





CENTENE® Corporation

2026 PROXY STATEMENT

Notice of 2026 Annual Meeting of Stockholders and Proxy Statement | May 12, 2026







Our Mission

Transforming the health of the communities we serve, one person at a time.

Since its founding as a single local healthcare plan in 1984, Centene's heart and soul has been linked to supporting the health of the communities we proudly serve. We are committed to providing access to quality, culturally sensitive care for our members and communities.

Now, forty years later, this long-held commitment to supporting the health and health care of our members is encapsulated in our mission: Transforming the health of the communities we serve, one person at a time.

Our Values

These values support our efforts to realize our mission.



Letter to Stockholders

From Our Chief Executive Officer and Our Chairman of the Board

March 26, 2026

Dear Stockholders:

The past year marked a period of significant change for Centene — change that, while challenging, sharpened our focus and clarified our path forward. The scale and velocity of transformation across the U.S. healthcare system in 2025 shaped our financial performance and reinforced the importance of disciplined execution and operational agility as we pursue the creation of long-term shareholder value.

During 2025, we faced material disruption across multiple parts of our business, including volatility in Medicaid trends and a meaningful shift in the Marketplace risk pool. We were disappointed to lower our financial outlook last July amid a seismic shift in morbidity within the broader population served by Marketplace products. These dynamics tested our assumptions and our execution, and our financial results reflected those pressures.

What matters most, however, is how we responded.

We closed 2025 with full-year adjusted diluted earnings per share (EPS) of **$2.08** — modest compared to our outlook at the start of the year — though improved execution in the fourth quarter put us slightly ahead of the expectations we provided to investors in October.

When it became clear that certain programs no longer met our risk and return thresholds, we made difficult but necessary decisions to protect the long-term health of the enterprise. We acted decisively, communicated transparently, and prioritized disciplined execution over short-term growth. In doing so, we reinforced a core principle of this organization: we do what is right, not what is easy.

As we move forward, Centene is a more focused company with a clearer strategic foundation. Our core businesses — **Medicaid, Medicare Advantage, and the Health Insurance Marketplace** — remain strong, differentiated platforms serving complex, high-need populations and facilitating access to healthcare for millions of Americans. We are applying the lessons of the past year to evolve how we operate these businesses, with greater rigor in pricing, risk management, and operational execution. We see significant embedded earnings power across the enterprise, and we are focused on restoring and sustaining it over time.

Several priorities define this evolution.

First, we are strengthening strategic agility. The healthcare landscape continues to change rapidly, and success requires the ability to adapt early and act with conviction. We are embedding more dynamic feedback loops into how we assess program performance, regulatory change, and market risk. For 2026, we updated our Marketplace go-to-market strategy to better accommodate a higher-morbidity population while positioning the company to improve profitability.

Second, we are deepening operational focus. Across the enterprise, teams are simplifying processes, tightening controls, and driving consistency at scale. These efforts are improving visibility, accountability, and performance — particularly in areas that directly impact medical cost management, member experience, and clinical outcomes. Since 2023, we have delivered double-digit improvements in blood pressure and diabetes control across Medicaid, Medicare, and Marketplace, along with meaningful gains in maternal and child health, including increased timeliness of prenatal care and postpartum visits. We are also strengthening service quality through disciplined execution and technology-enabled oversight: in 2025, **93.3% of 2.9 million** post-call survey respondents reported satisfaction and **94.5%** reported full resolution.

Third, we are continuing to invest in modernization. Technology, data, and analytics are essential enablers of our strategy — from more precise underwriting and care management to better tools for our frontline teams. These investments are deliberate and targeted, designed to strengthen core capabilities rather than add complexity. We are also deploying advanced analytics to more quickly detect and prevent fraud, waste, and abuse. For example, using a combination of data analytics and traditional investigative techniques, we identified suspicious billing patterns among laboratories in one state and took action — preventing more than **$38 million** in likely fraudulent payments.

Underlying all of this work is our culture. Even during an extraordinarily difficult year, our colleagues demonstrated resilience, integrity, and unwavering commitment to our mission. The strength of One CenTeam is not an abstraction — it shows up in how challenges are surfaced, how decisions are made, and how we serve members and partners every day.

Looking ahead to 2026, we expect improving fundamentals across the portfolio, including Medicaid margin stabilization, meaningful recovery in Marketplace margins, and continued progress toward breakeven in Medicare Advantage. As we enter 2026, we are positioned to deliver meaningful margin expansion and renewed adjusted diluted EPS growth. We expect full-year 2026 adjusted diluted EPS to exceed **$3.00**[1], representing more than 40% year-over-year growth, an important step toward restoring the enterprise's embedded earnings power. With a more disciplined operating model and a sharpened strategic lens, we believe Centene is positioned to rebuild earnings power and deliver sustainable shareholder value over time.

We are grateful for your continued support and engagement as we execute this next chapter. Our mission — to transform the health of the communities we serve, one person at a time — remains our north star, and we are confident in our ability to fulfill it while creating long-term value for our shareholders.

Sincerely,



Sarah London

Sarah M. London

Chief Executive Officer



Frederick H. Eppinger

Chairman of the Board of Directors

[1] Please refer to the press release filed as Exhibit 99.1 to the Form 8-K on February 6, 2026, for a reconciliation of GAAP diluted EPS to adjusted diluted EPS.

Notice of 2026 Annual Meeting of Stockholders

Time and Date
10:00 AM, Central Time, on Tuesday, May 12, 2026

Place
Centene Plaza
7700 Forsyth Boulevard
St. Louis, Missouri 63105
Centene Auditorium

Record Date
Stockholders as of March 13, 2026, are entitled to vote

Voting Items Proposal	Board Vote Recommendation	For Further Details
(1) To elect nine directors to hold office until the 2027 Annual Meeting of Stockholders or until their successors are duly elected and qualified;	✓ FOR each director nominee	Page 23
(2) To cast a non-binding advisory vote on the compensation of the Company's Named Executive Officers;	✓ FOR	Page 64
(3) To ratify the appointment of KPMG LLP as our independent registered public accounting firm for the fiscal year ending December 31, 2026;	✓ FOR	Page 109
(4) Stockholder proposal	✗ AGAINST	Page 115

Stockholders will also transact such other business as may properly come before the Annual Meeting or at any convening or reconvening of the Annual Meeting following a postponement or adjournment of the Annual Meeting.

Stockholders or their legal proxy holders who wish to attend the Annual Meeting must preregister. Requests for preregistration must be received by us no later than 11:59 AM Eastern Time on May 8, 2026. For complete instructions for preregistering, see page 121 of this proxy statement.

On or about March 26, 2026, we mailed to our stockholders either 1) a copy of our proxy statement, a proxy card and 2025 Annual Report on Form 10-K or 2) a Notice of Internet Availability of Proxy Materials (Availability Notice), which indicates how to access the proxy materials on the internet. We believe furnishing proxy materials to our stockholders on the internet provides our stockholders with the information they need while lowering the costs of delivery and reducing the environmental impact of the distribution process.

By order of the Board of Directors,



Christopher A. Koster

Secretary and General Counsel

St. Louis, Missouri
March 26, 2026

How to Vote

Internet: www.ProxyVote.com

Telephone: 1-800-690-6903

Mail
Mark, sign, date and promptly mail the enclosed proxy card in the postage-paid envelope

QR Code
Scan this QR code to vote with your mobile device

Important Notice Regarding the Availability of Proxy Materials for the 2026 Annual Meeting of Stockholders to be held on May 12, 2026: The accompanying proxy statement and the 2025 Annual Report on Form 10-K are available at www.ProxyVote.com.

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Who We Are

Based on the most recent publicly available membership data, Centene is the nation's largest Medicaid and Marketplace insurer, as well as the largest stand-alone Medicare Prescription Drug Plan (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. In addition, Centene is uniquely positioned to serve individuals who are dually eligible for both Medicaid and Medicare.

#1 carrier in the nation
on the Health Insurance Marketplace*

#42
FORTUNE GLOBAL 500® (2025)

#23
FORTUNE 500® (2025)

$38.8 billion
in cash and investments**

$174.6 billion
2025 premium and service revenues

61,100
employees**

27.6 million
members**

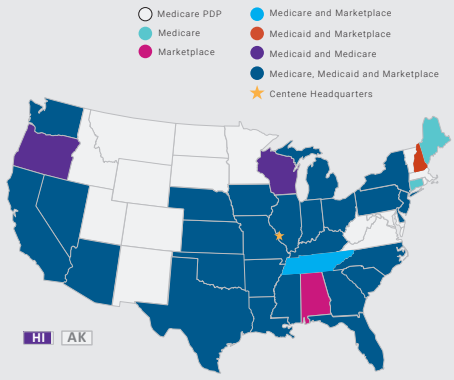
* Based on the most recent publicly available membership data.

** As of December 31, 2025.

More than 1 in 15 individuals across all 50 states

Centene offers affordable and high-quality products to more than 1 in 15 individuals across the nation, including Medicaid and Medicare members (including Medicare PDP) as well as individuals and families served by the Health Insurance Marketplace.

2026 Footprint



Addressing member needs through innovation

Advanced Technology Systems and Tools

Incentives for Healthier Living

Personal Member Outreach and Support

Helping Mothers and their Babies

Company Overview

Centene is a leading healthcare enterprise that is committed to helping people live healthier lives. The Company takes a local approach – with local brands and local teams – to provide fully integrated, high-quality and cost-effective services to government-sponsored and commercial healthcare programs, focusing on under-insured individuals. Centene offers affordable and high-quality products to more than 1 in 15 individuals across the nation, including Medicaid and Medicare members (including Medicare PDP) as well as individuals and families served by the Health Insurance Marketplace. Our mission is to transform the health of the communities we serve, one person at a time.

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 deliver healthcare with a personal approach, with 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.

Centene's Path Forward

03

Focus on Medicaid, Marketplace and Medicare, capitalizing on the significant expansion opportunities in each market

MEDICAID
MARKETPLACE
MEDICARE

02

Build from the strength of our market positions, evolve with the market and create significant disruptive growth by leveraging our inherent and differentiated strengths to explore logical extensions to our core lines of business

DUALS
+
ICHRA

01

Transform our business by leveraging industry-leading, mission-driven talent, and continuing to invest in our data analytics and capabilities

ONE CenTEAM

2025 Financial and Business Highlights

Select 2025 financial and business highlights are as follows:

$194.8 billion
Total Revenues, a 19% increase vs. 2024

$(13.53)
Diluted Loss Per Share

$2.08
Adjusted Diluted Earnings per Share (EPS)

Medicaid	Marketplace	Medicare
We are the largest Medicaid Managed Care Organization*	We are the #1 carrier on the Health Insurance Marketplace*	Our Medicare Advantage business includes one of the highest concentrations of Dual Eligible Special Needs Plans (D-SNP) members among our peers*
12.5 million members across **30** states**	**5.5** million members across **29** states**	**1.0** million Medicare Advantage members across **32** states and **8.1** million PDP members in **50** states**

* Based on the most recent publicly available membership data.

** As of December 31, 2025.

Refer to Appendix A for reconciliations of non-GAAP measures included throughout this proxy statement.

Execution of Strategy

Over the last few years, we have delivered numerous accomplishments, including:



$39.1 billion growth
'25 vs. '22
Premium and Service Revenue[1]

71.6 million
shares repurchased[2]

$189 million
of par value Senior Notes repurchased[3]



Investment grade
rating by 2 of the 3 major rating agencies

12 Divestitures
- USMM
- PANTHERx
- Ribera Salud
- Magellan Rx
- HealthSmart
- Centurion
- Magellan Specialty
- Apixio
- Circle Health
- Operose Health
- Collaborative Health Systems
- Magellan Health[4]



- Momentum on **Stars and quality**
- Investing & building in long-term **growth areas** and opportunities (HIDE/FIDE[5], ICHRA)
- Successful management of our third-party **PBM contract**
- Ongoing **SG&A efficiencies**, incorporating simplification of operations
- Team and **talent** successes

[1] Premium and Service Revenue growth based on $174.6 billion as of December 31, 2025 compared to $135.5 billion as of December 31, 2022.

[2] Shares repurchased from January 2023 through December 2025.

[3] Par value Senior Notes repurchased in 2025.

[4] Agreement signed, subject to closing.

[5] Highly Integrated Dual Eligible (HIDE) and Fully Integrated Dual Eligible (FIDE) plans.

Our growth over the past decade has positioned us to be a leader in the healthcare industry and enabled the Company to stay focused on its mission while also delivering strong financial performance for its stockholders. Centene has a unique and powerful platform, and we are working to fortify its foundation to fuel our next phase of innovation and growth. We are focused on strong, long-term growth grounded in our core product lines, investing in becoming easy to work with by building modern systems and processes and curating an enhanced network of partnerships designed to drive value across our portfolio.

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.

In response to the challenges faced in 2025, we have taken quick and decisive actions to restore profitability for future years, including:

- Led the industry in understanding the implications of the changes in morbidity of the Marketplace population that we became aware of late in the second quarter of 2025 and took corrective pricing actions for 2026 in states covering 95% of Marketplace membership.
- Advocated with our Medicaid state partners for increases in rates to reflect more recent experience.
- Strategically designed our 2026 Medicare Advantage bid and pricing strategy with a focus on profitability.
- Continued to advocate for healthcare affordability and access with the state and federal government partners.

Our 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 engaged in 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.

Corporate Sustainability

Driven by Our Commitment to Health

Centene is dedicated to delivering accessible, high-quality healthcare while prioritizing partnerships with local communities to pave the way to a sustainable future.

Centene's core philosophy is that quality healthcare is best delivered locally. Through local brands and local teams, we provide fully integrated, high-quality and cost-effective services to Medicaid and Medicare members (including those with Medicare PDP), as well as individuals and families served by the Health Insurance Marketplace.

As we continually work to enhance care delivery for our members, our unwavering commitment lies in integrating principles of corporate responsibility and strong governance across all facets of our operations. Together, we are driving a sustainable enterprise focused on building healthy and resilient communities, establishing Centene as a preferred partner for our state and federal government customers, and empowering our employees to do their best work while delivering value for our shareholders.

Together, we are shaping a future where healthcare is provided as a service to create holistic well-being for all.

Corporate Sustainability Assessment and Framework

We review our corporate sustainability efforts annually and conduct a formal materiality assessment at least every three years to maintain alignment with our mission and strategy. Our corporate sustainability approach is designed to support our mission and the key topics that guide our commitments in each of these areas:

One CenTeam

- Culture, Talent and Well-being

Care Where it Counts

- Healthcare Quality
- Healthcare Access and Drivers of Health
- Environmental Impacts on Health
- Community Impact
- Public Policy

The Future of Healthcare

- Healthcare Innovation and Thought Leadership
- Customer Experience and Relationship Management

Business Accountability and Integrity

- Governance and Accountability
- Environmental Sustainability
- Ethics and Compliance
- Data Privacy and Security
- Risk Management

One CenTeam

Our One CenTeam culture underpins our ability to make an impact and strengthening the values and behaviors that define it is an enterprise priority. We believe doing this makes us the best we can be for our members, providers and customers, and when we're united in these common values, we can make significant progress toward our mission and transform lives. Centene's culture, talent and well-being efforts are grounded in the belief that our people are central to how we deliver high-quality care. By creating an environment where people feel supported and connected, we help ensure our workforce is equipped to make a meaningful impact on the members and communities we serve.

Care Where it Counts

To advance our mission of transforming the health of the communities we serve, one person at a time, we work to ensure access to quality healthcare and address the social, economic and environmental factors that affect health beyond the doctor's office. These challenges are bigger than any one organization, which is why we collaborate with partners, policymakers and others across the industry to improve outcomes. Together, we're elevating quality, expanding access and addressing unmet health needs across the communities we serve.

The Future of Healthcare

Healthcare is changing, and we are built for evolution. Centene has a clear mission, a durable strategy and an industry-leading team that is committed to long-term success by accelerating and innovating through times of change Centene drives innovation by turning data into insights and insights into action. Through advanced technology, data analysis and clinical expertise, we identify barriers to care and create solutions that improve outcomes for our members. We are focused on delivering simpler, more connected experiences for members through personalized care, digital innovation and proactive engagement. We are also strengthening relationships with providers through responsive collaborations and streamlined interactions, supporting care coordination and improving satisfaction to ensure individuals and communities can access high-quality, coordinated care.

Business Accountability and Integrity

Centene is committed to operating with integrity, transparency and strong governance across all aspects of our business. We hold ourselves accountable to our stakeholders by maintaining rigorous compliance standards, proactively managing risk and building a culture that prioritizes ethical behavior and responsible decision-making.

Centene manages its environmental impact with the same purpose and discipline that guides our healthcare operations. Grounded in our *Environmental Guiding Principles – Conserve, Clean, Contribute, Commit* – we focus on responsible consumption of natural resources, pursuing projects that generate positive environmental impact and measuring and disclosing our performance. These principles help us minimize our footprint and reinforce the connection between environmental stewardship and community health.

We are deeply committed to integrity, ethical decision-making and regulatory compliance across all of our businesses. In 2025, Centene executed Compliance Transformation that included an enterprise-wide reorganization and the implementation of a new Compliance Operating Model. This transformation focused on ensuring the compliance program was appropriately designed and resourced to meet the expectations of government partners, improve visibility of risks and issues, streamline escalation protocols and standardize core compliance processes.

Centene uses data science, AI, machine learning and advanced analytics to improve operations, enhance member experience, strengthen clinical support and reduce unnecessary costs. We ensure these tools are designed and used responsibly, prioritizing human well-being, fairness, accountability and transparency.

Additional Corporate Sustainability Information and Related Disclosures

Corporate sustainability information and related disclosures are available on our external website, including the following:



Our **Corporate Responsibility Report** details the key partnerships, initiatives and programs that exemplify our commitment to sustainability.

Visit https://investors.centene.com/sustainability.



Our **Political Activity Report** sets forth details about political contributions, lobbying efforts and membership in industry trade associations.

Visit https://investors.centene.com/governance-documents.

Additional corporate sustainability information and related disclosures:

- We issue a Sustainability Accounting Standards Board Index (SASB Index) to provide stakeholders with disclosures aligned with the SASB Managed Care Sustainability Accounting Standard. Corporate sustainability disclosures were also included for workforce turnover and engagement. The index is available at https://www.centene.com/who-we-are/corporate-facts-reports.html.
- We report our environmental efforts to the CDP and publish our Environmental Guiding Principles. See https://www.centene.com/why-were-different/corporate-sustainability/healthy-environment/environmental-sustainability.html.

Proxy Summary

This summary highlights information contained in this proxy statement. It does not contain all of the information you should consider. You should read the entire proxy statement carefully before voting. Please see the Questions and Answers section beginning on page 121 for important information about proxy materials, voting, the annual meeting, Company documents and communications.

1 PROPOSAL

Election of Directors

The Board recommends a vote **FOR** each director nominee.

See page 23

Board Information

Director Nominees

The following table provides summary information about each of the nine director nominees.

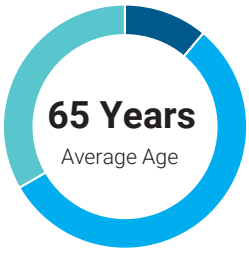
	Name and Primary (or Former) Occupation	Age	Director Since	Other Public Boards	Committee Memberships ACC	CTC	GC	QC
	**Jessica L. Blume** IND Retired Vice Chairman of Deloitte LLP	71	2018	Publix Super Markets, Inc.[1]	●		▲	
	**Kenneth A. Burdick** Executive Chairman of National Veterinary Associates; Chairman of LifeStance Health Group, Inc.; Former Executive Vice President of Products and Markets of Centene Corporation	67	2022	LifeStance Health Group, Inc.				▲
	**Christopher J. Coughlin** IND Retired Executive Vice President and Chief Financial Officer, Tyco International Ltd.	73	2022		●	▲		
	**H. James Dallas** IND Former Senior Vice President, Quality and Operations, Medtronic Public Limited Company	67	2020	KeyCorp	●			●
	**Frederick H. Eppinger** IND Director, President and Chief Executive Officer of Stewart Information Services Company	67	2006	Stewart Information Services Company		●		●
	**Monte E. Ford** IND Principal Partner, Chief Information Officer Strategy Exchange	66	2022	Akamai Technologies, Inc. Iron Mountain, Inc. Jet Blue Airways Corporation		●		●
	**Sarah M. London** Chief Executive Officer of Centene Corporation	45	2021					
	**Theodore R. Samuels** IND Former President, Capital Guardian Trust Company	71	2022	Bristol Myers Squibb Company Iron Mountain, Inc.		●	●	
	**Kenneth Y. Tanji** IND Former Chief Financial Officer, Prudential Financial, Inc.	60	2025	The Public Service Enterprise Group, Inc. Putnam Mutual Funds	▲		●	

[1] Securities registered pursuant to Section 12(g) of the Securities Act.

ACC = Audit and Compliance Committee
CTC = Compensation and Talent Committee
GC = Governance Committee
QC = Quality Committee
▲ Chair
● Member
IND Independent

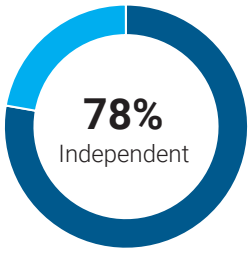
Director Nominee Snapshot

Age



40's 70's
60's

Independence



7 Independent
2 Non-Independent

Attributes



5 Diverse
4 Non-Diverse

Tenure



0-2 Years 6+ Years
3-5 Years

Director Tenure and Commitment to Refreshment

In response to feedback from our stockholders, we have made significant refreshments to our Board resulting in a current median tenure of less than 5 years.



In addition, our Board has a mandatory retirement age for non-management directors of 75 years and we have established a targeted period of seven years as a maximum tenure of a committee chairman. During 2023, we conducted a Board composition assessment and engaged with our third-party director search firm to conduct an evergreen director recruiting process in 2024 and 2025. Through that process, Mr. Tanji was appointed as a director in February 2025. In 2026, we have engaged another director search firm to recruit additional board candidates.

We believe our mix of director tenures, with our chairman serving for almost 20 years, and six members serving for less than five years, provides a desirable balance of knowledge continuity and director refreshment. Our three directors that have over six years of service with the Board provide insight into institutional knowledge and lessons learned from prior periods of corporate and industry changes.

Qualifications and Experience

Below we identify and describe the key experience, qualifications and skills our directors bring to the Board that are important considering the Company's business and structure.



Leadership (9/9)





Healthcare and Insurance (9/9)





Technology (5/9)





Business Development and Corporate Transactions (9/9)





Finance and Accounting (7/9)





Public Company Board and Governance (9/9)





Regulated Industry (9/9)





Corporate Sustainability and Community Involvement (9/9)

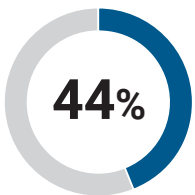
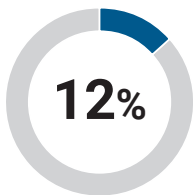


2025 Stockholder Engagement and Response

We believe that engaging with stockholders is fundamental to the Company's success and our commitment to good governance. Since our 2025 Annual Meeting of Stockholders, a combination of management and independent directors met with Centene stockholders as well as the leading proxy advisory firms to discuss governance-related topics. Feedback received from these discussions, as well as a review of feedback from previous years, has helped guide changes to our governance practices and our executive compensation program and further improve our sustainability disclosures and practices.

Beyond our governance-focused engagement, our investor relations team and members of our senior management team, including our Chief Executive Officer and Chief Financial Officer, regularly communicate with investors in connection with quarterly earnings calls, investor and industry conferences, analyst meetings and individual discussions with stockholders. Engaging with our stockholders remains a high priority, and our disclosures in this year's proxy statement directly reflect stockholder feedback. See page 56 for additional information regarding our stockholder engagement efforts.

Our governance-focused engagement efforts are summarized below:

Who We Engaged	**Proactively reached out to stockholders representing:**  **of our outstanding shares** Including **14** institutional investors	**Met with stockholders representing:**  **of our outstanding shares** Including **3** institutional investors
Company Representatives	• Chief Accounting Officer • General Counsel	• Head of Investor Relations • Head of Total Rewards
Topics Discussed	• Executive Compensation • Board Culture and Refreshment • Leadership Transitions	• Quality Improvement • Corporate Sustainability

Governance Highlights

In light of the positive stockholder feedback we have received in connection with our enhancements to our governance, we have continued the following:



Stockholder Rights

- Annual Election of Directors
- Majority Voting Uncontested Director Elections
- Directors Can Be Removed With or Without Cause
- "Proxy Access" Right for Stockholders
- 10% of Shares Can Call a Special Meeting
- Stockholders Can Act by Written Consent
- No Supermajority Vote Provisions
- No Stockholder Rights Plan or "Poison Pill"



Board Practices

- Commitment to Board Refreshment
- 78% of Board Independent
- Non-Executive, Independent Chairman
- Robust Board Evaluation Process
- Active Stockholder Engagement
- Mandatory Retirement Age of 75
- Limits on Public Company Directorships
- Continuing Education for Directors

2 PROPOSAL

Advisory Resolution to Approve Executive Compensation

The Board recommends a vote **FOR** this proposal.

See page 64

Executive Compensation Overview

The 2025 plan design and awards resulted in the following pay elements and average target pay mix for our CEO and other NEOs:

	2025 Pay Elements					
	CEO	Other NEOs	Award Type	Mix	Metrics	Purpose
Fixed	Base Salary 7%	13%	Cash			To recognize individual contribution, time in role, scope of responsibility, leadership skills and experience.
Variable	Annual Cash Incentive Plan 15%	14%	Cash		• Adjusted Diluted EPS (60%) • Organic Premium & Service Revenue Growth (20%) • Quality & Strategic Goals (20%)	To reward executives for performance on key financial and operational measures, factoring in individual contributions toward enterprise goals.
	Long-Term Incentive Awards 78%	73%	Equity	PSUs (60%) RSUs (40%)	• Relative Total Shareholder Return (TSR) (25%) • Medicare breakeven by 2027 (25%) • Average Adjusted Pre-Tax Earnings Margins (50%)	To retain and motivate executives to drive long-term stockholder value and align their actions to drive successful business outcomes.

2025 Annual Cash Incentive Plan Results

Metrics	Threshold	Target	Maximum	Result	Weighting	Weighted Payout %
Adjusted Diluted EPS[1]	Actual Result: $2.08 · 50% $6.50 · No Payout	100% $7.25 - $7.55	200% $8.30	-%	60%	-%
Organic Premium & Service Revenue Growth	50% $148B · No Payout	100% $159B	200% $170B · Actual Result: $174.6B	200%	20%	40%
Quality & Strategic Goals	50% · No Payout	100%	200%	158%	20%	31.6%
						71.6%

[1] Refer to Appendix A for reconciliations of non-GAAP measures included throughout this proxy statement.

2023 - 2025 Performance-Based Restricted Stock Unit Award Results

Metrics	Threshold	Target	Maximum	Weight	Weighted Metric Performance	Weighted Vesting %
Adjusted Pre-Tax Earnings Growth Compound Annual Growth Rate (CAGR)[1]	Actual Result: <0% · 6.0% · no payout	7.5%	9.5%	34%	—%	—%
2025 Adjusted Net Earnings Margin[2]	Actual Result: 0.6% · 2.9% · no payout	3.3%	3.7%	33%	—%	—%
Peer Group Relative TSR Percentile Rank	Actual Result: 0th · 25th · no payout	55th	80th	33%	—%	—%
						—%

[1] The 3-Year CAGR is calculated using adjusted pre-tax net earnings of $1.3 billion and $4.3 billion for December 31, 2025 and 2022, respectively. Refer to Appendix A for reconciliations of non-GAAP measures included throughout this proxy statement.

[2] The adjusted net earnings margin as of December 31, 2025 is derived from adjusted net earnings of $1.0 billion divided by premium and service revenues of $174.6 billion. Refer to Appendix A for reconciliations of non-GAAP measures throughout this proxy statement.

Compensation Best Practices

The Compensation and Talent Committee establishes and administers the executive compensation philosophy and program and assists the Board of Directors in the development and oversight of all aspects of executive compensation. Presented in the table below are highlights of our compensation practices:

What We Do

Pay for Performance
A majority of our NEOs' compensation is tied to performance with clearly articulated financial and other performance goals.

Competitive Compensation
Each component of the NEOs' annual total direct compensation is generally targeted at the 50th percentile of peer group compensation. The Compensation and Talent Committee may consider differences from the median in certain cases.

Performance-Based Long-Term Incentive Awards
We reward continuous performance on multiple metrics and vest at the end of a three-year period.

Formula-Based Annual Incentive Plan
Awards under the Annual Cash Incentive plan are formula based.

Tally Sheets
Tally sheets for each NEO are reviewed annually.

Annual Compensation Risk Assessment
We regularly analyze risks related to our compensation program and we conduct broad risk assessments.

Stock Ownership Requirements
We maintain rigorous stock ownership requirements for our directors, executives and other members of senior management. Our CEO's requirement is 6x annual base pay; other NEOs' requirements are 3x annual base pay.

Clawbacks
We can recover performance-based cash and equity incentive compensation paid to executives in various circumstances.

Independent Compensation Consultant
The Compensation and Talent Committee retains an independent compensation consultant to advise the committee on executive compensation matters.

Executive Severance Arrangements
The Compensation and Talent Committee reviews severance policies annually and limits the usage of one-off arrangements.

What We Don't Do

No Excessive Risk-Taking
The long-term incentive plans use multiple performance measures, capped payouts and other features intended to minimize the incentive to take overly risky actions.

No Tax Gross-Ups
There are no tax "gross-ups" for perquisites or excise tax gross-ups in the event of a change of control related termination.

No Single-Trigger Employment Agreements
Any cash payments in executive employment agreements are subject to a "double-trigger" change in control condition.

No Backdating or Repricing of Stock Options
Stock options are never backdated or issued with below-market exercise prices. Repricing of stock options without stockholder approval is expressly prohibited.

No Hedging or Pledging
Directors and executives are prohibited from hedging, pledging or engaging in any derivatives trading with respect to Company stock.

No Single-Trigger Stock Grants
Equity compensation awards are subject to a "double-trigger" change in control condition.

3
PROPOSAL

Ratification of Appointment of Independent Registered Public Accounting Firm

The Board recommends a vote **FOR** this proposal.

See page 109

KPMG LLP audited our financial statements for the fiscal year ended December 31, 2025. The Audit and Compliance Committee has appointed KPMG LLP to serve as our independent registered public accounting firm for the current fiscal year, and we are asking stockholders to ratify this appointment. KPMG LLP has been retained as our external auditor continuously since 2005.

4
PROPOSAL

Stockholder Proposal

The Board recommends a vote **AGAINST** this proposal.

See page 115

Board and Governance Matters

1 PROPOSAL Election of Directors

The first proposal on the agenda for the meeting is the election of 9 nominees to serve for a one-year term beginning at the meeting and ending at our 2027 Annual Meeting of Stockholders.

The Board has nominated Jessica Blume, Kenneth Burdick, Christopher Coughlin, James Dallas, Frederick Eppinger, Monte Ford, Sarah London, Theodore Samuels and Kenneth Tanji for re-election to the Board. We expect that all nominees will be able to serve if elected. If any of them are not able to serve, proxies may be voted for a substitute nominee or nominees or the Board may choose to reduce the size of the Board.

The Board believes the election of these 9 nominees is in our best interests and the best interests of our stockholders and recommends a vote **"FOR"** the election of the 9 nominees.

Board Overview

Director Qualifications

We believe that our directors should understand the wide range of populations we serve and possess the highest personal and professional ethics, integrity and values and be committed to representing the interests of our stockholders. They must also have an inquisitive and objective perspective, practical wisdom, mature judgment and demonstrated leadership skills. We also endeavor to have a Board of Directors representing a range of experiences in areas that are relevant to the Company's business activities.

Below we identify and describe the key experience, qualifications and skills criteria we believe are important for our Board of Directors, as a whole, to possess. These are the criteria our Governance Committee considers when evaluating director nominees.



Leadership Experience
We believe that directors with experience in significant leadership positions over an extended period, especially chief executive officers, chief financial officers and other senior executives, provide the Company with valuable insights and strategic thinking. These individuals generally possess extraordinary leadership qualities and the ability to identify and develop those qualities in others. They demonstrate a practical understanding of organizations, processes, strategy, risk management and the methods to drive change and growth.



Finance and Accounting Experience
We believe that directors with experience in public accounting, investment banking and financial services companies possess an understanding of finance and the financial reporting process with which to manage our business. We measure our operating and strategic performance by reference to financial targets. In addition, accurate financial reporting and robust auditing are critical to our success and developing stockholders' confidence in our reporting processes under the Sarbanes-Oxley Act of 2002.



Healthcare and Insurance Industry Experience
Our industry is complex and rapidly evolving. Healthcare and insurance industry experience includes expertise with healthcare operations, healthcare technology, insurance and other experience. Directors with industry experience help the Company stay abreast of industry best practices and innovations and help us to benchmark our practices against those of our competitors.



Corporate Sustainability Experience and Community Involvement
As a corporate citizen, we believe that sustainable operations are both financially and operationally beneficial to our business, and critical to the health of our employees and the communities in which we operate. We seek directors with experience in building strong environmental, labor, health & safety and ethical practices.



Information Technology and Security Experience
Because effective information systems and the integrity and timeliness of data we use to serve our customers and healthcare professionals are integral to the operation of our business, and because technology plays a central role in healthcare, including the diagnosis, management and treatment of disease, we seek directors with experience in relevant technology and who have experience managing cybersecurity and information security risks.



Public Company Board and Governance Experience
Directors with public company board experience understand the dynamics and operation of a corporate board, the relationship of a public company board to the Chief Executive Officer and other senior management personnel, the legal and regulatory landscape in which public companies must operate, the importance of particular agenda and oversight issues and how to oversee an ever-changing mix of strategic, operational and compliance-related matters.



