third-party vendors' information systems, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal and state fraud, waste and abuse laws;
- litigation arising out of general business activities, such as tax matters, disputes related to healthcare benefits coverage or reimbursement, putative securities class actions, and medical malpractice, privacy, real estate, intellectual property, vendor disputes and employment-related claims; and
- disputes regarding reinsurance arrangements, claims arising out of the acquisition or divestiture of various assets, class actions, and claims relating to the performance of contractual and non-contractual obligations to providers, members, employer groups, vendors and others, including, but not limited to, the alleged failure to properly pay claims and challenges to the manner in which the Company processes claims, claims related to network adequacy, and claims alleging that the Company has engaged in unfair business practices.

Among other things, these matters may result in corrective action plans, awards of damages, fines, or penalties, which could be substantial, and/or could require changes to the Company's business and cause reputational harm. The Company intends to vigorously defend itself against legal and regulatory proceedings to which it is currently a party; however, these proceedings are subject to many uncertainties. In some cases pending against the Company, substantial non-economic or punitive damages are being sought.

The Company records reserves and accrues costs for certain legal proceedings and regulatory matters to the extent that it determines an unfavorable outcome is probable and the amount of the loss can be reasonably estimated. While such reserves and accrued costs reflect the Company's best estimate of the probable loss for such matters, the recorded amounts may differ materially from the actual amount of any such losses. In some cases, no estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made because of the inherently unpredictable nature of legal and regulatory proceedings, which may be exacerbated by various factors, including but not limited to, they may involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or legal uncertainties; involve disputed facts; represent a shift in regulatory policy; involve a large number of parties, claimants or regulatory bodies; are in the early stages of the proceedings; involve a number of separate proceedings and/or a wide range of potential outcomes; or result in a change of business practices.

As of the date of this report, amounts accrued for legal proceedings and regulatory matters were not material. Except for the matters discussed below, the Company believes that the ultimate outcome of any of the regulatory and legal proceedings that are currently pending against it should not have a material adverse effect on financial condition, results of operations, cash flow or liquidity. However, it is possible that in a particular quarter or annual period the Company's financial condition, results of operations, cash flow, and/or liquidity could be materially adversely affected by an ultimate unfavorable resolution of or development in legal and/or regulatory proceedings.

Federal Securities Class Action and Derivative Lawsuits

On July 9, 2025, a putative federal securities class action, Brock Lunstrum v. Centene Corp., et al. (the Securities Action), was filed against the Company and certain of its executives in the U.S. District Court for the Southern District of New York. The plaintiffs in the lawsuits allege that the Company made false and misleading statements with respect to the Company's 2025 earnings guidance in violation of federal securities laws. Five related derivative lawsuits were subsequently filed — Franchi v. London, et al. (filed July 31, 2025), Keippel v. London, et al. (filed August 14, 2025), and Shipon v. London, et al. (filed August 26, 2025) in the Southern District of New York, and Nante v. London, et al. (filed September 30, 2025) in the Eastern District of Missouri and Rosenbaum v. London, et. al, (filed January 30, 2026) in the District of Delaware (together, the Derivative Actions) — against the Company, as nominal defendant, members of the board of directors, and certain officers. The plaintiffs in the Derivative Actions allege that the individual defendants breached their fiduciary duties and committed other alleged misconduct in connection with the statements at issue in the Securities Action. The Company denies any wrongdoing and is vigorously defending itself against the claims in the Securities Action and Derivative Actions. Nevertheless, these matters are subject to many uncertainties and the Company cannot predict how long these lawsuits will last, whether additional litigation will be filed with similar claims, or what the ultimate outcome will be, and an adverse outcome in any of these matters could potentially have a materially adverse impact on the Company's financial position and results of operations, cash flow or liquidity.

18. Earnings Per Share

The following table sets forth the calculation of basic and diluted net earnings per common share ($ in millions, except per share data in dollars and shares in thousands):

	Year Ended December 31,		
	2025	**2024**	**2023**
Earnings (loss) attributable to Centene Corporation	$ (6,674)	$ 3,305	$ 2,702
Shares used in computing per share amounts:			
Weighted average number of common shares outstanding	493,116	521,790	543,319
Common stock equivalents (as determined by applying the treasury stock method)	—	1,954	2,385
Weighted average number of common shares and potential dilutive common shares outstanding	493,116	523,744	545,704
Net earnings (loss) per common share attributable to Centene Corporation:			
Basic earnings (loss) per common share	$ (13.53)	$ 6.33	$ 4.97
Diluted earnings (loss) per common share	$ (13.53)	$ 6.31	$ 4.95

The calculation of diluted loss per common share for 2025 excludes the impact of 5,658 thousand shares related to stock options, restricted stock and restricted stock units as their effect would have been anti-dilutive due to the net loss for the year. The calculation of diluted earnings per common share for 2024 and 2023 exclude 278 thousand shares and 376 thousand shares, respectively, related to anti-dilutive stock options and restricted stock units.

19. Segment Information

The Company operates in four segments: (1) a Medicaid segment, (2) a Medicare segment, (3) a Commercial segment and (4) an Other segment. The Medicaid, Medicare and Commercial segments primarily represent the government-sponsored or subsidized programs under which the Company offers managed healthcare services. The Other segment includes the Company's pharmacy operations, vision and dental services, clinical healthcare, behavioral health, and centralized services, among others. The Company signed a definitive agreement to divest the remaining Magellan Health businesses in December 2025.

Factors used in determining the reportable business segments include the nature of operating activities, the existence of separate senior management teams and the type of information presented to the Company's chief operating decision-maker (CODM) to evaluate all results of operations. The Company's CODM is its Chief Executive Officer. The Company's CODM focuses primarily on each segment's ability to generate sufficient revenues and manage expenses associated with health benefits and cost of services (including estimated costs incurred). As such, the CODM measures operating performance at the segment level based on gross margin, including evaluation of budget to actual variances, to determine the allocation of financial and capital resources for each segment. The Company does not report total assets by segment since this is not a metric used by the Company's CODM to allocate resources or evaluate segment performance.

Segment information for the year ended December 31, 2025, is as follows ($ in millions):

	Medicaid	Medicare	Commercial	Other/Eliminations	Consolidated Total
Premium	$ 90,137	$ 37,210	$ 42,001	$ 2,208	$ 171,556
Service	101	—	2	2,922	3,025
Premium and service revenues	90,238	37,210	42,003	5,130	174,581
Premium tax	20,196	—	—	—	20,196
Total external revenues	110,434	37,210	42,003	5,130	194,777
Internal revenues	—	—	—	16,854	16,854
Eliminations	—	—	—	(16,854)	(16,854)
Total revenues	$ 110,434	$ 37,210	$ 42,003	$ 5,130	$ 194,777
Medical costs	$ 84,450	$ 34,227	$ 36,902	$ 2,123	$ 157,702
Cost of services	98	—	—	2,572	2,670
Other operating expenses [1]					42,028
Other income (expense) [2]					895
Loss before income tax expense					$ (6,728)
Segment gross margin [3]	$ 5,690	$ 2,983	$ 5,101	$ 435	$ 14,209

[1] Other operating expenses include selling, general and administrative expenses, depreciation, amortization, premium tax expense and impairment.
[2] Other income (expense) includes investment and other income, debt extinguishment and interest expense.
[3] Segment gross margin represents premium and service revenues less medical costs and cost of services.

Segment information for the year ended December 31, 2024, is as follows ($ in millions):

	Medicaid	Medicare	Commercial	Other/Eliminations	Consolidated Total
Premium	$ 83,758	$ 23,032	$ 33,699	$ 1,814	$ 142,303
Service	93	—	3	3,106	3,202
Premium and service revenues	83,851	23,032	33,702	4,920	145,505
Premium tax	17,566	—	—	—	17,566
Total external revenues	101,417	23,032	33,702	4,920	163,071
Internal revenues	—	—	—	16,879	16,879
Eliminations	—	—	—	(16,879)	(16,879)
Total revenues	$ 101,417	$ 23,032	$ 33,702	$ 4,920	$ 163,071
Medical costs	$ 77,516	$ 20,437	$ 26,039	$ 1,715	$ 125,707
Cost of services	89	—	—	2,640	2,729
Other operating expenses [1]					31,460
Other income (expense) [2]					1,082
Earnings before income tax expense					$ 4,257
Segment gross margin [3]	$ 6,246	$ 2,595	$ 7,663	$ 565	$ 17,069

[1] Other operating expenses include selling, general and administrative expenses, depreciation, amortization, premium tax expense and impairment.
[2] Other income (expense) includes investment and other income, debt extinguishment and interest expense.
[3] Segment gross margin represents premium and service revenues less medical costs and cost of services.

Segment information for the year ended December 31, 2023, is as follows ($ in millions):

	Medicaid	Medicare	Commercial	Other/Eliminations	Consolidated Total
Premium	$ 86,853	$ 22,261	$ 24,843	$ 1,679	$ 135,636
Service	2	—	2	4,455	4,459
Premium and service revenues	86,855	22,261	24,845	6,134	140,095
Premium tax	13,904	—	—	—	13,904
Total external revenues	100,759	22,261	24,845	6,134	153,999
Internal revenues	—	—	—	16,735	16,735
Eliminations	—	—	—	(16,735)	(16,735)
Total revenues	$ 100,759	$ 22,261	$ 24,845	$ 6,134	$ 153,999
Medical costs	$ 78,210	$ 19,394	$ 19,816	$ 1,474	$ 118,894
Cost of services	4	—	—	3,560	3,564
Other operating expenses [1]					28,611
Other income (expense) [2]					668
Earnings before income tax expense					$ 3,598
Segment gross margin [3]	$ 8,641	$ 2,867	$ 5,029	$ 1,100	$ 17,637

[1] Other operating expenses include selling, general and administrative expenses, depreciation, amortization, premium tax expense and impairment.
[2] Other income (expense) includes investment and other income, debt extinguishment and interest expense.
[3] Segment gross margin represents premium and service revenues less medical costs and cost of services.

20. Condensed Financial Information of Registrant

Centene Corporation (Parent Company Only)
Condensed Balance Sheets
(In millions, except shares in thousands and per share data in dollars)

	December 31, 2025	December 31, 2024
ASSETS		
Current assets:		
Cash and cash equivalents	$ —	$ 7
Other current assets	1	9
Total current assets	1	16
Long-term investments	251	206
Investment in subsidiaries	37,445	45,148
Other long-term assets	104	85
Total assets	$ 37,801	$ 45,455
LIABILITIES, REDEEMABLE NONCONTROLLING INTERESTS AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Current liabilities	$ 172	$ 243
Current portion of long-term debt	50	110
Total current liabilities	222	353
Long-term debt	17,351	18,423
Other long-term liabilities	172	169
Total liabilities	17,745	18,945
Commitments and contingencies		
Redeemable noncontrolling interest	23	10
Stockholders' equity:		
Preferred stock, $0.001 par value; authorized 10,000 shares; no shares issued or outstanding at December 31, 2025 and December 31, 2024	—	—
Common stock, $0.001 par value; authorized 800,000 shares; 623,463 issued and 491,757 outstanding at December 31, 2025, and 620,195 issued and 495,907 outstanding at December 31, 2024	1	1
Additional paid-in capital	20,777	20,562
Accumulated other comprehensive (loss)	(58)	(504)
Retained earnings	8,674	15,348
Treasury stock, at cost (131,706 and 124,288 shares, respectively)	(9,441)	(8,997)
Total Centene stockholders' equity	19,953	26,410
Nonredeemable noncontrolling interest	80	90
Total stockholders' equity	20,033	26,500
Total liabilities, redeemable noncontrolling interests and stockholders' equity	$ 37,801	$ 45,455

See notes to condensed financial information of registrant.

Centene Corporation (Parent Company Only)
Condensed Statements of Operations
(In millions, except per share data in dollars)

	Year Ended December 31,		
	2025	**2024**	**2023**
Expenses:			
Selling, general and administrative expenses	$ 15	$ 13	$ 14
Other income (expense):			
Investment and other income (expense)	24	(34)	(47)
Gain (loss) on divestiture	—	(34)	108
Debt extinguishment	1	—	—
Interest expense	(677)	(700)	(710)
(Loss) before income taxes	(667)	(781)	(663)
Income tax (benefit)	(85)	(76)	(118)
Net (loss) before equity in subsidiaries	(582)	(705)	(545)
Equity in earnings (loss) from subsidiaries	(6,095)	3,999	3,244
Net earnings (loss)	(6,677)	3,294	2,699
Loss attributable to noncontrolling interests	3	11	3
Net earnings (loss) attributable to Centene Corporation	$ (6,674)	$ 3,305	$ 2,702
Net earnings (loss) per common share attributable to Centene Corporation:			
Basic earnings (loss) per common share	$ (13.53)	$ 6.33	$ 4.97
Diluted earnings (loss) per common share	$ (13.53)	$ 6.31	$ 4.95

See notes to condensed financial information of registrant.

Centene Corporation (Parent Company Only)
Condensed Statements of Cash Flows
(In millions)

	Year Ended December 31,		
	2025	**2024**	**2023**
Cash flows from operating activities:			
Dividends from subsidiaries	$ 1,671	$ 1,797	$ 2,823
Payments for legal settlement	(41)	(263)	(326)
Other operating activities, net	(584)	(422)	(334)
Net cash provided by operating activities	1,046	1,112	2,163
Cash flows from investing activities:			
Capital contributions to subsidiaries	(2,001)	(730)	(443)
Purchases of investments	(20)	(2)	(202)
Sales and maturities of investments	1	—	—
Return of capital from subsidiaries to parent company	1,599	321	85
Proceeds from divestitures	—	—	325
Intercompany activities	989	1,693	(357)
Net cash (used in) provided by investing activities	568	1,282	(592)
Cash flows from financing activities:			
Proceeds from long-term debt	750	1,300	2,305
Payments and repurchases of long-term debt	(1,895)	(610)	(2,290)
Common stock repurchases	(475)	(3,124)	(1,633)
Proceeds from common stock issuances	37	46	44
Purchase of noncontrolling interest	(19)	—	—
Other financing activities, net	(19)	(6)	(2)
Net cash used in financing activities	(1,621)	(2,394)	(1,576)
Net increase (decrease) in cash and cash equivalents	(7)	—	(5)
Cash and cash equivalents, beginning of period	7	7	12
Cash and cash equivalents, end of period	$ —	$ 7	$ 7

See notes to condensed financial information of registrant.

Notes to Condensed Financial Information of Registrant

Note A - Basis of Presentation and Significant Accounting Policies

The parent company only financial statements should be read in conjunction with Centene Corporation's audited consolidated financial statements and the notes to consolidated financial statements included in this Form 10-K.

The parent company's investment in subsidiaries is stated at cost plus equity in undistributed earnings of the subsidiaries. The parent company's share of net income of its unconsolidated subsidiaries is included in income using the equity method of accounting. Certain unrestricted subsidiaries receive monthly management fees from the Company's restricted subsidiaries. The management and service fees received by its unrestricted subsidiaries are associated with all of the functions required to manage the restricted subsidiaries which often include salaries and wages for personnel, rent, utilities, population health management, provider contracting, compliance, member services, claims processing, pharmacy oversight services, information technology, cash management, finance and accounting and other services. The management fees are based on a cost basis reimbursement.

Due to the Company's centralized cash management function, cash flows generated by its unrestricted subsidiaries are utilized by the parent company to the extent required, primarily to repay borrowings on the parent company's credit facilities, repurchase the parent company's common stock, make acquisitions, fund capital contributions to subsidiaries and fund its operations.

Certain amounts presented in the parent company only financial statements are eliminated in the consolidated financial statements of Centene Corporation.

21. Subsequent Events

CMS Part D risk-sharing receivables

The Company has receivables due from CMS for Part D risk-sharing programs attributable to the 2025 plan year that are expected to be paid by CMS within a year after the plan year closes. As of December 31, 2025, the stand-alone Part D risk-sharing programs receivable balance for the 2025 plan year was $3,992 million.

On February 13, 2026, the Company entered into a master receivable purchase agreement (the February 2026 Receivable Purchase Agreement). The February 2026 Receivable Purchase Agreement allows the Company to from time to time offer up to the full amount of its 2025 plan year stand-alone Part D risk-sharing programs receivable to the purchaser, which the purchaser may elect to purchase. The purchase price for each purchased receivable portion equals the net estimated invoice amount of such portion minus the discount, which is determined by reference to Secured Overnight Financing Rate (SOFR) plus a spread. The Company will account for the transfer of all or any portion of this receivable as a sale of accounts receivable. The difference between the balance of the receivable (or portion thereof) sold and cash proceeds received will be recorded as a loss on sale of receivables and included in selling, general and administrative expenses in the Consolidated Statements of Operations. The Company will act as a servicer for the transferred receivable. As of the date of this report, no receivable (or any portions thereof) was transferred pursuant to the February 2026 Receivable Purchase Agreement.

Senior Note Debt Repurchase Program

In January 2026, the Company repurchased an additional $29 million of its par value Senior Notes due 2027 for $29 million.

In February 2026, the Company's Board of Directors authorized an increase under the program of $1,000 million. With this increase, as of February 2026, there was $1,484 million available under the senior note debt repurchase program.

Item 9. *Changes in and Disagreements With Accountants on Accounting and Financial Disclosure*

None.

Item 9A. ***Controls and Procedures***

Evaluation of Disclosure Controls and Procedures - Our management, with the participation of our Chief Executive Officer and Chief Financial Officer, evaluated the effectiveness of our disclosure controls and procedures as of December 31, 2025. The term "disclosure controls and procedures," as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act, means controls and other procedures of a company that are designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported, within the time periods specified in the SEC's rules and forms. Disclosure controls and procedures include, without limitation, controls and procedures designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is accumulated and communicated to the company's management, including its principal executive and principal financial officers, as appropriate to allow timely decisions regarding required disclosure. Management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving their objectives and management necessarily applies its judgment in evaluating the cost-benefit relationship of possible controls and procedures. Based on the evaluation of our disclosure controls and procedures as of December 31, 2025, our Chief Executive Officer and Chief Financial Officer concluded that, as of such date, our disclosure controls and procedures were effective.

Management's Report on Internal Control Over Financial Reporting - Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Exchange Act Rules 13a-15(f) and 15d-15(f). Under the supervision and with the participation of our management, including our principal executive officer and principal financial officer, we conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on our evaluation under the framework in *Internal Control - Integrated Framework (2013)*, our management concluded that our internal control over financial reporting was effective at the reasonable assurance level as of December 31, 2025. Our management's assessment of the effectiveness of our internal control over financial reporting as of December 31, 2025, has been audited by KPMG LLP, an independent registered public accounting firm, as stated in their report which is included herein.

Changes in Internal Control Over Financial Reporting - No change in our internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) occurred during the year ended December 31, 2025 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Report of Independent Registered Public Accounting Firm

To the Stockholders and Board of Directors
Centene Corporation:

Opinion on Internal Control Over Financial Reporting

We have audited Centene Corporation and subsidiaries' (the Company) internal control over financial reporting as of December 31, 2025, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2025, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of the Company as of December 31, 2025 and 2024, the related consolidated statements of operations, comprehensive earnings (loss), stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2025, and the related notes (collectively, the consolidated financial statements), and our report dated February 17, 2026 expressed an unqualified opinion on those consolidated financial statements.

Basis for Opinion

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

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control Over Financial Reporting

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

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

/s/ KPMG LLP

St. Louis, Missouri
February 17, 2026

Item 9B. ***Other Information***

(a) On February 13, 2026, we entered into a master receivable purchase agreement (the February 2026 Receivable Purchase Agreement) with MUFG Bank, Ltd. (the purchaser). The February 2026 Receivable Purchase Agreement allows us to from time to time offer up to the full amount of our 2025 plan year stand-alone Part D risk-sharing programs receivable to the purchaser, which the purchaser may elect to purchase. The purchase price for each purchased receivable portion equals the net estimated invoice amount of such portion minus the discount, which is determined by reference to the Secured Overnight Financing Rate (SOFR) plus a spread. We will account for the transfer of all or any portion of this receivable as a sale of accounts receivable. The difference between the balance of the receivable (or portion thereof) sold and cash proceeds received will be recorded as a loss on sale of receivables and included in selling, general and administrative expenses in the Consolidated Statements of Operations. We will act as a servicer for the transferred receivable. As of the date of this report, no receivable (or any portions thereof) were transferred pursuant to the February 2026 Receivable Purchase Agreement.

The parties to the February 2026 Receivable Purchase Agreement have each made customary representations and warranties. We agreed to various covenants and agreements, including, among others, our agreement to perform in all material respects all terms, covenants and other provisions required to be performed by us thereunder and to service any receivable (or portion thereof) sold thereunder. The February 2026 Receivable Purchase Agreement contains specified repurchase obligations that would require us to repurchase the purchased receivable portions upon the purchaser's request if certain events occur in respect of the purchased receivable portions prior to the termination of the February 2026 Receivable Purchase Agreement.

The above description of the February 2026 Receivable Purchase Agreement does not purport to be complete and is subject to, and qualified in its entirety by, reference to the February 2026 Receivable Purchase Agreement and the related performance guaranty provided by us, copies of which are filed as Exhibits 2.1 and 2.2 to this Annual Report on Form 10-K and are incorporated herein by reference.

(b) During the three months ended December 31, 2025, no director or officer of the Company adopted or terminated a "Rule 10b5-1 trading arrangement" or "non-Rule 10b5-1 trading arrangement," as each term is defined in Item 408(a) of Regulation S-K.

Item 9C. ***Disclosure Regarding Foreign Jurisdictions that Prevent Inspections***

Not applicable

PART III

Item 10. ***Directors, Executive Officers and Corporate Governance***

(a) Directors of the Registrant

Information concerning our directors will appear in our Proxy Statement for our 2026 annual meeting of stockholders under "Proposal One: Election of Directors." This portion of the Proxy Statement is incorporated herein by reference.

(b) Information about our Executive Officers

Pursuant to General Instruction G(3) to Form 10-K and the Instruction to Item 401 of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Information about our Executive Officers."

Information concerning our executive officers' compliance with Section 16(a) of the Exchange Act will appear in our Proxy Statement for our 2026 annual meeting of stockholders under "Delinquent Section 16(a) Reports," if applicable.

(c) Corporate Governance

Information concerning certain corporate governance matters, including information concerning our audit committee financial expert, identification of our Audit and Compliance Committee and our code of ethics will appear in our Proxy Statement for our 2026 annual meeting of stockholders under "Corporate Governance." These portions of our Proxy Statement are incorporated herein by reference.

(d) Insider Trading Policies and Procedures

The Company has adopted the Policy on Inside Information and Insider Trading attached as Exhibit 19.1 hereto, which governs the purchase, sale and/or other dispositions of the Company's securities by directors, officers and employees, and by the Company itself, and is reasonably designed to promote compliance with insider trading laws, rules and regulations, and the NYSE listing standards.

Item 11. ***Executive Compensation***

Information concerning executive compensation will appear in our Proxy Statement for our 2026 Annual Meeting of Stockholders under "Executive Compensation." Information concerning Compensation and Talent Committee interlocks and insider participation will appear in the Proxy Statement for our 2026 Annual Meeting of Stockholders under "Compensation & Talent Committee Interlocks and Insider Participation." These portions of the Proxy Statement are incorporated herein by reference.

Item 12. ***Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters***

Information concerning the security ownership of certain beneficial owners and management and our equity compensation plans will appear in our Proxy Statement for our 2026 annual meeting of stockholders under "Security Ownership of Certain Beneficial Owners and Management" and "Equity Compensation Plan Information." These portions of the Proxy Statement are incorporated herein by reference.

Item 13. ***Certain Relationships and Related Transactions, and Director Independence***

Information concerning director independence, certain relationships and related transactions will appear in our Proxy Statement for our 2026 annual meeting of stockholders under "Corporate Governance," "Independence of Directors" and "Related Party Transactions." These portions of our Proxy Statement are incorporated herein by reference.

Item 14. ***Principal Accountant Fees and Services***

Our independent registered public accounting firm is KPMG LLP, St. Louis, MO. The Auditor Firm ID is 185.

Information concerning principal accountant fees and services will appear in our Proxy Statement for our 2026 annual meeting of stockholders under "Proposal Three: Ratification of Appointment of Independent Registered Public Accounting Firm." This portion of our Proxy Statement is incorporated herein by reference.

PART IV

Item 15. ***Exhibits and Financial Statement Schedules***

(a) **Financial Statements and Schedules**

The following documents are filed under Item 8 of this report:

1. Financial Statements:

   Report of Independent Registered Public Accounting Firm
   Consolidated Balance Sheets as of December 31, 2025 and 2024
   Consolidated Statements of Operations for the years ended December 31, 2025, 2024 and 2023
   Consolidated Statements of Comprehensive Earnings (Loss) for the years ended December 31, 2025, 2024 and 2023
   Consolidated Statements of Stockholders' Equity for the years ended December 31, 2025, 2024 and 2023
   Consolidated Statements of Cash Flows for the years ended December 31, 2025, 2024 and 2023
   Notes to Consolidated Financial Statements

2. Financial Statement Schedules:

   None.