Business Development and Corporate Transactions
Part of the Company's strategy includes taking advantage of opportunities when they arise to grow the Company consistent with its focus on its core business lines. Directors with experience in business development and corporate transactions provide oversight to assist the Company in evaluating the financial and operational aspects of such opportunities, enabling the Company to maintain its competitive position.



Regulated Industry
Experience in highly-regulated industries, such as healthcare, finance, airline transportation and public utilities help the Company navigate the complex regulatory and public policy issues that arise. Such experience also assists the Company to adapt to the changing regulatory environment.

Background & Experience

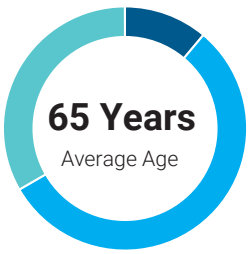
Below we identify and describe the key experience, qualifications and skills our directors bring to the Board that are important considering the Company's business and structure.

	Leadership	Finance and Accounting Experience	Healthcare and Insurance Industry Experience	Corporate Sustainability and Community Involvement	Technology	Public Company Board and Governance Experience	Business Development and Corporate Transactions	Regulated Industry
 Jessica L. Blume	●	●	●	●	●	●	●	●
 Kenneth A. Burdick	●	●	●	●	●	●	●	●
 Christopher J. Coughlin	●	●	●	●		●	●	●
 H. James Dallas	●		●	●	●	●	●	●
 Frederick H. Eppinger	●	●	●	●		●	●	●
 Monte E. Ford	●		●	●	●	●	●	●
 Sarah M. London	●	●	●	●	●	●	●	●
 Theodore R. Samuels	●	●	●	●		●	●	●
 Kenneth Y. Tanji	●	●	●	●		●	●	●

Board Refreshment

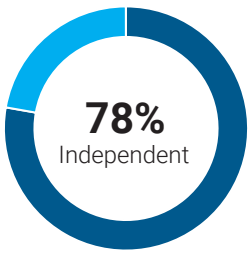
In making its recommendations to our Board, the Governance Committee considers the qualifications of individual director candidates applying the director criteria described above. We believe a range of backgrounds, viewpoints and experiences ensures different perspectives are heard and considered and assists our Board in reaching the best decisions for our Company and the members we serve.

Age



40's 70's
60's

Independence



7 Independent
2 Non-Independent

Attributes



5 Diverse
4 Non-Diverse

Tenure



0-2 Years 6+ Years
3-5 Years

Commitment to Investor Engagement and Overview of Responsive Actions

We continue to make enhancements to our governance and compensation practices in response to stockholder feedback. Below we summarize key stockholder feedback the Company has received from investors and the highlights of actions the Company took in response to feedback received.

HISTORY OF PROACTIVELY RESPONDING TO STOCKHOLDER FEEDBACK TO HELP ENSURE BEST-IN-CLASS GOVERNANCE, COMPENSATION, AND DISCLOSURE PRACTICES

2020

- Two new independent members appointed to the Board
- Implemented double-trigger vesting provisions for all new grants in the event of a change in control
- Began publishing Political Activity report

2021

- Elected new Lead Independent Director
- One independent member left the Board
- One new executive appointed to the Board
- Rotated Governance Committee chair and membership
- Adopted mandatory retirement age of 75 years for non-management directors

2022

- Separated CEO and Chairman roles, appointed new Independent Chairman
- Four independent members left the Board
- Five directors appointed to the Board
- Declassified the Board
- Allowed stockholders with 10% ownership rights to call a special meeting
- Provided stockholders the right to act by written consent
- Shortened proxy access ownership rights to 3 years and advance notice window to 90 - 120 days
- Rotated membership of committees
- Reduced committees from seven to four
- New CEO compensation set slightly below the median
- Appointed Frederick W. Cook & Co., Inc. (FW Cook) as new compensation consultant
- Adopted cash severance policy to limit cash severance to 2.99 times annual salary and bonus

2023

- Three independent directors left the Board
- Rotated Independent Chairman role
- Rotated membership of committees and chair of Audit and Compliance Committee
- Quality Committee replaced Value Creation Committee
- 2023-2025 Long-Term Incentive Plan no longer includes performance-based stock options
- 2023-2025 Long-Term Incentive Plan no longer includes Cash LTIP
- 2023-2025 Long-Term Incentive Plan metrics include relative Shareholder Return
- Implemented a formal Clawback Policy

2024

- One independent member appointed to the Board
- 2024-2026 Long-Term Incentive Plan includes average adjusted pre-tax margin
- Increased stock ownership requirements for CEO and other NEOs
- Improved plans, policies and procedures informed by “best practice” market trends

2025

- One independent member appointed to the Board.
- Three independent directors left the Board
- Rotated membership of the chair of the Audit and Compliance Committee and membership of committees

2026 Director Nominees

We have 9 nominees for the Board of Directors, all of whom serve on our current Board of Directors. We expect that all nominees will be able to serve if elected. If elected, each nominee would hold office until the 2027 Annual Meeting of Stockholders and until his or her respective successor is elected and qualified or until the earlier of his or her death, removal or resignation.

Pursuant to our Corporate Governance Guidelines, any director nominee who receives a greater number of votes "against" his or her election than votes "for" such election shall, promptly following certification of the stockholder vote, offer his or her resignation to the Board. The resignation offer shall be in writing and shall be an irrevocable resignation offer pending acceptance or rejection by the Board.

The Governance Committee shall consider the resignation offer and make a recommendation to the Board. In deciding the action to be taken with respect to any such resignation offer, the Board shall consider what it believes is in the best interests of Centene and its stockholders. In this regard, the Board will consider all factors it deems relevant. An accepted resignation offer will become effective immediately upon acceptance or upon such other time as determined by the Board. The Board's decision shall be made within 90 days of the certification of election results. The decision, and an explanation of the decision, shall be disclosed as soon as practicable by press release or Form 8-K.

Information about these nominees, including their ages at the date of this proxy statement and the year in which they first became directors are summarized below. The Board of Directors has affirmatively determined that each of the nominees, other than Mr. Burdick and Ms. London, is independent from the Company and its management under the New York Stock Exchange's (NYSE) independence standards.

Jessica L. Blume | 71



Retired Vice Chairman of Deloitte LLP

Director Since: February 2018

Independent Yes

Board Committees
Audit and Compliance; Governance (Chair)

Current Directorships
- Publix Super Markets, Inc.

Prior Directorships
None

EXPERIENCE:

Deloitte LLP, a leading PCAOB registered public accounting firm.
- Vice Chairman (2012 to 2015)
- Partner (1989 to 2015)

Prior to Deloitte, she served as Chief Financial Officer for one of the largest US local governments.
Bachelor of Science from the University of Central Florida
Former CPA

SKILLS AND REASONS FOR NOMINATION:

Leadership Experience	Three years as Vice Chairman of Deloitte LLP. 26 year career with Deloitte included service on the firm's US Executive Committee and Board of Directors, as the Chair of the Executive Compensation and Evaluation Committee, as a member of the Finance, Governance, Strategic Investment and Risk Committees.
Finance and Accounting Experience	Ms. Blume served at Deloitte as a licensed CPA, and she served as CFO for one of the largest US local governments. In addition, she currently serves on the audit committee of another company with SEC-registered securities.
Healthcare and Insurance	While at Deloitte, led consulting relationships for healthcare and insurance companies.
Corporate Sustainability and Community Involvement	Established and managed Deloitte's sustainability practice. Serves on the Board of University of Central Florida Foundation; Member of International Women's Forum and Women Corporate Directors.
Technology	Deloitte consulting practice included implementing large technology initiatives, including state Medicaid eligibility systems and large enterprise systems.
Public Company Board and Governance	Service on the Board of Directors of Deloitte LLP and Publix Super Markets, with SEC-registered securities.
Business Development and Corporate Transactions	While at Deloitte, Ms. Blume led several large-scale business transformations, including the reintegration of Deloitte Consulting with the Deloitte US Firm.
Regulated Industry	While at Deloitte, led consulting relationships with federal and state governments and in a variety of regulated industries, including healthcare and insurance companies.

Kenneth A. Burdick | 67



Executive Chairman of National Veterinary Associates; Chairman of LifeStance Health Group, Inc.; Former Executive Vice President of Products and Markets of Centene Corporation

Director Since:
January 2022

Independent
No

Board Committees
Quality (Chair)

Current Directorships
- LifeStance Health Group, Inc.

Prior Directorships
- WellCare Health Plans, Inc.
- Orion Acquisition Corporation
- First Horizon National Corporation

EXPERIENCE:

National Veterinary Associates, a private veterinary health company.
- Executive Chairman (2025 to present)

LifeStance Health, Inc., a Nasdaq-listed public company specializing in outpatient mental healthcare.
- Chairman (2026 to present)
- Executive Chairman (2025 to 2026)
- Chief Executive Officer and Chairman (2022 to 2025)

Centene Corporation
- Executive Vice President of Markets and Products (2020 to 2021)

WellCare Health Plans, Inc., a NYSE-listed public company providing government-sponsored healthcare programs.
- Chief Executive Officer and Director (2015 to 2020)
- Other positions of increasing responsibility, including President and Chief Operating Officer (2014 to 2015)

Blue Cross and Blue Shield of Minnesota, commercial health insurance plans.
- President and Chief Executive Officer and Director (2012)

Coventry Health Care, Inc., a NYSE-listed public company providing government-sponsored healthcare programs.
- Chief Executive Officer of the Medicaid and Behavioral Health businesses (2010 to 2012)

UnitedHealth Group, Inc., a NYSE-listed public company health insurer.
- Chief Executive Officer of Secured Horizons (Medicare division of UnitedHealthcare) (2008 to 2009)
- Other positions of increasing responsibility, including Chief Executive Officer of UnitedHealthcare (1995 to 2008)

Bachelor of Arts from Amherst College

Juris Doctorate from the University of Connecticut

SKILLS AND REASONS FOR NOMINATION:

Leadership Experience	Over 30 years of healthcare executive and operations experience, including prior roles as a Fortune 500 public-company chief executive officer and board member.
Finance and Accounting Experience	In roles as a chief executive officer, supervision of the accounting and financial reporting functions.
Healthcare and Insurance	Over 30 years of healthcare executive experience, including at LifeStance, Centene and WellCare Health Plans.
Corporate Sustainability and Community Involvement	Service as a director of Big Brothers, Big Sisters, Tampa General Hospital and in his roles as a chief executive officer, supervision of the sustainability functions.
Technology	In roles as a healthcare executive, supervisor of the technology functions and the implementation of large technology initiatives.
Public Company Board and Governance	Service on the Board of Directors of WellCare Health Plans, First Horizon National Corporation and LifeStance Health Group.
Business Development and Corporate Transactions	While at WellCare, Mr. Burdick supervised the acquisition of WellCare Health Plans, Inc. by Centene Corporation, and the acquisition by WellCare of Universal American, among others, resulting in the growth of the Company during his tenure.
Regulated Industry	Executive experience at healthcare companies, as well as a director of a financial institution.

Christopher J. Coughlin | 73



Retired Executive Vice President and Chief Financial Officer, Tyco International Ltd.

Director Since: January 2022

Independent Yes

Board Committees
Audit and Compliance;
Compensation and Talent (Chair)

Current Directorships
- None

Prior Directorships
- Allergan plc
- Alexion Pharmaceuticals, Inc.
- Covidien plc
- Dipexium Pharmaceuticals, Inc.
- Perrigo Company
- Prestige Consumer Healthcare, Inc.
- Karuna Therapeutics, Inc.
- Hologic Inc.
- Dun & Bradstreet Corp.
- Forest Laboratories, LLC
- Interpublic Group of Companies
- Monsanto Company

EXPERIENCE:

Tyco International Ltd., a NYSE-listed public manufacturing, healthcare and security systems company.
- Senior Advisor to the Chief Executive Officer and member of Board of Directors (2010 to 2012)
- Executive Vice President and Chief Financial Officer (2005 to 2010)

Interpublic Group of Companies, a NYSE-listed public multimedia company.
- Chief Operating Officer (2003 to 2004)
- Chief Financial Officer (2003 to 2004)

Pharmacia Corporation, a NYSE-listed public pharmaceuticals company.
- Executive Vice President and Chief Financial Officer (1998 to 2003)

Received a Bachelor of Science from Boston College

SKILLS AND REASONS FOR NOMINATION:

Leadership Experience	Over 40 years of executive, financial and accounting experience, including prior roles as a Fortune 500 public-company chief financial officer and board member.
Finance and Accounting Experience	In roles as a chief financial officer, supervision of the accounting and financial reporting functions.
Healthcare and Insurance	Over 40 years of healthcare and insurance experience, including at Pharmacia and Tyco International.
Corporate Sustainability and Community Involvement	In his roles as a chief financial officer and public company director, supervision of the sustainability functions.
Public Company Board and Governance	Over 30 years of service at 10 different public companies. Named a 2022 Director of the Year by the New Jersey Chapter of the National Association of Corporate Directors (NACD) and named the NACD Corporate Director of the Year in 2015.
Business Development and Corporate Transactions	While at Tyco, he was instrumental in turning the company around after a management and financial scandal and ultimately separated it into six separate public companies. Significant experience both as an executive and a board member in numerous large mergers and acquisition transactions.
Regulated Industry	Executive experience at pharmaceutical and manufacturing companies.

H. James Dallas | 67



Former Senior Vice President, Quality and Operations, Medtronic Public Limited Company

Director Since: January 2020

Independent Yes

Board Committees
Audit and Compliance; Quality

Current Directorships
- KeyCorp

Prior Directorships
- WellCare Health Plans, Inc.
- Strategic Education, Inc.
- Capella Education Company

EXPERIENCE:

Independent Consultant
- Focusing on change management, information technology strategy and risk (2013 to present)

Medtronic Plc, a NYSE-listed global medical technology company.
- Senior Vice President of Quality and Operations (2011 to 2013)
- Senior Vice President and Chief Information Officer (2006 to 2011)

Georgia-Pacific Corporation, a NYSE-listed public company which manufactures tissue, pulp, paper, packaging, building products and related chemicals.
- Vice President and Chief Information Officer (2002 to 2006)
- President, Lumber Division and other roles of increasing responsibility (1984 to 2002)

Bachelor of Science from the University of South Carolina - Aiken

Master of Business Administration from Emory University

SKILLS AND REASONS FOR NOMINATION:

Leadership Experience	Over 40 years of executive and information technology experience, including prior roles as a Fortune 500 public-company chief information officer.
Healthcare and Insurance	Prior service as director WellCare Health Plans, Inc. and continued service as a director of healthcare provider Grady Memorial Hospital Corporation.
Corporate Sustainability and Community Involvement	Service as a director of the Atlanta Food Bank, Atlanta Habitat for Humanity and Grady Memorial Hospital Corporation, the public hospital for the city of Atlanta.
Technology	In roles as a chief information officer, in-depth knowledge of enterprise change management, operational risk management, information technology, information technology security and data privacy.
Public Company Board and Governance	Over 15 years of service as a director at five different public companies.
Business Development and Corporate Transactions	As a director, he participated in the acquisition of WellCare Health Plans, Inc. by Centene and Capella Education Company by Strategic Education, Inc. Successful implementation of more than 10 transformational and turnaround initiatives, 30 acquisition integrations, five operations/quality shared services centers and three innovation centers.
Regulated Industry	Executive experience at manufacturing, medical technology companies and director experience at a bank.

Frederick H. Eppinger | 67



Director, President and Chief Executive Officer of Stewart Information Services Company

Director Since: April 2006

Independent Yes

Board Committees
Compensation and Talent; Quality

Current Directorships
- Stewart Information Services Company

Prior Directorships
- The Hanover Insurance Group, Inc.
- QBE Insurance Group Ltd.

EXPERIENCE:

Stewart Information Services Company, a NYSE-listed global real estate services and title insurance company.
- Chief Executive Officer (2019 to present)
- Director (2016 to present)

The Hanover Insurance Group, a NYSE-listed property and casualty insurance company.
- Director, President and Chief Executive Officer (2003 to 2016)

Hartford Financial Service Group, a NYSE-listed investment and insurance company.
- Executive Vice President of Property and Casualty Field and Service Operations (2001 to 2003)

Channel Point, a business-to-business technology firm for insurance companies.
- Executive Vice President of Industry Services, Marketing and Service Operations (2000 to 2001)

McKinsey & Co., a global management consultancy firm.
- Senior Director and Partner (1985 to 2000)

Coopers & Lybrand, an accounting firm.
- Accountant

Bachelor of Arts from the College of the Holy Cross
Master of Business Administration from the Tuck School of Business Administration at Dartmouth College

SKILLS AND REASONS FOR NOMINATION:

Leadership Experience	Over 20 years of executive experience, including prior roles as a Fortune 500 public-company chief executive officer.
Finance and Accounting Experience	In roles as a chief executive officer, supervision of the accounting and financial reporting functions. He began his career as an accountant with Coopers & Lybrand.
Healthcare and Insurance	More than 35 years of experience in the insurance industry. His service at McKinsey included work in insurance, financial services and health practices.
Corporate Sustainability and Community Involvement	In his role as a chief executive officer, supervision of the sustainability function, corporate giving and charitable foundations.
Public Company Board and Governance	Over 20 years of service as a director at three different US public companies. He also served as a director of QBE Insurance Group Ltd, which is listed on the Australian stock exchange.
Business Development and Corporate Transactions	As chief executive officer of Hanover Insurance, Mr. Eppinger led the company's growth from its regional status to a global property/casualty carrier.
Regulated Industry	More than 35 years of experience in the insurance industry.

Monte E. Ford | 66



Principal Partner, Chief Information Officer Strategy Exchange

Director Since: November 2022

Independent Yes

Board Committees
Compensation and Talent; Quality

Current Directorships
- JetBlue Airways Corporation
- Iron Mountain Inc.
- Akamai Technologies, Inc.

Prior Directorships
- Health Care Service Corporation (HCSC)
- MoneyGram International, Inc.
- Oncor Electric Delivery Company LLC
- Meta Group
- Michael's Stores

EXPERIENCE:

CIO Strategy Exchange (CIOSE), a leading cross-industry consortium of Chief Information Officers from many of the world's largest companies.
- Principal Partner (2015 to present)

Aptean Inc., an ERP software and technology company.
- Chief Executive Officer (2012 to 2013)

American Airlines, Inc., a NYSE-listed public airline company.
- Chief Information Officer (2000 to 2012)

Associates First Capital, a financial services company.
- President, Associates Services Corporation (1997 to 2000)
- Chief Information Officer (1994 to 2000)

Bank of Boston, a regional bank.
- Senior Vice President (1990 to 1994)

Digital Equipment Corporation, a NYSE-listed public computer manufacturer.
- Various senior sales, marketing and technology positions (1982 to 1990)

Bachelor of Science from Northeastern University

SKILLS OR REASONS FOR NOMINATION:

Leadership Experience	Over 40 years of senior executive and information technology experience, including prior roles as a Fortune 100 public-company chief information officer.
Healthcare and Insurance	Prior service as director of Health Care Service Corporation, a commercial health insurance provider, and as a director of Baylor Grapevine Hospital and a director of Children's Hospital, Dallas.
Corporate Sustainability and Community Involvement	Oversight of sustainability as a director for a combined 15 years at both a large electric utility and a large data center company.
Technology	In roles as a chief information officer, in-depth knowledge of consumer technologies, enterprise change management, information technology, information technology, security and data privacy.
Public Company Board and Governance	Over 23 years of service as a director at 7 different public companies and several private companies, including Michael's Stores, Inc.
Business Development and Corporate Transactions	Executive responsible for M&A Integration at American Airlines, Associates First Capital and Bank of Boston. Closed several acquisitions as chief executive officer of a technology company. Extensive successful sales and marketing background.
Regulated Industry	Executive experience in the airline and financial services industries as well as director experience at a financial institution, electric utility, healthcare insurer and healthcare providers.

Sarah M. London | 45



Chief Executive Officer of Centene Corporation

Director Since: September 2021

Independent No

Board Committees
None

Current Directorships
None

Prior Directorships
None

EXPERIENCE:

Centene Corporation
- Chief Executive Officer (March 2022 to present)
- Vice Chairman (September 2021 to March 2022)
- President, Health Care Enterprises and Executive Vice President, Advanced Technology (March 2021 to September 2021)
- Senior Vice President, Technology and Modernization (September 2020 to March 2021)

Optum Ventures, a division of UnitedHealth Group, a NYSE-listed health insurance company.
- Senior Principal and Operating Partner (May 2018 to March 2020)

Optum Analytics, a division of UnitedHealth Group, a NYSE-listed health insurance company.
- Chief Product Officer (March 2016 to May 2018)
- Vice President, Client Management and Operations (March 2014 to March 2016)

Bachelor of Arts from Harvard College

Master of Business Administration from the University of Chicago Booth School of Business

SKILLS AND REASONS FOR NOMINATION:

Leadership Experience	Over 10 years of executive experience, including four years as Chief Executive Officer of the Company.
Finance and Accounting Experience	In her role as Chief Executive Officer, supervision of the accounting and financial reporting functions. She has executed on a disciplined strategy of cost savings and gross margin expansion.
Healthcare and Insurance	More than 10 years of experience in the healthcare industry.
Corporate Sustainability and Community Involvement	In her role as Chief Executive Officer, supervision of the Company's sustainability initiatives as well as service as a director of the Centene Foundation.
Technology	Her roles in healthcare technology companies as well as Chief Executive Officer of Centene have provided her with in-depth knowledge of enterprise change management and information technology business needs and solutions.
Public Company Board and Governance	Over four years of service as a director of Centene.
Business Development and Corporate Transactions	In her role as Chief Executive Officer of the Company, supervision of 11 divestitures and the Express Scripts, Inc. (ESI) PBM implementation.
Regulated Industry	More than 10 years of experience in the healthcare industry.

Theodore R. Samuels | 71



Former President, Capital Guardian Trust Company

Director Since: January 2022

Independent Yes

Board Committees
Compensation and Talent; Governance

Current Directorships
- Bristol Myers Squibb
- Iron Mountain, Inc.

Prior Directorships
- Stamps.com
- Perrigo Company, plc.

EXPERIENCE:

Capital Guardian Trust Company, part of the Capital Group, an investment manager.
- President (2010 to 2017)
- Investor and Global Equity Portfolio Manager (1981 to 2016)
- Capital Group Finance Committee (2013 to 2016)
- Capital Group Board (2005 to 2009)
- Numerous Investment and Management Committees (1981 to 2017)

Bachelor of Arts from Harvard College

Master of Business Administration from Harvard Business School

SKILLS AND REASONS FOR NOMINATION:

Leadership Experience	Over 35 years of executive experience, including as President of Capital Guardian Trust Company. While at Capital Group he served on numerous management and investment committees, with an eye towards long-term stockholder value creation.
Finance and Accounting Experience	Over 35 years of experience in the financial industry with extensive expertise, particularly with respect to economics, capital markets and investment decision making.
Healthcare and Insurance	Over nine years of service on the boards of pharmaceutical, life science and healthcare consumer products companies, and sixteen years of service on the boards of Children's Hospital Los Angeles and seven years of service on the board of BJC Healthcare Systems.
Corporate Sustainability and Community Involvement	Serves as a director of BJC Healthcare System, and a trustee for the Edward Mallinckrodt, Jr. Foundation and served on the board of the John Burroughs School and as a director for Children's Hospital Los Angeles.
Public Company Board and Governance	Nine years of service as a director with five different public companies and various private companies.
Business Development and Corporate Transactions	While at Capital group he served on numerous management and investment committees, focused on long-term stockholder value creation. As a director of numerous public companies, evaluated business development opportunities, corporate transactions and integration of acquisitions.
Regulated Industry	More than 35 years of experience in the financial services industry and service as a director on boards of hospitals, pharmaceutical, life science and healthcare consumer product companies.

Kenneth Tanji | 60



Former Chief Financial Officer, Prudential Financial, Inc.

Director Since: February 2025

Independent Yes

Board Committees
Audit and Compliance (Chair); Governance

Current Directorships
- The Public Service Enterprise Group, Inc
- Putnam Mutual Funds

Prior Directorships
- None

EXPERIENCE:

Prudential Financial, Inc., a NYSE-listed international financial services firm.
- Executive Vice President and Chief Financial Officer (2018 to 2024)
- Senior Vice President and Treasurer (2013 to 2018)
- Chief Financial Officer, International Insurance (2010 to 2013)
- Chief Financial Officer, Prudential Annuities (2006 to 2010)
- Chief Financial Officer, Prudential Investment Management (2004 to 2006)
- Vice President of Finance, Investment Division (2002 to 2004)
- Senior Vice President, Prudential Securities (1994 to 2002)
- Various roles of increasing importance, including healthcare insurance (1988 to 1994)

Bachelor of Arts from Yale University

Master of Business Administration from University of Minnesota

SKILLS AND REASONS FOR NOMINATION:

Leadership Experience	Over 35 years of executive, financial and accounting experience, including prior roles as a Fortune 500 public-company chief financial officer.
Finance and Accounting Experience	Significant experience in internal controls, capital markets, corporate governance, risk management and strategic planning from both an insurance company and public accounting perspective.
Healthcare and Insurance	Previously chief financial officer of a large insurance company.
Corporate Sustainability and Community Involvement	In his roles as a chief financial officer and public company director, he supervised sustainability. He also serves as a director of various community boards.
Public Company Board and Governance	Over two years of service as a director for a public utility company.
Business Development and Corporate Transactions	In his role as chief financial officer of Prudential Financial, Inc., he led corporate development in evaluating and executing strategies to optimize business profile and mix. Through his experience at Prudential, he led several significant business acquisitions and dispositions.
Regulated Industry	Executive experience in the insurance industry and as a director of a public utility company.

Independence of Directors

In accordance with the NYSE's listing requirements, the Board has evaluated, for each of the director nominees, his or her independence from the Company and its management. In its evaluation, the Board reviewed whether any transactions or relationships exist currently, or existed during the past three years, when relevant, between each nominee and the Company or its subsidiaries, affiliates or independent auditors. The Board also examined whether there were any transactions between each nominee and members of the senior management of the Company or their affiliates.

Based on this review and the NYSE's definition of "independence," the Board has affirmatively determined that all director nominees are and all directors who served during 2025 were independent as defined under the rules of the NYSE, except for Ms. London due to her current employment by the Company and Mr. Burdick due to his related party transaction. As disclosed under "Related Party Transactions," Mr. Burdick was the executive chairman of LifeStance Health Group, Inc. until March 14, 2026, to which the Company has made payments. The independent directors currently are Ms. Blume, Mr. Coughlin, Mr. Dallas, Mr. Eppinger, Mr. Ford, Mr. Samuels and Mr. Tanji. The Board has also determined that each of the members of our Compensation and Talent Committee meet the enhanced independence requirements under the rules of the NYSE. The Board has also determined that each of the members of our Audit and Compliance Committee is "independent" for purposes of Rule 10A-3 under the Securities Exchange Act of 1934, as amended (the Exchange Act), and the NYSE's listing requirements, and that each of Ms. Blume, Mr. Coughlin, and Mr. Tanji is an "audit committee financial expert" as that term is defined by SEC regulations.

No director or director nominee, excluding Ms. London and Mr. Burdick, has a direct or indirect material relationship with us except for their role as a director or stockholder. No director, including any director standing for election, or any associate of a director, is a party adverse to us or any of our subsidiaries in any material proceeding or has any material interest adverse to us or any of our subsidiaries. No director, including any director standing for election, is related by blood, marriage or adoption to any other director or any executive officer.

Director Nomination Process

In making its annual director nominations determination, the Board's objective is to recommend a group of directors that can best ensure the continuing success of our business and represent stockholder interests through the exercise of sound judgment using its diversity of experience and perspectives.

01 Assess Board Composition

We contracted with our search firm to provide us with a Board composition study that was presented to the Board in September 2023, which analyzed the attributes of our directors and potential refreshment possibilities to develop evaluation criteria for Board candidates. The Board and Governance Committee continue to meet with the third party search firms to prioritize the criteria for new director candidates.

02 Identify Candidate Pool

When the Governance Committee recruits new director candidates, the process typically involves either a search firm or one or more members of the Governance Committee or Board reviewing potential candidates from a range of backgrounds based on the evaluation criteria developed with the search firm and contacting prospective candidates to assess interest and availability.

03 Evaluate Candidates

A candidate will then meet with members of the Board, including our Chief Executive Officer. At the same time, the Governance Committee and the search firm will contact references for the candidate. A background check is completed before a final candidate recommendation is made to the Board.

04 Recommend Candidate to Board

The Governance Committee recommends to the Board director candidates for nomination and election during the Annual Stockholders' Meeting or for appointment to fill vacancies.

The Governance Committee works with our Board to determine the characteristics, skills and experience for the Board as a whole and its individual members with the objective of having a board with the most suitable candidates. The Board includes candidates from a broad spectrum of skills, perspectives and experience in the selection process for a director role.

We engaged a third-party director search firm to conduct an evergreen recruiting process, and in connection with that, Mr. Tanji was identified and appointed to serve on the Board in February 2025. The Company has engaged another third-party director search firm to recruit additional director candidates.

The Board does not believe that directors should expect to be re-nominated annually. In determining whether to recommend a director for re-election, the Governance Committee considers the director's tenure, participation in and contributions to the activities of the Board, the results of the most recent Board evaluation, meeting attendance and how the director's experience, qualifications and skills complement the experience, qualifications and skills of the Board as a whole.

Stockholder Recommendations of Director Candidates

Stockholders may recommend individuals to the Governance Committee for consideration as potential director candidates by submitting their names, together with appropriate biographical information and background materials to Governance Committee, c/o Corporate Secretary, Centene Corporation, 7700 Forsyth Boulevard, St. Louis, Missouri 63105. The Governance Committee will evaluate stockholder-recommended candidates by following substantially the same process and applying substantially the same criteria as it follows for candidates submitted by others.

Stockholders may nominate directors by submitting the names and other relevant information on a timely basis in accordance with the procedures set forth in our By-laws, which are summarized below in "Other Matters—Stockholder Proposals and Director Nominations."

Corporate Governance

Corporate Governance Guidelines

The Governance Committee developed and recommended to the Board a set of corporate governance guidelines, which the Board adopted. Our Corporate Governance Guidelines may be found on our website at www.centene.com. These guidelines include: a limitation on the number of boards on which a director may serve, qualifications for directors (including a requirement that directors be prepared to resign from the Board in the event of any significant change in their personal circumstances that could affect the discharge of their responsibilities), director orientation, continuing education and a requirement that the Board and each of its Committees perform an annual self-evaluation.

Our Governance Practices

We strive to implement best practices in stockholder rights and strong corporate governance policies that promote the long-term interests of stockholders, strengthen Board and management accountability and build on our sustainability leadership. We have enhanced our corporate governance framework over time based on input from our Board, stockholders and other governance experts. Our governance practices include:

Boards are accountable to stockholders

- **Annual Election of Directors.** We have an unclassified Board. All directors are elected annually for one-year terms.
- **Majority Voting Uncontested Director Elections.** Any director nominee must resign if they do not receive an affirmative vote of a majority of votes cast in an uncontested election. The Board will then determine whether to accept the resignation and disclose any decision not to accept the resignation.
- **Removal Rights.** Stockholders can remove directors with or without cause.
- **Proxy Access.** Up to 20 stockholders owning at least 3% of shares continuously for three years may nominate up to the greater of two individuals or 20% of our Board.
- **Special Meeting Rights.** Stockholders owning at least 10% of our outstanding shares have the right to call a special meeting of the stockholders.
- **Action by Written Consent Rights.** Stockholders have the right to act by written consent.
- **No Stockholder Rights Plan.** We do not have a stockholder rights plan, commonly referred to as a "poison pill."

Boards should be responsive to stockholders and be proactive in order to understand their perspectives

- **Engagement with Stockholders.** Independent directors meet regularly with stockholders, including participation of independent committee chairs.
- **Political Contributions Disclosures.** We publicly disclose our political contributions and public advocacy efforts and the contributions of our federal and state political action committees.
- **Strong Code of Conduct.** Centene is committed to operating its business with the highest level of ethics and integrity and has adopted a code of conduct that apply to all directors and to all employees.

Boards should adopt structures and practices that enhance their effectiveness

- **Commitment to Board Refreshment.** 6 of our 9 director nominees have joined the Board in the last 5 years and have expanded the Board's scope of experience.
- **Committee Charters.** Each standing committee operates under a written charter that has been approved by the Board and is reviewed annually.
- **Regular Review of Committee Membership.** The Governance Committee annually reviews the committee membership.
- **Independent Board.** Over 75% of the director nominees are independent.
- **Executive Sessions.** Independent directors meet regularly without management and non-management directors at both full Board and committee meetings.
- **Mandatory Retirement Age.** Mandatory retirement age of 75 provides regular opportunities for Board refreshment.
- **Limits on Public Company Directorships.** To ensure directors are able to devote sufficient time and attention to their responsibilities as board members, directors may not serve on more than three boards of other public companies.
- **Board and Committee Self-Evaluation Process.** Our Board and committees conduct annual performance self-evaluations led by the chair of the Governance Committee, including one-on-one interviews.
- **Continuing Education for Directors.** The Board is regularly updated on the Company's businesses, strategies, customers, operations and employee matters, as well as external trends and issues that affect the Company. Directors also are encouraged to attend continuing education courses relevant to their service on our Board.

Boards should have strong, independent leadership

- **Independent Board Leadership.** Our Chairman of the Board is a non-executive, independent director.
- **Independent Board Committees.** Each of the Audit and Compliance Committee, Compensation and Talent Committee and Governance Committee is comprised entirely of independent directors.

Stockholders should be entitled to voting rights in proportion to their economic interest

- **No Supermajority Vote Provisions.** We do not have any supermajority vote provisions in our Articles of Incorporation or By-laws.
- **No Cumulative Voting.** We have a single class of shares with equal voting rights.

Boards should develop management incentive structures that are aligned with the long-term strategy of the company

- **Pay-for-Performance Compensation Philosophy.** The Compensation and Talent Committee reviews our compensation practices, including short and long-term goals to ensure they are aligned with the Company's strategy.

The Board continuously reviews our governance practices, assesses the regulatory and legislative environment and adopts the governance practices that best serve the interests of our stockholders.

Proxy Access

Proxy access allows stockholders who meet minimum stock ownership and holding period requirements, and who comply with specified procedural and disclosure requirements, the opportunity to include their director nominees in the Company's proxy materials. We believe proxy access gives our long-term stockholders a valuable right and enables them to have an important voice in director elections. The following is a summary outlining key details of requirements related to our proxy access By-law:

Ownership Threshold	*at least 3% of the Company's outstanding common stock*
Group Ownership	*a group of 20 or less holders*
Ownership Period	*at least 3 years of continuous ownership*
Number of Nominees	*the greater of two individuals or 20% of the Board*

Board and Committee Structure

Board Leadership Structure

The Board determines the most suitable leadership structure from time to time. At present, the Board has chosen to separate the roles of Chief Executive Officer and Chairman of the Board. Sarah London is our Chief Executive Officer and Frederick Eppinger is our independent, non-executive Chairman of the Board. We believe this structure is optimal for Centene at this time because it allows Ms. London to focus on leading the organization while our Chairman focuses on leading the Board. Mr. Eppinger was chosen to serve as Chairman due to his long tenure as a director of the Company and his experience as chief executive officer, providing continuity, management expertise and institutional knowledge, which balances the recent influx of newer directors. The Board believes that its leadership structure supports its risk oversight efforts.

Role of the Board Chair



Duties/Responsibilities:

- **Presiding at meetings of Board**, including executive sessions of the non-management directors, which occur at least quarterly.
- **Approving the agenda for the Board** in consultation with the Chief Executive Officer.
- **Calling executive sessions** of the non-management directors.
- **Facilitating the critical flow of information** between the Board and senior management, including ensuring that such information is timely and adequate.
- **Advising senior management** on stockholder engagement strategy and long-term strategy.
- **Being available** for consultations and communications with stockholders as appropriate.

Structure of Board of Directors

Our Amended and Restated By-laws provide that our Board of Directors shall consist of five to 14 directors, with the exact number of directors on the Board being fixed from time to time by resolution adopted by the affirmative vote of a majority of the total number of directors then in office. Currently, the Board is fixed at nine directors, with seven of the nine directors determined to be independent. Frederick Eppinger serves as non-executive Independent Chairman of the Board. Nine members of the Board are standing for re-election to hold office until the 2027 Annual Meeting of Stockholders.

Board Committees and Functions

The Board has the following four standing committees:

- **Audit and Compliance Committee**
- **Compensation and Talent Committee**
- **Governance Committee**
- **Quality Committee**

The charters for each of the standing committees is available on our website at investors.centene.com. The table below shows membership as of December 31, 2025 and March 19, 2026 in our standing committees and the number of meetings of each committee held in 2025.

Current Directors	Audit and Compliance Committee	Compensation and Talent Committee	Governance Committee	Quality Committee
Jessica L. Blume	●		▲	
Kenneth A. Burdick				▲
Christopher J. Coughlin	●	▲		
H. James Dallas	●			●
Frederick H. Eppinger		●		●
Monte E. Ford		●		●
Sarah M. London				
Theodore R. Samuels		●	●	
Kenneth Y. Tanji	▲		●	
Number of Meetings Held in 2025	**9**	**6**	**5**	**4**

▲ Chair ● Member

Audit and Compliance Committee

Membership as of March 19, 2026



Kenneth Tanji (Chair)



Jessica Blume



Christopher Coughlin



H. James Dallas

9 committee meetings in 2025

OVERVIEW:

The **Audit and Compliance Committee** has jurisdiction over financial statements and disclosures; controls and procedures (including information technology and cybersecurity controls and procedures); the independent auditor; oversight of risk management; capital structure; compliance; and those aspects of sustainability that relate to financial reporting.

RESPONSIBILITIES:

- Appoints, evaluates, oversees the work and compensation of, and removal of, the Independent Auditors; reviews and approves in advance the terms of the engagement of the Independent Auditors and all audit and permissible non-audit services to be provided by the Independent Auditors.
- Oversees the Internal Audit function and reviews with Internal Audit the risk assessment process, results and resulting annual audit plan for the upcoming year and the results of internal audit activities.
- Oversees policies with respect to risk assessment and risk management, oversees the Company's financial risks and discusses with management the Company's enterprise risk management program.
- Reviews with the Independent Auditors and management both management's assessment and the Independent Auditors' annual report on the effectiveness of the Company's internal controls and reviews with management the adequacy and effectiveness of the Company's internal controls, financial controls and disclosure controls and procedures, including with regard to sustainability.
- Reviews with management and, if appropriate, the Independent Auditors, the Company's annual and quarterly financial statements, earnings press releases and significant accounting policies regarding financial information and earnings guidance provided to analysts and rating agencies.
- Reviews litigation and other legal or regulatory matters that may have a material impact on the Company's financial statements.
- Reviews the Company's information technology security program and reviews and discusses the controls around cybersecurity, including the Company's business continuity and disaster recovery plans.
- Establishes, oversees and reviews procedures related to (i) the receipt, retention and treatment of complaints regarding accounting, internal accounting controls, auditing matters or federal securities laws reporting and disclosure matters; and (ii) the confidential, anonymous submission of concerns regarding questionable accounting or auditing matters by employees.
- Reviews capital structure, insurance programs, tax policies and mergers and acquisitions.
- Oversees the Ethics and Compliance Program, and matters related to the Company's compliance with laws and regulations.

MEMBER QUALIFICATIONS:

- Each member of the Audit and Compliance Committee is independent, in accordance with the NYSE standards, SEC rules and the Company's Corporate Governance Principles.
- Each member of the Audit and Compliance Committee meets the financial literacy requirements of the NYSE Listed Company rules.
- In addition, our Board has determined that each of Messrs. Coughlin, Tanji and Ms. Blume qualifies as an "audit committee financial expert" within the meaning of SEC regulation.

REPORT:

The Audit and Compliance Committee Report is on page 113.

Compensation and Talent Committee

Membership as of March 19, 2026



Christopher Coughlin (Chair)



Frederick Eppinger



Monte Ford



Theodore Samuels

6 committee meetings in 2025

OVERVIEW:

The **Compensation and Talent Committee** has jurisdiction over executive compensation and human capital management.

RESPONSIBILITIES:

- Annually reviews and approves corporate goals and objectives relevant to our CEO's compensation.
- Approves or makes recommendations to the Board with respect to our CEO's compensation.
- Reviews and approves the compensation of our other executive officers.
- Oversees an evaluation of our senior executives.
- Oversees and administers our incentive plans, including our equity incentive plans.
- Reviews and discusses with management the compensation, discussion and analysis section of the proxy statement.
- Assists in the oversight of risks associated with our compensation plans and policies.
- Reviews and makes recommendations to the Board with respect to director compensation.
- Oversees stock ownership guidelines applicable to the Board and the executive officers.
- Oversees any clawback policy.
- Reviews the results of any advisory stockholder vote on executive compensation and considers whether to make or recommend adjustments to the Company's executive compensation as a result of such vote.
- Retains and terminates any compensation consultant to be used to assist the Compensation and Talent Committee in the evaluation of executive compensation.
- Reviews human capital management strategies.

MEMBER QUALIFICATIONS:

Each member of the Compensation and Talent Committee is independent, in accordance with the NYSE standards, including the heightened standards for compensation and talent committee members and the Company's Corporate Governance Guidelines, and is a "non-employee" director as defined by Rule 16b-3 under the Exchange Act.

REPORT:

The Compensation and Talent Committee Report is on page 94.

Governance Committee

Membership as of March 19, 2026



Jessica Blume (Chair)



Theodore Samuels



Kenneth Tanji

5 committee meetings in 2025

OVERVIEW:

The **Governance Committee** has jurisdiction over the director evaluation process; the Board and committee composition; succession planning; general environmental, social and governance matters, except for sustainability issues related to financial reporting which are overseen by the Audit and Compliance Committee; government relations; and bi-annual review of the political activity report.

RESPONSIBILITIES:

- Oversees the Board and each committee's composition (including member qualifications), structure, size and succession planning.
- Monitors corporate governance developments and recommends changes to our Certificate of Incorporation, By-laws and Corporate Governance Guidelines to the Board.
- Reviews the Company's Sustainability Report.
- Oversees key public policy issues relating to environmental and social responsibility, social drivers of health and healthcare reform.
- Oversees the evaluation of the Board, its committees and each director.
- Reviews any related party transactions.
- Oversees policies by which interested parties, including stockholders, may make significant concerns known to the Board.
- Oversees policies and practices regarding political and charitable activities, including any contributions therewith.
- Oversees Board and management succession planning.
- Oversees risks related to corporate governance and sustainability issues and political and regulatory changes.

MEMBER QUALIFICATIONS:

Each member of the Governance Committee is independent, in accordance with the NYSE standards and the Company's Corporate Governance Guidelines.

Quality Committee

Membership as of March 19, 2026



Kenneth Burdick (Chair)



H. James Dallas



Frederick Eppinger



Monte Ford

4 committee meetings in 2025

OVERVIEW:

The **Quality Committee** has jurisdiction over quality improvement, which includes member experience, provider experience and strategy, data and technology strategy.

RESPONSIBILITIES:

- Reviews the Company's quality improvement program for each line of business, including enterprise initiatives, clinical programs, health equity and member experience and satisfaction.
- As part of the Company's quality improvement strategy, reviews provider experience and strategy, including network access and accuracy, value-based contracting and provider engagement.
- As part of the Company's quality improvement strategy, reviews data and technology strategy, including the information technology roadmap and business enablement outcomes, data and analytics infrastructure and potentially disruptive technologies.

Director Engagement

Board Meetings and Attendance

	2025 Meetings
Board	13
Audit and Compliance Committee	9
Compensation and Talent Committee	6
Governance Committee	5
Quality Committee	4

37

Board and Committee Meetings held in 2025

During 2025, each of our directors attended at least 75% of the aggregate number of meetings of the Board and all committees held during the period in which the director served. Average Board and committee meeting attendance by all directors serving during 2025 was 93%. As stated in our Corporate Governance Guidelines, we believe it is important for the members of our Board to attend the annual meeting of stockholders. All directors who were members of the Board at the time of the 2025 annual meeting of stockholders attended the meeting. During each regularly scheduled Board and Committee meeting, and as appropriate during special meetings, the non-management directors meet privately in executive session.

Director Education and Orientation Program

The Company provides an orientation and continuing education process for Board members to enable them to stay current on developments related to their Board and committee service. Educational opportunities may include seminars, presentations, relevant materials, meetings with key management and/ or visits to Company facilities. The Governance Committee is responsible for reviewing the Company's programs relating to director orientation and continuing education from time to time.

New Director Orientation	Shortly after joining the Board, the Company provides an in-person, customized orientation and onboarding experience. At the end of their orientation, new directors should: have key information about Centene's business, vision, strategy, leaders and organization; and be well-informed about their responsibilities and duties as directors and on any committees in which they serve; and have access to resources, information and contacts that will enable them to be effective in their role.
Continuing Education	We joined the National Association of Corporate Directors and encourage our Board members to take advantage of its numerous educational resources and programs. The Company provides quarterly updates on continuing education opportunities and, pursuant to our director education policy, will reimburse Board members for the cost of any programs Board members attend as well as costs related to membership in relevant associations.
Beyond the Boardroom	Throughout their service, our directors have discussions with each other and senior leadership of the Company outside of regularly scheduled Board and committee meetings in order to share ideas and perspectives, build relationships and gain a deeper understanding of the Company's business.

Annual Board and Committee Self-Evaluations

Our Corporate Governance Guidelines and each of our committee charters require the Board and each committee to conduct an annual self-evaluation to determine whether the Board and its committees are functioning effectively.

01 Evaluation Survey

The Governance Committee reviews and approves evaluation survey forms for each committee and the Board. These surveys are completed by each Board and committee member.

The evaluations ask for feedback on the leadership of the Board and committee, the content of the meetings, the role and structure of the committees, interaction with management and each individual's performance. The evaluations also survey the Board members on the topics they deemed most important to discuss.

02 One-on-One Director Discussions

The Chair of the Governance Committee or the Chairman of the Board conducts individual meetings with each director to obtain candid feedback.

03 Executive Session

Each committee and the Board discusses the results of the evaluations during executive session. The Chair of the Governance Committee and the Chairman of the Board also shares the feedback from the one-on-one meetings with the Board to focus on areas in which the Board believes that it could improve.

04 Implementation

Areas for improvement are communicated to the Board, management and the committees and action plans are developed and implemented. For example, one area of change is having board-only dinners and executive sessions earlier in the meeting schedule to allow for robust and candid discussion. In addition, management has included executive summaries of the Board materials to enhance and contextualize the information shared with the Board.

Board Oversight of Risk Management

Strategic Oversight

Our Board oversees and provides advice and guidance to senior management on the formulation and implementation of the Company's strategic plans, including the development of growth strategies by our senior management team.

- This occurs year-round through presentations and discussions covering the competitive landscape, strategy, business planning and growth initiatives, both during and outside Board and committee meetings.
- The Board annually holds a Board retreat focused on the Company's long-term strategy.
- Our Board's focus on overseeing risk management enhances our directors' ability to provide insight and feedback to senior management on its development and implementation of the Company's long-term strategic plan.
- Our Chairman helps facilitate our Board's oversight of strategy, including through discussions with independent directors during executive sessions, as needed.

Throughout 2025, our Board engaged on an ongoing basis with our CEO and CFO, as well as other key members of senior management to refine our long-term growth strategy.

- This took various forms, ranging from high-level discussions regarding strategic direction, reviews of existing and new business initiatives and organic and inorganic growth opportunities.
- The Board provided oversight on the execution of several key milestones in our strategy, including:

01 completing 11 divestitures since December 2021, with another expected to close in 2026, resulting in proceeds of over $5 billion,

02 completing $8.0 billion of common stock repurchases from 2022 to 2025,

03 completing $189 million of Senior Note debt repurchases in 2025,

04 improving Medicare Advantage Star Ratings to 60% of Medicare Advantage members in plans rated 3.5 stars or higher, with 20% in 4-star plans, and

05 reacting to an evolving regulatory and market environment and took corrective pricing actions for 2026 in states covering 95% of Marketplace membership.

- Discussions are focused on the quality and experience of our people as well as alignment with our long-term growth strategy for our stockholders and underscored by considerations such as risk management, culture and reputation.

Our Board will continue to receive regular updates from, and provide advice to, management as they execute on the Company's strategy.

Risk Oversight

The Board has overall responsibility for the oversight of enterprise-wide risk management at Centene, while management is responsible for day-to-day risk management. The Board implements its risk oversight function both as a whole and through its committees. Each Board committee oversees risks associated with its respective principal areas of focus and then reports to the Board.

The oversight responsibility of the Board and its committees is assisted by management reporting processes designed to provide visibility to the Board of the identification, assessment, prioritization and management of critical risks and management's risk mitigation strategies. The Company's enterprise risk management process is facilitated by the Company's Risk Management department and is based on a blend of principles associated with the Committee of Sponsoring Organizations of the Treadway Commission (COSO) enterprise risk management framework, Enterprise Risk Management – Integrating with Strategy and Performance and ISO 31000: 2018 Risk Management. The primary goals of the enterprise risk management program are to enhance management's ability to identify and assess the Company's current risk profile, gain insights on emerging risks, improve management's strategic and operational decision-making ability and provide clear and timely communication of cross-functional risks to management and the Board. An enterprise risk committee comprised of senior leaders within the Company meets at least four times per year to discuss the most significant risks to the Company identified by the Company's enterprise risk management process and the steps management has taken to identify, monitor, assess and control or avoid such exposures. The enterprise risk committee also reviews performance measures against the company's risk appetite and tolerance and provides recommendation(s) of corrective action, where appropriate. Enterprise risk management is an active process and is continually enhanced and updated.

The Company's Risk Management department provides an enterprise risk management report to the full Board at least four times per year. Each Board committee reports to the Board any significant issues relating to their relevant risk areas.

The principal areas of focus for risk oversight by the Board and each of its committees are summarized below. Each committee may meet in executive session with key management personnel and representatives of outside advisors as the committee members deem appropriate.

Primary Areas of Risk Oversight



Full Board

- Strategic, financial, operational and execution risks and exposures associated with the annual operating plan and long-term strategic plan.
- Capital allocation, industry trends and stockholder sentiment.
- Major litigation, compliance and regulatory exposures, information security and other current matters that may present material risk to the Company's operations, plans, prospects or reputation and material acquisitions and divestitures.

Audit and Compliance Committee

- Risks and exposures associated with financial matters and regulatory requirements, including financial reporting, accounting, disclosure and compliance, internal control over financial reporting, financial policies, capital structure investment guidelines, liquidity matters and the Company's regulatory compliance programs.
- Legal and compliance risks.
- Risks associated with information technology, including cybersecurity, artificial intelligence, privacy, disaster recovery and critical infrastructure assets.
- Reviews the Centene Foundation's activities.

Compensation and Talent Committee

- Risks and exposures associated with leadership assessment and executive and non-executive compensation programs and arrangements, including incentive plans.
- Risks and exposures associated with human capital management.

Governance Committee

- Risks and exposures relating to the Company's programs and policies relating to compliance with SEC governance requirements, NYSE listing requirements and similar legal requirements.
- Corporate governance and director independence.
- Director and chief executive officer succession planning.
- Risks associated with sustainability and healthcare reform related risks and opportunities.
- Risks associated with political and regulatory changes.
- Political spending and activity.

Quality Committee

- Risks and exposures associated with quality improvement and clinical programs, and member experience and satisfaction.
- Risks and exposures associated with provider experience and strategy, including network access and accuracy and value-based contracting.
- Risks associated with the execution and operational issues related the Company's data technology strategy, including potentially disruptive technologies.

Management Roles/Responsibilities

- Identifying risks and assessing them in accordance with the Company's enterprise risk management framework.
- Implementing suitable risk mitigation plans, processes and controls.
- Appropriately managing risks in a manner that serves the best interests of the Company, its stockholders and other stakeholders.
- Quarterly reporting to the Board and its committees on its risk assessments and risk mitigation strategies for the significant risks of our business.

Selected Areas of Oversight



Oversight of Information Technology, including Cybersecurity, Artificial Intelligence and Critical Infrastructure

The 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 and the risks associated with the use of artificial intelligence through two of its committees.

The Audit and Compliance Committee oversees the Company's enterprise risk management process. This includes programs designed to identify, manage, respond to and mitigate risks related to cybersecurity, artificial intelligence, privacy, critical infrastructure and disaster recovery. The committee also oversees the Company's strategy for identifying and evaluating the potential threats and severity of incidents, risk mitigations against cyberattacks and breach and crisis response. The Quality Committee has oversight responsibility for overall data and technology strategy. Each committee reports to the full Board on a regular basis.

The Audit and Compliance Committee receives quarterly updates on the Company's cybersecurity risk management program, which is part of our enterprise-wide risk management practices. Management also escalates significant cybersecurity events to the Audit and Compliance Committee and the Board as appropriate. In addition, our Board and management have conducted tabletop cybersecurity crisis simulation exercises.

The Audit and Compliance Committee also receives regular reports on the Company's risks associated with artificial intelligence.

The Quality Committee oversees the use of artificial intelligence to enable business outcomes and receives regular reports on technology initiatives.

The Board also receives reports from the committees summarizing these risks and opportunities and also oversees the competitive landscape as well as strategic investments, including with respect to the use and risks of artificial intelligence. For example, in 2025, demonstrations of technology advances, including AI applications, were shared with the Board.



Oversight of Government Relations and Political Activity

We believe that engagement with governmental officials and agencies plays a key role in influencing sound public healthcare policy as well as shaping regulations and legislation that govern our business now and into the future. In keeping with our purpose to transform the health of the community, one person at a time, and in an effort to be transparent about the principles that govern our participation in the political process, in 2020, we began posting disclosures concerning our political and lobbying activities on our corporate website. Our Political Activity Reports are available at www.centene.com. Our Governance Committee oversees policies and practices regarding political activities, including our twice yearly political activity report and the contributions reported therein.



Oversight of Human Capital Management

The Board of Directors has delegated primary oversight of human capital management to the Compensation and Talent Committee. This includes compensation planning, talent development and culture, supported by regular updates on employee engagement survey results, key workforce metrics and incentive compensation design.

Succession Planning

As reflected in our Corporate Governance Guidelines, the Board's primary responsibilities include planning for CEO succession and monitoring and advising on succession planning for other executive officers. The Board's goal is to have a long-term and continuous program for effective senior leadership development and succession. The Board also has contingency plans in place for emergencies such as departure, death or disability of the Chairman of the Board, the CEO or other executive officers.

This involves extensive planning and oversight, including:

- The entire Board works with the Governance Committee to evaluate potential successors to the CEO.
- The CEO regularly evaluates and recommends potential successors for her role as well as other senior management roles and recommends development plans for such individuals to the Governance Committee.
- The CEO discusses with the Compensation and Talent Committee individuals with high potential for succession.
- High-potential executives are regularly challenged with additional responsibilities to expose them to our diverse operations, as we strive to develop well-rounded and experienced senior leaders.
- Potential successors attend Board and Committee meetings and interact frequently with the Board in informal settings, so directors can get to know and evaluate them.
- The Governance Committee formally reports to the full Board at least annually on succession planning, and the Board discusses succession planning regularly at scheduled meetings, including in executive sessions, as appropriate.

Management focuses on succession planning for critical roles throughout the organization. Leaders identify high-performing talent who are potential successors for critical roles, as well as any areas where we may have gaps.

Role of Compensation Consultant

The Compensation and Talent Committee has the sole authority to retain compensation consultants to assist in its evaluation of executive compensation, including the authority to approve the consultant’s reasonable fees and other retention terms. The Compensation and Talent Committee directly engaged Frederic W. Cook & Co., Inc. (FW Cook) as its independent compensation consultant for the fiscal year ended December 31, 2025. FW Cook’s engagement included:

- compiling a group of peer companies to use as a reference in making executive compensation decisions, evaluating current executive pay practices and considering different compensation programs to aid making executive pay decisions for the fiscal year ended December 31, 2025;
- evaluating the efficacy of our existing executive compensation strategy and practices in supporting and reinforcing our long-term goals;
- periodically reviewing and advising on compensation trends and regulatory developments; and
- periodically conducting a review of our non-employee director compensation policies and practices.

The Compensation and Talent Committee has analyzed whether the work of FW Cook as compensation consultant raises any conflict of interest, taking into account relevant factors in accordance with SEC rules and the applicable NYSE listing standards. FW Cook did not perform any work for us in 2025, other than in its role as the compensation consultant to the Compensation and Talent Committee, which included executive compensation and human capital matters. Based on its analysis, the Compensation and Talent Committee determined that the work of FW Cook and the individual compensation advisors employed by FW Cook does not create any conflict of interest pursuant to the U.S. Securities and Exchange Commission (the SEC) rules and NYSE listing standards.

Oversight of Corporate Sustainability

Centene's Corporate Sustainability Leadership

The Governance Committee and Audit and Compliance Committee of Centene's Board of Directors provide oversight of our corporate sustainability function. The Governance Committee oversees the management of risks related to environmental and social issues of importance to Centene and makes recommendations to the Board regarding our Company's position on key issues relating to environmental and social responsibility. The Audit and Compliance Committee oversees the Company's sustainability financial reporting disclosures.

Enterprise Risk Committee (ERC): The ERC is a cross functional governance group chaired by the Chief Risk, Ethics & Compliance Officer and is composed of members of the Executive Leadership Team. The ERC assists the Board in its oversight responsibilities for risk management as well as the process used to identify, assess, respond to and report on risk and corporate sustainability matters, including climate-related and environmental issues.

Enterprise Risk Management (ERM) Team: Centene's ERM team has primary responsibility for corporate sustainability activities, including maintaining Centene's framework. The team coordinates the identification, monitoring and reporting of key risks and performance metrics, including climate-related indicators.

Corporate Sustainability Champions Network & Environmental Employee Engagement Group (EEEG): The ERM team maintains relationships with leaders from across the organization, which allows for the sharing of best practices, identification and assessment of climate-related risks and opportunities, and recommendation of enhancements to Centene's sustainability capabilities.

The EEEG is a cross-functional group of Centene employees and business leaders dedicated to promoting environmental awareness and action through communications and events held throughout the year.

Stockholder Engagement

We believe that engaging with stockholders and other stakeholders is fundamental to the Company's success and our commitment to good governance. We seek to proactively listen to, understand and consider the opinions of our stockholders to stay aligned with stockholder priorities.

Over the past several years, we have significantly expanded our governance-focused engagement program to better understand the issues that are important to our stockholders and incorporate feedback into the Board's decision-making process. Members of our management team and certain directors regularly meet with stockholders to gather their perspectives on key topics including our performance and strategy, corporate governance, management succession planning, executive compensation, human capital management and corporate responsibility.

Beyond our governance-focused engagement, our investor relations team and members of our senior management team, including our CEO and CFO, regularly communicate with investors on financial and operational performance in connection with quarterly earnings calls, investor and industry conferences, analyst meetings and individual discussions with stockholders.

As described in the diagram below, we report stockholder feedback regularly to our Board, which in turn uses this feedback to evaluate any changes to the Company's practices year-round.

September - November (Fall)

- Conduct meetings with some of our largest stockholders, to discuss corporate governance, corporate responsibility and executive compensation matters and solicit feedback.
- Share the feedback with the Board for discussion and consideration.

December - February (Winter)

- Incorporate feedback from stockholder meetings into annual meeting planning, including potential changes to corporate governance practices, the executive compensation program and corporate responsibility.
- Review stockholder proposals and determine next steps.



May - August (Summer)

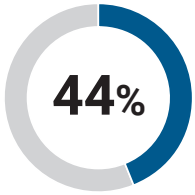
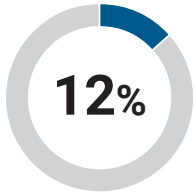
- Review annual meeting results, ongoing stockholder feedback and determine any next steps, including corporate governance and compensation trends to help develop stockholder engagement priorities.

March - April (Spring)

- Conduct stockholder meetings in advance of the annual meeting to answer questions and obtain feedback on proxy matters.

Who We Engaged with Since our 2025 Annual Meeting

Our governance-focused engagement is described below:

Who We Engaged	**Proactively reached out to stockholders representing:**  **of our outstanding shares** Including **14** institutional investors	**Met with stockholders representing:**  **of our outstanding shares** Including **3** institutional investors
Company Representatives	• Chief Accounting Officer • General Counsel	• Head of Investor Relations • Head of Total Rewards
Topics Discussed	• Executive Compensation • Board Culture and Refreshment • Leadership Transitions	• Quality Improvement • Corporate Sustainability

Commitment to Investor Engagement and Overview of Responsive Actions

We continue to make enhancements to our governance and compensation practices in response to stockholder feedback. Below we summarize key stockholder feedback the Company has received from investors and the highlights of actions the Company took in response to feedback received.

HISTORY OF PROACTIVELY RESPONDING TO STOCKHOLDER FEEDBACK TO HELP ENSURE BEST-IN-CLASS GOVERNANCE, COMPENSATION, AND DISCLOSURE PRACTICES

2020

- Two new independent members appointed to the Board
- Implemented double-trigger vesting provisions for all new grants in the event of a change in control
- Began publishing Political Activity report

2021

- Elected new Lead Independent Director
- One independent member left the Board
- One new executive appointed to the Board
- Rotated Governance Committee chair and membership
- Adopted mandatory retirement age of 75 years for non-management directors

2022

- Separated CEO and Chairman roles, appointed new Independent Chairman
- Four independent members left the Board
- Five directors appointed to the Board
- Declassified the Board
- Allowed stockholders with 10% ownership rights to call a special meeting
- Provided stockholders the right to act by written consent
- Shortened proxy access ownership rights to 3 years and advance notice window to 90 - 120 days
- Rotated membership of committees
- Reduced committees from seven to four
- New CEO compensation set slightly below the median
- Appointed Frederick W. Cook & Co., Inc. (FW Cook) as new compensation consultant
- Adopted cash severance policy to limit cash severance to 2.99 times annual salary and bonus

2023

- Three independent directors left the Board
- Rotated Independent Chairman role
- Rotated membership of committees and chair of Audit and Compliance Committee
- Quality Committee replaced Value Creation Committee
- 2023-2025 Long-Term Incentive Plan no longer includes performance-based stock options
- 2023-2025 Long-Term Incentive Plan no longer includes Cash LTIP
- 2023-2025 Long-Term Incentive Plan metrics include relative Shareholder Return
- Implemented a formal Clawback Policy

2024

- One independent member appointed to the Board
- 2024-2026 Long-Term Incentive Plan includes average adjusted pre-tax margin
- Increased stock ownership requirements for CEO and other NEOs
- Improved plans, policies and procedures informed by "best practice" market trends

2025

- One independent member appointed to the Board.
- Three independent directors left the Board
- Rotated membership of the chair of the Audit and Compliance Committee and membership of committees

Communications with the Board of Directors

The Board has established a process by which stockholders and other interested persons may send communications to the Board as a whole, the non-employee Directors as a group, any director or Board committee, or the Chairman of the Board. You may send communications to our Directors, including any concerns regarding Centene's accounting, internal controls, auditing or other matters, to the following address: Designated directors c/o Corporate Secretary, Centene Corporation, 7700 Forsyth Boulevard, St. Louis, Missouri 63105. You may submit your concern anonymously or confidentially. You may also indicate whether you are a stockholder, customer, supplier or other interested party. Communications relating to the Company's accounting, internal controls or auditing matters will be relayed to the Audit and Compliance Committee. Communications relating to governance will be relayed to the Governance Committee. All other communications will be referred to other areas of the Company for handling as appropriate under the facts and circumstances outlined in the communications. Certain items that are unrelated to the duties of the Board will be excluded, such as: business solicitations; junk mail, mass mailings and spam; resumes and other employment inquiries; and surveys.

Other Governance Policies and Practices

Code of Conduct

The Company has published its Code of Conduct on its website (www.centene.com), which applies to all officers, employees and directors. Any waiver of, or amendments to, the Code of Conduct for directors or executive officers, including the chief executive officer, the chief financial officer and the principal accounting officer, must be approved by the Governance Committee, and any such waivers or amendments will be disclosed within four business days by the Company by posting such waivers or amendments to its website. Both the Audit and Compliance Committee and the Governance Committee review management's monitoring of compliance with the Company's Code of Conduct.

Compensation & Talent Committee Interlocks and Insider Participation

During all or part of 2025, Christopher Coughlin, Frederick Eppinger, Monte Ford, Thomas Greco and Theodore Samuels served as members of the Compensation and Talent Committee. Christopher Coughlin serves as chairman. None of these directors served as an officer or employee of the Company or any of its subsidiaries before or at the time he or she served on the Compensation and Talent Committee or had any relationship during 2025 that would require disclosure under Item 404 of SEC Regulation S-K. During 2025, none of our executive officers served on the Compensation and Talent Committee (or its equivalent) or board of directors of another entity, one of whose executive officers served on our Board or Compensation and Talent Committee.

Related Party Transactions

We have a written policy for reviewing transactions between us and our executive officers, directors and certain of their immediate family members and other related persons, including those required to be reported under Item 404 of Regulation S-K. Under this policy, the Governance Committee must approve transactions in which we participate that involves more than $120,000 and in which a related person has a direct or indirect material interest. Pursuant to our policy, we enter into a transaction with such related persons only if the transaction is on terms deemed comparable to those that could be obtained in arm's length dealings with an unrelated third party and is otherwise fair to us.

Kenneth Burdick served as Executive Chairman of LifeStance Health Group, Inc. from March 2025 until March 14, 2026. Prior to that, Mr. Burdick served as Chairman and Chief Executive Officer of LifeStance from September 2022 to March 2025. In 2025, Centene has continued to pay LifeStance for behavioral health services provided by LifeStance to the Company's health plans in accordance with contracts entered into between the companies prior to Mr. Burdick's employment with LifeStance. These contracts were obtained on arms' length dealings prior to the time that Mr. Burdick became affiliated with LifeStance.

In 2025, one of our executive officers had an immediate family member employed by the Company who earned total compensation above $120,000. The employee's compensation and benefits were consistent with total compensation and benefits provided to other employees of the same level with similar responsibilities.

Compensation of Directors

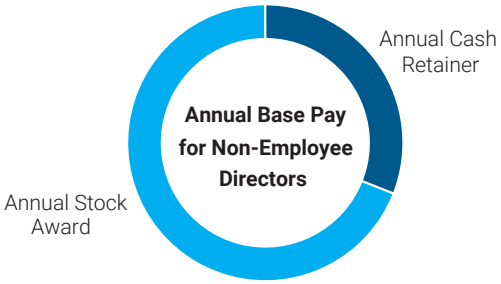
For 2025, non-employee directors received an annual cash retainer of $100,000. If applicable, fees are pro-rated based on time served on the Board or the respective committee during the year.

Directors can elect to receive any of these annual cash retainers in deferred stock units under the Non-Employee Directors Deferred Stock Compensation Plan. Expense recognized in conjunction with the deferred stock election is included in the "Fees Earned or Paid in Cash" in the Director Compensation Table below.

The Board's fee structure is set forth below.