3. The exhibits listed in the accompanying Exhibit Index are filed or incorporated by reference as part of this filing.

EXHIBIT INDEX

EXHIBIT NUMBER		DESCRIPTION	FILED WITH THIS FORM 10-K	INCORPORATED BY REFERENCE		
				FORM	FILING DATE WITH SEC	EXHIBIT NUMBER
2.1		Receivable Purchase Agreement, dated as of February 13, 2026	X			
2.2		Performance Guaranty, dated as of February 13, 2026	X			
3.1		Amended and Restated Certificate of Incorporation of Centene Corporation, dated September 27, 2022		8-K	September 30, 2022	3.1
3.2		Amended and Restated By-laws of Centene Corporation, dated December 8, 2023		8-K	December 13, 2023	3.1
4.1		Description of Securities of the Company		S-3ASR	February 21, 2024	
4.2		Indenture, dated as of December 6, 2019, by and between Centene Corporation, as issuer, and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to the Company's 4.25% Senior Notes due 2027 (including the Form of Global Note attached thereto)		8-K	December 6, 2019	4.2
4.3		Indenture, dated as of December 6, 2019, by and between Centene Corporation, as issuer, and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to the Company's 4.625% Senior Notes due 2029 (including the Form of Global Note attached thereto)		8-K	December 6, 2019	4.3
4.4		Indenture, dated as of February 13, 2020, by and between Centene Corporation, as issuer, and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to the Company's 3.375% Senior Notes due 2030 (including the Form of Global Note attached thereto)		8-K	February 13, 2020	4.1
4.5		Base Indenture, dated as of October 7, 2020, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee		8-K	October 7, 2020	4.1
4.6		First Supplemental Indenture, dated as of October 7, 2020, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee		8-K	October 7, 2020	4.2
4.7		Second Supplemental Indenture, dated as of February 17, 2021, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee		8-K	February 17, 2021	4.2
4.8		Third Supplemental Indenture, dated as of July 1, 2021, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee		8-K	July 1, 2021	4.2
4.9		Fourth Supplemental Indenture, dated as of August 12, 2021, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee		8-K	August 12, 2021	4.4
10.1	*	2002 Employee Stock Purchase Plan, as amended and restated		10-Q	July 23, 2019	10.1
10.2	*	Amendment No.1 to the 2002 Employee Stock Purchase Plan, as amended and restated		S-8	May 22, 2020	4.2
10.3	*	Centene Corporation 2012 Stock Incentive Plan, as amended		8-K	April 30, 2021	10.1
10.4	*	Centene Corporation 2025 Stock Incentive Plan (incorporated by reference to Appendix B to the Registrant's definitive proxy statement on Schedule 14A, filed on March 27, 2025)		DEF 14A	March 27, 2025	
10.5	*	Amended and Restated Non-Employee Directors Deferred Stock Compensation Plan		10-Q	July 25, 2025	10.3

10.6	*	Amended and Restated Voluntary Nonqualified Deferred Compensation Plan		10-K	February 20, 2024	10.5
10.7	*	Centene Corporation 2007 Long-Term Incentive Plan, as amended		10-K	February 22, 2021	10.6
10.8	*	Centene Corporation Short-Term Executive Compensation Plan		10-K	February 22, 2011	10.12
10.9	*	Executive Severance and Change in Control Plan		10-Q	October 25, 2024	10.1
10.10	*	Form of Non-Employee Director Compensation Policy		10-Q	July 25, 2025	10.1
10.11	*	Form of Non-Employee Director Restricted Stock Unit Agreement #1		10-Q	July 25, 2025	10.2
10.12	*	Form of Non-statutory Stock Option Agreement (Employees) #1		10-K	February 22, 2021	10.11
10.13	*	Form of Non-statutory Stock Option Agreement (Employees) #2		10-K	February 22, 2022	10.12
10.14	*	Form of Non-statutory Stock Option Agreement (Directors)		10-K	February 21, 2023	10.13
10.15	*	Form of Restricted Stock Agreement (Directors) #1		10-K	February 21, 2023	10.14
10.16	*	Form of Restricted Stock Agreement (Directors) #2		10-Q	July 28, 2023	10.1
10.17	*	Form of Restricted Stock Unit Agreement #1		8-K	December 21, 2020	10.1
10.18	*	Form of Restricted Stock Unit Agreement #2		10-Q	April 25, 2023	10.1
10.19	*	Form of Restricted Stock Unit Agreement #3		10-Q	April 25, 2023	10.2
10.20	*	Form of Restricted Stock Unit Agreement #4		10-Q	April 26, 2024	10.1
10.21	*	Form of Restricted Stock Unit Agreement #5		10-Q	April 25, 2025	10.1
10.22	*	Form of Restricted Stock Unit Agreement #6	X			
10.23	*	Form of Performance Based Restricted Stock Unit Agreement #1		8-K	December 21, 2020	10.2
10.24	*	Form of Performance Based Restricted Stock Unit Agreement #2		10-Q	April 25, 2023	10.3
10.25	*	Form of Performance Based Restricted Stock Unit Agreement #3		10-Q	April 26, 2024	10.2
10.26	*	Form of Performance Based Restricted Stock Unit Agreement #4		10-Q	April 25, 2025	10.2
10.27	*	Form of Performance Based Restricted Stock Unit Agreement #5	X			
10.28	*	Performance Based Restricted Stock Unit Agreement for Andrew Asher		10-Q	April 25, 2025	10.3
10.29	*	Form of Long-Term Incentive Plan Agreement		8-K	December 21, 2020	10.3
10.30		Credit Agreement, dated as of March 5, 2025, by and among Centene Corporation, the lenders from time to time party thereto and Wells Fargo Bank, National Association, as the administrative agent for the lenders		8-K	March 5, 2025	10.1
10.31		Fourth Amended and Restated Credit Agreement, dated as of August 16, 2021, among the Company, Wells Fargo Bank, National Association, as administrative agent, and the lenders and other parties thereto		8-K	August 18, 2021	1.1
10.31a		First Amendment to the Fourth Amended and Restated Credit Agreement, dated as of May 31, 2023, by and among Centene Corporation, the several banks and other financial institutions party thereto, and Wells Fargo Bank, National Association, as the administrative agent		8-K	June 6, 2023	10.1

10.32	*	Executive Employment Agreement between Centene Corporation and Sarah M. London, dated April 27, 2022		10-Q	July 26, 2022	10.1
10.32a	*	Amendment of Executive Employment Agreement between Centene Corporation and Sarah M. London, dated February 20, 2023		10-K	February 21, 2023	10.22a
10.33	*	Executive Employment Agreement between Centene Corporation and Andrew Asher, dated April 28, 2022		10-Q	July 26, 2022	10.3
10.33a	*	Amendment of Executive Employment Agreement between Centene Corporation and Andrew Asher, dated February 20, 2023		10-K	February 21, 2023	10.23a
10.34	*	Executive Employment Agreement between Centene Corporation and Kenneth Fasola, dated February 20, 2023		10-K	February 21, 2023	10.24
10.35	*	Executive Officer Cash Severance Policy		10-K	February 21, 2023	10.31
10.36	*	Executive Restricted Covenant Agreement		10-K	February 20, 2024	10.31
19.1		Policy on Inside Information and Insider Trading	X			
21		List of subsidiaries	X			
23		Consent of Independent Registered Public Accounting Firm incorporated by reference in each prospectus constituting part of the Registration Statements on Form S-8 (File Numbers 333-261993, 333-255735, 333-238597, 333-236036, 333-217634, 333-210376, 333-197737, 333-180976, 333-90976, and 333-287399) and Form S-3 (File Number 333-277218)	X			
31.1		Certification Pursuant to Rule 13a-14(a) and 15d-14(a) of the Exchange Act, as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 (Chief Executive Officer)	X			
31.2		Certification Pursuant to Rule 13a-14(a) and 15d-14(a) of the Exchange Act, as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 (Chief Financial Officer)	X			
32.1	#	Certification Pursuant to 18 U.S.C. Section 1350 (Chief Executive Officer)	X			
32.2	#	Certification Pursuant to 18 U.S.C. Section 1350 (Chief Financial Officer)	X			
97	*	Centene Corporation Clawback Policy		10-K	February 20, 2024	97
101		The following materials from the Centene Corporation Annual Report on Form 10-K for the fiscal year ended December 31, 2025, formatted in Inline Extensible Business Reporting Language (iXBRL): (i) the Consolidated Balance Sheets, (ii) the Consolidated Statements of Operations, (iii) the Consolidated Statements of Comprehensive Earnings (Loss), (iv) the Consolidated Statements of Stockholders' Equity, (v) the Consolidated Statements of Cash Flows and (vi) related notes.	X			
104		Cover Page Interactive Data File (embedded within the Inline XBRL document)	X			

* Indicates a management contract or compensatory plan or arrangement.

This certification is deemed not filed for purposes of Section 18 of the Exchange Act, or otherwise subject to the liability of that section, nor shall it be deemed incorporated by reference into any filing under the Securities Act of 1933, as amended, or the Exchange Act.

Item 16. ***Form 10-K Summary***

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, as of February 17, 2026.

CENTENE CORPORATION

By: /s/ SARAH M. LONDON
Sarah M. London
Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities as indicated, as of February 17, 2026.

Signature	Title
/s/ Sarah M. London **Sarah M. London**	Chief Executive Officer (principal executive officer)
/s/ Andrew L. Asher **Andrew L. Asher**	Executive Vice President, Chief Financial Officer (principal financial officer)
/s/ Katie N. Casso **Katie N. Casso**	Senior Vice President, Finance, Corporate Controller and Chief Accounting Officer (principal accounting officer)
/s/ Jessica L. Blume **Jessica L. Blume**	Director
/s/ Kenneth A. Burdick **Kenneth A. Burdick**	Director
/s/ Christopher J. Coughlin **Christopher J. Coughlin**	Director
/s/ H. James Dallas **H. James Dallas**	Director
/s/ Fred H. Eppinger **Fred H. Eppinger**	Director
/s/ Monte E. Ford **Monte E. Ford**	Director
/s/ Theodore R. Samuels **Theodore R. Samuels**	Director
/s/ Kenneth Y. Tanji **Kenneth Y. Tanji**	Director

EXHIBIT 2.1

MASTER RECEIVABLES PURCHASE AGREEMENT

between

WELLCARE PRESCRIPTION INSURANCE, INC.,

as Seller,

and

MUFG BANK, LTD.,
as Purchaser

Dated as of February 13, 2026

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MASTER RECEIVABLES PURCHASE AGREEMENT

This MASTER RECEIVABLES PURCHASE AGREEMENT (this "Agreement") is entered into as of February 13, 2026, by and between WELLCARE PRESCRIPTION INSURANCE, INC., an Arizona corporation ("Wellcare" or the "Seller"), and MUFG BANK, LTD. ("MUFG Bank"), as purchaser (the "Purchaser").

RECITALS

The Seller is a prescription drug plan sponsor under the Social Security Act for the operation of a voluntary Medicare Prescription Drug Plan that has an agreement with The Centers for Medicare and Medicaid Services, a federal agency of the United States of America, or its permitted assigns ("CMS" or the "Approved Account Debtor"), to accept enrollments to provide basic prescription drug coverage and operate a voluntary prescription drug plan for eligible recipients.

The Seller desires to sell certain of its Receivable Portions from time to time, based on all electronic prescription drug events ("PDEs") that have been accepted by CMS as of the applicable Purchase Date, and the Purchaser may be willing to purchase from the Seller such Receivable Portions, in which case the terms set forth herein shall apply to such purchase. Each capitalized term used but not defined herein shall have the meaning set forth in, or by reference in, Exhibit A hereto, and the interpretive provisions set out in Exhibit A hereto shall be applied in the interpretation of this Agreement.

Accordingly, the parties hereto agree as follows:

1. Sale and Purchase.

(a) Sales of Receivable Portions. From time to time during the Availability Period, the Seller may submit to the Purchaser a request (a "Purchase Request") via the MUFG Platform that the Purchaser purchase from the Seller the Proposed Receivable Portions described in such Purchase Request as well as the proposed Purchase Date thereof; provided, however, and notwithstanding anything herein to the contrary, if (i) the MUFG Platform is not operational or is otherwise offline or (ii) the Purchaser has, in its discretion, instructed the Seller that the MUFG Platform is no longer available for use, then the Seller may deliver a Purchase Request to the Purchaser in form and substance satisfactory to the Purchaser, and this Agreement shall be construed and interpreted accordingly, *mutatis mutandis*. If the Purchaser, in its sole and absolute discretion, accepts a Purchase Request, then the Purchaser shall purchase, and the Seller shall sell, all of the Seller's right, title and interest (but none of the Seller's underlying obligations to the applicable Account Debtor) with respect to such Proposed Receivable Portions as of the Purchase Date (all such Proposed Receivable Portions, once sold and purchased, or purported to be sold and purchased, hereunder, collectively, the "Purchased Receivable Portions"). The Purchaser acknowledges and agrees that the Purchaser shall have no right, title and interest in, or any other claim in respect of, the Seller's Retained Interest in any Subject Receivable.

(b) **UNCOMMITTED ARRANGEMENT. THE SELLER ACKNOWLEDGES THAT THIS IS AN UNCOMMITTED ARRANGEMENT, AND THAT THE SELLER HAS NOT PAID, NOR IS REQUIRED TO PAY, A COMMITMENT FEE OR COMPARABLE FEE TO THE PURCHASER. NOTWITHSTANDING ANYTHING TO THE CONTRARY CONTAINED IN THIS AGREEMENT, THE SELLER EXPRESSLY AGREES THAT THE PURCHASER WILL NOT BE OBLIGATED TO PURCHASE ANY RECEIVABLE PORTION FROM THE SELLER, AND THE PURCHASER MAY REFUSE, FOR ANY REASON OR FOR NO REASON, TO PURCHASE ANY RECEIVABLE PORTION OFFERED FOR PURCHASE BY THE SELLER EXCEPT IN CIRCUMSTANCES WHERE THE PURCHASER HAS DELIVERED A NOTIFICATION OF ACCEPTANCE WITH RESPECT TO THE PURCHASE REQUEST FOR A RECEIVABLE PORTION IN ITS SOLE AND ABSOLUTE DISCRETION AND THE OTHER CONDITIONS PRECEDENT SET FORTH IN SECTION 1(d) HAVE BEEN SATISFIED WITH RESPECT TO SUCH PURCHASE.**

(c) Conditions to Effectiveness. This Agreement shall become effective at such time as each of the conditions precedent set forth on Exhibit B to this Agreement has been satisfied to the satisfaction of the Purchaser.

(d) Conditions Precedent to Each Purchase. Without limiting the uncommitted nature of the Purchaser's obligations as discussed in Section 1(b), the Purchaser shall only be obligated to purchase the Proposed Receivable Portions described in any Purchase Request that the Purchaser has accepted if the following conditions have been satisfied in connection therewith:

(i) the Purchaser has received such Purchase Request via the MUFG Platform (or, if applicable, in physical form in form and substance satisfactory to the Purchaser) with respect to the Proposed Receivable Portions at least three (3) Business Days (or such shorter period as is agreed to by the Purchaser in its sole discretion) prior to the applicable Purchase Date, together with any such additional supporting documentation that the Purchaser may have reasonably requested;

(ii) the Purchaser has accepted such Purchase Request and notified the Seller thereof;

(iii) each of the representations and warranties made by the Seller and any Performance Guarantor in this Agreement and each of the other Transaction Documents is true and correct in all material respects as of such Purchase Date or, in the case of any representation or warranty that speaks as to a particular date or period, as of that particular date or period;

(iv) the Subject Receivable with respect to each Proposed Receivable Portion is an Eligible Receivable;

(v) immediately following the sale and purchase of the Proposed Receivable Portions set forth in the related Purchase Request, (A) the Outstanding Purchase Amount will not exceed the Maximum Outstanding Purchase Amount and (B) the Outstanding Purchase Amount with respect to the Purchased Receivable Portions owing by any Approved Account Debtor will not exceed such Approved Account Debtor's Purchase Sublimit; and

(vi) no Termination Event or Unmatured Termination Event has occurred and is continuing, and no Termination Event or Unmatured Termination Event would result from such sale and purchase.

Each Purchase Request submitted by the Seller shall constitute a representation and warranty that each of the conditions outlined in this Section 1(d)(iv) through (vi) has been satisfied.

(e) Purchase Price. The purchase price for each Purchased Receivable Portion purchased on any Purchase Date shall equal (i) the Estimated Net Invoice Amount of such Purchased Receivable Portion *minus* (ii) the Discount (such amount herein referred to as the "Purchase Price"). The Purchaser shall pay the Purchase Price with respect to each Purchased Receivable by depositing the amount thereof into the Seller's Account in immediately available funds denominated in Dollars on the applicable Purchase Date.

(f) True Sale; No Recourse. Except as otherwise provided in this Agreement, each purchase of a Purchased Receivable Portion is made without recourse to the Seller and the Seller shall have no liability to the Purchaser for the failure of any Account Debtor to pay any Purchased Receivable when it is due and payable under the terms applicable thereto. The Purchaser and the Seller have structured the transactions contemplated by this Agreement as absolute and irrevocable sales of participation interests in Subject Receivables, and the Purchaser and the Seller agree to treat each such transaction as a "true sale" for all purposes, including, without limitation, in their respective books, records, computer files, tax and regulatory and governmental filings, and each shall reflect such sales in their respective financial statements. The Seller will advise all Persons inquiring about the ownership of any Subject Receivable or any Purchased Receivable Portion, with respect thereto, that such Purchased Receivable Portions with respect thereto have been sold to the Purchaser. In the event that, contrary to the mutual intent of the parties hereto, any purchase of Purchased Receivable Portions is not characterized as a true sale of a participation interest in the related Subject Receivable, the Seller hereby grants to the Purchaser a security interest in and to any and all present and future Purchased Receivable Portions and the proceeds thereof to secure all obligations of the Seller arising in connection with this Agreement and each of the other Transaction Documents, whether now or hereafter existing, due or to become due, direct or indirect, absolute or contingent. This Agreement shall be deemed to be a security agreement under Applicable Law. The Purchaser may, at its discretion, file one or more UCC financing statements (or, if applicable, any foreign law equivalent thereof) evidencing the sale of the Purchased Receivable Portions as well as the foregoing grant of security. With respect to such grant of a security interest, the Purchaser may at its option exercise from time to time any and all rights and remedies available to it hereunder, under the UCC or otherwise to the extent the exercise of any such rights and remedies would not violate Applicable Law.

(g) Effect of Benchmark Transition Event. Notwithstanding anything to the contrary in this Agreement, if a Benchmark Transition Event and its related Benchmark Replacement Date have occurred prior to any setting of the then-current Benchmark, then the Benchmark Replacement will replace such Benchmark for all purposes hereunder in respect of such Benchmark setting and subsequent Benchmark settings without any amendment to this Agreement or any further action or consent of the Seller.

The Purchaser will promptly notify the Seller of (i) the implementation of any Benchmark Replacement and (ii) the effectiveness of any Conforming Changes in connection with the use, administration, adoption or implementation of a Benchmark Replacement. Any determination, decision or election that may be made by the Purchaser pursuant to the provisions hereof, including any determination with respect to a tenor, rate or adjustment or of the occurrence or non-occurrence of an event, circumstance or date and any decision to take or refrain from taking any action, will be conclusive and binding absent manifest error and may be made in the Purchaser's sole discretion and without consent from the Seller.

(h) Participations. The Seller acknowledges that the Purchaser has arranged to participate portions of the Maximum Outstanding Purchase Amount and Purchase Sublimits to one or more participants pursuant to one or more participation agreements. Notwithstanding any other provision of this Agreement (including, without limitation, Sections 1(b) and 1(c)), should any such participant fail to provide funding in connection with any purchase of any Receivable Portions hereunder (each such participant, a "Non-Funding Participant"), the Purchaser may decline to purchase the amount of such Receivable Portion corresponding to the amount for which such Non-Funding Participant failed to provide funding.

2. Representations and Warranties. The Seller represents and warrants to the Purchaser on the Closing Date and on each Purchase Date that (i) the representations and warranties set forth on Exhibit C hereto are true and correct in all respects as of the Closing Date or such Purchase Date or, in the case of any representation or warranty that speaks as to a particular date or period, as of that particular date or period and (ii) the Subject Receivable with respect to each Proposed Receivable Portion is an Eligible Receivable.

3. Covenants. The Seller agrees to perform each of the covenants set forth on Exhibit D hereto.

4. Servicing Activities.

(a) Appointment of Seller as Servicer. The Purchaser appoints the Seller as its servicer and agent for the administration and servicing of its Purchased Receivable Portions sold to the Purchaser hereunder, and the Seller hereby accepts such appointment and agrees to assume the duties and the administration and servicing obligations as a servicer, and perform all necessary and appropriate commercial servicing and collection activities in arranging the timely payment of amounts due and owing by any Account Debtor (including the identification of the proceeds of the Purchased Receivable Portions and related record-keeping that shall be made available to the Purchaser upon its reasonable request) all in accordance with Applicable Laws, with reasonable care and diligence; provided, however, that such appointment as servicer shall not release the Seller from any of its duties, responsibilities, liabilities and obligations resulting from or arising hereunder. In connection with its servicing obligations, the Seller shall (i) be responsible for identifying, matching and reconciling any payments received from Account Debtors with the Receivable associated with such payment and (ii) perform its duties under the Contract related to a Subject Receivable with the same care and applying the same policies as it applies to its own Receivables generally and would exercise and apply if it had not sold any Purchased Receivable Portion with respect to such Subject Receivable. The Seller shall allocate any offsets, write-offs, recoupments, reduction, returns, fines, penalties or other allowances by CMS in accordance with the applicable CMS Monthly Plan Payment Report; provided, however, any such amounts that do not reasonably relate to a Subject Receivable shall be allocated first to any Receivables owing from CMS to the Seller that are not Subject Receivables before allocating such amount to any Subject Receivable, notwithstanding any alternative deduction by CMS. The Seller shall not discriminate in its servicing activities pursuant to its appointment as servicer under this clause (a) between any Purchased Receivable Portion and the Seller's Retained Interest with respect the applicable Subject Receivable. The Seller agrees that the Purchase Price for each Purchased Receivable Portion includes consideration for the cost of servicing such Purchased Receivable Portion, and no other or further servicing compensation is required from the Purchaser.

(b) Transfer of Collections to the Purchaser. Subject to Sections 4(d) and 5(a) below, the Seller covenants and agrees to identify and deposit in the Purchaser's Account all Collections and other amounts received by the Seller (or any of its respective Affiliates) with respect to Purchased Receivable Portions without adjustment, setoff or deduction of any kind or nature by no later than one (1) Business Day after such Collections are received. Until remitted to the Purchaser's Account, the Seller will hold such funds in trust as the Purchaser's exclusive property and safeguard such funds for the benefit of the Purchaser. For the avoidance of doubt, the Seller and the Purchaser acknowledge and agree that the Seller may retain for its own benefit the ratable share of Collections received in respect of the Seller's Retained Interests and any Collections received in respect of the

Subject Receivable that are in excess of the amount of Collections that would be necessary to cause the Outstanding Purchase Amount with respect to the related Subject Receivable to be reduced to $0.

(c) Misdirected Payments. If the Purchaser receives any payment from an Account Debtor not representing a Collection on a Purchased Receivable Portion, the Purchaser will return such payment to the Seller upon receipt of satisfactory evidence that such amount does not constitute a Collection on a Purchased Receivable Portion.

(d) No Changes to Receivables. Other than as specifically permitted by Section 5(a) (i) the Seller will not amend, modify or extend the payment terms under any Subject Receivable, unless approved in writing in advance by the Purchaser, and shall not otherwise waive or permit or agree to any deviation from the terms or conditions of any Subject Receivable and (ii) the Seller will not take, or cause to be taken, any action that otherwise reduces the amount payable of any Subject Receivable or materially impairs the full and timely collection thereof.

(e) Reconciliation Report. Concurrently with (a) each transfer of funds by the Seller to the Purchaser's Account pursuant to Sections 4 and 5 hereof and (b) each request by the Seller for a return of payments received by the Purchaser that do not represent Collections on Purchased Receivable Portions in accordance with Section 4(d), the Seller shall provide to the Purchaser, in form and substance reasonably satisfactory to the Purchaser, a full reconciliation of all Collections and adjustments (including repurchases thereof, indemnifications and setoffs with respect thereto, if any) with respect to the Subject Receivable and each Purchased Receivable Portion related thereto of an Account Debtor for which Collections were received (each, a "Reconciliation Report"). The Seller shall submit each Reconciliation Report to the Purchaser via the MUFG Platform; provided, however, and notwithstanding anything herein to the contrary, if (i) the MUFG Platform is not operational or is otherwise offline or (ii) the Purchaser has, in its discretion, instructed the Seller that the MUFG Platform is no longer available for use, then the Seller may deliver a written Reconciliation Report to the Purchaser, and this Agreement shall be construed and interpreted accordingly, *mutatis mutandis*.

(f) Non-Payment Report.

(i) If a Purchased Receivable Portion remains unpaid, in part or in full, past the date that is fifteen (15) days after the applicable Due Date therefor, the Seller shall report to the Purchaser in a written report describing in reasonable detail the cause of such non-payment, including whether a Dispute or Insolvency Event exists with respect to the applicable Account Debtor (each a "Non-Payment Report").

(ii) If a Purchased Receivable Portion remains unpaid, in part or in full, past the date that is forty-five (45) days after the applicable Due Date therefor, the Seller shall deliver to the Purchaser by such date, a certification and report identifying such Purchased Receivable Portion and the Account Debtor and certifying the cause of such non-payment. If such cause is not an Insolvency Event of the relevant Account Debtor, or if the Seller does not deliver such certification and report when due, a Dispute shall be deemed to have occurred with respect to such Purchased Receivable Portion, which Dispute shall constitute a Repurchase Event.

(iii) For the avoidance of doubt, the rights of the Purchaser described in clauses (i) and (ii) above, respectively, are independent and the Purchaser may, in its sole discretion, enforce its rights set forth in either or both of clauses (i) and (ii) above in accordance with their terms with respect to any Purchased Receivable Portion.

5. Deemed Collections; Repurchase Events; Indemnities and Set-Off.

(a) Deemed Collections. If, on any day, the outstanding balance of a Purchased Receivable Portion is reduced (but not cancelled) as a result of any Dilution, the Seller shall be deemed to have received on such day a Collection of such Purchased Receivable Portion in the amount of such reduction. If on any day a Purchased Receivable Portion is cancelled (or reduced to zero) as a result of any Dilution, the Seller shall be deemed to have received on such day a Collection of such Purchased Receivable Portion in the amount of the Outstanding Purchase Amount of such Purchased Receivable Portion (as determined immediately prior to such Dilution). Any amount deemed to have been received under this Section 5(a) shall constitute a "Deemed Collection."

(b) Repurchase Events. If any of the following events (each, a "Repurchase Event") occurs with respect to a Subject Receivable:

(i) such Subject Receivable was not an Eligible Receivable at the time of purchase by the Purchaser of the applicable Purchased Receivable Portion hereunder;

(ii) the Seller fails to perform or observe any other term, covenant or agreement with respect to such Subject Receivable set forth in any Transaction Document or any related Contract and such failure shall or could reasonably be expected to have a material adverse effect on the timely payment, validity or enforceability of such Subject Receivable;

(iii) the applicable Account Debtor has asserted a Dispute with respect to such Subject Receivable that is not resolved within five (5) Business Days; or

(iv) a Dispute shall have been deemed to have occurred pursuant to Section 4(f),

then, the Seller shall immediately deliver notice thereof to the Purchaser. Upon the occurrence of a Repurchase Event, the Seller shall, at the time, in the manner and otherwise as hereinafter set forth, repurchase the applicable Purchased Receivable Portion at the Purchaser's option and demand; provided that if such Repurchase Event is caused by a deemed Dispute under the provisions of Section 4(f) and a court of competent jurisdiction determines in a final non-appealable judgment that such repurchased Purchased Receivable Portion was actually unpaid because such Account Debtor did not have the financial capacity to make such payment on its Due Date, the Purchaser shall, at the request of the Seller, purchase from the Seller all of the Seller's right, title and interest in such repurchased Purchased Receivable Portion in exchange for payment to the Seller by the Purchaser of the Repurchase Price previously paid. The repurchase price for a Purchased Receivable Portion shall be the amount equal to (i) the Purchase Price for such Purchased Receivable Portion, net of any Collections or other payments received by the Purchaser with respect to such Purchased Receivable Portion, *plus* (ii) the Discount applicable to such Purchased Receivable Portion and accrued for the period from the applicable Purchase Date to the date on which such Purchased Receivable Portion is repurchased, *plus* (iii) all other amounts then payable by the Seller under the Transaction Documents with respect to such Purchased Receivable Portion as of the date on which such Purchased Receivable Portion is repurchased (such amount herein referred to as the "Repurchase Price"). The Repurchase Price for any Purchased Receivable Portion shall be paid to the Purchaser's Account in immediately available funds by no later than the third (3rd) Business Day following demand therefor by the Purchaser. Upon the payment in full of the Repurchase Price with respect to a Purchased Receivable Portion, such Purchased Receivable shall hereby be, and be deemed to be, repurchased by the Seller from the Purchaser without recourse to or warranty by the Purchaser. If a Repurchase Event occurs that is caused by a Dispute deemed to have occurred pursuant to Section 4(f), the Seller has repurchased the applicable Purchased Receivable Portion (or part thereof) and a court of competent jurisdiction determines in a final non-appealable judgment that such Purchased Receivable Portion (or a part thereof) was actually unpaid because the applicable Account Debtor did not have the financial capacity to make such payment, the Purchaser shall, at the request of the Seller, purchase from the Seller all of the Seller's right, title and interest in such Purchased Receivable Portion (or part thereof that such court determined was actually unpaid because such Account Debtor did not have the financial capacity to make such payment) for an amount equal to the Repurchase Price that the Seller previously paid to the Purchaser to repurchase such Purchased Receivable Portion (or part thereof).

(c) Indemnification. The Seller hereby agrees to indemnify and hold harmless the Purchaser and its officers, directors, agents, representatives, shareholders, counsel, employees and each of their respective Affiliates, successors and assigns (each, an "Indemnified Person") from and against any and all damages, claims, losses, costs, expenses and liabilities (including, without limitation, reasonable attorneys' fees and expenses) (all of the foregoing being collectively referred to as "Indemnified Amounts") arising out of or resulting from or related to this Agreement or any other Transaction Document or the ownership, maintenance or funding, directly or indirectly, of the Purchased Receivable Portions (or any of them) or otherwise arising out of or resulting from the actions or inactions of the Seller or any of its Affiliates, including, without limitation, any of the following: (i) any representation or warranty made or deemed made by the Seller (or any of its officers) under or in connection with this Agreement or any other Transaction Document that shall have been incorrect when made; (ii) the failure by the Seller to perform any of its covenants or obligations under any Transaction Document; (iii) the failure by the Seller or any Subject Receivable or Contract to comply with any Applicable Law; (iv) the failure to vest in the Purchaser ownership of, and a first-priority perfected security interest (within the meaning of the UCC) in, each Purchased Receivable Portion and all Collections in respect thereof, free and clear of any Adverse Claim; (v) any Dispute, Dilution or any other claim resulting from the services performed or merchandise furnished in connection with any Subject Receivable or the furnishing or failure to furnish such services or merchandise or relating to collection activities with respect to any Purchased Receivable; (vi) any suit or claim related to any Subject Receivable, any Contract or any Transaction Document; (vii) the failure of the Seller to notify any Account Debtor of the sale of the Purchased Receivable Portions to the Purchaser to the extent required under this Agreement; (viii) the commingling

by the Seller of Collections at any time with other funds of the Seller or any other Person or (ix) any civil penalty or fine assessed by OFAC or any other Governmental Authority administering any Anti-Corruption Laws or Sanctions, and all reasonable and documented out-of-pocket costs and expenses (including reasonable and documented out-of-pocket legal fees and disbursements of one counsel for the Indemnified Persons (and, if applicable, one local counsel for the Indemnified Persons in each relevant jurisdiction)) incurred in connection with defense thereof by, any Indemnified Person in connection with the Transaction Documents as a result of any action of the Seller or any of its Affiliates; provided, however, that in all events there shall be excluded from the foregoing indemnification any Indemnified Amounts to the extent resulting solely from (x) the gross negligence or willful misconduct of an Indemnified Person as determined in a final non-appealable judgment by a court of competent jurisdiction or (y) the failure of an Account Debtor to pay any sum due under its Purchased Receivable Portions by reason of the financial or credit condition of such Account Debtor (including, without limitation, the occurrence of an Insolvency Event with respect to such Account Debtor). Any amount due and payable pursuant to this Section shall be paid to the Purchaser's Account in immediately available funds by no later than the second (2nd) Business Day following demand therefor by the Purchaser.

(d) Tax Matters.

(i) Indemnification. All payments on the Purchased Receivable Portions or otherwise made hereunder from the Account Debtors and the Seller will be made free and clear of any present or future taxes, levies, imposts, energy surcharges, duties, deductions, withholdings, assessments, fees or other charges whatsoever (but for the avoidance of doubt not including (x) taxes imposed upon the Purchaser with respect to its overall net income, franchise taxes and branch profit taxes and (y) taxes attributable to the Purchaser's failure to comply with Section 5(d)(iii) below), including any interest, additions to tax or penalties applicable thereto, and including whether imposed on the making of such a payment or whether arising by reason of the sale of the Purchased Receivable Portions to the Purchaser or relating to the underlying transactions between the Seller and the related Account Debtors that gave rise to the applicable Subject Receivables (any such taxes, "Transaction Taxes") and Other Taxes, and the sum payable to the Purchaser shall be increased to the extent necessary to ensure that, after making any withholding or payment of Transaction Taxes and Other Taxes, if any, the Purchaser receives on the due date and retains (free from any liability in respect of any Transaction Taxes and Other Taxes) a net sum equal to what it would have received and so retained, had no such withholding or payment of Transaction Taxes and Other Taxes been present, imposed, required or made. The Seller will indemnify the Purchaser and hold the Purchaser harmless from any Transaction Taxes and Other Taxes, whether or not such taxes were correctly or legally imposed or asserted by the relevant Governmental Authority. Any amount due and payable pursuant to this section shall be paid to the Purchaser's Account in immediately available funds by no later than the tenth (10th) Business Day following demand therefor by the Purchaser.

(ii) Form Delivery. The Purchaser will deliver a properly completed and executed IRS Form W-9 (or a properly completed and executed IRS Form W-8BEN, IRS Form W-8BEN-E, IRS Form W-8ECI or W-8IMY, as applicable) to the Seller, and shall also deliver any other properly completed and executed documentation reasonably requested by the Seller as will allow the Seller to satisfy its tax reporting or withholding obligations to the extent the Purchaser is legally entitled to do so and the completion, execution and submission of such documentation would not in the Purchaser's reasonable judgment (in consultation with such Seller) subject the Purchaser to any unreimbursed cost or expense or would prejudice the legal or commercial position of the Purchaser.

(iii) Other Taxes. The Seller shall timely pay to the relevant Governmental Authority in accordance with Applicable Law, or at the option of the Purchaser timely reimburse it for the payment of, any Other Taxes.

(e) Set-Off. The Seller hereby irrevocably instructs and authorizes the Purchaser to setoff, appropriate and apply (without presentment, demand, protest or other notice which are hereby expressly waived) any deposits and any other indebtedness held or owing by the Purchaser or any branch, agency or Affiliate thereof, including the payment of the Purchase Price for any Proposed Receivable Portions, to, or for the account of, the Seller or any of its respective Affiliates against amounts owing by the Seller hereunder or under any other Transaction Document (even if contingent or unmatured).

(f) UCC. The rights granted to the Purchaser hereunder are in addition to all other rights and remedies afforded to the Purchaser as a secured party under the UCC.

6. Notices. Unless otherwise provided herein, all communications by any party to any other party hereunder or under any other Transaction Document shall be in a writing personally delivered or sent by a recognized overnight delivery service, or certified mail, postage prepaid, return receipt requested, or by email to such party, as the case may be, at its address set forth below:

If to Wellcare, as Seller:	WellCare Prescription Insurance, Inc. 7700 Forsyth Rd St. Louis, MO 63105 Attention: Christopher A. Koster Tel: 314-320-9689 Email: Christopher.a.koster@centene.com
If to the Purchaser (other than Purchase Requests):	MUFG Bank, Ltd. 1221 Avenue of the Americas New York, New York 10020 Attention: Alec Blodi Craig Pinsly Tel: 646-767-1729 212-782-4498 Email: ablodi@us.mufg.jp cpinsly@us.mufg.jp
With a copy to:	MUFG Bank, Ltd. 1221 Avenue of the Americas New York, New York 10020-1104 Attention: Amy Mellon Grandis Tel: 212-782-4638 Email: amellon@us.mufg.jp
If to the Purchaser (other than Purchase Requests):	MUFG Bank, Ltd. 1221 Avenue of the Americas New York, New York 10020 Attention: Alec Blodi Craig Pinsly Tel: 646-767-1729 212-782-4498 Email: ablodi@us.mufg.jp cpinsly@us.mufg.jp

The Seller agrees that the Purchaser may presume the authenticity, genuineness, accuracy, completeness and due execution of any email bearing a facsimile or scanned signature resembling a signature of an authorized Person of the Seller without further verification or inquiry by the Purchaser. Notwithstanding the foregoing, the Purchaser in its sole discretion may elect not to act or rely upon such a communication and shall be entitled (but not obligated) to make inquiries or require further action by the Seller to authenticate any such communication.

Any Purchase Request, and any supporting documentation in connection herewith or therewith, such as copies of invoices, not submitted via the MUFG Platform may be sent by the Seller by electronic mail attachment in portable document format (.pdf).

A party may change the address at which it is to receive notices hereunder by written notice in the foregoing manner given to the other parties hereto.

7. Expenses. The Seller hereby agrees to reimburse the Purchaser on demand for:

(a) all reasonable and documented out-of-pocket costs and expenses (including due diligence expenses) incurred by the Purchaser in connection with the negotiation, preparation and execution of the Transaction Documents (including this Agreement), including all reasonable and documented out-of-pocket expenses and accountants', consultants' and attorneys' fees incurred in connection therewith;

(b) all reasonable and documented out-of-pocket costs and expenses incurred by the Purchaser in connection with the administration (including periodic auditing as provided for herein) of this Agreement and the other Transaction Documents and the transactions contemplated hereby and thereby, including all reasonable and documented out-of-pocket expenses and reasonable and documented out-of-pocket accountants', consultants' and attorneys' fees incurred in connection with the administration and maintenance of this Agreement and the other Transaction Documents and the transactions contemplated hereby and thereby;

(c) all reasonable and documented out-of-pocket costs and expenses (including reasonable and documented out-of-pocket attorneys' fees and expenses) the Purchaser incurs in connection with the enforcement of this Section 7, or any of its other rights under this Agreement or any of the other Transaction Documents; and

(d) all Other Taxes.

8. Interest on Overdue Amounts. All amounts due for payment by the Seller to the Purchaser pursuant to this Agreement shall accrue interest at the Overdue Payment Rate from the date on which payment thereof is due until the date on which payment thereof is made in accordance with the terms of this Agreement.

9. Governing Law. THIS AGREEMENT, INCLUDING THE RIGHTS AND DUTIES OF THE PARTIES HERETO, SHALL BE GOVERNED BY, AND CONSTRUED IN ACCORDANCE WITH, THE LAWS OF THE STATE OF NEW YORK (INCLUDING SECTIONS 5-1401 AND 5-1402 OF THE GENERAL OBLIGATIONS LAW OF THE STATE OF NEW YORK, BUT WITHOUT REGARD TO ANY OTHER CONFLICTS OF LAW PROVISIONS THEREOF, EXCEPT TO THE EXTENT THAT THE PERFECTION, THE EFFECT OF PERFECTION OR PRIORITY OF THE INTERESTS OF THE PURCHASER IN THE PURCHASED RECEIVABLE PORTIONS IS GOVERNED BY THE LAWS OF A JURISDICTION OTHER THAN THE STATE OF NEW YORK).

10. No Non-Direct Damages. To the fullest extent permitted by Applicable Law, the Seller shall not assert, and the Seller hereby waives, any claim against any Indemnified Person, on any theory of liability, for special, indirect, consequential or punitive damages (as opposed to direct or actual damages) arising out of, in connection with, or as a result of, this Agreement, any other Transaction Document or any agreement or instrument contemplated hereby or thereby or the transactions contemplated hereby or thereby. No Indemnified Person shall be liable for any damages arising from the use by unintended recipients of any information or other materials distributed by it through telecommunications, electronic or other information transmission systems in connection with this Agreement or the other Transaction Documents or the transactions contemplated hereby or thereby; provided that the waiver provided for in this sentence shall not apply to damages resulting directly from such Indemnified Person's own gross negligence or willful misconduct as determined by a court of competent jurisdiction in a final and non-appealable judgment.

11. General Provisions.

(a) Final Agreement; Amendments and Waivers. This Agreement represents the final agreement of the parties hereto with respect to the subject matter hereof and supersedes all prior and contemporaneous understandings and agreements with respect to such subject matter. No provision of this Agreement may be amended or waived except by a writing signed by the parties hereto. This Agreement shall bind and inure to the benefit of the respective successors and permitted assigns of each of the parties; provided, however, that neither the Seller nor the Purchaser may assign any of its rights hereunder without the other's prior written consent, given or withheld in its sole discretion. The Purchaser shall have the right, without the consent of or notice to the Seller, to sell, transfer, negotiate, or grant participations in all or any part of, or any interest in, the Purchaser's obligations, rights and benefits hereunder (including in any Purchased Receivable Portions) so long as the Purchaser remains liable to the Sellers for its obligations hereunder.

(b) Severability. Any provisions of this Agreement that are prohibited or unenforceable in any jurisdiction shall, as to such jurisdiction, be ineffective to the extent of such prohibition or unenforceability without invalidating the remaining provisions hereof, and any such prohibition or unenforceability in any jurisdiction shall not invalidate or render unenforceable such provision in any other jurisdiction.

(c) Execution; Counterparts. This Agreement may be executed in any number of counterparts and by different parties on separate counterparts, each of which, when executed and delivered, shall be deemed to be an original, and all of which, when taken together, shall constitute but one and the same agreement. Delivery of an executed counterpart of a signature page to this Agreement by electronic mail attachment in portable document format (.pdf) or any other electronic means that reproduces an image of the actual executed signature page shall be effective as delivery of a manually executed counterpart of this Agreement. The words "execution," "signed," "signature," "delivery," and words of like import in or relating to any document to be signed in connection with this Agreement and the transactions contemplated hereby shall be deemed to include an electronic sound, symbol, or process attached to, or associated with, a contract or other record and adopted by a Person with the intent to sign, authenticate or accept such contract or record, deliveries or the keeping of records in electronic form, each of which shall be of the same legal effect, validity or enforceability as a manually executed signature, physical delivery thereof or the use of a paper-based recordkeeping system, as the case may be, to the extent and as provided for in any applicable law, including the Federal Electronic Signatures in Global and National Commerce Act, the New York State Electronic Signatures and Records Act, or any other similar state laws based on the Uniform Electronic Transactions Act.

(d) Termination. Purchases of Receivable Portions under this Agreement may be effected during the period from the initial effective date hereof until the date designated by either the Purchaser or the Seller at any time by thirty (30) days' prior written notice to the other party or, if a Termination Event shall have occurred and be continuing, immediately by the Purchaser upon written notice to the Seller (such period, the "Availability Period"). This Agreement shall terminate automatically on the Final Collection Date. Notwithstanding the foregoing, the Seller's obligations to indemnify the Purchaser with respect to the expenses, damages, losses, costs and liabilities shall survive until the later of (x) the Final Collection Date and (y) such time as all applicable statute of limitations periods with respect to actions that may be brought by the Purchaser under the Transaction Documents have run.

(e) Judgment Currency. If, for the purposes of obtaining judgment in any court, it is necessary to convert a sum due hereunder in one currency into another currency, the rate of exchange used shall be that at which in accordance with normal banking procedures the Purchaser could purchase the first currency with such other currency on the Business Day preceding that on which final judgment is given. The obligation of the Seller in respect of any such sum due from it to the Purchaser hereunder shall, notwithstanding any judgment in a currency (the "Judgment Currency") other than that in which such sum is denominated in accordance with the applicable provisions of this Agreement (the "Agreement Currency"), be discharged only to the extent that on the Business Day following receipt by the Purchaser of any sum adjudged to be so due in the Judgment Currency, the Purchaser may in accordance with normal banking procedures purchase the Agreement Currency with the Judgment Currency. If the amount of the Agreement Currency so purchased is less than the sum originally due to the Purchaser from the Seller in the Agreement Currency, the Seller agrees, as a separate obligation and notwithstanding any such judgment, to indemnify the Purchaser against such loss. If the amount of the Agreement Currency so purchased is greater than the sum originally due to the Purchaser in such currency, the Purchaser agrees to return the amount of any excess to the Seller (or to any other Person who may be entitled thereto under Applicable Law).

(f) Calculation of Interest. All interest amounts calculated on a per annum basis hereunder are calculated on the basis of a year of three hundred and sixty (360) days.

(g) WAIVER OF JURY TRIAL. EACH PARTY HERETO HEREBY IRREVOCABLY WAIVES ANY RIGHT THAT IT MAY HAVE TO A JURY TRIAL OF ANY CLAIM OR CAUSE OF ACTION BASED UPON OR ARISING OUT OF ANY OF THE TRANSACTIONS CONTEMPLATED HEREIN, INCLUDING CONTRACT CLAIMS, TORT CLAIMS, BREACH OF DUTY CLAIMS AND ALL OTHER COMMON LAW OR STATUTORY CLAIMS.

(h) CONSENT TO JURISDICTION. EACH PARTY HERETO HEREBY ACKNOWLEDGES AND AGREES THAT IT IRREVOCABLY (i) SUBMITS TO THE JURISDICTION, FIRST, OF ANY UNITED STATES FEDERAL COURT, AND SECOND, IF FEDERAL JURISDICTION IS NOT AVAILABLE, OF ANY NEW YORK STATE COURT, IN EITHER CASE SITTING IN NEW YORK CITY, NEW YORK, IN ANY ACTION OR PROCEEDING ARISING OUT OF OR RELATING TO THIS AGREEMENT AND ANY OTHER TRANSACTION DOCUMENT, (ii) AGREES THAT ALL CLAIMS IN RESPECT OF SUCH ACTION OR PROCEEDING MAY BE HEARD AND DETERMINED ONLY IN SUCH NEW YORK STATE OR FEDERAL COURT AND NOT IN ANY OTHER COURT, AND (iii) WAIVES, TO THE FULLEST EXTENT IT MAY EFFECTIVELY DO SO, THE DEFENSE OF AN INCONVENIENT FORUM TO THE MAINTENANCE OF SUCH ACTION OR PROCEEDING.

(i) WAIVER OF IMMUNITIES. EACH PARTY HERETO HEREBY ACKNOWLEDGES AND AGREES THAT TO THE EXTENT THAT IT HAS OR HEREAFTER MAY ACQUIRE ANY IMMUNITY FROM THE JURISDICTION OF ANY COURT OR FROM ANY LEGAL PROCESS (WHETHER THROUGH SERVICE OR NOTICE, ATTACHMENT PRIOR TO JUDGMENT, ATTACHMENT IN AID TO EXECUTION, EXECUTION OR OTHERWISE) WITH RESPECT TO ITSELF OR ITS PROPERTY, IT HEREBY IRREVOCABLY WAIVES SUCH IMMUNITY IN RESPECT OF ITS OBLIGATIONS UNDER OR IN CONNECTION WITH THIS AGREEMENT.

(j) No Party Deemed Drafter. The Seller and the Purchaser agree that no party hereto shall be deemed to be the drafter of this Agreement.

(k) PATRIOT Act. The Purchaser hereby notifies each other party hereto that pursuant to the requirements of the Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act of 2001 (Title III of Pub. L. 107-56 (signed into law October 26, 2001)) (the "PATRIOT Act"), it is required to obtain, verify and record information that identifies each such party, which information includes the name, address, tax identification number and other information that will allow the Purchaser to identify such party in accordance with the PATRIOT Act. This notice is given in accordance with the requirements of the PATRIOT Act. Upon the reasonable request of the Purchaser, the Seller shall provide to the Purchaser the documentation and other information so requested in connection with applicable "know your customer" and anti-money-laundering and counter-terrorist financing laws, rules, and regulations. The Seller shall promptly notify the Purchaser of any change(s) to beneficial ownership or control party information.

(l) Divisions. For all purposes under the Transaction Documents, in connection with any division or plan of division under Delaware law (or any comparable event under a different jurisdiction's laws): (i) if any asset, right, obligation or liability of any Person becomes the asset, right, obligation or liability of a different Person, then it shall be deemed to have been transferred from the original Person to the subsequent Person, and (ii) if any new Person comes into existence, such new Person shall be deemed to have been organized on the first date of its existence by the holders of its Capital Stock at such time.

(m) Accounting Treatment; Non-Reliance. The Seller agrees and acknowledges that (i) it is a sophisticated party in relation to this Agreement; (ii) it has made its own independent decision to enter into this Agreement, the other Transaction Documents to which it is a party and the transactions contemplated hereby and thereby and, in connection therewith, has obtained such independent accounting, legal, tax, financial and other advice as it deems necessary and appropriate (including, without limitation, as to the appropriate treatment of such transactions for accounting, legal, tax and other purposes) and (iii) it has not relied upon any representation or advice from the Purchaser, any of its Affiliates or any of their respective directors, officers, employees, contractors, counsel, advisors or other representatives in this regard.

(n) Confidentiality. Each party hereto agrees to hold the Transaction Documents, the transactions contemplated thereby and all non-public information received by it in connection therewith from any other party hereto or its agents or representatives in confidence and agrees not to provide any Person with copies of this Agreement, the other Transaction Documents or such non-public information other than to (i) its Affiliates and any officers, directors, members, managers, employees or outside accountants, auditors or attorneys of such party or its Affiliates, (ii) any prospective or actual assignee or participant which (in each case) has signed a confidentiality agreement containing provisions substantively similar to this Section 11(n) or has agreed to be subject to the terms of this Section 1(n), (iii) credit support providers (including providers of credit insurance and brokers for providers

of credit insurance) if they agree to hold it confidential pursuant to customary commercial terms, (iv) Governmental Authorities with appropriate jurisdiction (including filings required under securities laws) and (v) appropriate filings under the UCC. Notwithstanding the above stated obligations, the parties hereto will not be liable for disclosure or use of such information which: (i) was required by Applicable Law, including pursuant to a valid subpoena or other legal process, (ii) is disclosed or used in connection with the exercise of any remedies hereunder or any suit, action or proceeding relating to this Agreement or any other Transaction Document or the enforcement of rights hereunder or thereunder, (iii) was in such Person's possession or known to such Person prior to receipt or (iv) is or becomes known to the public through disclosure in a printed publication (without breach of any of such Person's obligations hereunder).

(o) Third Party Rights. Other than as specifically provided in this Agreement, no Person not a party to this Agreement shall be deemed a third party beneficiary hereof.

12. Register. The Purchaser, acting solely for this purpose as a non-fiduciary agent of the Seller, shall maintain a register (the "Register") on which it shall record the rights of the Purchaser and any assignee or participant of the Purchaser with respect to the rights under this Agreement and any Purchased Receivable Portion, and each assignment or participation. The Register shall include the names and addresses of the Purchaser, assignees, participants or successors and the percentage or portion of such rights and obligations assigned or participated. The entries in the Register shall be conclusive absent manifest error; provided, however, that a failure to make any such recordation, or any error in such recordation shall not affect the Seller's obligations in respect of such rights.

[Signatures Commence on the Following Page]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed as of the date first above written.

WELLCARE PRESCRIPTION INSURANCE, INC.,
as Seller

By:_____
Name:
Title:

MUFG BANK, LTD., as Purchaser

By:_____
Name:
Title:

PERFORMANCE GUARANTY

This PERFORMANCE GUARANTY, dated as of February 13, 2026 (this "Guaranty"), is made by CENTENE CORPORATION, a Delaware corporation (the "Performance Guarantor"), in favor of MUFG BANK, LTD. ("MUFG"), as the Purchaser (as defined below).

WITNESSETH

WHEREAS, WELLCARE PRESCRIPTION INSURANCE, Inc. ("Wellcare" or the "Seller"), and MUFG, as purchaser (the "Purchaser"), have entered into that certain Master Receivables Purchase Agreement, dated as of the date hereof (as amended, restated, amended and restated, supplemented or otherwise modified from time to time, the "Agreement"), pursuant to which the Purchaser may from time to time purchase Receivable Portions from the Seller; and

WHEREAS, it is a condition precedent for the parties to enter into the Agreement that the Performance Guarantor execute and deliver this Guaranty.

NOW THEREFORE, in consideration of the foregoing and in order to induce the Purchaser to enter into the Agreement, the Performance Guarantor agrees as follows:

1. Performance Guaranty. For value received by it and the Seller, the Performance Guarantor hereby absolutely, unconditionally and irrevocably assures and undertakes (as primary obligor and not merely as surety) for the benefit of the Purchaser, the due and punctual payment of any and all amounts due by the Seller (and, any of its successors and assigns) to the Purchaser and the performance of any and all other monetary obligations of the Seller under the Agreement, under the Agreement and each other Transaction Document (including all of the Seller's payment, repurchase, indemnity or similar obligations) (collectively, the "Guaranteed Obligations"). For the avoidance of doubt, the Guaranteed Obligations shall in no event exceed the Sellers' liability under the Transaction Documents for any failure of performance that triggers the Guaranteed Obligations hereunder.

2. Expense Undertaking. The Performance Guarantor absolutely, unconditionally, and irrevocably agrees to pay promptly on demand all reasonable and documented costs and expenses of the Purchaser (including, without limitation, reasonable counsel fees and out-of-pocket expenses), if any, in connection with enforcement (whether through negotiation, legal proceedings or otherwise) of its rights under this Guaranty or any other Transaction Document (the "Expense Obligations").

3. Obligations Absolute. The Performance Guarantor agrees to perform and pay the Guaranteed Obligations and Expense Obligations, regardless of any Applicable Law now or hereafter in effect in any jurisdiction affecting any terms of any Transaction Document or the rights of the Purchaser with respect thereto, and notwithstanding a discharge in bankruptcy of all or any part of the Seller's obligations under the Transaction Documents. The liability of the Performance Guarantor hereunder shall be an absolute and primary obligation of payment and the Purchaser shall not be required to first (a) proceed against the Seller; (b) proceed against or exhaust any security held from the Seller; or (c) pursue any other remedies it may have, including remedies against other guarantors, if any.