Annual Restricted Stock Units	
Non-Employee Director	$225,000

Annual Retainer	
Non-Employee Director	$100,000



Additional Annual Restricted Stock Units	
Independent Chairman/ Lead Independent Director	$150,000

Additional Annual Retainers	
Independent Chairman/ Lead Independent Director	$90,000
Chairman of the Audit and Compliance Committee	$30,000
Chairman of the Compensation and Talent Committee	$20,000
Chairman of the Governance Committee	$20,000
Chairman of the Quality Committee	$20,000

For 2025, the annual grant of restricted stock units was valued at $225,000 based on the closing stock price on the trading day immediately preceding the meeting and resulted in a grant of 3,579 restricted stock units of our common stock in May 2025. The restricted stock units vest on the earlier of May 13, 2026, or the 2026 Annual Meeting of Stockholders. Directors may elect to defer the receipt of restricted stock units.

Directors are reimbursed for all reasonable expenses incurred in connection with their service. Directors who are also our employees receive no additional compensation for serving on our Board of Directors. No changes were made to the director compensation program in 2025.

In February 2026, the Compensation Committee made the following changes to the director compensation program to maintain competitiveness with peer market data:

- Increased the annual cash retainer from $100,000 to $120,000.
- Increased the Independent Chairman/Lead Independent Director additional annual retainer from $90,000 to $95,000.
- Increased the Compensation & Talent, Governance, and Quality Committee leadership additional annual retainers from $20,000 to $25,000.

Stock ownership guidelines for members of our Board require them to own 7.5 times the annual cash retainer within five years of being appointed to the Board. As of December 31, 2025, all directors were in compliance with this requirement.

Director Compensation Table

The following table sets forth the compensation paid to each individual who served as a non-employee member of our Board in 2025:

Name[1]	Fees Earned or Paid in Cash[2] ($)	Stock Awards[3] ($)	All Other Compensation[4] ($)	Total ($)
Jessica L. Blume	$ 120,000	$ 225,012	$ 25,000	$ 370,012
Kenneth A. Burdick	120,000 [5]	225,012	42,619	387,631
Christopher J. Coughlin	120,000 [5]	225,012	25,000	370,012
H. James Dallas	100,000	225,012	25,000	350,012
Wayne S. DeVeydt	76,302 [5]	225,012	—	301,314
Frederick H. Eppinger	190,000 [5]	375,020	25,000	590,020
Monte E. Ford	100,000	225,012	25,000	350,012
Thomas R. Greco	64,402	225,012	—	289,414
Lori J. Robinson	36,813	—	—	36,813
Theodore R. Samuels	100,000 [5]	225,012	25,000	350,012
Kenneth Y. Tanji	96,569 [5]	275,538	25,000	397,107

[1] Mr. Tanji was appointed to the Board on February 20, 2025 and Messrs. DeVeydt and Greco resigned from the Board August 1, 2025 and August 22, 2025, respectively.

[2] The amounts included in this column represent the cash retainers earned by each director in 2025. Certain directors converted some or all cash compensation payable into deferred restricted stock units. For directors making such election, the cash value of the base retainer is included in this column. See Footnote 5 below for amounts of cash compensation converted into deferred restricted stock units, and see Footnote 3 below for the grant date fair value of those awards converted from cash compensation.

[3] The following table shows the components of "Stock Awards" and total equity award value for directors who elected to receive some or all of their cash compensation in restricted stock units for fiscal year 2025. The amounts included in the table represent the full grant date fair value of restricted stock units granted to non-employee directors in 2025 under the 2012 Stock Incentive Plan and the 2025 Stock Incentive Plan calculated in accordance with FASB ASC Topic 718. These amounts reflect the accounting expense that we will recognize over the vesting term of these awards and do not correspond to the actual value that may be realized by the directors. Additionally, Messrs. DeVeydt and Greco's annual stock awards were forfeited upon their resignation from the Board on August 1, 2025 and August 22, 2025, respectively.

	Grant Date Fair Value of Awards			
Name	Initial Restricted Stock Units[a] ($)	Annual Restricted Stock Units[b] ($)	Cash Compensation Converted into Deferred Restricted Stock Units[c] ($)	Total Stock Awards ($)
Jessica L. Blume	$ —	$ 225,012	$ —	$ 225,012
Kenneth A. Burdick	—	225,012	120,036	345,047
Christopher J. Coughlin	—	225,012	120,036	345,047
H. James Dallas	—	225,012	—	225,012
Wayne S. DeVeydt	—	225,012	76,259	301,271
Frederick H. Eppinger	—	375,020	99,992	475,012
Monte E. Ford	—	225,012	—	225,012
Thomas R. Greco	—	225,012	—	225,012
Theodore R. Samuels	—	225,012	99,992	325,004
Kenneth Y. Tanji	50,526	225,012	96,587	372,125

[a] On February 21, 2025, Mr. Tanji was granted a prorated annual restricted stock unit award of 864 shares with a value of approximately $50,526 in connection with his appointment to the Board. Mr. Tanji's award was granted under the 2012 Stock Incentive Plan, calculated in accordance with FASB ASC Topic 718 and vested in full on May 13, 2025, which was the date of our 2025 Annual Meeting of Stockholders.

[b] On May 13, 2025, the date of our 2025 Annual Meeting of Stockholders, each non-employee director who was elected was granted an annual restricted stock unit award of 3,579 shares with a value of approximately $225,012. Additionally, the Independent Chairman was granted an additional restricted stock unit award of 2,386 shares with a value of approximately $150,008. These annual equity awards were granted under the 2025 Stock Incentive Plan, calculated in accordance with FASB ASC Topic 718, and will vest in full on the earlier of the date of the 2026 Annual Meeting of Stockholders or May 13, 2026. Messrs. DeVeydt and Greco's awards were forfeited upon their resignation from the Board on August 1, 2025 and August 22, 2025, respectively.

[c] Represents the value of cash compensation the director elected to convert into deferred restricted stock units granted under the Non-Employee Directors Deferred Stock Compensation Plan calculated in accordance with FASB ASC Topic 718.

[4] All other compensation includes the Company match of charitable contributions of $25,000 made or pledged during 2025 under the Company's Board of Directors Charitable Matching Gift Program for Ms. Blume, Mr. Burdick, Mr. Coughlin, Mr. Dallas, Mr. Eppinger, Mr. Ford, Mr. Samuels and Mr. Tanji. In addition, all other compensation for Mr. Burdick includes costs related to personal security services and group excess liability insurance policy premiums paid by the Company. Amounts reported herein represent the aggregate incremental cost to the Company for these services.

[5] Each of Mr. Burdick, Mr. Coughlin, Mr. Eppinger and Mr. Samuels elected to convert the $100,000 annual non-employee director cash retainer into deferred restricted stock units. Additionally, Mr. Burdick elected to convert the $20,000 retainer for the Quality Committee Chairman and Mr. Coughlin elected to convert the $20,000 retainer for the Compensation and Talent Committee Chairman. Mr. DeVeydt and Mr. Tanji elected to convert the prorated $100,000 annual non-employee director cash retainer and the prorated $30,000 retainer for the Audit Committee Chairman into deferred restricted stock units.

The Board of Directors has approved the Board of Directors Charitable Matching Gift Program. Under the program, the Company will match a Board member's qualifying charitable donations of up to $25,000 per calendar year. Charitable donations must be made to a qualified tax exempt U.S. organization under the Internal Revenue Code Section 501(c)(3) and within the Company's charitable contribution guidelines.

The following table shows the number of shares covered by exercisable and unexercisable options and unvested restricted stock units held by our non-employee directors on December 31, 2025.

	Option Awards		Stock Awards
Name	Number of Securities Underlying Unexercised Options (Exercisable) (#)	Number of Securities Underlying Unexercised Options (Unexercisable) (#)	Number of Shares that Have Not Vested (#)
Jessica L. Blume	20,000	—	3,579
Kenneth A. Burdick	10,000	—	3,579
Christopher J. Coughlin	10,000	—	3,579
H. James Dallas	10,000	—	3,579
Frederick H. Eppinger	—	—	5,965
Monte E. Ford	10,000	—	3,579
Theodore R. Samuels	10,000	—	3,579
Kenneth Y. Tanji	—	—	3,579

Executive Officers

The names of our executive officers, ages and certain information about each of them as of March 19, 2026 are set forth below.

Sarah M. London

Chief Executive Officer, 45

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 Operating Partner for Optum Ventures from May 2018 to March 2020 and Chief Product Officer of Optum Analytics from March 2016 to May 2018.

Andrew L. Asher

Chief Financial Officer, 57

Mr. Asher has served as our 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.

Christopher A. Koster

Secretary and General Counsel, 61

Mr. Koster has served as our Secretary and General Counsel since February 2020. 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

Chief People Officer, 52

Ms. McNally has served as our Chief People Officer since March 2023. From January 2023 to March 2023, she served as our Interim Chief People Officer. From May 2022 to December 2022, she served as our Regional Vice President, Human Resources. From January 2020 to May 2022, she served as our 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.

Theodore J. Pienkos

Corporate Controller & Chief Accounting Officer, 44

Mr. Pienkos has served as our Corporate Controller and Chief Accounting Officer since March 18, 2026. Prior to that, he had served as our Deputy Corporate Controller for Centene since August 2024. Prior to that, he served as our Vice President of Finance & Accounting from August 2017 to August 2024.

Susan R. Smith

Chief Operating Officer, 50

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.

2 PROPOSAL Advisory Resolution to Approve Executive Compensation

At our 2025 Annual Meeting of Stockholders, our stockholders voted to approve the Company's executive compensation. Pursuant to Section 14A of the Securities Exchange Act of 1934, as amended (the Exchange Act), we are again holding an advisory vote on the Company's executive compensation, as described in this proxy statement (commonly referred to as say-on-pay). In accordance with the results of the vote we conducted at the 2023 Annual Meeting on the frequency of say-on-pay votes, we present a say-on-pay vote every year.

The Board of Directors strongly endorses the Company's executive compensation program and recommends that stockholders vote in favor of the following resolution:

> *RESOLVED, that the stockholders approve the compensation of those NEOs listed in the Summary Compensation Table of this proxy statement, as disclosed pursuant to the compensation disclosure rules of the SEC, including the Compensation Discussion and Analysis and the tabular and narrative disclosure included herein under "Executive Compensation."*

Because the vote is advisory, it will not be binding upon the Board of Directors or the Compensation and Talent Committee and neither the Board of Directors nor the Compensation and Talent Committee will be required to take any action as a result of the outcome of the vote on this proposal. The Compensation and Talent Committee strongly considers the views of the Company's stockholders when making compensation decisions. Additionally, the Compensation and Talent Committee monitors the results of the annual advisory "say-on-pay" proposal and incorporates such results as one of many factors considered in connection with the discharge of its responsibilities.



The Board recommends a vote "**FOR**" the approval of the compensation of the NEOs.

Executive Compensation

Compensation Discussion and Analysis

This CD&A describes the compensation principles, objectives, and policies and arrangements of our executive compensation program which are generally applicable to all of our senior officers. This CD&A focuses primarily on our Chief Executive Officer and the other executive officers whose 2025 compensation is included in the Summary Compensation Table, whom we collectively refer to in this proxy as our Named Executive Officers (NEOs).

Sarah M. London	**Andrew L. Asher**	**Christopher A. Koster**	**Tanya M. McNally**	**Susan R. Smith**
Chief Executive Officer	Chief Financial Officer	Secretary and General Counsel	Chief People Officer	Chief Operating Officer

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Executive Summary

Compensation Philosophy

Our compensation programs are designed to attract, retain and motivate highly qualified, industry-leading executives. Our compensation philosophy is centered on the guiding pillars described below.



Pay for Performance

Link executive compensation to performance and the achievement of both Company and individual goals. Superior performance and the achievement of goals results in higher compensation.



Alignment with Long-Term Stockholder Value

Use both performance-based and service-based long-term incentive awards with meaningful retention requirements to encourage sustained stockholder value creation.



Attract and Retain Top Executive Talent

Offer competitive pay to attract, motivate and retain industry-leading executives with the skills and experience to drive long-term Company success.



Accelerate Mission and Culture

Motivate executives to advance the Company's key strategic objectives and manage risk while enabling a best-in-class workplace focused on the Company's mission and culture.

In evaluating Company performance, the Compensation and Talent Committee considers both financial results and operational performance. While the Company's 2025 earnings performance was impacted by an unprecedented shift in the Marketplace risk pool, the Company delivered strong top line financial growth and delivered on key operational initiatives expected to create future earnings growth. We are confident that the management team's mitigation efforts and strategic priorities are positioning the Company for meaningful earnings restoration, long-term growth, transformation, and shareholder value creation.

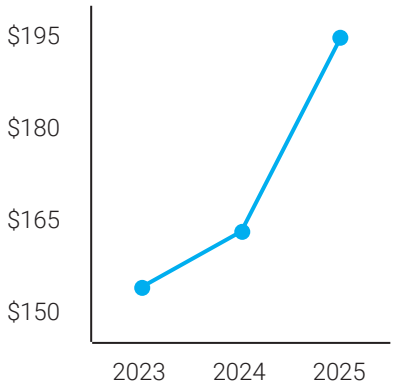
The Company delivered strong top line growth, but lower than expected earnings performance:

- Total revenues of $195 billion, an increase of 19% over 2024.
- Three-year total revenues compound annual growth rate of 10%.
- GAAP diluted loss per share of $13.53.
- Adjusted diluted EPS[1] of $2.08, a decrease of 70% over 2024.
- Three-year compound annual stock price decline of 21%.

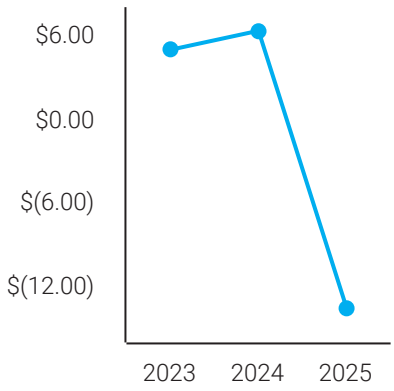
[1] Refer to Appendix A for reconciliations of non-GAAP measures included throughout this proxy statement.

Total Revenues

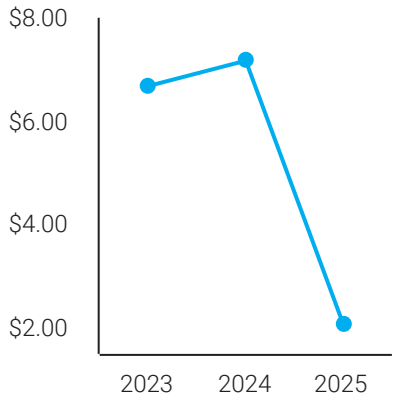
($ in billions)



GAAP Diluted Earnings (Loss) Per Share



Adjusted Diluted EPS[1]



[1] Refer to Appendix A for reconciliations of non-GAAP measures included throughout this proxy statement.

In response to the challenges faced in 2025, the Company has taken quick and decisive actions to restore profitability for future years, including:

- Led the industry in understanding the implications of the changes in morbidity of the Marketplace population that we became aware of late in the second quarter of 2025 and took corrective pricing actions for 2026 in states covering 95% of Marketplace membership.
- Advocated with our Medicaid state partners for increases in rates to reflect more recent experience.
- Strategically designed our 2026 Medicare Advantage bid and pricing strategy with a focus on profitability.
- Continued to advocate for healthcare affordability and access with the state and federal government partners.

Evolution of Our Compensation Program

Our compensation program continues to evolve to maintain alignment with our compensation philosophy, be responsive to stockholder feedback and improve our governance practices. The following provides an overview of our compensation evolution for our NEOs:

2023

Annual Cash Incentive

- 65% Adjusted Diluted EPS
- 25% Enterprise & Individual Goals
- 10% Quality

Long-Term Incentives

- Added relative TSR PSUs with target payout requiring above median performance
- Eliminated duplicative measures
- Eliminated stock options
- Eliminated Cash Long-term Incentive Plan (LTIP)

Other

- No salary increases for NEOs, except for a promotion increase for our President

2024

Annual Cash Incentive

- 65% Adjusted Diluted EPS
- 25% Enterprise & Individual Goals
- 10% Quality
- Goals streamlined

Long-Term Incentives

- Replaced adjusted net earnings margin metric with average adjusted pre-tax margin metric

Other

- Improved plans, policies and procedures
- No salary increases for NEOs, except for a promotion-related increase for our Chief Operating Officer

2025

Annual Cash Incentive

- 60% Adjusted Diluted EPS
- 20% Organic Premium and Service Revenues
- 20% Quality and Strategic Goals

Long-Term Incentives

- Replaced pre-tax earnings growth CAGR with Medicare performance

2026

Annual Cash Incentive

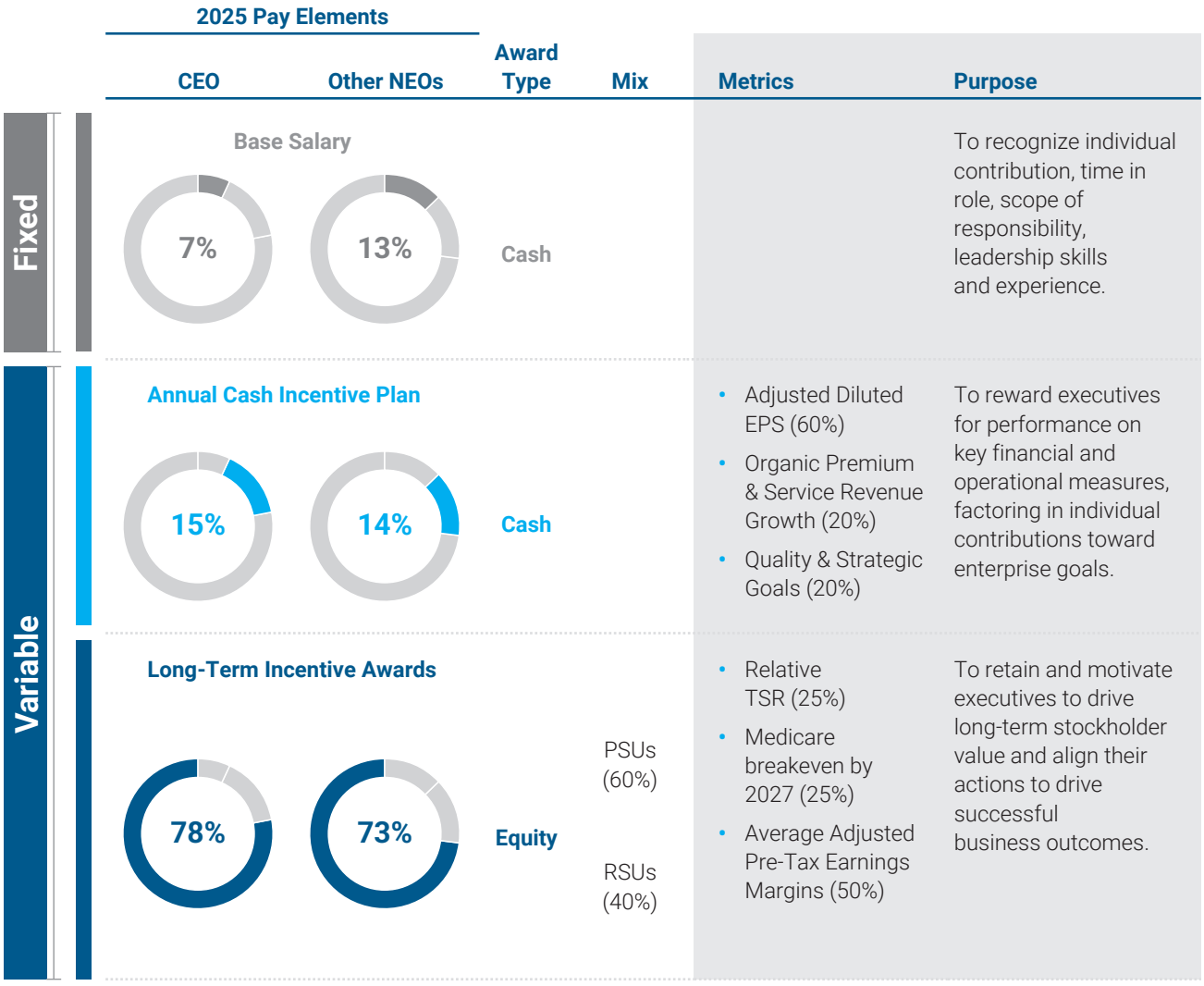
- 60% Adjusted Diluted EPS
- 20% Health Benefits Ratio (HBR)
- 20% Strategic Goals

Long-Term Incentives

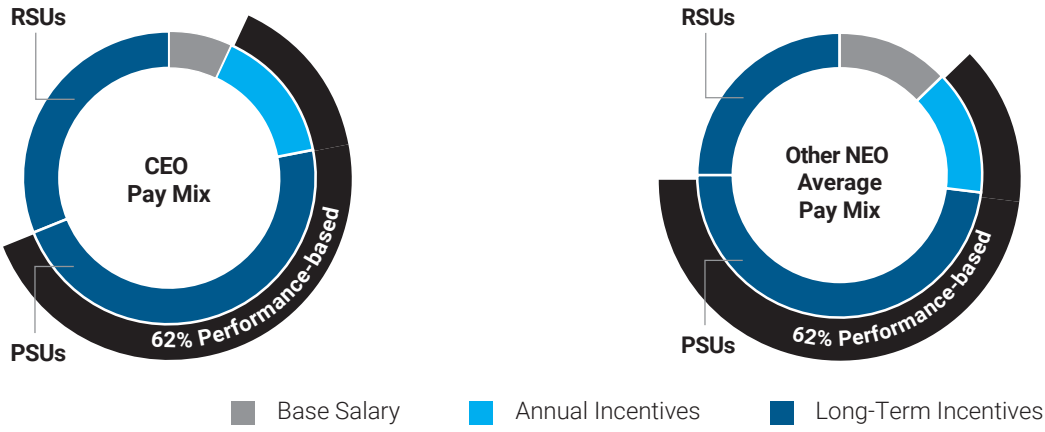
- Revised PSU structure to absolute TSR to closely align executive compensation outcomes with stock price performance

2025 Compensation Component Overview

The 2025 plan design and awards resulted in the following pay elements and average target pay mix for our CEO and other NEOs:



CEO and NEO Target Pay Mix



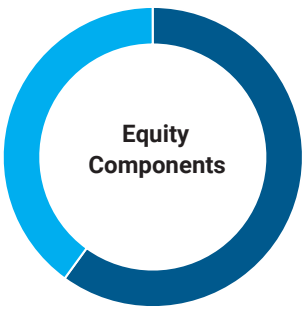
Annual Cash Incentive Plan



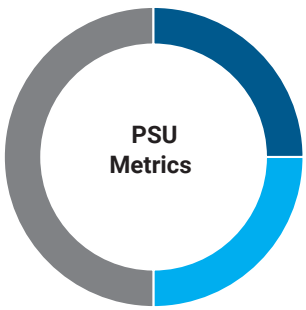
Performance Measure

- 60% Adjusted Diluted EPS Target
- 20% Organic Premium & Service Revenue Growth
- 20% Quality & Strategic Goals

2025 - 2027 Long-Term Incentive Plan



- 60% Performance-based RSUs
- 40% Service-based RSUs



- 25% Relative TSR
- 25% Medicare breakeven by 2027
- 50% Average Adjusted Pre-Tax Earnings Margin

Our Compensation Programs and Governance Practices

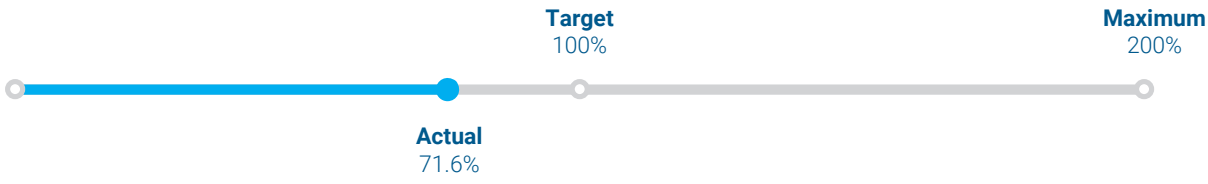
Alignment of Pay and Performance

We are a healthcare leader with $195 billion in total revenues, ranking No. 23 on the Fortune 500 list, and have been named to Fortune's 2025 list of World's Most Admired Companies for the eighth consecutive year. When reviewing the NEOs' compensation with our independent executive compensation consultant, FW Cook, the Compensation and Talent Committee considered these factors in conjunction with our executive compensation program in continuing to recognize our pay-for-performance culture through the following three primary components:

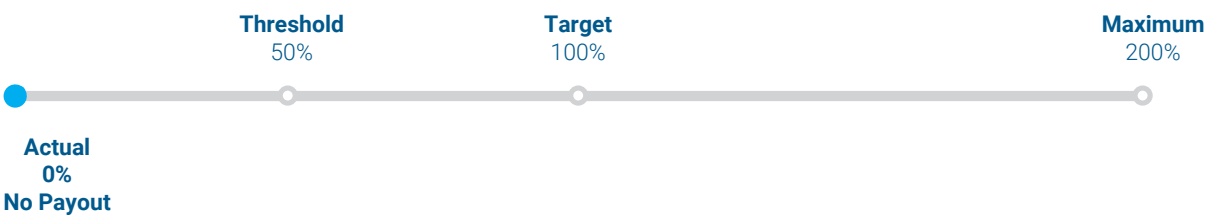
Base Pay + **Cash Awards Under Our Annual Incentive Plan** + **Long-Term Incentives**
- Performance-based RSUs
- Time-based RSUs

In 2025, the Company delivered growth in total revenues, but a decrease in earnings driven by a significant shift in the Marketplace risk pool and other industry pressures. This decrease in earnings had a negative impact on the compensation earned by our executive team consistent with our pay-for-performance philosophy. Although we experienced lower than expected earnings, our total revenues in 2025 increased 19% over 2024, with a 10% three-year CAGR. Our NEOs' total incentive compensation opportunities are contingent on their ability to achieve profitable growth and improve margins that will provide a basis for increasing sustainable long-term value for our stockholders. Payouts in both the annual and long-term programs reflect rigorous pay-for-performance goals. While our lower than expected 2025 earnings and depressed stock price put significant pressure on our goals, we achieved success in top line revenue growth, quality performance and other operational achievements. In addition, we took quick and decisive actions to restore profitability for future years. Our overall performance translated into a below target payout under the annual cash incentive plan, and no payout for the 2023-2025 long-term incentive plan due to underperforming financial results and stock price.

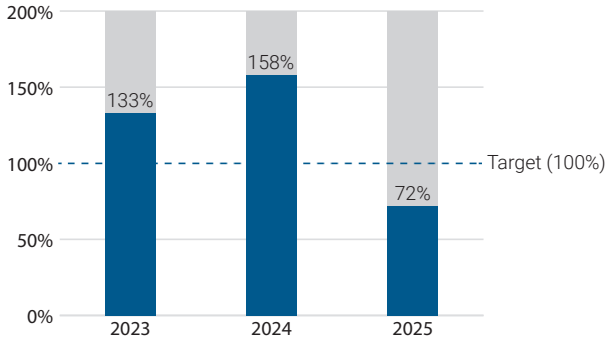
2025 Annual Cash Incentive Plan Results



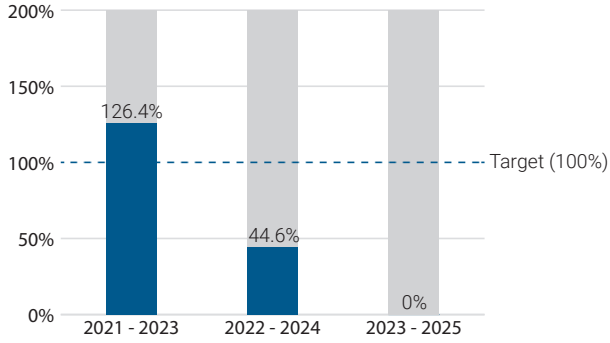
2023-2025 Performance Based RSUs



CEO Annual Incentive Award as % of Target



Long-Term Performance Share Unit Payouts as % of Target

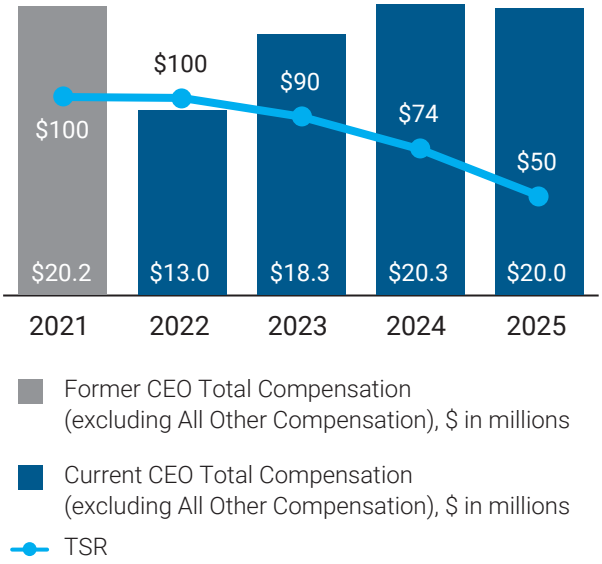


Company Performance and CEO Compensation Alignment

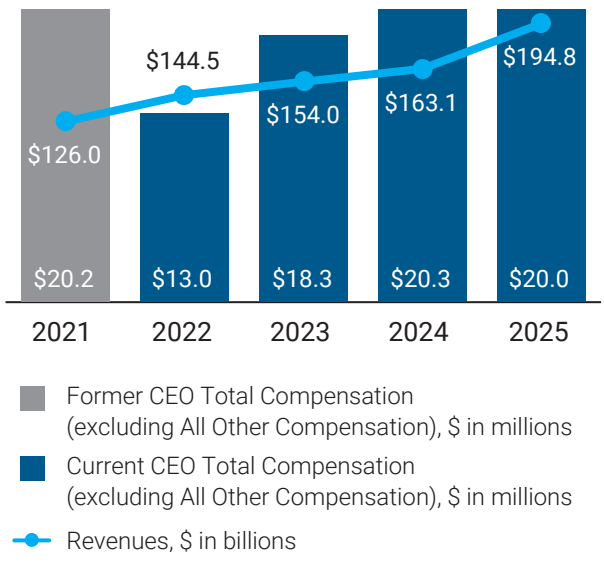
Our CEO's total compensation, as reported in the Summary Compensation Table, (where 2021 was earned by Michael Neidorff; and 2022-2025 was earned by Sarah London) alignment with the Company's TSR, revenue and EPS performance metrics is illustrated in the following graphs:

TSR and CEO Total Compensation

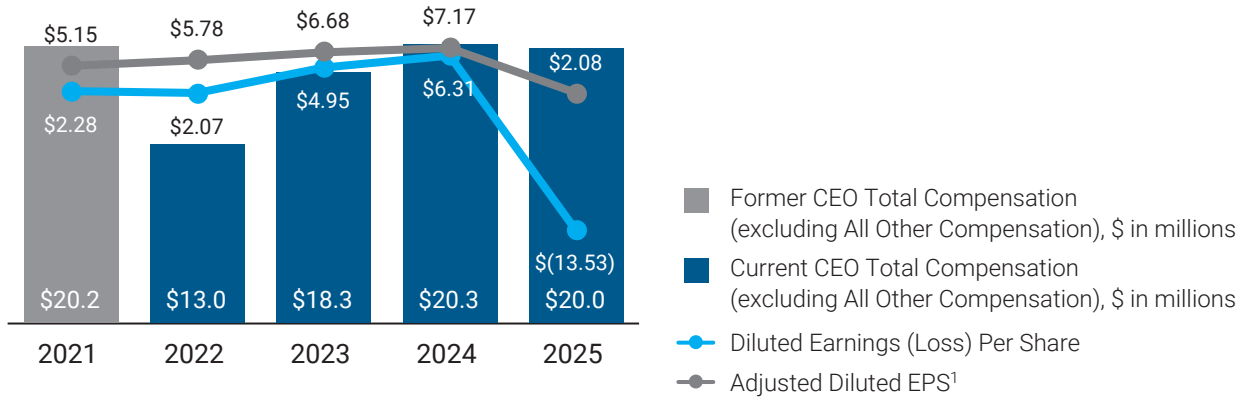
TSR Indexed to $100 on December 31, 2021



Revenue and CEO Total Compensation



Diluted Earnings (Loss) Per Share/Adjusted Diluted EPS and CEO Total Compensation



[1] Refer to Appendix A for reconciliations of non-GAAP measures included throughout this proxy statement.

For an additional perspective on pay for performance, refer to the tabular disclosure as required by SEC rules beginning on page 105, with the accompanying narrative disclosure and supplemental charts. As demonstrated in the performance tables, in 2025, Ms. London's Compensation Actually Paid was only 24% of her Summary Compensation Table total, reflecting our pay-for-performance philosophy and demonstrating that our compensation plan design is aligned with stockholder value creation.

Executive Compensation Best Practices

The Compensation and Talent Committee establishes and administers the executive compensation philosophy and program and assists the Board of Directors in the development and oversight of all aspects of executive compensation. Presented in the table below are highlights of our compensation practices:

What We Do

- **Pay for Performance**
  A majority of our NEOs' compensation is tied to performance with clearly articulated financial and other performance goals.
- **Competitive Compensation**
  Each component of the NEOs' annual total direct compensation is generally targeted at the 50th percentile of peer group compensation. The Compensation and Talent Committee may consider differences from the median in certain cases.
- **Performance-Based Long-Term Incentive Awards**
  We reward continuous performance on multiple metrics and vest at the end of a three-year period.
- **Formula-Based Annual Incentive Plan**
  Awards under the Annual Cash Incentive plan are formula based.
- **Tally Sheets**
  Tally sheets for each NEO are reviewed annually.
- **Annual Compensation Risk Assessment**
  We regularly analyze risks related to our compensation program and we conduct broad risk assessments.
- **Stock Ownership Requirements**
  We maintain rigorous stock ownership requirements for our directors, executives and other members of senior management. Our CEO's requirement is 6x annual base pay; other NEOs' requirements are 3x annual base pay.
- **Clawbacks**
  We can recover performance-based cash and equity incentive compensation paid to executives in various circumstances.
- **Independent Compensation Consultant**
  The Compensation and Talent Committee retains an independent compensation consultant to advise the committee on executive compensation matters.
- **Executive Severance Arrangements**
  The Compensation and Talent Committee reviews severance policies annually and limits the usage of one-off arrangements.