4. Waivers. The Performance Guarantor unconditionally and irrevocably waives promptness, diligence, notice of acceptance hereof, and all other notices and demands of any kind to which the Performance Guarantor may be entitled as a guarantor, including, without

limitation, demands of payment and notices of nonpayment, default, protest and dishonor to the Seller. The Performance Guarantor further hereby waives notice of, consents to, and irrevocably waives any defenses it may now have or hereafter acquire in any way relating to any or all of the following: (a) any agreement or arrangement for payment, extension or subordination, of the whole or any part of the Seller's obligations under the Transaction Documents, (b) the modification, amendment, waiver or consent to departure of any of the terms of the Transaction Documents, including, without limitation, in the time, place or manner of payment or any increase in the Guaranteed Obligations, (c) the forbearance by the Purchaser in the exercise of any rights against the Seller, (d) the change in location or release of any collateral of the Seller (if any) or the taking of a security interest in any additional or substituted collateral of the Seller (if any), (e) any lack of validity or enforceability of any Transaction Document or any agreement or instrument relating thereto (including, for the avoidance of doubt, as against the Seller), (f) to the extent permitted by Applicable Law, any defense arising by reason of any claim or defense based upon an election of remedies by the Purchaser that in any manner impairs, reduces, releases or otherwise adversely affects the subrogation, reimbursement, exoneration, contribution or indemnification rights of the Performance Guarantor or other rights of the Performance Guarantor to proceed against the Seller, (g) any defense based on the right of set-off or counterclaim against or in respect of the obligations owed by the Seller under the Transaction Documents, or (h) any other circumstance (including, without limitation, (i) any statute of limitations, (ii) any law governing usury or insolvency and (iii) any other law providing the Seller with a defense from non-payment) or any existence of or reliance on any representation by the Purchaser that might otherwise constitute a defense available to, or a discharge of the Seller or any other guarantor or surety. The only defense the Performance Guarantor shall have under this Guaranty is the payment and performance in full of the Guaranteed Obligations and Expense Obligations.

5. Reinstatement. This Guaranty will continue to be effective or will be reinstated, as the case may be, if at any time any payment made to the Purchaser is rescinded or must be returned upon the occurrence of any bankruptcy proceeding of the Seller as if such payment had not been made.

6. Continuing Guaranty. This Guaranty is a continuing guaranty and shall continue in full force and effect until terminated pursuant to this Section 6. This Guaranty shall automatically terminate upon the termination of the Agreement and the payment and performance in full of the Guaranteed Obligations and Expense Obligations (whether by the Seller or otherwise), other than contingent indemnification obligations with respect to which no claim has been made; provided, that any such termination shall be subject to the reinstatement provisions set forth in Section 5 of this Guaranty.

7. Subrogation and Other Rights. The Performance Guarantor hereby unconditionally and irrevocably agrees not to exercise any rights that it may now have or hereafter acquire against the Seller that arise from the existence, payment, performance or enforcement of this Guaranty, including, without limitation, any right of subrogation, reimbursement, exoneration, contribution or indemnification and any right to participate in any claim or remedy of the Purchaser against the Seller whether or not such claim, remedy or right arises in equity or under contract, statute or common law, unless and until all of the Guaranteed Obligations and Expense Obligations shall have been paid in full in cash and the Agreement has been terminated. If any amount shall be paid to the Performance Guarantor in violation of the immediately preceding sentence at any time prior to the payment in full in cash of the Guaranteed Obligations and Expense Obligations and the termination of the Agreement, such amount shall be received and held in trust for the benefit of the Purchaser, and shall forthwith be paid or delivered to the Purchaser in the same form as so received (with any necessary endorsement or assignment) to be credited and applied to the Guaranteed Obligations and Expense Obligations, as applicable, and all other amounts payable under this Guaranty.

8. GOVERNING LAW. THIS GUARANTY, INCLUDING THE RIGHTS AND DUTIES OF THE PARTIES HERETO, SHALL BE GOVERNED BY, AND CONSTRUED IN ACCORDANCE WITH, THE LAWS OF THE STATE OF NEW YORK (INCLUDING SECTIONS 5-1401 AND 5-1402 OF THE GENERAL OBLIGATIONS LAW OF THE STATE OF NEW YORK, BUT WITHOUT REGARD TO ANY OTHER CONFLICTS OF LAW PROVISIONS THEREOF).

9. WAIVER OF JURY TRIAL. EACH PARTY HERETO HEREBY IRREVOCABLY WAIVES ANY RIGHT THAT IT MAY HAVE TO A JURY TRIAL OF ANY CLAIM OR CAUSE OF ACTION BASED UPON OR ARISING OUT OF ANY OF THE TRANSACTIONS CONTEMPLATED HEREIN, INCLUDING CONTRACT CLAIMS, TORT CLAIMS, BREACH OF DUTY CLAIMS AND ALL OTHER COMMON LAW OR STATUTORY CLAIMS.

10. CONSENT TO JURISDICTION. EACH PARTY HERETO HEREBY ACKNOWLEDGES AND AGREES THAT IT IRREVOCABLY (i) SUBMITS TO THE JURISDICTION, FIRST, OF ANY UNITED STATES FEDERAL COURT, AND SECOND, IF FEDERAL JURISDICTION IS NOT AVAILABLE, OF ANY NEW YORK STATE COURT, IN EITHER CASE SITTING IN NEW YORK CITY, NEW YORK, IN ANY ACTION OR PROCEEDING ARISING OUT OF OR RELATING TO THIS GUARANTY AND ANY OTHER TRANSACTION DOCUMENT, (ii) AGREES THAT ALL CLAIMS IN RESPECT OF SUCH ACTION OR PROCEEDING MAY BE HEARD AND DETERMINED ONLY IN SUCH NEW YORK STATE OR FEDERAL COURT AND NOT IN ANY OTHER COURT, AND (iii) WAIVES, TO THE FULLEST EXTENT IT MAY EFFECTIVELY DO SO, THE DEFENSE OF AN INCONVENIENT FORUM TO THE MAINTENANCE OF SUCH ACTION OR PROCEEDING.

11. WAIVER OF IMMUNITIES. EACH PARTY HERETO HEREBY ACKNOWLEDGES AND AGREES THAT TO THE EXTENT THAT IT HAS OR HEREAFTER MAY ACQUIRE ANY IMMUNITY FROM THE JURISDICTION OF ANY COURT OR FROM ANY LEGAL PROCESS (WHETHER THROUGH SERVICE OR NOTICE, ATTACHMENT PRIOR TO JUDGMENT, ATTACHMENT IN AID TO EXECUTION, EXECUTION OR OTHERWISE) WITH RESPECT TO ITSELF OR ITS PROPERTY, IT HEREBY IRREVOCABLY WAIVES SUCH IMMUNITY IN RESPECT OF ITS OBLIGATIONS UNDER OR IN CONNECTION WITH THIS GUARANTY.

12. Representations and Warranties. The Performance Guarantor hereby makes the following representations and warranties for the benefit of the Purchaser as of the Closing Date and on each Purchase Date:

(a) It is duly incorporated, validly existing and in good standing under the laws of its jurisdiction of organization and is duly qualified to do business, and is in good standing, in every jurisdiction where the nature of its business requires it to be so qualified, in each case except where the failure to be so qualified would not reasonably be expected to result in a Material Adverse Change with respect to the Performance Guarantor.

(b) The execution, delivery and performance by it of this Guaranty and the other Transaction Documents to which it is party and each other document to be delivered by it thereunder, (i) are within its corporate powers, (ii) have been duly authorized by all necessary corporate action, (iii) do not contravene, violate or breach (1) its charter or by-laws, (2) any Applicable Law, (3) any indenture, sale agreement, credit agreement, loan agreement, security agreement, mortgage, deed of trust or other agreement or instrument to which it is a party or by

which it or any of its property is bound, or (4) any order, writ, judgment, award, injunction or decree binding on or affecting it or its property and (iv) do not result in the creation or imposition of any Adverse Claim upon any of its properties pursuant to the terms of any such indenture, credit agreement, loan agreement, agreement, mortgage, deed of trust or other agreement or instrument, other than this Guaranty and the other Transaction Documents, except, in the case of clauses (iii) (other than clause (iii)(1)) and (iv), as could not reasonably be expected to result in a Material Adverse Change with respect to the Performance Guarantor.

(c) This Guaranty and each Transaction Document to which it is party has been duly executed and delivered by it.

(d) No authorization or approval or other action by, and no notice to, license from or filing with, any Governmental Authority is required for the due execution, delivery and performance by it of this Guaranty and each Transaction Document to which it is party or any other document to be delivered by it hereunder or thereunder, except as could not reasonably be expected to result in a Material Adverse Change with respect to it. Notwithstanding the foregoing, it is understood and agreed that, under current Applicable Law, the Purchaser may not be permitted to service, enforce or otherwise collect monies due or to become due under the CMS Contract.

(e) This Guaranty and each Transaction Document to which it is a party constitutes the legal, valid and binding obligation of the Performance Guarantor, enforceable against it in accordance with its terms, except as limited by bankruptcy, insolvency, moratorium, fraudulent conveyance or other laws relating to the enforcement of creditors' rights generally and general principles of equity (regardless of whether enforcement is sought at equity or law).

(f) There is no pending or, to its knowledge, threatened action, proceeding, investigation or injunction, writ or restraining order affecting it or any of its Affiliates before any Governmental Authority that could reasonably be expected to result in a Material Adverse Change with respect to it.

(g) It is Solvent and no Insolvency Event has occurred with respect to it.

(h) No Material Adverse Change or event which, individually or in the aggregate, could reasonably be expected to result in a Material Adverse Change has occurred with respect to it.

(i) No Change of Control has occurred.

(j) It is not an "investment company" as defined in, or required to be registered as an "investment company" under, the Investment Company Act of 1940.

(k) None of: (a) the Performance Guarantor, any controlled Affiliate thereof or any of their respective directors, officers, or employees; and (b) any person acting on behalf of the Performance Guarantor or any Affiliate thereof that will act in any capacity in connection with or benefit from the Agreement is a Sanctioned Person.

(l) No use of proceeds or other transaction contemplated by the Agreement will violate Sanctions applicable to any party to the Agreement.

13. Covenants. The Performance Guarantor covenants and agrees that it will, unless this Guaranty shall have terminated in accordance with Section 6, hereof comply with all Applicable Laws and preserve and maintain its corporate existence, rights, franchises, qualifications and privileges, except where any failure to so comply or to so maintain its rights, franchises, qualifications and privileges would not reasonably be expected, individually or in the aggregate, to result in a Material Adverse Change with respect to the Performance Guarantor.

14. No Setoff or Deductions; Taxes; Payments. The Performance Guarantor shall make all payments hereunder without setoff or counterclaim and free and clear of and without deduction for any taxes, levies, imposts, duties, charges, fees, deductions, withholdings, compulsory loans, restrictions or conditions of any nature now or hereafter imposed or levied by any jurisdiction or any political subdivision thereof or taxing or other authority therein unless the Performance Guarantor is compelled by law to make such deduction or withholding. If any such obligation (other than one arising with respect to taxes based on or measured by the income or profits of the Purchaser) is imposed upon the Performance Guarantor with respect to any amount payable by it hereunder, the Performance Guarantor will pay to the Purchaser, on the date on which such amount is due and payable hereunder, such additional amount in Dollars as shall be necessary to enable the Purchaser to receive the same net amount which the Purchaser would have received on such due date had no such obligation been imposed upon the Performance Guarantor. The Performance Guarantor will deliver promptly to the Purchaser certificates or other valid vouchers for all taxes or other charges deducted from or paid with respect to payments made by the Performance Guarantor hereunder. The obligations of the Performance Guarantor under this Section shall survive the payment in full of the Guaranteed Obligations and termination of this Guaranty.

15. PATRIOT Act. The Purchaser hereby notifies the Performance Guarantor that pursuant to the PATRIOT Act it is required to obtain, verify and record information that identifies the Performance Guarantor, which information includes the name, address, tax identification number and other information that will allow the Purchaser to identify such party in accordance with the PATRIOT Act. This notice is given in accordance with the requirements of the PATRIOT Act. Upon the reasonable request of the Purchaser, the Performance Guarantor shall provide to the Purchaser the documentation and other information so requested in connection with applicable "know your customer" and anti-money-laundering and counter-terrorist financing laws, rules, and regulations. The Performance Guarantor shall promptly notify the Purchaser of any change(s) to beneficial ownership or control party information.

16. Confidentiality and Notice Provisions. The provisions set out in Section 6 (*Notices*) and Section 11(n) (*Confidentiality*) of the Agreement shall be expressly and specifically incorporated into this Guaranty, as though they were set out in full in this Guaranty. In the event of any conflict between the provisions of this Guaranty and Section 6 (*Notices*) or Section 11(n) (*Confidentiality*) of the Agreement, the provisions of this Guaranty shall prevail.

17. Notices. All notices, requests and demands given or made under this Guaranty to the Performance Guarantor shall be given or made in writing and unless otherwise stated shall be made by email or letter using the address as specified below:

Centene Corporation
Address: 7700 Forsyth Boulevard
St Louis, MO 63105
Attention: General Counsel
Tel - 314-320-9689
Email - Christopher.a.koster@centene.com

18. Defined Terms. Capitalized terms used herein but not defined shall have the meanings assigned to such terms in the Agreement.

[Signature pages follow.]

IN WITNESS WHEREOF, the Performance Guarantor has executed this Guaranty as of the date first written above

CENTENE CORPORATION,
as Performance Guarantor

By:_____
Name:
Title:

ACCEPTED AND ACKNOWLEDGED, as of the date first written above.

MUFG BANK.,
as Performance Guarantor

By:_____
Name:
Title:

CENTENE CORPORATION

Restricted Stock Unit Agreement Granted Under
2025 Stock Incentive Plan

THIS AGREEMENT is entered into by Centene Corporation, a Delaware corporation (hereinafter the "Company"), and **<<Participant Name>>** (hereinafter the "Participant").

WHEREAS, the Participant renders important services to the Company and acquires access to Confidential Information (as defined below) of the Company in connection with the Participant's relationship with the Company; and

WHEREAS, the Company desires to align the long-term interests of its valued employees with those of the Company by providing the ownership interest granted herein;

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements herein contained, the parties hereto hereby agree as follows:

1. Grant of RSUs.

This Agreement evidences the grant by the Company on <<**Grant Date**>> (or the "Grant Date") to <<**Participant Name**>> of <<**RSU#**>> restricted stock units (each an "RSU," and collectively, the "RSUs") pursuant to the Company's 2025 Stock Incentive Plan (the "Plan"), that will settle in shares of common stock, $.001 par value per share, of the Company ("Common Stock"), as provided in this RSU Agreement (the "Agreement"). The shares of Common Stock that are issuable upon vesting of the RSUs are referred to in this Agreement as "Shares." Capitalized terms not otherwise defined in this Agreement have the meanings ascribed to such terms in the Plan.

2. Vesting.

(a) Subject to Sections 3 and 4 of this Agreement, the table outlined on the last page of this Agreement (the "Appendix") sets forth each date upon which RSUs shall become vested (each such date, a "Vesting Date"); provided that the continuous service of Participant continues through and on the applicable Vesting Date.

#VestingDateandQuantity#

(b) In the event the Participant has an employment agreement, and RSUs qualify for accelerated or continued vesting under such employment agreement, as in effect from time to time, all RSUs shall vest in accordance with the provisions outlined in the Participant's employment agreement; *provided* that such accelerated or continued vesting shall not change the timing of settlement of the RSUs, which shall continue to be governed by this Agreement. Furthermore, if any defined term used herein is also defined in the Participant's employment agreement, then the definition that is more favorable to the Participant will control.

3. Reorganization Event.

The foregoing vesting schedule notwithstanding, if a Change in Control (as defined in the Plan) occurs and the Participant's employment with the Company (and any parent or subsidiary thereof) is terminated by the Company (or a parent or subsidiary thereof) without Cause (as defined below) or by the Participant for Good Reason (as defined below), and the Participant's date of termination occurs (or in the case of the Participant's termination of employment for Good Reason, the event giving rise to Good Reason occurs) within twenty-four (24) months following the Change in Control, all unvested RSUs shall automatically become 100% vested and shall be paid on the Participant's date of termination ("CIC Termination Payment"). "Cause" shall mean acts or omissions that the Company determines, after affording the Participant an opportunity to be heard, (i) are criminal, dishonest or fraudulent or constitute misconduct that reflects negatively on the reputation of the Company (including any parent, subsidiary, Affiliate or division of the Company); (ii) could expose the Company or any parent, subsidiary, Affiliate or division of the Company to claims of illegal harassment or discrimination in employment; (iii) are material

breaches of this Agreement or other agreement with the Company; or (iv) reflect continued and repeated failure to (A) perform substantially the duties of his/her employment (other than any such failure resulting from the Participant's physical or mental impairment or incapacity) or (B) to comply with any material written policy of the Company. "Good Reason" shall mean: (a) if the Participant is a party to the Executive Severance and Change in Control Plan or the Centene Corporation Severance Pay Plan (as may be amended from time to time, as applicable, the "Severance Plan") or an employment or service agreement with the Company or its Affiliates and such agreement provides for a definition of Good Reason, the definition contained therein; or (b) if the Participant is not party to such agreement or if such agreement does not define Good Reason, without the Participant's prior written consent, at or after a Change in Control, (i) a reduction in the Participant's annual base salary or annual target bonus opportunity from those in effect immediately prior to the Change in Control; (ii) a material reduction in the Participant's authority, duties or responsibilities from those in effect immediately prior to the Change in Control, or (iii) a demand by the Company or the entity surviving the transaction that resulted in the Change in Control that the Participant relocate to a primary work location more than fifty (50) miles from the Participant's primary work location immediately prior to such relocation; *provided* that such proposed relocation results in a greater commute for the Participant based on the Participant's residence immediately prior to such relocation. The Participant must provide written notice to the Company of the existence of Good Reason no later than ninety (90) days after its initial existence, and the Company shall have a period of thirty (30) days following its receipt of such written notice during which it may remedy in all material respects the Good Reason condition identified in such written notice. If the Company fails to remedy in all material respects such Good Reason condition, the Participant shall have ninety (90) days to terminate his/her employment for Good Reason.

4. Distribution of Shares.

(a) Timing of Distribution. The Company will distribute to the Participant (or to the Participant's beneficiary in the event of the death of the Participant occurring after a Vesting Date but before distribution of the corresponding Shares), as soon as administratively practicable after each Vesting Date, but no later than the latest date permitted by Treasury Regulation Section 1.409A-3(d), the Shares represented by RSUs that vested on such Vesting Date, except that, payment shall occur earlier and extinguish any further payment on any future Vesting Date in the event that a CIC Termination Payment occurs or payment on death or disability occurs in accordance with Section 4(c).

(b) No Fractional Shares. No fractional Shares shall be issuable pursuant to any RSU. In lieu of any fractional Shares to which the Participant would otherwise be entitled, the Company may, in its discretion, determine whether to pay, in lieu of such fractional Share, cash in an amount equal to such fractional Share multiplied by the Fair Market Value (as defined in the Plan) of a share of Common Stock, or whether any such fractional Share should be rounded down to the nearest whole Share, forfeited without consideration therefor, or otherwise eliminated.

(c) Termination of Employment.

(i) If the Participant is party to an employment agreement, upon termination of employment, the employment agreement will control, in accordance with Section 2 of this Agreement. In the event the Participant is not party to an employment agreement or such employment agreement does not provide for treatment of RSUs upon termination of employment, the following shall apply:

(ii) The RSUs shall cease vesting as of the date of termination if the Participant's employment with the Company (and any parent or subsidiary thereof) is terminated for any reason by the Company or by the Participant other than:

- (i) by reason of death or disability (within the meaning of Section 409A(a)(2)(c) of the Internal Revenue Code of 1986, as amended (the "Code")), In the event the Participant's employment with the Company (and any parent or subsidiary thereof) is terminated by reason of death or disability (as defined previously in this Section 4(c)), the pro-rata amount of RSUs attributable to the number of completed months employed between the Grant Date and the Termination Date shall immediately vest and be paid on the date of such death or disability (or within thirty (30) days thereafter);

- (ii) the Participant is covered by the Severance Plan and the RSUs will be treated in accordance with the Severance Plan; or

- (iii) by reason of Qualified Retirement. In the event the Participant's employment with the Company (and any parent or subsidiary thereof) is terminated by reason of a Qualified Retirement, the RSUs shall cease vesting one year following the date of termination, and any RSUs that vest during such one-year period shall be payable on the applicable Vesting Date on which they otherwise would have been paid in accordance with Section 4(a). A Qualified Retirement is a retirement made pursuant to a bona-fide notice of retirement made 90 days in advance, by a Participant who is at least 55 years old and has been employed at the Company for at least 10 years.

(d) Compliance Restrictions. The Company shall not be obligated to issue to the Participant the Shares upon the vesting of any RSU (or otherwise) unless (i) the Participant has complied with covenants set forth in Section 9 of this Agreement and (ii) the issuance and delivery of such Shares shall comply with all relevant provisions of law and other legal requirements including any applicable federal or state securities laws and the requirements of any stock exchange or quotation system upon which Common Stock may then be listed or quoted.

5. Restrictions on Transfer.

The RSUs may not be sold, assigned, transferred, pledged or otherwise encumbered by the Participant, either voluntarily or by operation of law, except to the Participant's beneficiary as provided in Section 4(a) in the event of the Participant's death. The Participant's beneficiary can be designated and recorded with the Company's stock plan administrator or, if no election is made with the stock plan administrator, Shares will be distributed to the Participant's beneficiary under the Centene Management Corporation Retirement Plan. In the absence of any such beneficiary designation, benefits remaining unpaid at the Participant's death shall be paid to the Participant's executor, administrator, or legal representative.

6. No Rights as a Stockholder; Dividend Equivalents.

Except as set forth in the Plan, neither the Participant nor any person claiming under or through the Participant shall be, or shall have any rights or privileges of, a stockholder of the Company in respect of any Share issuable pursuant to the RSUs granted hereunder until such Share has been delivered to the Participant. Notwithstanding the foregoing or any provision of the Plan to the contrary, to the extent dividends are paid on shares of Common Stock and such dividends have a record date that is on or after the Grant Date but prior to the distribution of the Shares pursuant to the vesting of the RSUs, then the Participant shall be credited with an amount equivalent to the dividends that would have been paid to the Participant for each RSU granted to the Participant pursuant to this Agreement, as determined by the Compensation Committee in its sole discretion ("Dividend Equivalents"), and such Dividend Equivalents shall be subject to the same vesting and forfeiture restrictions as the RSUs to which they are attributable. Any such Dividend Equivalents shall be paid in cash on any Shares delivered in connection with vested RSUs, subject to applicable tax withholding, no later than thirty (30) days after the RSUs to which such Dividend Equivalents are attributable are distributed; *provided*, that no interest or other earnings will be credited to the Participant with respect to any such Dividend Equivalents.

7. Withholding Taxes; Section 83(b) Election.

(a) No Shares will be delivered pursuant to the vesting of an RSU unless and until the Participant pays to the Company, or makes provision satisfactory to the Company for payment of, the amount required or permitted by federal, state, local and/or foreign tax laws to be withheld with respect to the vesting or settlement of such RSU; *provided*, that, notwithstanding the foregoing, the Participant shall be permitted, with the Company's consent, to satisfy the applicable tax obligations with respect to any shares of RSUs by net share settlement, pursuant to which the Company shall repurchase the largest whole number of shares of RSUs having a Fair Market Value equal to the applicable tax obligations.

(b) The Participant acknowledges that no election under Section 83(b) of the Code may be filed with respect to the RSUs.

8. Provisions of the Plan.

The RSUs are subject to the provisions of the Plan, a copy of which is being furnished to the Participant with this Agreement.

9. Participant's Covenants.

As a material inducement to the Company granting Participant RSUs hereunder, and in exchange for the Company providing Participant access to Company confidential information, Participant agrees to the following, subject to the limitations set forth in Section 9(k):

(a) Non-Competition. During Participant's employment with the Company or any Affiliate of the Company, and for a period of six (6) months after the date Participant's employment ends for any reason (whether voluntarily or involuntarily and whether with or without Cause) (the "Termination Date"), Participant shall not, directly or indirectly, for Participant's own benefit, or on behalf of any other person or entity, (x) become employed by or provide services to any Competitor in a Competing Position within the Restricted Area, or (y) become an owner or holder of any stock or other ownership interest in any competitor, other than as an owner of less than 1% of the outstanding stock of a publicly traded company. Participant shall obtain the Company's written consent prior to accepting a role with a Competitor in a Competing Position by contacting Participant's HR Business Partner at the Company. For the purposes of this Section 9(a), the following definitions shall apply:

(i) The term "Competitor" means any business engaged in any area of business that is the same or substantially similar to any area(s) of business in which the Company and/or any of its Affiliates are engaged as of the Termination Date.

(ii) The term "Competing Position" means a position involving job duties in any segment(s) or area(s) of the Competitor's business that is the same or substantially similar to the segment(s) or area(s) of the Company's or its Affiliates' business (A) in which Participant was involved or had job duties at any time during the last twenty-four (24) months of Participant's employment, or (B) about which Participant learned Confidential Information at any time during the last twenty-four (24) months of Participant's employment.

(iii) The term "Restricted Area" means any state in which the Company or any of its Affiliates conducts business and (A) in which Participant provided services in the last twenty-four (24) months of Participant's employment, or (B) about which Participant learned Confidential Information concerning the Company's or its Affiliates' business in such state in the last twenty-four (24) months of Participant's employment. Without limiting the foregoing, if Participant's job duties in the last twenty-four (24) months of employment materially involved duties pertaining to the business nationwide, the term "Restricted Area" means the entire United States.

(b) Non-Solicitation. Without limiting Participant's obligations in Section 9(a) above, during Participant's employment with the Company or any Affiliate, and for a period of one (1) year after the Termination Date, Participant shall not, directly or indirectly, for Participant's own benefit, or on behalf of any other person or entity:

(i) solicit or accept business from or otherwise divert from Company or any Affiliate any Customers for products or services that are similar to or competitive with products or services offered or sold by the Company or any Affiliate as of the Termination Date;

(ii) attempt to attract any Vendor away from the Company or any Affiliate, or use information regarding the Company's or any Affiliate's Vendors in any way that would detrimentally affect the Company or any Affiliate;

(iii) solicit, hire, recruit, divert or take away: (A) from the Company or any Affiliate the services of any of the employees or agents of the Company or any Affiliate, or induce in any way any non-performance of any of the obligations of such employees or agents to the Company or Affiliate; or (B) from any Vendor providing services to the Company or any Affiliate, any employees or agents of such Vendor if such employees or agents of Vendor are providing services to the Company or any Affiliate through such Vendor.

(c) For the purposes of this Agreement, the following definitions shall apply:

(i) The term "Customers" means any customers of the Company or its Affiliates (1) with which Participant had contact and with which the Company or any Affiliate conducted business in the twenty-four (24)-month period preceding the Termination Date, or (2) about which Participant learned Confidential Information in the twenty-four (24)-month period preceding the Termination Date.

(ii) The phrase "employees or agents" as used in Section 9(b)(iii) above means employees or agents with whom Participant had contact or with whom Participant communicated in the last twenty-four (24) months of Participant's employment with the Company or Affiliate.

(iii) The term "Vendors" means any vendors or suppliers of the Company or its Affiliates (1) with which Participant had contact and with which the Company or any Affiliate conducted business in the twenty-four (24)-month period preceding the Termination Date, or (2) about which Participant learned Confidential Information in the twenty-four (24)-month period preceding the Termination.

(iv) The term "Affiliate" or "Affiliates" means any company controlled by, or under common control with, the Company, including all direct and indirect subsidiaries of the Company.

(d) Confidential Information. Participant agrees, during their employment with the Company or any Affiliate of the Company and at all times after the date Participant's employment ends for any reason, not to use, copy, duplicate, or disclose any Confidential Information owned by or entrusted to Company or its Affiliate(s). For the purposes of this Section 9(d), the following definitions shall apply:

(i) "Confidential Information" shall mean the Company's and any Affiliate's trade secrets and other non-public proprietary information relating to the Company or the business of the Company or any Affiliate, including, but not limited to, information relating to financial statements, customer lists and identities, potential customers, customer contacts, employee skills and compensation, employee data, suppliers, acquisition targets, servicing methods, equipment, programs, strategies and information, analyses, marketing plans and strategies, profit margins, financial, promotional, marketing, training or operational information, and other information developed or used by the Company or any Affiliate that is not known generally to the public or the industry. Confidential Information shall not include any information that is in the public domain or becomes known in the public domain through no wrongful act on the part of Participant.

(e) Subject to Exhibit A, to the extent Participant has agreed or does agree to any post-employment restrictions in any other agreement with the Company or its Affiliates, including the Severance Plan ("Other Agreement"), the post-employment restrictions set forth herein (i.e., Sections 9(a), 9(b) and 9(d)) will run concurrently with the restrictions in the Other Agreement. If there are any inconsistencies between the restrictions in this Agreement and the restrictions in such Other Agreement, the more restrictive restrictions shall still apply.

(f) Defend Trade Secrets Act Notice to Participant. Notwithstanding the foregoing, Participant will not be held criminally or civilly liable under any Federal or State trade secret law for the disclosure of a trade secret that: (i) is made (A) in confidence to a Federal, State, or local government official, either directly or indirectly, or to an attorney, and (B) solely for the purpose of reporting or investigating a suspected violation of law; or (ii) is made in a complaint or other document filed in a lawsuit or other proceeding, if such filing is made under seal. In addition, if Participant files a lawsuit for retaliation by Company for reporting a suspected violation of law, Participant may disclose the trade secret to Participant's attorney and use the trade secret information in the court proceeding if Participant files any document containing the trade secret under seal and does not disclose the trade secret except pursuant to court order.

(g) Return of Information. Any Confidential Information and other business information shall be and remain solely and exclusively the property of Company (or its Affiliate(s), as applicable). Upon the termination of Participant's employment (regardless of whether such termination is with Cause or without Cause or voluntary or involuntary), Participant shall promptly deliver the Confidential Information, along with any and all other documents and electronic files obtained by Participant in the course of Participant's employment with Company or its Affiliate(s) (irrespective of whether such documents and files contain Confidential Information, but excluding documents pertaining to Participant's compensation and benefits), without retaining any copies, notes, or excerpts thereof. Participant shall not remove from the property or premises of Company or its Affiliate(s) any Confidential Information or any other documents or data relating to the business, work, services or sales of Company and/or of its Affiliates, or copies thereof. All Confidential Information, other business information or copies, whether made by Participant or by others, are acknowledged by Participant to be the property of Company and/or its Affiliate(s), and not to be used for the benefit of Participant or for any other person's benefit.

(h) Tolling of Restrictions. Should Participant violate any of the terms of Sections 9(a), 9(b) or 9(d) of this Agreement, the duration of the restrictions contained in Sections 9(a), 9(b) and 9(d) shall be extended by the duration of time during which Participant was in violation of the same.

(i) Assignment of Inventions and other Developments. Participant agrees that his or her duties may include the development, refinement, and/or documentation of Confidential Information or other sensitive business information, including any ideas, inventions, products, programs, and/or works of authorship for the current and intended business and prospects of Company or any of its Affiliates (collectively, "Developments"), all for the exclusive benefit of Company or applicable Affiliate(s). Participant agrees to assign and hereby assigns to Company all rights, titles, and interests Participant may have in or to any invention, innovation, computer program, software, database, discovery, idea, writing, improvement, process, technique or other works (collectively "Intellectual Property") created or conceived by Participant, either alone or jointly with others, during Participant's employment, whether patentable or unpatentable, that: (i) relates in any manner to the actual or anticipated business, research, or development of Company; (ii) results from work assigned to or performed by Participant for Company; and/or (iii) is conceived of or made with the use of Company systems, equipment, supplies, materials, facilities, computer programs, confidential information and/or trade secret information (collectively "Company Resources"). This assignment does not apply to Intellectual Property that meets all of the following criteria: (i) no Company Resources were used in its creation; (ii) the Intellectual Property was developed entirely on Participants own time; (iii) at the time of conception or reduction to practice the Intellectual Property does not relate to Company's business, actual or anticipated research or development; and (iv) the Intellectual Property does not result from any work performed by Participant for Company. Participant shall disclose to Company all Intellectual Property developed during Participant's employment so that Company may determine any rights it may have in such Intellectual Property.

(j) Future Cooperation. Participant agrees to cooperate and be available to the Company on a reasonable basis and at reasonable times to timely respond to questions from the Company that arise out of Participant's former responsibilities with the Company. Additionally, Participant agrees to cooperate and be available to assist in the defense of, and serve as a witness in, any administrative proceeding or litigation faced by the Company concerning matters in which Participant was involved or had knowledge while an employee of the Company.

(k) State-Law Addendum: Modifications and Exceptions. Notwithstanding the restrictions set forth above in this Section 9, if at the time of the Grant Date or the date Participant executes this Agreement Participant primarily resides and works in a state listed in Exhibit A hereto, then the modifications and/or exceptions set forth for such state in Exhibit A shall apply to Participant. In addition, as a general matter, the Company will only seek to enforce this Agreement to the extent permitted under the applicable law of the state where Participant primarily resided and worked for the Company at the time Participant executed this Agreement. Furthermore, with respect to a Participant who is an attorney and employed by the Company or an Affiliate in his or her capacity as an attorney, Section 9(a) shall not apply to such Participant.

(l) Remedies for Breach.

(i) Because the Participant's services are unique and because the Participant has access to the Company's Confidential Information, the parties agree that any breach or threatened breach of any of the terms of this Section 9 will cause irreparable harm to the Company and that money damages alone would be an inadequate remedy. The parties therefore agree that, in the event of any breach or threatened breach of this Section 9, and in addition to all other rights and remedies available to it, the Company may apply to any court of competent jurisdiction for specific performance and/or injunctive or other relief, without a bond, in order to enforce or prevent any violations of the provisions of this Section 9.

(ii) In the event Participant breaches any of the terms of this Section 9, Participant shall immediately forfeit all unvested RSUs, and shall be required to immediately pay to the Company a cash sum in the principal amount equal to the Fair Market Value of all RSUs in which Participant vested in the twenty-four (24)-month period preceding Participant's first breach of Section 9 and of all RSUs vested after Participant's first breach of Section 9, less $2,500, which Participant shall retain as consideration for Participant's continued obligations under Section 9 of this Agreement. For the purposes of this provision, "Fair Market Value" shall mean the stock price for Centene's stock (symbol: CNC) on the New York Stock Exchange (NYSE) as of the closing of the date on which the Shares in question vested (multiplied by the number of Shares vested).

(iii) The rights and remedies set forth above shall be cumulative and in addition to any other rights or remedies to which the Company and its Affiliates may be entitled under any agreement or under the law.

(iv) Nothing in this Agreement, or any other agreement between the Participant and the Company or any of its Affiliates, or otherwise, limits the Participant's ability to communicate directly with and provide information, including documents, not otherwise protected from disclosure by any applicable law or privilege to the U.S. Securities and Exchange Commission (the "SEC") or any other federal, state, local or foreign governmental agency or commission ("Government Agency") or self-regulatory organization regarding possible legal violations, without disclosure to the Company. The Company may not retaliate against the Participant for any of these activities, and nothing in this Agreement requires the Participant to waive any monetary award or other payment that the Participant might become entitled to from the SEC or any other Government Agency or self-regulatory organization. Further, nothing in this Agreement precludes the Participant from filing a charge of discrimination with the U.S. Equal Employment Opportunity Commission or a like charge or complaint with a state or local fair employment practice agency. However, once this Agreement becomes effective, you may not receive a monetary award or any other form of personal relief from the Company in connection with any such charge or complaint that you filed or is filed on your behalf.

(m) Survival. The provisions of this Section 9 shall survive and continue in full force in accordance with their terms notwithstanding any forfeiture, termination or expiration of this Agreement in accordance with its terms or any termination of the Participant's employment for any reason (whether voluntary or involuntary).

10. Miscellaneous.

(a) Severability. The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provision of this Agreement, and each other provision of this Agreement shall be severable and enforceable to the extent permitted by law. If a court of competent jurisdiction should determine that any of the geographic, durational or other provisions of Section 9 of this Agreement are overbroad or otherwise unenforceable because of the scope of such provisions, to the extent allowed by law, such court shall modify such provisions in a manner to render them enforceable, and such provisions, as may be modified, shall be fully enforceable as though set forth herein. Any such modification shall not affect the other provisions or clauses of this Agreement in any respect.

(b) Waiver. Any provision for the benefit of the Company contained in this Agreement may be waived, either generally or in any particular instance, by the Board of Directors of the Company.

(c) Binding Effect. This Agreement shall be binding upon and inure to the benefit of the Company and the Participant and their respective heirs, executors, administrators, legal representatives, successors and assigns, subject to the restrictions on transfer set forth in Section 5 of this Agreement.

(d) Notice. All notices required or permitted hereunder shall be in writing and deemed effectively given upon personal delivery or five days after delivery to a United States Post Office, by registered or certified mail, postage prepaid, addressed to the other party hereto at the address shown beneath his or its respective signature to this Agreement, or at such other address or addresses as either party shall designate to the other in accordance with this subparagraph (d).

(e) Entire Agreement. Other than as provided in Section 2, this Agreement and the Plan constitute the entire agreement between the parties concerning the RSUs, and supersede all prior agreements and understandings relating to the RSUs.

(f) Participant's Acknowledgments. The Participant acknowledges that he or she: (i) has read this Agreement; (ii) has been represented in the preparation, negotiation, and execution of this Agreement by legal counsel of the Participant's own choice or has voluntarily declined to seek such counsel; (iii) understands the terms and consequences of this Agreement; and (iv) is fully aware of the legal and binding effect of this Agreement.

(g) Unfunded Rights. The right of the Participant to receive Common Stock pursuant to this Agreement is an unfunded and unsecured obligation of the Company. The Participant shall have no rights under this Agreement other than those of an unsecured general creditor of the Company.

(h) Deferral. Neither the Company nor the Participant may defer delivery of any Shares issuable under unvested RSUs except to the extent that such deferral complies with the provisions of Section 409A of the Code ("Section 409A").

(i) Clawback. By accepting the grant of the RSUs hereunder, the Participant is agreeing to be bound by the Company's clawback policies and procedures, as in effect or as may be adopted and/or modified from time to time by the Company in its discretion (including, without limitation, to comply with applicable law or stock exchange listing requirements).

(j) Section 409A.

(i) This Agreement is intended to comply with the requirements of Section 409A, including the exceptions thereto, and shall be construed and administered in accordance with such intent. Notwithstanding any other provision of this Agreement, payments provided under this Agreement may only be made upon an event and in a manner that complies with Section 409A or an applicable exemption. For purposes of Section 409A, each installment payment provided under this Agreement shall be treated as a separate payment. Any payments to be made under this Agreement in connection with a termination of employment shall only be made if such termination of employment constitutes a "separation from service" under Section 409A. Notwithstanding the foregoing, the Company makes no representations that the payments and benefits provided under this Agreement comply with Section 409A and in no event shall the Company be liable for all or any portion of any taxes, penalties, interest or other expenses that may be incurred by the Participant on account of non-compliance with Section 409A.

(ii) If any provision of this Agreement or the Plan shall be invalid or unenforceable, in whole or in part, or as applied to any circumstance, under the laws of any jurisdiction that may govern for such purpose, or if any provision of this Agreement or the Plan needs to be interpreted to comply with the requirements of Section 409A, then such provision shall be deemed to be modified or restricted, or so interpreted, to the extent and in the manner necessary to render the same valid and enforceable, or to the extent and in the manner necessary to be interpreted in compliance with such requirements of the Code, either generally or as applied to such circumstance, or shall be deemed excised from this Agreement or the Plan, as the case may require, and this Agreement or the Plan shall be construed and enforced to the maximum extent permitted by law as if such provision had been originally incorporated herein as so modified or restricted, or as if such provision had not been originally incorporated herein, as the case may be.

(iii) Notwithstanding any other provision of this Agreement, if at the time of the Participant's termination of employment, the Participant is a "specified employee," determined in accordance with Section 409A, any payments and benefits provided under this Agreement that constitute "nonqualified deferred compensation" subject to Section 409A that are provided to the Participant on account of separation from service shall not be paid until the first payroll date to occur following the six (6)-month anniversary of the Participant's Termination Date ("Specified Employee Payment Date"). The aggregate amount of any payments that would otherwise have been made during such six (6)-month period shall be paid in a lump sum on the Specified Employee Payment Date without interest. If the Participant dies before the Specified Employee Payment Date, any delayed payments shall be paid to the Participant's beneficiary in a lump sum within upon the Participant's death.

(k) Provisions Related to Golden Parachute Excise Tax.

(i) Change in Control When the Shares are Not Publicly Traded. Notwithstanding anything to the contrary contained in this Agreement, to the extent that, upon a Change in Control prior to the time at which the Shares have become publicly traded, any of the payments and benefits provided for under the Plan, any award agreement or any other agreement or arrangement between the Company or any of its Affiliates and the Participant (collectively, the "Payments") would constitute a "parachute payment" within the meaning of Section 280G of the Code (a "Parachute Payment"), the amount of such Payments shall be reduced to the amount (the "Safe Harbor Amount") that would result in no portion of the Payments being treated as an excess parachute payment pursuant to Section 280G of the Code (the "Excise Tax"). If, upon a Change in Control prior to the time at which the Shares have become publicly traded, the Parachute Payments that would otherwise be reduced or eliminated, as the case may be, pursuant to this Section 10(k)(i) could be paid without the loss of a deduction under Section 280G of the Code if the shareholder approval exception to treatment as a Parachute Payment can be and is satisfied, then the Company shall use its reasonable best efforts to cause such Parachute Payments to be submitted for such approval in accordance with Section 280G(b)(5)(B) prior to the Change in Control giving rise to such Parachute Payments. If such approval is received, any reduction or forfeiture pursuant to this Section 10(k)(i) shall be reversed, and the subject amount shall be payable to the Participant without regard to this Section 10(k).

(ii) Change in Control When the Shares are Publicly Traded. If upon a Change in Control occurring at any time that the Shares are publicly traded, any Payments would constitute Parachute Payments, then, if and solely to the extent that reducing the benefits payable hereunder would result in the Participant's receiving a greater amount, on an after-tax basis, taking into account any Excise Tax and all applicable income, employment and other taxes payable on such amounts, the amounts payable hereunder shall be reduced or eliminated, as the case may be, so that the total amount of Parachute Payments received by the Participant do not exceed the Safe Harbor Amount.

(iii) Order of Reduction in Payments. Any reduction in the amount of compensation or benefits effected pursuant to this Section 10(k) shall first come, in order and, in each case, solely to the extent necessary, from any cash severance benefits payable to the Participant, then from any other payments which are treated in their entirety as Parachute Payments and then from any other Parachute Payments payable to the Participant with the later possible payment or Vesting Date being reduced or eliminated before a payment or benefit with an earlier payment or Vesting Date; *provided* that if the foregoing order of reduction or elimination would violate Section 409A, then the reduction shall be made pro-rata among the payments or benefits otherwise due or payable to the Participant.

(l) Consent to Electronic Delivery; Electronic Signature.

In lieu of receiving documents in paper format, the Participant accepts the electronic delivery of any documents by the Company, or any third party involved in administering the Plan that the Company may designate, may deliver in connection with this Award (including the Plan, this Agreement, account statements, or other communications or information) whether via the Company's intranet or the internet site of such third party or via email or such other means of electronic delivery specified by the Company. The Participant hereby consents to receive such documents by electronic delivery and agrees to participate in the Plan through an on-line or electronic system established and maintained by the Company or any third party involved in administering the Plan that the Company may designate and agrees that the Participant's electronic signature is the same as, and shall have the same force and effect as, the Participant's manual signature.

ELECTRONIC ACCEPTANCE

By the Participant's electronic acceptance hereof, the Participant and the Company agree that this Award is granted and governed by the terms and conditions of the Plan and this Agreement.

By the Participant's electronic acceptance hereof, the Participant agrees that in lieu of receiving documents in paper format, the Participant accepts the electronic delivery of any documents by the Company, or any third party involved in administering the Plan that the Company may designate, may deliver in connection with this Award (including the Plan, this Agreement, account statements, or other communications or information) whether via the Company's intranet or the internet site of such third party or via email or such other means of electronic delivery specified by the Company. The Participant hereby consents to receive such documents by electronic delivery and agrees to participate in the Plan through an on-line or electronic system established and maintained by the Company or any third party involved in administering the Plan that the Company may designate.

Exhibit A

State Law Addendum:

Modifications and Exceptions to Restrictions in Restricted Stock Unit Agreement

If Participant primarily resides and works in one of the following states as of the date Participant executes this Restricted Stock Unit Agreement ("Effective Date") (to which this Exhibit A is attached) (the "Agreement"), the following exceptions and acknowledgments applicable to such state shall apply to Participant, notwithstanding anything to the contrary in this Agreement or the Plan:

**ARKANSAS. (a)If Participant is a person holding a professional license under Arkansas Code Title 17, Subtitle 3, Section 9(a) will not apply to Participant; (b) if Participant is a physician, Section 9(a) shall not restrict such Participant's right to practice medicine within the physician's scope of practice; and (c)the duration of the restriction in Section 9(d) shall be during Participant's employment and for a period of five (5) years after the date Participant's employment ends for any reason for Confidential Information that does not constitute a "trade secret" under applicable state or federal law, and during Participant's employment and at all times after the date Participant's employment ends for any reason for Confidential Information that does constitute a "trade secret" under applicable state or federal law.

**CALIFORNIA.

Section 9(a) and (b) will only apply to Participant during Participant's employment. In addition, California law shall apply to Participant's rights and obligations under the Agreement and, unless preempted by federal law, under the Plan.

Participant understands and acknowledges that any provision in this Agreement requiring the Participant to assign (or otherwise providing for ownership by the Company of) rights to an invention does not apply to any invention that qualifies fully under the provisions of California Labor Code Section 2870 (a copy of which is attached below), including any idea or invention that is developed entirely on Participant's own time without using the Company's equipment, supplies, facilities or trade secret information, and that does not either (i) relate to the Company's business, or actual or demonstrably anticipated research or development of the Company or (ii) result from any work performed by the Participant for the Company.

**COLORADO. (1) Participant acknowledges that Participant was provided a copy of this Agreement at least 14 days before the earlier of the effective date of the RSU Agreement and Sections 9(a) and (b) contained therein; (2) if Participant is a healthcare provider as defined under Colorado Revised Statutes Section 8-2-113, et seq., Sections 9(a) and (b) shall not be interpreted to restrict Participant practicing medicine, nursing, midwifery or dentistry; and (3) Colorado law shall apply to Participant's rights and obligations under Section 9 of the RSU Agreement.

**FLORIDA. (1) Participant shall have at least 7 calendar days to review and consider this Agreement from the date Participant received this document; *provided*, *however*, Participant is permitted to accept this Award before the expiration of the foregoing 7-day period; and (2) the Company hereby advises Participant to consult with an attorney prior to accepting and entering into the Agreement (however, any such legal consultation shall be at Participant's own expense). Also, and in order to comply with applicable Florida statutory law: The duration of the restriction in Section 9(d) shall be during Participant's employment and for a period of five (5) years after the date Participant's employment ends for any reason for Confidential Information that does not constitute a "trade secret" under applicable state or federal law, and during Participant's employment and for a period of ten (10) years after the date Participant's employment ends for any reason for Confidential Information that does constitute a "trade secret" under applicable state or federal law.

**ILLINOIS. (1) Participant shall have at least 14 calendar days to review and consider this Agreement from the date Participant received this document; *provided*, *however*, Participant is permitted to accept this Award before the expiration of the foregoing 14-day period; (2) the Company hereby advises Participant to consult with an attorney prior to accepting and entering into the Agreement (however, any such legal consultation shall be at Participant's own expense); and (3) the restrictions in Section 9(a) and (b) shall not apply with respect to the provision of mental health services to veterans and first responders by any licensed mental health professional in the state of Illinois if the enforcement of such provisions is likely to result in an increase in cost or difficulty for any veteran or first responder seeking mental health services.

**LOUISIANA. After the termination of Participant's employment Sections 9(a) and 9(b) shall apply only in the following parishes in the State of Louisiana: Acadia, Allen, Ascension, Assumption, Avoyelles, Beauregard, Bienville, Bossier, Caddo, Calcasieu, Caldwell, Cameron, Catahoula, Claiborne, Concordia, De Soto, East Baton Rouge, East Carroll, East, Feliciana, Evangeline, Franklin, Grant, Iberia, Iberville, Jackson, Jefferson, Jefferson Davis, La Salle, Lafayette, Lafourche, Lincoln, Livingston, Madison, Morehouse, Natchitoches, Orleans, Ouachita, Plaquemines, Pointe Coupee, Rapides, Red River, Richland, Sabine, St. Bernard, St. Charles, St. Helena, St. James, St. John The Baptist, St. Landry, St. Martin, St. Mary, St. Tammany, Tangipahoa, Tensas, Terrebonne, Union, Vermilion, Vernon, Washington, Webster, West Baton Rouge, West Carroll, West Feliciana, and Winn. Provided, however, that if Participant is a physician and practiced medicine as the Company's or an affiliate's employee, Sections 9(a) and 9(b) shall not restrict Participant practicing primarily in family medicine, general internal medicine, general pediatrics, general obstetrics, or gynecology.

**MAINE. (1) The terms of Section 9(a) of this Agreement regarding Participant's post-termination obligations do not take effect until the later of (a) one (1) year of Participant's employment with the Company or (b) a period of six (6) months from the date that Participant accepted the RSU Agreement; (2) Participant acknowledges that Participant was provided with at least 3 days to review this Agreement from the date Participant received the Award document; *provided*, *however*, that Participant is permitted to accept this Agreement earlier than the expiration of such (3) day review period.

**MASSACHUSETTS. (1) Participant acknowledges that Participant was provided with at least 10 business days to review this Agreement from the date Participant received this document; *provided*, *however*, Participant is permitted to accept this Agreement earlier than the expiration of such 10 day review period; (2) Participant understands that Participant has the right to consult with an attorney prior to accepting the Agreement, but that any legal consultation is at Participant's own expense; (3) Participant acknowledges that Participant has had an adequate opportunity to consult with an attorney, Participant has read and understands this Agreement, and is voluntarily accepting the Agreement; (4) the terms of this Agreement, including the benefits of the Plan, are being provided as consideration for Participant's agreement to the restrictions in Section 9(a) of the Agreement; (5) Section 9(a) will not apply if Participant is terminated without Cause or laid off, unless the Parties enter into a separation or severance agreement, pursuant to which Participant receives severance pay (in which case the non-compete restriction in Section 9(a) shall be limited to the duration of the severance pay); and (6) Sections 9(a) and 9(b) shall not be enforced to restrict the right of any physician, psychologist, nurse or social worker from engaging in the practice of their profession (i.e. providing services to individual patients and clients).

**MINNESOTA. Section 9(a) will only apply to Participant during Participant's employment. In addition, Minnesota law shall apply to Participant's rights and obligations under Section 9 of the Agreement.

**NEBRASKA. Section 9(a) will not apply after the termination of Participant's employment.

**NEVADA. (1) After the termination of Participant's employment Sections 9(a) and 9(b) will not prohibit Participant from providing service to a former provider or customer of the Company if Participant can demonstrate that (a) Participant did not solicit the former provider or customer, (b) the former provider or customer voluntarily chose to leave the Company and seek services from Participant, and (c) Participant is otherwise complying with the limitations in this Agreement other than any limitation on providing services to a former provider or customer who seeks the services of Participant without any contact instigated by Participant; and (2) if Participant's employment is terminated as a result of a reduction of force, reorganization, or similar restructuring, Section 9(a) will only apply during the period Company is paying the Participant's salary, benefits, or equivalent compensation including, without limitation, severance pay.

**NORTH DAKOTA. Sections 9(a) and 9(b) will apply to Participant only during Participant's employment and will not apply after Participant's employment ends.

**OKLAHOMA. (1) Section 9(a) will not apply after the termination of Participant's employment; and (2) Section 9(b) with respect to providers and customers, will apply after Participant's employment only with respect to providers or customers of the Company that are "established customers" of the Company per Okla. Stat. Ann. tit. 15, § 219A.

**OREGON. (1) Participant acknowledges that Participant was provided with at least two weeks to review this Agreement and that accepting this Agreement before the expiration of this two-week period shall serve as a waiver of the two-week review period; and (2) Participant acknowledges that the benefits set out in the Plan constitutes consideration for the Agreement.

California Labor Code § 2870.

Employment agreements; assignment of rights

(a) Any provision in an employment agreement which provides that an employee shall assign, or offer to assign, any of his or her rights in an invention to his or her employer shall not apply to an invention that the employee developed entirely on his or her own time without using the employer's equipment, supplies, facilities, or trade secret information except for those inventions that either:

(1) Relate at the time of conception or reduction to practice of the invention to the employer's business, or actual or demonstrably anticipated research or development of the employer; or

(2) Result from any work performed by the employee for the employer.

(b) To the extent a provision in an employment agreement purports to require an employee to assign an invention otherwise excluded from being required to be assigned under subdivision (a), the provision is against the public policy of this state and is unenforceable.