What We Don't Do

- **No Excessive Risk-Taking**
  The long-term incentive plans use multiple performance measures, capped payouts and other features intended to minimize the incentive to take overly risky actions.
- **No Tax Gross-Ups**
  There are no tax "gross-ups" for perquisites or excise tax gross-ups in the event of a change of control related termination.
- **No Single-Trigger Employment Agreements**
  Any cash payments in executive employment agreements are subject to a "double-trigger" change in control condition.
- **No Backdating or Repricing of Stock Options**
  Stock options are never backdated or issued with below-market exercise prices. Repricing of stock options without stockholder approval is expressly prohibited.
- **No Hedging or Pledging**
  Directors and executives are prohibited from hedging, pledging or engaging in any derivatives trading with respect to Company stock.
- **No Single-Trigger Stock Grants**
  Equity compensation awards are subject to a "double-trigger" change in control condition.

The Decision-Making Process

Roles and Responsibilities

Management

Management reviews the Company's compensation plan design and the Company's results against established metrics.

CEO

The CEO evaluates the other NEOs' contributions to those results and recommends compensation to the Compensation and Talent Committee.

Compensation & Talent Committee

The Compensation and Talent Committee evaluates the Company, CEO and other NEOs' performance against metrics.

Independent Consultant

FW Cook advises the Compensation and Talent Committee on the appropriateness and competitiveness of compensation and plan design based on relevant market comparisons.

Board of Directors

The Board of Directors determines the CEO compensation, and the Compensation and Talent Committee determines other NEOs' compensation and the overall compensation plan design.

The processes governing our compensation program occur year-round.

- Quarterly review of year-to-date Company results and progress on strategic initiatives
- Quarterly review of projected performance on short-term and long-term incentive awards
- Quarterly engagement with our independent compensation consultant to discuss compensation trends and the Company's performance

1st Quarter

- Finalize incentive compensation decisions for NEOs based on completion of short and long-term performance cycles.
- Implement program design changes in light of compensation trends, performance against peers, market influences, stockholder feedback and independent compensation consultant observations.
- Establish current year compensation targets for our NEOs and set new long-term and short-term incentive targets.

2nd Quarter

- Conduct stockholder meetings in advance of the Annual Stockholders' Meeting and obtain and reflect on feedback on proxy matters.

3rd Quarter

- Conduct meetings with our largest stockholders, to discuss governance and executive compensation matters and solicit feedback. Share feedback with the Board for discussion and consideration. Review overall market trends from proxy season.

4th Quarter

- Discuss and evaluate feedback from stockholders, Company performance, performance against peers and compensation trends from our independent compensation consultant. Translate feedback into potential program design changes for the following fiscal year.

Competitive Pay Design

Our compensation and benefit practices are designed to attract and retain the best talent and achieve robust operating objectives. Programs are designed to both motivate our employees and reward them for exceptional performance. The Company views both private equity firms and competitors with larger market capitalization as significant competition for talent. We also recognize that our Company is a source for these firms and competitors to recruit talent if the appropriate compensation programs are not in place.

For the components of target total compensation, the Compensation and Talent Committee's objectives are for base salaries, short-term incentives and total target compensation to approximate the median of peer group practice (or applicable survey sources). Long-term incentives are granted at levels, which when combined with base salary and target short-term incentives, result in the desired competitive positioning of total target compensation. Variations from the market median can be taken into account due to several factors, such as employee performance, retention needs, length of service, and recruitment demands.

In order to achieve these objectives, the Compensation and Talent Committee establishes target, market-based total compensation levels (e.g. base salary, annual cash incentive target and long-term incentives) from market data from two different peer groups.

Peer Group

Healthcare Industry Peer Group

The Compensation and Talent Committee annually reviews the Company's peer group that it uses to conduct market analyses and determine competitive pay ranges for our executives. In determining the peer group, objectives considered include general industry, revenue size, market capitalization and business complexity. Using the Standard and Poor's Global Industry Classification System (GICS) codes and other relevant industry parameters, the Company and its compensation consultant analyzed the managed care industry and determined there are six key segments in the industry: Managed Health Care, Healthcare Distributors, Healthcare Services, Drug Retail, Healthcare Facilities, and Insurance.

Objective Criteria Considered	2025 Peer Group			
	Managed Health Care (Direct Competitors)	**Healthcare Distributors**	**Healthcare Services & Drug Retail**	**Healthcare Facilities & Insurance**
• **Common Industries** • **Revenue** • **Market Capitalization** • **EBITDA** • **Total Assets** • **Number of Employees**	• Cigna Corporation (CI) • Elevance Health, Inc. (ELV) • Humana, Inc. (HUM) • Molina Healthcare, Inc. (MOH) • UnitedHealth Group, Inc. (UNH)	• Cencora (COR) • Cardinal Health, Inc. (CAH) • McKesson Corporation (MCK)	• CVS Health Corporation (CVS) • Walgreens Boots Alliance, Inc. (WBA)	• HCA Healthcare, Inc. (HCA) • MetLife, Inc. (MET) • Prudential Financial, Inc. (PRU)

Based on FW Cook's independent review and recommendation, no additional companies were added to the Healthcare Industry (HCI) Peer Group for 2026 compensation decisions. Walgreens Boots Alliance will no longer be in the peer group going forward as it is no longer publicly traded, but it was included for 2026 compensation benchmarking purposes.

Based on data compiled by FW Cook at the time of the peer group review, our positioning on the two most important key financial metrics relative to the peer group was as follows:

	Market Capitalization[1]	Revenues[2]
Centene Corporation	$28.5 billion	$159.6 billion
Relative Peer Group Position	15th percentile	43rd percentile

1 Represents 12-month average market capitalization as of August 31, 2025.

2 Represents premium and service revenues and investment and other income for the trailing four quarters ended August 31, 2025.

General Industry Group

Since there is a market for executive talent both within and outside our industry, we also benchmark against the general industry. Therefore, the market data the Compensation and Talent Committee utilizes includes not only the HCI Peer Group, but also a General Industry (GI) peer group of approximately 400 companies derived from the FW Cook Executive Compensation Survey for a broader perspective of compensation practices and trends in the market as a whole.

Benchmarking Methodology

The Compensation and Talent Committee's independent compensation consultant, FW Cook, gathered, analyzed and summarized the market data from the S&P Capital IQ database for the CEO and the other NEOs.

For this analysis, which is utilized in determining compensation for the forthcoming year, we use size-adjusted general industry data in line with our revenue to determine base salaries, annual cash incentive targets and LTI targets.

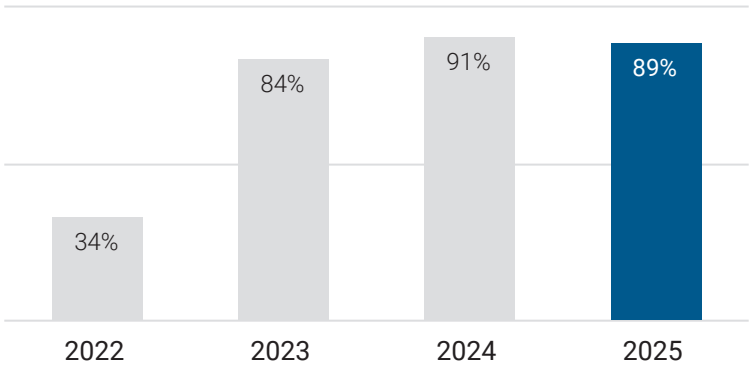
All elements of compensation are valued and reviewed in evaluating the relative competitiveness of our compensation practices against both market data and the Compensation and Talent Committee's competitive objectives. In addition, the Compensation and Talent Committee annually reviews a tally sheet for each NEO, which includes the current value of all outstanding equity-based awards, benefits and perquisites. The Compensation and Talent Committee uses the tally sheets to analyze each NEO's base salary, annual incentive target and long-term incentive opportunity in relation to the market and each component of compensation as a percentage of total compensation to determine if there is any risk of retention of key executives.

The Compensation and Talent Committee and CEO review the performance of each NEO and align compensation based on this analysis. The CEO is not involved in evaluating or determining her compensation.

Stockholder Responsiveness

Members of our management team and Board regularly meet with stockholders and proxy advisor firms to gather their perspectives on key topics including our performance and strategy, corporate governance, management succession planning, board refreshment, executive compensation, human capital management, culture and corporate responsibility. Our 2025 stockholder engagement is outlined on page 56. In response to the feedback we received from stockholders, we have made important changes to our compensation program in recent years including, but not limited to: (1) increasing the formula-based weighting of our annual cash incentive metrics, (2) no longer granting performance-based options, (3) no longer granting cash-based LTI awards, (4) removing duplicative measures in the annual and long-term incentive plans, (5) including absolute and relative TSR in PSU metrics, and (6) increasing stock ownership requirements for our CEO and other NEOs. Refer to a summary of key compensation changes since 2023 on page 68, "Evolution of our Compensation Program."

Say-on-Pay Votes "For"



Based on our outreach and engagement with stockholders and changes to our compensation programs over the past few years, our Say-on-Pay support level increased by over 50 percentage points since 2022. We hope to continue to receive strong support from our stockholders due to our demonstrated commitment to a pay-for-performance philosophy and strong governance practices.

Risk Disclosure

The Compensation and Talent Committee is aware of the consequences to companies that have not appropriately balanced risk and rewards in executive compensation. The Compensation and Talent Committee believes that in order for our overall compensation not to encourage or reward excessive risk-taking, it must emphasize long-term performance. Risk is further limited by both the ownership guidelines mentioned previously. In addition, we have adopted the Centene Corporation Clawback Policy (the Clawback Policy) in compliance with the requirements of Section 954 of the Dodd-Frank Wall Street Reform and Consumer Protection Act further discussed on page 91.

The Company's compensation strategy is intended to mitigate risk by emphasizing long-term compensation and financial performance measures correlated with growing stockholder value rather than rewarding shorter performance and payout periods. A recent review of the Company's compensation programs by the Compensation and Talent Committee, with the support of FW Cook, did not identify any programs that unduly incentivize employees to take any excessive risks. Based on this review, our Compensation and Talent Committee concluded that our compensation programs, taken as a whole, are not reasonably likely to have a material adverse effect on the Company.

2025 Executive Compensation Program

The 2025 compensation plan design and metrics were developed by management and the Compensation and Talent Committee in early 2025. They reflect our compensation philosophy and modernized incentive design. Based on the positive feedback received from stockholders regarding our current compensation practices, we made limited changes to our existing compensation program during 2025.

The following is an overview of our 2025 executive compensation program.

Base Salary

In February 2025, the Compensation and Talent Committee evaluated the 2025 base salaries of our NEOs and took into account the Company's 2025 projected revenue of approximately $168 billion. Our NEOs' base salaries were compared to competitive market data and the Compensation and Talent Committee makes salary adjustments to address market data, individual contributions, intentional compensation glide paths and role scope increases. In general, executives do not receive base pay increases every year unless they are on an intentional compensation glide path and/or trailing the market median. Executives are often placed on an intentional compensation glide path early in the tenure of their role.

The NEOs are paid competitive base salaries as determined by the evaluation of the market value for each specific job. Since Centene is a pay-for-performance company, in 2025, only 7% of the CEO's total target compensation was comprised of base salary and, on average, 13% of all other NEOs' target compensation was comprised of base salary.

While reviewing market data to determine appropriate annual base salaries, the Compensation and Talent Committee also considers:

- the CEO's compensation recommendations for all other NEOs;
- the scope of responsibility, experience, time in position and individual performance of each executive, including the CEO;
- each executive's leadership performance and potential to enhance long-term stockholder value; and
- internal benchmarking.

Based on the Compensation Committee's review of current market data and evaluation of responsibilities and performance, adjustments were made to NEO's base salaries for 2025. Ms. London, Mr. Asher and Mr. Koster had not received base salary increases since 2022. Ms. London and Mr. Asher's new base salaries also reflect the increased scope and responsibilities of their roles following the retirement of our former President. Additionally, Ms. McNally's salary adjustment reflects her intentional glide path into her role and moves her closer to the 50th percentile relative to peer group compensation.

	2025 Annual Base Salary ($)	Percentage Increase (%)
Sarah M. London	$ 1,500,000	7%
Andrew L. Asher	1,200,000	17%
Christopher A. Koster	775,000	3%
Tanya M. McNally	675,000	13%
Susan R. Smith	725,000	4%

Annual Cash Incentive Plan

The Compensation and Talent Committee rewards NEOs with an annual cash incentive award if the Company achieves its annual cash incentive objectives. The cash incentive payout is based on multiple metrics which were evaluated by the Compensation and Talent Committee to determine the award earned for 2025. Based on a review of market data, the Compensation and Talent Committee approved an annual cash incentive plan target opportunity in 2025 as follows:

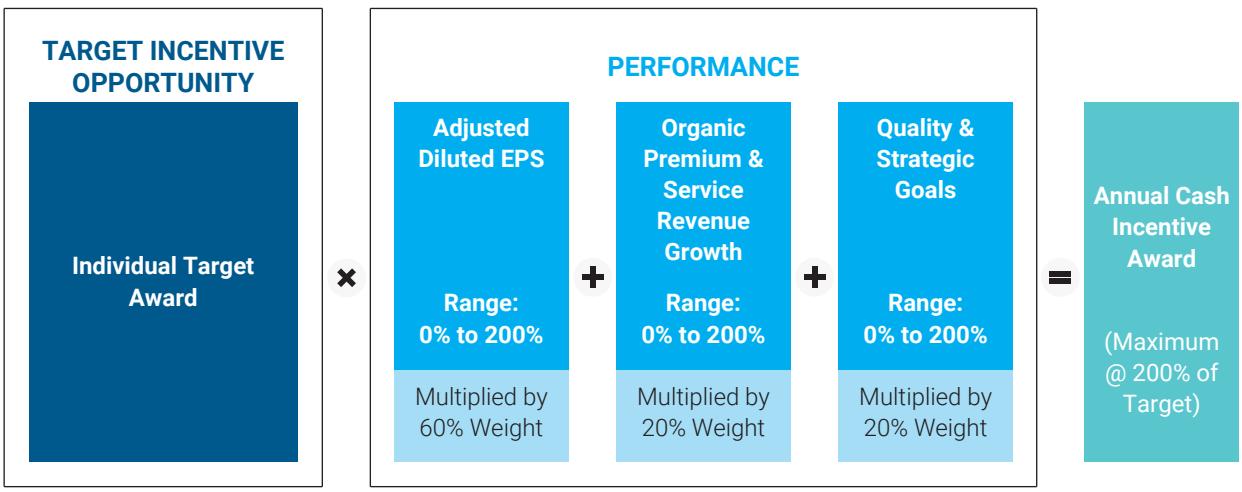
	2025 Target Annual Cash Incentive as % of Base Salary
Sarah M. London	200%
Andrew L. Asher	150%
Christopher A. Koster	100%
Tanya M. McNally	100%
Susan R. Smith	100%

2025 Annual Cash Incentive Metrics

In 2025, the Compensation and Talent Committee made minor updates to the annual cash incentive design and structure based on positive feedback from stockholders on the Company's existing approach. The Compensation and Talent Committee discussed and evaluated feedback from stockholders, considered peer practice and compensation trends, and considered Company-specific factors.

Based on this assessment, the Compensation and Talent Committee incorporated organic premium and service revenue into the annual cash incentive reflecting a philosophy that revenue growth is critical for profitable growth and adjusted the weighting of other metrics, reflecting an overall shift to more formulaic metrics.

Metric	Weight
Adjusted Diluted EPS	60%
Organic Premium & Service Revenue Growth	20%
Quality & Strategic Goals	20%
	100%



Annual Cash Incentive Plan Measures

Below is a summary of our performance of the Annual Cash Incentive Plan measures, which resulted in a total payout of 71.6%.

Metrics	Threshold	Target	Maximum	Result	Weighting	Weighted Payout %
Adjusted Diluted EPS[1]	Actual Result: $2.08 · 50% $6.50 · No Payout	100% $7.25 - $7.55	200% $8.30	-%	60%	-%
Organic Premium & Service Revenue Growth	50% $148B · No Payout	100% $159B	200% $170B · Actual Result: $174.6B	200%	20%	40%
Quality & Strategic Goals	50% · No Payout	100%	200%	158%	20%	31.6%
						71.6%

[1] Refer to Appendix A for reconciliations of non-GAAP measures included throughout this proxy statement.

Achievement of Adjusted Diluted EPS Objective

The Adjusted Diluted EPS objective is established during our annual operating planning process. Our annual cash incentive plan is developed each year based on a pay-for-performance approach with rigorous performance metrics that the Compensation and Talent Committee believes are challenging but attainable for our short-term and long-term incentive programs. In addition, the performance metrics align closely with our business environment and incorporate initiatives and investments during the year that will extend beyond near-term benefits and will support favorable longer-term impact on our business.

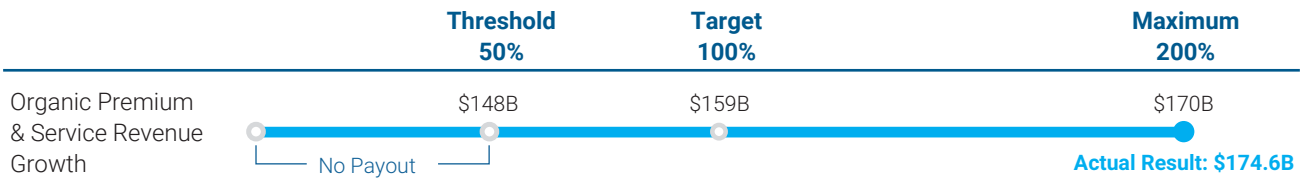
While the Company continues to execute on a rigorous growth strategy, the Compensation and Talent Committee continues to set metrics that reflect a continued focus on increased profitability. As illustrated below, based upon the approved Adjusted Diluted EPS metrics, the Compensation and Talent Committee had increased these profitability targets for 2025. The Compensation and Talent Committee included a target range to incorporate more rigor to the goal and limited upside until significant outperformance of our stated earnings guidance threshold. The Company reported Adjusted Diluted EPS for 2025 of $2.08, resulting in an achievement of **0%**.

	Threshold 50%	Target 100%	Maximum 200%
Adjusted Diluted EPS[1]	Actual Result: $2.08 · $6.50 · No Payout	$7.25 - $7.55	$8.30

[1] Refer to Appendix A for reconciliations of non-GAAP measures included throughout this proxy statement.

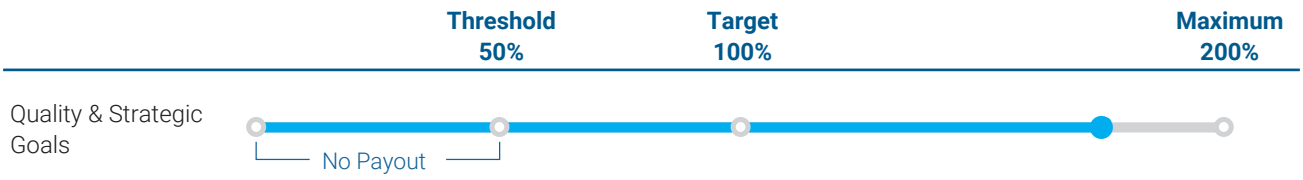
Organic Premium and Service Revenue Growth

The revenue objective is established during our annual operating planning process. The committee considered several design and metrics options landing on revenue growth, as defined as our GAAP premium & service revenue, due to a collective belief that the key to margin growth starts with revenue growth. Based on the evaluation of these key milestones, the Compensation and Talent Committee assigned a **200%** achievement level for this metric.



Quality & Strategic Goals

For 2025, the Compensation and Talent Committee used a balanced scorecard approach for a number of quantitative and qualitative quality and strategic goals. The goals are established at the beginning of the fiscal year; the target payout levels were designed to be challenging but achievable, while payouts at the maximum levels were designed to be stretch goals. The evaluation of our goals involved a review of the performance of quality and two strategic goals with critical initiatives to execute in 2025. The blended performance of all enterprise unit goals was **158%**.



Quality

Our quality scores in 2025 reflect steady progress and measurable improvement across all three lines of our core business amid a tightening environment as state agencies continue to prioritize quality in healthcare delivery. Performance in the Medicare Star Ratings program notably climbed again. 60% of our members were in plans with a 3.5 Star rating or higher, and 20% of those members were in 4-Star plans resulting in significant future revenue growth. An impressive 97% of our Medicaid plans were rated at 3-stars or higher by the National Committee for Quality Assurance, far surpassing our target goal. While not directly tied to our 2025 annual cash incentive plan, we hit a major quality milestone with 93% of eligible Ambetter plans achieving a Quality Rating System (QRS) rating of 3-stars or higher for the most recent measurement year, surpassing our targets. Ambetter's overall parent score for the most recent measurement year was 3.14, up from 2.97.

Profitable Growth

Our profitable growth objectives were intentionally aligned to core drivers, strategic pillars, and foundational elements that support and underpin sustained growth and long-term value creation. Our profitable growth goals in 2025 were focused on successful reprocurement results, the extension of the enhanced Advance Premium Tax Credits (eAPTCs) and/or execution of mitigation efforts in preparation for the expiration and potential non-renewal of the credits, the implementation of a duals operating model, and the implementation of an employee individual coverage health reimbursement arrangement (ICHRA) benefit.

We were successful winning new contracts and/or securing reprocurements in Nevada, Illinois and Pennsylvania. Additionally, strong trust with our state partners provided the opportunity for the absorption of membership in Oregon and Indiana due to payor exits. We were unsuccessful in our Florida Children's Medical Services (Florida CMS) reprocurement due to our intentional pricing which put us below competitors. Our thoughtful bid pricing reflected our commitment to profitable growth.

We thoughtfully priced our products for the 2026 open enrollment period knowing the eAPTCs were expiring and extension was unknown. We advocated for the extension of the eAPTCs; although not successful, we continue to engage with members as well as with our legislators on the importance of the eAPTCs, which many Americans relied on to make their healthcare more affordable and accessible.

During 2025, we prepared for an implementation of a new Duals Operating Model intended to make navigating care and benefits easier for our dual eligible population. The model went live effective January 1, 2026 in eight states with no access to care issues. The successful implementation demonstrates the strength of readiness efforts and cross-function coordination of our teams and allows for expansion to additional markets.

We successfully launched an employee ICHRA benefit in the state of Indiana, resulting in significant interest in the product. Approximately 600 Centene employees enrolled in an individual plan with most employees choosing a Gold or Platinum plan, and the ICHRA subsidy covering all or most of the employee's premiums. These employees are now active in their individual insurance coverage. We believe this will be a model for other large organizations to explore the product for employee cohorts and sets the stage for ICHRA expansion.

Talent and Culture

Our talent and culture goals centered on the deployment of a new engagement monitoring tool, improvement in culture survey results, and the development of succession plans for the top 30 critical roles in the organization.

For Centene, culture is how our values come to life in the way we work, lead, and collaborate. Our annual Culture Survey results measure our progress and shape our culture journey going forward. In 2025, we had over 35,000 employees participate in the survey and demonstrated improvement in all 23 measures. Additionally, we deployed a new engagement monitoring tool, Centene Voice, to gather feedback throughout the year from our employees. AI capabilities allowed us to analyze thousands of responses, giving leaders timely, relevant insights. Nearly 90% of our employees participated in at least one survey. Overall engagement rose, closing out the year at industry-leading scores across management support, recognition, and growth.

Finally, in an effort to build leadership from within and ensure the long-term success and stability of our organization, we delivered succession plans for the top 30 critical roles and an additional 30 key talent roles within the organization, far surpassing our goal. Cross-functional teams were formed to support the activation of development plans and shareable talent was discussed to support forward-looking opportunities. In 2025, 43% of our VP+ openings were filled by internal talent.

Evaluation of Individual Performance

The Compensation and Talent Committee assessed how each NEO contributed to achieving the Company's Adjusted Diluted EPS, revenue objectives, and quality and strategic goals established at the beginning of the year. Based on their assessment of each NEO's contributions toward our strategic goals, and aligned our One CenTeam culture, no individual performance adjustments were made for 2025.

The Compensation and Talent Committee approved the following annual cash incentive awards:

NEO	Target Opportunity % of Salary	Target Opportunity ($)	Funding Rate	Payout ($)
Sarah M. London	200 %	$ 2,946,154	71.6 %	$ 2,109,446
Andrew L. Asher	150 %	1,729,327	71.6 %	1,238,198
Christopher A. Koster	100 %	768,269	71.6 %	550,081
Tanya M. McNally	100 %	654,808	71.6 %	468,843
Susan R. Smith	100 %	718,269	71.6 %	514,281

Long-Term Incentive Awards

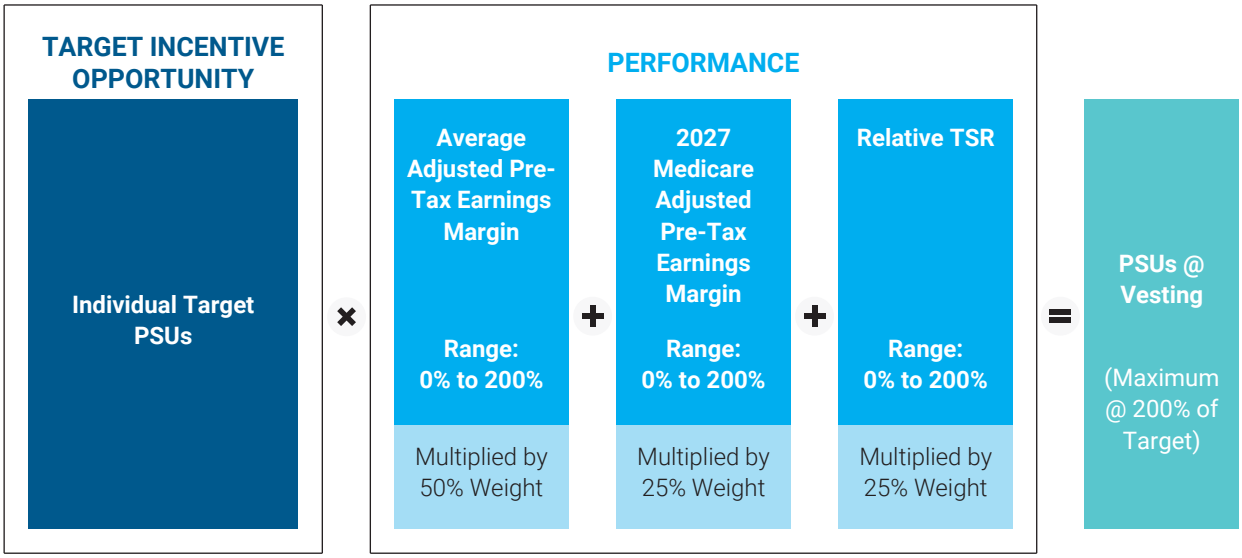
2025 Annual Long-Term Incentives

In 2025, as a result of positive feedback from our stockholders and a desire for stability, we only made minor changes to our long-term incentive design and metrics. The 2025 awards were granted in March and consisted of the following:

- **Performance-based Restricted Stock Units (PSUs) (60% of shares granted)** - The metrics for the 2025-2027 performance period are three-year average adjusted pre-tax earnings margin (50% weight), breakeven 2027 Medicare adjusted pre-tax earnings margin (25% weight) and three-year TSR relative to our peers (25% weight). Threshold, target and maximum metric achievement will result in 50%, 100% or 200% attainment of each metric, respectively. The threshold, target and maximum level of achievement for the relative TSR metric is set to the 25th percentile, 55th percentile and 80th percentile, respectively. If the Company's relative TSR for the performance period is negative, then the payout for this component will not exceed 100% of target. If earned, PSUs will vest in March 2028.

Metric	Weight
Average Adjusted Pre-Tax Earnings Margin	50%
Breakeven 2027 Medicare Adjusted Pre-Tax Earnings Margin	25%
Relative TSR	25%
	100%

- **Service-based Restricted Stock Units (RSUs) (40% of shares granted)** - One-third vest annually based on continued service with the Company.



Below is a summary of long-term target compensation awarded to our NEOs in 2025:

NEO	Performance-Based RSUs ($)	Service-Based RSUs ($)	Total Target Long-Term Compensation ($)
Sarah M. London	$ 9,457,751	$6,079,982	$15,537,733
Andrew L. Asher	10,162,939	3,199,984	13,362,923
Christopher A. Koster	3,111,089	1,999,990	5,111,079
Tanya M. McNally	1,197,728	770,028	1,967,756
Susan R. Smith	2,177,789	1,399,993	3,577,782

2023-2025 Performance-Based Restricted Stock Unit Award Results

In March 2023, the Compensation and Talent Committee established the following metrics, targets and weights for the 2023-2025 PSUs. The Company results are shown below; none of the metrics achieved a threshold result. Therefore, each metric was earned at 0% of target and no shares vested under the 2023-2025 PSUs:

Metrics	Threshold	Target	Maximum	Weight	Weighted Metric Performance	Weighted Vesting %
Adjusted Pre-Tax Earnings Growth CAGR[1]	Actual Result: <0% 6.0% no payout	7.5%	9.5%	34%	—%	—%
2025 Adjusted Net Earnings Margin[2]	Actual Result: 0.6% 2.9% no payout	3.3%	3.7%	33%	—%	—%
Peer Group Relative TSR Percentile Rank	Actual Result: 0th 25th no payout	55th	80th	33%	—%	—%
						—%

[1] The 3-Year CAGR is calculated using adjusted pre-tax net earnings of $1.3 billion and $4.3 billion for December 31, 2025 and 2022, respectively. Refer to Appendix A for reconciliations of non-GAAP measures included throughout this proxy statement.

[2] The adjusted net earnings margin as of December 31, 2025 is calculated using adjusted net earnings of $1.0 billion divided by premium and service revenues of $174.6 billion. Refer to Appendix A for reconciliations of non-GAAP measures throughout this proxy statement.

The number of shares earned compared to target earned by each NEO are reflected in the table below, demonstrating our rigorous goals and commitment to a pay for performance philosophy:

Name	Target (#)	Vested Shares (#)
Sarah M. London	141,103	—
Andrew L. Asher	67,985	—
Christopher A. Koster	26,939	—
Tanya M. McNally	2,073	—
Susan R. Smith	9,651	—

Status of LTI Award Programs

Relative TSR-Based LTI Award Status Through December 31, 2025

LTI Performance Period	2023	2024	2025	Status
2023-2025 3-year LTI	100% Complete			🔴
2024-2026 3-year LTI		67% Complete		🔴
2025-2027 3-year LTI			33% Complete	🔴

Status Legend:

- 🟢 Tracking Above Target / Above Target Payout
- 🟡 Tracking On Target / On Target Payout
- 🔴 Tracking Below Target / Below Target Payout

Other Benefits

We provide our NEOs with a defined contribution 401(k) retirement program, which is the same program that is generally provided to all our employees. We also provide our NEOs with a non-qualified deferred compensation plan to make up for matching contributions that are capped by compensation limits imposed on qualified retirement plans under the Internal Revenue Code. We do not provide our NEOs with a defined benefit retirement program. We also do not provide retiree medical coverage to our NEOs.

With respect to most other benefits, the benefits provided to NEOs and other executive officers are comparable to those provided to the majority of salaried and hourly Company employees. However, benefits for our NEOs also include premiums for insurance policies.

We believe that the personal safety and security of our NEOs is of the utmost importance to the Company and our stockholders. We provide security services to certain executives as part of proper risk management. Security services may include, in some cases, personal security services, including the use of Company provided aircraft. These protections are provided due to the range of security issues encountered by executive officers of large corporations in our industry.

2026 Compensation Decisions

In 2026, the Compensation and Talent Committee made updates to both the annual cash incentive and long-term incentive plan designs and metrics to prioritize bottom line growth and closely align compensation with stock price performance. The revenue growth component in the annual cash incentive plan has been replaced with an HBR metric. In the long-term incentive plan, while the plan design has historically included both financial and stock price performance measurements, the PSUs for the 2026 - 2028 performance cycle are tied solely to Centene's stock price performance over the three-year period. A rigorous compound annual growth rate has been assigned to meet the target payout. The 2026 shift to an absolute TSR metric reflects our commitment to stockholder alignment.

2026 Annual Cash Incentive

The Compensation and Talent Committee rewards NEOs with an annual cash incentive award for achieving the Company's predefined annual metrics. For the 2026 annual cash incentive awards, the Compensation and Talent Committee included Adjusted Diluted EPS, HBR performance, and strategic goals. The replacement of revenue growth with HBR prioritizes margin expansion and profitable growth.

The Adjusted Diluted EPS and HBR performance targets align with the 2026 guidance announced in connection with the 2025 year-end earnings release. Our annual cash incentive plan targets are developed each year based on a pay-for-performance approach with rigorous performance metrics that the Compensation and Talent Committee believes are challenging but attainable and include stretch goals to reach to pay above target.

2026 Annual Cash Incentive Metrics

Metric	Weight
Adjusted Diluted EPS	60%
Health Benefits Ratio (HBR)	20%
Strategic Goals	20%
	100%

The Compensation and Talent Committee will assess and evaluate how each NEO contributed to achieving these goals and the Company's overall objectives. Individual performance adjustments may be incorporated to reflect the executives' contributions towards financial and non-financial goals.