CENTENE CORPORATION

Performance-Based Restricted Stock Unit Agreement Granted Under
2025 Stock Incentive Plan

THIS AGREEMENT is entered into by Centene Corporation, a Delaware corporation (hereinafter the "Company"), and **<<Participant Name>>** (hereinafter the "Participant").

WHEREAS, the Participant renders important services to the Company and acquires access to Confidential Information (as defined below) of the Company in connection with the Participant's relationship with the Company; and

WHEREAS, the Company desires to align the long-term interests of its valued employees with those of the Company by providing the ownership interest granted herein;

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements herein contained, the parties hereto hereby agree as follows:

1. Grant of RSUs.

This Agreement evidences the grant by the Company on **<<Grant Date>>** (or the "Grant Date") to **<<Participant Name>>** of **<<PSU Target>>** restricted stock units (each an "RSU," and collectively, the "RSUs") pursuant to the Company's 2025 Stock Incentive Plan (the "Plan"), that will settle in shares of common stock, $.001 par value per share, of the Company ("Common Stock"), as provided in this RSU Agreement (the "Agreement"). The shares of Common Stock that are issuable upon vesting of the RSUs are referred to in this Agreement as "Shares." Capitalized terms not otherwise defined in this Agreement have the meanings ascribed to such terms in the Plan.

2. Performance Condition and Vesting.

(a) Subject to Sections 3 and 4 of this Agreement, the RSUs vest on **[Vest Date]** (the "Vesting Date"), subject to satisfying the performance conditions set forth on Exhibit A and on the Participant's continued employment with the Company through the Vesting Date. For each RSU earned as set forth on Exhibit A, the Participant will be entitled to receive between zero and two Shares, based upon the level of achievement of the applicable performance conditions in the manner set forth on Exhibit A.

(b) In the event the Participant has an employment agreement, and RSUs qualify for accelerated or continued vesting under such employment agreement, as in effect from time to time, all RSUs shall vest in accordance with the provisions outlined in the Participant's employment agreement; provided that such accelerated or continued vesting shall not change the timing of settlement of the RSUs, which shall continue to be governed by this Agreement, and unless specifically provided in the Participant's employment agreement, the level of achievement of the applicable performance conditions shall remain subject to Exhibit A. Furthermore, if any defined term used herein is also defined in the Participant's employment agreement, then the definition that is more favorable to the Participant will control.

3. Reorganization Event.

The foregoing vesting schedule notwithstanding, if a Change in Control (as defined in the Plan) occurs prior to the end of the performance period, the relevant performance conditions set forth in Exhibit A will be deemed satisfied at the greater of the actual performance level at the time of the Change in Control and the target performance level (the greater of such levels, the "Deemed Performance Level").

If the RSUs are not assumed, continued or substituted pursuant to the Section 9(j)(i) of the Plan, then the RSUs will accelerate at the Deemed Performance Level upon the Change in Control in accordance with Section 9(j)(ii) of the Plan.

If the RSUs are assumed, continued or substituted pursuant to Section 9(j)(i) of the Plan, then the RSUs will remain outstanding based on the Deemed Performance Level and will continue to vest in accordance with their terms following the Change in Control. Furthermore, in such event, if the Participant's employment with the Company (and any parent or subsidiary thereof) is terminated by the Company (or a parent or subsidiary thereof) without Cause (as defined below) or by the Participant for Good Reason (as defined below), and the Participant's date of termination occurs (or in the case of the Participant's termination of employment for Good Reason, the event giving rise to Good Reason occurs) within twenty-four (24) months following the Change in Control, all of the RSUs that are not vested at the time of the Participant's termination shall vest at the Deemed Performance Level, and other vesting criteria shall be deemed met as of the date of the Participant's termination. "Cause" shall mean acts or omissions that the Company determines, after affording the Participant an opportunity to be heard, (i) are criminal, dishonest or fraudulent or constitute misconduct that reflects negatively on the reputation of the Company (including any parent, subsidiary, Affiliate or division of the Company); (ii) could expose the Company or any parent, subsidiary, Affiliate or division of the Company to claims of illegal harassment or discrimination in employment; (iii) are material breaches of this Agreement or other agreement with the Company; or (iv) reflect continued and repeated failure to (A) perform substantially the duties of his/her employment (other than any such failure resulting from the Participant's physical or mental impairment or incapacity) or (B) to comply with any material written policy of the Company. "Good Reason" shall mean: (a) if the Participant is a party to the Executive Severance and Change in Control Plan or the Centene Corporation Severance Pay Plan (as may be amended from time to time, as applicable, the "Severance Plan) or an employment or service agreement with the Company or its Affiliates and such agreement provides for a definition of Good Reason, the definition contained therein; or (b) if the Participant is not party to such agreement or if such agreement does not define Good Reason, without the Participant's prior written consent, at or after a Change in Control, (i) a reduction in the Participant's annual base salary or annual target bonus opportunity from those in effect immediately prior to the Change in Control; (ii) a material reduction in the Participant's authority, duties or responsibilities from those in effect immediately prior to the Change in Control, or (iii) a demand by the Company or the entity surviving the transaction that resulted in the Change in Control that the Participant relocate to a primary work location more than fifty (50) miles from the Participant's primary work location immediately prior to such relocation; *provided* that such proposed relocation results in a greater commute for the Participant based on the Participant's residence immediately prior to such relocation. The Participant must provide written notice to the Company of the existence of Good Reason no later than ninety (90) days after its initial existence, and the Company shall have a period of thirty (30) days following its receipt of such written notice during which it may remedy in all material respects the Good Reason condition identified in such written notice. If the Company fails to remedy in all material respects such Good Reason condition, the Participant shall have ninety (90) days to terminate his/her employment for Good Reason.

4. Distribution of Shares.

(a) Timing of Distribution. The Company will distribute to the Participant (or to the Participant's beneficiary in the event of the death of the Participant occurring after a Vesting Date but before distribution of the corresponding Shares), as soon as administratively practicable after the Vesting Date (but in no event later than March 15 of the year following the year vesting occurs or, if the RSUs are "nonqualified deferred compensation" within the meaning of Section 409A of the Internal Revenue Code of 1986, as amended (the "Code," and collectively, "Section 409A")), by no later than the latest date permitted by Treasury Regulation Section 1.409A-3(d)), the Shares represented by RSUs that vested on such Vesting Date.

(b) No Fractional Shares. No fractional Shares shall be issuable pursuant to any RSU. In lieu of any fractional Shares to which the Participant would otherwise be entitled, the Company may, in its discretion, determine whether to pay, in lieu of such fractional Share, cash in an amount equal to such fractional Share multiplied by the Fair Market Value (as defined in the Plan) of a share of Common Stock, or whether any such fractional Share should be rounded down to the nearest whole Share, forfeited without consideration therefor, or otherwise eliminated.

(c) Termination of Employment.

- If the Participant is party to an employment agreement, upon termination of employment, the employment agreement will control, in accordance with Section 2 of this Agreement. In the event the Participant is not party to an employment agreement or such employment agreement does not provide for treatment of RSUs upon termination of employment, the following shall apply:

- The RSUs shall cease vesting as of the date of termination if the Participant's employment with the Company (and any parent or subsidiary thereof) is terminated for any reason by the Company or by the Participant other than:

  (i) by reason of death or disability (within the meaning of Section 409A(a)(2)(c) of the Code). In the event the Participant's employment with the Company (and any parent or subsidiary thereof) is terminated by reason of death or disability (as defined previously in this Section 4(c)), the pro-rata amount of RSUs at target performance level (or, following a Change in Control, at the Deemed Performance Level), based on the number of full months employed with the Company during the period commencing on the Grant Date and ending on the Vesting Date, shall immediately vest and be payable.

  (ii) by reason of Qualified Retirement (as defined below). In the event the Participant's employment with the Company (and any parent or subsidiary thereof) is terminated by reason of a Qualified Retirement, the pro-rata amount of RSUs, based on the number of full months employed with the Company during the vesting period, shall remain eligible to vest based on the Company's performance during the performance period compared to the metrics as described in Exhibit A (and, if a Change in Control occurs before the end of the performance period, the Company performance shall be deemed met based on the Deemed Performance Level). Any such RSUs which are earned shall be distributed in accordance with Section 4(a) above. A Qualified Retirement is a retirement made pursuant to a bona-fide notice of retirement made ninety (90) days in advance by a Participant who is at least fifty-five (55) years old and has been employed at the Company for at least ten (10) years.

  (iii) If the Participant is covered by the Severance Plan, the RSUs will be treated in accordance with the Severance Plan.

(d) Compliance Restrictions. The Company shall not be obligated to issue to the Participant the Shares upon the vesting of any RSU (or otherwise) unless (i) the Participant has complied with covenants set forth in Section 9 of this Agreement and (ii) the issuance and delivery of such Shares shall comply with all relevant provisions of law and other legal requirements including any applicable federal or state securities laws and the requirements of any stock exchange or quotation system upon which Common Stock may then be listed or quoted.

5. Restrictions on Transfer.

The RSUs may not be sold, assigned, transferred, pledged or otherwise encumbered by the Participant, either voluntarily or by operation of law, except to the Participant's beneficiary as provided in Section 4(a) in the event of the Participant's death. The Participant's beneficiary can be designated and recorded with the Company's stock plan administrator or, if no election is made with the stock plan administrator, Shares will be distributed to the Participant's beneficiary under the Centene Management Corporation Retirement Plan. In the absence of any such beneficiary designation, benefits remaining unpaid at the Participant's death shall be paid to the Participant's executor, administrator, or legal representative.

6. No Rights as a Stockholder; Dividend Equivalents.

Except as set forth in the Plan, neither the Participant nor any person claiming under or through the Participant shall be, or shall have any rights or privileges of, a stockholder of the Company in respect of any Share issuable pursuant to the RSUs granted hereunder until such Share has been delivered to the Participant. Notwithstanding the foregoing or any provision of the Plan to the contrary, to the extent dividends are paid on shares of Common Stock and such dividends have a record date that is on or after the Grant Date but prior to the distribution of the Shares pursuant to the vesting of the RSUs, then the Participant shall be credited with an amount equivalent to the dividends that would have been paid to the Participant for each RSU granted to the Participant pursuant to this Agreement (assuming maximum performance), as determined by the Compensation Committee in its sole discretion ("Dividend Equivalents"), and such Dividend Equivalents shall be subject to the same vesting and forfeiture restrictions as the RSUs to which they are attributable. Any such Dividend Equivalents shall be paid in cash on any Shares delivered in connection with vested RSUs, subject to applicable tax withholding, no later than thirty (30) days after the RSUs to which such Dividend Equivalents are attributable are distributed; *provided*, that no interest or other earnings will be credited to the Participant with respect to any such Dividend Equivalents.

7. Withholding Taxes; Section 83(b) Election.

(a) No Shares will be delivered pursuant to the vesting of an RSU unless and until the Participant pays to the Company, or makes provision satisfactory to the Company for payment of, the amount required or permitted by federal, state, local and/or foreign tax laws to be withheld with respect to the vesting or settlement of such RSU; *provided*, that, notwithstanding the foregoing, the Participant shall be permitted, with the Company's consent, to satisfy the applicable tax obligations with respect to any shares of RSUs by net share settlement, pursuant to which the Company shall repurchase the largest whole number of shares of RSUs having a Fair Market Value equal to the applicable tax obligations.

(b) The Participant acknowledges that no election under Section 83(b) of the Code may be filed with respect to the RSUs.

8. Provisions of the Plan.

The RSUs are subject to the provisions of the Plan, a copy of which is being furnished to the Participant with this Agreement.

9. Participant's Covenants.

As a material inducement to the Company granting Participant RSUs hereunder, and in exchange for the Company providing Participant access to Company confidential information, Participant agrees to the following, subject to the limitations set forth in Section 9(k):

(a) Non-Competition. During Participant's employment with the Company or any Affiliate of the Company, and for a period of nine (9) months after the date Participant's employment ends for any reason (whether voluntarily or involuntarily and whether with or without Cause) (the "Termination Date"), Participant shall not, directly or indirectly, for Participant's own benefit, or on behalf of any other person or entity, (x) become employed by or provide services to any Competitor in a Competing Position within the Restricted Area, or (y) become an owner or holder of any stock or other ownership interest in any competitor, other than as an owner of less than 1% of the outstanding stock of a publicly traded company. Participant shall obtain the Company's written consent prior to accepting a role with a Competitor in a Competing Position by contacting Participant's HR Business Partner at the Company. For the purposes of this Section 9(a), the following definitions shall apply:

(i) The term "Competitor" means any business engaged in any area of business that is the same or substantially similar to any area(s) of business in which the Company and/or any of its Affiliates are engaged as of the Termination Date.

(ii) The term "Competing Position" means a position involving job duties in any segment(s) or area(s) of the Competitor's business that is the same or substantially similar to the segment(s) or area(s) of the Company's or its Affiliates' business (A) in which Participant was involved or had job duties at any time during the last twenty-four (24) months of Participant's employment, or (B) about which Participant learned Confidential Information at any time during the last twenty-four (24) months of Participant's employment.

(iii) The term "Restricted Area" means any state in which the Company or any of its Affiliates conducts business and (A) in which Participant provided services in the last twenty-four (24) months of Participant's employment, or (B) about which Participant learned Confidential Information concerning the Company's or its Affiliates' business in such state in the last twenty-four (24) months of Participant's employment. Without limiting the foregoing, if Participant's job duties in the last twenty-four (24) months of employment materially involved duties pertaining to the business nationwide, the term "Restricted Area" means the entire United States.

(b) Non-Solicitation. Without limiting Participant's obligations in Section 9(a) above, during Participant's employment with the Company or any Affiliate, and for a period of one (1) year after the Termination Date, Participant shall not, directly or indirectly, for Participant's own benefit, or on behalf of any other person or entity:

(i) solicit or accept business from or otherwise divert from Company or any Affiliate any Customers for products or services that are similar to or competitive with products or services offered or sold by the Company or any Affiliate as of the Termination Date;

(ii) attempt to attract any Vendor away from the Company or any Affiliate, or use information regarding the Company's or any Affiliate's Vendors in any way that would detrimentally affect the Company or any Affiliate;

(iii) solicit, hire, recruit, divert or take away: (A) from the Company or any Affiliate the services of any of the employees or agents of the Company or any Affiliate, or induce in any way any non-performance of any of the obligations of such employees or agents to the Company or Affiliate; or (B) from any Vendor providing services to the Company or any Affiliate, any employees or agents of such Vendor if such employees or agents of Vendor are providing services to the Company or any Affiliate through such Vendor.

(c) For the purposes of this Agreement, the following definitions shall apply:

(i) The term "Customers" means any customers of the Company or its Affiliates (1) with which Participant had contact and with which the Company or any Affiliate conducted business in the twenty-four (24)-month period preceding the Termination Date, or (2) about which Participant learned Confidential Information in the twenty-four (24)-month period preceding the Termination Date.

(ii) The phrase "employees or agents" as used in Section 9(b)(iii) above means employees or agents with whom Participant had contact or with whom Participant communicated in the last twenty-four (24) months of Participant's employment with the Company or Affiliate.

(iii) The term "Vendors" means any vendors or suppliers of the Company or its Affiliates (1) with which Participant had contact and with which the Company or any Affiliate conducted business in the twenty-four (24)-month period preceding the Termination Date, or (2) about which Participant learned Confidential Information in the twenty-four (24)-month period preceding the Termination.

(iv) The term "Affiliate" or "Affiliates" means any company controlled by, or under common control with, the Company, including all direct and indirect subsidiaries of the Company.

(d) Confidential Information. Participant agrees, during their employment with the Company or any Affiliate of the Company and at all times after the date Participant's employment ends for any reason, not to use, copy, duplicate, or disclose any Confidential Information owned by or entrusted to Company or its Affiliate(s). For the purposes of this Section 9(d), the following definitions shall apply:

(i) "Confidential Information" shall mean the Company's and any Affiliate's trade secrets and other non-public proprietary information relating to the Company or the business of the Company or any Affiliate, including, but not limited to, information relating to financial statements, customer lists and identities, potential customers, customer contacts, employee skills and compensation, employee data, suppliers, acquisition targets, servicing methods, equipment, programs, strategies and information, analyses, marketing plans and strategies, profit margins, financial, promotional, marketing, training or operational information, and other information developed or used by the Company or any Affiliate that is not known generally to the public or the industry. Confidential Information shall not include any information that is in the public domain or becomes known in the public domain through no wrongful act on the part of Participant.

(e) Subject to Exhibit B, to the extent Participant has agreed or does agree to any post-employment restrictions in any other agreement with the Company or its Affiliates, including the Severance Plan ("Other Agreement"), the post-employment restrictions set forth herein (i.e., Sections 9(a), 9(b) and 9(d)) will run concurrently with the restrictions in the Other Agreement. If there are any inconsistencies between the restrictions in this Agreement and the restrictions in such Other Agreement, the more restrictive restrictions shall still apply.

(f) Defend Trade Secrets Act Notice to Participant. Notwithstanding the foregoing, Participant will not be held criminally or civilly liable under any Federal or State trade secret law for the disclosure of a trade secret that: (i) is made (A) in confidence to a Federal, State, or local government official, either directly or indirectly, or to an attorney, and (B) solely for the purpose of reporting or investigating a suspected violation of law; or (ii) is made in a complaint or other document filed in a lawsuit or other proceeding, if such filing is made under seal. In addition, if Participant files a lawsuit for retaliation by Company for reporting a suspected violation of law, Participant may disclose the trade secret to Participant's attorney and use the trade secret information in the court proceeding if Participant files any document containing the trade secret under seal and does not disclose the trade secret except pursuant to court order.

(g) Return of Information. Any Confidential Information and other business information shall be and remain solely and exclusively the property of Company (or its Affiliate(s), as applicable). Upon the termination of Participant's employment (regardless of whether such termination is with Cause or without Cause or voluntary or involuntary), Participant shall promptly deliver the Confidential Information, along with any and all other documents and electronic files obtained by Participant in the course of Participant's employment with Company or its Affiliate(s) (irrespective of whether such documents and files contain Confidential Information, but excluding documents pertaining to Participant's compensation and benefits), without retaining any copies, notes, or excerpts thereof. Participant shall not remove from the property or premises of Company or its Affiliate(s) any Confidential Information or any other documents or data relating to the business, work, services or sales of Company and/or of its Affiliates, or copies thereof. All Confidential Information, other business information or copies, whether made by Participant or by others, are acknowledged by Participant to be the property of Company and/or its Affiliate(s), and not to be used for the benefit of Participant or for any other person's benefit.

(h) Tolling of Restrictions. Should Participant violate any of the terms of Sections 9(a), 9(b) or 9(d) of this Agreement, the duration of the restrictions contained in Sections 9(a), 9(b) and 9(d) shall be extended by the duration of time during which Participant was in violation of the same.

(i) Assignment of Inventions and other Developments. Participant agrees that his or her duties may include the development, refinement, and/or documentation of Confidential Information or other sensitive business information, including any ideas, inventions, products, programs, and/or works of authorship for the current and intended business and prospects of Company or any of its Affiliates (collectively, "Developments"), all for the exclusive benefit of Company or applicable Affiliate(s). Participant agrees to assign and hereby assigns to Company all rights, titles, and interests Participant may have in or to any invention, innovation, computer program, software,

database, discovery, idea, writing, improvement, process, technique or other works (collectively "Intellectual Property") created or conceived by Participant, either alone or jointly with others, during Participant's employment, whether patentable or unpatentable, that: (i) relates in any manner to the actual or anticipated business, research, or development of Company; (ii) results from work assigned to or performed by Participant for Company; and/or (iii) is conceived of or made with the use of Company systems, equipment, supplies, materials, facilities, computer programs, confidential information and/or trade secret information (collectively "Company Resources"). This assignment does not apply to Intellectual Property that meets all of the following criteria: (i) no Company Resources were used in its creation; (ii) the Intellectual Property was developed entirely on Participants own time; (iii) at the time of conception or reduction to practice the Intellectual Property does not relate to Company's business, actual or anticipated research or development; and (iv) the Intellectual Property does not result from any work performed by Participant for Company. Participant shall disclose to Company all Intellectual Property developed during Participant's employment so that Company may determine any rights it may have in such Intellectual Property.

(j) Future Cooperation. Participant agrees to cooperate and be available to the Company on a reasonable basis and at reasonable times to timely respond to questions from the Company that arise out of Participant's former responsibilities with the Company.Additionally, Participant agrees to cooperate and be available to assist in the defense of, and serve as a witness in, any administrative proceeding or litigation faced by the Company concerning matters in which Participant was involved or had knowledge while an employee of the Company.

(k) State-Law Addendum: Modifications and Exceptions. Notwithstanding the restrictions set forth above in this Section 9, if at the time of the Grant Date or the date Participant executes this Agreement Participant primarily resides and works in a state listed in Exhibit B hereto, then the modifications and/or exceptions set forth for such state in Exhibit B shall apply to Participant. In addition, as a general matter, the Company will only seek to enforce this Agreement to the extent permitted under the applicable law of the state where Participant primarily resided and worked for the Company at the time Participant executed this Agreement. Furthermore, with respect to a Participant who is an attorney and employed by the Company or an Affiliate in his or her capacity as an attorney, Section 9(a) shall not apply to such Participant.

(l) Remedies for Breach.

(i) Because the Participant's services are unique and because the Participant has access to the Company's Confidential Information, the parties agree that any breach or threatened breach of any of the terms of this Section 9 will cause irreparable harm to the Company and that money damages alone would be an inadequate remedy. The parties therefore agree that, in the event of any breach or threatened breach of this Section 9, and in addition to all other rights and remedies available to it, the Company may apply to any court of competent jurisdiction for specific performance and/or injunctive or other relief, without a bond, in order to enforce or prevent any violations of the provisions of this Section 9.

(ii) In the event Participant breaches any of the terms of this Section 9, Participant shall immediately forfeit all unvested RSUs, and shall be required to immediately pay to the Company a cash sum in the principal amount equal to the Fair Market Value of all RSUs in which Participant vested in the twenty-four (24)-month period preceding Participant's first breach of Section 9 and of all RSUs vested after Participant's first breach of Section 9, less $2,500, which Participant shall retain as consideration for Participant's continued obligations under Section 9 of this Agreement. For the purposes of this provision, "Fair Market Value" shall mean the stock price for Centene's stock (symbol: CNC) on the New York Stock Exchange (NYSE) as of the closing of the date on which the Shares in question vested (multiplied by the number of Shares vested).

(iii) The rights and remedies set forth above shall be cumulative and in addition to any other rights or remedies to which the Company and its Affiliates may be entitled under any agreement or under the law.

(iv) Nothing in this Agreement, or any other agreement between the Participant and the Company or any of its Affiliates, or otherwise, limits the Participant's ability to communicate directly with and provide information, including documents, not otherwise protected from disclosure by any applicable law or

privilege to the U.S. Securities and Exchange Commission (the "SEC") or any other federal, state, local or foreign governmental agency or commission ("Government Agency") or self-regulatory organization regarding possible legal violations, without disclosure to the Company. The Company may not retaliate against the Participant for any of these activities, and nothing in this Agreement requires the Participant to waive any monetary award or other payment that the Participant might become entitled to from the SEC or any other Government Agency or self-regulatory organization. Further, nothing in this Agreement precludes the Participant from filing a charge of discrimination with the U.S. Equal Employment Opportunity Commission or a like charge or complaint with a state or local fair employment practice agency. However, once this Agreement becomes effective, you may not receive a monetary award or any other form of personal relief from the Company in connection with any such charge or complaint that you filed or is filed on your behalf.

(m) Survival. The provisions of this Section 9 shall survive and continue in full force in accordance with their terms notwithstanding any forfeiture, termination or expiration of this Agreement in accordance with its terms or any termination of the Participant's employment for any reason (whether voluntary or involuntary).

10. Miscellaneous.

(a) Severability. The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provision of this Agreement, and each other provision of this Agreement shall be severable and enforceable to the extent permitted by law. If a court of competent jurisdiction should determine that any of the geographic, durational or other provisions of Section 9 of this Agreement are overbroad or otherwise unenforceable because of the scope of such provisions, to the extent allowed by law, such court shall modify such provisions in a manner to render them enforceable, and such provisions, as may be modified, shall be fully enforceable as though set forth herein. Any such modification shall not affect the other provisions or clauses of this Agreement in any respect.

(b) Waiver. Any provision for the benefit of the Company contained in this Agreement may be waived, either generally or in any particular instance, by the Board of Directors of the Company.

(c) Binding Effect. This Agreement shall be binding upon and inure to the benefit of the Company and the Participant and their respective heirs, executors, administrators, legal representatives, successors and assigns, subject to the restrictions on transfer set forth in Section 5 of this Agreement.

(d) Notice. All notices required or permitted hereunder shall be in writing and deemed effectively given upon personal delivery or five days after delivery to a United States Post Office, by registered or certified mail, postage prepaid, addressed to the other party hereto at the address shown beneath his or its respective signature to this Agreement, or at such other address or addresses as either party shall designate to the other in accordance with this subparagraph (d).

(e) Entire Agreement. Other than as provided in Section 2, this Agreement and the Plan constitute the entire agreement between the parties concerning the RSUs, and supersede all prior agreements and understandings relating to the RSUs.

(f) Participant's Acknowledgments. The Participant acknowledges that he or she: (i) has read this Agreement; (ii) has been represented in the preparation, negotiation, and execution of this Agreement by legal counsel of the Participant's own choice or has voluntarily declined to seek such counsel; (iii) understands the terms and consequences of this Agreement; and (iv) is fully aware of the legal and binding effect of this Agreement.

(g) Unfunded Rights. The right of the Participant to receive Common Stock pursuant to this Agreement is an unfunded and unsecured obligation of the Company. The Participant shall have no rights under this Agreement other than those of an unsecured general creditor of the Company.

(h) Deferral. Neither the Company nor the Participant may defer delivery of any Shares issuable under unvested RSUs except to the extent that such deferral complies with the provisions of Section 409A.

(i) Clawback. By accepting the grant of the RSUs hereunder, the Participant is agreeing to be bound by the Company's clawback policies and procedures, as in effect or as may be adopted and/or modified from time to time by the Company in its discretion (including, without limitation, to comply with applicable law or stock exchange listing requirements).

(j) Section 409A.

(i) This Agreement is intended to comply with the requirements of Section 409A, including the exceptions thereto, and shall be construed and administered in accordance with such intent. Notwithstanding any other provision of this Agreement, payments provided under this Agreement may only be made upon an event and in a manner that complies with Section 409A or an applicable exemption. For purposes of Section 409A, each installment payment provided under this Agreement shall be treated as a separate payment. Any payments to be made under this Agreement in connection with a termination of employment shall only be made if such termination of employment constitutes a "separation from service" under Section 409A. Notwithstanding the foregoing, the Company makes no representations that the payments and benefits provided under this Agreement comply with Section 409A and in no event shall the Company be liable for all or any portion of any taxes, penalties, interest or other expenses that may be incurred by the Participant on account of non-compliance with Section 409A.