Individual awards under our annual cash incentive plan are approved by the Compensation and Talent Committee based primarily upon:

- business performance versus our business plan;
- the effectiveness of each executive's leadership performance and potential to enhance long-term stockholder value;
- targeted cash incentive amounts, which are based upon market data; and
- the recommendation of the Chief Executive Officer (for all NEOs other than the CEO).

Overall, 60% of each award is aligned with the Adjusted Diluted EPS target, 20% is based on the achievement of HBR targets, and 20% is based on the achievement of the Company's strategic goals.

In 2026, we will continue to focus on long-term stockholder value through meeting our financial metrics that are measurable against key financial and operational priorities. We are focused on key initiatives related to long-term growth, optimization, transformation, customer and member experience, and continuing to promote best-in-class talent & culture.

2026-2028 Long-Term Incentives

Our long-term incentive compensation is designed to attract and retain key executives, build an integrated management team, reward for innovation and appropriate risk-taking, balance short-term planning with long-term success and align executive and stockholder interests. While our long-term PSU grants have historically been based on both financial measures and stock price performance, the Committee has determined that given the steep stock price decline in July 2025 and subsequent stock price volatility, it is in the best interest of stockholders for management's long-term incentives in the form of PSUs to be based on absolute stock price growth. As a result, 100% of the PSUs granted for the 2026 - 2028 performance cycle are based on Centene's stock price performance over the three-year period. A rigorous compound annual growth rate has been assigned to meet the target payout.

These long-term incentives take the form of the following:

- **PSUs (60% of stock granted)** that are based on meeting predetermined performance targets (absolute TSR performance over three-year performance period).
- **RSUs (40% of stock granted)** that vest ratably over three years.

Long-term incentives are provided through equity, ensuring that the maximum number of shares of common stock granted in any calendar year (excluding shares granted in connection with an acquisition) does not exceed a level associated with competitive practice. Due to the competitive and complex nature of our business and the necessity of retaining key management level employees, equity grants are awarded to levels below senior executives. Annual PSU and RSU awards are generally granted in March to eligible employees but may also be approved at other times for a promotion, retention, a newly hired executive or as determined by the Compensation and Talent Committee.

Other Compensation Policies and Information

Individual Employment and Severance Agreements

The Company is party to employment agreements with Sarah M. London and Andrew L. Asher. The Board has determined that it is in the best interests of the Company and our stockholders that such executives enter into employment agreements to ensure their commitment to individual duties, compliance with restrictive covenants and the continued dedication of the executive, notwithstanding the possibility, threat or occurrence of a termination of employment, in particular upon a change in control. The Board believes it is imperative to diminish the inevitable distraction of the executive by virtue of the personal uncertainties and risks created by a pending or threatened change in control, to encourage the executive's full attention and dedication to the Company and to provide the executive with compensation and benefits arrangements upon a change in control which (i) will satisfy the executive's compensation and benefits expectations and (ii) are competitive with those of other major corporations.

Ms. London is party to an employment agreement dated April 27, 2022, entered into in connection with her appointment to the role of CEO. Pursuant to an employment agreement dated April 28, 2022, Mr. Asher agreed to continue serving as our Chief Financial Officer. In an effort to further align our executives' compensation with the interests of stockholders and promote corporate best practices, Ms. London and Mr. Asher's employment agreements were amended on February 20, 2023, to eliminate multi-year guaranteed long-term compensation awards. Future long-term compensation awards shall be annually determined by the Compensation and Talent Committee in its sole discretion.

Under the terms of any employment agreement and under the Centene Corporation Amended and Restated Executive Severance and Change in Control Plan (the Executive Severance Plan), if any components or amounts payable under the agreement are deemed to be "excess parachute payments" within the meaning of Section 280G of the Code or similar provision, the amount shall be reduced to the extent necessary so that no amounts paid shall be deemed excess parachute payments or, if the net benefit is greater, no reduction will be made, however the executive will be required to pay any additional taxes. No agreement provides for an excise tax gross-up.

In their respective agreements, the executives agree to non-competition and non-solicitation provisions that may extend through the first anniversary of termination of employment (for Ms. London, the period is 24 months). In the event of a termination due to a change in control, Ms. London's non-competition and non-solicitation period will be reduced to 12 months and Mr. Asher will no longer be subject to such covenants. For a further description of the material terms of the employment agreements with Ms. London and Mr. Asher, see the "Individual Employment Agreements" section.

Executive Severance Plan

Christopher A. Koster, Tanya M. McNally, and Susan R. Smith are each subject to restrictive covenant agreements and eligible for benefits under the Company's Executive Severance Plan.

Under the Executive Severance Plan, if Mr. Koster, Ms. McNally, or Ms. Smith undergoes a termination of employment without cause (other than a change in control termination), he or she will receive the following: (i) a lump sum equal to one times his/her base salary plus prorated target bonus; (ii) the Company portion of COBRA premiums for medical and dental benefits for 12 months; (iii) outstanding equity awards will continue to vest and stock option and stock appreciation rights will continue to be exercisable (if not expired by their terms) for 12 months, with PSUs vesting based on actual performance; and (iv) outplacement assistance for six months following the termination. If Mr. Koster, Ms. McNally, or Ms. Smith undergoes a termination of employment without cause or for good reason within 24 months after a change in control (or a termination without cause during the six months prior to a change in control, if requested by a third party participating in or causing the change in control), he or she will receive the following: (i) a lump sum equal to two times his/her base salary plus two times his/her average bonus plus a prorated target bonus; (ii) the Company portion of COBRA premiums for medical and dental benefits for 18 months; (iii) outstanding equity awards will fully vest and become exercisable as of the date of termination, and stock option and stock appreciation rights will continue to be exercisable until the earlier to occur of 12 months after the change in control termination or the expiration date of the award, with any applicable performance goals deemed achieved at the greater of target or actual performance prior to the change in control; and (iv) outplacement assistance for 6 months following the termination. Additionally, Mr. Koster, Ms. McNally, and Ms. Smith are subject to a non-competition and non-solicitation (of Company employees or customers) obligation, each for a period of 12 months after termination for any reason, as well as ongoing confidentiality requirements. The non-competition obligation does not apply if Mr. Koster, Ms. McNally, or Ms. Smith undergoes a change in control termination.

Retirement Provisions

In addition, for all Company employees, Company awards include a qualified retirement definition. NEOs who are at least 55 years of age and have 10 years of employment at the time of retirement are eligible for the following:

- A pro-rated number of PSUs vesting at the end of the performance period, based on the amount of time employed during the vesting period and actual performance outcomes.
- One-year continuation of vesting of RSUs upon a qualified retirement.
- A pro-rated annual paid bonus, if employed for six months of the calendar year, paid at actual performance generally at the same time when bonuses are paid to other employees.

Mr. Asher is eligible for qualified retirement treatment. His employment agreement also provides for the acceleration of equity awards upon retirement.

Clawback Policy

We have adopted the Clawback Policy in compliance with the requirements of Section 954 of the Dodd-Frank Wall Street Reform and Consumer Protection Act. Pursuant to the Clawback Policy, in the event of an accounting restatement, any erroneously awarded compensation received during the three completed fiscal years prior to the accounting restatement (a) that is then-outstanding but has not yet been paid shall be automatically and immediately forfeited and (b) that has been paid to the executive officers shall be subject to reasonably prompt repayment to the Company. Recovery of any erroneously awarded compensation under the Clawback Policy is not dependent on fraud or misconduct by any person in connection with the accounting restatement.

Stock Ownership Guidelines

We utilize stock ownership guidelines for our NEOs, corporate officers and Board. We believe that ownership of our stock helps align the interests of our executives and stockholders and encourages executives to act in a manner that is expected to increase stockholder value. The stock ownership guidelines for our officers are as follows:

Role	Salary Multiple
Chief Executive Officer	6x
President & Executive Vice Presidents	3x
Senior Vice Presidents	2x
Other Business Unit & Product Leaders	1x

What Counts as Ownership?

- Shares owned directly
- Unvested RSUs
- "Phantom shares" held in the deferred compensation plan

What Does Not Count as Ownership?

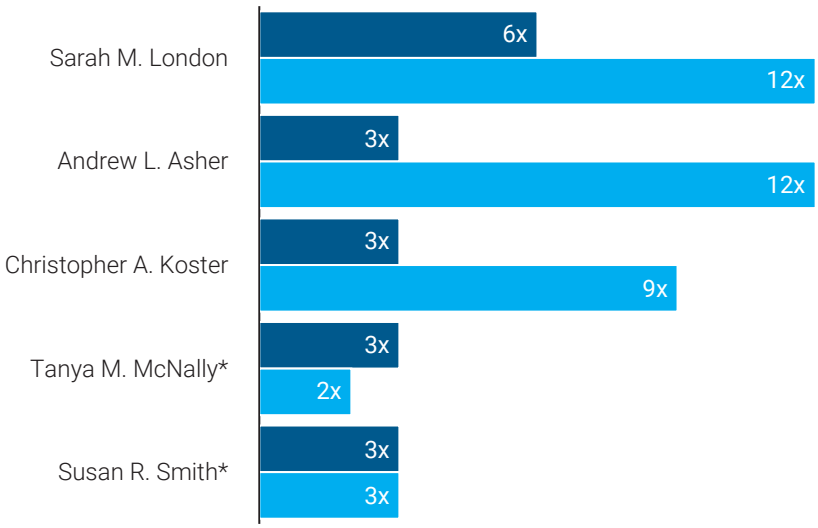
- Shares subject to unexercised options whether or not vested
- Unearned PSUs

The Compensation and Talent Committee annually reviews the stock ownership levels of the Board and all officers. Future stock awards take into consideration the executive's level of attainment of the suggested stock ownership amount. The Compensation and Talent Committee may elect to award the annual incentive to an executive in stock instead of cash if the suggested stock ownership amount is not achieved.

The Board has established a policy requiring executive officers to retain ownership of the shares received from the vesting or payout of any RSU and PSU awards granted under our stock incentive plan (net of any shares used to satisfy tax obligations) for one year following such vesting or payout. An executive may substitute the tax basis of the shares under restriction for other shares held outright.

As of the close of the last fiscal year and the date of this report, all NEOs subject to the ownership guidelines are in compliance with the guidelines. Executives have five years to attain ownership guidelines. At $41.15 per share (the December 31, 2025 closing stock price), our NEOs held Company stock as of a multiple of their ending 2025 base salaries as follows:

Stock Ownership Achievement



* Ms. McNally and Ms. Smith are within the five year window to attain required ownership levels.

Minimum Ownership Requirement as a Multiple of Base Salary

Ownership as a Multiple of 2025 Base Salary

Stock ownership guidelines for members of our Board require them to own 7.5 times the annual cash retainer within five years of being appointed to the Board. As of December 31, 2025, all directors were in compliance with this requirement.

Insider Trading Policy

The Company maintains insider trading policies and procedures governing the purchase, sale, and/or other dispositions of the Company's securities by directors, officers, and employees, as well as the Company itself, that we believe are reasonably designed to promote compliance with insider trading laws, rules, and regulations, as well as NYSE listing standards. A copy of our insider trading policy was filed as Exhibit 19.1 to our Annual Report on Form 10-K.

Hedging and Pledging Policy

The Board maintains the Company's insider trading policy, which prohibits hedging and pledging of shares by all employees, including executive officers, consultants, contractors, members of the Board and any persons that reside in the same household as any of the foregoing persons. Our insider trading policy also prohibits members of the Board and any employees from engaging in short-term or speculative transactions involving our securities. Our insider trading policy provides that members of the Board and employees may not engage in short sales of our securities, including short sales "against the box," or purchases or sales of puts or calls for speculative purposes. Our insider trading policy also strictly prohibits trading in call or put options involving Centene securities and other derivative securities and holding Centene securities in a margin account. The Board also maintains a policy regarding material nonpublic information, which sets forth prohibition against trading in Centene's securities and entering into or amending 10b5-1 plans during a specified period for certain employees and pre-clearance procedures for section 16 officers. As of March 13, 2026, all executive officers and directors were in compliance with these policies.

Deductibility of Executive Compensation

Section 162(m)(6), which was enacted as part of the Patient Protection and Affordable Care Act, amended the Code to limit the amount that certain healthcare insurers and providers, including the Company, may deduct for compensation to any employee in excess of $500,000 for a tax year beginning after December 31, 2012. This legislation does not create any exceptions for performance-based compensation and is not otherwise impacted by the adoption of the Tax Cuts and Jobs Act enacted on December 22, 2017. The Compensation and Talent Committee reserves the right to use its judgment to authorize compensation payments that may be subject to the limit when the Compensation and Talent Committee believes such payments are appropriate and in the best interests of our stockholders, after taking into consideration changing business conditions and the performance of its employees. We were subject to the limitation in 2025.

Policies on the Timing of Options

Item 402(x) of Regulation S-K requires us to discuss our policies and practices on the timing of awards of options in relation to the disclosure by us of material nonpublic information. We historically do not strategically time option awards in coordination with the release of material nonpublic information and have never had a practice of doing so. We do not currently grant stock options or similar awards and have not granted any such awards to employees since 2021.

Compensation and Talent Committee Report

The Compensation and Talent Committee, comprised solely of independent directors, has reviewed and discussed the "Compensation Discussion and Analysis" with the Company's management. Based on this review and discussion, the Compensation and Talent Committee recommended to the Board of Directors that the "Compensation Discussion and Analysis" be included in this proxy statement on Schedule 14A and incorporated by reference into the Company's Annual Report on Form 10-K for the year ended December 31, 2025.

COMPENSATION AND TALENT COMMITTEE

Christopher J. Coughlin, Chair
Frederick H. Eppinger
Monte E. Ford
Theodore R. Samuels

Executive Compensation Tables

Summary Compensation Table

The following table summarizes the compensation of our NEOs for the fiscal years ended December 31, 2025, 2024 and 2023. Additional descriptions of each component of compensation for our NEOs are included elsewhere in this proxy statement under the caption, "Compensation Discussion and Analysis."

For 2025, our NEOs included our Chief Executive Officer, Chief Financial Officer, Secretary and General Counsel, Chief People Officer, and Chief Operating Officer.

Name & Principal Position	Year	Salary ($)	Bonus ($)	Stock Awards ($)[1]	Option Awards ($)	Non-Equity Incentive Plan Compensation ($)[2]	All Other Compensation ($)[3]	Total ($)
Sarah M. London	2025	$1,473,077	$ —	$15,537,733	$ —	$2,109,446	$386,042	$19,506,298
Chief Executive Officer	2024	1,400,000	—	14,630,132	—	4,289,125	282,891	20,602,148
	2023	1,400,000	—	13,573,031	—	3,298,600	285,335	18,556,966
Andrew L. Asher	2025	1,152,885	—	13,362,923	—	1,238,198	318,874	16,072,880
Chief Financial Officer	2024	1,025,000	—	7,179,353	—	2,779,925	198,134	11,182,412
	2023	1,025,000	—	6,539,668	—	2,320,263	27,133	9,912,064
Christopher A. Koster	2025	768,269	—	5,111,079	—	550,081	79,364	6,508,793
Secretary and General Counsel	2024	750,000	—	2,920,884	—	1,352,250	40,404	5,063,538
	2023	750,000	—	2,591,281	—	1,424,100	78,956	4,844,337
Tanya McNally	2025	654,808	—	1,967,756	—	468,843	80,949	3,172,356
Chief People Officer								
Susan R. Smith	2025	718,269	—	3,577,782	—	514,281	76,751	4,887,083
Chief Operating Officer	2024	696,154	—	1,654,307	—	1,099,923	72,068	3,522,452

[1] The amounts reported as Stock Awards and Option Awards for Ms. London, McNally, and Smith, and Messrs. Asher and Koster, reflect the grant date fair value of grants made during the current year under the 2012 Stock Incentive Plan computed in accordance with FASB ASC 718. Note 15 of the Notes to the Consolidated Financial Statements of our Annual Report on Form 10-K for the year ended December 31, 2025, describes the assumptions used to determine the grant date fair value for Company equity awards. There can be no assurance that the grant date fair value of Stock Awards will ever be realized.

Stock awards granted to the NEOs include PSUs. PSUs are disclosed at target value. The 2025 PSUs have a maximum payout of 200%. If the maximum performance metrics are achieved, the grant date fair value of the performance awards would be $18,915,502 for Ms. London, $20,325,877 for Mr. Asher, $6,222,177 for Mr. Koster, $2,395,455 for Ms. McNally, and $4,355,577 for Ms. Smith.

[2] The amounts shown in the Non-Equity Incentive Plan Compensation column include both the annual cash incentive and the Cash LTIP award payouts for 2023 and 2024. There was no Cash LTIP in 2025.

[3] The following table shows the components of "All Other Compensation" for fiscal year 2025:

Name	401(k) Match ($)	Non-qualified Deferred Compensation Match ($)	Life Insurance ($)	Personal Security ($)[a]	Personal Aircraft Usage ($)[b]	Other ($)[c]	Total Other Compensation ($)
Sarah M. London	$ 9,692	$ 150,630	$25,000	$49,510	$147,343	$3,867	$386,042
Andrew L. Asher	10,500	100,962	15,000	177,526	11,883	3,003	318,874
Christopher A. Koster	6,125	52,473	15,000	—	—	5,766	79,364
Tanya M. McNally	8,577	34,540	15,000	19,829	—	3,003	80,949
Susan R. Smith	10,500	44,046	15,000	4,167	—	3,038	76,751

[a] Beginning in December 2024, we pay for costs related to personal security services for certain NEOs. Amounts reported herein represent the aggregate incremental cost to the Company for these services. Additional descriptions of security services for certain NEOs are included under "Compensation Discussion & Analysis - Other Benefits."

[b] For flights on corporate aircraft, the cost is calculated based on an average cost-per-flight-hour charge, which reflects the operating and periodic maintenance costs of the aircraft, crew travel expenses and other miscellaneous costs, and represents the aggregate incremental cost to the Company.

[c] "Other" includes liability insurance for all NEOs. Ms. London's and Mr. Koster's "Other" compensation also includes personal use of Company event tickets. Ms. Smith's "Other" compensation also includes a health insurance incentive available to all employees.

Grants of Plan-Based Awards Table

The following table provides information on 2025 grants of PSUs and RSUs under the 2012 Stock Incentive Plan as well as 2025 cash-based grants under the Annual Cash Incentive Plan to each of our NEOs. The grant date fair values of these RSUs and PSUs are included in the Summary Compensation Table. The vesting provisions of the equity awards are included in the footnotes to the Outstanding Equity Awards at Fiscal Year-End Table.

Name	Grant Date	Date of Board Action	Estimated Future Payouts Under Non-Equity Incentive Plan Awards[1] Threshold ($)	Target ($)	Maximum ($)	Estimated Future Payouts Under Equity Incentive Plan Awards[2] Threshold (#)	Target (#)	Maximum (#)	All Other Stock Awards: Number of Shares of Stock or Units (#)[3]	Grant Date Fair Value of Stock and Option Awards ($)[4]
Sarah M. London	2/21/2025	2/21/2025	$147,308	$2,946,154	$5,892,308	—	—	—	—	$ —
	3/15/2025	2/20/2025	—	—	—	39,182	78,364 [5]	156,728	—	4,560,001
	3/15/2025	2/20/2025	—	—	—	19,591	39,182 [6]	78,364	—	2,280,001
	3/15/2025	2/20/2025	—	—	—	19,591	39,182 [7]	78,364	—	2,617,749
	3/15/2025	2/20/2025	—	—	—	—	—	—	104,485	6,079,982
Andrew L. Asher	1/24/2025	1/24/2025	86,466	1,729,328	3,458,655	—	—	—	—	—
	3/15/2025	2/20/2025	—	—	—	20,622	41,244 [5]	82,488	—	2,399,988
	3/15/2025	2/20/2025	—	—	—	10,312	20,623 [6]	41,246	—	1,200,052
	3/15/2025	2/20/2025	—	—	—	10,311	20,622 [7]	41,244	—	1,377,757
	3/15/2025	2/20/2025	—	—	—	21,482	42,963 [5]	85,926	—	2,500,017
	3/15/2025	2/20/2025	—	—	—	10,741	21,481 [6]	42,962	—	1,249,979
	3/15/2025	2/20/2025	—	—	—	10,741	21,481 [7]	42,962	—	1,435,146
	3/15/2025	2/20/2025	—	—	—	—	—	—	54,992	3,199,984
Christopher A. Koster	1/24/2025	1/24/2025	38,413	768,269	1,536,538	—	—	—	—	—
	3/15/2025	2/20/2025	—	—	—	12,889	25,778 [5]	51,556	—	1,500,022
	3/15/2025	2/20/2025	—	—	—	6,444	12,888 [6]	25,776	—	749,953
	3/15/2025	2/20/2025	—	—	—	6,445	12,889 [7]	25,778	—	861,114
	3/15/2025	2/20/2025	—	—	—	—	—	—	34,370	1,999,990
Tanya M. McNally	1/24/2025	1/24/2025	32,740	654,808	1,309,616	—	—	—	—	—
	3/15/2025	2/20/2025	—	—	—	4,962	9,924 [5]	19,848	—	577,478
	3/15/2025	2/20/2025	—	—	—	2,481	4,962 [6]	9,924	—	288,739
	3/15/2025	2/20/2025	—	—	—	2,481	4,962 [7]	9,924	—	331,511
	3/15/2025	2/20/2025	—	—	—	—	—	—	13,233	770,028
Susan R. Smith	1/24/2025	1/24/2025	35,913	718,269	1,436,538	—	—	—	—	—
	3/15/2025	2/20/2025	—	—	—	9,022	18,044 [5]	36,088	—	1,049,980
	3/15/2025	2/20/2025	—	—	—	4,512	9,023 [6]	18,046	—	525,048
	3/15/2025	2/20/2025	—	—	—	4,511	9,022 [7]	18,044	—	602,761
	3/15/2025	2/20/2025	—	—	—	—	—	—	24,059	1,399,993

[1] The amounts shown in the Estimated Future Payouts Under Non-Equity Incentive Plan Awards columns represent the range of the annual cash incentive awards as described in the section titled "Annual Cash Incentive Plan" in the Compensation Discussion and Analysis above.

[2] The amounts shown in the Estimated Future Payouts Under Equity Incentive Plan Awards columns represent the range of shares that may be earned at the end of the 2025-2027 performance period applicable to our PSUs assuming achievement of the relevant performance objectives.

[3] The amounts shown in the All Other Stock Awards column represent the RSUs described in the section titled "2025 Annual Long-Term Incentives" in the Compensation Discussion and Analysis above.

[4] The amounts shown in the Grant Date Fair Value of Stock Awards column represent the grant date fair value, measured in accordance with FASB ASC 718.

[5] Equity incentive grants contain a performance condition based upon our 2025-2027 Average Adjusted Pre-Tax Earnings Margin. For performance between the threshold and the target or the target and the maximum, the number of PSUs earned will be interpolated.

[6] Equity incentive grants contain a performance condition based upon our 2027 Medicare Adjusted Pre-Tax Earnings Margin. For performance between the threshold and the target or the target and the maximum, the number of PSUs earned will be interpolated.

[7] Equity incentive grants contain a performance condition based upon our 2025-2027 relative TSR. For performance between the threshold and the target or the target and the maximum, the number of PSUs earned will be interpolated. If the Company's absolute TSR for the performance period is negative, the payout will not exceed 100% of target.

Individual Employment Agreements

The following is a description of the material terms of the employment agreements with Ms. London and Mr. Asher. The terms of payments they would receive upon termination of employment and restrictive covenants are described in "Potential Payments Upon Termination or Change in Control."

Sarah M. London

Ms. London's employment agreement, dated April 27, 2022, as amended on February 20, 2023, provides for (i) an annual base salary for the years 2022 and 2023 of $1.4 million, (ii) an annual cash incentive bonus target of no less than 150% of base salary and (iii) long-term equity incentive awards with amounts and terms determined by the Compensation and Talent Committee.

Andrew L. Asher

Mr. Asher's employment agreement, dated April 28, 2022, as amended on February 20, 2023, provides for (i) an annual base salary of $1,025,000, (ii) an annual cash incentive bonus target of 125% of base salary and (iii) long-term equity incentive awards with amounts and terms determined by the Compensation and Talent Committee. Mr. Asher’s actual total target level of compensation shall be annually determined by the Compensation and Talent Committee in its sole discretion. The Compensation and Talent Committee shall determine in its sole discretion, consistent with the principles set forth in Mr. Asher's employment agreement, the specific components of total compensation for any future calendar years in the employment term.

Outstanding Equity Awards at Fiscal Year-End Table

The following table shows the number of shares covered by exercisable and unexercisable options and unvested RSUs and PSUs held by our NEOs on December 31, 2025.

	Option Awards					Stock Awards			
Name	Number of Securities Underlying Unexercised Options (#) Exercisable	Number of Securities Underlying Unexercised Options (#) Unexercisable	Equity Incentive Plan Awards: Number of Securities Underlying Unexercised Unearned Options (#)	Option Exercise Price ($)	Option Expiration Date	Number of Shares or Units of Stock That Have Not Vested (#)[1,2]	Market Value of Shares or Units of Stock That Have Not Vested ($)[3]	Equity Incentive Plan Awards: Number of Unearned Shares, Units or Other Rights That Have Not Vested (#)[1,4]	Equity Incentive Plan Awards: Market or Payout Value of Unearned Shares, Units or Other Rights That Have Not Vested ($)[3]
Sarah M. London	—	—	13,449	$ 81.85	12/15/2031 [5]	173,227	$ 7,128,291	138,834	$ 5,713,019
Andrew L. Asher	—	—	13,449	81.85	12/15/2031 [5]	88,500	3,641,775	113,881	4,686,203
Christopher A. Koster	—	—	15,690	81.85	12/15/2031 [5]	47,873	1,969,974	37,851	1,557,569
Tanya M. McNally	—	—	—	—	—	21,350	878,553	13,770	566,636
Susan R. Smith	—	—	—	—	—	30,702	1,263,387	24,882	1,023,894

[1] Upon the occurrence of a change in control and subsequent termination, any unvested RSUs and PSUs will vest, with the PSUs vesting at the greater of the actual or target level of performance.

[2] The amounts in this column represent the number of shares of unvested RSUs granted in 2023, 2024 and 2025. Although this column typically includes earned PSUs, no PSUs are reflected for the 2023-2025 performance period because performance conditions were not met as of December 31, 2025 and no shares were earned.

[3] Based on the $41.15 closing stock price of Centene common stock on December 31, 2025.

[4] The amounts in this column represent the threshold number of PSUs granted to our NEOs in 2024 and 2025. The PSUs will vest or be forfeited based on whether the applicable three-year performance metrics are attained.

[5] Performance Stock Option granted on December 15, 2021, may become exercisable on or after the third anniversary of the grant date if the average closing price of Centene common stock equals or exceeds $100 per share for 20 consecutive trading days following the grant date.

These unvested equity grants are detailed by vesting date in the table below.

Name	Vesting Date	Restricted Stock Units (#)	Performance Stock Units Granted in 2024[1] (#)	Performance Stock Units Granted in 2025[1] (#)
Sarah M. London	3/15/2026	81,862	—	—
	3/15/2027	56,536	60,470	—
	3/15/2028	34,829	—	78,364
Andrew L. Asher	3/15/2026	41,185	—	—
	3/15/2027	28,984	29,674	—
	3/15/2028	18,331	—	84,207
Christopher A. Koster	3/15/2026	20,625	—	—
	3/15/2027	15,791	12,073	—
	3/15/2028	11,457	—	25,778
Tanya M. McNally	1/15/2026	1,623	—	—
	3/15/2026	7,075	—	—
	4/15/2026	2,449	—	—
	3/15/2027	5,792	3,846	—
	3/15/2028	4,411	—	9,924
Susan R. Smith	3/15/2026	10,474	—	—
	6/15/2026	1,733	—	—
	3/15/2027	10,475	6,837	—
	3/15/2028	8,020	—	18,045

[1] PSUs reported at threshold performance level.

Option Exercises and Stock Vested Table

The following table shows the number of shares of our stock acquired by our NEOs in 2025 upon vesting of RSUs or PSUs. No option awards were exercised by our NEOs in 2025.

	Option Awards		Stock Awards	
Name	Number of Shares Acquired on Exercise (#)	Value Realized on Exercise ($)	Number of Shares Acquired on Vesting (#)	Value Realized on Vesting ($)
Sarah M. London	—	$ —	94,285	$ 5,799,725
Andrew L. Asher	—	—	57,762	3,396,166
Christopher A. Koster	—	—	17,750	1,089,771
Tanya M. McNally	—	—	7,543	459,182
Susan R. Smith	—	—	19,654	1,092,582

Non-qualified Deferred Compensation Table

Under the Company's Deferred Compensation Plan, the NEOs may contribute a designated percentage of salary and/or bonus into the plan which serves as an excess savings plan due to tax limitations under our tax qualified 401(k) plan. The following table shows the change in the Non-qualified Deferred Compensation balances for our NEOs who participated for the fiscal year ended December 31, 2025:

Name	Executive Contributions in Last FY ($)[1]	Registrant Contributions in Last FY ($)[2]	Aggregate Earnings (Losses) in Last FY ($)[3]	Aggregate Withdrawals / Distributions ($)	Aggregate Balance at Last FYE ($)[4]
Sarah M. London	$ 320,645	$ 150,630	$ 61,604	$ —	$ 1,391,544
Andrew L. Asher	222,923	100,962	455,597	—	3,096,642
Christopher A. Koster	147,927	52,473	234,822	—	1,972,562
Tanya M. McNally	112,425	34,540	62,212	—	476,501
Susan R. Smith	109,092	44,046	34,404	—	243,632

[1] Executive contributions were included in the Salary and/or Non-Equity Incentive Plan Compensation columns in the Summary Compensation Table to the extent the executive was named in the proxy statement in the fiscal year in which such contributions were earned.

[2] All registrant contributions are included in the All Other Compensation column in the Summary Compensation Table for 2025.

[3] The Company does not pay above market interest or preferential dividends on investments in the Deferred Compensation Plan. Investment options in the Deferred Compensation Plan are substantially the same as the 401(k) plan, with the exception of the investment in Centene common stock. The returns on the investments available to employees during 2025 ranged from -32.1% to 33.7%, with a median return of 15.2% for the year ended December 31, 2025.

[4] The amounts shown in the Aggregate Balance at Last Fiscal Year-End column include amounts the Company owes these individuals for salaries and incentive compensation they earned in prior years but did not receive because they elected to defer receipt of it until a later time. For prior years, all amounts contributed by a NEO in such years have been reported in the Summary Compensation Table in our previously filed proxy statements in the year earned, to the extent the executive was named in such proxy statements and the amounts were so required to be reported in such tables. The amounts reported in the Summary Compensation Table for the years ended December 31, 2025, 2024 and 2023 are summarized below.

Name	2025 Summary Compensation Table ($)	2024 Summary Compensation Table ($)	2023 Summary Compensation Table ($)
Sarah M. London	$ 239,015	$ 347,910	$ 100,604
Andrew L. Asher	170,135	286,772	115,816
Christopher A. Koster	129,300	163,408	129,656
Tanya M. McNally	100,020	— [a]	— [a]
Susan R. Smith	87,142	118,299	— [a]

[a] Ms. McNally was not a Named Executive Officer in the Company's 2023 or 2024 proxy statement. Ms. Smith was not a Named Executive Officer in the Company's 2023 proxy statement.

Potential Payments Upon Termination or Change in Control

As previously discussed, Ms. London and Mr. Asher are party to employment agreements, pursuant to which they will receive severance payments and benefits upon certain terminations of employment. Mr. Koster, Ms. McNally, and Ms. Smith are not party to individual employment agreements providing for severance, and instead, are party to the Executive Severance Plan.

Sarah M. London

Upon a termination without cause, with good reason or due to the Company's non-renewal of Ms. London's term, absent a change in control, Ms. London will receive the following payments and benefits: (i) an amount equal to two times the sum of base salary and the greater of target annual bonus then in effect or the average of the annual bonuses earned for the two most recent calendar years for which a bonus had been determined, (ii) a prorated annual bonus, (iii) 24 months of medical coverage, (iv) continued vesting of performance-vested restricted stock units granted on March 29, 2022, and (v) immediate acceleration of the vesting of all other time-vested equity and equity-based awards that would otherwise vest during the 24 month period following the termination, pro-rata vesting and payment of all other performance-based awards based upon adding an additional 24 months service and the greater of target or Company performance. Upon a termination without cause, with good reason or due to the non-renewal of Ms. London's term within 2 years following or 120 days prior to a change in control, Ms. London will receive the following payments and benefits: (a) an amount equal to 2.99 times the sum of base salary and the greater of target annual bonus then in effect or the average of the annual bonuses earned for the two most recent calendar years for which a bonus had been determined, (b) a prorated annual bonus, (c) 36 months of medical coverage and (d) full vesting of any outstanding equity or equity-based awards. Upon a termination due to death or disability, Ms. London will receive the same benefits as with good reason or due to non-renewal except for the benefit described in (i) above. Under her employment agreement, Ms. London is required to execute a general release and waiver of claims against the Company and to resign from her position upon termination of her employment for any reason in order to receive any severance payments. Ms. London is subject to a non-competition provision, a non-solicitation (of Company employees) obligation and an obligation not to interfere with Company customer relationships for a period of 24 months after termination for any reason (or in the event of a change in control, 12 months). Additionally, Ms. London is subject to ongoing non-disparagement and confidentiality requirements.