(ii) If any provision of this Agreement or the Plan shall be invalid or unenforceable, in whole or in part, or as applied to any circumstance, under the laws of any jurisdiction that may govern for such purpose, or if any provision of this Agreement or the Plan needs to be interpreted to comply with the requirements of Section 409A, then such provision shall be deemed to be modified or restricted, or so interpreted, to the extent and in the manner necessary to render the same valid and enforceable, or to the extent and in the manner necessary to be interpreted in compliance with such requirements of the Code, either generally or as applied to such circumstance, or shall be deemed excised from this Agreement or the Plan, as the case may require, and this Agreement or the Plan shall be construed and enforced to the maximum extent permitted by law as if such provision had been originally incorporated herein as so modified or restricted, or as if such provision had not been originally incorporated herein, as the case may be.

(iii) Notwithstanding any other provision of this Agreement, if at the time of the Participant's termination of employment, the Participant is a "specified employee," determined in accordance with Section 409A, any payments and benefits provided under this Agreement that constitute "nonqualified deferred compensation" subject to Section 409A that are provided to the Participant on account of separation from service shall not be paid until the first payroll date to occur following the six (6)-month anniversary of the Participant's Termination Date ("Specified Employee Payment Date"). The aggregate amount of any payments that would otherwise have been made during such six (6)-month period shall be paid in a lump sum on the Specified Employee Payment Date without interest. If the Participant dies before the Specified Employee Payment Date, any delayed payments shall be paid to the Participant's beneficiary in a lump sum within upon the Participant's death.

(k) Provisions Related to Golden Parachute Excise Tax.

(i) Change in Control When the Shares are Not Publicly Traded. Notwithstanding anything to the contrary contained in this Agreement, to the extent that, upon a Change in Control prior to the time at which the Shares have become publicly traded, any of the payments and benefits provided for under the Plan, any award agreement or any other agreement or arrangement between the Company or any of its Affiliates and the Participant (collectively, the "Payments") would constitute a "parachute payment" within the meaning of Section 280G of the Code (a "Parachute Payment"), the amount of such Payments shall be reduced to the amount (the "Safe Harbor Amount") that would result in no portion of the Payments being treated as an excess parachute payment pursuant to Section 280G of the Code (the "Excise Tax"). If, upon a Change in Control prior to the time at which the Shares have become publicly traded, the Parachute Payments that would otherwise be reduced or eliminated, as the case may be, pursuant to this Section 10(k)(i) could be paid without the loss of a deduction under Section 280G of the Code if the shareholder approval exception to treatment as a Parachute Payment can be and is satisfied, then the Company shall use its reasonable best efforts to cause such Parachute Payments to be submitted for such approval in accordance with Section 280G(b)(5)(B) prior to the Change in Control giving rise to such Parachute Payments. If

such approval is received, any reduction or forfeiture pursuant to this Section 10(k)(i) shall be reversed, and the subject amount shall be payable to the Participant without regard to this Section 10(k).

(ii) Change in Control When the Shares are Publicly Traded. If upon a Change in Control occurring at any time that the Shares are publicly traded, any Payments would constitute Parachute Payments, then, if and solely to the extent that reducing the benefits payable hereunder would result in the Participant's receiving a greater amount, on an after-tax basis, taking into account any Excise Tax and all applicable income, employment and other taxes payable on such amounts, the amounts payable hereunder shall be reduced or eliminated, as the case may be, so that the total amount of Parachute Payments received by the Participant do not exceed the Safe Harbor Amount.

(iii) Order of Reduction in Payments. Any reduction in the amount of compensation or benefits effected pursuant to this Section 10(k) shall first come, in order and, in each case, solely to the extent necessary, from any cash severance benefits payable to the Participant, then from any other payments which are treated in their entirety as Parachute Payments and then from any other Parachute Payments payable to the Participant with the later possible payment or Vesting Date being reduced or eliminated before a payment or benefit with an earlier payment or Vesting Date; *provided* that if the foregoing order of reduction or elimination would violate Section 409A, then the reduction shall be made pro-rata among the payments or benefits otherwise due or payable to the Participant.

11. Consent to Electronic Delivery; Electronic Signature. In lieu of receiving documents in paper format, the Participant accepts the electronic delivery of any documents by the Company, or any third party involved in administering the Plan that the Company may designate, may deliver in connection with this Award (including the Plan, this Agreement, account statements, or other communications or information) whether via the Company's intranet or the internet site of such third party or via email or such other means of electronic delivery specified by the Company. The Participant hereby consents to receive such documents by electronic delivery and agrees to participate in the Plan through an on-line or electronic system established and maintained by the Company or any third party involved in administering the Plan that the Company may designate, and agrees that the Participant's electronic signature is the same as, and shall have the same force and effect as, the Participant's manual signature.

ELECTRONIC ACCEPTANCE

By the Participant's electronic acceptance hereof, the Participant and the Company agree that this Award is granted and governed by the terms and conditions of the Plan and this Agreement.

By the Participant's electronic acceptance hereof, the Participant agrees that in lieu of receiving documents in paper format, the Participant accepts the electronic delivery of any documents by the Company, or any third party involved in administering the Plan that the Company may designate, may deliver in connection with this Award (including the Plan, this Agreement, account statements, or other communications or information) whether via the Company's intranet or the internet site of such third party or via email or such other means of electronic delivery specified by the Company. The Participant hereby consents to receive such documents by electronic delivery and agrees to participate in the Plan through an on-line or electronic system established and maintained by the Company or any third party involved in administering the Plan that the Company may designate.

Exhibit A

Performance Period: January 1, 20XX, through (and including) December 31, 20XX

Metric	Threshold	Target	Max

Exhibit B

State Law Addendum:

Modifications and Exceptions to Restrictions in Restricted Stock Unit Agreement if Participant primarily resides and works in one of the following states as of the date Participant executes this Restricted Stock Unit Agreement ("Effective Date") (to which this Exhibit A is attached) (the "Agreement"), the following exceptions and acknowledgments applicable to such state shall apply to Participant, notwithstanding anything to the contrary in this Agreement or the Plan:

**ARKANSAS. (a)If Participant is a person holding a professional license under Arkansas Code Title 17, Subtitle 3, Section 9(a) will not apply to Participant; (b) if Participant is a physician, Section 9(a) shall not restrict such Participant's right to practice medicine within the physician's scope of practice; and (c)the duration of the restriction in Section 9(d) shall be during Participant's employment and for a period of five (5) years after the date Participant's employment ends for any reason for Confidential Information that does not constitute a "trade secret" under applicable state or federal law, and during Participant's employment and at all times after the date Participant's employment ends for any reason for Confidential Information that does constitute a "trade secret" under applicable state or federal law.

**CALIFORNIA. Section 9(a) and (b) will only apply to Participant during Participant's employment. In addition, California law shall apply to Participant's rights and obligations under the Agreement and, unless preempted by federal law, under the Plan.
Participant understands and acknowledges that any provision in this Agreement requiring the Participant to assign (or otherwise providing for ownership by the Company of) rights to an invention does not apply to any invention that qualifies fully under the provisions of California Labor Code Section 2870 (a copy of which is attached below), including any idea or invention that is developed entirely on Participant's own time without using the Company's equipment, supplies, facilities or trade secret information, and that does not either (i) relate to the Company's business, or actual or demonstrably anticipated research or development of the Company or (ii) result from any work performed by the Participant for the Company.

**COLORADO. (1) Participant acknowledges that Participant was provided a copy of this Agreement at least 14 days before the earlier of the effective date of the RSU Agreement and Sections 9(a) and (b) contained therein; (2) if Participant is a healthcare provider as defined under Colorado Revised Statutes Section 8-2-113, et seq., Sections 9(a) and (b) shall not be interpreted to restrict Participant practicing medicine, nursing, midwifery or dentistry; and (3) Colorado law shall apply to Participant's rights and obligations under Section 9 of the RSU Agreement.

**FLORIDA. (1) Participant shall have at least 7 calendar days to review and consider this Agreement from the date Participant received this document; *provided*, *however*, Participant is permitted to accept this Award before the expiration of the foregoing 7-day period; and (2) the Company hereby advises Participant to consult with an attorney prior to accepting and entering into the Agreement (however, any such legal consultation shall be at Participant's own expense). Also, and in order to comply with applicable Florida statutory law: The duration of the restriction in Section 9(d) shall be during Participant's employment and for a period of five (5) years after the date Participant's employment ends for any reason for Confidential Information that does not constitute a "trade secret" under applicable state or federal law, and during Participant's employment and for a period of ten (10) years after the date Participant's employment ends for any reason for Confidential Information that does constitute a "trade secret" under applicable state or federal law.

**ILLINOIS. (1) Participant shall have at least 14 calendar days to review and consider this Agreement from the date Participant received this document; *provided*, *however*, Participant is permitted to accept this Award before the expiration of the foregoing 14-day period; (2) the Company hereby advises Participant to consult with an attorney prior to accepting and entering into the Agreement (however, any such legal consultation shall be at Participant's own expense); and (3) the restrictions in Section 9(a) and (b) shall not apply with respect to the provision of mental health services to veterans and first responders by any licensed mental health professional in the state of Illinois if

the enforcement of such provisions is likely to result in an increase in cost or difficulty for any veteran or first responder seeking mental health services.

**LOUISIANA. After the termination of Participant's employment Sections 9(a) and 9(b) shall apply only in the following parishes in the State of Louisiana: Acadia, Allen, Ascension, Assumption, Avoyelles, Beauregard, Bienville, Bossier, Caddo, Calcasieu, Caldwell, Cameron, Catahoula, Claiborne, Concordia, De Soto, East Baton Rouge, East Carroll, East, Feliciana, Evangeline, Franklin, Grant, Iberia, Iberville, Jackson, Jefferson, Jefferson Davis, La Salle, Lafayette, Lafourche, Lincoln, Livingston, Madison, Morehouse, Natchitoches, Orleans, Ouachita, Plaquemines, Pointe Coupee, Rapides, Red River, Richland, Sabine, St. Bernard, St. Charles, St. Helena, St. James, St. John The Baptist, St. Landry, St. Martin, St. Mary, St. Tammany, Tangipahoa, Tensas, Terrebonne, Union, Vermilion, Vernon, Washington, Webster, West Baton Rouge, West Carroll, West Feliciana, and Winn. Provided, however, that if Participant is a physician and practiced medicine as the Company's or an affiliate's employee, Sections 9(a) and 9(b) shall not restrict Participant practicing primarily in family medicine, general internal medicine, general pediatrics, general obstetrics, or gynecology.

**MAINE. (1) The terms of Section 9(a) of this Agreement regarding Participant's post-termination obligations do not take effect until the later of (a) one (1) year of Participant's employment with the Company or (b) a period of six (6) months from the date that Participant accepted the RSU Agreement; (2) Participant acknowledges that Participant was provided with at least 3 days to review this Agreement from the date Participant received the Award document; *provided*, *however*, that Participant is permitted to accept this Agreement earlier than the expiration of such (3) day review period.

**MASSACHUSETTS. (1) Participant acknowledges that Participant was provided with at least 10 business days to review this Agreement from the date Participant received this document; *provided*, *however*, Participant is permitted to accept this Agreement earlier than the expiration of such 10 day review period; (2) Participant understands that Participant has the right to consult with an attorney prior to accepting the Agreement, but that any legal consultation is at Participant's own expense; (3) Participant acknowledges that Participant has had an adequate opportunity to consult with an attorney, Participant has read and understands this Agreement, and is voluntarily accepting the Agreement; (4) the terms of this Agreement, including the benefits of the Plan, are being provided as consideration for Participant's agreement to the restrictions in Section 9(a) of the Agreement; (5) Section 9(a) will not apply if Participant is terminated without Cause or laid off, unless the Parties enter into a separation or severance agreement, pursuant to which Participant receives severance pay (in which case the non-compete restriction in Section 9(a) shall be limited to the duration of the severance pay); and (6) Sections 9(a) and 9(b) shall not be enforced to restrict the right of any physician, psychologist, nurse or social worker from engaging in the practice of their profession (i.e. providing services to individual patients and clients).

**MINNESOTA. Section 9(a) will only apply to Participant during Participant's employment. In addition, Minnesota law shall apply to Participant's rights and obligations under Section 9 of the Agreement.

**NEBRASKA. Section 9(a) will not apply after the termination of Participant's employment.

**NEVADA. (1) After the termination of Participant's employment Sections 9(a) and 9(b) will not prohibit Participant from providing service to a former provider or customer of the Company if Participant can demonstrate that (a) Participant did not solicit the former provider or customer, (b) the former provider or customer voluntarily chose to leave the Company and seek services from Participant, and (c) Participant is otherwise complying with the limitations in this Agreement other than any limitation on providing services to a former provider or customer who seeks the services of Participant without any contact instigated by Participant; and (2) if Participant's employment is terminated as a result of a reduction of force, reorganization, or similar restructuring, Section 9(a) will only apply during the period Company is paying the Participant's salary, benefits, or equivalent compensation including, without limitation, severance pay.

**NORTH DAKOTA. Sections 9(a) and 9(b) will apply to Participant only during Participant's employment and will not apply after Participant's employment ends.

**OKLAHOMA. (1) Section 9(a) will not apply after the termination of Participant's employment; and (2) Section 9(b) with respect to providers and customers, will apply after Participant's employment only with respect to providers or customers of the Company that are "established customers" of the Company per Okla. Stat. Ann. tit. 15, § 219A.

**OREGON. (1) Participant acknowledges that Participant was provided with at least two weeks to review this Agreement and that accepting this Agreement before the expiration of this two-week period shall serve as a waiver of the two-week review period; and (2) Participant acknowledges that the benefits set out in the Plan constitutes consideration for the Agreement.

California Labor Code § 2870.
Employment agreements; assignment of rights

(a) Any provision in an employment agreement which provides that an employee shall assign, or offer to assign, any of his or her rights in an invention to his or her employer shall not apply to an invention that the employee developed entirely on his or her own time without using the employer's equipment, supplies, facilities, or trade secret information except for those inventions that either:

(1) Relate at the time of conception or reduction to practice of the invention to the employer's business, or actual or demonstrably anticipated research or development of the employer; or
(2) Result from any work performed by the employee for the employer.

(b) To the extent a provision in an employment agreement purports to require an employee to assign an invention otherwise excluded from being required to be assigned under subdivision (a), the provision is against the public policy of this state and is unenforceable.

EXHIBIT 19.1

CENTENE CORPORATION

Policy on Inside Information and Insider Trading

I. BACKGROUND/PURPOSE:

Under federal and state securities laws, it is illegal to purchase or sell securities of a company while in possession of material, non-public information related to, affecting or regarding that company or its subsidiaries (such information, "Inside Information"), or to disclose Inside Information to others who then trade in company securities. Insider trading violations are pursued vigorously by the United States Securities and Exchange Commission (the "SEC") and other governmental agencies and can result in severe penalties. While the regulatory authorities usually concentrate their efforts on the individuals who trade, or who tip material, non-public information to others who trade, the federal securities laws also impose potential liability on companies and other "controlling persons" if they fail to take reasonable steps to prevent insider trading by company personnel.

Centene Corporation ("Centene") has adopted this Policy on Inside Information and Insider Trading (this "Policy") both to promote compliance with insider trading laws, rules and regulations, and to help Centene personnel avoid violating insider trading laws, rules and regulations.

II. APPLICABILITY OF POLICY

A. Covered Persons

This Policy applies to all employees of Centene and its subsidiaries, all members of the Board of Directors of Centene and the boards of directors of Centene's subsidiaries (collectively, "directors"), consultants, contractors and any persons (including, but not limited to family members) that reside in the same household as any of the foregoing persons as provided herein. This Policy also applies to any person, partnership, trust or other entity or account whose securities trading decisions are influenced or controlled by any of the foregoing persons. The failure of any person subject to this Policy to observe and strictly adhere to the policies and procedures set forth herein at all times will be grounds for disciplinary action, up to and including termination of employment.

In addition, all those listed on Schedule A hereto (as may be amended from time to time by the General Counsel), as well as any other persons (whether Family Members (as defined below) or not) that reside in the same household as those persons are subject to additional restrictions on their ability to engage in purchase or sale transactions involving Centene securities as discussed in Section IV below.

B. Covered Transactions

This Policy applies to all transactions in Centene's securities, including common stock, debt securities and any securities that are exercisable for, or convertible or exchangeable into, common stock, and any other securities Centene may issue from time to time whether or not pursuant to any benefit plan adopted by Centene except as provided below.

Rule 10b5-1 Plans. Rule 10b5-1 under the Securities Exchange Act of 1934, as amended (the "Exchange Act"), provides an affirmative defense from insider trading liability under the federal securities laws for written trading plans that meet certain requirements ("10b5-1 plans"). You must act in good faith with respect to a 10b5-1 plan when the plan is adopted and for the duration of the plan, and must not enter into a 10b5-1 plan as part of a plan or scheme to evade the prohibitions of Exchange Act Rule 10b-5. A 10b5-1 plan must be adopted at a time when you are not in possession of Inside Information and must (i) specify the amount of securities to be purchased or sold and the price at which and the date on which the securities are to be purchased or sold, (ii) specify or set an objective formula or algorithm for determining the amount of securities to be purchased or sold and the price at which and the date on which the securities are to be purchased or sold, or (iii) delegate discretion on how, when, or whether to effect purchases or sales to an independent third party. You may not adopt or amend a 10b5-1 plan at a time when you are subject to a black-out period, as discussed below. Once a 10b5-1 plan is adopted, you must not exercise any influence over the amount of securities to be traded, the price at which they are to be traded or the date of the trade. Centene requires that all 10b5-1 plans, and any amendment, suspension and termination of such plans, be approved in writing in advance by the General Counsel, and meet the requirements of Rule 10b5-1(c) under the Exchange Act, including:

- 10b5-1 plans may not provide for trades (i) if you are a "Section 16 Person" as defined below, until the later of (a) 90 days after the adoption or amendment of the 10b5-1 plan or (b) two business days following Centene's filing of the Form 10-Q or 10-K for the quarter in which the 10b5-1 plan was adopted or amended, for a maximum of 120 days after the adoption or amendment of the 10b5-1 plan, or (ii) if you are not a Section 16 Person, until at least 30 days following the adoption or amendment of the 10b5-1 plan. The period of delayed effectiveness after adoption or amendment of a 10b5-1 plan is called a "cooling-off period."
- You may not have more than one 10b5-1 plan in effect for open market purchases or sales of Centene securities, except in the following circumstances:
    - This prohibition does not apply to 10b5-1 plans authorizing a written, irrevocable election (an "election") to sell a portion of shares as necessary to satisfy statutory tax withholding obligations arising solely from the vesting of compensatory awards (not including options) ("sales to cover"), provided that (i) the election is made outside a black-out period, (ii) at the time of the election, you are not in possession of any Inside Information, (iii) the sales to cover are made in good faith and not as part of a plan or scheme to evade the prohibitions of Exchange Act Rule 10b-5, (iv) you do not have, and will not attempt to exercise, authority, influence or control over any such sales to cover, and (v) the election contains appropriate representations as to clauses (ii)-(iv);[1]
    - You may maintain two separate 10b5-1 plans, provided that trading under the later-commencing 10b5-1 plan is not authorized to begin until after all trades under the earlier-commencing 10b5-1 plan are completed or have expired without execution (subject to any applicable cooling-off periods), and provided further that if you terminate an earlier-commencing 10b5-1 plan (i.e., the earlier-commencing plan does not end by its terms and without any action by you), the later-commencing 10b5-1 plan will be subject to a cooling-off period beginning on the termination date of the earlier-commencing plan; and
    - A series of separate contracts with different brokers to execute trades under a 10b5-1 plan may be treated as a single plan, provided that this arrangement and each contract have been pre-cleared in writing by the General Counsel and meet the conditions under Exchange Act Rule 10b5-1, and provided further that any amendment of one contract is treated as an amendment of all of the contracts under the plan.

[1] Note: The Company's equity awards granted to employees generally provide for the forfeiture to Centene of equity to cover tax withholding obligations upon vesting as set forth under "*Equity Grants*".

- In any 12-month period, you may not enter into more than one "single-trade" 10b5-1 plan (i.e., a 10b5-1 plan designed to effect the open market purchase or sale of the total amount of Centene securities subject to the plan as a single transaction). This prohibition does not apply to plans (i) authorizing sales to cover, provided that you do not control the timing of such sale or (ii) that give discretion to an agent over whether to execute the 10b5-1 plan as a single transaction or that provide the agent's future acts depend on facts not known at the time of the 10b5-1 plan's adoption and might reasonably result in multiple transactions.

- Any Section 16 Person adopting or modifying a 10b5-1 plan must include in the 10b5-1 plan a written representation certifying that he or she (i) is not aware of Inside Information and (ii) is adopting or modifying the 10b5-1 plan in good faith and not as part of a plan or scheme to evade the prohibitions of Exchange Act Rule 10b-5.

- You may make amendments to 10b5-1 plans without triggering a cooling-off period so long as the amendment does not change the pricing provisions of the 10b5-1 plan, the amount of securities covered under the 10b5-1 plan or the timing of trades under the 10b5-1 plan, or where a broker executing trades on your behalf is substituted by a different broker (so long as the purchase or sales instructions remain the same).

Purchases or sales of Centene securities executed pursuant to a valid 10b5-1 plan approved as provided herein are not subject to the trading restrictions covered by this Policy.

Equity Grants. Certain transactions between you and Centene with respect to grants to you under its equity incentive plans (or, to the extent applicable, granted outside such plans) are not subject to the trading restrictions covered by this Policy. Such transactions include, without limitation, the following:

- the exercise of stock options by paying Centene the exercise price, plus an amount equal to the related tax withholding obligations, in cash (generally referred to as an "exercise-and-hold" transaction);
- the exercise of stock options on a "net exercise" basis pursuant to which an optionee either (i) delivers to Centene outstanding shares of Centene stock or (ii) authorizes Centene to withhold from issuance shares of stock issuable upon exercise of the option, in either case, having a fair market value on the date of exercise equal to the aggregate exercise price;
- the forfeiture to Centene of restricted stock, restricted stock units, or performance stock units, to cover withholding tax obligations upon vesting of restricted stock, restricted stock units or performance stock units; or
- purchases of Centene stock pursuant to Centene's employee stock purchase plan, deferred compensation plan and/or 401(k) plan resulting from your periodic contribution of money to the plan pursuant to an election you make at the time you enroll in the plan, provided that that the trading restrictions contained in this Policy would apply to your election to participate in an employee stock purchase plan for any enrollment period, and to your subsequent sales of Centene stock purchased pursuant to the plan.

Thus, restrictions contained in this Policy would apply to the sale of Centene stock in the open market to pay the exercise price of an option and to the "cashless exercise" affected through a broker or "same day sale" of an option. In addition, any sale of the underlying stock acquired upon the exercise of a stock option is subject to the Policy.

Gifts. Bona fide gifts of Centene securities (e.g., to charities, churches, non-profit organizations) should only be made (i) when you are not in possession of Inside Information and (ii) for Restricted Persons, outside a black-out period. Gifts of Centene securities are otherwise subject to the trading restrictions covered by this Policy. In addition, if you are a "Section 16 Person" as defined below, you will need to obtain pre-clearance for any gifts of Centene securities.

Prohibitions. In addition to the other restrictions set forth in this Policy, the following transactions are strictly prohibited at all times:

- trading in call or put options involving Centene securities and other derivative securities;
- engaging in short sales of Centene securities;
- holding Centene securities in a margin account;
- hedging (directly or indirectly) Centene securities, or otherwise engaging in transactions that hedge or offset, or are designed to hedge or offset, any decrease in the market value of Centene securities, including (but not limited to) collars, equity swaps, exchange funds and prepaid variable forward sale contracts; and
- pledging Centene's securities, including to secure margin or other loans or to purchase Centene securities on margin.

If you are unsure whether or not a particular transaction is prohibited under this Policy, you should consult with Centene's General Counsel, prior to engaging in, or entering into an agreement, understanding or arrangement to engage in, such transaction.

C. Applicability of Policy to Trading in Other Companies' Securities

You may not place a purchase or sale order (including investment through a retirement account), or recommend that another person place a purchase or sale order, in the securities of another company, including Centene's customers, vendors, suppliers, counterparties or possible acquisition targets, if your trade is based on material, non-public information concerning such company or its securities, which information was obtained in the course of your employment with, or while you are performing other services on behalf of, Centene. For example, it would be a violation of the securities laws if a Centene employee learned through his or her role at Centene that Centene intended to amend or terminate a material vendor or supplier contract and then placed an order to buy or sell stock in that vendor or supplier company because of the likely increase or decrease in the value of its securities. In addition, all employees should treat material non-public information about such other companies with the same care required with respect to information related directly to Centene.

D. Post-Termination Transactions

This Policy continues to apply following termination of employment with, or cessation of service to, Centene as follows: if you are aware of Inside Information when your employment or service relationship terminates, you may not engage in transactions involving Centene securities until that information has become public or is no longer material. In all other respects, the procedures set forth in this Policy will cease to apply to your transactions in Centene securities at the time of your termination of employment or service.

E. Applicability of U.S. Securities Laws to International Transactions

The U.S. securities laws may be applicable to trades in Centene's securities executed outside the United States, as well as to the securities of Centene's subsidiaries or affiliates, even if they are located outside the United States or if you are located outside the United States. Transactions involving securities of subsidiaries or affiliates should be carefully reviewed by counsel for compliance not only with local law but also for possible application of U.S. securities laws.

III. GENERAL POLICY

A. Possession and Use of Information

No director, employee, consultant or contractor of Centene or its subsidiaries who is in possession of Inside Information may, either directly or indirectly (including, without limitation, through a Family Member (as defined below), friend, anyone to whom you provide significant financial support or entity in which you or any of your Family Members is a director, officer or controlling equity holder or beneficiary), (a) purchase or sell Centene's securities, (b) engage in any other action to take advantage of Inside Information or (c) provide Inside Information to any other person outside of Centene, including Family Members and friends. These restrictions do not apply to transactions specifically exempt from this Policy, including transactions made under an approved 10b5-1 plan and transactions between you and Centene with respect to grants under its equity incentive plans (or, to the extent applicable, granted outside such plans). For purposes of this Policy, "Family Members" refers to spouses, domestic partners, and minor children (even if financially independent).