Andrew L. Asher

Upon a termination without cause, with good reason absent a change in control, or due to death or disability, Mr. Asher will receive the following payments and benefits: (i) an amount equal to annual base salary, (ii) a prorated annual bonus, (iii) 12 months of medical coverage and (iv) acceleration of the vesting of any cash award granted in 2021, vesting of RSUs and PSUs, and an additional year of service for outstanding cash awards. Mr. Asher is eligible for qualified retirement, which allows for the vesting of outstanding RSUs and PSUs as previously described on page 91. Upon a termination without cause or with good reason within 2 years following or 120 days prior to a change in control, Mr. Asher will receive the following payments and benefits: (a) an amount equal to two times the sum of base salary and the average of the last two annual bonuses, (b) a prorated target bonus, (c) 18 months of medical coverage and (d) full vesting of any outstanding equity or equity-based awards. Under his employment agreement, Mr. Asher is required to execute a general release and waiver of claims against the Company and to resign from his position upon termination of his employment for any reason in order to receive any severance payments. Mr. Asher is subject to a non-competition provision and a non-solicitation (of Company employees or customers) obligation for a period of 12 months after termination for any reason (other than if a change in control occurs). Additionally, Mr. Asher is subject to ongoing non-disparagement and confidentiality requirements.

Christopher A. Koster, Tanya M. McNally, and Susan R. Smith

Mr. Koster, Ms. McNally, and Ms. Smith are covered by the Company's Executive Severance Plan. Under the Executive Severance Plan, upon a termination other than for cause, Mr. Koster, Ms. McNally, and Ms. Smith will receive (i) a lump sum equal to one times base salary plus prorated target bonus, (ii) 12 months of medical coverage and (iv) 12 months of continued vesting of the executive's existing equity awards. Upon a termination, other than for cause, or for good reason within 24 months following a change in control, Mr. Koster, Ms. McNally, and Ms. Smith will receive (a) a lump sum equal to two times base salary plus two times the average of the executive's last two annual bonuses and prorated target bonus (b) 18 months of medical coverage and (c) full vesting of any outstanding equity awards, including stock options. Additionally, Mr. Koster, Ms. McNally, and Ms. Smith are subject to a non-competition and non-solicitation (of Company employees or customers) obligation, each for a period of 12 months after termination for any reason, as well as ongoing confidentiality requirements. The non-competition obligation does not apply if Mr. Koster, Ms. McNally, or Ms. Smith undergoes a change in control termination.

Retirement Provisions

As of December 31, 2025, Mr. Asher is eligible for qualified retirement treatment as described in the Other Compensation Policies and Information section under Compensation Discussion and Analysis.

Termination and Change-in-Control Tables

The section below describes the payments that may be made to our NEOs upon termination or a change in control. Our NEOs may also be entitled to payments under the Company's Deferred Compensation Plan as set forth in the Non-qualified Deferred Compensation Table section above.

The amounts presented below assume the termination or change in control occurred as of December 31, 2025, based on the employment agreements and the Executive Severance Plan in place at December 31, 2025, in accordance with the applicable SEC rules. The change in control cash payments are subject to the conditions of the "double-trigger" criteria in each of the NEO's employment agreement or Executive Severance Plan, meaning they are only entitled to payment if there is a change in control and the executive officer's employment is terminated without "cause" or the executive officer terminates his or her employment for "good reason" within twenty-four months of the change in control. The equity award acceleration amounts below were calculated using the closing price of our common stock on December 31, 2025 of $41.15. In the Change in Control column, the PSU awards are generally included at the greater of the target or actual level of performance as of December 31, 2025. Our equity award agreements include a "double-trigger" provision, which provides for accelerated vesting only if there is a change in control and the executive officer's employment is terminated without "cause" or the executive officer terminates his or her employment for "good reason" within twenty-four months of the change in control.

Sarah M. London

Executive Benefits and Payments Upon Terminations	Voluntary Termination/ Retirement ($)	Involuntary Not for Cause Termination ($)	For Cause Termination ($)	Death ($)	Disability ($)	Termination Following a Change in Control ($)
Cash Severance	$ —	$ 9,664,000	$ —	$ —	$ —	$14,496,000
Pro rata Bonus Payment	—	3,332,000	—	3,332,000	3,332,000	3,332,000
Unvested RSUs and PSUs	—	22,685,666	—	22,685,666	22,685,666	24,683,186
Welfare Benefits Values	—	54,180	—	1,144,180	54,180	81,270

Andrew L. Asher

Executive Benefits and Payments Upon Terminations	Voluntary Termination/ Retirement ($)	Involuntary Not for Cause Termination or Voluntary with Good Reason ($)	For Cause Termination ($)	Death ($)	Disability ($)	Termination Following a Change in Control ($)
Cash Severance	$ —	$ 1,200,000	$ —	$ 1,200,000	$ 1,200,000	$ 6,666,563
Pro rata Bonus Payment	1,288,800	1,288,800	—	1,288,800	1,288,800	1,800,000
Unvested RSUs and PSUs	5,508,751	10,251,041	—	10,251,041	10,251,041	16,158,288
Welfare Benefits Values	—	27,090	—	457,090	27,090	478,661
Outplacement	—	25,000	—	—	—	—

Christopher A. Koster

Executive Benefits and Payments Upon Terminations	Voluntary Termination/ Retirement ($)	Involuntary Not for Cause Termination ($)	For Cause Termination ($)	Death ($)	Disability ($)	Termination Following a Change in Control ($)
Cash Severance	$ —	$ 1,550,000	$ —	$ —	$ —	$ 4,507,500
Unvested RSUs and PSUs	—	848,719	—	2,762,718	2,762,718	6,299,678
Welfare Benefits Values	—	26,182	—	340,000	—	39,273
Outplacement	—	25,000	—	—	—	25,000

Susan R. Smith

Executive Benefits and Payments Upon Terminations	Voluntary Termination/ Retirement ($)	Involuntary Not for Cause Termination ($)	For Cause Termination ($)	Death ($)	Disability ($)	Termination Following a Change in Control ($)
Cash Severance	$ —	$ 1,450,000	$ —	$ —	$ —	$ 3,999,923
Unvested RSUs and PSUs	—	502,318	—	1,419,675	1,419,675	3,782,590
Welfare Benefits Values	—	28,090	—	250,000	—	42,135
Outplacement	—	25,000	—	—	—	25,000

Tanya M. McNally

Executive Benefits and Payments Upon Terminations	Voluntary Termination/ Retirement ($)	Involuntary Not for Cause Termination ($)	For Cause Termination ($)	Death ($)	Disability ($)	Termination Following a Change in Control ($)
Cash Severance	$ —	$ 1,350,000	$ —	$ —	$ —	$ 3,380,807
Unvested RSUs and PSUs	—	458,699	—	813,865	813,865	2,137,948
Welfare Benefits Values	—	16,745	—	250,000	—	25,118
Outplacement	—	25,000	—	—	—	25,000

Pay Versus Performance

The following table illustrates the relation between executive compensation and certain Company performance metrics for the fiscal years ended December 31, 2025, 2024, 2023, 2022 and 2021. Amounts disclosed below reflect compensation to our Principal Executive Officers (PEO) and Non-PEO Named Executive Officers (Non-PEO NEO), including compensation reflected on the Summary Compensation Table (SCT) and Compensation Actually Paid (CAP). Performance metrics include TSR for the Company, TSR for the S&P Health Care Index effective as of December 31, 2025, Company Net Income (Loss) and Adjusted Diluted EPS, which is the measure selected by the Company as the most important financial metric for determining CAP in the current year. Additional description of Compensation Actually Paid is outlined in a footnote to the table below.

Year	Summary Compensation Table Total for First PEO[1] ($)	Summary Compensation Table Total for Second PEO[2] ($)	Compensation Actually Paid to First PEO[1,3] ($)	Compensation Actually Paid to Second PEO[2,3] ($)	Average Summary Compensation Table Total for Non-PEO NEO[4] ($)	Average Compensation Actually Paid to Non-PEO NEO [4,5] ($)	Value of Initial Fixed $100 Investment Based On: Total Shareholder Return ($)	Value of Initial Fixed $100 Investment Based On: Peer Group Total Shareholder Return[6] ($)	Net Income (Loss) ($)	Adjusted Diluted EPS[7] ($)
2025	$19,506,298	$ —	$ 4,646,963	$ —	$7,660,278	$3,190,854	$ 68.55	$148.37	$(6,674)	$2.08
2024	20,602,148	—	5,380,644	—	7,197,901	2,470,464	100.92	129.47	3,305	7.17
2023	18,556,966	—	13,968,419	—	7,571,326	6,661,957	123.62	126.21	2,702	6.68
2022	13,246,447	7,599,513	12,622,902	6,829,908	6,659,921	6,508,126	136.62	123.67	1,202	5.78
2021	—	20,637,990	—	42,314,846	9,904,692	8,682,563	137.26	126.13	1,347	5.15

[1] Represents compensation for Ms. London, the Company's current CEO.

[2] Represents compensation for Mr. Neidorff, the Company's former CEO.

[3] PEO Compensation Actually Paid. The amounts in the following table represent each of the amounts deducted and added to the equity award values for the PEOs for 2025 for purposes of computing the "compensation actually paid" amounts appearing in this column of the Pay Versus Performance table:

	2025
PEO Summary Compensation Table Total	$ 19,506,298
SCT "Stock Awards Total" column value	(15,537,733)
Year-end fair value of outstanding equity awards granted in applicable year	9,131,090
Change in fair value of outstanding equity awards granted in prior years	(8,540,633)
Change in fair value of prior-year equity awards vested in applicable year	87,941
PEO Compensation Actually Paid	$ 4,646,963

[4] Non-PEO NEOs for the applicable years were as follows: 2025 - Andrew Asher, Christopher Koster, Tanya McNally and Susan Smith; 2024 - Andrew Asher, Kenneth Fasola, Christopher Koster and Susan Smith; 2023 - Andrew Asher, Kenneth Fasola, Christopher Koster, David Thomas and James Murray; 2022 - Andrew Asher, Kenneth Fasola, Christopher Koster, Brent Layton, James Murray and David Thomas; and 2021 - Andrew Asher, Jesse Hunter, Christopher Koster, Brent Layton, Sarah London and Jeffrey Schwaneke.

[5] Average Non-PEO NEO Compensation Actually Paid. The amounts in the following table represent each of the amounts deducted and added to the equity award values for the non-PEO NEOs for 2025 for purposes of computing the "compensation actually paid" amounts appearing in this column of the Pay Versus Performance table:

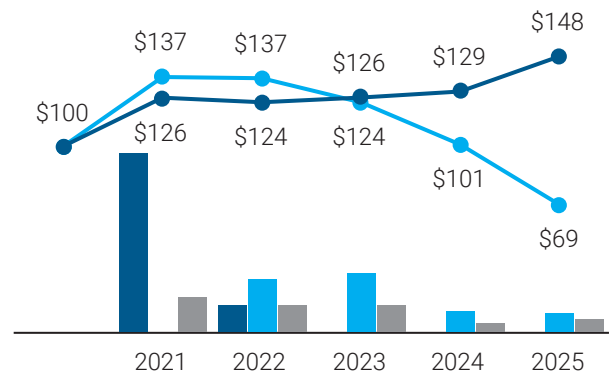
	2025
Average Non-PEO NEO Summary Compensation Table Total	$ 7,660,278
SCT "Stock Awards Total" column value	(6,004,885)
Year-end fair value of outstanding equity awards granted in applicable year	3,429,328
Change in fair value of outstanding equity awards granted in prior years	(1,847,766)
Change in fair value of prior-year equity awards vested in applicable year	(46,101)
Average Non-PEO NEO Compensation Actually Paid	$ 3,190,854

[6] Represents the TSR for the S&P Health Care Index.

[7] The Company has identified Adjusted Diluted EPS, a non-GAAP measure, as our company-selected measure, as it represents the most important financial performance measure used to link compensation actually paid to the PEO and the non-PEO NEOs in 2025 to the Company's performance. See Appendix A for reconciliation of non-GAAP measures.

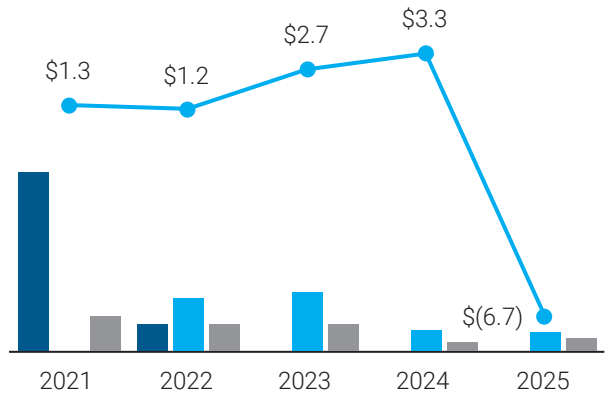
The graphs below describe the relationship between the PEO and Non-PEO NEOs' Compensation Actually Paid to the Company's TSR, Net Income (Loss) and Adjusted Diluted EPS.

Compensation Actually Paid vs. TSR



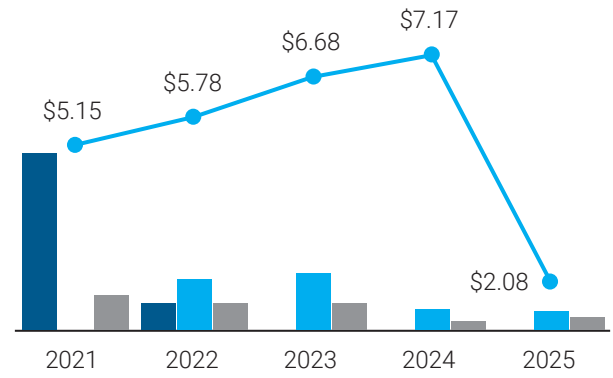
- CAP to Second PEO ($ in millions)
- CAP to First PEO ($ in millions)
- Average Compensation Actually Paid to Non-PEO NEOs ($ in millions)
- Company TSR
- S&P Health Care Index TSR

Compensation Actually Paid vs. Net Income (Loss)



- CAP to Second PEO ($ in millions)
- CAP to First PEO ($ in millions)
- Average Compensation Actually Paid to Non-PEO NEOs ($ in millions)
- Net Income (Loss) ($ in billions)

Compensation Actually Paid vs. Adjusted Diluted EPS[1]



CAP to Second PEO ($ in millions)
CAP to First PEO ($ in millions)
Average Compensation Actually Paid to Non-PEO NEOs ($ in millions)
Adjusted Diluted EPS

1 Represents non-GAAP measure. Refer to Appendix A for reconciliation of non-GAAP measures.

The following table lists the five financial performance measures that we believe represent the most important performance measures we used during 2025 to link compensation actually paid to our NEOs to our performance:

Most Important Performance Measures		
Adjusted Diluted EPS	Adjusted Net Earnings Margin	Total Shareholder Return (TSR)
Adjusted Pre-tax Margin	Revenue Growth Compound Annual Growth	

CEO to Median Employee Pay Ratio Information

Pursuant to Item 402(u) of Regulation S-K, we have included below a disclosure of the ratio of the median employee's annual total compensation to the annual total compensation of our CEO, Ms. London. Since the applicable SEC rules allow companies to use a variety of methods to determine this ratio, the ratio disclosed by the Company may not be comparable to the ratio disclosed by other companies.

Ms. London's annual total compensation for the year ended December 31, 2025 was $19,516,298, which reflects the amount reported in the Summary Compensation Table, plus $10,000 of the Company-paid portion of Ms. London's medical plan premiums. The annual total compensation for the median employee for the year ending December 31, 2025 was $94,800, inclusive of $10,000 of the Company-paid portion of the employee's medical plan premiums. Ms. London's annual total compensation was 206 times that of our median employee's pay.

We most recently determined the median employee in the fourth quarter of 2024 by analyzing total cash compensation for employees, excluding our CEO, who were employed by the Company as of October 11, 2024. In conducting this analysis, compensation for employees hired during the year was annualized. The population included all employees, whether employed on a full-time or part-time basis, except approximately 100 employees who had anomalous pay characteristics. As a result, a total of 59,378 employees were included in the determination of our median employee.

We calculated annual total compensation of the median employee using the same methodology used for our NEOs within the Summary Compensation Table of this proxy statement, plus company-paid medical plan premiums capped at $10,000.

3
PROPOSAL

Ratification of Appointment of Independent Registered Public Accounting Firm

KPMG LLP audited our financial statements for the fiscal year ended December 31, 2025. The Audit and Compliance Committee is directly responsible for the appointment, compensation, retention and oversight of the independent external audit firm retained to audit our financial statements. The Audit and Compliance Committee has appointed KPMG LLP to serve as our independent registered public accounting firm for the current fiscal year, and we are asking stockholders to ratify this appointment.

KPMG LLP has been retained as our external auditor continuously since 2005. The Audit and Compliance Committee believes the continued retention of KPMG LLP to serve as our independent registered public accounting firm is in the best interests of the Company and our stockholders because of the quality of accounting firm, the level of service provided by the firm, its efficient and innovative audit processes and competitive fee structure.

Stockholder ratification of this selection is not required by our By-laws or other applicable legal requirements. Our Board of Directors is, however, submitting the selection of KPMG LLP to stockholders for ratification as a matter of good corporate practice. In the event that stockholders fail to ratify the selection, the Audit and Compliance Committee will consider whether or not to retain that firm. Even if the selection is ratified, the Audit and Compliance Committee, in its discretion, may direct the appointment of a different independent registered public accounting firm at any time during the year if the Audit and Compliance Committee believes that a change would be in the best interests of the Company and our stockholders.

We expect that representatives of KPMG LLP will be present at our Annual Meeting of Stockholders to answer appropriate questions. They will have the opportunity to make a statement if they desire to do so.

The affirmative vote of the holders of a majority of the votes cast at the meeting is being sought to ratify the selection of KPMG LLP as our independent registered public accounting firm for the current fiscal year.

The Board recommends that stockholders vote "**FOR**" the ratification of the selection of KPMG LLP to serve as our independent registered public accounting firm for the fiscal year ending December 31, 2026.

Evaluation of the Independent Auditor

The Audit and Compliance Committee regularly considers the independence, qualifications, compensation and performance of its independent auditor. The Audit and Compliance Committee considered the following factors in its annual review and determination of whether to retain KPMG LLP as the Company's independent auditor during 2026.

Quality of the Independent Audit Firm and Audit Process

- The risks associated with the independent audit firm based on their financial stability, compliance with applicable laws and professional standards, pending litigation or judgments against the independent audit firm and results of applicable independent audit firm inspections.
- Results of the most recent PCAOB inspection report.

Level of Service Provided by the Independent Audit Firm

- Results of annual satisfaction surveys distributed to management with high interactions with the independent audit firm as well as the Audit and Compliance Committee.
- Open access and engagement with KPMG subject matter experts providing valuable insights on matters important to the Company.

Good Faith Negotiation of Fees

- Robust fee negotiation process resulting in rationalization of fees through identification of areas of opportunity and improvement, including the use of technology.
- Review of fees incurred for reasonableness against the annually approved fees and reported current fee estimates provided to the Committee.

Independence and Tenure

The committee engaged in an assessment of KPMG's independence controls through the provision of its required communications. Representatives of KPMG will participate in the annual meeting to answer questions and will have the opportunity to make a statement.

KPMG LLP has served as the Company's independent auditor since 2005. In considering the independence and tenure of KPMG as our independent auditor, the Audit and Compliance Committee carefully considers the benefits of auditor experience in light of the robust controls in place to safeguard independence.

Benefits of Tenure

- **Enhanced Audit Quality.** KPMG's deep familiarity with the healthcare insurance industry and Centene's business and operations, accounting policies and practices and internal controls over financial reporting is valuable to the Company and its stockholders. Their institutional knowledge and experience is balanced by the fresh perspective delivered by changes in the audit team resulting from mandatory audit partner rotation and routine turnover with the team that provides for new perspectives while still keeping the historic understanding of the Company.
- **Continuity.** Changing independent auditors, without reasonable cause, would require management to devote significant resources and time to educating a new independent auditor to reach a comparable level of familiarity with our business and control framework, potentially distracting from management's focus on financial reporting and controls.
- **Efficient Audit Plans.** KPMG's knowledge of our business and control framework allows them to develop and implement efficient and innovative audit processes, enabling the provision of services for fees considered by the committee to be competitive.

Key Independence Controls

- **Committee Oversight.** The Audit and Compliance Committee and its chair hold regular private sessions with the independent auditor; the Audit and Compliance Committee regularly discusses with the independent auditor the scope of their audit; the Committee reviews with the independent auditor any problems or difficulties they may have encountered. Additionally, on at least an annual basis, KPMG provides the Committee reports regarding their independence.
- **Lead Partner Rotation.** Under current legal requirements, the lead engagement partner for the independent audit firm may not serve in that role for more than five consecutive fiscal years, and the Audit and Compliance Committee ensures the regular rotation of the audit engagement team partner as required by law. The Audit and Compliance Committee has been directly involved in the appointment of a new lead engagement partner for 2025 and supported the smooth transition.
- **Limits on Non-audit Services.** The Audit and Compliance Committee has exclusive authority to pre-approve non-audit services and determine whether such services are consistent with auditor independence.
- **Independence Assessment.** On at least an annual basis, KPMG provides the Audit and Compliance Committee reports regarding independence, conducts periodic internal reviews of its audit and other work and assesses the adequacy of partners and other staff serving the Company's account consistent with independence requirements.

Independent Registered Public Accounting Firm Fees & Services

The following table discloses the aggregate fees for services related to 2025 and 2024 by KPMG LLP, our independent registered public accounting firm ($ in thousands):

	KPMG	
	2025	2024
Audit Fees	$ 13,363	$ 13,665
Audit-Related Fees	1,510	1,465
Tax Fees	—	5
All Other Fees	—	—

Audit-related fees in 2025 and 2024 consist primarily of fees for operational control reviews.

The Audit and Compliance Committee is responsible for the audit fee negotiations associated with our retention of KPMG LLP. When assessing services rendered by our auditor and evaluating the quality of their work, the Audit and Compliance Committee considers a variety of factors, including: independence, insight provided to the Audit and Compliance Committee, ability to meet deadlines and respond to issues, management feedback and relative costs of services.

Audit and Non-Audit Services Pre-Approval Policy

The Audit and Compliance Committee has adopted an Audit and Non-Audit Services Pre-Approval Policy that is designed to assure that the services performed for us by our independent registered public accounting firm do not impair its independence from the Company. This policy sets forth guidelines and procedures the Audit and Compliance Committee follows when retaining an independent registered public accounting firm to perform audit, audit-related, tax and other services. The policy provides detailed descriptions of the types of services that may be provided under these four categories and also sets forth a list of services that our independent registered public accounting firm may not perform for us.

Prior to engagement, the Audit and Compliance Committee pre-approves the services and fees of the independent registered public accounting firm within each of the above categories. During the year, it may become necessary to engage the independent registered public accounting firm for additional services not previously contemplated as part of the engagement. In those instances, the Audit and Non-Audit Services Pre-Approval Policy requires that the Audit and Compliance Committee specifically approve the services prior to the independent registered public accounting firm's commencement of those additional services. Under the Audit and Non-Audit Services Pre-Approval Policy, the Audit and Compliance Committee has delegated the ability to pre-approve audit and non-audit services to the Audit and Compliance Committee chairman, provided the chairman reports any pre-approval decision to the Audit and Compliance Committee at its next scheduled meeting. The policy does not provide for a de minimis exception to the pre-approval requirements. Accordingly, all of the 2025 and 2024 fees described above were pre-approved by the Audit and Compliance Committee in accordance with the Audit and Non-Audit Services Pre-Approval Policy.

Audit and Compliance Committee Report

The Audit and Compliance Committee operates under a written charter adopted by the Board of Directors. The charter outlines the Audit and Compliance Committee's duties and responsibilities. The Audit and Compliance Committee reviews the charter annually and works with the Board to amend the charter, as necessary, based on the Audit and Compliance Committee's evolving responsibilities. The Audit and Compliance Committee charter is available on the Company's website at investors.centene.com.

The Audit and Compliance Committee consists of four non-employee directors. Each member of the Audit and Compliance Committee is an independent director under the SEC rules for audit committees and "financially literate" under New York Stock Exchange standards. Each of Jessica L. Blume, Christopher J. Coughlin, and Kenneth Y. Tanji is an "audit committee financial expert" under SEC rules. The Audit and Compliance Committee assists the Board in its oversight of the integrity of the Company's financial statements, the qualifications and independence of the Company's independent auditor and the performance of the Company's internal audit function and independent registered public accountant and the Company's compliance with legal and regulatory requirements. Specifically, the Audit and Compliance Committee has responsibility for providing independent, objective oversight of the accounting and financial reporting process of the Company. These responsibilities include:

- appointing, evaluating and retaining the independent registered public accounting firm, which reports directly to the Audit and Compliance Committee;
- reviewing and discussing with the auditing firm, and recommending that the Board include, the audited financial statements in the Company's Annual Report on Form 10-K;
- reviewing the Company's other financial disclosures; and
- assisting the Board in its oversight of the Company's internal control over financial reporting, disclosure controls and procedures, code of business ethics and conduct and the performance of the Company's internal audit function.

Management is responsible for the preparation of the Company's financial statements and the overall reporting process, for maintaining adequate internal control over financial reporting and, with the assistance of the Company's internal auditors, for assessing the effectiveness of the Company's internal control over financial reporting. The Company's independent registered public accounting firm is responsible for performing an independent audit of the Company's financial statements in accordance with the standards of the Public Company Accounting Oversight Board (the PCAOB), expressing an opinion as to the conformity of the financial statements with generally accepted accounting principles in the United States of America and auditing management's assessment of the effectiveness of internal control over financial reporting. KPMG LLP has served as the Company's independent registered public accounting firm since 2005.

Management represented to the Audit and Compliance Committee that the financial statements were prepared in accordance with generally accepted accounting principles and that there were no material weaknesses in its internal control over financial reporting. The Audit and Compliance Committee met and held discussions with management and KPMG LLP to review and discuss the financial statements and the Company's internal control over financial reporting. The Audit and Compliance Committee has also discussed with KPMG LLP the firm's judgments as to the quality and the acceptability of the Company's financial reporting and such other matters as are required to be discussed by the applicable requirements of the PCAOB and the SEC. KPMG LLP also provided the Audit and Compliance Committee with the written disclosures and the letter required by applicable requirements of the PCAOB regarding the independent accountant's communications with the Audit and Compliance Committee concerning independence. The Audit and Compliance Committee has discussed with KPMG LLP their independence with respect to the Company, including a review of audit and non-audit fees and services and concluded that KPMG LLP is independent.

In fulfilling its oversight responsibilities for reviewing the services performed by KPMG LLP, the Audit and Compliance Committee has the sole authority to select, evaluate and replace the outside auditors. The Audit and Compliance Committee discusses the overall scope of the annual audit, the proposed audit fee and annually evaluates the qualifications, performance and independence of KPMG LLP as independent registered public accountants and the performance of its lead audit partner. The Audit and Compliance Committee meets regularly with the internal auditors and independent registered public accounting firm, with and without management present, to discuss the results of their respective examinations, the evaluation of the Company's internal control over financial reporting and the overall quality of the Company's accounting.

Based upon the review and discussions with the Company's management and KPMG LLP referred to above, and its review of the representations and information provided by management and KPMG LLP, the Audit and Compliance Committee recommended to the Board that the audited financial statements be included in the Company's Annual Report on Form 10-K for the year ended December 31, 2025, for filing with the SEC. The Audit and Compliance Committee also reappointed KPMG LLP to serve as the Company's independent registered public accounting firm for 2026.

AUDIT AND COMPLIANCE COMMITTEE

Kenneth Y. Tanji, Chair
Jessica L. Blume
Christopher J. Coughlin
H. James Dallas

4 PROPOSAL Stockholder Proposal

In October 2025, the Company received correspondence from a stockholder, John Chevedden, 2215 Nelson Avenue, No. 205, Redondo Beach, CA 90278, beneficial owner of at least $2,000 in market value, of Centene common stock since September 20, 2022 and for the requisite period, who intends to propose the following resolution on an independent board chairman at the annual meeting.

Stockholder Statement Regarding Independent Board Chairman

Proposal Four — Independent Board Chairman



Shareholders request that the Board of Directors adopt an enduring policy, and amend the governing documents as necessary in order that 2 separate people hold the office of the Chairman and the office of the CEO as soon as possible.

The Chairman of the Board shall be an Independent Director. A Lead Director shall not be a substitute for an independent Board Chairman.

The Board shall have the discretion to select an interim Chairman of the Board, who is not an Independent Director, to serve while the Board is required to seek an Independent Chairman of the Board on an accelerated basis. This policy could be phased in when there is a contract renewal for our current CEO or for the next CEO transition although it is better to adopt it now.

An independent Board Chairman at all times improves corporate governance by bringing impartiality, objective oversight, and external expertise to board decisions, mitigating conflicts of interest, enhancing transparency, and boosting shareholder confidence.

This detached perspective allows the chairman to focus on shareholder interests, strengthen management accountability, and provide critical checks and balances, ultimately contributing to long-term sustainability and credibility.

This may be a particularly good time to consider the merits of this proposal. Centene stock was at $74 in 2018 and fell to $35 in late 2025 despite a robust stock market.

Unfavorable news reports regarding Centene emerged in 2025.

On July I, 2025, Centene abruptly withdrew its full-year earnings guidance. This was prompted by data from an independent actuarial firm showing lower-than-expected market growth and higher morbidity (sicker patients) in its Health Insurance Marketplace plans. Following the announcement, Centene's stock plummeted over 40% in a single day. The news wiped out billions in shareholder value.

Centene disclosed that it expected a $1.8 billion reduction in its risk-adjustment revenue. This corresponded to a projected hit of $2.75 to its adjusted earnings per share. On July 25, 2025, Centene reported a second-quarter diluted loss per share of $(0.51), which was a direct result of the reduced revenue estimate.

In September, Barclays cut its price target on Centene and signaled continued concern about the company's financial outlook. Goldman Sachs issued a "Sell" recommendation in October.

In August 2025, several law firms, including Hagens Berman, announced a class-action lawsuit against Centene and its executives. The suit alleges that the company misled investors by painting an overly optimistic picture of its financial health and future prospects. The lawsuit claims that Centene inflated enrollment numbers and underestimated patient health risks in its public statements between December 2024 and June 2025 despite internal data to the contrary.

As of March 2025 more than 20 states had settled with Centene over allegations of overcharging Medicaid programs related to its pharmacy benefit manager operations. These settlements amounted to over $1 billion.

Please vote yes:
Independent Board Chairman - Proposal 4

Board of Directors' Statement in Opposition to Proposal Four

The Board has considered this proposal and does not believe that its adoption is in the best interests of Centene or its stockholders. Since March 22, 2022, Centene has operated with a separate Chairman and CEO. While the Board believes that separation of the CEO and Chairman roles is currently the most appropriate structure and is working well, the Board believes it is in the best interests of the Company and its stockholders to maintain flexibility regarding the Board's leadership structure as the Company's circumstances evolve.

The Board believes that any decision to maintain a separate Chairman of the Board and CEO role or to combine these roles should be based on the Company's specific circumstances, the composition, independence and capabilities of its directors, the views of our stockholders and other stakeholders, and the leadership provided by its CEO.

The Board does not believe that separating the roles of Chair of the Board and CEO should be mandated or that maintaining such a separation would, by itself, deliver additional benefit for shareholders. Any changes to the Board's leadership structure will be reflected on our website shortly after becoming effective and disclosed in compliance with applicable regulatory requirements.

The Board believes that its current leadership structure and governance practices provide effective, independent oversight without mandating a predetermined Board leadership structure:

- **Current Independent Chairman.** Our current Chairman, Frederick H. Eppinger, has served as chairman for three years, and as an independent Board member for almost 20 years. The responsibilities of the Independent Chairman include approving the agenda for the Board and being available for consultations and communications with stockholders as further described under "Role of the Board Chair." The Board believes Mr. Eppinger's executive and insurance industry experience provides effective leadership of the Board.
- **Robust Lead Independent Director Responsibilities.** In the event that the chairman is not determined to be independent, the Corporate Governance Guidelines set forth robust lead independent director responsibilities, to ensure that effective, independent oversight will be maintained.
- **Continuous Board Refreshment.** The Board has continuously refreshed its Board, with a median tenure of 4.2 years and annual elections of directors. It has also engaged an independent search firm to recruit for additional directors.
- **Independent Committee Chairs and Members.** The chairs and each member of each of the Audit and Compliance Committee, the Governance Committee and the Compensation and Talent Committee are independent and hold regular executive sessions providing opportunities for robust discussion independent of management.
- **No Clear Market Practice.** Under the Spencer Stuart 2025 Board Index, 42% of S&P 500 companies have an independent chair, while 39% of S&P 500 companies have a combined Chair/CEO structure.
- **Regular Stockholder Engagement.** Company executives and independent directors regularly meet with stockholders to discuss their concerns regarding a variety of topics, including board refreshment.

For these reasons, the Board believes that adopting a mandatory policy requiring an independent chair is not in the best interests of the Company or its stockholders. The Board remains committed to strong, independent oversight and to maintaining the flexibility necessary to select the leadership structure that best serves stockholders over the long term. Accordingly, the Board recommends that stockholders vote "AGAINST" this proposal.



The Board recommends that stockholders vote "**AGAINST**" **Proposal No. 4.**

Security Ownership of Certain Beneficial Owners and Management

Five Percent Beneficial Owners of Common Stock

The following table sets forth the beneficial ownership of our common stock as of March 13, 2026, by (a) each person known to us to be the beneficial owner of more than five percent of the Company's common stock, (b) each of our NEOs and directors, including our director nominees and (c) all directors and executive officers as a group.

	Amount and Nature of Beneficial Ownership			
Name and Address of Beneficial Owner	Outstanding Shares (#)	Shares Acquirable Within 60 Days (#)	Total Beneficial Ownership (#)	Percent of Class (%)[1]
The Vanguard Group, Inc. 100 Vanguard Blvd. Malvern, PA 19355	61,190,588	—	61,190,588	12.4
BlackRock, Inc. 50 Hudson Yards New York, NY 10001	38,215,413	—	38,215,413	7.8
AQR Capital Management, LLC AQR Capital Management Holdings, LLC One Greenwich Plaza, Suite 130 Greenwich Connecticut 06830	31,798,738	—	31,798,738	6.5
Kenneth A. Burdick	349,607	19,985	369,592 [2]	*
Frederick H. Eppinger	181,183	179,178	360,361 [2]	*
Sarah M. London	253,277	81,862	335,139	*
Andrew L. Asher	273,395	41,185	314,580	*
Christopher A. Koster	111,524	20,625	132,149	*
Theodore R. Samuels	42,776	19,037	61,813 [2]	*
H. James Dallas	35,963	19,612	55,575 [2]	*
Christopher J. Coughlin	33,014	20,057	53,071 [2]	*
Jessica L. Blume	25,036	23,579	48,615	*
Susan Smith	22,349	10,474	32,823	*
Monte E. Ford	7,256	13,579	20,835	*
Tanya McNally	9,429	9,524	18,953	*
Kenneth Y. Tanji	923	5,815	6,738 [2]	*
All directors and executive officers as a group (14 persons)	1,354,754	469,167	1,823,921	*

* Represents less than 1% of outstanding shares of common stock.

[1] The ownership percentages set forth in this column are based on the assumption that each beneficial owner of more than five percent of the Company's common stock continued to own the number of shares reflected in the table above on March 13, 2026.

[2] Shares beneficially owned by Messrs. Eppinger, Coughlin, Burdick, Dallas, Samuels and Tanji include 173,213, 6,478, 6,406, 6,033, 5,458 and 2,236, respectively, RSUs acquired through the Non-Employee Directors Deferred Stock Compensation Plan.

As of March 13, 2026, there were 491,772,493 shares of our common stock outstanding. Beneficial ownership is determined in accordance with the rules of the SEC. To calculate a stockholder's percentage of beneficial ownership, we include in the numerator and denominator those shares underlying options and stock units beneficially owned by that stockholder that are vested or that will vest within 60 days of March 13, 2026. Options held by other stockholders, however, are disregarded in the calculation of beneficial ownership. Therefore, the denominator used in calculating beneficial ownership among our stockholders may differ.

Unless otherwise indicated, the persons or entities identified in this table have sole voting and investment power with respect to all shares shown as beneficially owned by them, except to the extent authority is shared by spouses under applicable community property laws.

No director, executive officer, affiliate or owner of record, or beneficial owner of more than five percent of any class of our voting securities, or any associate of such individuals or entities, is a party adverse to us or any of our subsidiaries in any material proceeding or has any material interest adverse to us or any of our subsidiaries.

Information with respect to the outstanding shares beneficially owned by The Vanguard Group, Inc. is based on Schedule 13G/A filed with the SEC on February 13, 2024, by such firm, related to their Centene ownership. The Vanguard Group, Inc. beneficially owns 61,190,588 shares. Of the shares The Vanguard Group, Inc. owns, it has shared voting power over 717,036 shares, shared dispositive power over 2,313,336 shares and sole dispositive power over 58,877,252 shares.

Information with respect to the outstanding shares beneficially owned by BlackRock, Inc. is based on Schedule 13G/A filed with the SEC on July 16, 2025 by such firm, related to their Centene ownership. BlackRock, Inc. beneficially owns 38,215,413 shares. Of the shares BlackRock, Inc. owns, it has sole voting power over 34,086,009 shares and sole dispositive power over 38,215,413 shares.

Information with respect to the outstanding shares beneficially owned by AQR Capital Management, LLC and AQR Capital Management Holdings, LLC is based on Schedule 13G filed with the SEC on February 13, 2026, by such firm, related to their Centene ownership. AQR Capital Management, LLC and AQR Capital Management Holdings, LLC. beneficially owns 31,798,738 shares. Of the shares AQR Capital Management, LLC and AQR Capital Management Holdings, LLC owns, it has sole voting and dispositive power over no shares and shared voting and dispositive power over 31,798,738 shares.

Delinquent Section 16(a) Reports

Section 16(a) of the Exchange Act, requires our directors, executive officers and persons who beneficially own more than 10% of our outstanding common stock to file reports of their stock ownership and changes in their ownership of our common stock with the SEC. Based on Company records and other information, Centene believes that all SEC filing requirements applicable to its directors and executive officers were complied with timely for 2025.

Equity Compensation Plan Information

The following table provides information as of December 31, 2025, about the securities authorized for issuance under our equity compensation plans consisting of our 2025 Stock Incentive Plan, 2012 Stock Incentive Plan and the 2002 Employee Stock Purchase Plan.

Plan Category[1,2]	(a) Number of Securities to be Issued Upon Exercise of Outstanding Options, Warrants and Rights (#)	(b) Weighted-Average Exercise Price of Outstanding Options, Warrants and Rights ($)	(c) Number of Securities Remaining Available For Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column (a)) (#)
Equity compensation plans approved by stockholders	11,701,303	$ 77.28	13,663,623
Equity compensation plans not approved by stockholders	—	—	—
Total	11,701,303	$ 77.28	13,663,623

[1] Does not include 2,948 shares of common stock issuable pursuant to outstanding restricted stock units and 236,975 stock options with a weighted average remaining life of 2.2 years and weighted average price of $67.13 granted under the Magellan Health, Inc. 2016 Management Incentive Plan and Magellan Health Services, Inc. 2011 Management Incentive Plan (the Magellan Plans), which were assumed by the Company in connection with the acquisition on January 4, 2022. The Company has not made, and will not make, any further grants or awards of equity securities under the Magellan Plans.

[2] Does not include 196,360 deferred restricted stock units outstanding under the Non-Employee Directors Deferred Stock Compensation Plan (the Director Plan) and 761,988 shares that remained available for future deferrals under the Director Plan.

The number of securities in column (a) and footnote 1 includes 393,047 options with a weighted-average remaining life of 3.5 years and 11,548,179 shares of restricted stock units.

The number of securities in column (c) includes 2,129,451 shares available for future issuance under the 2002 Employee Stock Purchase Plan.

Commonly Asked Questions and Answers About the Annual Meeting

1. Why am I receiving these materials?

These materials are being sent to you on behalf of our Board. You are receiving these materials because you are a stockholder of Centene that is entitled to receive notice of the Annual Meeting and to vote on matters that are properly presented at the Annual Meeting.

2. What is the purpose of the Annual Meeting?

Our stockholders meet annually to elect directors and to vote on other matters that are presented at the Annual Meeting.

3. What is a proxy?

If you designate another person to vote your shares, that other person is called a proxy. If you designate someone as your proxy in a written document, that document is also called a proxy or a proxy card. If you complete the enclosed proxy card to give us your proxy, you will have designated Sarah London, the Company's Chief Executive Officer, and Christopher Koster, the Company's Secretary, or their designees or such other individuals as the Board may later designate, as your proxies to vote your shares as directed.

4. What is the purpose of this proxy statement?

This proxy statement provides information regarding matters to be voted on by stockholders at the Annual Meeting and other information regarding the governance of the Company.

5. Where is the Annual Meeting?

The Annual Meeting will be held at 10:00 AM, Central Time, on Tuesday, May 12, 2026, at our corporate headquarters in the Centene Auditorium at 7700 Forsyth Boulevard, St. Louis, Missouri 63105.

6. How do I gain admission to the Annual Meeting?

Preregistration is required if you desire to attend the annual meeting in person. To be admitted to the 2026 annual meeting, you must have been a stockholder at the close of business on the record date of March 13, 2026 or be the legal proxy holder or qualified representative of a stockholder, preregister for the annual meeting by 11:59 AM Eastern Time on May 8, 2026, and bring with you a valid government-issued photo identification card (federal, state or local), such as a driver's license or passport. Persons failing to preregister for the annual meeting or failing to provide proper identification may be denied admission to the annual meeting.

To preregister for the annual meeting, go to www.proxyvote.com. You will need to enter your 16-digit control number, which can be found on your Notice of Internet Availability of Proxy Materials (the Availability Notice), voter instruction form and proxy card. The deadline to preregister to attend the annual meeting is 11:59 AM Eastern Time on May 8, 2026.

Please note that you will need to preregister in order to attend the annual meeting whether you vote before or at the meeting, and regardless of whether you are a registered or beneficial stockholder. If you are attending the meeting as a proxy or qualified representative for a stockholder, you will need to bring your legal proxy or authorization letter, in addition to having preregistered for the annual meeting and bringing your government-issued photo identification card.

Stockholders must provide advance written notice to the Company if they intend to have a legal proxy (other than the persons appointed as proxies on the Company's proxy card) or qualified representative attend the annual meeting on their behalf. The notice must include the name and address of the legal proxy or qualified representative and must be received by 11:59 AM Eastern Time on May 8, 2026 via www.proxyvote.com in order to allow enough time for the preregistration of such person.

Requests for preregistration will be processed in the order received. Please note that seating is limited, and requests for preregistration will be handled on a first-come, first-served basis.

To ensure the safety of all persons, in person attendees will also be required to enter through a security check point before being granted access to the meeting. Security measures may include bag, metal detector and hand-wand searches. The use of cameras (including cell phones with photographic capabilities), recording devices, smart phones and other electronic devices is strictly prohibited. We strongly encourage you not to bring any bags to the meeting. Any bags brought to the meeting will be subject to inspection and must be clear plastic, vinyl or PVC and not exceed 12" x 6" x 12" or 30.5 x 15.25 x 30.5 cm. Any other bags will not be allowed.

We appreciate the opportunity to hear the views of our stockholders. In fairness to all stockholders and participants at our annual meeting, and in the interest of an orderly and constructive meeting, stockholder comments at our annual meeting will be subject to rules of conduct that will be enforced. Copies of these rules will be available at our annual meeting. Only stockholders, their valid proxy holders or other previously authorized representatives may address our annual meeting. Only proposals that meet the requirements of Rule 14a-8 of the Exchange Act or our by-laws will be eligible for consideration at our annual meeting.

7. What does it mean if I receive more than one package of proxy materials?

This means that you have multiple accounts holding Centene shares. These may include: accounts with our transfer agent, Broadridge Corporate Issuer Solutions, Inc., accounts holding shares that you have acquired under the Company's stock plans; and accounts with a broker, bank or other holder of record. Please vote all proxy cards and voting instruction forms that you receive with each package of proxy materials to ensure that all of your shares are voted.

8. Why did I receive a one-page notice in the mail regarding the Internet availability of proxy materials instead of a full set of printed proxy materials?

Under rules adopted by the SEC, we provide access to our proxy materials on the internet. Accordingly, we are sending a Notice of Internet Availability of Proxy Materials (the Availability Notice) to some of our stockholders. If you received an Availability Notice by mail, you will not receive a printed copy of the proxy materials unless you request one. The Availability Notice will tell you how to access and review the proxy materials on the internet at www.ProxyVote.com. The Availability Notice also tells you how to access your proxy card to vote on the internet. If you received an Availability Notice by mail and would like to receive a printed copy of our proxy materials, please follow the instructions on the Availability Notice.

9. What is the record date and what does it mean?

The record date for the Annual Meeting is March 13, 2026. Holders of the Company's common stock at the close of business on the record date are entitled to receive notice of the Annual Meeting and to vote at the meeting.

10. Is there a minimum number of shares that must be represented in person or by proxy to hold the Annual Meeting?

Yes. A quorum is the minimum number of shares that must be present to conduct business at the Annual Meeting. The quorum requirement is the number of shares that represent a majority of the voting power of the outstanding shares of the Company and entitled to vote thereat as of the record date, present in person or represented by proxy. Shares necessary to meet the quorum requirement may be present in person or represented by proxy. There were 491,772,493 shares of our common stock issued and outstanding on the record date. Therefore, at least 245,886,247 shares of our common stock must be present in person or represented by proxy at the Annual Meeting to satisfy the quorum requirement.

Your shares will be counted to determine whether there is a quorum if you submit a valid proxy card or voting instruction form, give proper instructions over the telephone or on the internet or register to attend the Annual Meeting in person. Pursuant to Delaware law, proxies received but marked as abstentions and broker non-votes (which are discussed in Question 17 below) are counted as present for purposes of determining a quorum.

11. Who can vote on matters that will be presented at the Annual Meeting?

You can vote if you were a stockholder of the Company at the close of business on the record date of March 13, 2026.

12. What is the difference between a registered stockholder and a beneficial owner?

Many Centene stockholders hold their shares through a stockbroker, bank or other nominee rather than directly in their own names. As summarized below, there are some distinctions between shares held of record and those owned beneficially.

- **Registered stockholder:** If your shares are registered directly in your name with the Company's transfer agent, Broadridge Corporate Issuer Solutions, Inc., you are considered, with respect to those shares, the "stockholder of record" or a "registered stockholder," and these proxy materials are being sent directly to you by the Company. As the stockholder of record, you have the right to deliver your voting proxy directly to the Company or to vote in person at the Annual Meeting.
- **Beneficial owner:** If your shares are held in a stock brokerage account or by a bank, trustee or other nominee, you are considered the "beneficial owner" of those shares, and these proxy materials are being forwarded to you by your broker, bank or other holder of record who is considered, with respect to those shares, the stockholder of record. As the beneficial owner you have the right to direct your broker, bank or other holder of record on how to vote your shares and you are invited to register to attend the Annual Meeting. Your broker, bank, trustee or nominee is obligated to provide you with a voting instruction form for you to use.

13. How many votes am I entitled to per share?

Each share of common stock outstanding on the record date is entitled to one vote on each matter properly presented at the Annual Meeting. Stockholders do not have a right to cumulate their votes.

14. Who will count the vote?

Broadridge Investor Communications Solutions, Inc. was appointed by our Board to tabulate the vote and act as Inspector of Election. Information about Broadridge Investor Communications Solutions, Inc. is available at www.broadridge.com.

15. How do I cast my vote?

Registered stockholders: There are four ways you can cast your vote:

- Vote on the internet at www.ProxyVote.com using the control number provided to you by 11:59 PM. Eastern Time on May 11, 2026;
- Vote by telephone at 1-800-690-6903 using the control number provided to you by 11:59 PM. Eastern Time on May 11, 2026;
- If you received a proxy card, complete and properly sign, date and return it in the postage paid envelope provided. If voting by mail, please allow sufficient time for the postal service to deliver your proxy card before the Annual Meeting; or
- Preregister to attend the Annual Meeting by 11:59 AM Eastern Time on May 8, 2026 and deliver your completed proxy card or complete a ballot in person.

Beneficial owners: Your proxy materials should include a voting instruction form from the institution holding your shares. There are up to four ways you can cast your vote:

- Vote on the internet at www.ProxyVote.com using the control number provided to you by the institution holding your shares by 11:59 PM. Eastern Time on May 11, 2026;
- Vote by telephone using the telephone number and the control number provided to you (note: the availability of telephone voting will depend upon the institution's voting processes);
- Complete and properly sign, date and return a voting instruction form from the institution holding your shares. Please allow sufficient time for your instructions to be received by the institution before the Annual Meeting; or
- Preregister to attend the annual meeting in person as described in Question 6 above by 11:59 AM Eastern Time on May 8, 2026 and obtain a legal proxy from the institution holding your shares to vote in person at the Annual Meeting.
- Please contact the institution holding your shares for additional information, including its deadline for voting.

16. What is the voting requirement to approve each of the proposals? How do abstentions and broker non-votes affect the vote outcome?

Proposal 1: Each director will be elected by a majority of votes cast, which means a majority of the votes cast "for" the particular director. As discussed further on page 28, our Corporate Governance Guidelines provide that any director nominee who receives a greater number of votes "against" his or her election than votes "for" such election shall, promptly following certificate of the vote, offer his or her resignation to the Board, the acceptance or rejection of which will be subject to Board action and subsequent disclosure.

Proposals 2, 3, 4: Proposals 2, 3 and 4 will pass with the votes of a majority of votes cast, which means a majority of the votes cast "for" the proposal.

A broker non-vote (a broker non-vote is explained in the answer to Question 17) on a proposal is considered a share not entitled to vote on that proposal and is not a vote cast. Accordingly, a broker non-vote will have no effect on the vote outcome of any proposal.

Abstentions are considered shares entitled to vote on a proposal but are not considered as having been cast "for" or "against" a proposal. Therefore, abstentions will have no effect on the vote outcome of any proposal.

Discretionary voting by brokers will be permitted by the New York Stock Exchange only in connection with Proposal 3. Discretionary voting is explained in the answer to Question 17.

17. What if I return my proxy card or voting instruction form but do not provide voting instructions?

Registered stockholders: If you are a registered stockholder and you return your signed proxy card, your shares will be voted as you designate on the proxy card. If you do not return your voted proxy card, vote by phone or the internet or if you submit your proxy card with an unclear voting designation, your shares will not be voted. If you return your signed proxy card and do not provide a voting designation, your shares will be voted FOR the election of all director nominees listed in Proposal 1; FOR Proposals 2 and 3; and AGAINST Proposal 4. The proxy holders will vote in their discretion as to any other matters that arise at the Annual Meeting.

Beneficial owners: In limited instances, your shares may be voted if they are held in the name of a broker, bank or other intermediary, even if you do not provide the holder with voting instructions. This is called "*discretionary voting*." Brokerage firms and banks generally have the authority, under NYSE rules, to vote shares on certain "routine" matters for which their customers do not provide voting instructions. Of the four proposals scheduled to be presented at the Annual Meeting, only Proposal 3, Ratification of the Appointment of Independent Registered Public Accounting Firm, is considered a routine matter under the NYSE's rules. Proposals 1, 2 and 4 and any other matter that may be presented at the Annual Meeting, are not considered routine. When a proposal is not a routine matter and the institution holding the shares has not received voting instructions from the beneficial owner of the shares with respect to that proposal, the institution cannot vote the shares on that proposal. This is called a "*broker non-vote*." In tabulating the voting result for any particular proposal, shares represented at the Annual Meeting that constitute broker non-votes will not be included in vote totals. As a result, they will have no effect on the outcome of any vote.

18. Can I change my mind after I submit my proxy?

Yes, if you vote by proxy, you may revoke that proxy by:

- voting again on the internet or by telephone prior to the applicable deadline for the votes to be tabulated at the Annual Meeting;
- signing another proxy card with a later date and mailing it, provided it is *received* prior to the Annual Meeting; or
- preregistering to attend the Annual Meeting in person as described in Question 6 above by 11:59 AM Eastern Time on May 8, 2026, and delivering your proxy or casting a ballot in person.

If you are a beneficial owner of our stock, you must obtain a legal proxy from the institution holding your shares to vote in person at the Annual Meeting and preregister to attend the annual meeting in person as described in Question 6 above by 11:59 AM Eastern Time on May 8, 2026.

19. Where can I find the voting results of the Annual Meeting?

We intend to announce preliminary voting results at the Annual Meeting and publish voting results on a Current Report on Form 8-K within four business days after the conclusion of the Annual Meeting. The Form 8-K will be accessible at the SEC's website at www.sec.gov or on our website at www.centene.com.

20. What if I have additional questions that are not addressed here?

You may call Investor Relations at (212) 549-1306, e-mail Investor Relations at investors@centene.com or call the Office of the Secretary at (314) 725-4477.

Other Matters

Committee Reports

The information contained in the Compensation and Talent Committee Report and the Audit and Compliance Committee Report does not constitute soliciting material and should not be deemed filed or incorporated by reference into any other of our filings under the Securities Act of 1933 or the Exchange Act, except to the extent the filing specifically incorporates such information by reference therein.

Proxy Solicitation Costs

This proxy solicitation is sent on behalf of our Board, and all costs and expenses associated with soliciting proxies will be borne by the Company. In addition to the use of the mailings, our directors, executive officers and our associates by personal interview, telephone or telegram may solicit proxies. Such directors, executive officers and associates will not be additionally compensated for such solicitation but may be reimbursed for out-of-pocket expenses incurred in connection therewith. Arrangements will also be made with custodians, nominees and fiduciaries for the forwarding of solicitation material to the beneficial owners of our common stock held of record by such persons, and we will reimburse such custodians, nominees and fiduciaries for their reasonable out-of-pocket expenses incurred in connection therewith. We have retained Saratoga Proxy Consulting, LLC, a proxy soliciting firm, to assist with the solicitation of proxies for a fee of $12,500 plus fees for any retail stockholder outreach services and reimbursement for out-of-pocket expenses.

Stockholder Proposals and Director Nominations

Stockholder Proposals for Inclusion in our 2027 Proxy Statement. For our 2027 Annual Meeting of Stockholders, to be eligible for inclusion in our 2027 proxy statement under the SEC's Rule 14a-8 requirements, any stockholder proposals under Rule 14a-8 must be submitted to Christopher A. Koster, our Secretary, at 7700 Forsyth Boulevard, St. Louis, Missouri 63105, no later than November 26, 2026.

Director Nominations under our Proxy Access By-laws. Our By-laws provide for a right of proxy access. This enables stockholders, under specified conditions, to include their nominees for election as directors in our proxy statement. Under our By-laws, a stockholder (or group of up to 20 stockholders) who has continuously owned at least 3% of the outstanding shares of our common stock for at least three consecutive years and has complied with the other requirements in our By-laws may nominate up to the greater of two individuals or 20% of the Board and have such nominee(s) included in our proxy statement. Notice of nominees for our 2027 annual meeting of stockholders must be received by the Secretary not later than February 11, 2027 and not earlier than January 12, 2027.

Director Nominations and other Stockholder Proposals for Presentation at the 2026 Annual Meeting. Our advance notice By-laws also provide procedures regarding nominations of directors and other proposals that a stockholder wishes to have considered at a meeting of stockholders. Under our By-laws, written notice of such stockholder nominations to the Board of Directors or any other business proposed by a stockholder must be delivered to our Secretary not less than 90 days nor more than 120 days prior to the first anniversary of the preceding year's annual meeting. Accordingly, any stockholder who wishes to nominate a director other than under our proxy access By-law or propose other business to be considered at the 2026 annual meeting of stockholders must deliver a written notice (containing the information specified in our By-laws regarding the stockholder and the proposed action) to Christopher A. Koster, our Secretary, at 7700 Forsyth Boulevard, St. Louis, Missouri 63105, not later than February 11, 2027 and not earlier than January 12, 2027.

Please be aware that merely submitting a proposal to us is not a guarantee that it will either be included in our 2027 proxy statement or considered at our 2027 Annual Meeting of Stockholders.

Multiple Stockholders Having the Same Address

We have adopted a process called "householding" for mailing proxy materials in order to reduce costs. Householding means that stockholders who share the same last name and address will receive only one copy of our 2025 Annual Report on Form 10-K and this proxy statement (collectively, the proxy materials) unless we receive contrary instructions. For those stockholders receiving our Notice of Internet Availability of Proxy Materials (Availability Notice), we will provide a separate Availability Notice for each stockholder. For those households receiving copies of our Annual Report on Form 10-K and proxy statement, we will continue to mail a proxy card to each stockholder of record. If you prefer to receive multiple copies of the proxy materials at the same address, additional copies will be provided to you promptly upon request. If you hold your shares in street name or are a registered holder, you should direct your request to Broadridge, Householding Department, 51 Mercedes Way, Edgewood, NY 11717, telephone number (800) 542-1061. You may also request copies of our proxy materials or notify us that you wish to receive a separate copy of these documents for each stockholder, or a single copy for each address, by writing to Investor Relations Department, Centene Corporation, 7700 Forsyth Boulevard, St. Louis, Missouri 63105, or by calling (314) 725-4477. The Company's Annual Report on Form 10-K for the year ended December 31, 2025 and this proxy statement are also available at www.ProxyVote.com.

Requests for Additional Information

We will provide without charge to each beneficial holder of our common stock on the record date, upon the written request of any such person, a copy of our Annual Report on Form 10-K (without exhibits) for the fiscal year ended December 31, 2025, as filed with the SEC. We will provide copies of any exhibit(s) to our Annual Report on Form 10-K upon request and upon payment of a reasonable fee not to exceed our costs in providing such copy. We will also provide to any person without charge, upon request, a copy of our Code of Conduct, our Corporate Governance Guidelines and our Board Committee Charters. Any such requests should be made in writing to Investor Relations, Centene Corporation, 7700 Forsyth Boulevard, St. Louis, Missouri 63105. A copy of these documents and our other SEC filings are also available on our website at www.centene.com. We intend to disclose future amendments to, or waivers, if any, from the provisions of the Code of Conduct made with respect to any of our directors and executive officers on our website. The information contained in any website or report referenced in this proxy statement is not incorporated by reference into, and does not form a part of, this proxy statement.

Forward-Looking Statements

All statements, other than statements of current or historical fact, contained in this proxy statement 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 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 proxy statement are based on information available to us on the date hereof. Except as may be otherwise required by law, we undertake no obligation to update or revise the forward-looking statements included in this proxy statement, whether as a result of new information, future events, or otherwise, after the date hereof. 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 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 SEC, including our annual report on Form 10-K, 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.

Appendix A - Reconciliation of Non-GAAP Measures

This proxy statement includes certain non-GAAP financial measures 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 and discussion below provide reconciliations of non-GAAP items.

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

	Year Ended December 31,				
	2025	**2024**	**2023**	**2022**	**2021**
GAAP net earnings (loss) attributable to Centene	$(6,674)	$ 3,305	$ 2,702	$ 1,202	$ 1,347
Amortization of acquired intangible assets	685	692	718	817	770
Acquisition and divestiture related expenses	4	82	70	213	185
Other adjustments[1]	7,328	(117)	464	1,540	1,275
Income tax effects of adjustments[2]	(315)	(209)	(308)	(410)	(537)
Adjusted net earnings	**$ 1,028**	**$ 3,753**	**$ 3,646**	**$ 3,362**	**$ 3,040**

	Year Ended December 31,				
	2025	**2024**	**2023**	**2022**	**2021**
GAAP net earnings (loss) before income tax	$(6,728)			$ 1,962	
Amortization of acquired intangible assets	685			817	
Acquisition and divestiture related expenses	4			213	
Other adjustments[1]	7,328			1,540	
Removal of entities divested subsequent to base year	—			(251)	
Adjusted pre-tax net earnings	**$ 1,289**			**$ 4,281**	

	Year Ended December 31,				
	2025	2024	2023	2022	2021
GAAP diluted earnings (loss) per share attributable to Centene	$(13.53)	$ 6.31	$ 4.95	$ 2.07	$ 2.28
Amortization of acquired intangible assets	1.39	1.32	1.32	1.40	1.31
Acquisition and divestiture related expenses	0.01	0.16	0.13	0.36	0.31
Other adjustments[1]	14.86	(0.22)	0.85	2.65	2.16
Income tax effects of adjustments[2]	(0.64)	(0.40)	(0.57)	(0.70)	(0.91)
Effect of basic to diluted shares[3]	(0.01)	—	—	—	—
Adjusted diluted EPS	**$ 2.08**	**$ 7.17**	**$ 6.68**	**$ 5.78**	**$ 5.15**

[1] Other adjustments include the following items:

2025 - 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 - 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 - Circle Health impairment of $292 million, or $0.53 per share ($0.47 after-tax), Operose Health Group 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).

2022 - real estate impairments of $1,642 million, or $2.82 per share ($2.08 after-tax), PANTHERx Rare (PANTHERx) divestiture gain of $490 million, or $0.84 per share ($0.65 after-tax), impairments of assets associated with the divestitures of our Spanish and Central European, Centurion and HealthSmart businesses of $458 million, or $0.78 per share ($0.60 after-tax), Magellan Rx divestiture gain of $269 million, or $0.46 per share ($0.17 after-tax), Health Net Federal Services asset impairment of $233 million, or $0.40 per share ($0.39 after-tax), gain on debt extinguishment of $27 million, or $0.04 per share ($0.03 after-tax), increase to the previously reported gain on the divestiture of U.S. Medical Management (USMM) due to the finalization of working capital adjustments of $13 million, or $0.02 per share ($0.02 after-tax), and costs related to the pharmacy benefits management (PBM) legal settlement of $6 million, or $0.01 per share ($0.00 after-tax).

2021 - PBM legal settlement expense of $1,264 million, or $2.14 per share ($1.76 after-tax), gain related to the acquisition of the remaining 60% interest of Circle Health of $309 million, or $0.52 per share ($0.52 after-tax), impairment of our equity method investment in RxAdvance of $229 million, or $0.39 per share ($0.32 after-tax), gain related to the divestiture of USMM of $150 million or $0.25 per share ($0.23 after-tax), debt extinguishment costs of $125 million, or $0.21 per share ($0.16 after-tax), reduction to the previously reported gain on divestiture of certain products of our Illinois health plan of $62 million, or $0.10 per share ($0.08 after-tax), and severance costs due to a restructuring of $54 million, or $0.09 per share ($0.06 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. The year ended December 31, 2022, includes tax expense of $107 million, or $0.18 per share, related to the Magellan Specialty Health divestiture and a $15 million, or $0.03 per share, tax benefit related to the RxAdvance impairment.

[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.

Reconciliation of GAAP net earnings (loss) to adjusted EBITDA ($ in millions):

	Year Ended December 31,	
	2025	2022
GAAP net earnings (loss) attributable to Centene	$(6,674)	$ 1,202
Income tax (benefit) expense	(51)	760
Interest expense	678	665
Depreciation	590	614
Amortization	685	913
Stock compensation expense	204	234
Other adjustments[1]	7,309	1,540
Adjusted EBITDA	**$ 2,741**	**$ 5,928**

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

[a] for the year ended December 31, 2025: goodwill impairment of $6,723 million, Magellan Health impairment of $513 million, intangible asset impairment related to the wind-down of certain contracts in the Other segment of $55 million, and a net loss on real estate transactions of $18 million.

[b] for the year ended December 31, 2022: real estate impairments of $1,642 million, PANTHERx divestiture gain of $490 million, impairments of assets associated with the divestitures of our Spanish and Central European, Centurion, and HealthSmart businesses of $458 million, Magellan Rx divestiture gain of $269 million, Health Net Federal Services asset impairment of $233 million, gain on debt extinguishment of $27 million, increase to the previously reported gain on the divestiture of USMM due to the finalization of working capital adjustments of $13 million and costs related to the PBM legal settlement of $6 million.

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)

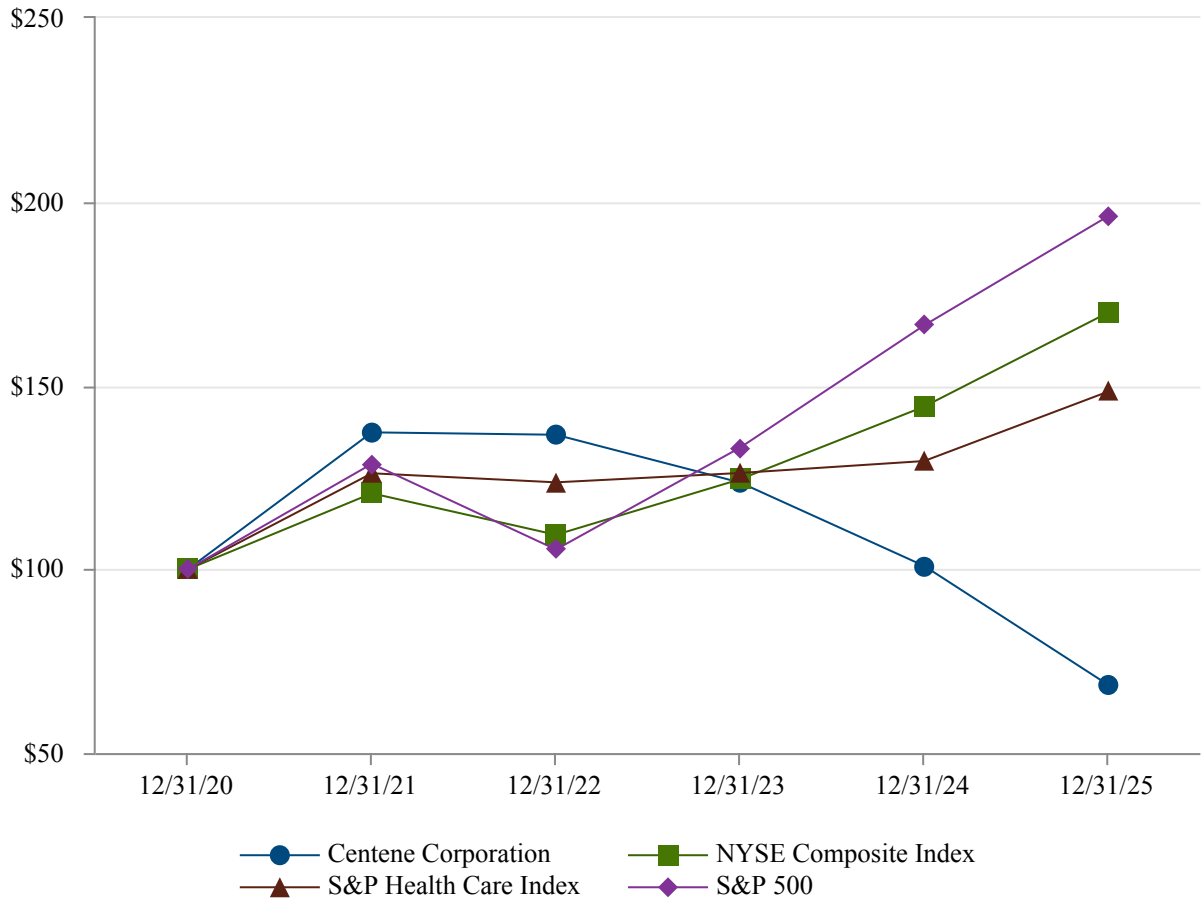
Execution Date	Total Number of Shares Purchased[1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs ($ in millions)[2]
October 1, 2025 - October 31, 2025	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	Non controlling 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.

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	Weighted Average Useful Life in Years 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 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)


CENTENE®
Corporation