In addition, Centene itself must comply with U.S. securities laws applicable to its own securities trading activities, and will not effect transactions in respect of its securities, or adopt any securities repurchase plans, when it is in possession of Inside Information, other than in compliance with applicable law, subject to the policies and procedures adopted by Centene, if applicable, and the prior approval of the General Counsel.

B. "Tipping" of Information

Persons subject to this Policy may not disclose, convey or "tip" Inside Information to any person by providing him or her with Inside Information other than to disclose on a "need to know" basis to Centene employees or representatives in the course of performing their duties for Centene. When sharing Inside Information with other Centene employees or representatives, such information should be confined to as small as group as possible and the importance of the limited use of such information should be conveyed to the recipient. Unlawful tipping includes passing on Inside Information to friends, family members or acquaintances under circumstances that suggest that persons subject to this Policy were trying to help the recipients of such information make a profit or avoid a loss by trading in Centene securities based on such information.

IV. SPECIFIC POLICIES

A. Black-out Periods

All those listed on Schedule A hereto (as may be amended from time to time by the General Counsel), as well as any other persons (whether Family Members or not) that reside in the same household as those persons (all of the foregoing being "Restricted Persons") are subject to additional restrictions on their ability to engage in purchase or sale transactions involving Centene securities. Centene believes Restricted Persons are more likely to have access to Inside Information regarding Centene because of their positions with Centene and, as a result, their trades in Centene securities are more likely to be subject to greater scrutiny. Accordingly, except as otherwise provided in this Policy with regard to purchases and/or sales of Centene stock pursuant to an approved 10b5-1 plan, Restricted Persons are prohibited from trading in Centene securities, and from entering into or amending a 10b5-1 plan, during the period beginning on the 7th calendar day prior to the end of each fiscal quarter and ending immediately prior to the opening of the market on the 2nd full trading day following public disclosure of the financial results for that quarter or the full year. For example, if Centene were to publicly disclose its financial results for a quarter on a Tuesday before the market opened, Wednesday would be the first eligible trading day for Restricted Persons.

In addition, from time to time, Centene will impose special black-out periods on Restricted Persons and other employees if, in the judgment of the General Counsel, it is likely that such person or persons have become aware of significant corporate developments that may be material and have not yet been disclosed to the public, even when trading otherwise may be permitted. In the event that certain Restricted Persons or other employees become subject to a special black-out period, such persons are prohibited from (a) trading in Centene securities and (b) disclosing to others the fact they are subject to such special black-out period. These special black-out periods may vary in length and may or may not be broadly communicated to Centene employees. Centene would re-open trading at the beginning of the 2nd day following the date of public disclosure of such significant corporate developments, or when Centene no longer has Inside Information.

B. Pre-clearance

Except as otherwise provided in the following paragraph, members of the Board of Directors of Centene and "officers" (as such term is defined in Rule 16a-1(f) under the Exchange Act) of Centene (each, a "Section 16 Person") must obtain written pre-clearance from the General Counsel before such Section 16 Person makes any purchases, sales or gifts of Centene's securities, regardless of whether or not a black-out period is then in effect. The request for pre-clearance must be sent to the General Counsel at least two business days prior to commencing the trade. In evaluating each proposed transaction, the General Counsel will consult as necessary with senior management and/or outside counsel before clearing any proposed trade. Pre-clearance of a proposed transaction is valid for no more than five trading days immediately following receipt by the Section 16 Person of such clearance. If the transaction does not take place during that time, the Section 16 Person must re-request pre-clearance through the same process. The General Counsel is under no obligation to approve a transaction submitted for pre-clearance. If pre-clearance is denied, the fact of such denial must be kept confidential by the Section 16 Person requesting such pre-clearance. The approval of pre-clearance of a transaction is subject to revocation at any time prior to the sale or purchase in the sole discretion of the General Counsel.

Pre-clearance does not constitute legal advice, does not constitute confirmation that you do not possess Inside Information, does not insulate you from liability for insider trading and does not relieve you of your obligations under federal and state securities laws; it is a safeguard that Centene has put in place to help protect you and Centene.

A person subject to this Policy does not need to receive pre-clearance for trades pursuant to an approved 10b5-1 plan, but must receive prior approval from the General Counsel before adopting, amending, suspending or terminating such a plan. In evaluating the proposed 10b5-1 plan, or the amendment, suspension or termination of an existing 10b5-1 plan, the General Counsel will consult as necessary with senior management and/or outside counsel before approving a proposed 10b5-1 plan (or any amendment, suspension of termination of an existing plan). Approval to adopt, amend, suspend or terminate a 10b5-1 plan is valid for no more than the five trading days immediately following receipt by the person requesting such approval. If approval is denied, the fact of such denial must be kept confidential by the person requesting such approval. The prior approval of a 10b5-1 plan is subject to revocation at any time prior to the implementation of the plan in the sole discretion of the General Counsel. The General Counsel is under no obligation to approve a 10b5-1 plan submitted for approval.

Prior approval of a 10b5-1 plan does not constitute legal advice, does not constitute confirmation that you do not possess Inside Information at the time you enter into a 10b5-1 plan, does not insulate you from liability for insider trading and does not relieve you of your obligations under federal and state securities laws.

C. Notification

Section 16 Persons must report, or cause such person's broker to report, within 24 hours following a transaction involving Centene's securities, including purchases, sales, gifts, transfers, pledges and 10b5-1 plan transactions, to Centene's Deputy Corporate Controller or Board Secretary or their designee the details of such transaction in writing.

V. COMPLIANCE

All persons subject to this Policy must promptly report to Centene's Compliance Department, pursuant to the procedures set forth in Centene's Business Ethics and Code of Conduct, including through the use of Centene's Ethics & Compliance Helpline at 1-800-345-1642, any trading in Centene's securities by Centene personnel, or any disclosure of Inside Information or material, non-public information concerning other companies by Centene personnel, that such person has reason to believe may violate this Policy or federal or state securities laws.

VI. ADDITIONAL INFORMATION

What is Inside Information?

"Inside information" is material, non-public information related to, affecting or regarding Centene or its subsidiaries. Information generally becomes available to the public when it is made available on a broad-based non-exclusionary basis (e.g., when it has been disclosed by Centene or third parties in a press release or other authorized public statement, including any filing with the SEC). In general, information is considered to have been made available to the public on the second trading day after the formal release of the information. In other words, there is a presumption that the public needs approximately one complete trading day to receive and absorb such information.

Information obtained through the course of employment with, or while performing other services on behalf of, Centene, does not belong to individual insiders who may handle it or otherwise become knowledgeable about it. The information is an asset of Centene. Any person who uses such information for personal benefit or discloses it to others outside Centene in breach of a duty of trust or confidence owed to Centene may be in breach of his or her fiduciary, loyalty or other duties to Centene.

What is Material Information?

As a general rule, information about Centene (or another company) is "material" if it could reasonably be expected to affect someone's decision to buy, hold or sell Centene's securities (or the securities of another company), and if it could be viewed by a reasonable investor as having significantly altered the 'total mix' of information made available. In particular, information is considered to be material if its disclosure to the public would be reasonably likely to affect an investor's decision to buy, hold or sell the securities of the company to which the information relates, or the market price of that company's securities. Material information can be favorable or unfavorable. While it is not possible to identify in advance all information that will likely be deemed to be material, some examples of information that may be material would include the following:

- earnings, including whether the Company will or will not meet expectations (and reaffirming or confirming previously issued guidance)
- significant changes in financial results and/or financial condition and financial projections;
- news of major new contracts or possible loss of business;
- changes in the board, management or control;
- significant mergers, acquisitions, reorganizations, tender offers, dispositions of assets or joint ventures;
- significant litigation or regulatory developments;
- significant data breaches or similar cybersecurity events;
- financings and other events regarding the Company's securities (e.g., defaults on debt securities, calls of securities for redemption, repurchase plans, dividends, stock splits, public or private sales of additional securities);
- changes in debt ratings, or analyst upgrades or downgrades of the issuer or one of its securities;
- significant changes in accounting treatment, write-offs or effective tax rate;
- liquidity problems or impending bankruptcy;
- changes in auditors or auditor notification that the company may no longer rely on an audit report; and
- transactions with directors, officers or principal security holders.

It can sometimes be difficult to know whether information would be considered "material." The determination whether information is material is almost always clearer after the fact, when the effect of that information on the market may be more susceptible to quantification. Although you may have information about Centene that you do not consider to be material, federal regulators and others may conclude (with the benefit of hindsight) that such information was material. Therefore, trading in Centene securities when you possess non-public information about Centene can be risky. When doubt exists, the information should be presumed to be material. If you are unsure whether you are in possession of material, non-public information, you should consult with Centene's General Counsel, prior to engaging in, or entering into an agreement, understanding or arrangement to engage in, a purchase or sale transaction involving Centene securities.

Twenty-Twenty Hindsight

If securities transactions ever become the subject of scrutiny, they are likely to be viewed after-the-fact with the benefit of hindsight. As a result, before engaging in any transaction you should carefully consider how your transaction may be construed in the bright light of hindsight. Again, in the event of any questions or uncertainties about the Policy, please consult with Centene's General Counsel.

What is the Penalty for Insider Trading?

Trading on Inside Information is a crime. The consequences of insider trading and tipping are severe and may, in some cases, be applied to Centene as well as to the individual who illegally trades or tips. Possible consequences include criminal prosecution with the potential for prison terms and additional fines up to three times of the profits earned if convicted, in addition to civil penalties (up to three times of the profits earned), termination of employment and personal embarrassment resulting from adverse publicity.

VII. REVIEW

This Policy is subject to the periodic review of the Audit and Compliance Committee (the "Audit and Compliance Committee") of the Board. Any proposed changes will be reviewed by the Audit and Compliance Committee and recommended to the Board for its approval.

VIII. CERTIFICATION

The Company shall take reasonable steps designed to ensure that all employees and directors of the Company and are educated about, and periodically reminded of, the federal securities law restrictions and Company policies regarding insider trading. Employees and directors shall be required to certify their understanding of, and intent to comply with, this Policy.

If you have any questions with regard to this Policy, you should consult with Centene's General Counsel.

EXHIBIT 21

List of Subsidiaries as of December 31, 2025

Absolute Total Care, Inc, a South Carolina corporation
AcariaHealth Pharmacy #11, Inc, a Texas corporation
AcariaHealth Pharmacy #12, Inc, a New York corporation
AcariaHealth Pharmacy #14, Inc, a California corporation
AcariaHealth Pharmacy #26, Inc, a Delaware corporation
AcariaHealth Pharmacy, Inc, a California corporation
AcariaHealth, Inc., a Delaware corporation
Access Medical Acquisition, LLC, a Delaware LLC
Access Medical Group of Florida City, LLC, a Florida LLC
Access Medical Group of Hialeah, LLC, a Florida LLC
Access Medical Group of Hillsborough Peds, LLC, a Florida LLC
Access Medical Group of Kendall, LLC, a Florida LLC
Access Medical Group of Lakeland, LLC, a Florida LLC
Access Medical Group of Lauderdale Lakes, LLC, a Florida LLC
Access Medical Group of Margate, LLC, a Florida LLC
Access Medical Group of Miami, LLC, a Florida LLC
Access Medical Group of Miami Medicare, LLC, a Florida LLC
Access Medical Group of North Miami Beach, LLC, a Florida LLC
Access Medical Group of Opa-Locka, LLC, a Florida LLC
Access Medical Group of Pembroke Pines, LLC, a Florida LLC
Access Medical Group of Perrine, LLC, a Florida LLC
Access Medical Group of Riverview, LLC, a Florida LLC
Access Medical Group of Sand Lake, LLC, a Florida LLC
Access Medical Group of Tampa II, LLC, a Florida LLC
Access Medical Group of Tampa III, LLC, a Florida LLC
Access Medical Group of Tampa, LLC, a Florida LLC
Access Medical Group of Westchester, LLC, a Florida LLC
Agate Resources, Inc., an Oregon corporation
Ambetter Health of Florida, Inc., a Florida corporation
Ambetter Health of Louisiana, Inc., a Louisiana corporation
Ambetter Health of Texas, Inc., a Texas corporation
Ambetter of Magnolia, Inc, a Mississippi corporation
Ambetter of North Carolina, Inc., a North Carolina corporation
Ambetter of Peach State Inc., a Georgia corporation
American Progressive Life and Health Insurance Company of New York, a New York corporation
America's 1st Choice California Holdings, LLC, a Florida corporation
Ardan TacOpps I, LLC, a Delaware LLC
Arizona Biodyne, Inc., an Arizona corporation
Arkansas Health & Wellness Health Plan, Inc., an Arkansas corporation
Arkansas Total Care, Inc., an Arkansas corporation
Aurelia Health, LLC, an Arizona corporation
Bankers Reserve Life Insurance Company of Wisconsin, a Wisconsin corporation
Bridgeway Health Solutions of Arizona, Inc., an Arizona corporation
Bridgeway Health Solutions, LLC, a Delaware LLC
Buckeye Community Health Plan, Inc, an Ohio corporation
Buckeye Health Plan Community Solutions, Inc., an Ohio corporation

California Health and Wellness Plan, a California corporation
Carolina Complete Health Holding Company Partnership, a Delaware partnership
Carolina Complete Health, Inc., a North Carolina corporation
Celtic Group, Inc, a Delaware corporation
Celtic Insurance Company, an Illinois corporation
Cenpatico Behavioral Health, LLC, a California LLC
Centene Center I, LLC, a Delaware LLC
Centene Center II, LLC, a Delaware LLC
Centene Center LLC, a Delaware LLC
Centene Health Plan Holdings, Inc., a Delaware corporation
Centene Institute for Advanced Health Education, LLC, a Delaware LLC
Centene Management Company LLC, a Wisconsin LLC
Centene Pharmacy Services, Inc., a Delaware corporation
Centene Venture Company Alabama Health Plan, Inc., an Alabama corporation
Centene Venture Company Florida, Inc., a Florida corporation
Centene Venture Company Illinois, Inc., an Illinois corporation
Centene Venture Company Indiana, Inc., an Indiana corporation
Centene Venture Company Kansas, Inc., a Kansas corporation
Centene Venture Company Michigan, Inc., a Michigan corporation
Centene Venture Company Tennessee, Inc., a Tennessee corporation
Centene Venture Insurance Company Texas, Inc., a Texas corporation
CMC Real Estate Company, LLC, a Delaware LLC
Cobalt Therapeutics, LLC, a Delaware LLC
Community Medical Holdings Corp, a Delaware corporation
Comprehensive Health Management, LLC, a Florida LLC
Coordinated Care Corporation, an Indiana corporation
Coordinated Care of Washington, Inc, a Washington corporation
Delaware First Health Complete, Inc., a Delaware corporation
Delaware First Health, Inc., a Delaware corporation
DeNova Collaborative Health, LLC, an Arizona LLC
District Community Care Inc., a Washington D.C. corporation
Envolve Benefits Options, Inc., a Delaware corporation
Envolve Dental IPA of New York, Inc., a New York corporation
Envolve Dental of Florida, Inc., a Florida corporation
Envolve Dental of Texas, Inc., a Texas corporation
Envolve Dental, Inc., a Delaware corporation
Envolve Holdings, LLC, a Delaware LLC
Envolve Pharmacy IPA, LLC, a New York LLC
Envolve Total Vision, Inc., a Delaware corporation
Envolve Vision Benefits, Inc., a Delaware corporation
Envolve Vision IPA of New York, Inc., a New York corporation
Envolve Vision of Florida, Inc., a Florida corporation
Envolve Vision of Texas, Inc., a Texas corporation
Envolve Vision, Inc., a Delaware corporation
Envolve, Inc., a Delaware corporation
Foundation Care, LLC, a Missouri LLC
Granite State Health Plan, Inc, a New Hampshire corporation
Harmony Health Plan, Inc., an Illinois corporation
Harmony Health Systems Inc., a New Jersey corporation

Health Care Enterprises, LLC, a Delaware LLC
Health Net Community Solutions of Arizona, Inc., an Arizona corporation
Health Net Community Solutions, Inc., a California corporation
Health Net Federal Services, LLC, a Delaware LLC
Health Net Health Plan of Oregon, Inc., an Oregon corporation
Health Net Life Insurance Company, a California corporation
Health Net Life Reinsurance Company, a Cayman Islands corporation
Health Net of Arizona, Inc., an Arizona corporation
Health Net of California, Inc., a California corporation
Health Net, LLC, a Delaware LLC
Health Plan Real Estate Holding, Inc., a Missouri corporation
Health Plan Real Estate Holding II, Inc., a Missouri corporation
Healthy Louisiana Holdings LLC, a Delaware LLC
Healthy Missouri Holdings, Inc, a Missouri corporation
Healthy Washington Holdings, Inc, a Delaware corporation
Heritage Health Systems of Texas, Inc., a Texas corporation
Heritage Health Systems, Inc., a Texas corporation
HHS Texas Management, Inc., a Texas corporation
HHS Texas Management, LP, a Texas limited partnership
HLM Strategic Investment Fund, L.P., a Delaware limited partnership
Home State Health Plan, Inc, a Missouri corporation
HomeScripts.com, LLC, a Michigan LLC
Human Affairs International of California, a California corporation
Illinois Health Practice Alliance, LLC, a Delaware corporation
Integrated Mental Health Services, a Texas corporation
Interpreta Holdings, Inc., a Delaware corporation
Interpreta, Inc., a Delaware corporation
Iowa Total Care, Inc, an Iowa corporation
LifeShare Management Group, LLC, a New Hampshire LLC
Louisiana Healthcare Connections, Inc, a Louisiana corporation
Magellan Behavioral Health of Florida, Inc., a Florida corporation
Magellan Behavioral Health of New Jersey, LLC, a New Jersey LLC
Magellan Behavioral Health of Pennsylvania, Inc., a Pennsylvania corporation
Magellan Behavioral Health Systems, LLC, a Utah LLC
Magellan Behavioral of Michigan, Inc., a Michigan corporation
Magellan Capital, LLC, a Nevada LLC
Magellan Cares Foundation, Inc., a Delaware corporation
Magellan Complete Care of Louisiana, Inc., a Louisiana corporation
Magellan Complete Care of Pennsylvania, Inc., a Pennsylvania corporation
Magellan Federal, Inc., a Virginia corporation
Magellan Financial Capital, LLC, a Delaware LLC
Magellan Health QI0, LLC, a Nebraska LLC
Magellan Health Services of Arizona, Inc., an Arizona corporation
Magellan Health Services of California, Inc. - Employer Services, a California corporation
Magellan Health Services of New Mexico, Inc., a New Mexico corporation
Magellan Health, Inc, a Delaware corporation
Magellan Healthcare Provider Group, Inc., a Maryland corporation
Magellan Healthcare, Inc., a Delaware corporation
Magellan HRSC, Inc., an Ohio corporation

Magellan Life Insurance Company, a Delaware corporation
Magellan of Georgia, Inc., a Georgia corporation
Magellan of Idaho, LLC, an Idaho LLC
Magellan of Maryland, LLC, a Maryland LLC
Magellan of Nevada, LLC, a Nevada LLC
Magellan Pharmacy Services, Inc., a Delaware corporation
Magellan Providers of Texas, Inc., a Texas corporation
Magnolia Health Plan, Inc, a Mississippi corporation
Magnolia Joint Venture Holding Company, Inc., a Delaware corporation
Managed Health Network, a California corporation
Managed Health Network, LLC, a Delaware LLC
Managed Health Services Insurance Corporation, a Wisconsin corporation
Meridian Health Plan of Illinois, Inc., an Illinois corporation
Meridian Health Plan of Michigan, Inc., a Michigan corporation
Meridian Management Company, LLC, a Michigan LLC
Meridian Network Services, LLC, a Michigan LLC
Merit Behavioral Care Corporation, a Delaware corporation
MHN Services, LLC, a California LLC
Nebraska Total Care, Inc., a Nebraska corporation
Network Providers, LLC, a Delaware LLC
New York Quality Healthcare Corporation, a New York corporation
Next Door Neighbors, Inc., a Delaware corporation
Next Door Neighbors, LLC., a Delaware LLC
Novasys Health, Inc, a Delaware corporation
Ohana Health Plan, Inc., a Hawaii corporation
Oklahoma Complete Health Holding Company, LLC, a Delaware LLC
Oklahoma Complete Health Inc., an Oklahoma corporation
One Care by Care 1st Health Plan of Arizona, Inc., an Arizona corporation
P.P.C., Inc., a Missouri corporation
Peach State Health Plan, Inc, a Georgia corporation
Penn Marketing America, LLC, a Delaware LLC
Pennsylvania Health and Wellness, Inc., a Pennsylvania corporation
PPC Group, Inc., a Delaware corporation
Premier Marketing Group, LLC, a Delaware LLC
Presonyx, Inc., a Delaware corporation
QCA Health Plan, Inc., an Arkansas corporation
Qualchoice Life and Health Insurance Company, Inc., an Arkansas corporation
Rhythm Health Tennessee, Inc., a Tennessee corporation
RI Health & Wellness, Inc., a Rhode Island corporation
SelectCare of Texas, Inc., a Texas corporation
SilverSummit Healthplan, Inc., a Nevada corporation
Social Health Bridge Trust, a Delaware trust
Social Health Bridge, LLC, a Delaware LLC
Specialty Therapeutic Care Holdings, LLC, a Delaware LLC
Sunflower State Health Plan, Inc, a Kansas corporation
Sunshine Health Community Solutions, Inc., a Florida corporation
Sunshine Health Holding LLC, a Florida LLC
Sunshine State Health Plan, Inc, a Florida corporation
Superior Health Management Advisors, LLC

Superior HealthPlan, Inc, a Texas corporation
The WellCare Management Group, Inc., a New York corporation
Transplant Health Solutions IPA, Inc., a New York corporation
Trillium Community Health Plan, Inc., an Oregon corporation
U.S. IPA Providers, Inc., a New York corporation
UAM Agent Services Corp., an Iowa corporation
Universal American Corp., a Delaware corporation
Universal American Financial Services, Inc., a Delaware corporation
Universal American Holdings, LLC, a Delaware LLC
WCG Health Management, Inc., a Delaware corporation
WellCare Health Insurance Company of America, an Arkansas corporation
WellCare Health Insurance Company of Kentucky, Inc., a Kentucky corporation
WellCare Health Insurance Company of Louisiana, Inc., a Louisiana corporation
WellCare Health Insurance Company of Nevada, Inc., a Nevada corporation
WellCare Health Insurance Company of New Hampshire, Inc., a New Hampshire corporation
WellCare Health Insurance Company of New Jersey, Inc., a New Jersey corporation
WellCare Health Insurance Company of Oklahoma, Inc., an Oklahoma corporation
WellCare Health Insurance Company of Washington, Inc., a Washington corporation
WellCare Health Insurance of Arizona, Inc., an Arizona corporation
WellCare Health Insurance of Connecticut, Inc., a Connecticut corporation
WellCare Health Insurance of Hawaii, Inc., a Hawaii corporation
WellCare Health Insurance of New York, Inc., a New York corporation
WellCare Health Insurance of North Carolina, Inc., a North Carolina corporation
WellCare Health Insurance of Tennessee, Inc., a Tennessee corporation
WellCare Health Insurance of the Southwest, Inc., an Arizona corporation
WellCare Health Plans of Kentucky, Inc., a Kentucky corporation
WellCare Health Plans of Massachusetts, Inc, a Massachusetts corporation
WellCare Health Plans of Missouri, Inc., a Missouri corporation
WellCare Health Plans of New Jersey, Inc., a New Jersey corporation
WellCare Health Plans of Rhode Island, Inc., a Rhode Island corporation
WellCare Health Plans of Vermont, Inc., an Iowa corporation
WellCare Health Plans, Inc., a Delaware corporation
WellCare National Health Insurance Company, a Texas corporation
WellCare of Alabama, Inc., an Alabama corporation
WellCare of California, Inc., a California corporation
WellCare of Connecticut, Inc., a Connecticut corporation
WellCare of Georgia, Inc., a Georgia corporation
WellCare of Illinois, Inc., an Illinois corporation
WellCare of Indiana, Inc., an Indiana corporation
WellCare of Maine, Inc., a Maine corporation
WellCare of Michigan Holding Company, a Michigan corporation
WellCare of Mississippi, Inc., a Mississippi corporation
WellCare of Missouri Health Insurance Company, Inc., a Missouri corporation
WellCare of New Hampshire, Inc., a New Hampshire corporation
WellCare of North Carolina, Inc., a North Carolina corporation
WellCare of Oklahoma, Inc., an Oklahoma corporation
WellCare of South Carolina, Inc., a South Carolina corporation
WellCare of Texas, Inc., a Texas corporation
WellCare of Virginia, Inc., a Virginia corporation

WellCare of Washington, Inc., a Washington corporation
WellCare Prescription Insurance, Inc., an Arizona corporation
Western Sky Community Care, Inc., a New Mexico corporation
Worlco Management Services, Inc., a New York corporation

EXHIBIT 23

Consent of Independent Registered Public Accounting Firm

We consent to the incorporation by reference in the registration statements Nos. 333-261993, 333-255735, 333-238597, 333-236036, 333-217634, 333-210376, 333-197737, 333-180976, 333-90976, and 333-287399 on Form S-8 and in the registration statement No. 333-277218 on Form S-3 of our reports dated February 17, 2026, with respect to the consolidated financial statements of Centene Corporation and the effectiveness of internal control over financial reporting.

/s/ KPMG LLP

St. Louis, Missouri
February 17, 2026

EXHIBIT 31.1

CERTIFICATION

I, Sarah M. London, certify that:

1. I have reviewed this Annual Report on Form 10-K of Centene Corporation;

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

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

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

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

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

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

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

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

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

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

Dated: February 17, 2026

/s/ SARAH M. LONDON

Chief Executive Officer
(principal executive officer)

EXHIBIT 31.2

CERTIFICATION

I, Andrew L. Asher, certify that:

1. I have reviewed this Annual Report on Form 10-K of Centene Corporation;

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

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

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

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

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

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

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

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

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

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

Dated: February 17, 2026

/s/ ANDREW L. ASHER

Executive Vice President, Chief Financial Officer
(principal financial officer)

EXHIBIT 32.1

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

In connection with the Annual Report on Form 10-K of Centene Corporation (the Company) for the period ended December 31, 2025, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, Sarah M. London, Chief Executive Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

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

Dated: February 17, 2026

/s/ SARAH M. LONDON

Chief Executive Officer
(principal executive officer)

EXHIBIT 32.2

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

In connection with the Annual Report on Form 10-K of Centene Corporation (the Company) for the period ended December 31, 2025, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, Andrew L. Asher, Executive Vice President and Chief Financial Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

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

Dated: February 17, 2026

/s/ ANDREW L. ASHER

Executive Vice President, Chief Financial Officer
(principal financial officer)